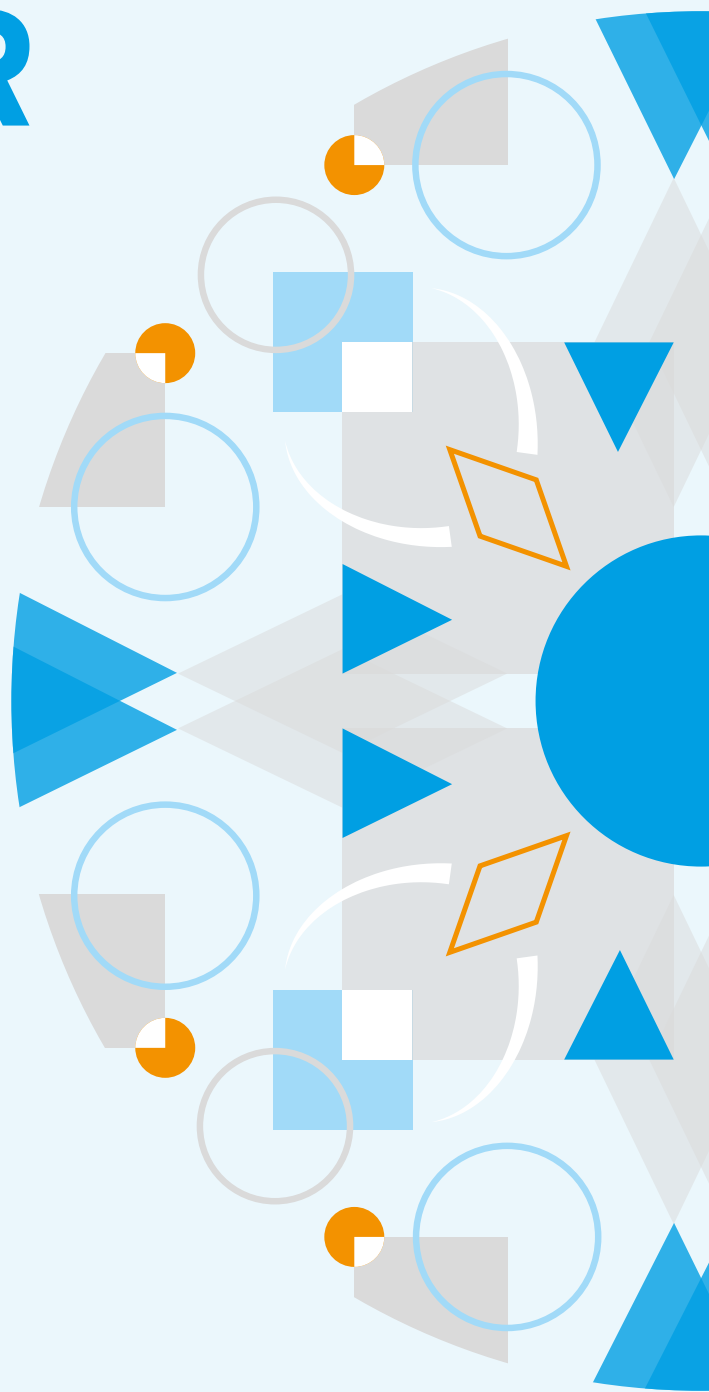


HEALTH CLUSTER GUIDE

A PRACTICAL
HANDBOOK



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A PRACTICAL HANDBOOK



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Contents

Chapter 1		
Humanitarian principles and international humanitarian coordination mechanisms		3
1.1 Introduction		3
1.2 Humanitarian principles		3
1.3 Key humanitarian issues		4
1.3.1	When to engage?	4
1.3.2	Humanitarian emergencies and public health events	5
1.3.3	Humanitarian coordination	5
1.4 Global Health Cluster		6
1.4.1	WHO responsibilities as Global Health Cluster lead agency	6
1.4.2	Global Health Cluster vision and mission	7
1.4.3	Guiding principles of the Global Health Cluster	7
1.5 Humanitarian reform, the Transformative Agenda and new ways of working		8
1.5.1	Humanitarian reform	8
1.5.2	Transformative Agenda	12
1.5.3	The “triple nexus” of humanitarian, development and peacebuilding actors	17
1.6 Centrality of protection in humanitarian action		18
1.6.1	What is protection mainstreaming?	18
1.6.2	Health: tips for protection mainstreaming	19
1.7 Protection from sexual exploitation and abuse		22
1.8 Accountability to affected populations		23
1.8.1	What is accountability to affected populations?	23
1.8.2	Incorporating accountability to affected populations into the health cluster response at country level	24
1.8.3	What is the link between accountability to affected populations and protection?	25
1.8.4	Mainstreaming a comprehensive people-centred approach in the health response	26
References		27
Endnotes		30
Boxes		
Box 1.1	Humanitarian Programme Cycle	12
Box 1.2	Gender-based violence	26
Figures		
Figure 1.1	The cluster approach: clusters and lead agencies	9
Figure 1.2	Humanitarian Programme Cycle in protracted emergencies	11
Tables		
Table 1.1	Humanitarian principles and their underlying concepts	3
Table 1.2	Criteria considered for initiating a scale-up activation	14

Chapter 2		
Establishing a health cluster at country level: functions, roles and responsibilities		36
2.1 Introduction		36
2.2 Humanitarian coordination architecture at country level		36
2.2.1 Humanitarian country team		36
2.2.2 Emergency coordination options		38
2.2.3 Emergency health coordination options		40
2.2.4 Health cluster activation		42
2.3 Purpose and functions of the country health cluster		45
2.3.1 Purpose of the health cluster		45
2.3.2 Core functions of the health cluster		45
2.3.3 Principles of partnership		49
2.4 Composition and structure of a health cluster		50
2.4.1 Composition of a health cluster		50
2.4.2 Structure of a country health cluster		50
2.4.3 Health cluster structure at subnational level		56
2.5 Sharing leadership and coordination responsibility in a formally activated health cluster		59
2.5.1 Sharing leadership and coordination responsibility with health authorities		59
2.5.2 Sharing leadership and coordination responsibility with NGOs		60
2.6 Inter-cluster coordination		63
2.6.1 Definition and purpose of inter-cluster coordination		63
2.6.2 Inter-cluster coordination group		64
2.6.3 Modalities for inter-cluster coordination		66
2.6.4 Thematic inter-cluster coordination of relevance to the health cluster		67
2.6.5 Promoting collaboration and coordination with key clusters		72
2.7 Working with other coordinating bodies		73
2.7.1 Principles of engagement with other bodies		73
2.7.2 Emergency medical teams		74
2.7.4 Global Outbreak Alert and Response Network		77
2.7.5 Cluster engagement and coordination with the military		78
2.8 Participation in the health cluster		79
2.8.1 Minimum commitments for participation in the health cluster		79
2.8.2 Respective roles, responsibilities and accountabilities		81
2.9 Cluster coordination performance monitoring and architecture review		86
2.9.1 Cluster coordination performance monitoring		86
2.9.2 Cluster coordination architecture review		87
2.10 Health cluster transition and deactivation		88
2.10.1 Definition and modalities of health cluster transition and deactivation		88
2.10.2 Timing of deactivation of a health cluster		88
2.10.3 Tips for smooth transition and deactivation of an activated health cluster		89
2.10.4 Systematic steps for transition and deactivation of a health cluster		90
References		92
Endnotes		94
Boxes		
Box 2.1	Principles of partnership established by Global Humanitarian Platform, 2007	49
Box 2.2	Representation at inter-cluster coordination group meetings	65
Box 2.3	Ukraine inter-cluster coordination group: TOR	65
Box 2.4	Minimum commitments for partner participation in clusters	80
Box 2.5	Provider of last resort	81
Figures		
Figure 2.1	Formally activated health cluster within wider humanitarian coordination architecture	44
Figure 2.2	Typical country health cluster structure	51
Tables		
Table 2.1	Humanitarian coordination in different settings	39
Table 2.2	Core functions of the country health cluster	45
Table 2.3	Purpose, roles, composition and leadership of strategic advisory group	53
Table 2.4	Thematic focus areas for inter-cluster coordination mechanisms	70

Chapter 3		
Building and maintaining an effective health cluster: key coordination skills		99
3.1 Introduction		99
3.2 Health cluster efficiency and effectiveness		99
3.2.1 Characteristics of a well-managed cluster		99
3.2.2 Factors in effective cluster operation		100
3.3 Key coordination skills		103
3.3.1 Leadership skills		103
3.3.2 Decision-making style		106
3.3.3 Communication skills		107
3.3.4 Relationship-building and engaging health authorities and health cluster partners		110
3.3.5 Building consensus and conflict resolution		116
3.3.6 Preparing for and managing effective health cluster coordination meetings		122
3.3.7 Common cluster coordination challenges and how to overcome them		128
References		132
Annex 3.1 Managing effective health cluster meetings		133
Endnotes		146
Boxes		
Box 3.1 Encouraging engagement of local partners and implementing agencies		116
Box 3.2 What makes a bad meeting?		124
Figures		
Figure 3.1 What makes clusters work?		101
Figure 3.2 Barriers to effective cluster coordination		102
Figure 3.3 Decision-making processes		106
Figure 3.4 Communication skills and techniques		108
Figure 3.5 Characteristics of successful meetings		122
Tables		
Table 3.1 Leadership styles		105
Table 3.2 Elements of the decision-making process		107
Table 3.3 Overcoming barriers or challenges to coordination		129
Chapter 4		
Information management to support the humanitarian health response		149
4.1 Overview of information management within the context of the health cluster		149
4.1.1 What is information management?		149
4.1.2 Why do we need health information?		150
4.1.3 Who is responsible for information management in emergencies?		150
4.1.4 Basic principles of health information management		151
4.1.5 Principles of humanitarian information management and exchange in emergencies		152
4.2 Key health information management services and outputs		154
4.2.1 Standards for PHIS in activated health clusters and other humanitarian coordination mechanisms		154
4.2.2 Domains of PHIS		155
4.2.3 Health status of and threats to affected populations		156
4.2.4 Availability of health resources and services		159
4.2.5 Health system performance		164
4.3 Roles and responsibilities in information management		168
4.3.1 Role of the health cluster coordinator		168
4.3.2 Role of the information management officer		169
4.3.3 Role of national authorities in information management		169
4.3.4 Role of the cluster lead agency in information management		170
4.3.5 Role of health cluster partners		170
4.3.6 Role of OCHA in information management		171
4.4 Conclusion		174
References		175
Endnotes		177

Chapter 5		
Promoting standards for a quality health response		182
5.1 Definition of quality of care		182
5.1.1	Quality of health care in humanitarian settings	183
5.1.2	Challenges to providing quality health care in humanitarian settings	185
5.2 Establishing quality of care processes		188
5.3 Ensuring standards and promoting best practices for a quality health response		191
5.3.1	What are standards and why are they needed?	191
5.3.2	Types of international and national standards	192
5.4 Setting standards		204
5.4.1	Identifying gaps in standards	204
5.4.2	Developing standards in different scenarios	204
5.4.3	Steps to be taken in developing standards	206
5.5 Building capacity to ensure standards and promote best practice		207
References		209
Endnotes		212
Boxes		
Box 5.1	Why is it necessary to promote standards?	192
Box 5.2	Sphere Protection Principles	195
Box 5.3	Health systems standards	198
Box 5.4	Essential health care standards	199
Figures		
Figure 5.1	Domains of quality of care	185
Figure 5.2	The eight elements of national quality policy and strategy (NQPS)	189
Figure 5.3	Successful interventions for quality improvement	190
Figure 5.4	CHS commitments	193
Tables		
Table 5.1	Examples of challenges to delivering quality of care in humanitarian settings	186
Table 5.2	Different scenarios relating to standards for health response in humanitarian settings	205
Table 5.3	Steps in developing standards and roles of key actors	206
Chapter 6		
Humanitarian–development nexus		216
6.1 Introduction: the humanitarian–development nexus and its links to peace		216
6.2 Implications of the humanitarian–development nexus for the health sector		219
6.2.1	Influencing collective outcomes	219
6.2.2	Interpreting collective outcomes in the health sector	219
6.2.3	Interpreting joint analysis for the health sector	220
6.2.4	Interpreting joint planning for the health sector	220
6.2.5	Interpreting the link with peacebuilding for the health sector	221
6.3 Typology of context		222
6.4 Health system strengthening, resilience and early recovery		224
6.5 Principles of early recovery		227
6.6 Implementing the humanitarian–development–peace nexus: entry points, health system bottlenecks and approaches		228
6.6.1	Health service delivery: packages and platforms	230
6.6.2	Human resources for health	231
6.6.3	Health information systems	232
6.6.4	Essential medical products and technologies	233
6.6.5	Health financing	234
6.6.6	Leadership and governance	236

6.7	Creating operational links with peacebuilding	238
6.7.1	Social cohesion and peacebuilding: promoting State–citizen and intercommunal cohesion through health	238
6.7.2	Social cohesion and peacebuilding: promoting trust	239
6.8	Initiating and operationalizing the humanitarian–development–peace nexus process	240
6.9	Localization	241
	References	243
Annex 6.1	Health system synergies between humanitarian, development and peacebuilding activities	245
	Endnotes	250
	Figures	
Figure 6.1	Different interventions at different stages of the conflict cycle	222
Figure 6.2	Typologies of response and engagement within the humanitarian–development–peace nexus	223
Figure 6.3	Interlinked elements contributing to universal health coverage and health system resilience	225
Figure 6.4	International approaches to conflict and transitional settings	226
	Chapter 7	
	Effective emergency health advocacy	253
7.1	Introduction	253
7.2	What is advocacy?	253
7.3	Humanitarian principles and the right to health as advocacy tools	254
7.4	Health cluster: complementarity between collective and agency advocacy	255
7.5	Steps for effective humanitarian health advocacy	256
Step 1.	Identify problems requiring advocacy	257
Step 2.	Identify advocacy goals and objectives	257
Step 3.	Identify targets, influencers and allies	258
Step 4.	Develop key messages	259
Step 5.	Select advocacy actions	260
Step 6.	Articulating an advocacy action plan	263
Step 7.	Carrying out monitoring and evaluation	263
7.6	Respective roles and responsibilities in relation to health advocacy in a humanitarian response	264
	References	267
	Endnotes	268
	Boxes	
Box 7.1	Potential unintended consequences of advocacy actions	260
Box 7.2	Attacks on health care: example of data-supported advocacy	261
	Figures	
Figure 7.1	Steps for effective advocacy	256
	Tables	
Table 7.1	Useful definitions: advocacy actors	259
Table 7.2	Suggested structure of core messages	260
Table 7.3	Advocacy objective and indicators	264

Chapter 8		
Integrated programming for better health outcomes: a multisectoral response		271
8.1 Rationale for integrated programming for better health outcomes		271
8.2 What is integrated programming for better health outcomes?		271
8.3 Applying a multisectoral approach for collective action and better health outcomes		277
8.3.1	Joint assessment and analysis of the situation	278
8.3.2	Planning a multi-cluster response	282
8.3.3	Incorporating advocacy as required	283
8.3.4	Resource mobilization	283
8.3.5	Implementation of a multisectoral integrated programme	284
8.3.6	Monitoring and evaluating a multisectoral response	285
8.4 Principles to enhance a multisectoral integrated response for improved outcomes		285
8.5 Health cluster coordination checklist to ensure a multisectoral, integrated response for collective action and better health outcomes		286
References		287
Endnotes		288
Boxes		
Box 8.1	Common features of humanitarian clusters	272
Box 8.2	Afghanistan and South Sudan: joint assessment and analysis	279
Box 8.3	Cox's Bazar, Bangladesh: joint analysis of gender-based violence services	282
Box 8.4	Joint operational framework for effective cholera preparedness and response	283
Box 8.5	Iraq: integrated programming to combat gender-based violence	284
Figures		
Figure 8.1	Integrated programming for better health outcomes	275
Figure 8.2	Afghanistan Humanitarian Response Plan, 2017: contributions of clusters to strategic objectives	277
Tables		
Table 8.1	Integration approaches: advantages and examples of activities	273
Chapter 9		
Health cluster in emergency preparedness		291
9.1 Role of health cluster in health emergency and disaster risk management		291
9.1.1	What is emergency preparedness and when does it happen?	291
9.1.2	Continuum of health emergency and disaster risk management measures	292
9.1.3	Why should the cluster be involved in emergency preparedness?	294
9.1.4	Role of the health cluster in emergency preparedness	295
9.2 Preparedness activities		300
9.2.1	Emergency Response Preparedness (ERP) and contingency planning	300
9.2.2	Role of the health cluster coordinator	300
9.2.3	Health cluster preparedness activities in support of national emergency preparedness	301
References		308
Resources		309
Figures		
Figure 9.1	Humanitarian Programme Cycle	293
Figure 9.2	Activities enhancing the level of emergency preparedness	298
Figure 9.3	Contingency planning: functions and objective	302

Chapter 10		314
Needs assessment		314
10.1 General overview		314
10.2 Purpose and definitions		314
10.2.1	Scope of needs assessment	315
10.2.2	Data collection methodologies	315
10.2.3	Secondary data	315
10.2.4	Primary data	317
10.2.5	Measurement levels	320
10.2.6	Sampling	320
10.3 Types of needs assessment		321
10.3.1	Coordinated assessments	323
10.3.2	Health-specific assessments	325
10.4 Roles and responsibilities		327
10.5 When to conduct a needs assessment		327
10.5.1	Humanitarian needs overview (HNO)	328
10.5.2	People in need	328
10.6 Steps for conducting a needs assessment		329
Step 1.	Plan and design	329
Step 2.	Implement	336
Step 3.	Clean and process data	338
Step 4.	Analyse	340
Step 5.	Share findings	342
10.7 Tools		344
10.7.1	Technology and needs assessment	344
10.7.2	Checklist to give affected communities a voice	347
10.7.3	Team checklist (composition, skills, equipment, training)	347
10.8 Basic principles for needs assessment		349
References		352
Endnotes		353
Boxes		
Box 10.1	Enumerator training for data collection	337
Figures		
Figure 10.1	Steps for conducting a needs assessment	329
Figure 10.2	Flowchart to determine most appropriate data collection methods	332
Figure 10.3	Assessment framework: example of information for inclusion	333
Figure 10.4	Assessment framework for question formulation and data collection	334
Figure 10.5	Analytical steps of needs assessment	341
Tables		
Table 10.1	Pre-crisis data and in-crisis data: examples	316
Table 10.2	Types of needs assessment: key features	322
Table 10.3	Roles and responsibilities for actors in a coordinated assessment	327
Table 10.4	Needs assessment: competencies checklist	348

Chapter 11		
Health cluster strategic response planning		358
11.1 Introduction		358
11.2 The importance of strategic response planning		358
11.3 Strategic response planning process		359
11.4 Development of a flash appeal and role of health cluster coordinator		361
11.4.1 Flash appeal: definition and purpose		361
11.4.2 Role of the health cluster coordinator in development of a flash appeal		362
11.4.3 Key actions of health cluster coordinator		362
11.5 What is a humanitarian response plan and when is one developed?		363
11.5.1 Country strategy: part 1 of the humanitarian response plan		365
11.5.2 Health cluster response plan: part 2 of the humanitarian response plan		367
11.6 Steps for developing the health cluster response plan		369
11.6.1 Ensuring a consultative process in developing a health cluster response plan		369
11.6.2 Ensuring inter-cluster coordination to support an effective multi-cluster approach for better health outcomes		371
11.6.3 Defining the health cluster response plan		371
11.6.4 Costing of the health cluster response		381
11.6.5 Drafting the health cluster response plan		382
11.7 Coordinated project development: projects for inclusion in the health cluster response plan		382
11.7.1 Tasks of health cluster coordinators		382
11.7.2 Tasks of health cluster partners		385
References		386
Endnotes		388
Boxes		
Box 11.1	Determining number of people in need across all sectors	366
Box 11.2	Comparison of country strategy and health cluster response plan	368
Box 11.3	Main features of the health cluster response plan	369
Box 11.4	OCHA humanitarian indicator registry	373
Box 11.5	Key definitions when determining humanitarian caseloads	374
Box 11.6	Considering environmental concerns	378
Box 11.7	Considering capacity-building issues	380
Box 11.8	Health cluster peer review of partner project proposals	384
Figures		
Figure 11.1	Strategic planning within the Humanitarian Programme Cycle	364
Tables		
Table 11.1	Steps in strategic response plan	360
Chapter 12		
Monitoring the health cluster/sector response		391
12.1 Introduction		391
12.2 What is humanitarian response monitoring and who is involved?		392
12.2.1 Definition, purpose and scope		392
12.2.2 Types of monitoring		393
12.2.3 Relationship between planning and monitoring		396
12.2.4 Humanitarian response monitoring framework		397
12.2.5 Roles and responsibilities		398
12.3 Developing response monitoring frameworks		400
12.3.1 Preparing a humanitarian response monitoring framework		400
12.3.2 Preparing a health cluster response monitoring framework		402
12.3.3 Applying the humanitarian and health response monitoring frameworks along the HRP cycle		407
12.3.4 Reporting: presenting monitoring information		408

References		411
Endnotes		412
Figures		
Figure 12.1	Relationship between planning and monitoring	397
Figure 12.2	Key steps: preparing the monitoring framework	400
Figure 12.3	Ukraine, 2016: example of country-level response monitoring framework	402
Figure 12.4	Example of a monitoring report schedule	402
Figure 12.5	Monitoring levels and examples	403
Figure 12.6	Ukraine, 2016: example of health cluster response monitoring framework	405
Figure 12.7	Key steps: applying the monitoring framework	407
Figure 12.8	South Sudan: example of Humanitarian Dashboard	409
Tables		
Table 12.1	Key monitoring questions for periodic review of the health response	406
Chapter 13		
Resource mobilization		415
13.1 Introduction: what is resource mobilization?		415
13.2 Humanitarian funding: the international landscape		415
13.3 Country-level health cluster resource mobilization		416
13.4 Multi-year planning and funding		417
13.5 Monitoring health cluster funding status and determining funding gaps		418
13.6 Engaging and talking to donors		419
13.7 Supporting national and local organizations to access humanitarian funding		422
13.8 Humanitarian pooled funding mechanisms		423
13.8.1	Central Emergency Response Fund (CERF)	423
13.8.2	Country-based pooled funds	428
13.9 Humanitarian funding within the wider context of development funding		434
13.9.1	Country-level humanitarian funding	434
13.9.2	Allocation of humanitarian funding for health within wider context of development funding	434
References		438
Endnotes		440
Boxes		
Box 13.1	Financial Tracking Service	418
Box 13.2	The Start Fund	423
Box 13.3	CERF objectives and funding criteria	424
Box 13.4	Impact of conflict on drug availability and subsequent need for humanitarian support for procurement of essential medicines in Syrian Arab Republic	435
Box 13.5	Examples of development programmes of importance to health cluster	435
Box 13.6	South Sudan: ensuring continuation of service provision despite shift in funding from humanitarian to developmental mechanisms	437
Figures		
Figure 13.1	Resource mobilization within the Humanitarian Programme Cycle	416
Figure 13.2	Steps in the process for CBPF standard and reserve allocations	432
Tables		
Table 13.1	Resource mobilization cycle	421

Purpose

This *Health cluster guide* advises 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.

It highlights key principles of humanitarian health action and how coordination and joint efforts among health and other sector actors working in partnership can increase the effectiveness and efficiency of health interventions and promote better health outcomes. It draws on Inter-Agency Standing Committee 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 groups that seek to achieve effective health action in countries where the cluster approach has not been formally adopted.

Throughout the *Health cluster guide*, the term “health cluster” may refer to “health cluster or sector coordination group”.

The guide should be useful in different humanitarian crisis contexts, including sudden onset and slow onset crises and protracted emergencies. It does not address all the specificities of the different contexts.

Structure



CHAPTER 1

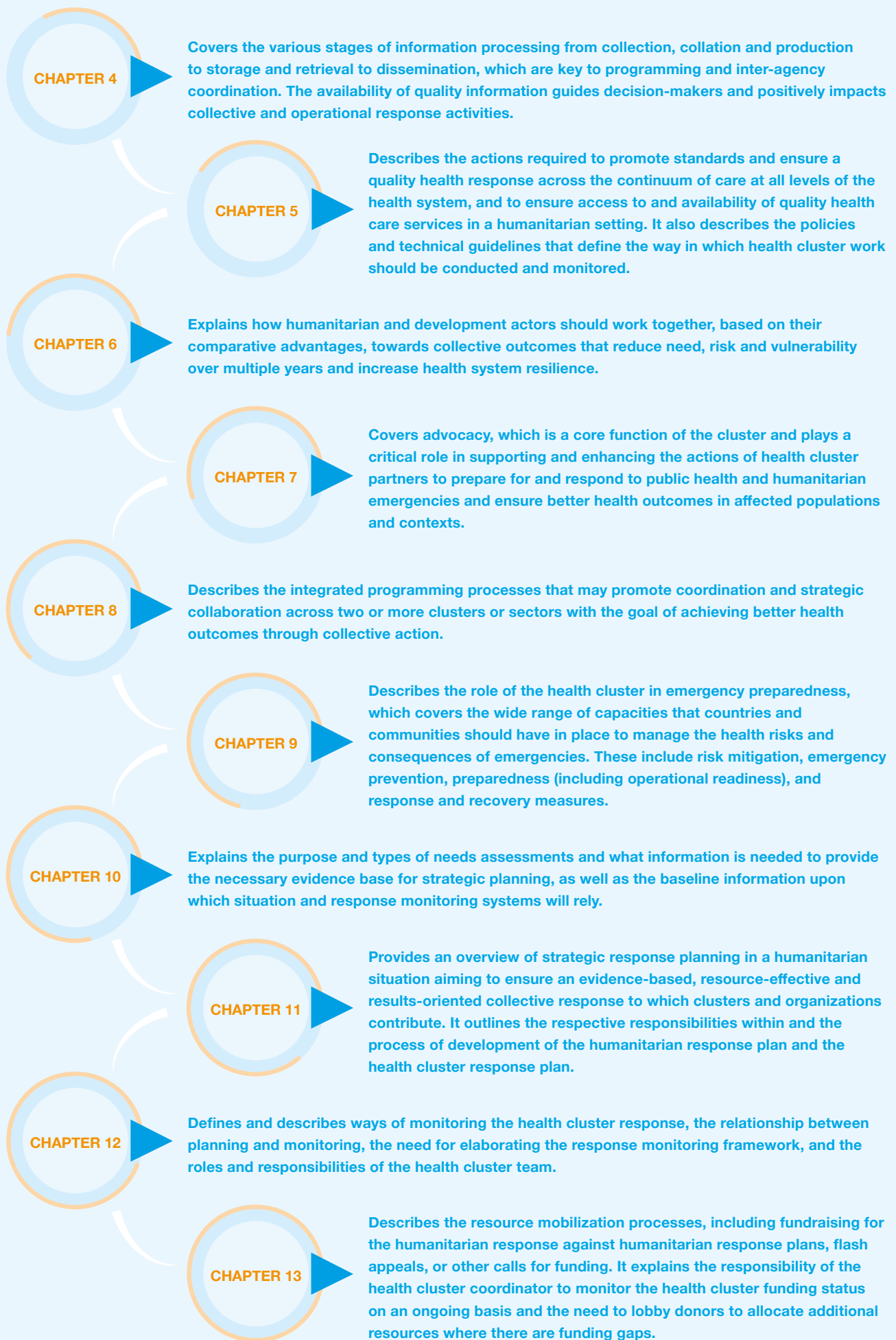
Explains the humanitarian coordination mechanism and principles and how humanitarian action has evolved in recent decades. It includes an overview of humanitarian principles and other key global initiatives that have helped shape humanitarian coordination.

CHAPTER 2

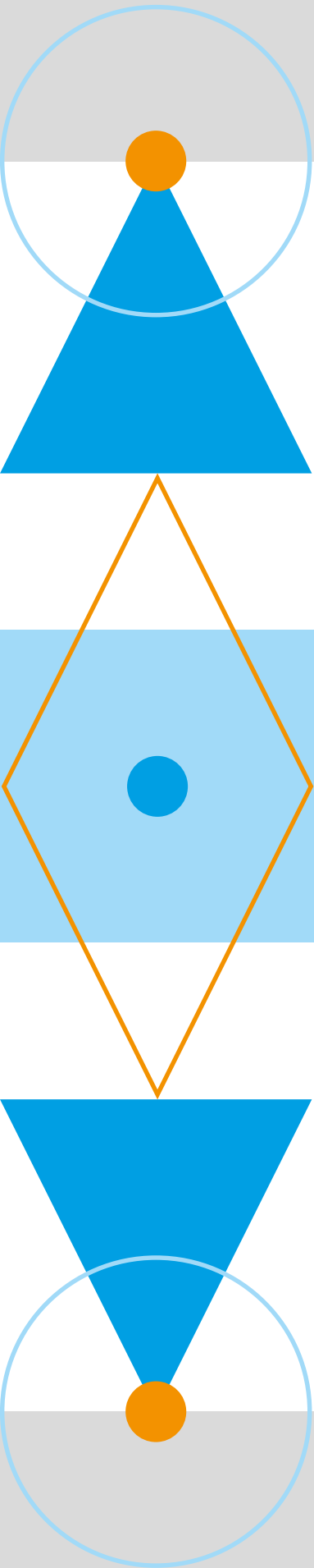
Outlines how to establish a health cluster at country level. It summarizes the broader humanitarian coordination architecture, the core functions of the health cluster, the process for activation and deactivation of the health cluster, and the structure and composition of the health cluster at national and subnational levels. The chapter also summarizes inter-cluster coordination and the respective roles and responsibilities of the World Health Organization as cluster lead agency, the health cluster coordination team and health cluster partners.

CHAPTER 3

Explains how to build and maintain an effective health cluster. It provides an overview of key skills required for effective health cluster coordination, along with good practice tips for a health cluster coordinator. The skills covered in this chapter include leadership and decision-making; communication and facilitation; relationship- and partnership-building, and engaging partners; consensus-building and conflict resolution; advocacy; and management of effective health cluster meetings.



Humanitarian principles and international humanitarian coordination mechanisms



01

Contents

Chapter 1		
Humanitarian principles and international humanitarian coordination mechanisms		3
1.1 Introduction		3
1.2 Humanitarian principles		3
1.3 Key humanitarian issues		4
1.3.1	When to engage?	4
1.3.2	Humanitarian emergencies and public health events	5
1.3.3	Humanitarian coordination	5
1.4 Global Health Cluster		6
1.4.1	WHO responsibilities as Global Health Cluster lead agency	6
1.4.2	Global Health Cluster vision and mission	7
1.4.3	Guiding principles of the Global Health Cluster	7
1.5 Humanitarian reform, the Transformative Agenda and new ways of working		8
1.5.1	Humanitarian reform	8
1.5.2	Transformative Agenda	12
1.5.3	The “triple nexus” of humanitarian, development and peacebuilding actors	17
1.6 Centrality of protection in humanitarian action		18
1.6.1	What is protection mainstreaming?	18
1.6.2	Health: tips for protection mainstreaming	19
1.7 Protection from sexual exploitation and abuse		22
1.8 Accountability to affected populations		23
1.8.1	What is accountability to affected populations?	23
1.8.2	Incorporating accountability to affected populations into the health cluster response at country level	24
1.8.3	What is the link between accountability to affected populations and protection?	25
1.8.4	Mainstreaming a comprehensive people-centred approach in the health response	26
References		27
Endnotes		30
Boxes		
Box 1.1	Humanitarian Programme Cycle	12
Box 1.2	Gender-based violence	26
Figures		
Figure 1.1	The cluster approach: clusters and lead agencies	9
Figure 1.2	Humanitarian Programme Cycle in protracted emergencies	11
Tables		
Table 1.1	Humanitarian principles and their underlying concepts	3
Table 1.2	Criteria considered for initiating a scale-up activation	14

Abbreviations

CHS	Core Humanitarian Standard on Quality and Accountability
FAO	Food and Agriculture Organization of the United Nations
IASC	Inter-Agency Standing Committee
IHR	International Health Regulations
NGO	nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OIE	World Organisation for Animal Health
SDG	Sustainable Development Goal
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

1. Humanitarian principles and international humanitarian coordination mechanisms

1.1 Introduction

This chapter provides a summary of how humanitarian action has evolved in recent decades. It includes an overview of humanitarian principles and other key global initiatives that have helped shape humanitarian coordination. For additional information, refer to the humanitarian response and Inter-Agency Standing Committee (IASC) websites.¹

1.2 Humanitarian principles

Four humanitarian principles – humanity, neutrality, impartiality and independence – provide the fundamental foundations for humanitarian action and are central to establishing and maintaining access to affected populations, whether in the context of a natural disaster, an armed conflict or a complex emergency. Table 1.1 presents the underlying concepts on which those principles are based.

► **Table 1.1** Humanitarian principles and their underlying concepts

PRINCIPLE	CONCEPTS
Humanity	Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.
Neutrality	Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.
Impartiality	Humanitarian action must be carried out based on need alone, giving priority to the most urgent cases of distress and making no distinctions based on nationality, race, gender, religious belief, class or political opinion.
Independence	Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold about areas where humanitarian action is being implemented.

Note: The first three humanitarian principles were endorsed in United Nations General Assembly resolution 46/182 of 1991, known as the “humanitarian response resolution”. The fourth principle (independence) was endorsed in 2004 under resolution 58/114.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph ● 1.1 ● 1.2 ● 1.3 ● 1.4 ● 1.5 ● 1.6 ● 1.7 ● 1.8

Box ● 1.1 ● 1.2 Figure ● 1.1 ● 1.2 Table ● 1.1 ● 1.2

- Contents
- References
- Endnotes

Promoting compliance with humanitarian principles in humanitarian response is an essential element of effective humanitarian coordination. United Nations agencies are mandated to embrace all four of these principles. Commitment to the four humanitarian principles is expressed at institutional level by the majority of international humanitarian organizations. Furthermore, globally over 450 organizations are signatory to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief, which includes a commitment to adhere to these humanitarian principles (1).²

1.3 Key humanitarian issues

1.3.1 When to engage?

International humanitarian law in all types of armed conflict – whether international or non-international – imposes obligations on the warring parties to use their best efforts to collect and care for the wounded and sick (2, 3).³ This means either that the parties to armed conflicts perform these medical activities themselves, traditionally through their military medical corps, or, where they are unable or unwilling to do so, that they permit others, such as the local civilian administration or impartial humanitarian organizations, to assist them. In practice, the civilian administration is often unable to provide assistance in conflict settings, leaving victims – especially civilians – without access to adequate care. As a result, the World Health Organization (WHO) and humanitarian actors increasingly find themselves in a situation where, despite multiple reminders to the parties to the conflict, victims are deprived of the health care they need.

When the warring parties and civil administration cannot carry out this role, the Global Health Cluster should look to other partners to see if they are able to engage as a first step. If that is not possible, WHO can then invoke its “provider of last resort” obligations as the lead agency of the IASC Global Health Cluster to ensure that victims of the conflict can access lifesaving trauma care. WHO has developed operational guidance on the provision of trauma care in a conflict situation.⁴

- When necessary services are not provided in a situation where the IASC cluster system is activated, it falls upon the Global Health Cluster lead agency – WHO for the health sector – to serve as the provider of last resort. This means that “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” (4).



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8					
Box	●	●											
	1.1	1.2											
Figure	●	●											
	1.1	1.2											
Table	●	●											
	1.1	1.2											

- [Contents](#)
- [References](#)
- [Endnotes](#)

- In all other situations Article 2(d) of the WHO Constitution applies, under which WHO contributes to its objective of attainment by all peoples of the highest possible level of health by furnishing “appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments” (5).

1.3.2 Humanitarian emergencies and public health events

A **humanitarian emergency** is defined as a situation impacting the lives and well-being of a large number of people or a significant percentage of a population, and requiring substantial multisectoral assistance (6, 7).

A **public health event** is defined as any event that may have negative consequences for human health. The term includes events that have not yet led to disease in humans but have the potential to cause human disease through exposure to infected or contaminated food, water, animals, manufactured products or environments (6).

Humanitarian emergencies take many forms. They may result from natural disasters, such as flooding or earthquakes, or they may be due to conflict. They may occur very quickly (acute onset) or may evolve slowly over time (slow onset).

Humanitarian emergencies will also differ in duration; they may be limited to a finite time or continue over many years (continuing or protracted emergency). Countries may experience repeated emergencies or face combinations of different types of emergencies, for example, an acute onset emergency in a country that is already undergoing a protracted crisis.

1.3.3 Humanitarian coordination

“Humanitarian coordination involves bringing humanitarian actors together to ensure a coherent and principled response to emergencies” (8).

Humanitarian coordination underpins an effective humanitarian response. It serves to identify and meet priority needs, address gaps and reduce duplication in humanitarian response. It facilitates the development of a humanitarian strategy and ensures that assistance is delivered in a cohesive, principled and effective manner, following international standards and in line with the direction and objectives of the humanitarian strategy. Humanitarian coordination also facilitates monitoring the response, with an emphasis on ensuring adherence to humanitarian and technical quality standards.

Humanitarian coordination is not just about coordination of the emergency response. There are critical actions to be conducted prior to the onset of an



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8						
Box	●	●												
	1.1	1.2												
Figure	●	●												
	1.1	1.2												
Table	●	●												
	1.1	1.2												

- [Contents](#)
- [References](#)
- [Endnotes](#)

emergency in relation to disaster risk reduction, emergency preparedness and contingency planning, capacity-building, and information management. There are also critical activities to be conducted during the emergency response to ensure that structures, standards and capacities are in place to enable a sustainable transition to a post-emergency phase, as and when appropriate, in relation to continuation of residual humanitarian services and activities.

1.4 Global Health Cluster

The Global Health Cluster was established in 2005 under the leadership of WHO to promote and support collective action at global and country levels to ensure more effective, efficient and predictable humanitarian health action.

Whilst significant improvements were made following the establishment of the Global Health Cluster, nevertheless, in recognition of the need for strengthening the global capacity for humanitarian health action, the World Health Assembly, through resolution WHA65.20 of 2012, called on the WHO Director-General to (a) have in place the organizational capacity and resources to enable itself to discharge its function as the Global Health Cluster lead agency and assume a role as health cluster lead agency in the field; and (b) define the core commitment, core functions and performance standards of the Organization in humanitarian emergencies, including its role as the Global Health Cluster lead agency and as health cluster lead agency in the field.

The Emergency Response Framework (2013), developed by the WHO Global Emergency Management Team, explicitly mentions the Global Health Cluster as the mechanism to achieve the coordination function of WHO in emergencies.⁵

1.4.1 WHO responsibilities as Global Health Cluster lead agency

WHO is ultimately responsible to the Emergency Relief Coordinator for ensuring the fulfilment of its lead agency role in the Global Health Cluster. At global level these responsibilities include:⁶

- mainstreaming the cluster approach and the Transformative Agenda within WHO and promoting their understanding within WHO departments and offices at global, regional and country levels;
- negotiating with other United Nations agencies around cluster issues that need to be reflected in global-level documentation;



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8						
Box	●	●												
	1.1	1.2												
Figure	●	●												
	1.1	1.2												
Table	●	●												
	1.1	1.2												

- [Contents](#)
- [References](#)
- [Endnotes](#)

- engaging in advocacy at the highest levels of the IASC (including the Emergency Directors Group), and with donors and other concerned bodies, on the needs and position of the Global Health Cluster;
- ensuring that adequate human and financial resources and administrative structures are availed at global, regional and country levels;
- liaison and collaboration with other global clusters to enhance holistic multi-cluster humanitarian responses for improved health outcomes and improved health.⁷

1.4.2 Global Health Cluster vision and mission

The *vision* of the Global Health Cluster is to save lives and promote dignity in humanitarian and public health emergencies.

The *mission* of the Global Health Cluster is to collectively prepare for and respond to humanitarian and public health emergencies to improve the health outcomes of affected populations through timely, predictable, appropriate and effective coordinated health action.

1.4.3 Guiding principles of the Global Health Cluster

As a multi-agency platform, the overall approach and work of the Global Health Cluster is underpinned by five guiding principles.

- **Commitment and voluntary cooperation.** Effective coordination can only be voluntary, based on each partner’s willingness to join others in agreeing on priorities and overall response strategies and to adjust its actions to the particular humanitarian context as well as to other partners’ capacities. The cluster approach demands commitment and an openness to collaborate and adapt on the part of all agencies and individuals concerned.
- **Partnership.** Collaborative and complementary partnerships at all levels, based on transparency, mutual understanding and the tapping of comparative advantages and competencies, are essential to improving humanitarian action.
- **Community participation and accountability to affected populations.** Community-based programming is essential to successful cluster implementation and humanitarian health action. Affected populations must be involved in the actions of the country cluster, and the health cluster will actively seek ways to be accountable to the affected population.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8							
Box	●	●													
	1.1	1.2													
Figure	●	●													
	1.1	1.2													
Table	●	●													
	1.1	1.2													

- [Contents](#)
- [References](#)
- [Endnotes](#)

- **Support for national authorities' coordination efforts and priorities.** Clusters should support and complement existing national coordination mechanisms for response, preparedness and recovery. Where appropriate, national health counterparts should be actively encouraged to co-chair cluster meetings from an early stage.
- **Adherence to humanitarian principles and the right to health.** Health interventions will be based on humanitarian principles and on human rights, which state that humanitarian interventions should be provided based on needs alone, should be accessible without discrimination, and should be affordable for all. Universal access to primary health care is a fundamental element of any humanitarian health response for populations affected by crises.

1.5 Humanitarian reform, the Transformative Agenda and new ways of working

1.5.1 Humanitarian reform

In early 2004, responding to what was perceived as a lack of an appropriate and coordinated humanitarian response to the crisis in Darfur, Sudan, the United Nations Emergency Relief Coordinator commissioned a humanitarian response review. Recommendations from the review formed the basis for a major reform of humanitarian coordination, known as the Humanitarian Reform Agenda (2005), which aimed to improve the effectiveness of humanitarian response through greater predictability, accountability and partnership (9).⁸ The key elements were:

- the cluster approach
- a strengthened humanitarian coordination system
- more timely, flexible and effective humanitarian financing
- strong partnership as an enabling element.

The cluster approach

Implementation of the cluster approach is the most visible aspect of the 2005 Humanitarian Reform Agenda. Eleven clusters were established at global level and lead agencies were identified for each cluster (Figure 1.1).

The cluster approach was adopted by the IASC 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 did not go unaddressed.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2						
Figure	1.1	1.2						
Table	1.1	1.2						

- Contents
- References
- Endnotes

Figure 1.1 The cluster approach: clusters and lead agencies



IOM: International Organization for Migration; IFRC: International Federation of Red Cross and Red Crescent Societies; UNDP: United Nations Development Programme; UNHCR: UN Refugee Agency; WFP: World Food Programme.
Source: United Nations Office for the Coordination of Humanitarian Affairs (OCHA), humanitarian response (9).



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph 1.1 1.2 1.3 1.4 **1.5** 1.6 1.7 1.8
 Box 1.1 1.2 Figure 1.1 1.2 Table 1.1 1.2

- Contents
- References
- Endnotes

Cluster characteristics

IASC clusters are groups of humanitarian organizations, both inside and outside the United Nations system, in each of the main sectors of humanitarian action, including health, water and logistics. The clusters are formally designated by the IASC and have clear responsibilities for coordination. Clusters are created when existing coordination mechanisms are overwhelmed or constrained in their ability to respond to identified needs in line with humanitarian principles.

The cluster approach is not the only humanitarian coordination solution. In some cases, it may coexist with other forms of national or international coordination, and its application must take into account the specific needs of a country and the context.

Principles of partnership

Humanitarian reform is supported by a foundation of and commitment to strong and consistent partnership between United Nations and non-United Nations actors. The concept of partnership is based on the five principles of partnership developed by the Global Humanitarian Platform (10):⁹ equality, transparency, results-oriented approach, responsibility and complementarity.¹⁰

Humanitarian Programme Cycle

The Humanitarian Programme Cycle is the collective response framework activated in all countries and response contexts with activated clusters and humanitarian country teams (Figure 1.2 and Box 1.1). The Humanitarian Programme Cycle consists of the humanitarian needs overview and humanitarian response plan, which both serve as a platform for all humanitarian responders to strategically work together to achieve better collective results for affected people. Starting from the 2020 humanitarian needs overview and humanitarian response plan season (commencing in mid-2019), the goals of the Humanitarian Programme Cycle are to deliver a more evidence-based, cross-sectoral humanitarian response that:

- is based on coordinated needs assessments and analyses of risk;
- facilitates more accurate prioritization of the needs of affected populations (in line with the principle of accountability to affected populations);
- is delivered as locally as possible by national and local actors in line with the Grand Bargain, which the international community has committed to in order to better serve people in need (11).¹¹



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2						
Figure	1.1	1.2						
Table	1.1	1.2						

● Contents
● References
● Endnotes

● Box 1.1 Humanitarian Programme Cycle

The Humanitarian Programme Cycle is a coordinated series of actions undertaken to help prepare for, manage and deliver the humanitarian response.¹² It consists of five elements coordinated in a seamless manner, with one step logically building on the previous and leading to the next. The Humanitarian Programme Cycle elements are as follows:

- needs assessment and analysis
- strategic response planning
- resource mobilization
- implementation and monitoring
- operational review and evaluation.

The Humanitarian Programme Cycle normally begins in March with the initial data collection by humanitarian country team members and concludes in October/November with the finalization and implementation of the humanitarian response plan. Coordination and information management are key enablers throughout the entire process.

1.5.2 Transformative Agenda

Despite progress following the humanitarian reform in 2005, the humanitarian response to the Haiti earthquake and Pakistan floods in 2010 exposed the continuing weaknesses and inefficiencies in the international humanitarian response system. The IASC Principals therefore further reviewed the international humanitarian response system with the aim of adjusting and further improving humanitarian responses. The outcome of this process was the Transformative Agenda, which calls for a more effective response, recognizing that achieving this aim requires strengthened action and a change of attitudes in three key areas: leadership, coordination and accountability, known as the three pillars of the Transformative Agenda (13).

Underpinning these three pillars is the concept of shifting from “individual accountabilities to collective response”. This can also be expressed as stronger partnerships,¹³ working together better, and enhanced working relationships for a collective response. The Transformative Agenda recognizes that successful humanitarian action is dependent on this collective response. The following provides an overview of the key messages of the Transformative Agenda regarding each of the pillars.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2						
Figure	1.1	1.2						
Table	1.1	1.2						

● Contents
● References
● Endnotes

Ten protocols¹⁴ were developed to provide guidance on the agreed mechanisms and processes required for an improved coordinated response under the Transformative Agenda (14). Whilst the impetus for the Transformative Agenda was to improve the humanitarian response in large-scale, sudden onset emergencies, most of its protocols, including the spirit of working better together for a more effective response, are applicable to all humanitarian operations (15).¹⁵

In 2018, the IASC established three protocols related to the classification and management of large-scale humanitarian operations (16): Protocol 1, on definition and procedures for a humanitarian system-wide scale-up activation; Protocol 2, on “empowered leadership” in a humanitarian system-wide scale-up activation; and the Protocol for the Control of Infectious Disease Events (17–19).

IASC Protocol 1. Humanitarian system-wide scale-up activation: definition and procedures

The IASC humanitarian system-wide scale-up activation replaces the 13 April 2012 Transformative Agenda Level 3 definition and procedures. The scale-up activation is a system-wide mobilization in response to a sudden onset or rapidly deteriorating humanitarian situation in a given country, including at the subnational level, where capacity to lead, coordinate and deliver humanitarian assistance does not match the scale, complexity and urgency of the crisis. It can only be applied for a time-limited period of six months, unless one additional three-month extension is warranted. It is a short-term injection of additional capacity to meet urgent humanitarian needs.

Transition away from a scale-up activation to a less urgent degree of response activation does not necessarily mean a crisis is over, rather that the response is deemed sufficiently comprehensive to deliver results in a sudden onset crisis or significant deterioration in a humanitarian situation. If there are factors affecting the response that the scale-up activation cannot address, transition from scale-up may occur.

A scale-up activation may be initiated in any type of humanitarian emergency when the Emergency Relief Coordinator and the IASC Principals determine that the capacity to lead, coordinate and deliver humanitarian assistance and protection on the ground does not match the scale, complexity and urgency of the crisis. The decision will be based on an analysis of five key criteria: scale, complexity, urgency, capacity, and risk of failure to deliver effectively and at scale to affected populations, in relation to assessed needs and severity. Table 1.2 shows the main elements considered under each of these criteria.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph ● 1.1 ● 1.2 ● 1.3 ● 1.4 ● 1.5 ● 1.6 ● 1.7 ● 1.8

Box ● 1.1 ● 1.2 **Figure** ● 1.1 ● 1.2 **Table** ● 1.1 ● 1.2

- [Contents](#)
- [References](#)
- [Endnotes](#)

► **Table 1.2** Criteria considered for initiating a scale-up activation

CRITERION	ELEMENTS
Scale	<ul style="list-style-type: none"> • Number of affected or potentially affected populations, including in proportion to total country population • Size of affected areas
Complexity	<ul style="list-style-type: none"> • Multilayered emergency • Presence of a multitude of actors • High risk of politicization • Lack of humanitarian access • High security risks to humanitarian actors
Urgency	<ul style="list-style-type: none"> • Number of people displaced • Crude mortality rates • Minimal or no access to lifesaving support • Critical protection risks
Capacity	<ul style="list-style-type: none"> • Low levels of local or international response capacities, including lack of required specialized or technical expertise • Needs outweigh the capacity to respond • Inadequate humanitarian leadership
Risk of failure to deliver effectively and at scale to affected populations	<ul style="list-style-type: none"> • Violations of human rights and international humanitarian law • Exacerbation of food insecurity • Deterioration of civil unrest

Details regarding the division of responsibilities, the activation and deactivation procedure, and steps for decision-making and monitoring are presented in the protocol.

National authorities must always be informed of a scale-up activation. The scale-up activation is not contingent on an assessment of national capacity, nor is it a measure of the severity of the crisis, so it should not result in an exacerbation of any inequities in funding between crises.

A scale-up activation triggers the following to be completed within 72 hours:

- establishment of the humanitarian country team;
- deployment of coordination capacity, including a humanitarian coordinator, qualified cluster coordinators and information managers;
- activation of priority sector clusters;
- issuance of a statement of key strategic priorities by the resident coordinator or humanitarian coordinator;



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph ● 1.1 ● 1.2 ● 1.3 ● 1.4 ● 1.5 ● 1.6 ● 1.7 ● 1.8

Box ● 1.1 ● 1.2 **Figure** ● 1.1 ● 1.2 **Table** ● 1.1 ● 1.2

- [Contents](#)
- [References](#)
- [Endnotes](#)

- announcement of funding from the Central Emergency Response Fund (and country-based pooled fund if available), with allocations issued by the Emergency Relief Coordinator (or humanitarian coordinator for pooled funds), supporting the priorities in the strategic statement.

The head of the WHO country office will undertake certain responsibilities in the scale-up process, as defined and agreed.

Within a short period, there should be:

- a situation analysis from a rapid assessment, followed by a multisectoral assessment and report (within the first two weeks);
- a flash appeal (by day 5);
- activation of the “empowered leadership” model, as set out in the IASC concept paper;
- an operational peer review (no more than five months later);
- an inter-agency humanitarian evaluation (within 9–12 months).

IASC Protocol 2. “Empowered leadership” in a humanitarian system-wide scale-up activation

During a humanitarian crisis, it is possible that the roles and responsibilities of the humanitarian coordinator could be revised for an initial limited period of six months. These revised roles and responsibilities are outlined in the protocol on empowered leadership. They apply only for the period of scale-up activation and so may only be extended if the scale-up activation is extended.

The humanitarian coordinator is empowered to be the primary responsible agent for setting priorities, ensuring effective planning, taking the lead in cluster coordination, ensuring advocacy, and establishing and maintaining relationships with national authorities and donors. The humanitarian coordinator also has responsibility for monitoring and assessing the response and establishing mechanisms for monitoring and accountability.

Key aspects of these revised roles and responsibilities include the following.

- If a situation arises where it becomes urgent to have a decision by the humanitarian country team regarding essential actions required for affected communities, the humanitarian coordinator is authorized to make relevant decisions if no consensus can be achieved in a timely and expedient manner.
- To ensure effective analysis of a situation and priority needs and appropriate coordination by the humanitarian country team, the humanitarian coordinator



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8						
Box	●	●												
	1.1	1.2												
Figure	●	●												
	1.1	1.2												
Table	●	●												
	1.1	1.2												

- [Contents](#)
- [References](#)
- [Endnotes](#)

must have access to and be able to share all information regarding needs and necessary responses.

The humanitarian coordinator will be responsible for establishing agreements with humanitarian country team members as a basis for accountability in measuring agreed results and performances during the response period. The humanitarian coordinator works with the humanitarian country team to ensure accountability to affected populations.

Humanitarian system-wide scale-up activation: Protocol for the Control of Infectious Disease Events

Under the International Health Regulations (IHR) (2005), WHO assesses the risks associated with infectious disease events on an ongoing basis, consulting as necessary with the relevant governments, country offices, United Nations Children’s Fund (UNICEF), the Global Outbreak Alert and Response Network and partner agencies, including the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE). The WHO Director-General informs the United Nations Secretary-General and the Emergency Relief Coordinator of all public health events assessed as high or very high risk at regional or global levels, or when WHO declares an internal Grade 3 emergency (20).¹⁶

As stated in the Protocol for the Control of Infectious Disease Events (19):

The designation of a Scale-Up response to an infectious disease event will be issued by the Emergency Relief Coordinator (ERC), in close collaboration with the Director-General of WHO, and in consultation with IASC Principals and, potentially, Principals of other relevant entities. For infectious disease events, the designation of a Scale-Up activation should be based on both an analysis of the IASC’s five criteria [scale, urgency, complexity, capacity and risk of failure to deliver effectively and at scale to affected population] adapted to meet International Health Regulations (2005) (IHR) criteria ... and WHO’s formal risk assessment of the event.

Once a public health event is detected and WHO has verified it, WHO may decide to undertake a rapid risk assessment. The WHO formal rapid risk assessment is an internal document that will:

- impartially and independently assess the risk posed by an infectious disease event;
- provide transparency and reproducibility regarding the WHO decision-making process, through application of a standardized methodology and reporting template;
- document and summarize all relevant public health, operational and contextual information on the event;
- inform and support WHO, United Nations, and IASC decision-making on how to respond to the public health event.

When WHO indicates the need to discuss IASC scale-up activation, within 24 hours of having informed the United Nations Secretary-General about the event, WHO will provide to the United Nations Secretary-General and to the Emergency Relief Coordinator a draft statement of public health strategic priorities, proposed response structure, and the major activities required to control the infectious event.

The Emergency Relief Coordinator will make a final decision on the system-wide scale-up activation based on the recommendations of the Director-General of WHO and the IASC Emergency Directors Group, in consultation with the IASC Principals, and invited Principals of relevant non-IASC entities.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2	Figure	1.1	1.2	Table	1.1	1.2

- Contents
- References
- Endnotes

The initial duration of the scale-up activation will be defined by the Principals during their first meeting but should not exceed six months. That could be exceptionally extended by three additional months, as the primary purpose is to support the surge necessary for an effective response.

The activation commits IASC member organizations to ensure that they put in place the most appropriate systems and dedicate the required capacities and resources in a timely manner to contribute to the effectiveness of the response as per their mandated areas, cluster lead agency responsibilities, and commitments made in the statement of key strategic priorities.¹⁷

During the period of assessment and decision-making by the IASC Principals regarding scale-up activation, the response at country level is already under way.

1.5.3 The “triple nexus” of humanitarian, development and peacebuilding actors

Against the backdrop of the Sustainable Development Goals (SDGs) – with the promise of leaving no one behind – reducing risks and vulnerabilities for all people is now a shared commitment within the United Nations and the IASC (21).¹⁸

Reducing the impact of protracted crises on affected populations requires both meeting immediate needs and investing in the medium to long term to reduce chronic vulnerabilities and risks affecting communities. It requires boosting resilience and building self-reliance by strengthening formal and informal institutions and the capacities of communities, improving livelihoods, and increasing access to services that can enhance people’s ability to cope with current disasters and withstand future crises, while addressing the root causes of crises and vulnerabilities. In practice, this requires providing short-, medium- and longer-term assistance concurrently to vulnerable people, while prioritizing “reaching those furthest behind first”.

The notions of “collective outcomes” and a “whole-of-society” approach have emerged as elements of a strategic pathway to cut across traditional sectors and intervention time frames. Collective outcomes can capitalize on the comparative advantages and mandates of individual agencies. This entails defining a collective vision based on a joint analysis of context and risks, and setting out clear strategies, roles and responsibilities for relevant actors to deliver those outcomes. A collective outcome consists of an objective that envisions a sustained positive change, for example through reduction of vulnerability and risk. In most cases achievement of this sort of objective will require multi-year action and include the following components.

- Action must be needs based and target those furthest behind.
- It must also be quantifiable, with clear lines of accountability.
- Involvement must “do no harm” and be consistent with the norms of accountability to affected populations.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8					
Box	●	●	Figure	●	●	Table	●	●					
	1.1	1.2		1.1	1.2		1.1	1.2					

- Contents
- References
- Endnotes

- Civil society and local communities should be involved in planning and implementation.
- Action should take into account comparative advantage, including that of local actors.

This approach acknowledges that in protracted situations humanitarian, development and peacebuilding actors need to work together and collaborate. Context-specific analysis will need to take place to underpin the development of such collective outcomes and implement activities in the context of the “triple nexus”. The IASC and the United Nations system established a process flow¹⁹ to facilitate the definition of engagement opportunities by humanitarian actors in that process, and guidance will be produced early in 2020 to support country teams in the definition and implementation of collective outcomes. It is highly recommended that health clusters actively engage at country level in the definition and implementation of collective outcomes. Health humanitarian interventions are directly lifesaving, and functioning health systems are an essential foundation for both development and peace. It is recommended that health clusters support the development of collective outcomes that clearly lead to identifiable and measurable progress in the most critical health issues affecting the country, and oppose convenient but vague formulations bringing together different sectors (for example, formulations such as “better access to [unspecified] essential services” are too vague and unspecific to be operationally useful).

1.6 Centrality of protection in humanitarian action

In December 2013, IASC Principals endorsed a statement on the centrality of protection in humanitarian action (22). This statement affirms the commitment of the IASC Principals to ensuring the centrality of protection in humanitarian action and the role of humanitarian coordinators, humanitarian country teams and clusters in implementing this commitment in all aspects of humanitarian action. This was reinforced by the IASC Policy on Protection in Humanitarian Action, 2016, which defines the centrality of protection in humanitarian action as well as the process for its implementation at country level (23).

1.6.1 What is protection mainstreaming?

Protection mainstreaming is the process of incorporating protection principles and promoting meaningful access, safety and dignity in humanitarian aid. The following elements must be considered in all humanitarian activities (24, 25).



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph ● 1.1 ● 1.2 ● 1.3 ● 1.4 ● 1.5 ● 1.6 ● 1.7 ● 1.8

Box ● 1.1 ● 1.2 **Figure** ● 1.1 ● 1.2 **Table** ● 1.1 ● 1.2

- [Contents](#)
- [References](#)
- [Endnotes](#)

- **Prioritize safety and dignity, and avoid causing harm:** prevent and minimize as much as possible any unintended negative effects of your intervention that can increase people’s vulnerability to both physical and psychosocial risks.
- **Meaningful access:** arrange for people’s access to assistance and services in proportion to need and without any barriers (such as discrimination). Pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services.
- **Accountability:** set up appropriate mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints.
- **Participation and empowerment:** support the development of self-protection and capacities and assist people to claim their rights, including the rights to shelter, food, water and sanitation, health, and education.

1.6.2 Health: tips for protection mainstreaming

1. Prioritize safety and dignity, and avoid doing harm

Prevent and minimize, to the extent possible, any unintended negative effects of an intervention that can increase people’s vulnerability to physical and psychosocial risks.

- ✓ Ensure that the location of health facilities and routes to them are away from actual or potential threats such as violence, especially the risk or threat of gender-based violence, and attacks from armed groups.
- ✓ Make infrastructure adaptations such as ramps and railings to health facilities and latrines so that all individuals and groups can access and use them in safety and with dignity. Use direct observation and discussion groups with persons with disabilities in the community to identify the type of adaptations that are needed. Health facilities need latrines. Design must preserve the safety and dignity of users.
- ✓ Ensure that the health services are respectful and inclusive of cultural and religious practice.
- ✓ Ensure that confidentiality and privacy is respected in any form of consultation, counselling or personal information sharing.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8					
Box	●	●	Figure	●	●	Table	●	●					
	1.1	1.2		1.1	1.2		1.1	1.2					

- [Contents](#)
- [References](#)
- [Endnotes](#)

- ✓ Do not share identifiable information unless consent has been given by the beneficiary (including names, addresses, or traits and characteristics that can lead to identification).
- ✓ If setting up health facilities for displaced communities, consult them as well as host communities about health needs so as to avoid community tensions. Make sure that there is no tension or inequality that could lead to violence and harassment of one group by another.
- ✓ Employ female health staff members with skills and experience of working with women and children.
- ✓ Put in place guidelines and mechanisms for monitoring and reporting instances of abuse and exploitation (26).

2. Meaningful access

Arrange for people's access to assistance and services, in proportion to need and without any barriers (such as discrimination). Pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services.

- ✓ Ensure that the health facilities are accessible to all.
- ✓ Ensure that services can be accessed by persons with reduced mobility (for example, persons with physical disabilities, the elderly, bedridden individuals).
- ✓ Ensure that services can be accessed by persons with non-mobility-related disabilities (such as those with sight, hearing or intellectual disabilities).
- ✓ Ensure that health staff are representative of gender and ethnic differences.
- ✓ Ensure that health staff know how to respond to the specific needs of victims of grave human rights violations, including rape and physical abuse.
- ✓ Ensure that beneficiaries know their right to health care, and where and how to obtain it.
- ✓ Monitor access and discrimination, and whether any services are being diverted.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2	Figure	1.1	1.2	Table	1.1	1.2

- Contents
- References
- Endnotes

- ✓ Identify what are the power dynamics within the intervention area. Who has access to health care?

3. Accountability, participation and empowerment

Set up appropriate mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints.

- ✓ Identify local authorities and civil society groups specialized in working with persons with low mobility or disabilities. Strengthen and support their roles, and learn from their experience on how to improve service delivery.
- ✓ Ensure that health staff and committees are representative of all layers of society (by gender, age, ethnicity, socioeconomic group or ability).
- ✓ Before leaving an area, make sure that responsible actors and systems for health care are in place.
- ✓ Report and share protection concerns with the protection cluster, including the gender-based violence and child protection subclusters. Other actors may be able to provide assistance.
- ✓ Make sure that all layers of society are consulted when identifying and responding to health needs.
- ✓ Ensure that health committees are representative of all layers of society and that all members are trained on protection mainstreaming principles.
- ✓ Find out what the coping strategies are. Where do people go when they get sick? What kind of treatments can they expect? Are they placing their safety and dignity at risk? Does one group have access over others? Are women allowed to access formal health care? Do they need to be accompanied by male members of their families? Risks must be recognized as soon as possible and interventions undertaken to help people avoid resorting to negative coping strategies.
- ✓ Set up accessible, well understood mechanisms for suggestions and complaints.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8				
Box	●	●	Figure	●	●	Table	●	●				
	1.1	1.2		1.1	1.2		1.1	1.2				

- [Contents](#)
- [References](#)
- [Endnotes](#)

1.7 Protection from sexual exploitation and abuse

Sexual exploitation and abuse of affected community members by anyone associated with the provision of aid is a protection issue (26). It is also one of the most serious breaches of humanitarian accountability. Such exploitation may occur where the essential needs of those most at risk in communities are not adequately met. Issues of impunity and lack of accountability in relation to sexual exploitation and abuse are derived from existing asymmetries in the balance of power, and erode the confidence and trust of affected communities and other stakeholders (host States, donors, media and the public) in all those providing assistance. Therefore, protection from sexual exploitation and abuse is an essential issue of accountability.

The IASC six core principles relating to sexual exploitation and abuse are as follows (27).

1. Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
2. Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief regarding the age of a child is not a defence.
3. Exchange of money, employment, goods, or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour, is prohibited. This includes exchange of assistance that is due to beneficiaries.
4. Any sexual relationship between those providing humanitarian assistance and protection and a person benefiting from such humanitarian assistance and protection that involves improper use of rank or position is prohibited. Such relationships undermine the credibility and integrity of humanitarian aid work.
5. Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, he or she must report such concerns via established agency reporting mechanisms.
6. Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.

Upholding and promoting policies on sexual exploitation and abuse is critical in all WHO operations in all countries (28).



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2						
Figure	1.1	1.2						
Table	1.1	1.2						

●	Contents
●	References
●	Endnotes

The Global Health Cluster has a key role to play to:

- identify risks and integrate protection from sexual exploitation and abuse strategies into cluster workplans;
- encourage all cluster members to put in place appropriate mechanisms to deal with any issues of sexual exploitation and abuse;
- ensure that issues are brought to the attention of the appropriate stakeholders for action, such as the humanitarian coordinator.

1.8 Accountability to affected populations

Accountability to affected populations requires that humanitarian agencies develop a system-wide culture of accountability and collectively provide effective and quality programming that considers the needs and capacities of different groups in the community. It encompasses taking account of, giving account to, and being held to account by the affected population.

The IASC Commitments on Accountability to Affected Populations articulate commitments that leaders of humanitarian agencies undertake in relation to (a) leadership, (b) participation and partnership, (c) information, feedback and action, and (d) results (29).

1.8.1 What is accountability to affected populations?

In summary, accountability to affected populations is an active commitment by aid workers and organizations to use the power and resources entrusted to them ethically and responsibly; to work to develop a system-wide culture of accountability to affected populations; and collectively to provide effective and quality programming that recognizes the community's dignity, capacity and rights to participate in decisions that affect them. It encompasses taking account, giving account, and being held to account.

- **Taking account** involves giving affected populations influence over decision-making at all phases of the Humanitarian Programme Cycle, in a way that takes account of the diversity of communities and allows the views of the most vulnerable to be equally considered.
- **Giving account** refers to transparency and effective sharing of information to affected communities through all phases of the Humanitarian Programme Cycle.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2						
Figure	1.1	1.2						
Table	1.1	1.2						

- Contents
- References
- Endnotes

- **Being held to account** means being accountable for commitments, actions and decisions made, and for proper use of resources. It involves self-regulation and compliance verification and entails giving others the opportunity to assess and, if appropriate, sanction the actions of individuals and organizations.

When the IASC Principals endorsed the five Commitments on Accountability to Affected Populations they agreed to incorporate them into the policies and operational guidelines of their respective organizations and to promote them with operational partners, within humanitarian country teams and among cluster members.

The Commitments on Accountability to Affected Populations and the Core Humanitarian Standard on Quality and Accountability (CHS) are mutually supportive and reinforcing. Combined, they provide a solid base for building accountability to affected populations into humanitarian programming (30).

The CHS was developed in 2014 as a result of extensive consultation with humanitarian agencies (31, 32).²⁰ The CHS outlines what good humanitarian action looks like for communities and people affected by crisis, and for the staff and organizations involved in a response. Its purpose is to help organizations design, implement, assess and improve the quality of assistance while at the same time being accountable to communities and people affected by crisis.²¹

1.8.2 Incorporating accountability to affected populations into the health cluster response at country level

Many health cluster partners, including WHO, already have policies and practices in place that promote accountability to affected populations within their programmes. However, health clusters are key to ensuring that accountability to affected populations is addressed in a harmonized and cohesive manner.

- It will be important to build a shared vision within the health cluster on what it means to provide an emergency health response that ensures safe and equal access to quality health services and ensures accountability to affected populations (including taking account, giving account, and being held to account).
- Health cluster coordinators should utilize the available skills and expertise of specialized agencies and relevant focal points in a country on such accountability-related matters as age, diversity, gender and protection, and should help build understanding on these issues within the health cluster through



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph ● 1.1 ● 1.2 ● 1.3 ● 1.4 ● 1.5 ● 1.6 ● 1.7 ● 1.8 ●

Box ● 1.1 ● 1.2 ● **Figure** ● 1.1 ● 1.2 ● **Table** ● 1.1 ● 1.2 ●

- **Contents**
- **References**
- **Endnotes**

briefings, orientation and training, and adaptation of generic tools for use by the health cluster.

- It is the responsibility of the health cluster coordinator to improve accountability by placing affected populations at the centre of decision-making and at the centre of action to promote meaningful access, safety and dignity with a desire to meet humanitarian needs, to systematically reduce those needs, and to increase resilience. The Global Health Cluster Operational Guidance on Accountability to Affected Populations, August 2017, outlines actions, responsible actors and indicators to incorporate accountability to affected populations into coordination processes and each of the phases of the Humanitarian Programme Cycle for the health response (30).

1.8.3 What is the link between accountability to affected populations and protection?

Accountability and protection complement and mutually support each other. Without one, the other is not complete. Both are rooted in a rights-based approach. Accountability is not only about improving humanitarian programme effectiveness but also about ensuring that affected people can exercise their right to access services.

Protection mainstreaming involves incorporating protection principles and promoting meaningful access, safety and dignity in all aspects of humanitarian aid, and is a crucial pillar of programme quality in all sectors. The following protection-related issues must be considered in all humanitarian activities.

The health cluster has the responsibility of identifying risks and ensuring that protection strategies are appropriately incorporated into all phases of the Humanitarian Programme Cycle for the emergency health response (22).

Box 1.2 provides information on gender-based violence, an important aspect of protection.



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2						
Figure	1.1	1.2						
Table	1.1	1.2						

● Contents
● References
● Endnotes

● **Box 1.2 Gender-based violence**

Gender-based violence is a protection issue and as such WHO and the health cluster have responsibility to ensure that appropriate interventions to prevent and respond to gender-based violence are incorporated into all phases of the Humanitarian Programme Cycle for the emergency health response.

Gender-based violence prevention and response interventions should not be delayed due to lack of solid information or reporting on incidents of violence. Evidence shows that gender-based violence will usually be present in humanitarian situations, and hence the minimum set of prevention and response interventions should be established right at the beginning of an emergency.

1.8.4 Mainstreaming a comprehensive people-centred approach in the health response

It is the responsibility of the health cluster coordinator to ensure that a people-centred approach is incorporated into all phases of the Humanitarian Programme Cycle for the health response – preparedness, needs assessment and analysis, strategic response planning, response implementation, monitoring and evaluation, and learning. The Global Health Cluster Operational Guidance on Accountability to Affected Populations provides examples of key activities in mainstreaming a people-centred approach in the health sector (32).



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph ● 1.1 ● 1.2 ● 1.3 ● 1.4 ● 1.5 ● 1.6 ● 1.7 ● 1.8 ●

Box ● 1.1 ● 1.2 ● **Figure** ● 1.1 ● 1.2 ● **Table** ● 1.1 ● 1.2 ●

- [Contents](#)
- [References](#)
- [Endnotes](#)

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Humanitarian principles and international humanitarian coordination mechanisms

Paragraph ● ● ● ● ● ● ● ●

1.1 1.2 1.3 1.4 1.5 1.6 1.7 1.8

Box ● ● **Figure** ● ● **Table** ● ●

1.1 1.2 1.1 1.2 1.1 1.2

- Contents
- **References**
- Endnotes

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Humanitarian principles and international humanitarian coordination mechanisms

Paragraph ● ● ● ● ● ● ● ●

1.1 1.2 1.3 1.4 1.5 1.6 1.7 1.8

Box ● ● **Figure** ● ● **Table** ● ●

1.1 1.2 1.1 1.2 1.1 1.2

- Contents
- References
- Endnotes

Key reference materials

Websites

Inter-Agency Standing Committee: <https://www.interagencystandingcommittee.org>
Humanitarian Response: <https://www.humanitarianresponse.info/>
Agenda for Humanity: <https://www.agendaforhumanity.org>
United Nations Office for the Coordination of Humanitarian Affairs: <https://www.unocha.org>
Health Cluster: <https://www.who.int/health-cluster>

Further recommended reading

- Reference Module for Cluster Coordination at Country Level, IASC, July 2015
- Humanitarian Programme Cycle, IASC, revised July 2015
- Operational Framework for Accountability to Affected People, IASC, 2013
- Common Framework for Preparedness, IASC, October 2013
- Emergency Response Preparedness, Draft for field testing, IASC, July 2015
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- Commitment to Principles of Partnership – Global Humanitarian Platform 2007
- Agenda for Humanity – Annex to the report of the Secretary-General for the World Humanitarian Summit – Advanced, unedited version, <https://sustainabledevelopment.un.org/content/documents/2282agendaforhumanity.pdf>
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- The Grand Bargain – A shared commitment to better serve people in need, Istanbul, May 2016
- The Grand Bargain, <https://interagencystandingcommittee.org/grand-bargain>
- IASC Post WHS commitments – statement from IASC Principals Endorsed June 2016
- New Way of Working, OCHA, 2017, https://www.unocha.org/sites/unocha/files/NWOW%20Booklet%20low%20res.002_0.pdf



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2	Figure	1.1	1.2	Table	1.1	1.2

- Contents
- References
- Endnotes

Endnotes

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2. A list of signatories is found at <https://media.ifrc.org/ifrc/who-we-are/the-movement/code-of-conduct/>. Note that the Red Cross/NGO Code of Conduct includes principles beyond the four core principles endorsed by the General Assembly. However, for United Nations humanitarian agencies, these principles are considered to be the essential ones. Conceptually, many other principles can be linked back to the four endorsed by the General Assembly.
3. See, for instance, common article 3 to the 1949 Geneva Conventions; articles 12 and 15, First Geneva Convention; articles 16 and 17, Fourth Geneva Convention; article 10, Additional Protocol I of 1977; articles 7 and 8, Additional Protocol II of 1977; International Committee of the Red Cross study of customary international humanitarian law, rules 109 and 110 (2, 3).
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5. During its special session on Ebola, the 136th session of the WHO Executive Board (2015) called on Member States and relevant actors in humanitarian situations with health consequences to support WHO in fulfilling its role as lead agency of the Global Health Cluster within its mandate.
6. Global Health Cluster interim terms of reference, March 2015.
7. See Health Cluster website for more detail on the responsibilities of the Global Health Cluster: <https://www.who.int/health-cluster/about/en/>.
8. The foundations of the current international humanitarian coordination system were set by General Assembly resolution 46/182 of December 1991.
9. The Global Humanitarian Platform was established in 2006, bringing together leaders from the United Nations and related international organizations, NGOs and the International Red Cross and Red Crescent Movement to discuss how to improve partnership between very diverse humanitarian organizations. It was founded on the premise that the international humanitarian community was made up of three equal families – United Nations agencies, the International Red Cross and Red Crescent Movement, and NGOs – and with the underlying belief that no single humanitarian agency could cover all humanitarian needs. Collaboration was, therefore, not an option but a necessity. The principles of partnership were endorsed at a Global Humanitarian Platform meeting in 2007, where leaders of partner organizations agreed to implement the principles within their own organizational policies.
10. See subsection 2.3.3 of Chapter 2 for more details on the principles of partnership.
11. Grand Bargain: as part of the preparations for the World Humanitarian Summit in 2016, the High-Level Panel on Humanitarian Financing sought solutions to close the humanitarian financing gap. The outcome was the Grand Bargain: an agreement between some of the largest donors and humanitarian organizations that aims to get more means into the hands of people in need and to improve the effectiveness and efficiency of humanitarian action.
12. IASC Humanitarian Programme Cycle: <https://www.humanitarianresponse.info/en/programme-cycle/space>.
13. This refers to partnerships between all actors involved in humanitarian action, including governments, United Nations agencies, NGOs and civil society.
14. Eight protocols were developed in 2013 and a further two were developed in 2015.
15. An IASC Principals letter of 4 January 2013 stated that while the focus of the Transformative Agenda had been on massive Level 3 (L3) emergencies, most of the



Humanitarian principles and international humanitarian coordination mechanisms

Paragraph	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8
Box	1.1	1.2	Figure	1.1	1.2	Table	1.1	1.2

- Contents
- References
- Endnotes

Transformative Agenda – apart from some of the elements related to system-wide activation and empowered leadership – would generally apply in non-L3 situations (15).

16. Grading is an internal activation procedure that triggers WHO emergency procedures and activities for the management of the response. The grading assigned to an acute emergency indicates the level of operational response required by WHO for that emergency. In the WHO Emergency Response Framework, second edition, Grade 3 is defined as follows: “A single country or multiple country emergency, requiring a major/maximal WHO response. Organizational and/or external support required by the WCO [WHO country office] is major and requires the mobilization of Organization-wide assets. The provision of support to the WCO is coordinated by an Emergency coordinator in the Regional Office(s). An Emergency Officer is also appointed at headquarters, to assist with the coordination of Organization-wide inputs. On occasion, the WHE Executive Director and the Regional Director may agree to have the Emergency coordinator based in headquarters. For events or emergencies involving multiple regions, an Incident Management Support Team at headquarters will coordinate the response across the regions” (6).
17. Among the actions triggered by the scale-up activation, the Protocol for the Control of Infectious Disease Events lists the following: “Development of a ‘Statement of Key Strategic Priorities’ (SSP) by the [humanitarian coordinator/humanitarian country team] within four days of the Scale-Up activation, with the technical direction

of WHO and in accordance with the IASC template. The SSP will lay out priorities and a common strategic approach for controlling the infectious disease event, including community engagement strategies to build trust with affected communities, managing humanitarian consequences and, where appropriate, implementing preparedness measures. It will serve as a basis for the Flash Appeal and for the performance monitoring benchmarks” (19). See also Annex 2 of the protocol: Timelines for IASC infectious events protocol.

18. In 2016, at the World Humanitarian Summit, partners agreed on a commitment to action that would transcend the humanitarian–development divide. To this end, the Summit urged the international aid system, including the United Nations, NGOs and bilateral donors, to commit to working in a new paradigm marked by three fundamental shifts: (a) reinforce, do not replace, national and local systems; (b) anticipate, do not wait for, crises; and (c) transcend the humanitarian–development divide by working towards collective outcomes, based on comparative advantage and over multi-year time frames.
19. See chart in Chapter 6 on the humanitarian–development–peace nexus.
20. The CHS consultation was facilitated by HAP International, People In Aid and the Sphere Project, and drew upon a number of sources.
21. See Chapter 5 on promoting standards for a quality cluster response.

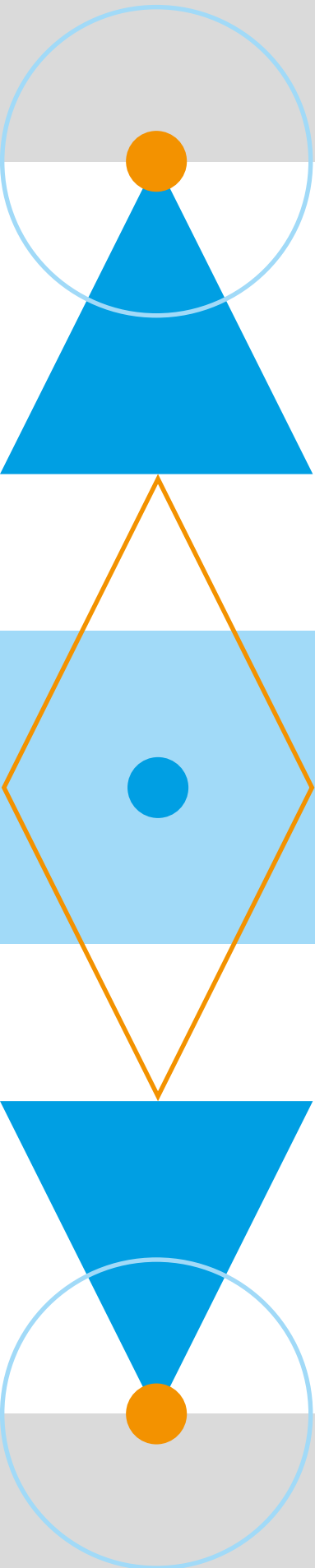


Humanitarian principles and international humanitarian coordination mechanisms

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- Contents
- References
- Endnotes

Establishing a health cluster at country level: functions, roles and responsibilities



02

Contents

Chapter 2		
Establishing a health cluster at country level: functions, roles and responsibilities		36
2.1 Introduction		36
2.2 Humanitarian coordination architecture at country level		36
2.2.1 Humanitarian country team		36
2.2.2 Emergency coordination options		38
2.2.3 Emergency health coordination options		40
2.2.4 Health cluster activation		42
2.3 Purpose and functions of the country health cluster		45
2.3.1 Purpose of the health cluster		45
2.3.2 Core functions of the health cluster		45
2.3.3 Principles of partnership		49
2.4 Composition and structure of a health cluster		50
2.4.1 Composition of a health cluster		50
2.4.2 Structure of a country health cluster		50
2.4.3 Health cluster structure at subnational level		56
2.5 Sharing leadership and coordination responsibility in a formally activated health cluster		59
2.5.1 Sharing leadership and coordination responsibility with health authorities		59
2.5.2 Sharing leadership and coordination responsibility with NGOs		60
2.6 Inter-cluster coordination		63
2.6.1 Definition and purpose of inter-cluster coordination		63
2.6.2 Inter-cluster coordination group		64
2.6.3 Modalities for inter-cluster coordination		66
2.6.4 Thematic inter-cluster coordination of relevance to the health cluster		67
2.6.5 Promoting collaboration and coordination with key clusters		72
2.7 Working with other coordinating bodies		73
2.7.1 Principles of engagement with other bodies		73
2.7.2 Emergency medical teams		74
2.7.4 Global Outbreak Alert and Response Network		77
2.7.5 Cluster engagement and coordination with the military		78
2.8 Participation in the health cluster		79
2.8.1 Minimum commitments for participation in the health cluster		79
2.8.2 Respective roles, responsibilities and accountabilities		81
2.9 Cluster coordination performance monitoring and architecture review		86
2.9.1 Cluster coordination performance monitoring		86
2.9.2 Cluster coordination architecture review		87
2.10 Health cluster transition and deactivation		88
2.10.1 Definition and modalities of health cluster transition and deactivation		88
2.10.2 Timing of deactivation of a health cluster		88
2.10.3 Tips for smooth transition and deactivation of an activated health cluster		89
2.10.4 Systematic steps for transition and deactivation of a health cluster		90
References		92
Endnotes		94
Boxes		
Box 2.1	Principles of partnership established by Global Humanitarian Platform, 2007	49
Box 2.2	Representation at inter-cluster coordination group meetings	65
Box 2.3	Ukraine inter-cluster coordination group: TOR	65
Box 2.4	Minimum commitments for partner participation in clusters	80
Box 2.5	Provider of last resort	81
Figures		
Figure 2.1	Formally activated health cluster within wider humanitarian coordination architecture	44
Figure 2.2	Typical country health cluster structure	51

Tables

Table 2.1	Humanitarian coordination in different settings	39
Table 2.2	Core functions of the country health cluster	45
Table 2.3	Purpose, roles, composition and leadership of strategic advisory group	53
Table 2.4	Thematic focus areas for inter-cluster coordination mechanisms	70

Abbreviations

CCPM	cluster coordination performance monitoring
EMT	emergency medical team
GOARN	Global Outbreak Alert and Response Network
HC	humanitarian coordinator
IASC	Inter-Agency Standing Committee
IHR	International Health Regulations
MOU	memorandum of understanding
NGO	nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
RC	resident coordinator
TOR	terms of reference
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization

2. Establishing a health cluster at country level: functions, roles and responsibilities

2.1 Introduction

This chapter provides an overview of the establishment of health cluster coordination at country level. It summarizes the broader humanitarian coordination architecture, the purpose and core functions of the health cluster at country level, the process for activation of the health cluster, and the structure and composition of the health cluster at national and subnational levels. The chapter also summarizes inter-cluster coordination and the respective roles and responsibilities of the World Health Organization (WHO) as cluster lead agency, the health cluster coordination team and health cluster partners, including the WHO Health Emergencies Programme.

2.2 Humanitarian coordination architecture at country level

2.2.1 Humanitarian country team

The humanitarian country team, under the leadership of the humanitarian coordinator (HC), is the centrepiece of the international humanitarian coordination architecture at country level. The HC is ultimately responsible for the overall response and is accountable to the populations in need and to the United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator. Where a separate HC position has not been established, the resident coordinator (RC) takes both roles and is accountable for humanitarian coordination functions in addition to being accountable for developmental activities (1, 2). In some countries, the HC may appoint a deputy humanitarian coordinator.

The Transformative Agenda affirms that international coordination arrangements should adapt to the operational context and should support national coordination



Establishing a health cluster at country level: functions, roles and responsibilities

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Figure	●	●												
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- Contents
- References
- Endnotes

efforts. It also affirms empowered leadership, with HCs, RCs and humanitarian country teams making decisions at country level in dialogue with national authorities (3).

Responsibilities of the humanitarian country team include:

- agreeing on strategic issues related to in-country humanitarian action, including setting and promoting common objectives and priorities, developing strategic plans, agreeing on the establishment of clusters and designation of cluster lead agencies, providing guidance to cluster lead agencies, activating resource mobilization mechanisms and advising the HC on allocation of in-country resources;
- agreeing on common policies related to in-country humanitarian action;
- promoting adherence to humanitarian principles, the principles of partnership¹ and Inter-Agency Standing Committee (IASC) policies and guidance;
- promoting actions that specifically improve accountability to affected populations in accordance with the IASC Commitments on Accountability to Affected Populations and the related Operational Framework on Accountability to Affected Populations.

Humanitarian country team composition

A humanitarian country team is made up of organizations that undertake in-country humanitarian action, and that commit to participate in coordination arrangements. This includes the United Nations agencies, national and international nongovernmental organizations (NGOs) and, subject to their individual mandates, components of the International Red Cross and Red Crescent Movement.² The size of a humanitarian country team is limited, but aims at equal participation of United Nations organizations, national and international NGOs, (or as decided by the wider heads of agencies group) to enable effective decision-making. Members of the humanitarian country team are represented at the highest level – country representative or equivalent.

WHO engagement in the humanitarian country team

As WHO is a major agency supporting in-country humanitarian action and has a commitment to participate in coordination of humanitarian action (4),³ the head of the WHO country office will be a member of the humanitarian country team.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

- The head of the WHO country office has the responsibility to proactively engage with the humanitarian country team in discussion and decision-making in all phases of the response, representing the interests of WHO and the interests of the Global Health Cluster.
- Where the health cluster has not been activated, the head of the WHO country office still has a responsibility to represent the interests of the emergency health partners as a collective.⁴

2.2.2 Emergency coordination options

The coordination mechanism selected for use in a humanitarian emergency will be determined by the context and scale of need.

Government-led emergency sector coordination mechanisms

Where coordination capacity is adequate, the emergency response may be led by government. In such cases, government-led emergency sector coordination mechanisms report to designated government bodies. The lifespan of emergency sector coordination is defined by government policies or declarations.

The designated cluster lead will augment national coordination capacity as required, using the principles of the cluster approach (5).⁵

During the World Humanitarian Summit (Istanbul, Turkey, 2016), commitments were made to pursue a New Way of Working in a humanitarian emergency, including reinforcing rather than replacing local and national systems for emergency preparedness and response efforts (6).

IASC cluster-led emergency coordination

IASC clusters may be formally activated by the IASC when existing coordination mechanisms are overwhelmed or constrained in their ability to respond to identified needs in line with humanitarian principles. A formally activated cluster has specific characteristics and accountabilities. It is accountable to the HC through the cluster lead agency, as well as to national authorities and to people affected by the crisis. IASC clusters are a temporary coordination solution and efforts should be made as soon as appropriate and possible to hand over coordination to the relevant authorities.⁶

Table 2.1 Compares humanitarian coordination in different settings.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

► **Table 2.1 Humanitarian coordination in different settings**

COORDINATION MECHANISM	EMERGENCY PHASE	RECOVERY PHASE
Government coordination capacity is adequate and not constrained	Government provides leadership. International partners may reinforce the government's coordination capacity.	Government leadership continues. Humanitarian coordination structures may transition to recovery and to development structures. International actors withdraw or support recovery, and help to prepare for future crises.
Government coordination capacity is limited or constrained	Clusters are activated where needed. Where appropriate and possible, co-leadership with government bodies and NGO partners is strongly encouraged.	Clusters are deactivated or devolve to national emergency or recovery and development coordination structures, where appropriate and possible. Government coordination is strengthened, where appropriate and possible.

Source: IASC Cluster Coordination Reference Module (5), page 7 and Annex I.

Coordination in the context of refugees

In a *refugee-only context* – where the affected population are primarily refugees and host communities directly affected by refugee presence – the United Nations High Commissioner for Refugees (UNHCR) is mandated to support the host government in leadership of the crisis. An HC will not be appointed, IASC coordination mechanisms do not apply, and IASC clusters will not be established.

In a *mixed situation* – where the population of humanitarian concern includes internally displaced persons, refugees and other groups – an HC will be appointed and IASC-mandated clusters will be established to address the needs of the internally displaced persons, while UNHCR will lead the refugee response. Close collaboration will be required to ensure an effective and efficient response, in line with globally mandated accountabilities. The joint note by UNHCR and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) on mixed situations clarifies leadership and coordination arrangements and sets out the respective roles and responsibilities of the UNHCR representative and the HC, and the practical interaction of IASC coordination and the refugee coordination arrangements of UNHCR, to ensure that coordination is streamlined, complementary and mutually reinforcing (7).



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

Coordination in a cross-border context

In a *cross-border situation*, the humanitarian response may be coordinated by NGOs. However, in special circumstances a United Nations resolution may be passed to allow United Nations agencies and humanitarian partners to use routes across conflict lines and across borders to ensure that humanitarian assistance reaches the affected populations.

2.2.3 Emergency health coordination options

Ministry of health-managed emergency health coordination

Ideally, an emergency health coordination mechanism is established within and managed by the ministry of health, with technical, operational and coordination support from WHO. Where emergency health coordination is established within and managed by the ministry of health, WHO has a responsibility to support emergency coordination functions⁷ in line with the principles of the cluster approach. In conflict settings and more fragile settings, alternative, more independent coordination mechanisms may be required.

Different emergency health coordination models may be used, depending on the ministry of health's capacity and internal management structures, the operational context, the scale of the emergency, the type of emergency, and the constraints on principled humanitarian action.

Examples of emergency health coordination mechanisms include health sector working group,⁸ emergency health coordination group (under the ministry of health), outbreak coordination group, activated health cluster, emergency medical team (EMT) coordination cell, and more informal bodies.

Public health emergency operations centre

A public health emergency operations centre (8) integrates traditional public health services and other functions into an emergency management model, recognizing that public health threats and consequences require coordinated responses. The public health emergency operations centre is a component of the network of emergency operations centres under existing national or subnational disaster management authorities or entities.

The International Health Regulations (IHR) (2005) require that States Parties develop, strengthen and maintain their capacity to respond promptly and effectively to public health risks and public health emergencies (9). A functional public health emergency operations centre is an important component of meeting those requirements.



Establishing a health cluster at country level: functions, roles and responsibilities

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Figure ● 2.1 ● 2.2

Table ● 2.1 ● 2.2 ● 2.3 ● 2.4

- Contents
- References
- Endnotes

An emergency operations centre is a place within which, in the context of an emergency, personnel responsible for planning, coordinating, organizing, acquiring and allocating resources and providing direction and control can focus these activities on responding to the emergency. An emergency operations centre is a generic concept, embracing a range of emergency management facilities from an on-scene incident command post at an emergency site to a national emergency coordination centre providing strategic direction and resources to multiple jurisdictions and agencies in a wide-area disaster. An emergency operations centre provides strategic policy, logistical and operational support to site-level responders and response agencies.

The public health emergency operations centre is part of a public health emergency management programme of risk analysis, preparedness, response and recovery. The programme includes:

- prevention and mitigation of hazards;
- enhancing readiness by stockpiling response resources;
- establishing related institutional and technical capacities and capabilities (for example, laboratories, community clinics, and rapid response teams);
- implementing public health surveillance programmes;
- enhancing environmental health programmes;
- engaging communities;
- training staff and validating plans.

Role of health cluster coordinator in public health emergency operations centre

The role of the health cluster coordinator in the public health emergency operations centre includes the following:

- engaging in bilateral dialogue with national or subnational health disaster management authorities or entities to understand where the overall response coordination will be conducted and how the health cluster coordination could engage in support of the overall coordination mechanism;
- together with the national (co-)chair of the health cluster, acting as part of the public health emergency operations centre to ensure complementarity with



Establishing a health cluster at country level: functions, roles and responsibilities



- [Contents](#)
- [References](#)
- [Endnotes](#)

national response capacities and helping coordinate support from international partners;

- attending meetings held by the national or subnational disaster management authorities, especially those organized by the ministry of health;
- ensuring that the health cluster is sharing relevant health information for better decision-making processes and feeding back national strategies and action plans to the HC and other United Nations clusters, as required;
- understanding how the multisectoral integrated response would contribute to better health outcomes.

2.2.4 Health cluster activation

Under the Transformative Agenda, IASC Principals agreed that activation of clusters must be more strategic and less automatic, and should be time limited. To ensure that clusters continue to operate only while they are strictly needed, plans to deactivate and transition clusters should be prepared as soon as possible after activation, and enhancing the capacity of local partners and national and local health entities should be an objective from the outset.

The RC/HC, in consultation with the humanitarian country team, determines which clusters should be recommended for activation. In a situation where a humanitarian country team has not yet been established, the United Nations country team will take on this role.⁹ The humanitarian country team, in consultation with the national authorities, considers the recommendation, taking into account an analysis of the situation and the current state of preparedness planning, and the World Humanitarian Summit commitment to reinforce rather than replace local and national systems for emergency preparedness and response efforts. WHO has a responsibility to proactively engage in discussion, analysis and decision-making with regard to the activation of the health cluster and the other clusters in a country.

Criteria for cluster activation

Cluster activation may be recommended where the following criteria are found to apply.

- Response and coordination gaps exist due to a sharp deterioration or significant change in the humanitarian situation.
- Existing national response or coordination capacity is unable to meet needs in a manner that respects humanitarian principles, due to the scale of need, the



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

number of actors involved, the need for a more complex multisectoral approach, or other constraints on the ability of national mechanisms to respond to the situation or apply humanitarian principles.

Process for cluster activation and selection of cluster lead agency

The process for cluster activation and selection of the cluster lead agency will be as follows.

- The RC/HC, in consultation with the humanitarian country team, determines which clusters should be recommended for activation. This decision should be based on analysis of the context and the capacity of existing coordination structures on the ground, and should be made in consultation with national and local authorities.
- The RC/HC, again in consultation with the humanitarian country team, also selects the lead agencies for each cluster based on the agencies' coordination and response capacity, operational presence, and ability to scale up.
- Generally, WHO will be the cluster lead agency for the country health cluster, mirroring the global arrangement, but this may not always be the case. In exceptional circumstances there may be a situation where other organizations are better placed to lead the health cluster.
- The RC/HC recommends cluster activation to the Emergency Relief Coordinator at United Nations Headquarters in New York, who then forwards the actual decision on activation to the IASC.

WHO responsibilities when a health cluster has been formally activated

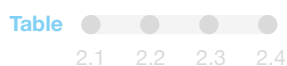
Upon formal activation of the health cluster, the responsibilities of WHO will be as follows.

- WHO, as cluster lead agency, has specific accountabilities for health cluster performance to the HC, the Emergency Relief Coordinator, the affected population, and the national authorities.¹⁰
- WHO should facilitate sharing of leadership and coordination responsibility with health authorities and is encouraged to do the same with appropriately experienced health NGOs.¹¹

Figure 2.1 illustrates how a formally activated health cluster relates to the wider humanitarian coordination architecture.



Establishing a health cluster at country level: functions, roles and responsibilities

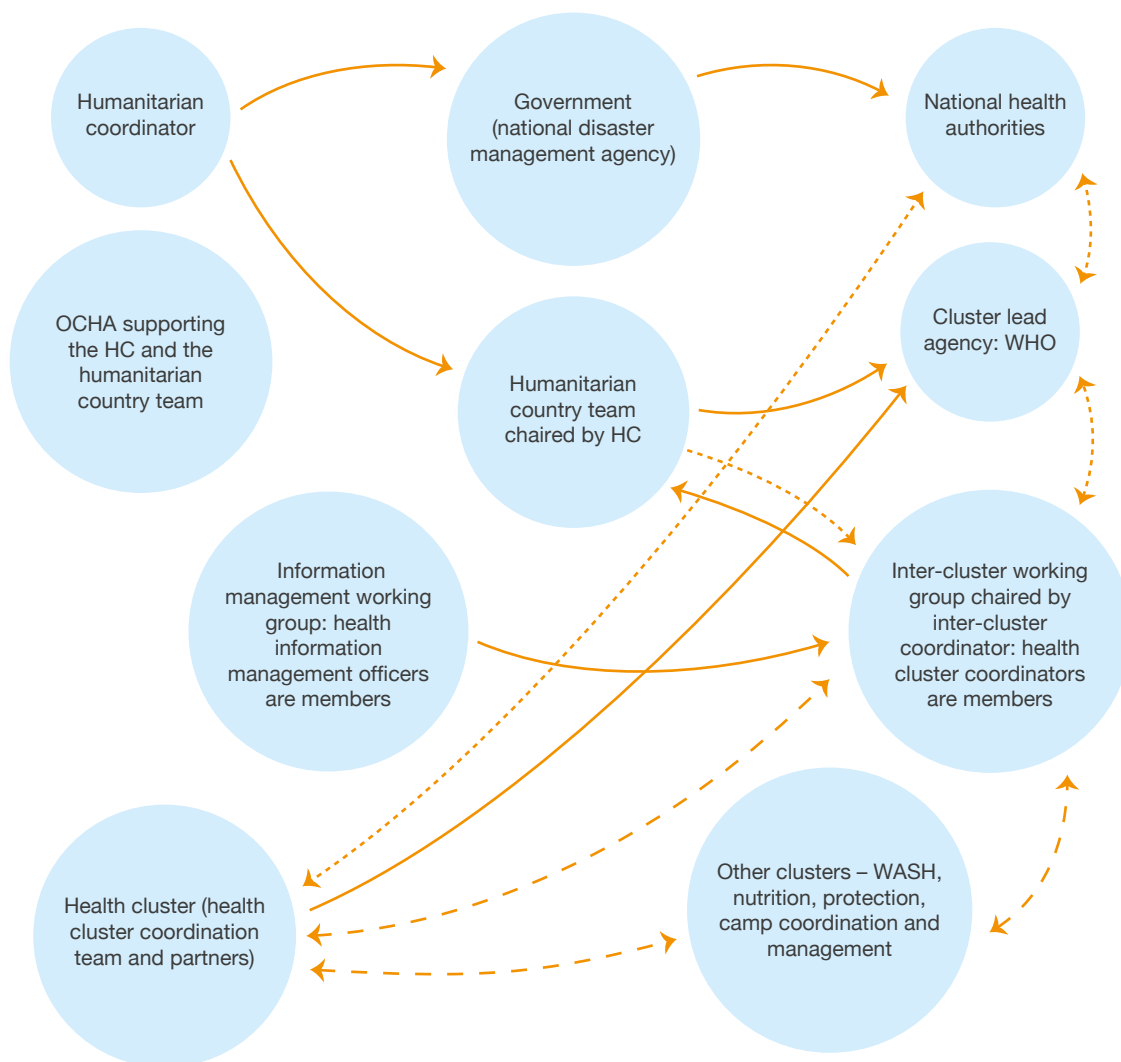


- Contents
- References
- Endnotes

Figure 2.1 Formally activated health cluster within wider humanitarian coordination architecture

NEW YORK

United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator



- Reporting line
- ⬅ - - - ➡ Reporting, collaboration, liaison and information sharing
- ⬅ ····· ➡ Coordination, liaison and information sharing



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

2.3 Purpose and functions of the country health cluster

2.3.1 Purpose of the health cluster

At country level, the purpose of the health cluster 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 and towards collective outcomes.

2.3.2 Core functions of the health cluster

The Cluster Coordination Reference Module outlines the six core functions that a country health cluster as a collective is expected to fulfil (Table 2.2) (5).¹²

► **Table 2.2 Core functions of the country health cluster**

NO.	CORE FUNCTIONS AND ACTIVITIES	CROSS-REFERENCING
1	<p>Support service delivery by:</p> <ul style="list-style-type: none"> • Providing a platform that ensures that service delivery is driven by the identified needs of affected populations, as reflected by key humanitarian partners for the sector, respecting their respective mandates and programme priorities; • Securing commitments from humanitarian partners in responding to needs and filling gaps, ensuring an appropriate distribution of responsibilities within the cluster group, with clearly designated focal points for specific issues where necessary; • Developing protocols for information sharing and operational coordination which ensures confidentiality where needed; • Ensuring comprehensive joint analysis of needs, response and gaps to support operational decision-making and advocacy; • Establishing operational connections with health development partner coordination structures for supporting activities related to implementation of the humanitarian–development nexus. 	Chapters 6 and 11



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

NO.	CORE FUNCTIONS AND ACTIVITIES	CROSS-REFERENCING
2	<p>Inform strategic decision-making by:</p> <ul style="list-style-type: none"> • Ensuring effective and harmonized joint needs assessment and analysis across the region, involving all relevant sectors and partners; • Ensuring health cluster partners agree on assessment tools and approaches (core indicators, vulnerability criteria, compatible assessment processes and analysis) through consensus-building mechanisms following the Global Health Cluster Public Health Information Services standards; • Ensuring integration of agreed priority cross-cutting issues in sectoral and intersectoral needs assessments, analysis, planning, monitoring and response (for example, gender, age, diversity, environment, protection and human rights), and contributing to the development of appropriate strategies to address cross-cutting issues; • Ensuring protection mainstreaming and gender-sensitive programming; • Providing regular health situation analysis reports; • Representing the interests of the cluster and cluster partners in discussions with the humanitarian coordinator and other stakeholders. 	Chapter 10
3	<p>Plan and develop strategy by:</p> <ul style="list-style-type: none"> • Developing or updating agreed response strategies and workplans for the cluster and ensuring that these are adequately reflected in overall humanitarian country team strategies; • Ensuring that response plans are in line with existing policy guidance and technical standards; • Ensuring adoption of a people-centred approach in development of the health cluster strategy; • Ensuring effective links with the inter-cluster coordination group and with other cluster groups, such as water, sanitation and hygiene (WASH), food security, logistics, nutrition and protection, in order to improve the humanitarian integrated response through joint planning; • Promoting emergency response actions while at the same time considering the need for early recovery and resilience planning as well as prevention and risk reduction concerns; • Clarifying funding requirements, helping to set priorities, and agreeing cluster contributions to the overall humanitarian funding proposals. 	Chapters 5, 11 and 13



Establishing a health cluster at country level: functions, roles and responsibilities

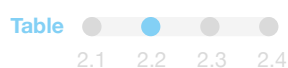


- Contents
- References
- Endnotes

NO.	CORE FUNCTIONS AND ACTIVITIES	CROSS-REFERENCING
4	<p>Monitor and evaluate performance by:</p> <ul style="list-style-type: none"> • Ensuring adequate monitoring mechanisms are in place to review the impact of the cluster activities and progress against the strategic health cluster objectives; • Periodically assessing the performance of the cluster through utilization of the Cluster Performance Monitoring Tool and ensuring that the information generated is then shared with partners for further learning and knowledge management; • Ensuring that cluster coordination mechanisms are adapted over time to reflect the capacities of local actors and the engagement of development partners; • Ensuring adequate data-sharing mechanisms are in place to review the impact of the cluster activities and progress against implementation plans; • Ensuring adequate reporting and effective information sharing, reflecting the agreed minimum standards. 	Chapter 12
5	<p>Build national capacity in preparedness and contingency planning by:</p> <ul style="list-style-type: none"> • Investing in the institutional capacities of local and national stakeholders and partners, including preparedness, response and coordination capacities; • Developing mechanisms to enhance capacity-building through in-country trainings; • Drawing lessons learned from past activities and revising strategies accordingly; • Serving as a forum for strengthening operational coordination and problem solving within the various health cluster coordination groups in the region; • Ensuring adequate contingency planning and preparedness for new emergencies and seasonal adaptation of responses; • Providing contingency planning scenarios for the health cluster response. 	Chapter 9



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

NO.	CORE FUNCTIONS AND ACTIVITIES	CROSS-REFERENCING
6	Undertake advocacy by: <ul style="list-style-type: none"> Identifying core advocacy concerns, including resource requirements, and contributing key messages to the broader advocacy initiatives of other actors; Encouraging donors to fund humanitarian actors to enable them to carry out priority activities in the areas concerned, while at the same time encouraging cluster participants to mobilize resources for their activities through their usual channels; Developing and implementing a communications and advocacy strategy on behalf of all cluster partners to ensure that key decision-makers, including government and donors, are aware of the needs, priorities, and geographical and programmatic gaps, and the importance of providing necessary support to sector activities; Representing the interests of the cluster groups in discussions with national, regional and global stakeholders on prioritization, resource mobilization and advocacy. 	Chapter 7

Source: Adapted from Cluster Coordination Reference Module (5).



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

2.3.3 Principles of partnership

The health cluster is expected to operate in line with the five principles of partnership: equality, transparency, results-oriented approach, responsibility and complementarity (Box 2.1) (10, 11).

● **Box 2.1 Principles of partnership established by Global Humanitarian Platform, 2007**

Equality. Equality requires mutual respect between members of the partnership, irrespective of size and power. The participants must respect each other's mandates, obligations and independence, and recognize each other's constraints and commitments. Mutual respect must not preclude the engagement of organizations in constructive dissent.

Transparency. Transparency is achieved through dialogue (on an equal footing), with an emphasis on early consultations and early sharing of information. Communications and transparency, including financial transparency, increase the level of trust among organizations.

Results-oriented approach. Effective humanitarian action must be reality based and action oriented. This requires results-oriented coordination based on effective capabilities and concrete operational capacities.

Responsibility. Humanitarian organizations have an ethical obligation 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 partners build on their comparative advantages and complement each other's contributions. Local capacity is one of the main assets for enhancing and building partnerships. Whenever possible, humanitarian organizations should strive to make local capacity an integral part of emergency response. Language and cultural barriers must be overcome.

Source: Adapted from Global Humanitarian Platform (10, 11).



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

2.4 Composition and structure of a health cluster

2.4.1 Composition of a health cluster

The country health cluster is open to all agencies committed to supporting the emergency health response in line with international standards and recognized good practice, and adhering to humanitarian principles and the principles of partnership.

At *national level*, the health cluster should be made up of all organizations providing or supporting health services in the affected areas. These include the national health authorities, international and national NGOs and faith-based organizations, International Committee of the Red Cross, the national Red Cross or Red Crescent society, United Nations agencies (including WHO as a partner as well as other United Nations agencies supporting the health response, for example the International Organization for Migration, United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA) and UNHCR), representatives of major private sector health service providers (where supporting health services), and the main health sector and humanitarian donors and other important stakeholders.

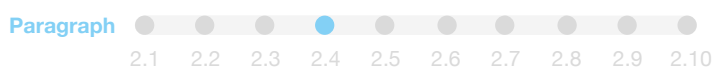
At *subnational level*, the health cluster would normally be composed of the local health authorities, international and national health NGOs active in the administrative area, community-based and other relevant civil society organizations, key health and humanitarian donors, and other health stakeholders present in the area.

2.4.2 Structure of a country health cluster

Health cluster structures will vary between countries, and indeed subnational structures may vary within a country, depending on the context. Typically, a country health cluster may include a strategic advisory group, a number of technical working groups or subclusters, and one or more subnational-level health clusters. While it is important to have a structure in place to facilitate health cluster effectiveness, it is equally important to ensure that health cluster coordinators and partners are not overburdened with a complicated and unwieldy structure (Figure 2.2).

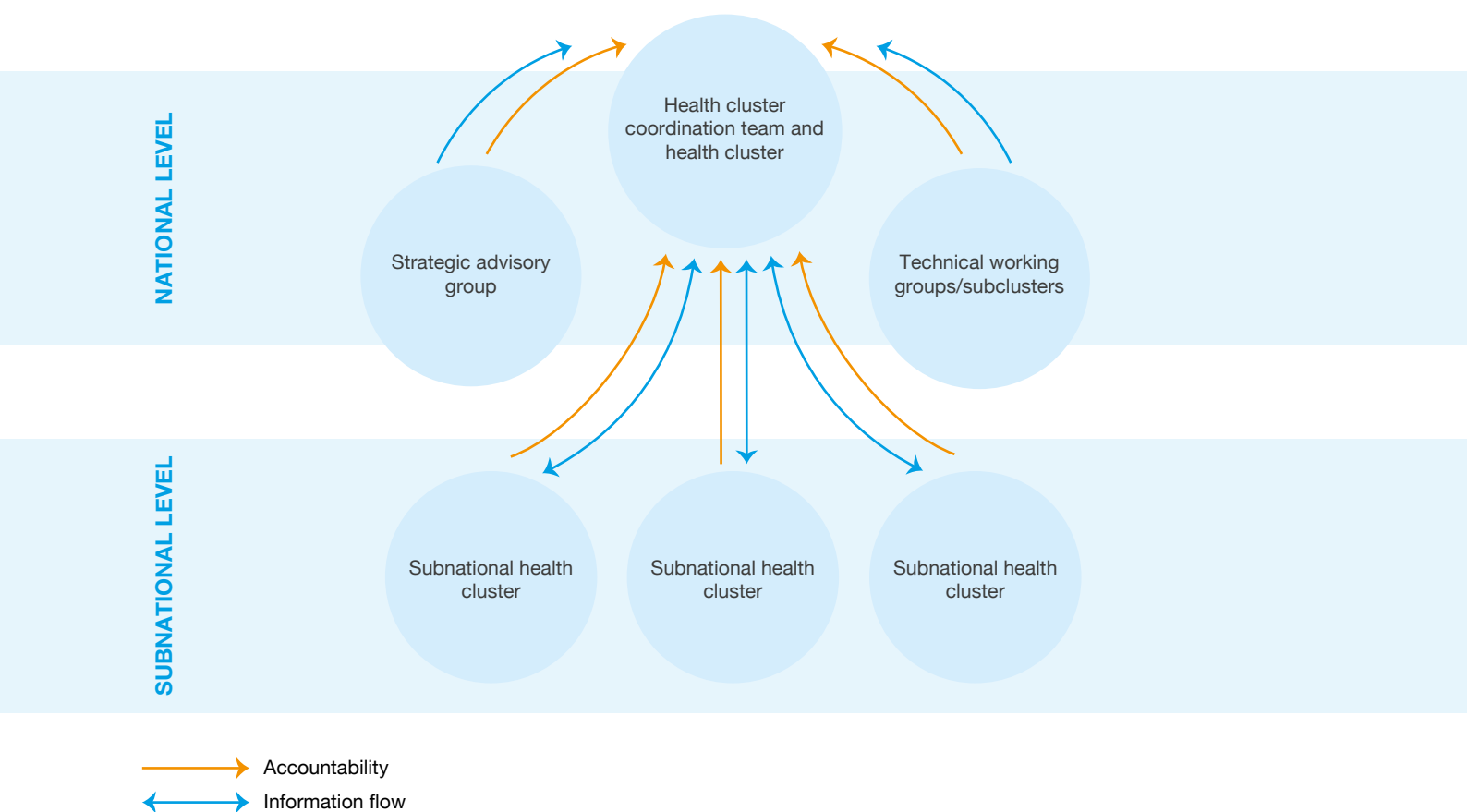


Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

Figure 2.2 Typical country health cluster structure



The structure of the health cluster, terms of reference (TOR) for the health cluster, and TOR for the various groups established under the auspices of the health cluster should be communicated to the wider health cluster membership. The structure of the health cluster should be periodically reviewed and amended accordingly.

On activation of a health cluster, TOR for the national health cluster and information management protocols should be established to ensure transparency and increased understanding of health cluster functioning. Both should be agreed upon by the health cluster members and health authorities, and endorsed by WHO as the cluster lead agency.

C 1 2 3 4 5 6 7 8 9 10 11 12 13

Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph 2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box 2.1 2.2 2.3 2.4 2.5 Figure 2.1 2.2 Table 2.1 2.2 2.3 2.4

● Contents
● References
● Endnotes

Clear TOR for the health cluster should be developed in the first month of activation, describing:

- goals, objectives, principles, methods and accountabilities;
- shared leadership;
- membership;
- the possible need for a strategic advisory group, technical working group, thematic coordination groups or subnational clusters, and a periodic review of the need for establishing such groups.

In addition, a clear information management protocol should be developed in the first month of activation, describing information collation and dissemination methods and systems.

These TOR and information management protocols should also be periodically reviewed and revised accordingly.

Strategic advisory group

Experience demonstrates that in a situation where there are a large number of partners engaged in the emergency health response, it is useful to establish a strategic advisory group or steering committee to provide oversight and guidance for the health cluster and facilitate more efficient partner engagement in decision-making.

Eligibility for health cluster partners to participate in the strategic advisory group is based on:

- operational relevance in the emergency;
- technical expertise;
- demonstrated capacity to contribute strategically and to provide practical support;
- commitment to contribute consistently.

Table 2.3 summarizes the purpose, roles, suggested composition and leadership of a strategic advisory group or steering committee.



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10		
Box	2.1	2.2	2.3	2.4	2.5							
Figure		2.1	2.2									
Table			2.1	2.2	2.3	2.4						

- Contents
- References
- Endnotes

► **Table 2.3 Purpose, roles, composition and leadership of strategic advisory group**

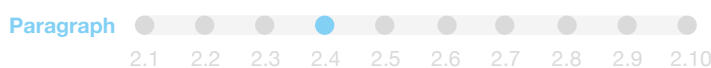
PURPOSE	ROLES	SUGGESTED COMPOSITION	LEADERSHIP
To enable decision-making on behalf of the wider cluster through a small group representing the health cluster partners	To provide overall strategic direction for the health cluster, including operational and coordination links with other clusters and with health development partner coordination structures	Health cluster coordinator and co-coordinator Representatives: 1 WHO (programmes) 1 national ministry of health (emergency programmes) 1 other United Nations agency	Where possible the national ministry of health representative should co-chair the strategic advisory group, along with the health cluster coordinator or NGO co-coordinator (health cluster coordinator and co-coordinator could alternate)
	To help formulate and provide input to the health cluster response strategy	1 or 2 international NGOs 1 or 2 national NGOs	It is the responsibility of the health cluster coordinator to ensure that decisions made by the strategic advisory group are communicated to health cluster partners, and to the national authorities in a situation where the ministry of health does not attend
	To provide oversight of implementation of the health cluster workplans, including the work of the technical working group	1 health or humanitarian donor	

Key points related to the strategic advisory group

- Ideally, in a large emergency health response, where there are multiple health cluster partners, a strategic advisory group will be established when the health cluster is activated and should function for the period that the health cluster is active to provide strategic direction for and oversight of the work of the health cluster.
- WHO (programmes) and ministry of health participation in the strategic advisory group would generally be automatic (given their organizational mandates), and they should be permanent members.
- Participation of other partners should be determined through an open, transparent selection process by the cluster.
- It is recommended that the membership rotates (suggest annually), other than WHO and the ministry of health.
- TOR should be developed for the strategic advisory group outlining its role and governance modalities.¹³



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

- ensure communication with each of these groups (regular bilateral communication with the focal persons from each group);
- provide support and guidance as necessary to ensure the various groups operate effectively;
- allocate appropriate space for each group on the agenda of health cluster meetings to share information and discuss relevant issues, as required;
- ensure each thematic area is included in cluster processes, for example for assessment or development of the humanitarian response plan and funding allocations;
- represent each of the groups during inter-cluster coordination group meetings and ensure that the focal points of each group are fully briefed on relevant decisions of the inter-cluster coordination group (focal points may be invited to attend inter-cluster coordination group meetings, where appropriate);
- ensure issues arising from groups are relayed to the head of the WHO country office as cluster lead agency so that progress, plans, problems and needs may be presented at humanitarian country team meetings.

The following tips will help ensure the effectiveness of working groups under the health cluster (for coordination of thematic areas and technical working groups).

- ✓ The relevant government agencies or sections from the ministry of health should be actively involved in the work of the groups from the time of their establishment, although it is not essential that they lead the groups.
- ✓ Where health cluster partner agencies are selected to lead working groups, they should ideally have institutional expertise in the relevant thematic area, and thus be in a position to use the organization to support the work of the group.
- ✓ TOR should be periodically reviewed and revised as required.
- ✓ Frequent updates on the work of these groups should be provided to the health cluster.



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●			
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10			
Box	●	●	●	●	●	Figure	●	●	Table	●	●	●	●
	2.1	2.2	2.3	2.4	2.5		2.1	2.2		2.1	2.2	2.3	2.4

●	Contents
●	References
●	Endnotes

Coordination of sexual and reproductive health and gender-based violence response

Provision of sexual and reproductive health services is essential in all humanitarian settings. The Minimum Initial Service Package for sexual and reproductive health is a set of priority services and activities to be implemented at the onset of every humanitarian emergency to prevent excess morbidity and mortality related to sexual and reproductive health (12). Comprehensive sexual and reproductive health services should then be implemented as soon as the situation stabilizes.¹⁵

At the onset of a humanitarian emergency where the (IASC) cluster system is activated, the WHO as health cluster lead agency must ensure that an agency is identified to lead and guide provision of sexual and reproductive health interventions within the health cluster. In a humanitarian setting where the cluster system is not activated, a lead agency for sexual and reproductive health should still be identified. Usually that agency is UNFPA. The sexual and reproductive health lead agency will identify a coordinator for the health cluster or sector coordination mechanism to ensure that coordination, technical and operational support is provided to all health cluster partners, initially in scaling up coverage of emergency sexual and reproductive health services in the crisis areas, and then in supporting the provision of comprehensive sexual and reproductive health services.

Prevention of sexual and gender-based violence and responding to the needs of survivors are key components of sexual and reproductive health programming (objective 2 of the Minimum Initial Service Package). To ensure programming beyond the clinical aspects of the response to gender-based violence, the sexual and reproductive health coordinator and the health cluster coordinator should actively participate in the wider inter-cluster coordination group discussion on prevention of and response to gender-based violence, and coordinate with the gender-based violence subcluster (under the protection cluster) to ensure effective referral pathways, standardized data collection and well articulated management and preventive measures.

2.4.3 Health cluster structure at subnational level

The health cluster structure does not necessarily need to mirror the national structure, nor will they necessarily have the same structure across all locations within the country. Subnational-level clusters should be adapted to the context of the specific locations where they have been activated.

C 1 2 3 4 5 6 7 8 9 10 11 12 13

Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph 2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box 2.1 2.2 2.3 2.4 2.5 Figure 2.1 2.2 Table 2.1 2.2 2.3 2.4

● Contents
 ● References
 ● Endnotes

While subnational coordination structures may vary across regions, they should all facilitate decentralized decision-making and shorten response time. Subnational coordination mechanisms are in a better position than their national counterparts to:

- strengthen accountability to affected populations;
- adapt the response, including priorities, to local circumstances;
- work closely with local authorities and partners;
- support real-time implementation of the humanitarian response plan;
- address cross-cutting and multidimensional issues arising in the immediate context.

Links between subnational and national clusters will:

- facilitate reporting, information sharing and collaboration with national and subnational clusters;
- promote coherence of national programming and overall coordination;
- help track trends;
- identify shared and common concerns in operational areas;
- develop more upstream advocacy and programming strategies.

Role of health cluster coordinator in establishment and maintenance of effective subnational clusters

Subnational cluster TOR should be formalized by health cluster partners, including the health authorities, and endorsed by the cluster lead agency. Clear lines of accountability between national and subnational levels should be articulated.¹⁶

Good communication between national and subnational coordination mechanisms is essential. Strategies to enhance effective linkages between the two include the following:

- national-level cluster staff to arrange regular support telephone calls with subnational coordination staff;



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10				
Box	●	●	●	●	●									
	2.1	2.2	2.3	2.4	2.5									
Figure	●	●												
	2.1	2.2												
Table	●	●	●	●										
	2.1	2.2	2.3	2.4										

- [Contents](#)
- [References](#)
- [Endnotes](#)

- national-level cluster staff to be available for additional ad hoc support telephone calls, as required;
- periodic support visits;
- regular reports submitted;
- timely analysis and feedback from national level on reports submitted;
- establishment of processes and mechanisms to ensure adequate subnational engagement in the national planning process;
- sharing of minutes from national-level meetings to subnational level and vice versa;
- meetings at national and subnational levels appropriately scheduled to enable one to feed into the other (subnational level to provide situation updates before national-level meetings and national level to provide relevant inputs prior to subnational-level meetings);
- national health cluster coordinator to attend subnational health cluster meetings periodically (supervisory visits timed to tie into this);
- subnational health cluster coordinators to have the opportunity to attend national health cluster meetings periodically;
- use of available technology to enable joint national and subnational meetings, as appropriate.

Tips to enhance effectiveness of subnational health clusters

It is essential that WHO as cluster lead agency recruit trained and experienced coordination and information management staff to fulfil effective coordination functions at subnational level.

Appropriate support should be provided by the national-level health cluster to strengthen subnational capacity:

- ✓ focus support on the identified highly vulnerable hotspot areas, in line with national-level practice, working with and through local entities and strengthening local capacities;



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10		
Box	●	●	●	●	●							
	2.1	2.2	2.3	2.4	2.5							
Figure	●	●										
	2.1	2.2										
Table	●	●	●	●								
	2.1	2.2	2.3	2.4								

- [Contents](#)
- [References](#)
- [Endnotes](#)

- ✓ ensure orientation for both coordinators and partners, and (ideally) conduct orientation at subnational level;
- ✓ provide policy and technical direction;
- ✓ ensure adequate human and financial resources are made available to enable effective subnational coordination – the choice of “double-hatted” or dedicated cluster coordination staff at subnational level should be related to the scale of the humanitarian need and the number of operational partners involved at subnational level rather than the desire to save money.

2.5 Sharing leadership and coordination responsibility in a formally activated health cluster

Sharing health cluster leadership is about sharing responsibility. The Cluster Coordination Reference Module states: “Shared leadership distributes global, national or subnational responsibilities for cluster lead agency or cluster coordination to two or more agencies.”¹⁷

Leadership of the health cluster encompasses cluster coordination at national and subnational levels. However, leadership of the health cluster also encompasses membership of and active engagement in the strategic advisory group and various technical working groups or subclusters that are established under the auspices of the health cluster and are essential for an effective health cluster response.¹⁸

The Cluster Coordination Reference Module focuses on sharing of leadership with NGOs. However, in reality in many contexts, WHO as cluster lead agency shares leadership of the health cluster with the health authorities or jointly with the health authorities and partner agencies.

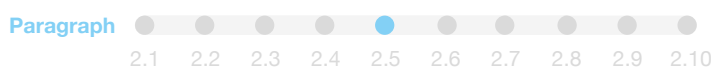
2.5.1 Sharing leadership and coordination responsibility with health authorities

Active engagement of national, subnational and local counterparts in leadership of a formally activated health cluster strengthens the effectiveness of the emergency response and enhances effective transition and deactivation of the health cluster in the longer term.

The level of engagement of the health authorities in health cluster coordination at national and subnational levels will vary depending on both the willingness and the



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

capacity of the national and subnational health authorities to lead or contribute to coordination of the response in line with humanitarian principles.

- **Co-leadership approach.** Where the national or subnational health authority is willing to engage in the leadership of coordination of the response but does not have the capacity to fully lead the response, WHO should aim to establish a co-leadership approach with the health authorities. Ideally, the health cluster coordinator will facilitate the health authorities and play a supporting and mentoring role. However, when and where required, the health cluster coordinator should be able to take on a more active role in facilitating the health cluster.
- **WHO leadership.** Where the national or subnational health authority is unable to meet the needs in a manner that respects humanitarian principles – due to the scale of need, the number of actors involved, or other constraints – then WHO should lead the health response. In such a situation, WHO, as the cluster lead agency and health cluster coordinator, will engage with the national and subnational health authorities as appropriate to the context. This may involve the health authorities formally taking responsibility for specific aspects of coordination. Alternatively, it may involve more informal engagement with the health authorities to negotiate with, share information with and update the authorities, as appropriate. The nuances of this engagement and the shared responsibility for coordination in this context will need to be handled maturely and sensitively by the health cluster coordinator and head of the WHO country office.

2.5.2 Sharing leadership and coordination responsibility with NGOs

Evaluations and research indicate that sharing cluster leadership between United Nations agencies, NGOs, international organizations and the International Red Cross and Red Crescent Movement leads to stronger engagement and better coordination. The Cluster Coordination Reference Module notes the following.

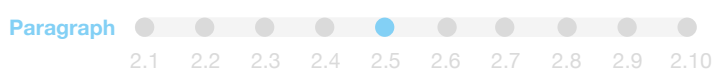
- NGOs are often well established in remote locations where the United Nations has limited or no presence.
- NGOs can offer technical expertise, different approaches to accountability to affected populations, long-term involvement in and knowledge of the community, and leadership potential.

Added value of NGO co-coordination of the health cluster includes:

- sending a message to health actors that the response is based on strong partnership between United Nations and non-United Nations agencies;



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

- broadening cluster membership through effective outreach to the NGO community, especially in a situation where there may be mistrust of the United Nations;
- increasing diversity of experience and skills in the health cluster coordination team through the generally different profiles of a United Nations-appointed health cluster coordinator and an NGO-appointed health cluster co-coordinator.

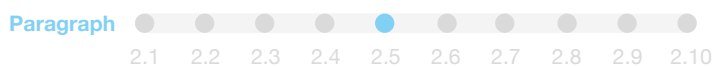
Sharing responsibility for coordination of clusters with an NGO partner is proactively encouraged by the Cluster Coordination Reference Module. Nevertheless, it must be appreciated that not all health cluster partners are willing or able to take on responsibility for coordination functions. It is recommended that selection of agencies to take on a shared responsibility for health cluster coordination should take into consideration the agencies’:

- operational and technical relevance in the emergency;
- ability to provide appropriately experienced staff for cluster coordination positions in a timely manner and (mostly) in a full-time dedicated capacity;
- ability to provide financial, logistic and administrative support to the health cluster co-coordinator;
- institutional knowledge of the cluster approach and the Transformative Agenda, including operational experience in a number of countries, thus having the capacity to appropriately support and manage the health cluster co-coordinator;
- institutional knowledge of international standards for health in emergencies, including Sphere Minimum Standards for Healthcare, Global Health Cluster standards, Minimum Initial Service Package for sexual and reproductive health, and other IASC guidelines supporting (as required) the health cluster co-coordinator on emergency health technical issues;
- demonstrated capacity at national level to contribute strategically to the health response.

Selection of an NGO to take on coordination responsibility should be made using the criteria above, through an open transparent process, and ideally reaching consensus through a consultative process within the cluster.



Establishing a health cluster at country level: functions, roles and responsibilities



- [Contents](#)
- [References](#)
- [Endnotes](#)

Process for selection of health cluster co-coordination with NGOs

A typical process for selection of health cluster co-coordination with NGOs is as follows.

- The health cluster coordinator puts out a call for co-coordination, outlining criteria, indicating the level of the position – for national or subnational level (or both) – and indicating whether the co-coordinator is required in a dedicated or double-hatted capacity.
- Interested agencies that meet the criteria above submit an expression of interest or application to the health cluster coordinator for the position or positions that the agency is interested in filling.
- Selection of the agency or agencies should be made on review of the expressions of interest or applications or through an interview process.
- Selection may be made by the strategic advisory group, an ad hoc selection committee (established specifically for the task), or by open voting of all health cluster partners (not relevant where interviews are conducted).

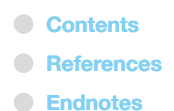
Points to consider in establishing shared responsibility for coordination with an NGO

Points to consider in establishing and maintaining effective shared responsibility for coordination of the health cluster with an NGO include the following.

- TOR and memoranda of understanding (MOUs) should be developed to ensure that all parties have a shared understanding of roles, responsibilities and accountabilities.
- Those agencies sharing the coordination should jointly determine which model works best for the context, and the TOR and MOUs must be completed and understood in advance, because organizations that take on responsibility for sharing cluster coordination will need to recruit full-time staff and secure funding.
 - TOR are developed for individuals recruited as coordinators or co-coordinators at national or subnational levels.
 - MOUs are developed between the agencies that will share responsibility for coordination of the health cluster.
 - It is essential that a health cluster NGO co-coordinator is treated as an equal member of the health cluster coordination team, and that coordination



Establishing a health cluster at country level: functions, roles and responsibilities



responsibility is shared between the WHO-appointed health cluster coordinator and the NGO-appointed health cluster co-coordinator.

- Sharing responsibility for cluster coordination has costs. Where a co-coordination model is desired and appropriate, it is essential that funding does not become an obstacle for agencies interested in and committed to taking this role. WHO as cluster lead agency should advocate allocation of resources from appropriate available funding mechanisms and additional donor support as required.
- It is a goal of every emergency health response to build the capacity of the national and subnational health authorities to fulfil their responsibilities to their people. Those in health cluster coordination leadership roles should help to build this capacity.


Options for sharing coordination responsibility with national NGOs

Options for sharing coordination responsibility with national NGOs should be explored and considered. Sharing responsibility for cluster coordination has tended to focus on international NGOs, as they often have the immediate capacity to provide appropriate staff and oversight, and have large strategic and operational relevance. However, this may not always be the case: at subnational level, national or local NGOs may be the largest providers closest to the populations. This factor needs to be considered when determining the model for co-coordination. For example, the Turkey Health Cluster hub for the Whole of Syria response collectively decided that the health cluster coordination team should be made up of a health cluster coordinator from WHO and two co-coordinators, one from an international NGO and one from a national NGO.

2.6 Inter-cluster coordination

2.6.1 Definition and purpose of inter-cluster coordination

- Inter-cluster coordination is a cooperative effort among sectors or clusters and the humanitarian country team to ensure coherence in achieving common objectives, avoiding duplication and ensuring that areas of need are prioritized (13). Inter-cluster coordination takes place at the national and subnational levels in order to coordinate the implementation of the response through each step of the humanitarian programme cycle.
- The HC and humanitarian country team provide an overall strategic direction to the humanitarian community in support of the national response. Guided by



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10				
Box	●	●	●	●	●									
	2.1	2.2	2.3	2.4	2.5									
Figure	●	●												
	2.1	2.2												
Table	●	●	●	●										
	2.1	2.2	2.3	2.4										

- [Contents](#)
- [References](#)
- [Endnotes](#)

the humanitarian country team, inter-cluster coordination provides a platform for clusters to work together to advance the delivery of assistance to affected populations effectively and efficiently. It does this by encouraging synergies between sectors, ensuring roles and responsibilities are clearly defined, closing potential gaps and eliminating duplication.

- Inter-cluster coordination plays a critical role in facilitating the development of the strategic response plan and ensuring a coherent and coordinated approach to planning and operationalizing the shared strategic objectives as set out in the strategic response plan. The inter-cluster coordination group is accountable to the humanitarian country team.

2.6.2 Inter-cluster coordination group

The inter-cluster coordination group comprises cluster coordinators and co-coordinators, is supported by OCHA, and is guided by the humanitarian country team.¹⁹

The inter-cluster coordination group supports common services and activities to enable an effective humanitarian response, for example by:

- ensuring common standards and approaches are developed and adopted (for example, Sphere standards and feedback mechanisms for affected populations);
- ensuring common information management tools are developed, updated and available (for example, the 4W Matrix tool for coordination, web platforms and mapping tools).

The inter-cluster coordination group encourages synergies between sectors, for example by:

- facilitating inter-cluster assessment and analysis and strategic planning;
- building cross-cluster linkages, facilitating key clusters to work together to address specific issues (for example, camp coordination and camp management, health, shelter, and WASH clusters to address public health responses, and food security, health, nutrition and WASH clusters to address malnutrition and cholera outbreak);
- facilitating nutrition-sensitive programming within all clusters;
- facilitating incorporation of protection mainstreaming and other cross-cutting



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

issues into the humanitarian response across all clusters to avoid duplication and make better use of available resources among partners.

OCHA supports inter-cluster coordination by:

- chairing inter-cluster coordination group meetings and providing direct support, facilitation, and secretariat services, as determined by the RC/HC and humanitarian country team;
- ensuring two-way communication between the humanitarian country team and the inter-cluster coordination group (the humanitarian country team is advised of operational developments impacting the overall response, and clusters receive overall strategic guidance from the humanitarian country team).

Box 2.2 presents information on representation at inter-cluster coordination group meetings, while Box 2.3 gives an example from Ukraine of TOR for an inter-cluster coordination group.

● **Box 2.2 Representation at inter-cluster coordination group meetings**

The health cluster coordinators have responsibility to proactively participate in the inter-cluster coordination group meetings, ensuring active representation of the health cluster.

In a situation where both the health cluster coordinator and co-coordinator are out of the location and so are not available to attend an inter-cluster coordination group meeting, a WHO staff member should attend the meeting to represent the health cluster. Alternatively, the representative from the co-lead agency, a strategic advisory group member, or an experienced, capable health cluster partner may represent the health cluster at the inter-cluster coordination group meeting.

● **Box 2.3 Ukraine inter-cluster coordination group: TOR**

In Ukraine, TOR were developed for the inter-cluster coordination group outlining objectives, responsibilities, membership, chairship, modus operandi and interface with other in-country coordination mechanisms. The TOR were developed by OCHA in consultation with and with input from the in-country cluster coordinators.

The TOR emphasized that the modus operandi is governed by principles of partnership; chairship style is consensual and facilitative; membership style is collaborative and constructive; and meetings are strategic and action oriented, producing reality-based decisions.

The TOR also emphasized that the inter-cluster coordination group does not replace other in-country coordination groups and that, where possible, it complements government-led coordination structures.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

2.6.3 Modalities for inter-cluster coordination

The health status of an affected population is impacted by multiple factors far beyond the provision of preventive and curative health services, including availability of shelter, environmental health, food security, nutritional support and protection.

Consequently, better health outcomes will require collective action from multiple clusters.²⁰

Clusters should have a common understanding of the humanitarian context, implying understanding of and agreement on:

- *where* is it happening? – geographical issues
- *who* are we talking about? – vulnerabilities (cross-cutting issues)
- *what* are we talking about? – service delivery
- *when* will it happen? – prioritization of interventions
- *how* can we best deliver as a consulted group? – joint planning for common outcomes.

Clusters have common mandates:

- gender and protection mainstreaming
- combating gender-based violence
- mental health and psychosocial support services
- accountability to affected populations – people-centred approach
- adherence to humanitarian principles and principles of partnership
- cross-cutting issues (age, HIV/AIDS, gender, disability, diversity)
- advocacy.



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph ● ● ● ● ● ● ● ● ● ●

2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box ● ● ● ● ●

2.1 2.2 2.3 2.4 2.5

Figure ● ●

2.1 2.2

Table ● ● ● ●

2.1 2.2 2.3 2.4

- Contents
- References
- Endnotes

Clusters may have common modalities for response implementation:

- cash and voucher assistance
- provision of package for multisectoral service delivery
- joint planning and integrated intersectoral response
- linking emergency response with development-oriented interventions
- joint resource mobilization for multisectoral service delivery.

However, other strategic objectives or specific areas of focus may require input or contribution from a more limited number of clusters, in which case smaller groups of key clusters will come together, potentially supported by members of the humanitarian country team, to address key thematic issues that require a coordinated response from key clusters, as outlined in the following subsections.

2.6.4 Thematic inter-cluster coordination of relevance to the health cluster

Some strategic objectives may require contributions from several clusters, in which case smaller groups of clusters, potentially supported by members of the humanitarian country team, may come together to discuss specific strategies and periodically for monitoring of their achievement, although all clusters and the humanitarian country team need to be aware of progress and challenges to ensure the appropriate overall linkages, as necessary.

Additional thematic inter-cluster coordination activities of importance to the health cluster include those with formal IASC mandates, and others without a formal mandate from IASC.

Inter-cluster coordination with a formal IASC mandate

Coordination of gender-based violence prevention, mitigation and response

- Effective gender-based violence prevention, mitigation and response activities require a unified inter-cluster approach.
- Coordination of those activities is the responsibility of the gender-based violence subcluster under the protection cluster, as mandated by IASC. Clinical management of gender-based violence is under the responsibility of the health cluster.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

The gender-based violence subcluster is generally led by UNFPA (global lead for Gender-Based Violence Area of Responsibility within the Global Protection Cluster) and should work with all clusters to ensure that gender-based violence prevention, mitigation and response activities across all sectors are appropriately coordinated and are mutually supporting, and that the required cross-cluster linkages and referral pathways are established in coordination with existing national efforts.

It is the responsibility of the health cluster coordinators to:

- proactively engage with the in-country gender-based violence coordinator or focal point;
- actively participate in the established gender-based violence subcluster, through appointing one focal point from the health cluster;
- proactively engage with the other relevant clusters on a bilateral basis as required to promote a better health response to gender-based violence;
- work with the gender-based violence coordinator or focal point and other relevant stakeholders to organize appropriate orientation and training for health partners and develop and adapt tools for use by the health cluster;
- invite the gender-based violence coordinator or focal point and other relevant stakeholders to participate in the health cluster meetings periodically (for the purpose of briefing, updating and guiding partners on effectively incorporating gender-based violence prevention and response into the health response);
- ensure that gender-based violence considerations are appropriately incorporated into the health cluster response across all phases of the Humanitarian Programme Cycle (in line with gender-based violence guidelines) (14);
- build a shared vision among health cluster partners about how to effectively incorporate gender-based violence prevention and response into the work of the health cluster as a routine component of emergency health response.

Coordination of mental health and psychosocial support services

Mental health and psychosocial problems in emergencies are highly interconnected and should address both pre-existing and emergency-induced problems (15). A multisectoral, multi-cluster approach is essential to provide the appropriate services required to promote mental health and psychosocial well-being in a humanitarian emergency. The IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings recommends the following.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

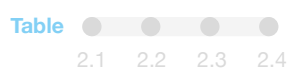
- Where multiple mental health and psychosocial support services actors are present, an inter-cluster, intersectoral coordination group for mental health and psychosocial support should be established.
- TOR should be developed in relation to the inter-cluster operational issues that should be addressed by this group.
- The coordination group for mental health and psychosocial support should work with all relevant clusters and sectors to ensure that their activities are conducted in a way that promotes mental health and psychosocial well-being.
- Experience has shown that it is usually best for the coordination group to be co-chaired by both a health agency and a protection agency (or by both a health agency and a community services agency in the case of refugee camp settings).
- The lead agencies should be knowledgeable in mental health and psychosocial support services and skilled in inclusive coordination processes, thus avoiding dominance by a particular approach or sector.
- The cluster lead agency or the coordinator should appoint a focal point for mental health and psychosocial support services from within the cluster to address the related operational issues, again with joint leadership (as above).

Key points are as follows:

- Thematic inter-cluster coordination groups may be established with involvement of key clusters to address specific aspects of the response that require coordinated input from these key clusters.
- These groups may be established at national or subnational level as and when required, depending on the context.
- It is recommended that these thematic focus inter-cluster coordination groups are co-chaired by two clusters.
- Potentially, if considered appropriate, these groups could be supported by a humanitarian country team member, which may assist in strengthening buy-in and putting the issue on the agenda at a higher level.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

Inter-cluster approaches without formal IASC mandate

Thematic focus areas for inter-cluster coordination

Inter-cluster coordination mechanisms may be established, depending on the context, to address specific areas of focus that require a coordinated response from key clusters (Table 2.4).

► **Table 2.4** Thematic focus areas for inter-cluster coordination mechanisms

THEMATIC FOCUS OF RELEVANCE TO HEALTH CLUSTER	KEY CLUSTERS POTENTIALLY INVOLVED
Diarrhoea prevention and response	Health, WASH, shelter, camp coordination and camp management, nutrition
Kala-azar prevention and response	Food security, health, education, nutrition, non-food items, WASH
Malaria prevention and response	Non-food items, WASH, health
Malnutrition prevention and response	Food security, health, nutrition, WASH
Outbreak/epidemic warning, preparedness and response	WASH, health

The role of the inter-cluster coordination group would be to:

- plan and implement joint assessment and analysis;
- agree priority geographical areas and target populations for these specific multi-cluster interventions;
- conduct joint planning and formulate agreements;
- identify specific intervention areas and responsibilities for each of the clusters;
- define clear referral mechanisms between the clusters at operational level;
- ensure adequate support and guidance from national to subnational and operational level for effective multi-cluster response;
- conduct joint monitoring and review of multi-cluster initiative;
- report back to the overall inter-cluster coordination group in terms of plans, progress and challenges (all clusters and the humanitarian country team need to be aware of plans, progress made and challenges faced, to ensure the appropriate overall linkages as necessary).



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●	●
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	

Box	●	●	●	●	●	Figure	●	●	Table	●	●	●	●
	2.1	2.2	2.3	2.4	2.5		2.1	2.2		2.1	2.2	2.3	2.4

- Contents
- References
- Endnotes

Coordination of multipurpose cash transfers

Multipurpose cash transfers are increasingly used as an intervention modality in emergency contexts. A multipurpose cash transfer is a defined amount of money transferred directly to patients or households to help them pay for their basic needs or recovery needs. In many cases, health is considered a basic need, along with food, water and shelter.

In countries where multipurpose cash transfers are considered in the humanitarian response plan, they are usually coordinated between partners and implemented under a cash working group. Because multipurpose cash transfers address financial needs across multiple sectors, the cash working group sits in the inter-cluster coordination group. Guidance for cash coordination is being developed, including TOR for the cash working group (16, 17).

It is important that the health cluster coordinator establishes explicit links with the cash working group:

- when household surveys are done, to identify needs in health services and barriers to access to health services, undertake market and system analysis, and establish health expenditures and response modalities, in order to ensure that health aspects are adequately reflected and appropriately analysed;
- to provide input for the health component of the minimum expenditure basket;
- to advise on a possible inclusion or top-up of the multipurpose cash transfer to reduce financial barriers for accessing health services within the broader health sector financing options;
- to include health appropriately in cash distribution monitoring surveys, for example by asking adequate questions on health expenditure, health behaviour, and health within the negative coping index;²¹
- to advise on appropriate health indicators and their analysis and interpretation in the monitoring and evaluations systems for multipurpose cash transfer assistance.

Furthermore, household surveys conducted by the cash working group can provide very useful information for health partners for situation and response analysis to identify problems and their underlying causes.

If any or a mix of cash transfer modalities are proposed alongside other health responses, the cash working group can provide technical assistance to health



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph ● ● ● ● ● ● ● ● ● ●
2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box ● ● ● ● ●
2.1 2.2 2.3 2.4 2.5

Figure ● ●
2.1 2.2

Table ● ● ● ●
2.1 2.2 2.3 2.4

- **Contents**
- **References**
- **Endnotes**

partners on effective and secure cash transfer platforms, for example to pay for health worker incentives.

2.6.5 Promoting collaboration and coordination with key clusters

Levels of inter-cluster engagement

Given the required linkages between the health cluster and other key clusters and the need for a multisectoral approach for better health outcomes, it is important that the health cluster coordinator proactively promotes collaboration and coordination with these key clusters, beyond participation in the inter-cluster coordination group and thematic focus coordination groups.

While it will be especially important to develop good relationships with the key clusters or sectors that directly impact morbidity and mortality (food security, nutrition, protection and WASH), it should be understood that there is no single solution to all challenges, and the level of engagement required with the various clusters or sectors will be determined to some extent by the specific context or crisis. It may be necessary to engage on a bilateral basis with some cluster coordinators on the importance of an integrated approach for better health outcomes.

Tips to enhance a multi-cluster, multisectoral, integrated approach for better health outcomes

The health cluster coordinator can promote collaboration and coordination through:

- engaging in bilateral dialogue with coordinators from the other key clusters or sectors;
- inviting other key cluster or sector coordinators to attend health cluster meetings and allocating space on the agenda for appropriate input from these key clusters for briefing and discussion on joint or coordinated activity;
- attendance of the health cluster coordinator at meetings held by other key clusters (food security, nutrition, WASH and protection) to brief on relevant issues and discuss issues of mutual concern;
- where the health cluster coordinator is unable to attend, assigning a key health cluster partner to represent the health cluster, reporting back at the next health cluster meeting, or directly to the health cluster coordinator if an urgent issue is raised;



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph ● ● ● ● ● ● ● ● ● ●
 2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box ● ● ● ● ●
 2.1 2.2 2.3 2.4 2.5

Figure ● ●
 2.1 2.2

Table ● ● ● ●
 2.1 2.2 2.3 2.4

- Contents
- References
- Endnotes

- ensuring two-way sharing of relevant information;
- organizing periodic joint meetings with other clusters where appropriate, for example to address a specific issue of mutual concern, such as high malnutrition rates or disease outbreaks (measles, diarrhoea, kala-azar);
- developing a shared vision within the health cluster and with the other key clusters of what a multisectoral, integrated response for better health outcomes looks like, including through:
 - allocating adequate space at key cluster meetings to discuss a multisectoral, integrated response;
 - sharing examples of good practice of integrated programming at health cluster meetings;
 - facilitating project learning visits to locations where there is effective multisectoral, integrated programming.²²

2.7 Working with other coordinating bodies

2.7.1 Principles of engagement with other bodies

It is the responsibility of the health cluster coordinator, along with WHO as cluster lead agency, to determine which groups are important to engage with and subsequently to build the necessary working relationships between these groups and the health cluster.

In addition to inter-cluster coordination mechanisms, it is essential that the health cluster proactively engages and coordinates with other relevant bodies, including developmental health coordinating bodies (where in existence), health sector budget working groups, NGO coordinating forums, national disaster bodies and development-focused donors.

In line with New Way of Working (6), appropriate engagement with relevant development-focused bodies is essential. This will ensure linkages between emergency and developmental programmes and interventions, including preparedness. Subsequently, it will promote optimal early recovery and effective transition enabling eventual deactivation of the health cluster so resources can be employed on sustainable emergency coordination functions. Furthermore, in contexts characterized by conflict, the health cluster coordinator needs to seek links with peacebuilding, and ensure that the health interventions are conflict sensitive and contribute to protection.²³



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph ● ● ● ● ● ● ● ● ● ●
2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box ● ● ● ● ● ● ● ● ● ● **Figure** ● ● ● ● ● ● ● ● ● ● **Table** ● ● ● ● ● ● ● ● ● ●
2.1 2.2 2.3 2.4 2.5 2.1 2.2 2.1 2.2 2.3 2.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

Examples of engagement include the following.

- The health cluster can use the NGO forum to share information with NGOs and to engage with NGOs on various issues.
- Where essential drugs are provided under emergency funding mechanisms, the health cluster should engage with health sector budget working groups to ensure that regular health budgets take on board cost of procurement of essential drugs, and that there is adequate lead time to allow for procurement before funding for emergency supplies is discontinued.
- Some of the various development-focused bodies may be expected to take on aspects of the emergency coordination functions after deactivation of the cluster.²⁴

2.7.2 Emergency medical teams

Emergency medical teams (EMTs) are groups of health professionals providing direct clinical care to populations affected by disasters, outbreaks and emergencies as surge capacity to support the local health system. The title is not a “brand” or indication of working “under” WHO, but an initiative and an ethos of quality care in emergencies founded after a collective effort to agree on terminology and minimum standards after poor responses to the Haiti 2010 earthquake and other disasters (18, 19).

The term applies to all clinical teams that deliver direct care, including local and international NGOs, governmental rapid response teams (national and international), International Red Cross and Red Crescent medical teams, and military medical teams.

WHO hosts the secretariat of the EMT initiative, with focal points at each regional office. It helps with capacity-building of national teams and national coordination mechanisms for clinical care response in emergencies,²⁵ as well as convening partners to set agreed standards, ensuring quality assurance through peer review, and supporting coordination during responses.

While EMT coordination normally sits with the health emergency operations centre of an affected country in non-conflict contexts, in cases of active conflict, EMT coordination will often be through a clinical case management or trauma working group acting under the health cluster or another independent coordination platform, such as the on-site operations coordination centre (19).



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

EMT coordination should occur within existing emergency response frameworks and if possible be led by the clinical care or emergency response sections of the ministry of health, within the health operations pillar of the health emergency operations centre. This EMT function may require WHO experts to support arriving EMTs, United Nations Disaster Assessment and Coordination team members, or direct bilateral expert deployments from neighbouring countries. Some international agencies and international NGOs may deploy EMTs and other health and thematic experts, for example in the areas of WASH, shelter or gender-based violence.

It is critical that the various coordination platforms communicate closely and coordinate internally. EMT coordination is a specialized field and requires training, ideally through the WHO EMT coordination cell course. If a national focal point is not available, then a ministry of health emergency officer should be designated as EMT coordinator, with strong support from an EMT expert coordinator from WHO or through the channels above.

During crises (for example, the earthquakes of Ecuador, Indonesia and Nepal, or the cyclones in Vanuatu and the Philippines), the ministry of health retains the right in almost all instances to license and register arriving clinical teams and deploy them where they are most needed. The ministry of health usually has the best information on health infrastructure damage and impact on pre-existing services, and requires a central coordination section – the EMT coordination cell – to deploy national and (as requested) international clinical teams arriving for a sudden onset disaster or outbreak. It receives daily operational updates and reports from all national and international teams using a minimum data set one-page reporting sheet.

EMT coordination cell methodology is now taught in over 130 countries by regional offices of WHO, and is closely aligned with the work of WHO in building the capacity of health emergency operations centres.

In cases of conflict, or where there is a need to have coordination mechanisms that are independent of government, the EMT coordination can be applied and termed a trauma (or clinical care) working group sitting within the health cluster.

There are three options for EMT or clinical care team coordination.

1. An EMT coordination cell is established and completely run by the ministry of health within the existing health emergency operations centre (as for the Japanese earthquake and tsunami of 2011 and the New Zealand earthquake of 2011).



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

2. An EMT coordination cell is established within the national health emergency operations centre but supported by WHO and partners (as for the West Africa Ebola outbreak of 2014–2015 and the Ecuador earthquake of 2016). The supported EMT coordination cell can also coexist within the national health emergency operations centre with an activated health cluster (as for the Nepal earthquake of 2015 and the Mozambique cyclone of 2019).
3. A trauma or clinical care working group is established under the health cluster (as for the conflict in Iraq in 2017).

2.7.3 Role of the health cluster coordinator with regard to EMTs

A deployed health cluster coordinator will need to undertake the following tasks.

- It is necessary to quickly establish which type of medical team coordination above is required.
- If there is need for an EMT coordination cell, then the health cluster coordinator should contact the EMT secretariat, with an indication as to whether the country requires assistance in setting one up.
- In a constrained or conflict setting, the health cluster coordinator can consider instead a clinical care or trauma working group approach to convene technical partners delivering direct care, and can ask for assistance from the EMT secretariat for this.
- It is critical that in scenario 2 above, with a nationally led health emergency operations centre and an internationally supported EMT coordination cell, the health cluster coordinator works closely with EMT coordination cell colleagues, shares information, requests copies of the minimum data set of combined reports daily, and attends EMT coordination cell meetings.
- Partners should understand which meeting (health cluster versus EMT coordination cell or trauma working group meeting) is most relevant to them. It is the role of the EMT coordinator and health cluster coordinator to articulate to partners the meeting purpose, so they can choose appropriate attendees and send the correct technical people to take part. In general, EMT coordination cell meetings are directly focused on clinical care and clinical coverage, patient transport and logistics, and operational support to clinical facilities.
- Transition back to normal clinical coordination by the ministry of health generally occurs within six to eight weeks of a sudden onset event, though operations may continue for months in an outbreak or for trauma working groups in conflict.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

2.7.5 Cluster engagement and coordination with the military

Over recent decades, military actors have been increasingly involved in relief activities, including (on occasion) providing direct assistance to crisis-affected populations, both in the context of natural disasters and in the context of complex emergency settings.²⁷ In some situations, humanitarian actors have invited the involvement of the military to support humanitarian interventions (NGOs requested military involvement in the Ebola response in West Africa in 2015, and the WHO plan for a stronger global health emergency workforce includes the potential use of the military) (21).

A key element of the United Nations Humanitarian Civil-Military Coordination guidelines is the application of the principle of last resort to the engagement of foreign military teams (22). In disasters in peacetime, in order to meet a critical humanitarian need, foreign military and civil defence assets should be utilized where there is no comparable civilian alternative in terms of timely deployment or capability. In complex emergencies, the principle is even more important: foreign military assets, including EMTs, should be used only if they are the last resort to respond to a critical life-threatening situation, that is, the need cannot be met with available civilian assets, and there are no other alternatives. As a matter of principle, foreign military assets of belligerent forces or of units actively engaged in combat should not be used to support humanitarian activities. Decision-makers must weigh the risk to relief workers and their ability to operate effectively at the moment and in the future against the immediacy of the needs of the affected population and the need for the use of foreign military assets.

Basic civil-military coordination strategies range from coexistence to cooperation. Cooperation is a form of humanitarian civil-military coordination that strives to ensure complementarity and coherence of efforts between humanitarian and military actors. Coexistence is a form of humanitarian civil-military coordination that aims at de-conflicting humanitarian and military activities; actors merely operate in the same space, albeit largely independently. In this instance, humanitarian civil-military coordination focuses on minimizing competition to enable different actors to work in the same geographical area with minimum disruption to each other's activities. Such an approach is often observed in the case of hazards resulting from human action and complex emergencies.

Regardless of the context of the emergency, humanitarian-military coordination is necessary in a humanitarian response. However, how this coordination is organized, and the level of cooperation between the humanitarian community and the military, depend on the context.



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph ●●●●●●●●●●●

2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box ●●●●●

2.1 2.2 2.3 2.4 2.5

Figure ●●

2.1 2.2

Table ●●●●

2.1 2.2 2.3 2.4

- Contents
- References
- Endnotes

The health cluster coordinator and WHO as cluster lead agency for health have the following responsibilities:

- facilitating or leading risk mapping of military involvement in health action;
- promoting close cooperation with the OCHA civil-military coordination officer in order to ensure recognition of health sector needs and issues related to civil-military coordination;
- facilitating the process of identifying civil-military coordination modalities suitable for the health sector in the local context in discussion with other humanitarian clusters under the leadership of the HC;
- if and when appropriate, serving as an interface between the military and health cluster members, including with regard to identifying and establishing clear procedures for medical evacuation, and identifying and defining the process for activating logistical support for distributing drugs and equipment (23);
- defining and disseminating the criteria to identify health facilities that need to be rehabilitated;
- ensuring that WHO as cluster lead agency and health cluster coordinator avoids putting a “humanitarian stamp” or “humanitarian label” on health activities carried out by military actors (21).

2.8 Participation in the health cluster

2.8.1 Minimum commitments for participation in the health cluster

All health cluster partners, including WHO as cluster lead agency and as an implementing partner, have a shared responsibility to meet the humanitarian needs of affected populations in a timely manner.

The minimum commitments for participation in country-level clusters set out what all local, national or international organizations undertake to commit to as cluster partners (Box 2.4).²⁸ The commitments do not seek to exclude organizations or national authorities from participating in clusters.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

● Box 2.4 Minimum commitments for partner participation in clusters

Twelve minimum commitments for partner participation in clusters are as follows:

1. commitment to humanitarian principles, the principles of partnership, cluster-specific guidance and internationally recognized programme standards, including the Secretary-General’s bulletin on special measures for protection from sexual exploitation and sexual abuse (24);
2. commitment to mainstream protection in programme delivery (including respect for principles of non-discrimination and “do no harm”);
3. readiness to participate in actions that specifically improve accountability to affected populations, in line with the IASC Commitments on Accountability to Affected Populations and the related Operational Framework;
4. demonstrated understanding of the duties and responsibilities associated with membership of the cluster, as defined by IASC TOR and guidance notes, cluster-specific guidance and country cluster TOR, where available;
5. active participation in the cluster and a commitment to consistently engage in the cluster’s collective work;
6. capacity and willingness to contribute to the cluster’s strategic response plan and activities, which must include inter-cluster coordination;
7. commitment to mainstream key programmatic cross-cutting issues (including age, gender, the environment and HIV);
8. commitment by a relevant senior staff member to work consistently with the cluster to fulfil its mission;
9. commitment to work cooperatively with other cluster partners to ensure optimal and strategic use of available resources, and share information on organizational resources;
10. willingness to take on leadership responsibilities in subnational or working groups as needed, subject to capacity and mandate;
11. readiness to undertake advocacy and disseminate advocacy messages to affected communities, the host government, donors, the humanitarian country team, cluster lead agencies, the media and other audiences;
12. willingness to ensure that the cluster provides interpretation (in an appropriate language) so that all cluster partners are able to participate, including local organizations (and national and local authorities, where appropriate).

Source: Adapted from Cluster Coordination Reference Module (5), page 24.

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1

2

3

4

5

6

7

8

9

10

11

12

13

Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph

2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box

2.1 2.2 2.3 2.4 2.5

Figure

2.1 2.2

Table

2.1 2.2 2.3 2.4

● Contents

● References

● Endnotes

2.8.2 Respective roles, responsibilities and accountabilities

This subsection outlines the respective roles and responsibilities of WHO as cluster lead agency, the health cluster coordination team and health cluster partners. It is important that these roles and responsibilities are fulfilled while operating with respect to and in line with the principles of partnership (equality, transparency, results-oriented approach, responsibility and complementarity).²⁹

Role, responsibility and accountability of WHO as cluster lead agency

It is the responsibility of WHO as the cluster lead agency to ensure the establishment of an adequate emergency coordination mechanism for the health sector. This involves the timely recruitment of sufficient numbers of staff with the appropriate coordination and information management skills and experience; ensuring appropriate relations are developed and maintained with the ministry of health; support for and management of the health cluster coordination team; and lobbying for resources for the humanitarian health partners. WHO as the cluster lead agency also serves as provider of last resort (Box 2.5).

● Box 2.5 Provider of last resort

Where a cluster is activated, the cluster lead agency must be ready to ensure provision of services to fill critical gaps that have been identified by the cluster and reflected in the strategic response plan (led by the HC and humanitarian country team), when access, security and funds are in place. Essentially, this means that as cluster lead agency, WHO commits to ensuring that affected populations get the required health services, and is obligated to provide these services where:

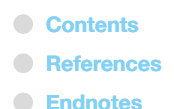
- they are identified by the cluster(s) as priority gaps within the context of the cluster strategic response plan;
- there are no other partners in a position to provide the services;
- access, security and funding allows.

The provider of last resort obligation would be activated only when advocacy with the national authorities and other partners to provide services proves to be unsuccessful. Where WHO as cluster lead agency is unsuccessful in fulfilling that role, WHO will be expected to continue with advocacy efforts, and to explain the constraints to the various stakeholders in justifying why it is not acting as provider of last resort.

Where there is a situation of co-coordination of the health cluster with an NGO, the NGO does not take on the provider of last resort responsibility.



Establishing a health cluster at country level: functions, roles and responsibilities



As cluster lead agency for the health cluster, WHO is responsible for representing the collective interests of the health cluster in the humanitarian country team, as well as representing the interests of WHO as an organization. This function requires knowledge and understanding of health cluster issues and challenges; it will therefore be essential for the head of the WHO country office to be well informed and up to date on health cluster activities, progress, plans and issues of concern. It also requires transparency on when the head of the WHO country office is speaking on behalf of the health cluster or on behalf of WHO as an organization.

As cluster lead agency for the health cluster, WHO is accountable to the HC and the Emergency Relief Coordinator in ensuring that health cluster leadership activities are carried out effectively (25).

Composition, roles and responsibilities of health cluster coordination teams at national and subnational levels

The size and composition of health cluster coordination teams will vary from country to country, depending on context (scale of the need and the coordination capacity and constraints), and indeed at subnational level within countries, depending on local context.

National-level health cluster coordination team

At the height of a large humanitarian crisis it would usually be recommended that a full team with a wide range of skills covering all of the core cluster functions be created at national level. This would include the health cluster coordinator, information management officer, data manager, public health officer, communications and advocacy officer, and NGO health cluster co-coordinator. These staff would preferably be dedicated cluster staff – that is, they would not have additional programme responsibilities.

In the context of an IASC humanitarian system-wide scale-up protocol activation or Grade 3 emergency, a minimum of two information management officers are needed – one to support needs assessment activities and one to establish and support monitoring and evaluation activities.

Where there is a need for rapid trauma care, an EMT cell will be created as a technical working group, and a coordinator will be appointed.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

Subnational health cluster coordination team

At the height of a large humanitarian crisis, it would usually be recommended that a subnational team be established, comprising a health cluster coordinator, information management officer, public health officer and logistician. The coordination and information management staff may be WHO employees or NGO employees. Ideally, as at national level, the staff would be dedicated cluster staff.

In exceptional circumstances, particularly in smaller-scale crises and in some protracted crises, it may not be operationally justifiable to have a large team fully dedicated to supporting health cluster coordination and information management activities at national or subnational level. In that case, a single person may fulfil both health cluster and WHO programme responsibilities (“double-hatting”). However, the decision to use double-hatted coordination and information management staff should be made based on solid analysis of the coordination needs, including the scale of the emergency and the number of health cluster partners.

There is no one-size-fits-all approach – each country health cluster will have specific needs that change over time as the emergency response evolves.

The health cluster coordination team, in collaboration with the health authority, is responsible for the day-to-day running of the health cluster, facilitating a process that ensures that activities under each of the core cluster functions are effectively carried out and monitored, and promoting interagency partnership in close collaboration with the national and local health authorities.

The health cluster coordinator is responsible for leadership and management of the health cluster coordination team and is accountable to the head of the WHO country office for the effective management of the health cluster (26).³⁰

Neutrality of the health cluster coordination team

The health cluster coordination team may be composed of WHO-employed staff or NGO-employed staff (where a co-ordination arrangement is in place), with surge support from health cluster partners.

Regardless of who employs staff, the health cluster coordination team has an overriding duty to the partners and must act as a neutral body working for the best interests of the health cluster as a collective, and not for the best interests of WHO as the cluster lead agency or the NGO co-coordinating agency, nor for the best interests of the United Nations agencies over NGOs, or NGOs over United Nations agencies.



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph ● ● ● ● ● ● ● ● ● ● ●
2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box ● ● ● ● ●
2.1 2.2 2.3 2.4 2.5

Figure ● ●
2.1 2.2

Table ● ● ● ●
2.1 2.2 2.3 2.4

● **Contents**
● **References**
● **Endnotes**

The credibility of the health cluster coordination team requires that its members demonstrate impartiality, autonomy and independence from the cluster lead agency and co-coordination agency. Coordination staff need to make a mental shift from agency affiliation to the cluster or sector as a collective. Similarly, information management staff and communications and advocacy officers need to ensure that information management outputs and processes, and communication and advocacy products, reflect the inputs of the health cluster as a whole and do not focus on WHO activities as a health cluster partner.

Neutrality of the health cluster coordination team may be promoted in the following ways.

- Dedicated staff are appointed with no responsibility for programme activities within the employing agency. This neutral position should be articulated in the various job descriptions and performance appraisals.
- The health cluster coordinator reports directly to the head of the WHO country office rather than to the WHO Health Emergencies Programme incident manager.
- The position of neutrality is emphasized with partners on a regular basis and backed up by practice:
 - Health cluster coordination team members should not be expected to represent their respective organizations or take on aspects of programme work on behalf of their employing agencies.
 - Senior programme staff from the WHO and co-coordination agencies should actively participate in health cluster meetings, representing their own agencies (so that the health cluster coordination team members do not have to), especially where funding allocations are being made.
 - In appropriate contexts, health cluster offices may be located outside WHO premises, though it is recognized that this is not always viable due to security and operational support requirements.

Other practical ways to promote neutrality are as follows:

- use of health cluster email addresses and signatures, and letterheads and business cards that do not carry the logo of WHO or the co-coordination agency;
- use of health cluster generic templates for visual presentations, rather than that of WHO or the co-coordination agency;
- creation of a health cluster website and communication products using the health cluster logo, rather than that of WHO or the co-coordination agency, and acknowledging and listing all partners on health cluster products;



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

- using a neutral venue away from WHO or co-ordination agency premises for meetings (ensuring adequate space and security);
- not wearing items visibly identifiable with WHO (such as WHO-branded clothing), except in a situation where it is advisable for health cluster coordination team members to be identified with the cluster lead agency for security reasons, for example outside the office in an insecure environment.

Double-hatting

Double-hatting occurs when a staff member performs a cluster role in addition to agency programme responsibilities. While it is the preference and recommendation of the Global Health Cluster to generally use dedicated health cluster coordination staff rather than double-hatted staff, in exceptional circumstances double-hatted coordination staff may be used. Experience has shown that where the scale of the emergency is not too great,³¹ double-hatting can work well at both national level and at subnational level, as long as the individuals appointed have coordination experience.

Poor-practice double-hatting can result in:

- coordination functions being considered as add-ons to normal business, to be carried out as time allows, and thus not afforded adequate focus or attention;
- lack of clear differentiation between health cluster and WHO functions and responsibilities, leading to confusion among partners;
- distrust and subsequent decreased engagement of partners with the health cluster, as partners feel their concerns are not being addressed, and WHO agency issues are being prioritized.

Effective double-hatting of health cluster coordination staff may be promoted through the following actions.

- Cluster coordination responsibilities and allocation of time for cluster functions are clearly articulated in the job description and performance appraisal of the double-hatted staff, and monitored as part of routine supervision to ensure that the dual role is maintained.
- Double-hatted coordination staff have coordination experience and solid understanding of the cluster approach.



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●	<ul style="list-style-type: none"> ● Contents ● References ● Endnotes 			
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10				
Box	●	●	●	●	●	Figure	●	●	Table	●		●	●	●
	2.1	2.2	2.3	2.4	2.5		2.1	2.2		2.1		2.2	2.3	2.4

- Double-hatted staff articulate very clearly whether they are speaking on behalf of the cluster as a collective or representing the specific view or position of their own employing agency.
- Where possible, another person should represent WHO or other co-coordinating agency at meetings, especially where WHO as the cluster lead agency or the NGO co-coordinating agency may have or take a different position from other cluster partners.
- It is absolutely essential that another person represents WHO as the cluster lead agency and the NGO co-coordinating agency where funding allocations are being discussed or determined.

Role and responsibility of health cluster partners

Health cluster partners have a responsibility to work together to agree objectives, define priorities and operational strategies, harmonize efforts to achieve the goals and objectives of the health cluster response, and operate in line with agreed policies and standards, resulting in effective delivery of a quality response.

Health cluster partners should operate in line with the principles of partnership and the minimum commitments of health cluster partners. With a focus on the collective response, health cluster partners should collaborate, share information and hold each other mutually accountable.

2.9 Cluster coordination performance monitoring and architecture review

2.9.1 Cluster coordination performance monitoring

Cluster coordination performance monitoring (CCPM) is a self-assessment of cluster performance in terms of the six core cluster functions and the principle of accountability to affected populations. CCPM reviews the cluster functions to see if they are being implemented adequately to support the delivery of the strategic response plan (27, 28).

CCPM is complementary to humanitarian response monitoring, which measures aid delivered to an affected population and the achieved results against the objectives set out in the strategic response plan.³²



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	<ul style="list-style-type: none"> ● Contents ● References ● Endnotes
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10				
Box	●	●	●	●	●									
	2.1	2.2	2.3	2.4	2.5									
Figure	●	●												
	2.1	2.2												
Table	●	●	●	●										
	2.1	2.2	2.3	2.4										

CCPM should be implemented three to six months after the onset of an emergency and annually thereafter. It is a country-level, country-led process, with support from global entities in terms of guidance of the process and analysis of the data generated by CCPM surveys.

Ideally, CCPM should be conducted by all clusters in the country at the same time. However, where deemed appropriate, a health cluster may conduct the process at another time, with the agreement and support of the Global Health Cluster.

CCPM provides an opportunity for partners to openly discuss how the health cluster functions, and to put corrective actions in place to address inefficiencies in relation to the six core functions and the principle of accountability to affected populations. It is important to compare the trends in cluster performance monitoring over the period of existence of the cluster.

It is recommended that the country health clusters use the opportunity of the CCPM process to also review health cluster management arrangements and adapt them as appropriate. This would include reviews of:

- leadership of the health cluster as a whole;
- membership and role of the strategic advisory group;
- membership, leadership and role of the various technical working groups or subclusters, and the need for continuation of each of these various working groups;
- how these various components of the coordination mechanism link together to ensure an effective and efficient health cluster.

2.9.2 Cluster coordination architecture review

The cluster coordination architecture review is an HC-led review, undertaken on an annual basis at a minimum, that examines the continued appropriateness and relevance of cluster coordination structures.

The cluster coordination architecture review assesses the appropriateness and relevance of cluster coordination structures in light of changes in context and the strategic objectives of the humanitarian response plan, and determines if clusters should be left unchanged, expanded, streamlined, merged or deactivated (with benchmarks for deactivation) (28).



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10	Contents			
Box	2.1	2.2	2.3	2.4	2.5	Figure	2.1	2.2	Table	2.1	2.2	2.3	2.4	References
														Endnotes

2.10 Health cluster transition and deactivation

2.10.1 Definition and modalities of health cluster transition and deactivation

Transition and deactivation of the health cluster is obviously linked to transition from emergency health response to longer-term developmental health programming. However, this section focuses on transition and deactivation of the health cluster, that is, transition of the mechanisms for coordination of key health cluster functions as outlined in the Cluster Coordination Reference Module (5).

- *Cluster deactivation* is the closure of a formally activated cluster. It includes the transfer of core functions from clusters that have international leadership and accountability to other structures. Functions may be transferred to existing or pre-crisis emergency coordination and response structures, or to new structures.
- *Cluster transition* refers to the process (and potentially the activities) by which the transfer of leadership and accountabilities is planned and implemented, leading to deactivation or to emergency coordination fully led by local health authorities.

Effective deactivation will require a plan to map phases of the transition, set transition or deactivation benchmarks for each phase, and schedule activities to meet these benchmarks.

The Transformative Agenda recommends that the humanitarian country team should conduct an annual review of the status of clusters in every country where clusters are active, with a view to recommending continuation, deactivation, scaling down or handover of clusters, as appropriate.

Where clusters are not formally activated, it is still recommended that regular reviews of the existing humanitarian coordination architecture are carried out to determine if it is necessary or appropriate to activate clusters.

2.10.2 Timing of deactivation of a health cluster

The deactivation of formally activated clusters may be considered when at least one of the conditions that led to its activation is no longer present:

1. The humanitarian situation improves, significantly reducing humanitarian needs and consequently reducing associated response and coordination gaps; or,



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10					
Box	●	●	●	●	●										
	2.1	2.2	2.3	2.4	2.5										
Figure	●	●													
	2.1	2.2													
Table	●	●	●	●											
	2.1	2.2	2.3	2.4											

- Contents
- References
- Endnotes

2. National structures acquire sufficient capacity to coordinate and meet residual humanitarian needs in line with humanitarian principles.

Five principles should guide and inform transition and deactivation processes.

- They should be initiated and led by the HC, in consultation with the humanitarian country team, wherever possible in close collaboration with national authorities and supported by OCHA. Cluster lead agencies, cluster partners and national counterparts should also be involved in drafting and agreeing on the review and its recommendations and preparing transition or deactivation plans.
- They should be based on an assessment of national capacity.
- They should also be based on an assessment of continuing or remaining humanitarian needs.
- They should take account of the context, including the role of government in the protection of the population.
- They should be guided by early recovery and resilience-building objectives.

Deactivation of a cluster does not mean that humanitarian funding is no longer required. Funding will be required to conduct transitional activities, including capacity-building, and to enable national and other authorities to coordinate residual or continuing humanitarian needs or strengthen preparedness. These ongoing costs should be included in WHO budgets for emergency health programming.

Lack of funding is not a reason to deactivate a cluster.

2.10.3 Tips for smooth transition and deactivation of an activated health cluster

How a health cluster was established and evolves over time will have significant impact on how it will transition and deactivate. The following approaches contribute to smooth deactivation of a health cluster, leaving sustainable emergency coordination functions in place:

- working to support and strengthen existing structures, unless in a situation where an existing health authority is unable to meet the needs in a manner that respects humanitarian principles;



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	●	● Contents ● References ● Endnotes	
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10						
Box	●	●	●	●	●	Figure	●	●	Table	●	●	●	●			
	2.1	2.2	2.3	2.4	2.5		2.1	2.2		2.1	2.2	2.3	2.4			

- promoting the active involvement of the national and subnational health authorities in the management and leadership of the health cluster, thereby ensuring that relevant government officials are familiar with the day-to-day emergency coordination activities, and will thus be in a stronger position to sustain these functions in the longer term;
- operating in line with the principles of partnership, thus encouraging buy-in and commitment from health partners;
- facilitating engagement of local NGOs in the cluster approach from the outset;
- building capacity of health partners in health emergency preparedness and response.

Transition and deactivation strategies should be considered from the initial establishment of the health cluster, and incorporated in health cluster planning documents.

- A preliminary transition or deactivation plan or position paper should be developed within the first few months of cluster activation and should be updated regularly (for example, six-monthly).
- It is important that a realistic time frame is set for transition and deactivation processes, to allow for health cluster partner consultation in developing a plan and subsequently implementing transition activities prior to deactivation.
- It is the responsibility of the head of the WHO country office as cluster lead agency to urge acceptance of a realistic time frame for transition and deactivation within the humanitarian country team, and to ensure that WHO continues to provide the required support for emergency coordination functions following deactivation.

A series of systematic steps are proposed for planning the transition and deactivation of the health cluster, as outlined in the following subsection.

2.10.4 Systematic steps for transition and deactivation of a health cluster

When preparing transition and deactivation plans, a cluster should:³³

- map preparedness arrangements, and response and coordination needs (based on the six cluster functions);



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10				
Box	●	●	●	●	●									
	2.1	2.2	2.3	2.4	2.5									
Figure	●	●												
	2.1	2.2												
Table	●	●	●	●										
	2.1	2.2	2.3	2.4										

- [Contents](#)
- [References](#)
- [Endnotes](#)

- identify government and other coordination and response mechanisms that are competent to assume leadership and accountability for the cluster’s functions, noting that responsibilities and accountabilities may pass to a range of officials or institutions and that not all need to be transferred at the same time;
- assess the capacity of these mechanisms to assume responsibility;
- determine what must be done over what period to build capacity, during the transition or to enable deactivation;
- define how cluster lead agencies and national counterparts are accountable for cluster functions during transition and deactivation and take steps to ensure accountability is preserved;
- set benchmarks to indicate phased transition towards deactivation;
- propose a timetable for transition or deactivation;
- propose a timetable for additional cluster reviews, as appropriate;
- decide how preparedness will be maintained or strengthened after deactivation and define any continued role for the cluster lead agency.



Establishing a health cluster at country level: functions, roles and responsibilities



- Contents
- References
- Endnotes

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Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph ● ● ● ● ● ● ● ● ● ● ● ●

2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

Box ● ● ● ● ●

2.1 2.2 2.3 2.4 2.5

Figure ● ●

2.1 2.2

Table ● ● ● ●

2.1 2.2 2.3 2.4

- Contents
- References
- Endnotes

Endnotes

1. See section 2.3.3 below.
2. Among the components of the International Red Cross and Red Crescent Movement, the International Committee of the Red Cross attends humanitarian country team meetings in an observer capacity. It will continue to coordinate with other humanitarian actors to the extent necessary to achieve efficient operational complementarity and a strengthened response for people affected by armed conflict and other situations of violence.
3. WHO commitment to coordination in emergencies is articulated in the WHO Emergency Response Framework (4), pages 10 and 11.
4. See Operational Guidance on Humanitarian Country Teams (2) for a more detailed description of humanitarian country team purpose, establishment, responsibilities, composition, chairing, modus operandi and interface with other in-country coordination mechanisms.
5. Cluster Coordination Reference Module (5), pages 7 and 8 and Annex I.
6. While government-led and IASC-activated emergency health coordination mechanisms are presented as two clear distinct models for emergency coordination, there are in reality a variety of hybrid models for emergency health coordination in existence across countries and also within countries. Indeed, flexibility of approach and use of a variety of models is necessary in design of a coordination model that is relevant to the varied operation contexts where emergency health coordination is required.
7. WHO commitment to coordination in emergencies is articulated in the WHO Emergency Response Framework (4), pages 10 and 11. See also Cluster Coordination Reference Module (5), page 5.
8. Not to be confused with health sector development partner coordination groups.
9. The United Nations country team is made up of all United Nations agencies carrying out operational activities for the development, emergency, recovery and transition programme in a country. Its role is to ensure interagency coordination and decision-making at the country level.
10. Cluster Coordination Reference Module (5), Annex I; and Emergency Response Framework (4), page 43.
11. Ibid. See also section 2.5 on sharing leadership.
12. Cluster Coordination Reference Module (5), page 13.
13. See, for example, the TOR for the Iraq health cluster strategic advisory group (<https://www.humanitarianresponse.info/en/operations/iraq/document/irq-tors-iraq-health-cluster-strategic-advisory-group-sag-april-2019>, accessed 6 December 2019).
14. Mental health and psychosocial support services and cash transfers are addressed under inter-cluster coordination (section 2.6).
15. See Chapter 5 on promoting standards for a quality health response.
16. Example of TOR for the subnational cluster coordinator: <https://www.who.int/health-cluster/resources/en/>.
17. Cluster Coordination Reference Module (5), page 21.
18. Strategic advisory group and technical working group composition and roles are covered in subsection 2.4.2 above.
19. Cluster Coordination Reference Module (5), pages 26–29 and Annex IV.
20. See Chapter 8 on integrated programming for better health outcomes.
21. See Chapter 6, subsection 6.6.5 for more information on health financing options.
22. Refer to Chapter 8 on integrated programming for details on implementing a multisectoral response.
23. See Chapter 6 on the humanitarian–development–peace nexus.
24. See section 2.10 below on health cluster transition and deactivation.
25. See Chapter 3.



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph	●	●	●	●	●	●	●	●	●	●			
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	2.10			
Box	●	●	●	●	Figure	●	●	Table	●	●	●	●	
	2.1	2.2	2.3	2.4	2.5		2.1	2.2		2.1	2.2	2.3	2.4

- Contents
- References
- Endnotes

26. Global Outbreak Alert and Response Network: <https://extranet.who.int/goarn/>.
27. This section addresses coordination with internationally deployed military actors involved in humanitarian response work and may guide coordination with national militaries within their own borders. However, it does not address engagement with non-State military groups.
28. Cluster Coordination Reference Module (5), page 24.
29. See also the health cluster coordination guidance for heads of WHO country offices: <https://www.who.int/health-cluster/capacity-building/HWCO-guidance/en/>.
30. See Chapter 4 for information on the role of information management staff supporting the health cluster.
31. As in the case of small (Grade 1), stable, protracted emergencies.
32. See Chapter 12 for information on humanitarian response monitoring.
33. Cluster Coordination Reference Module (5), page 40.



Establishing a health cluster at country level: functions, roles and responsibilities

Paragraph ● ● ● ● ● ● ● ● ● ●
 2.1 2.2 2.3 2.4 2.5 2.6 2.7 2.8 2.9 2.10

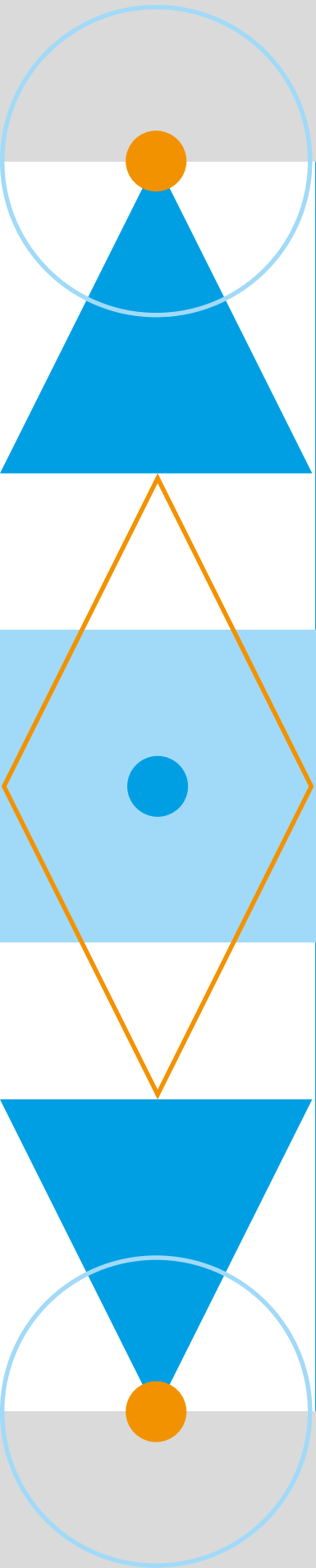
Box ● ● ● ● ●
 2.1 2.2 2.3 2.4 2.5

Figure ● ●
 2.1 2.2

Table ● ● ● ●
 2.1 2.2 2.3 2.4

- Contents
- References
- Endnotes

Building and maintaining an effective health cluster: key coordination skills



03

Contents

Chapter 3		
Building and maintaining an effective health cluster: key coordination skills		99
3.1 Introduction		99
3.2 Health cluster efficiency and effectiveness		99
3.2.1 Characteristics of a well-managed cluster		99
3.2.2 Factors in effective cluster operation		100
3.3 Key coordination skills		103
3.3.1 Leadership skills		103
3.3.2 Decision-making style		106
3.3.3 Communication skills		107
3.3.4 Relationship-building and engaging health authorities and health cluster partners		110
3.3.5 Building consensus and conflict resolution		116
3.3.6 Preparing for and managing effective health cluster coordination meetings		122
3.3.7 Common cluster coordination challenges and how to overcome them		128
References		132
Annex 3.1	Managing effective health cluster meetings	133
Endnotes		146
Boxes		
Box 3.1	Encouraging engagement of local partners and implementing agencies	116
Box 3.2	What makes a bad meeting?	124
Figures		
Figure 3.1	What makes clusters work?	101
Figure 3.2	Barriers to effective cluster coordination	102
Figure 3.3	Decision-making processes	106
Figure 3.4	Communication skills and techniques	108
Figure 3.5	Characteristics of successful meetings	122
Tables		
Table 3.1	Leadership styles	105
Table 3.2	Elements of the decision-making process	107
Table 3.3	Overcoming barriers or challenges to coordination	129

Abbreviations

MIRA	multi-cluster/sector initial rapid assessment
NGO	nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
WHO	World Health Organization

3. Building and maintaining an effective health cluster: key coordination skills

3.1 Introduction

This chapter provides an overview of key coordination skills required for effective health cluster coordination, along with good-practice tips for a health cluster coordinator. Coordination skills covered in this chapter include leadership and decision-making; communication and facilitation; relationship- and partnership-building, and engaging partners; consensus-building and conflict resolution; advocacy; and management of effective health cluster meetings.

3.2 Health cluster efficiency and effectiveness

3.2.1 Characteristics of a well-managed cluster

According to the Cluster Coordination Reference Module (1), efficient cluster management should:

- Monitor performance of the six core cluster functions, making sure that programmes clearly contribute to the implementation of strategic objectives and are based on sound field practices and agreed international benchmarks and standards.
- Monitor also performance of the minimum commitments for participation in the cluster.
- Establish and maintain a cluster, which will:
 - strengthen pre-existing sectoral coordination by increasing predictability and accountability;
 - reinforce the complementarity of partner actions by avoiding duplication and gaps;
 - advocate provision of adequate resources and ensure that resources are allocated according to agreed priorities and in a manner that fulfils the cluster response plan;



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 Annex ● 3.1

Box ● 3.1 ● 3.2 Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5

Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

- ensure effective and comprehensive integration of relevant cross-cutting issues, including age, gender, environment and HIV/AIDS;
 - link with specific advisers where available and identify in-cluster focal points;
 - use available resources and tools;
 - ensure that protection and early recovery are mainstreamed and integrated;
 - address early recovery needs that arise during the Humanitarian Programme Cycle, using humanitarian mechanisms that align with development principles and the multidimensional process of *recovery*;
 - promote and adopt agile leadership styles.
- Maintain the cluster's responsiveness to changes in the operating environment, including by adjusting requirements, capacity, and participation.
- Ensure that information is effectively transferred between cluster members and to and from other stakeholders, and is well used.
- Contribute effectively to inter-cluster and inter-sector coordination forums and cooperate with humanitarian actors, government counterparts, and relevant authorities (as appropriate) in planning, coordination, and operational activities.
- Promote integrated programming, including through joint needs assessment, joint implementation strategy in key locations, and joint monitoring.
- Aim to ensure a people-centred approach to achieve better health outcomes and improve accountability by placing affected populations (including people living with disabilities) at the centre of decision-making and at the centre of action to promote meaningful access, safety and dignity.
- Be accountable to affected people by ensuring that women and men, girls and boys, have equal opportunity to participate throughout the programme cycle, including through community feedback mechanisms that are inclusive and consultative.

3.2.2 Factors in effective cluster operation

Figure 3.1 illustrates the factors that can contribute to effective operation of clusters, while Figure 3.2 illustrates the barriers to effective cluster coordination (2). Health cluster coordinators may be defined as service providers, in which case it is to the benefit of partners to add value by committing to and maintaining the effectiveness of the cluster.



Building and maintaining an effective health cluster: key coordination skills

Paragraph	● 3.1	● 3.2	● 3.3	Annex	● 3.1	● Contents
Box	● 3.1	● 3.2				● References
Figure	● 3.1	● 3.2	● 3.3	● 3.4	● 3.5	● Endnotes
Table	● 3.1	● 3.2	● 3.3			

Figure 3.1 What makes clusters work?



Source: Adapted from ALNAP (2).



Building and maintaining an effective health cluster: key coordination skills

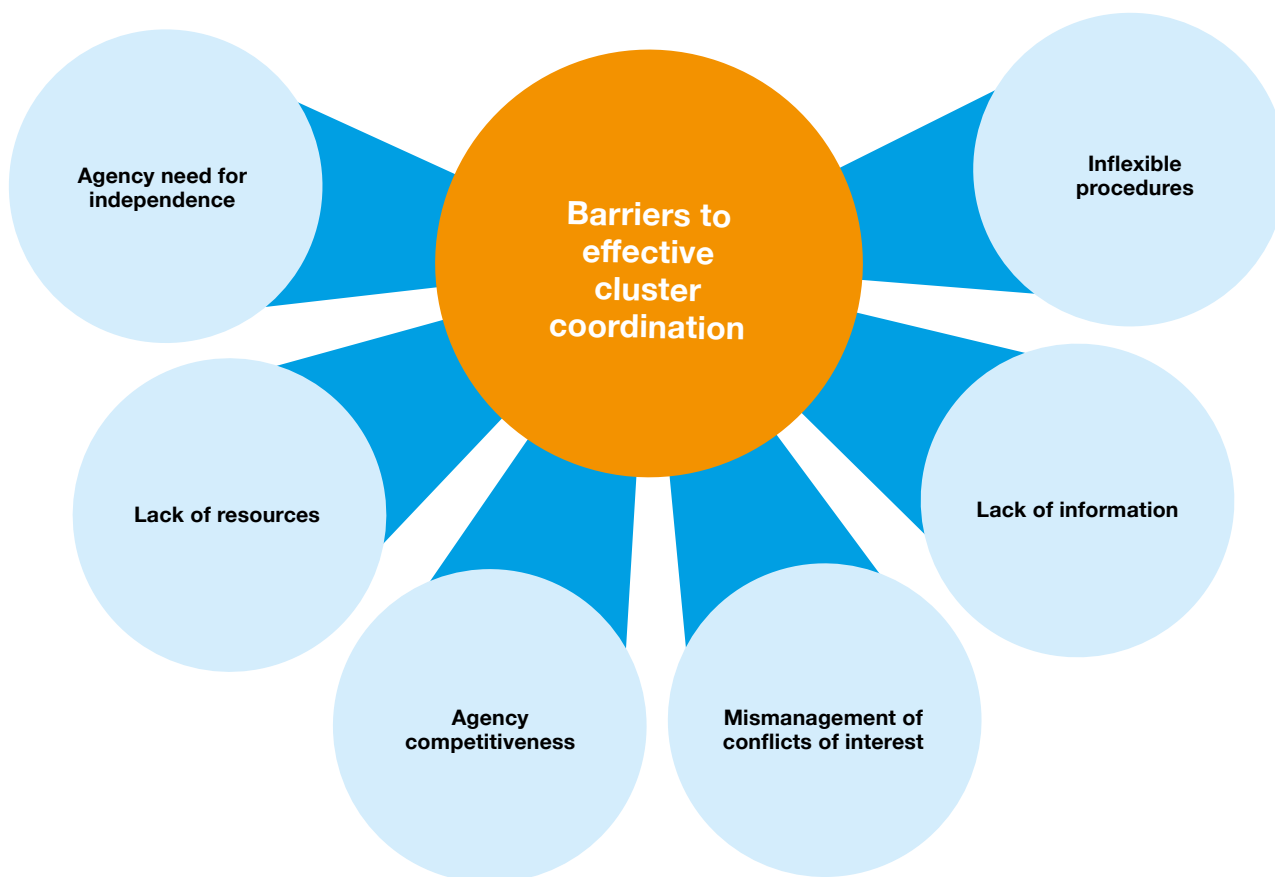
Paragraph ● 3.1 ● **3.2** ● 3.3 Annex ● 3.1

Box ● 3.1 ● 3.2 **Figure** ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5

Table ● 3.1 ● 3.2 ● 3.3

- Contents
- References
- Endnotes

Figure 3.2 Barriers to effective cluster coordination



Source: Adapted from ALNAP (2).

The position of cluster coordinator is central to the effectiveness of a cluster. An effective cluster coordinator should (2):

- be clear about their role;
- have soft skills – relationship-building, facilitation, team-building;
- be perceived as proactive and a good strategist;
- be perceived as impartial and thus able to play the role of mediator;
- have support from a broader coordination team (including information management, co-coordinators, administrative staff, and subnational clusters);



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 Annex ● 3.1

Box ● 3.1 ● 3.2 Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

- be able to develop relationships with cluster partners over time (cluster coordinators should not rotate frequently);
- have solid technical and contextual knowledge;
- provide effective and collaborative leadership.

3.3 Key coordination skills

3.3.1 Leadership skills

Effective health cluster coordination is based on collaborative leadership and partnership. It requires that health cluster partners constructively explore their differences and search for solutions that go beyond their own vision of what is possible in order to ensure a principled, timely, effective and efficient emergency health response. The health cluster coordinator provides leadership and works on behalf of the health cluster, facilitating all the activities and developing and maintaining a strategic vision and operational response plan through a consultative process with health cluster partners, ministry of health focal points and other health cluster stakeholders.

Experience has shown that in the context of the health cluster, different situations require different leadership styles and approaches (for example, participative, agile, delegative or directive). While the health coordinator needs to be a participative leader most of the time, there will be occasions where it will be necessary to use a more directive style, or delegate leadership responsibilities for certain activities.

Participative leadership is based on collaboration. It requires involving the wider health cluster membership and building consensus on the health cluster vision and direction.

Agile leadership is a relatively new, more flexible approach. It requires an ability to lead well in a wide range of circumstances, including in new emergencies and in changing and ambiguous, fragile, humanitarian situations. Agile leaders can re-engage their teams, revitalizing their functions and structures and changing the way work gets done. Agile leaders focus on the needs of others and are adaptive to situations.

Delegative leadership involves handing down responsibility for specific tasks or aspects of work to small groups. The approach often increases efficiency and maximizes the contribution of the wider health cluster membership.



Building and maintaining an effective health cluster: key coordination skills

Paragraph 3.1 3.2 3.3 Annex 3.1

Box 3.1 3.2 Figure 3.1 3.2 3.3 3.4 3.5 Table 3.1 3.2 3.3

Contents
 References
 Endnotes

Directive leadership is appropriate when there is a time constraint and decisions need to be taken quickly, for example in the early stages of establishment of the health cluster, or when health cluster partners lack experience but are motivated and are looking for guidance and direction.

No single leadership style is appropriate in all circumstances. The style adopted depends on the situation or context and the skills and experience of the health cluster partners. Each style has a role to play in effective health cluster coordination.

An effective health cluster coordinator should use all four styles of leadership, assessing the situation and choosing the appropriate leadership style in accordance with:

- the time available
- the knowledge, skills and experience of the partners
- the complexity of the task
- the motivation of individuals
- any conflicts or tensions within the group that need to be managed or controlled.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 **Annex** ● 3.1

Box ● 3.1 ● 3.2 **Figure** ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5

Table ● 3.1 ● 3.2 ● 3.3

- [Contents](#)
- [References](#)
- [Endnotes](#)

Table 3.1 presents further information on the characteristics and applicability of the various leadership styles.

► **Table 3.1 Leadership styles**

DIRECTIVE	PARTICIPATIVE	DELEGATIVE	AGILE
STYLE OF LEADERSHIP			
The directive style initiates action, structures activities, motivates others and gives feedback to participants. It is not threatening or demanding.	The participative style builds the trust and engagement of cluster participants. It establishes initial principles, plans and modes of operation. This is the main coordination leadership style, and time needs to be allocated to perform it successfully.	The delegative style lets the group make decisions and encourages others to use their expertise, while still maintaining responsibility for the overall outcomes. As the cluster or sector matures, it will be increasingly important to employ this style of leadership.	The agile style re-engages the teams, revitalizes the functions and structures, and changes the way work gets done. This leadership style gives the partners some flexibility to use their own intelligence and judgement to explore alternatives as necessary to find the best solution.
CHARACTERISTICS			
Directive styles tend to: <ul style="list-style-type: none"> control initiate tasks direct others be decisive 	Participative styles tend to: <ul style="list-style-type: none"> be democratic initiate processes or discussions involve others facilitate building consensus and decision-making 	Delegative styles tend to: <ul style="list-style-type: none"> let the group take ownership of a task allow the group to make decisions use the expertise of others 	Agile styles tend to: <ul style="list-style-type: none"> focus on the needs of others adapt to situations allow the management objective to shape the problem-solving approach
APPLICABILITY			
Be directive when: <ul style="list-style-type: none"> establishing the cluster time is short participants are motivated and looking for leadership 	Be participative when: <ul style="list-style-type: none"> establishing plans building trust and engagement participants understand the cluster approach 	Be delegative when: <ul style="list-style-type: none"> setting up working groups others have specialist knowledge the cluster matures 	Be agile when: <ul style="list-style-type: none"> solving an issue revising plans identifying common goals for the cluster aiming for improved outcomes



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

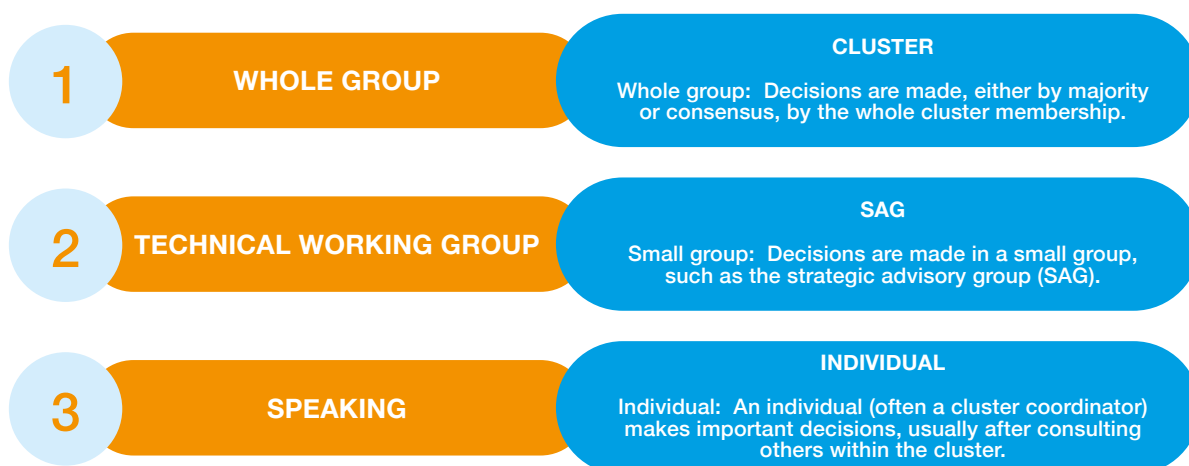
- Contents
- References
- Endnotes

3.3.2 Decision-making style

As with leadership approaches, the health cluster coordinator should employ different types of decision-making processes within the cluster, depending on the situation or context.

Decisions may be made by the health cluster or delegated to a smaller group of partners within the health cluster (strategic advisory group or technical working group), or decisions may be made individually (or unilaterally) by the health cluster coordinator (Figure 3.3). It is important to maintain transparency and inclusiveness in the decision-making process. Criteria can be applied as a guide to decision-making, for example, meeting attendance rate, regularity of information sharing, or operational status in a particular location. Who needs to be involved in decision-making, and the decision-making process to be used, are dependent on such factors as the nature of the issue and the time available (Table 3.2).

Figure 3.3 Decision-making processes



Source: ALNAP (2).



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

► **Table 3.2** Elements of the decision-making process

WHO IS INVOLVED	DECISION-MAKING PROCESS	RATIONALE FOR USING A PARTICULAR APPROACH	EXAMPLES
Decision made by whole group	Voting	When there is need to involve everyone and: <ul style="list-style-type: none"> • there is little time for consultation and to build consensus • issue is not complicated – simply need to know preference of partners 	Selection of partner agencies as members of health cluster strategic advisory group or technical working groups (in line with stated criteria) To decide on time and location of meetings
	Consultative¹	When buy-in from all stakeholders is needed – solutions are not obvious and there is time for consultation	To agree strategy to meet health cluster objectives and targets
Decision made by small group (strategic advisory group or technical working group)	Delegated	When the decision does not need contributions from everyone and there are experts involved in the process	When a technical expert decision is required, e.g. adaptation of technical guidance (with oversight from health cluster coordinator or strategic advisory group)
Decision made by individual (health cluster coordinator)	Unilateral	A decision is needed very quickly It is a technical expert decision It is not important enough to spend time on consultation	Appointment of partner agency to take responsibility for specific aspects of a public health outbreak
Decision made through criteria-based process	Consultative	When there is a need to involve everyone and obtain buy-in from all partners Agreement is needed on the selected criteria	When projects need to be selected based on agreed and transparent criteria When the mandates of partners and health cluster priorities and approaches provide equal opportunities for partners to be selected

3.3.3 Communication skills

Effective communication is an essential prerequisite for a well-functioning health cluster. It is therefore imperative that a health cluster coordinator has good communication skills. Communication skills include effective listening, clear verbal communication, use of non-verbal communication techniques, and facilitation of dialogue (Figure 3.4).



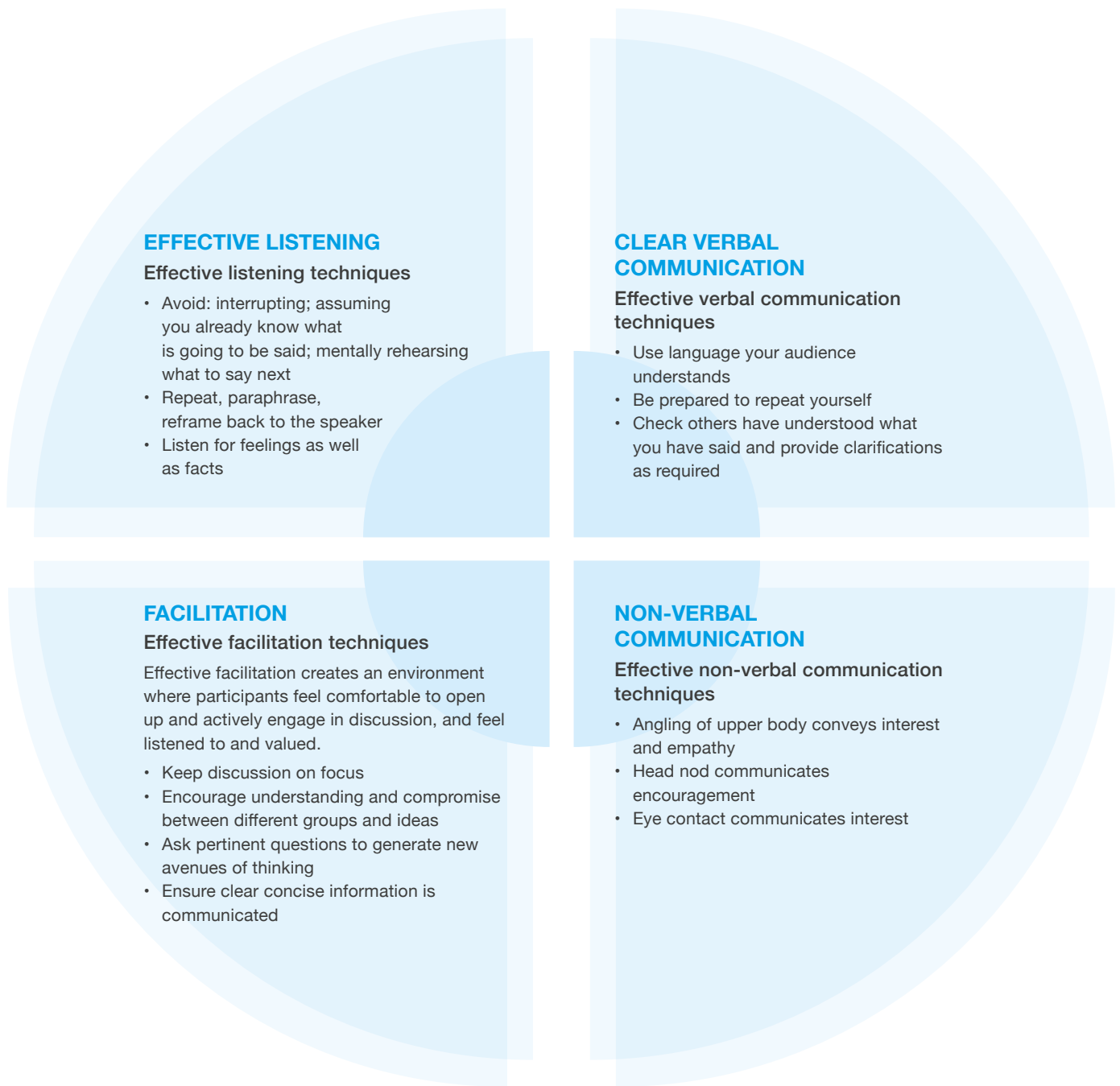
Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

Figure 3.4 Communication skills and techniques



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5

Table ● 3.1 ● 3.2 ● 3.3

- Contents
- References
- Endnotes

Tips for effective listening

- ✓ Show you are listening by responding to what is being said, without interrupting.
- ✓ Do not answer on someone else's behalf or finish off what is being said. Do not show impatience.
- ✓ Show you are listening by double-checking what you think you heard using phrases such as: "So if I have understood correctly, you are suggesting that ..."
- ✓ Use positive, non-verbal, body language techniques (see below).
- ✓ Actively listen to ensure information flows both ways during meetings.

Tips for effective verbal communication

- ✓ Use simple, direct words and short sentences.
- ✓ Avoid vague and abstract language.
- ✓ Use jargon and technical terms sparingly, and be prepared to explain any abbreviations.
- ✓ When using interpreters, use short phrases and pause for interpretation.
- ✓ Remember specialist vocabulary and United Nations abbreviations are difficult for non-specialists or non-United Nations personnel.

Tips for effective use of non-verbal communication techniques

- ✓ Use eye contact or head nodding to communicate interest and encouragement.
- ✓ Avoid defiant or defensive postures, for example arms tightly folded in front of you, which may be perceived as unwillingness to listen.
- ✓ In one-to-one meetings, where feasible, sit side by side rather than across the desk if the aim is to solve a problem together, as sitting behind a big desk may create a feeling of distance. However, be aware of context-specific gender and cultural behaviour.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● ● ● **Annex** ●
3.1 3.2 3.3 3.1

Box ● ● **Figure** ● ● ● ● ● **Table** ● ● ●
3.1 3.2 3.1 3.2 3.3 3.4 3.5 3.1 3.2 3.3

● **Contents**
● **References**
● **Endnotes**

Tips for effective facilitation

- ✓ Maintain neutrality and impartiality.
- ✓ Be responsive rather than reactive.
- ✓ Tap into the wisdom of each person.
- ✓ Actively listen and encourage two-way flow of information.
- ✓ Apply non-verbal communication techniques (see above).
- ✓ Acknowledge the contributions of all participants (and never make anyone feel “wrong” for what they have said).
- ✓ Do not interrupt unless a contributor is going far off the focus of discussion.
- ✓ Ask for clarification or elaboration where a contribution is unclear.
- ✓ Restate a contribution for clarity – for example, “To be clear, you are saying ...”
- ✓ Reflect and summarize key points in a discussion.
- ✓ Focus on action, particularly action based on the common goal of relieving suffering and saving lives.
- ✓ Keep the atmosphere fluid and flexible.

3.3.4 Relationship-building and engaging health authorities and health cluster partners

Building relationships with health authorities and health cluster partners will enhance the effectiveness of the health cluster. This requires investment of time on the part of the health cluster coordinator to engage with government health authorities and health cluster partners; open and transparent communication; and approachability on the part of the health cluster coordinator (so that individuals are comfortable with engaging in both formal and informal situations).

Tips for effective relationship-building

- ✓ Use time before and after formal meetings to converse with health authority counterparts and health cluster partners, actively listening as well as talking.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

- ✓ Visit agencies in their offices and invite them on different occasions.
- ✓ Use social events to break down barriers. Even in an emergency it is important to take time out and engage socially after work. This is often a good way to build relationships, as long as the social event is appropriate to the cultural context.
- ✓ Build trust by:
 - being open and transparent in all engagements;
 - not assuming you have the answers to all issues;
 - being prepared to take criticism and to hear things you might not like by focusing on the validity of what is being said rather than your own feelings;
 - accepting when you have made mistakes and taking steps to rectify them;
 - getting out into the community and visiting other organizations, talking to people but also listening to what people have to say;
 - making sure people understand you would rather know about any issues before they reach a crisis point to better explore solutions together;
 - remaining approachable and keeping in touch with individuals and organizations.

Basic principles to engage health authorities and health cluster partners

- ✓ Be inclusive; identify and involve all relevant health actors, United Nations agencies, international and national nongovernmental organizations (NGOs), community-based and faith organizations, health authorities and donors, and ensure interpretation and translation at meetings where necessary.
- ✓ Complement and strengthen existing health coordination structures and processes at both national and subnational levels, and avoid parallel systems.
- ✓ Learn from the past. Find out how health sector and cluster coordination processes operated in previous emergencies in the country – what worked well and what did not work, and why – and apply the learning.
- ✓ Ensure all partners have something to gain from being a health cluster partner. Benefits may include access to up-to-date critical information required for programming, technical guidance and support, opportunity to engage with health authorities to ease implementation and operations, and opportunity to engage with donors and to access funding and support for humanitarian access challenges that partners may face in their field operations.
- ✓ Stress that health cluster partners are working towards the common goal of saving lives.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

- ✓ Uphold and apply the principles of partnership.²

Effectively engaging with ministry of health and health governmental institutions

Health cluster staff need to proactively work to foster and maintain good working relationships with government institutions and colleagues, including by using a collaborative approach, ensuring open and transparent communication, being mindful (in word and deed), and treating others with respect.

It is the responsibility of the health cluster coordinator to ensure that government colleagues are fully briefed and updated on cluster activities, progress, plans and problems. Strategies that can be employed to enhance good relationships with health authorities based on trust include the following.

- ✓ Discuss sensitive issues on a bilateral basis rather than in a large open meeting.
- ✓ Brief government colleagues on relevant issues before cluster meetings.
- ✓ Invite relevant health authorities to participate in or chair the health cluster coordination meeting.
- ✓ Brief government colleagues prior to wider circulation of reports and other key documents.
- ✓ Create and utilize opportunities to have informal discussions and interactions with government counterparts in addition to formal discussions.
- ✓ Ensure that a health authority representative is involved in the strategic advisory group and technical working groups, and engaged in other decision-making processes.
- ✓ Promote and support government plans and initiatives, especially in protracted crises.
- ✓ Besides the ministry of health, engage with other government institutions directly or indirectly supporting the health response.

Effectively engaging with health cluster partners

Effectively engaging with health cluster partners is essential for a well functioning cluster. It is the responsibility of the health cluster coordination team, under the leadership of the health cluster coordinator, to proactively work to develop



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● **Annex** ● 3.1

Box ● 3.1 ● 3.2 ● **Figure** ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● **Table** ● 3.1 ● 3.2 ● 3.3

● **Contents**
● **References**
● **Endnotes**

and maintain relationships with health cluster partners and to enable partner engagement in health cluster coordination mechanisms and the health cluster emergency response.

Strategies that can be employed to enhance effective engagement of health cluster partners include the following.

Identify potential cluster partners

- ✓ Get lists of health actors and their relevant contact details through the ministry of health, existing health sector coordination mechanisms, the World Health Organization (WHO) and other organizations that have been working in the health sector in the country for some time, the NGO forum, as well as informal sources. Contact these agencies, explaining the role of the health cluster, and invite them to attend cluster coordination meetings.
- ✓ The health cluster coordination team will make themselves available in person or by email for incoming new health NGOs who wish to work with the health cluster.

Establish and maintain partner buy-in

- ✓ Build relationships and maintain regular contact with all health cluster partners; encourage partners to engage in health cluster dialogue.
- ✓ Be active rather than passive – meet partners individually. This can be very effective for developing good working relationships, especially in the case of those agencies that, due to their organizational mandate, do not wish to participate fully in the cluster, and for smaller agencies who may initially find it difficult to contribute in the large health cluster meetings. In some cases, it can be useful to visit agencies in their own offices, thus changing the power dynamics from a situation where an agency may feel intimidated visiting WHO offices. It may also be useful to visit health cluster partner programmes in order to increase knowledge of those programmes, while also building relationships with programme partners.
- ✓ Respect differing mandates, priorities and approaches.
- ✓ Respect sensitivities, including by recognizing the importance of anonymity and confidentiality in complex humanitarian terrains.
- ✓ Seek ways to build consensus on needs, risks, objectives and how best to address them equitably with the resources available.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

- ✓ Understand partners' expectations and constraints; ensure that partners' expectations are realistic and seek ways to help them overcome constraints.
- ✓ Keep an up-to-date registry of organizations involved in emergency health activities, including information on operations and capacities.
- ✓ Keep information demands to a minimum, and establish clear understanding on the information that is required from health cluster partners and other health actors and in what form and how often it should be presented.
- ✓ Use the preparation of a flash appeal, a humanitarian response plan and other cluster 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 cluster priorities.
- ✓ Make sure that information about meetings, decisions and current health issues is readily available to all actors.
- ✓ Make sure that meetings are productive, and ensure that partners have an opportunity to contribute to setting the meeting agenda.
- ✓ Seek feedback from cluster members on the effectiveness of the health cluster and how it could be enhanced.
- ✓ Facilitate partner involvement in strategic management of the health cluster through establishment of a strategic advisory group, thematic coordination groups or technical working groups.

Local health actors

There are certainly challenges to bringing local health actors into the emergency health coordination mechanisms, including technical capacity, funding, organizational culture, language and cultural issues, and balancing inclusiveness with effectiveness. Other challenges relate to local health actors not valuing cluster participation or having concerns as to whether the cluster will help address the issues that concern them.

Nevertheless, all evidence suggests that the active engagement of local health actors in the health cluster from the initial stages of its establishment will ultimately strengthen the emergency response and contribute to a stronger sustainable emergency health coordination mechanism in the longer term. As part of the



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

localization strategy, it is important to effectively engage with local NGOs and civil society organizations and other health actors working in communities.

The report of the World Humanitarian Summit of 2016 (3) emphasized the importance of more support for national and local preparedness and response efforts, and the need to invest in front-line responders and local capacities (core responsibilities four and five), while the New Way of Working highlights that humanitarian efforts should reinforce and strengthen the capacities that already exist at national and local levels (4).

As a critical partner in the emergency health response, WHO is frequently closest to the affected population. It is the duty of the health cluster coordinator and health cluster coordination team to understand the challenges and needs of local health actors and work proactively to enhance their participation in health cluster strategies, including by:

- attention to cultural sensitivities (context specific);
- interpretation at meetings and translation of key documents, as appropriate;
- ensuring agencies understand key terminologies;
- facilitating partnerships between more experienced NGOs and less experienced national NGOs, local NGOs and faith-based organizations, including for mentoring purposes;
- facilitating small-scale funding for national NGOs, local NGOs and faith-based organizations (potentially through larger NGOs);
- building the cluster approach through in-country workshops and linking local partners to relevant web-based training materials;
- including representation of national and local NGOs in the strategic advisory group and technical working groups (Box 3.1).



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● **Annex** ● 3.1

Box ● 3.1 ● 3.2 ● **Figure** ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● **Table** ● 3.1 ● 3.2 ● 3.3

● **Contents**
 ● **References**
 ● **Endnotes**

● **Box 3.1 Encouraging engagement of local partners and implementing agencies**

Where an implementing agency does not wish to formally participate as a full partner in the cluster, or where its mandate prevents its full participation, it should nevertheless be encouraged and facilitated to engage in coordination mechanisms and to share information on the general health situation and needs, the agency's health programmes and plans, and perceived gaps.

The health cluster coordinator has responsibility to ensure that the health cluster coordination team proactively facilitates this participation and engagement and brings all relevant players into the discussion (this may be through bilateral meetings or small side meetings with one or two partners rather than through the wider cluster coordination meeting forum).

The health cluster coordinator may need to spend considerable time engaging with some agencies to develop relationships and build trust before the agency is comfortable to actively participate and share information with the wider cluster. In some situations, partners may be sharing sensitive information, and it is essential that the agencies know they can trust the health cluster coordinator to treat this information sensitively.

In extreme cases, health cluster information management protocols should reflect the need for anonymity and confidentiality and describe systems for the protection of data.³

3.3.5 Building consensus and conflict resolution

Building consensus and inclusiveness

In the context of the health cluster, where there is no line management authority, consensus-building is an important process to encourage participation, ownership, inclusivity and ultimately buy-in to the cluster approach, which is essential for an effective health cluster response.

When members of groups have the opportunity to express their opinions, they are more likely to feel that the decision-making process is fair and consequently are more likely to support the decisions made.

Examples of areas where consensus is required in the health cluster include:

- agreement on priority interventions for the health cluster (technical and geographical, employing evidence-based decision-making);
- agreement on strategies to meet health cluster objectives and targets.

A consensus-building approach is not required in a situation when there is no potential for manoeuvring of positions or issues, for example in relation to implementation of technical or humanitarian standards.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

- Contents
- References
- Endnotes

Consensus-building does not require 100% agreement between partners – rather, it entails obtaining the maximum agreement within the group while drawing on everyone’s ideas and inputs to the extent possible. It is a process that encourages participation, broadens the understanding of a problem, and by extension generates possible solutions. It often leads to better decisions and increased ownership and buy-in.

Consensus-building requires the following:

- time
- willingness to contribute
- equal participation
- openness and honesty
- willingness to confront and resolve
- understanding that there are no right answers
- facilitation skills
- impartiality and neutrality.

Tips for consensus-building

- ✓ Limit own ideas.
- ✓ Approach the discussion with a problem-solving mindset.
- ✓ Review common goals.
- ✓ Encourage discussion of various positions and underlying interests – solutions are often found among the interests, not necessarily in the positions that each party brings to the table.
- ✓ Ask questions about each position.
- ✓ Ensure discussion is evidence based.
- ✓ Ensure balanced contributions.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 **Annex** ● 3.1

Box ● 3.1 ● 3.2 **Figure** ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 **Table** ● 3.1 ● 3.2 ● 3.3

- [Contents](#)
- [References](#)
- [Endnotes](#)

- ✓ Use effective listening skills.
- ✓ Link others' ideas.
- ✓ Check understanding.
- ✓ Facilitate brainstorming.
- ✓ Identify and grow “zones of agreement” – the areas and priorities on which the group agrees.
- ✓ Ask what needs to be changed to allow the maximum number of partners to support the issue or position.
- ✓ Summarize discussions and agreements, and compromises that may be required.
- ✓ Trust the process – the health cluster coordinator should project belief that the group can reach agreement.
- ✓ Remain calm and respectful to all members.

Successful consensus-building will result in a situation where, with adjustment and compromise, all members of the group can accept the result or position. Additionally, the process is likely to increase the cohesiveness of the group and heighten energy and interest within the group. Sometimes consensus cannot be achieved, and hence negotiation and conflict resolution strategies may need to be employed.

Conflict resolution

Where conflicts of interest or major differences of opinion between health cluster partners are stifled and not resolved, the effectiveness of the health cluster is likely to suffer. In such a situation, it is the responsibility of the health cluster coordinator to facilitate conflict resolution to ensure a cohesive, effective and productive health cluster. It is worth noting that conflicts of interest – and the negotiations around them – can often lead to more effective and sustainable solutions, drawing in a wider range of views and possible solutions.

A health cluster coordinator may handle the conflict directly with the specific agencies that have a difference of opinion, or may handle the conflict within the wider health cluster coordination mechanism.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 Table ● 3.1 ● 3.2 ● 3.3

● Contents
 ● References
 ● Endnotes

Conflict resolution may be required in the health cluster in the following situations:

- disagreement between agencies about respective responsibilities
- differences of opinion on health cluster priorities
- resource allocations to different partners (country pooled funds)
- agency perception of being unfairly treated by the health cluster.

Steps for handling conflict

Steps for handling conflict are as follows.

- **Recognize symptoms.** Overt symptoms include anger, disengagement in the process (may attend meetings but not actively contributing), formation of cliques, and arguments between cluster members. Hidden symptoms include low energy (within the cluster), non-attendance, arriving late or leaving early, and not socializing with partners.

Conflict is not necessarily “bad” so focus on the positive benefits or constructive outcomes of conflict, including:

- heightens awareness of problems
- encourages change
- improves decision-making
- enhances creativity
- increases energy in the group
- heightens interest
- promotes cohesiveness
- clears the air
- increases understanding.

- **Tackle conflict early.** Left unresolved, conflict spreads rapidly. What starts out as a difference of opinion between a few individuals or agencies can escalate to involve multiple partners if left unresolved, as those partners involved in the conflict seek allies from those not involved initially.
- **Identify the cause of conflict.** The cause may be related to one or more of the following issues:
 - strategies (lack of clarity of strategy, conflicting objectives, no common vision)
 - systems (poor methods of communicating)
 - structures (gaps and overlaps in organizational responsibilities)



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

- agency diversity (differing values among cluster partner agencies)
 - individuals (personalities and styles of working)
 - limited funding
 - non-humanitarian agenda.
- **Focus on core issues and problems.** It is important to avoid focusing on previous negative interactions. Additionally, it is useful to ask “what” questions rather than “why” questions – “what” questions open up discussion, whereas “why” questions may lead to defensiveness.
- **Consider each point of view.** Ensure that all partners are given a chance to air their positions.
- **Invite suggestions on the way forward.** Focus on solutions and building consensus (see consensus-building steps above).
- **Check agreement of all stakeholders.** Ensure that everyone (or the majority) accepts the resolution proposed.

Getting stuck with no resolution or agreement

Ideally, with strong facilitation skills and clear objectives, resolution of conflict and agreement between partners may be reached through consultation. However, this is not always the case; in some situations, an impasse occurs where key stakeholders are unable to reach agreement or find solutions to their differences. People feel stuck, frustrated, angry and disillusioned, and may be ready to withdraw. As a result, people may anchor themselves in extreme and rigid positions, or they might decide to just simply withdraw from the cluster altogether. As health cluster coordinator, be prepared for alternative options to emerge from deadlocked or status quo situations.

Either way, an impasse represents a turning point in efforts to negotiate a solution to the conflict, and may signal a breakthrough.

Suggested tips to break an impasse

- ✓ Remind everyone of the humanitarian consequences of failing to reach consensus, and how reaching agreement will benefit the community that all partners are there to serve.
- ✓ Remind them also of the possible consequences for the longer-term relationship and cooperation of partners if agreement is not reached.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 **Annex** ● 3.1

Box ● 3.1 ● 3.2 **Figure** ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 **Table** ● 3.1 ● 3.2 ● 3.3

- Contents
- References
- Endnotes

- ✓ Inform the group that you will set a time limit to debate the issues before taking a majority vote.
- ✓ Retrace progress and summarize areas of agreement and disagreement.
- ✓ Find out where people stand and how strongly they feel on the issue at this stage.
- ✓ Ask the primary disputants for suggestions on how to proceed.
- ✓ Brainstorm ways to break the impasse.
- ✓ Work in small groups to come up with solutions to report back to the larger group.
- ✓ Mix up small groups for new dynamics.
- ✓ It may be useful to take a break to defuse tensions, scheduling follow-up later that day or within a few days. This gives partners time to think and review their positions, and makes it easier to start afresh.
- ✓ Gather further information about the issue and points of view.
- ✓ Meet bilaterally with the primary disputants to discuss the issue and ask, “What can be changed so that you can support a decision on the issue?”
- ✓ Establish, in bilateral discussions, what compromises can be made on either side.
- ✓ Review the situation and summarize progress and status following the interventions suggested above.
- ✓ If there is still no obvious clear consensus at this stage, take a vote and go with the majority position.
- ✓ Get advice from other coordinators.
- ✓ Use the Global Health Cluster as a source of reference.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● ● ● ● Annex ●
 3.1 3.2 3.3 3.1

Box ● ● Figure ● ● ● ● ● Table ● ● ●
 3.1 3.2 3.1 3.2 3.3 3.4 3.5 3.1 3.2 3.3

- Contents
- References
- Endnotes

3.3.6 Preparing for and managing effective health cluster coordination meetings

Health cluster coordination meetings are an essential part of coordination. Adequate preparation, a clear and relevant agenda, good facilitation, and effective follow-up are all essential elements for successful, productive meetings (Figure 3.5). Where meetings are poorly organized, take too long, and are not perceived as being either relevant or productive, attendance will fall rapidly.

Figure 3.5 Characteristics of successful meetings



General principles for running effective health cluster meetings

- Be clear about the purpose of the meeting, and stress that a meeting is the most appropriate mechanism to achieve the required outputs (though there may be more appropriate alternative methods depending on the context).
- Agree the language of coordination. The choice of primary language for coordination should be as inclusive as possible, and arrangements should be made for interpretation and translation as required. Translation services can be expensive, and the health cluster coordinator should liaise with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) for support. WHO and other cluster partners may also be able to support this activity.
- Ensure that meetings focus on strategic matters – problem solving, prioritization and planning – and are not simply for information-sharing purposes.



Building and maintaining an effective health cluster: key coordination skills

Paragraph 3.1 3.2 3.3 Annex 3.1

Box 3.1 3.2 Figure 3.1 3.2 3.3 3.4 3.5 Table 3.1 3.2 3.3

● Contents
● References
● Endnotes

- Establish a culture of starting meetings on time, and maintaining good timekeeping throughout the meeting.
- Keep meetings as short as possible and adjust the frequency to the needs of the operation (likely to be much more frequent in the initial stages of a humanitarian emergency and then less frequent as the situation stabilizes).
- Arrange for small subgroups to work on specific issues and bring recommendations back to the next meeting, as appropriate, but avoid a proliferation of meetings.
- Ask for email feedback on drafts, limiting discussion in the meetings to key issues only.
- Involve partners in formulating agendas and identifying issues requiring specific work.
- Encourage partner participation and engagement in discussion of issues.⁴
- During the early stages of an emergency, ask newly arrived partners to come half an hour before the main cluster coordination meeting starts for a quick brief on the role of the cluster and background on what has been agreed at previous meetings, thus avoiding loss of time during the meeting.
- Ensure that funding for costs of coordination meetings is included in health cluster budgets.
- Develop a clear policy on attendance costs (for example, no per diems or payments for attendance).



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 **Annex** ● 3.1

Box ● 3.1 ● 3.2 **Figure** ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 **Table** ● 3.1 ● 3.2 ● 3.3

- [Contents](#)
- [References](#)
- [Endnotes](#)

Box 3.2 summarizes the characteristics of a bad meeting.

● **Box 3.2 What makes a bad meeting?**

Characteristics of a bad meeting include:

- poor venue or meeting place (location and security)
- space is inappropriate (size, facilities or equipment)
- wrong people are in attendance
- too many or too few people in attendance
- poor preparation by facilitator or participants
- no clear purpose or agenda, or poorly communicated
- people overlooked or not given space to speak
- no interpretation or translation
- some people dominate the meeting
- not enough participation
- not running to time or time is too short for agenda
- no clear outcomes or next steps.

The following subsection highlights some of the key issues to consider when preparing for and running effective health cluster meetings.⁵

Meeting preparation

When it has been determined that a meeting is required, then adequate preparation is essential. The health cluster coordinator should allocate adequate time for meeting preparation. The checklist below outlines steps that a health cluster coordinator needs to take and issues to consider in preparing for a health cluster coordination meeting.

Preparation for health cluster meetings involves the following actions:

- schedule the meeting at a suitable time so that it is convenient to the majority of key participants;
- book a suitable venue, offering security and convenience for travel and parking;
- prepare an agenda with involvement of partners and the ministry of health;



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● **Annex** ● 3.1

Box ● 3.1 ● 3.2 ● **Figure** ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5

Table ● 3.1 ● 3.2 ● 3.3

- [Contents](#)
- [References](#)
- [Endnotes](#)

- organize the chairing of the meeting in advance (where the ministry of health is co-leading or engaging with the cluster, it should be invited to chair or co-chair the meeting);
- invite partners, circulating an invitation with an agenda in advance of the meeting, giving at least 24 hours' notice in the acute emergency phase and one week's notice as the situation stabilizes;
- prepare any materials required, including presentations and handouts (information and maps) for circulating among participants, and forms or flip charts for participants to fill in information;
- organize translation and interpretation, as required;
- organize required information technology and audiovisual equipment and support;
- organize someone to take the minutes on a regular basis;
- prepare an attendance sheet (also a quarterly analysis to monitor the participation of different partners in cluster meetings).

Facilitation of health cluster coordination meetings

There are several very simple actions that will improve the facilitation of health cluster coordination meetings and enhance their effectiveness:

- ensure that a sign-in sheet with space for basic contact information is circulated during the meeting;
- make health cluster contact information available or visible, including website, email addresses and phone numbers of lead persons, as appropriate;
- introduce the chair and co-chair;
- ensure participants introduce themselves;
- set ground rules for meeting;
- ensure efficient time management to cover all agreed agenda points equally and effectively;
- state the purpose of the meeting;



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 Table ● 3.1 ● 3.2 ● 3.3

● Contents
● References
● Endnotes

- clarify the agenda, and give participants an opportunity to add to the agenda;
- review the minutes of the previous meeting and update partners on actions or developments arising from the previous meeting on issues not covered in the current agenda;
- move through the agenda, presenting issues and inviting speakers to present on each item, encouraging input from participants, summarizing the key points for each agenda item, making clarifications as required, and summarizing actions before moving on to next agenda item;
- conclude the meeting, reviewing key agreements and follow-up action points that have been agreed;
- confirm the date and time of the next meeting;
- make announcements of note for health cluster partners (including information on other meetings);
- ask participants if they have any suggestions to improve future meetings.

Facilitation tips to enhance the effectiveness of health cluster coordination meetings

- ✓ Ensure good timekeeping.
- ✓ Use projected visual displays (such as PowerPoint) to enhance the structure, clarity and visualization of presentations, while ensuring that the information displayed is consistent with, and does not overshadow, the content of the presentation.
- ✓ Use appropriate language that the audience understands.
- ✓ When interpreters are being used, speak slowly and clearly and pause for interpretation.
- ✓ Ask for clarification and elaboration where a point is vague.
- ✓ Understand what needs to be achieved and stay focused on that.
- ✓ Address conflicting interests – listen to the various viewpoints and try to link the discussion in a constructive manner.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 **Annex** ● 3.1

Box ● 3.1 ● 3.2 **Figure** ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 **Table** ● 3.1 ● 3.2 ● 3.3

● **Contents**
 ● **References**
 ● **Endnotes**

- ✓ Ensure productive outcomes – at the end of the meeting, summarize key points of agreement and follow-up action points, identifying the respective responsible agencies and individuals.
- ✓ Ensure that the meeting minutes detail the timetable for action with clear action points and responsible persons or partners.

Means of encouraging participation

- ✓ Create opportunities for partners to participate and feel they are being listened to and their contributions valued – ask specific individuals for information and opinions.
- ✓ Avoid domination of the meeting by strong characters – go around the table for input, and ask for input from other individuals before asking for the input of strong, domineering characters.
- ✓ Prevent side conversations, which can be distracting.
- ✓ Actively listen to participant contribution – encourage non-verbal signs (make eye contact, nod head).
- ✓ Do not interrupt, unless a participant is departing significantly from the agenda.
- ✓ Be aware of and sensitive to cultural norms and behaviours and engage appropriately (for example, an effort may have to be made to ensure female engagement in the discussion).

Follow-up of health cluster coordination meeting

Health cluster coordination meeting minutes should be circulated within a week of the meeting (unless the meeting agrees on another date) or as soon as possible, highlighting key issues discussed, follow-up actions to be conducted indicating who is responsible, and the time frame for these actions.

Alternative ways to communicate with partners

While regular meetings with all cluster partners are an essential aspect of cluster coordination, there are other ways for health cluster coordinators to engage or coordinate with partners.



Building and maintaining an effective health cluster: key coordination skills

Paragraph	● 3.1	● 3.2	● 3.3	Annex	● 3.1	● Contents							
Box	● 3.1	● 3.2	Figure	● 3.1	● 3.2	● 3.3	● 3.4	● 3.5	Table	● 3.1	● 3.2	● 3.3	● References
													● Endnotes

- In some situations, bilateral meetings with individual partners may be appropriate, where an agency does not wish to attend the open cluster meeting or where their mandate prevents this, but nevertheless the agency is a key emergency health actor. Bilateral meetings may also be useful to defuse contentious issues prior to the bigger cluster coordination meeting (so that decisions can be taken more easily in the meeting).
- It may be appropriate and time efficient to hold side meetings with a small group of partners to deal with an issue specifically related to those partners, rather than to try to address all issues at the wider partner meeting (for example, agreeing on operational engagement between partners or resolving a problem between partners).
- Phone calls can be made to key agencies to request specific information.
- Information can also be widely shared through use of email list groups, websites or other online media.
- Social media platforms can make information quickly available to a wide audience. Social media groups can be formulated either for the whole cluster to spread general information (such as meeting reminders or notice of change of meeting time or venue) or for specific areas of focus.
- Ad hoc cluster meetings can be organized.
- Connection can be made with cluster partners in remote locations through video or audio links.

3.3.7 Common cluster coordination challenges and how to overcome them

Although each coordination context is unique, there are some challenges that coordinators and team members are often faced with. Table 3.3 outlines a few of these common challenges with tips to overcome them.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

- Contents
- References
- Endnotes

► **Table 3.3** Overcoming barriers or challenges to coordination

BARRIER OR CHALLENGE TO COORDINATION	TIP TO OVERCOME CHALLENGE
<i>“Autonomy is threatened”</i> – there is a 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 working collectively will benefit all concerned and still allow freedom of action within the overall health crisis response strategy
<i>“Too many players”</i> – there is concern that the process will be complicated and any consensus or agreement difficult to achieve due to the large number of organizations involved	Establish a strategic advisory group or small working groups with representation from all stakeholder groups to address specific issues and make recommendations to the cluster as a whole
<i>“Decision-makers do not attend meetings”</i> – as a consequence of which participants constantly need to refer to their managers or headquarters before committing their organizations, or agreements are not ratified	Clearly indicate when decisions will need to be taken, communicate this early to ensure that relevant decision-makers are able to attend, and establish deadlines for decisions
<i>“Decisions are imposed – a few organizations dominate”</i> – the process of decision-making is not transparent; many partners do not have the opportunity to contribute	Use a collaborative leadership style – invest in engaging partners and building consensus of partners Form a strategic advisory group and working groups, through an open transparent process with representation of all stakeholder groups and rotating chairs, to work on specific issues and make recommendations to the cluster Record all decisions together with the rationale underlying them
<i>“Unilateral actions are being undertaken”</i> – individual organizations ignore established coordination processes and do not respect joint decisions	Have bilateral discussion 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



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3 ● Annex ● 3.1

Box ● 3.1 ● 3.2 ● Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5 ● Table ● 3.1 ● 3.2 ● 3.3

- Contents
- References
- Endnotes

BARRIER OR CHALLENGE TO COORDINATION	TIP TO OVERCOME CHALLENGE
--------------------------------------	---------------------------

<p><i>“The national authority doesn’t agree”</i> – recommendations or decisions are made by the health cluster but are not implemented as they are not consistent with national policy</p>	<p>Opening transparent facilitation of health cluster work and building good relationships with national authority counterparts may prevent this from happening</p> <p>Where there are good relationships, the health cluster coordinator may discuss issues bilaterally with the national authorities outlining the rationale for decisions (good communication and negotiation skills are required)</p> <p>The health cluster coordinator should always discuss sensitive issues with the ministry of health on a bilateral basis before raising them at the wider health cluster meeting</p> <p>In extreme cases where there is an impasse, the situation may require advocacy support from WHO as the cluster lead agency</p>
<p><i>“No benefit, a waste of time”</i> – partners may feel that the process does not provide sufficient benefits to justify the time invested</p>	<p>Ensure that the cluster is providing useful information and services to partners</p> <p>Establish a cluster plan with clear, agreed objectives and concrete, actionable deliverables</p> <p>Organize periodic participatory evaluations of partners’ satisfaction with cluster processes, activities and decision-making to determine how the cluster might be improved</p> <p>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 other funding processes</p>



Building and maintaining an effective health cluster: key coordination skills

Paragraph	● 3.1 ● 3.2 ● 3.3	Annex	● 3.1	● Contents
Box	● 3.1 ● 3.2	Figure	● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5	● References
		Table	● 3.1 ● 3.2 ● 3.3	● Endnotes

BARRIER OR CHALLENGE TO COORDINATION	TIP TO OVERCOME CHALLENGE
--------------------------------------	---------------------------

“Partners are not comfortable to share information openly at cluster meetings” – health cluster partners may be hesitant to share information, opinions or concerns in public, possibly due to participation in the cluster meeting of the national authority or other specific groups, or due to security issues, or caution about sharing sensitive financial information

In some contexts, there may be a need to hold separate bilateral meetings with one or more partners to address partner issues in a non-threatening way

Clarify health cluster protocol and practice in terms of sharing information, while maintaining confidentiality as and where required

Ensure introductions at the beginning of health cluster meetings so that those participating know who is attending the meeting (for example, media and donors) – this should be done in a sensitive manner, especially in insecure situations

Partners do not have to share financial information openly at cluster meetings, but should be informed that they will not be eligible to access resources through pooled funding mechanisms without sharing information on financial status through the Financial Tracking System

“There is high 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

Where turnover of partner staff is very high, establish mini briefings or orientations for newly arrived staff (for example, before a cluster meeting)

Encourage all partners to involve senior national staff in the work of the cluster in order to assure continuity in policy and action



Building and maintaining an effective health cluster: key coordination skills

Paragraph	● 3.1	● 3.2	● 3.3	Annex	● 3.1
Box	● 3.1	● 3.2		Figure	● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5
				Table	● 3.1 ● 3.2 ● 3.3

- [Contents](#)
- [References](#)
- [Endnotes](#)

References

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Building and maintaining an effective health cluster: key coordination skills

Paragraph ● ● ● Annex ●
3.1 3.2 3.3 3.1

Box ● ● Figure ● ● ● ● ● Table ● ● ●
3.1 3.2 3.1 3.2 3.3 3.4 3.5 3.1 3.2 3.3

- Contents
- References
- Endnotes

Annex 3.1

Managing effective health cluster meetings

Health cluster coordination meetings are an essential part of coordination. Adequate preparation, a clear and relevant agenda, good facilitation, and effective follow-up are all essential elements for successful, productive meetings (Figure 3.5). Where meetings are poorly organized, take too long, and are not perceived as being either relevant or productive, attendance will fall rapidly.



General principles for running effective health cluster meetings

- Be clear about the purpose of the meeting, and stress that a meeting is the most appropriate mechanism to achieve the required outputs (though there may be more appropriate alternative methods depending on the context).
- Agree the language of coordination. The choice of primary language for coordination should be as inclusive as possible, and arrangements should be made for interpretation and translation as required. Translation services can be expensive, and the health cluster coordinator should liaise with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) for support. WHO and other cluster partners may also be able to support this activity.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3

Annex ● 3.1

Box ● 3.1 ● 3.2

Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5

Table ● 3.1 ● 3.2 ● 3.3

- Contents
- References
- Endnotes

- Ensure that meetings focus on strategic matters – problem solving, prioritization and planning – and are not simply for information-sharing purposes.
- Establish a culture of starting meetings on time, and maintaining good timekeeping throughout the meeting.
- Keep meetings as short as possible and adjust the frequency to the needs of the operation (likely to be much more frequent in the initial stages of a humanitarian emergency and then less frequent as the situation stabilizes).
- Arrange for small subgroups to work on specific issues and bring recommendations back to the next meeting, as appropriate, but avoid a proliferation of meetings.
- Ask for email feedback on drafts, limiting discussion in the meetings to key issues only.
- Involve partners in formulating agendas and identifying issues requiring specific work.
- Encourage partner participation and engagement in discussion of issues (see subsection below on facilitation of health cluster coordination meetings).
- During the early stages of an emergency, ask newly arrived partners to come half an hour before the main cluster coordination meeting starts for a quick brief on the role of the cluster and background on what has been agreed at previous meetings, thus avoiding loss of time during the meeting.
- Ensure that funding for costs of coordination meetings is included in health cluster budgets.
- Develop a clear policy on attendance costs (for example, no per diems or payments for attendance).



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● ● ●
3.1 3.2 3.3

Annex ●
3.1

Box ● ●
3.1 3.2

Figure ● ● ● ● ●
3.1 3.2 3.3 3.4 3.5

Table ● ● ●
3.1 3.2 3.3

- Contents
- References
- Endnotes

Meeting preparation

When it has been determined that a meeting is required, then adequate preparation is essential. The health cluster coordinator should allocate adequate time for meeting preparation. The checklist below outlines steps that a health cluster coordinator needs to take and issues to consider in preparing for a health cluster coordination meeting.

CHECKLIST FOR PREPARATION FOR A HEALTH CLUSTER COORDINATION MEETING	
To do	To consider
Schedule meeting at suitable time	<ul style="list-style-type: none">✓ In a sudden onset emergency the first meeting should be convened within 24–48 hours, while for a slow onset emergency the meeting should be within the first 72 hours, even if the designated health cluster coordinator has not arrived in country✓ Where there is no existing health cluster or other coordinating group, WHO as cluster lead agency should contact the ministry of health and other main health actors and arrange a first meeting with as many partners as possible✓ Schedule the meeting at a suitable time so that it is convenient to the majority of key participants✓ Heads of agencies should be invited to the first emergency health coordination meeting✓ Liaise with OCHA to ensure that the health cluster meeting does not coincide with other meetings which many of your partners may have to attend (OCHA, national authorities, other cluster meetings)✓ In the early stage of the response, when heads of agencies are expected to attend, these individuals will also be engaging with other clusters; in later stages of the response, if the health cluster meeting coincides with meetings of other key clusters (for instance Nutrition, WASH), there will be no opportunity for representation from these clusters at the health meeting and vice versa✓ Where both national and subnational clusters are in operation, ensure the necessary information inputs from the various hubs are provided prior to the meetings (for instance national health cluster receives information from subnational prior to national level meeting and vice versa)✓ In the event that key partners or representatives from other clusters cannot attend, consider a follow-up briefing meeting



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● ● ●
3.1 3.2 3.3

Annex ●
3.1

Box ● ●
3.1 3.2

Figure ● ● ● ● ●
3.1 3.2 3.3 3.4 3.5

Table ● ● ●
3.1 3.2 3.3

● Contents
● References
● Endnotes

CHECKLIST FOR PREPARATION FOR A HEALTH CLUSTER COORDINATION MEETING

To do	To consider
Book venue	<ul style="list-style-type: none"> ✓ Ensure the location is convenient to the majority of participants, in terms of travel, parking and security access ✓ Ensure the venue is suitable in terms of space, ventilation and facilities (may need to be able to accommodate large number of partners) ✓ Optional venues to consider would include: i) ministry of health premises if the ministry of health is co-leading the cluster or engaging at any level; ii) WHO offices; or iii) a neutral venue (such as a hotel) ✓ Where security procedures require names for entry to the venue, ensure that security staff have the names of the organizations and individuals, and that they can contact you should others who are not on the list arrive to attend ✓ Ensure water is available for participants (other drinks/snacks may be provided as culturally appropriate/feasible)
Agenda and invitation	<ul style="list-style-type: none"> ✓ Prepare a realistic agenda focusing on key issues; as feasible, involve partners in preparation of agenda (ask for input at previous meeting and/or by email) ✓ Involve the ministry of health and ensure they agree on the agenda in advance (see below suggested agendas) ✓ Arrange for the ministry of health to chair or co-chair the meeting (where the ministry of health is co-leading or engaging with the health cluster). Where an NGO is co-leading the health cluster, the health cluster co-coordinator should co-chair the meeting with the health cluster coordinator ✓ Liaise with WHO to ensure that WHO as the cluster lead agency is represented by the Emergency Officer, as the health cluster coordinator should not be expected to represent WHO during this meeting ✓ Invite partners, circulating an invitation with an agenda in advance of the meeting, giving at least 24 hours' notice in the acute emergency phase and one week's notice as the situation stabilizes ✓ The invitation should indicate where the meeting will be held, and give directions on how to get there and any security requirements – for instance, if it is necessary, to submit to security in advance of the meeting, all names of those who will participate



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● ● ●
3.1 3.2 3.3

Annex ●
3.1

Box ● ●
3.1 3.2

Figure ● ● ● ● ●
3.1 3.2 3.3 3.4 3.5

Table ● ● ●
3.1 3.2 3.3

● Contents
● References
● Endnotes

CHECKLIST FOR PREPARATION FOR A HEALTH CLUSTER COORDINATION MEETING

To do	To consider
Presentations	<ul style="list-style-type: none"> ✓ Ensure presentations are prepared, including when others are invited to present ✓ Prepare handouts with information and maps as appropriate: when the cluster is well established these handouts could be shared electronically in advance of the meetings, with a few copies available for distribution at the meeting ✓ Prepare forms and/or flips charts to share the information that can be cross-checked by participants ✓ Prepare forms and/or flip charts during or after the meeting. (In the early stage of an emergency this may include 3W information (who, what, where) and contact details)
Translation	<ul style="list-style-type: none"> ✓ Ensure translation of documents as required ✓ Liaise with the translator to agree how translation should be conducted during the meeting (simultaneous or summary)
Equipment	<ul style="list-style-type: none"> ✓ Ensure necessary IT equipment is sourced, and IT support staff are available to set up and support IT as required during the meeting
Other	<ul style="list-style-type: none"> ✓ Organize someone to take minutes (this task may be undertaken by partners, or by cluster administration support staff) ✓ Prepare an attendance sheet (also a quarterly analysis to monitor the participation of different partners in cluster meetings)



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● 3.1 ● 3.2 ● 3.3

Annex ● 3.1

Box ● 3.1 ● 3.2

Figure ● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5

Table ● 3.1 ● 3.2 ● 3.3

- Contents
- References
- Endnotes

Suggested agendas for health cluster meetings

SUGGESTED AGENDA FOR INITIAL HEALTH CLUSTER MEETINGS

- Welcome and introductions
- Overview of cluster – the purpose of the health cluster and the role of the health cluster coordinator and cluster lead agency
- Purpose of meeting and agreement on agenda
- Ground rules for the meeting
- National authority/health cluster briefing – what is known about the emergency situation, the health needs, and actions that have already taken place and those planned
- Share information – initial who, what, where (3W) information
- Information gaps – identify major gaps in current information concerning specific geographical areas and/or specific health issues and agree how critical information gaps will be filled
- Priority health problems, risks, service gaps – identify major, life-threatening health risks and gaps in service (to address those risks) – discuss and agree on how the gaps will be filled (4W – who, what, where and when)
- Initial assessment – arrangements for MIRA or initial rapid health assessments (in collaboration with OCHA). Possibly to establish an assessment working group to lead this activity
- Define initial working arrangements for cluster, including frequency of meetings, language of communication, cluster structure, information sharing mechanism (see note below) and the need to create terms of reference for the group

SUGGESTED AGENDA FOR SUBSEQUENT HEALTH CLUSTER MEETINGS

- Welcome and introductions
- Purpose of the meeting
- Ground rules for the meeting
- Endorsement of previous minutes and agreement on agenda
- Update on action points from the previous agenda
- Update on situation and emerging issues
- Update on changes in the 3W information
- Update from other key clusters as appropriate
- Update on cross-cutting issues and vulnerable groups issues
- Feedback from strategic advisory group and other working groups (for instance assessment or reproductive health working groups)
- Any other business

Note: i) Information management focal point identified to receive and collate information from all health cluster partners;
 ii) Arrangements for the production and dissemination of an emergency health bulletin shared with partners;
 iii) cluster website, email and telephone details shared.



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● ● ●
 3.1 3.2 3.3

Annex ●
 3.1

Box ● ●
 3.1 3.2

Figure ● ● ● ● ●
 3.1 3.2 3.3 3.4 3.5

Table ● ● ●
 3.1 3.2 3.3

- Contents
- References
- Endnotes

Meeting facilitation

CHECKLIST FOR FACILITATION OF A HEALTH CLUSTER COORDINATION MEETING

To do	To consider
Sign-in sheet circulated	<ul style="list-style-type: none"> ✓ Provide sign-in sheet with space for basic contact information which is available for participants to fill in as they arrive before the meeting starts ✓ Ensure it is circulated before the end of the meeting ✓ Remind people to fill in the form including contact details
Health cluster contact information visible	<ul style="list-style-type: none"> ✓ Health cluster contact information and any relevant website information should be clearly displayed ✓ If possible, there should be a dedicated mobile phone number and email address for the health cluster coordinator and the information management positions. This will ensure continuity of access as the health cluster coordinator post-holder changes
Introductions	<ul style="list-style-type: none"> ✓ Introduce the chair and co-chair – if the health authority is co-leading the cluster, the representative may chair or co-chair the meeting with the health cluster coordinator. Alternatively, the health authority representative may open the meeting and hand over to the health cluster coordinator to chair the meeting ✓ Participants should be asked to introduce themselves, giving their name, the agency they work for and their function and position ✓ If there are very large numbers of participants attending health cluster meetings it may not be practical to make individual introductions at every meeting. The health cluster coordinator will have the participants' name, contact details and function on the attendance sheet, however speakers should mention their name, agency and function as they make a point or contribute to the discussion
Set ground rules for the meeting	<ul style="list-style-type: none"> ✓ Outline how the meeting will be conducted and highlight specific issues participants may need to be aware of



Building and maintaining an effective health cluster: key coordination skills

Paragraph	● 3.1 ● 3.2 ● 3.3	Annex	● 3.1	● Contents
Box	● 3.1 ● 3.2	Figure	● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5	● References
		Table	● 3.1 ● 3.2 ● 3.3	● Endnotes

CHECKLIST FOR FACILITATION OF A HEALTH CLUSTER COORDINATION MEETING

To do	To consider
State purpose of meeting	<ul style="list-style-type: none"> ✓ It is critical that those attending understand what the main outcomes of the meeting that day should be
Clarification of agenda	<ul style="list-style-type: none"> ✓ Review agenda and give participants an opportunity to add additional items to the agenda/potentially make minor changes. Additional relevant issues can be added under Any Other Business, with the consensus of those attending, where it is estimated there will be enough time to cover the issue. Issues that will require a lot of discussion may be deferred to the next meeting ✓ Ensure efficient time management to cover all agreed agenda points equally and effectively
Clarification on minutes	<ul style="list-style-type: none"> ✓ Clarify who is taking the minutes and advise the minute taker that the notes should be action-oriented, and capture the main points of discussions and decisions made
Review minutes of previous meeting	<ul style="list-style-type: none"> ✓ Partners should have a chance to review the minutes of the previous meeting and point out corrections or clarifications as required – these should then be incorporated into the updated version and circulated to the group. This may not be possible or necessary when meetings are being held on a daily basis at the beginning of a response ✓ Update partners on progress on issues outlined in the previous meeting which will not be covered in the agenda of the current meeting
Confirm minute taker	<ul style="list-style-type: none"> ✓ Confirm who will be taking minutes (determined prior to the meeting)



Building and maintaining an effective health cluster: key coordination skills

Paragraph ●●●
3.1 3.2 3.3

Annex ●
3.1

Box ●●
3.1 3.2

Figure ●●●●●
3.1 3.2 3.3 3.4 3.5

Table ●●●
3.1 3.2 3.3

- Contents
- References
- Endnotes

CHECKLIST FOR FACILITATION OF A HEALTH CLUSTER COORDINATION MEETING

To do	To consider
Move through the agenda	<ul style="list-style-type: none">✓ Present the issues and then invite speakers to present as per agenda✓ For each agenda item: encourage participant input; summarize key points; make clarifications as required; reformulate key discussion points; and summarize action points, before moving on to the next agenda item✓ Observe the body language of the group to ensure that participants are engaging in the meeting. Use facilitation skills to effectively lead the meeting (see tips in section below)
Conclude the meeting	<ul style="list-style-type: none">✓ Go through key agreements and action points taken at the meeting and follow up actions that have been decided upon, clarifying who is responsible for the various actions✓ Confirm when the next meeting will be held✓ Announce any other meetings/events of note for the health cluster partners
Suggestions to improve	<ul style="list-style-type: none">✓ Ask participants if they have suggestions on how the meeting could be improved, which may be shared at that point or bilaterally after the meeting

C

1

2

3

4

5

6

7

8

9

10

11

12

13

Building and maintaining an effective health cluster: key coordination skills

Paragraph

● 3.1 ● 3.2 ● 3.3

Annex

● 3.1

Box

● 3.1 ● 3.2

Figure

● 3.1 ● 3.2 ● 3.3 ● 3.4 ● 3.5

Table

● 3.1 ● 3.2 ● 3.3

● Contents

● References

● Endnotes

FACILITATION TIPS TO ENHANCE EFFECTIVENESS OF HEALTH CLUSTER COORDINATION MEETINGS

To do

To consider

Timekeeping

- ✓ Establish a culture of starting the meetings on time
- ✓ Allocate time for each item on the agenda and keep to these times
- ✓ Appoint a timekeeper

Use of PowerPoint presentation

- ✓ Effective use of PowerPoint presentations may be helpful to structure discussion, reinforce and clarify points and provide visual illustrations, so strengthening presentations
- ✓ It is important that PowerPoint slides do not overshadow the presentation with too much, or poorly organized, information, which can be confusing and cause participants to lose interest

Use appropriate language

- ✓ Use language your audience understands
- ✓ Use simple, direct words and short sentences
- ✓ Avoid vague and abstract language
- ✓ Use jargon and technical terms sparingly – and where you do use such language, check your audience understands the terms

Use interpreters

- ✓ When using interpreters, use short phrases and pause for translation

C

1

2

3

4

5

6

7

8

9

10

11

12

13

Building and maintaining an effective health cluster: key coordination skills

Paragraph

3.1 3.2 3.3

Annex

3.1

Box

3.1 3.2

Figure

3.1 3.2 3.3 3.4 3.5

Table

3.1 3.2 3.3

● Contents

● References

● Endnotes

FACILITATION TIPS TO ENHANCE EFFECTIVENESS OF HEALTH CLUSTER COORDINATION MEETINGS

To do

To consider

Encourage participation

- ✓ Create opportunities for partners to participate and feel they are being listened to and their contributions valued – ask specific individuals for information and opinions
- ✓ Avoid domination of the meeting by strong characters – go around the table for input, and ask for input from other individuals before asking for the input of strong, domineering characters
- ✓ Prevent side conversations, which can be distracting
- ✓ Actively listen to participant contribution – encourage non-verbal signs (make eye contact, nod head)
- ✓ Do not interrupt, unless a participant is departing significantly from the agenda
- ✓ Be aware of and sensitive to cultural norms and behaviours and engage appropriately (for example, an effort may have to be made to ensure female engagement in the discussion)

Make clarifications

- ✓ Check that others have understood what has been said, in particular local words and phrases that may be used with different meaning
- ✓ Ask for clarification and elaboration where a point is vague
- ✓ Rephrase a contribution to make it clearer – for example “to be clear, you are saying....”

C

1

2

3

4

5

6

7

8

9

10

11

12

13

Building and maintaining an effective health cluster: key coordination skills

Paragraph

3.1 3.2 3.3

Annex

3.1

Box

3.1 3.2

Figure

3.1 3.2 3.3 3.4 3.5

Table

3.1 3.2 3.3

● Contents

● References

● Endnotes

FACILITATION TIPS TO ENHANCE EFFECTIVENESS OF HEALTH CLUSTER COORDINATION MEETINGS

To do

To consider

Summarize key points

- ✓ Summarize key points and what has been agreed in discussion, specifically what has been agreed and action points as they are agreed and/or at the end of each agenda item
- ✓ Arrange for a volunteer to record key points as they arise, which helps the group to stay focused, avoids repetition and helps to reach consensus. The points can be recorded electronically and projected during the meeting

Keep on focus

- ✓ Understand what needs to be achieved and stay focused on that
- ✓ Limit discussion to those items on the agenda
- ✓ Where discussion is moving away from the agenda, but nevertheless an important point has been raised which needs to be dealt with, options are: i) put the point in Any Other Business to be addressed at the end of the agenda (especially appropriate where it is an issue of interest to most or all cluster partners); or ii) agree to schedule another time to deal with the issue (appropriate where it may not be of relevance to most of the cluster partners)
- ✓ Limit over-detailed explanation from participants, bringing the discussion back to key points on the agenda
- ✓ Encourage constructive discussion/debate



Building and maintaining an effective health cluster: key coordination skills

Paragraph ● ● ●
3.1 3.2 3.3

Annex ●
3.1

Box ● ●
3.1 3.2

Figure ● ● ● ● ●
3.1 3.2 3.3 3.4 3.5

Table ● ● ●
3.1 3.2 3.3

- Contents
- References
- Endnotes

FACILITATION TIPS TO ENHANCE EFFECTIVENESS OF HEALTH CLUSTER COORDINATION MEETINGS

To do

To consider

Address conflicting interests

- ✓ Listen to the various viewpoints being presented and try to link the discussion in a constructive manner
- ✓ Refer to relevant policies, guidelines and health cluster strategies and priorities where these can contribute to bringing consensus or defuse the conflicting interests
- ✓ Refer to what has been agreed in previous meetings, where an issue of conflicting interests is being raised again
- ✓ Where appropriate, it may be useful to invest in consultation with some individuals prior to the meeting to defuse contentious issues so that decisions may be taken more quickly

Ensure productive outcomes

- ✓ At the end of a health cluster meeting, summarize key points of agreement and follow-up action points, clearly identifying who (agencies and individuals) will be responsible for carrying out the various actions and the time frame for each
- ✓ Ensure that the meeting minutes detail the timetable for action with clear action points and responsible persons or partners

Follow-up of cluster coordination meeting

Health cluster coordination meeting minutes should be circulated within a week of the meeting (unless the meeting agrees on another date) or as soon as possible, highlighting key issues discussed, follow-up actions to be conducted indicating who is responsible, and the time frame for these actions.

C

1

2

3

4

5

6

7

8

9

10

11

12

13

Building and maintaining an effective health cluster: key coordination skills

Paragraph

3.1 3.2 3.3

Annex

3.1

Box

3.1 3.2

Figure

3.1 3.2 3.3 3.4 3.5

Table

3.1 3.2 3.3

● Contents

● References

● Endnotes

Endnotes

1. See subsection 3.3.5 on building consensus.
2. See Chapter 2.
3. See Chapter 4 on information management.
4. See subsection below on facilitation of health cluster coordination meetings.
5. More guidance on these issues is available in Annex 3.1, which presents information on (a) preparation for effective health cluster coordination meetings (including a checklist of steps to take and issues to consider); (b) suggested agendas for health cluster meetings (for initial and then subsequent meetings); and (c) facilitation of an effective health cluster coordination meeting (including a checklist of actions for effective health cluster coordination meetings and facilitation tips to enhance effectiveness of meetings).



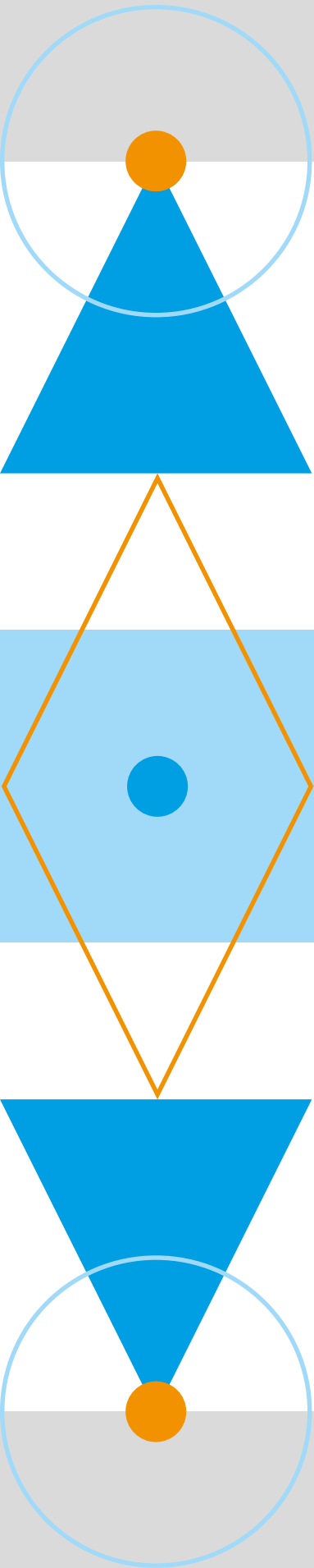
Building and maintaining an effective health cluster: key coordination skills

Paragraph ● ● ● Annex ●
3.1 3.2 3.3 3.1

Box ● ● Figure ● ● ● ● ● Table ● ● ●
3.1 3.2 3.1 3.2 3.3 3.4 3.5 3.1 3.2 3.3

- Contents
- References
- Endnotes

Information management to support the humanitarian health response



04

Contents

Chapter 4		
Information management to support the humanitarian health response		149
4.1 Overview of information management within the context of the health cluster		149
4.1.1	What is information management?	149
4.1.2	Why do we need health information?	150
4.1.3	Who is responsible for information management in emergencies?	150
4.1.4	Basic principles of health information management	151
4.1.5	Principles of humanitarian information management and exchange in emergencies	152
4.2 Key health information management services and outputs		154
4.2.1	Standards for PHIS in activated health clusters and other humanitarian coordination mechanisms	154
4.2.2	Domains of PHIS	155
4.2.3	Health status of and threats to affected populations	156
4.2.4	Availability of health resources and services	159
4.2.5	Health system performance	164
4.3 Roles and responsibilities in information management		168
4.3.1	Role of the health cluster coordinator	168
4.3.2	Role of the information management officer	169
4.3.3	Role of national authorities in information management	169
4.3.4	Role of the cluster lead agency in information management	170
4.3.5	Role of health cluster partners	170
4.3.6	Role of OCHA in information management	171
4.4 Conclusion		174
References		175
Endnotes		177

Abbreviations

3W/4W	who, what, where (and when)
COD	common operational data set
EWAR	early warning, alert and response
GIS	geographical information system
HeRAMS	Health Resources and Services Availability Monitoring System
HMIS	health management information system
MIRA	multi-cluster/sector initial rapid assessment
NGO	nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PHIS	public health information services
SSA	Surveillance System for Attacks on Health Care
TOR	terms of reference
WASH	water, sanitation and hygiene
WHO	World Health Organization

4. Information management to support the humanitarian health response

4.1 Overview of information management within the context of the health cluster

4.1.1 What is information management?

Information management covers the various stages of information processing, including production, storage, retrieval and dissemination. Effective information management contributes to the better working of an organization by improving the speed and accuracy of information delivered, creating a shared frame of reference that enables decision-makers to coordinate and plan response programming based on a clear understanding of the population's needs and the organization's response capacities.

Data sources

Information can be from internal and external sources and in any format. The quality of information available to decision-makers impacts collective and operational response activities (1).

Primary data are collected directly from first-hand sources, including the affected population, respondents and health facilities. Activities include face-to-face interviews, focus group discussions, surveys and direct observation. Primary data collection enables the collecting agency to adapt the collection methods to its precise needs. However, it is often costly and time intensive, and may not always be feasible.

Secondary data are data that have already been collected by others. They can comprise published research, Internet materials, previous assessments, pre-crisis data, epidemiological bulletins, health service data, ministry of health reports, dashboards, health cluster bulletins, media reports, and any other previously



Information management to support the humanitarian health response

Paragraph ● 4.1 4.2 4.3 4.4

- Contents
- References
- Endnotes

existing data. A strength of secondary data is that they are readily available, and therefore the cost of use is reduced. They may enable large sample sizes and may be collected comprehensively and on a routine basis. However, the format of secondary data, the data coverage, or the type of data collected may not be tailored to the specific data collection objectives, and they may not be recent enough to inform emergency needs.

Types of data

Both primary and secondary data can be either quantitative or qualitative.

- **Quantitative information.** Quantitative data consist of numerical or statistical information collected via various means, including surveys or surveillance, or from administration records. They provide a good overall picture of a population or geographical region. They can also be used to measure trends over time. This type of evidence can be used to describe the who, what, where and when of a particular situation.
- **Qualitative information.** Qualitative data provide non-numerical, narrative, descriptive information, which may be collected through interviews, focus group discussions or photographs. They provide broader information based on a few individuals or case examples. This type of evidence is usually used to describe the how and why of a situation.

4.1.2 Why do we need health information?

A key prerequisite for any effective humanitarian response is the availability of timely, reliable and robust information. In order to make sound operational decisions in a humanitarian health response, decision-makers need public health information to assess and monitor the health status of and risks faced by the affected population, the availability and actual functionality of health resources, and the performance of the health system.

Information needs arise throughout the key elements of the Humanitarian Programme Cycle (2).¹ As such, an effective information management function within the cluster response is critical. Public health information is also vital for advocacy and for any review process.

4.1.3 Who is responsible for information management in emergencies?

- The responsibility for ensuring relevant information management needed for an effective and coordinated *intra-cluster* (within one cluster) response lies with the cluster lead agency (3).



Information management to support the humanitarian health response

Paragraph ● ● ● ●
4.1 4.2 4.3 4.4

- Contents
- References
- Endnotes

- The responsibility for ensuring appropriate information management needed for an effective and coordinated *inter-cluster* response usually rests with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA). However, it could also be managed by other agencies in charge of coordination (for example, the World Health Organization (WHO) during the Ebola virus disease outbreak in the Democratic Republic of the Congo, 2018, and the United Nations Mission for Ebola Emergency Response, 2015) (4, 5).

In this context, a mechanism for information sharing and processing, such as an information management working group, raises the efficiency of the humanitarian community, saving individual agencies time and energy on information sharing and processing, and providing a common platform of available information that facilitates collaboration.²

4.1.4 Basic principles of health information management

- Data must be collected, collated and analysed in real time in order to inform policy and operational decisions for the health response.
- Secondary data should be maximized and encouraged at the beginning of a response in order to better identify information gaps and improve planning. All such data, whether relating to the current situation or to the pre-crisis situation, should be reviewed for reliability and the precise areas, populations and time periods to which they relate. Preparedness activities should ensure that common operational data sets (CODs), for example with regard to health zones and health boundaries, are agreed and available (6).
- Whenever possible, data should be disaggregated by age, sex and geographical area at the lowest feasible administrative unit level in order to determine who is affected and who is being reached, thereby providing a basis for planning. Data should also be inclusive of vulnerable groups, such as persons living with disabilities (7). This disaggregation may increase the risk of identification of vulnerable individuals or classes of persons and should be treated as sensitive (8).
- Data should be interpreted appropriately, and results disseminated and translated into meaningful public health action. An analysis working group, if active, helps to identify the steps in this process.
- Health cluster partners play a central role, being responsible and accountable for data collection for most services.



Information management to support the humanitarian health response

Paragraph ● ● ● ●
4.1 4.2 4.3 4.4

- Contents
- References
- Endnotes

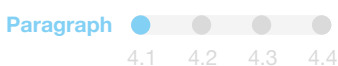
- Any personally identifiable information (such as individual medical records) must be treated with the utmost confidentiality and conform to appropriate standards of data protection (9).
- The health cluster must actively participate in inter-cluster initiatives and liaise closely with OCHA on information management. This is essential to avoid duplicative efforts in generating CODs,³ which are used by all clusters (for example, administrative data sets, population denominator figures), as well as to streamline the work on joint products (such as the multi-cluster/sector initial rapid assessment (MIRA) or humanitarian needs overview).
- All available information should be analysed together in order to arrive at a holistic understanding of the health situation. For example, locations of cases of disease should be compared against the availability of facilities that can provide treatment for that disease. Information integration is best accomplished by organizing all personnel involved in data and information management (surveillance data managers, vaccination data managers, health cluster information management officers) into a single administrative unit under an information management team leader. At a minimum, all such personnel, even if working in different units, should share information freely and meet regularly to avoid gaps and duplication and to promote integrated analysis.
- A set of core public health information services (PHIS) should be in place in all activated clusters (10). These include a public health situation analysis, rapid assessments (including the MIRA and rapid health assessment), an early warning, alert and response (EWAR) system, the Health Resources and Services Availability Monitoring System (HeRAMS), a who, what, where (and when) (3W/4W) matrix, and the production of regular health cluster bulletins.

4.1.5 Principles of humanitarian information management and exchange in emergencies

- **Confidentiality.** Sensitive data and information that are not to be shared publicly should be managed accordingly and clearly marked as such.
- **Accessibility.** Humanitarian information should be made accessible by applying easy-to-use formats and tools, translating information into common or local languages when necessary, and placing information in locations (such as websites) that are easily accessible by relevant partners.
- **Inclusiveness.** Information exchange should be based on a system of partnership with a high degree of ownership by multiple stakeholders, especially representatives of the affected population and government.



Information management to support the humanitarian health response

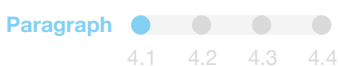


- [Contents](#)
- [References](#)
- [Endnotes](#)

- **Interoperability.** All sharable data and information should be made available in formats that can be easily retrieved, shared and used by humanitarian organizations.
- **Accountability.** Users must be able to evaluate the credibility of information by knowing its source and having access to methods of collection, transformation and analysis.
- **Validity.** Information should be relevant, accurate and consistent, and should be based on sound methodologies, validated by external sources, and analysed within the proper contextual framework.
- **Relevance.** Information should be practical, flexible, responsive, and driven by operational needs in support of decision-making throughout all phases of a crisis.
- **Objectivity.** A variety of sources should be used when collecting and analysing information so as to provide varied and balanced perspectives for addressing problems and recommending solutions.
- **Neutrality.** Information should be free of political interference or opinion that distorts a situation or the response.
- **Humanity.** Information should never be used to distort, mislead or cause harm to affected or at-risk populations, and should respect the dignity of those affected.
- **Timeliness.** Humanitarian information must be kept current and made available in a timely manner.
- **Sustainability.** Humanitarian information should be open sourced, preserved, catalogued and archived so that it can be retrieved for future use, such as for preparedness, analysis, lessons learned and evaluation.



Information management to support the humanitarian health response



- [Contents](#)
- [References](#)
- [Endnotes](#)

4.2 Key health information management services and outputs

4.2.1 Standards for PHIS in activated health clusters and other humanitarian coordination mechanisms

The Global Health Cluster has developed the Public Health Information Services (PHIS) standards, which provide essential guidance to plan, establish, implement and deliver PHIS and ensure adequate staffing to meet the service requirements (11).

PHIS are a critical function of humanitarian coordination mechanisms. The PHIS standards provide a detailed description of the information services that should be in place in activated health clusters (or equivalent health coordination mechanisms such as health sectors) and other processes that the cluster should be actively contributing to; the methods and software applications by which such services can be delivered; the timing of implementation and update of information products; and what staffing, competencies and resources are required to meet the needs of PHIS.

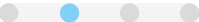
The PHIS function of activated health clusters encompasses a range of activities and products, from simple, administrative information tasks (such as maintenance of a list of health cluster partners) to far more technically complex activities (such as the implementation and analysis of mortality surveys or epidemic surveillance). This information needs to be generated throughout the Humanitarian Programme Cycle.

The guidance on PHIS standards (11) is structured around the following areas of PHIS:

- which public health information services and products should be expected of an activated health cluster, and who in the health cluster should be responsible for their delivery;
- the specific methods, software applications and tools that should be used to deliver these services;⁴
- how quickly and with what frequency of update each service should be delivered during different crisis scenarios;
- the staffing and resources that should be made available to activated health clusters in order to enable them to successfully discharge the PHIS function;



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

- the PHIS-related technical competencies that cluster staff should display when deploying into a health cluster role (these competencies can serve as a basis for recruitment, professional development and performance management).

PHIS should be appropriately adapted to the needs of the response, and must be harmonized with, and not duplicative of, inter-cluster information management activities (for example, the 3W/4W approaches).

Health cluster information management officers bear the main responsibility for designing and executing most data collection, as well as the management, analysis and reporting of data. They may be supported by epidemiologists, who are deployed to health clusters for specific activities, such as mortality estimation.

Health cluster coordinators and public health officers must request appropriate staffing for their teams, instigate data collection and interpret and act upon findings.

4.2.2 Domains of PHIS

Data and information⁵ need to be collected and systematically analysed following the three domains of emergency health information, as follows:

- **health status and threats to affected populations**, comprising information on the current health status of the affected population or specific groups (for example, mortality, morbidity and their major causes, baseline anthropometric status) and health risks in the context of the crisis (for example, potential epidemic-prone diseases, psychological trauma, risks linked to service or treatment discontinuation, and any other crisis-attributable threats to public health); curative health services, infrastructure, personnel and supplies provided by health authorities or other actors, as well as the degree of access that affected populations actually have to those services;
- **health system performance**, namely information on the sheer output, coverage, utilization and quality (or effectiveness) of health services available to the crisis-affected population;
- **availability of health resources and services**, namely information on utilization and quality (or effectiveness) of health services as well as availability of preventive care to the crisis-affected population.

In addition to those three domains, information is needed on the following.

- **Context.** This will include the political, social, economic and security conditions in the location, which will inform recommendations on actions to address priority



Information management to support the humanitarian health response

Paragraph 4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

health problems and gaps in services. Political information that may cause controversy, especially if not crucial to contextualizing the health issues, should be kept to a minimum to avoid unnecessary conflict with partners, such as the host government.

- **Lessons from responses to previous crises.** These may have occurred in the country or in other countries, and can offer the opportunity to build on successes and avoid repeating mistakes.

The following sections provide a brief outline of PHIS and their relevance to health cluster action and the prioritization of services in a given health cluster context.⁶

4.2.3 Health status of and threats to affected populations

Public health situation analysis

The public health situation analysis (12) aims to provide all health sector partners, including local and national authorities, nongovernmental organizations (NGOs), donor agencies and United Nations agencies, with a common and comprehensive understanding of the public health situation in a crisis in order to inform evidence-based collective humanitarian health response planning. The public health situation analysis may also be used to feed other sectoral and intersectoral products, such as providing the health input to the humanitarian needs overview.

Rapid assessment

Rapid assessment is any field assessment that uses primary data collection to fill gaps in existing information, for example gaps identified during the initial public health situation analysis. Examples of rapid assessments include the WHO rapid health assessment, or a multisectoral assessment approach (such as MIRA) that includes health questions.⁷

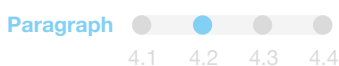
Early warning, alert and response (EWAR)

During humanitarian emergencies, broad public health surveillance systems may be underperforming, disrupted or non-existent; they may quickly become overwhelmed and unable to meet adequately the surveillance information needs of a humanitarian emergency, including provision of timely and high-quality data. EWAR is needed and is often set up to fill this gap, particularly in the acute phase of an emergency, while the routine systems recover from the effects of the disaster (13).

To measure the occurrence of epidemic-prone diseases and unusual health events (such as unexplained deaths) in the emergency-affected area, EWAR relies on a



Information management to support the humanitarian health response



- [Contents](#)
- [References](#)
- [Endnotes](#)

network of people responsible for the collection, investigation, reporting, analysis and dissemination of information from the field up the reporting chain to the central level, coupled with timely feedback. Facilities with well trained staff and adequate resources can ensure complete, reliable and regular reporting.

The most robust network available should be used for initial roll-out of EWAR; this involves selection of health facilities that have adequate capacity for the generation of high-quality and reliable data. This phase should be followed by gradual expansion towards universal coverage as the capacities of the remaining health facilities are strengthened and more resources become available.

Alerts are generated from unusual health events that can signal the early stages of an outbreak. They can be detected at the community level (for example, via community volunteers, rumours, social media posts, and local media) by setting an alert threshold for indicator-based surveillance, and at the stage of data analysis. It is important to distinguish between epidemic-prone diseases and other diseases of public health importance – EWAR should focus on the former.

Once an alert has been received by the EWAR district focal point or higher levels, a systematic verification process starting at the field level should be initiated within 24 hours. A standardized process should be used to verify the alert and, if an outbreak is confirmed, an on-site investigation should be started.

Timely feedback is critical for ensuring full engagement of EWAR stakeholders. Simplified language and graphs should be used to convey complex data and trends in a user-friendly format and, when possible, clear recommendations should be made to implementing organizations, highlighting priority areas and needs. Stakeholders should be encouraged to share feedback and dissemination all the way to the front-line health worker level.

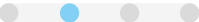
Information needs for large-scale population movement in emergencies

The following actions should be undertaken to improve the collection and analysis of information on population movement in order to guide the planning, implementation, monitoring and evaluation of evidence-based emergency health operations.

- Strengthen operational partnerships with entities collecting information on population movement, including displacement, and establish a mechanism for the public health analysis of such information. The Displacement Tracking Matrix of the International Organization for Migration is a system that tracks and monitors displacement and population movement (14). It is designed to regularly and systematically capture, process and disseminate information to provide



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

a better understanding of the movements and evolving needs of displaced populations and migrants, whether on site or en route.

- Where other entities are not operating, consider advocating adoption of or directly implementing methodologies and tools for the proactive collection of information on population movement, including its patterns and dynamics, to strengthen situational awareness and outbreak control measures. Components of information on population movement should include:
 - type of population movement and contributory factors, including displacement, economic or labour migration, daily commute, nomadism, cultural or religious practice, trade, security conditions, education, health care;
 - sociodemographic profile of those engaged in movement;
 - patterns of movement, including size and direction, origin and destination, mode of transportation, routes, seasonal variance;
 - points of transit or congregation where contact and interaction among travellers, as well as between travellers and host communities, are increased, such as refugee camps, displacement sites, airports, train stations, sea or river ports, markets, extraction sites, health facilities, traditional healers, festivals or sport centres, religious sites.

Mortality estimation

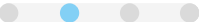
Population mortality – the rate at which people are dying in the affected population – is a key metric of physical health status and helps to benchmark the overall severity of a crisis. The crude death rate and the death rate among children aged under 5 years are the most commonly used indicators of population mortality in crises.

Mortality estimation may be performed on a one-off basis, most commonly through a retrospective household sample survey (either stand alone or as part of other commonly implemented surveys, such as the SMART nutrition and mortality methodology),⁸ or on an ongoing basis, for example through a community-based mortality surveillance system that relies on regularly updated collection of data. Note that in nearly all crisis settings, merely relying on deaths that occur in health facilities seriously underestimates total mortality.

Mortality estimation requires specialized epidemiologic expertise. Thus, health clusters wishing to undertake mortality estimation should seek support from an epidemiologist to determine the feasibility and best approach.



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

4.2.4 Availability of health resources and services

Health Resources and Services Availability Monitoring System (HeRAMS)

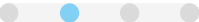
HeRAMS is an approach that aims to improve overall access to health care by contributing to the elaboration of a commonly agreed-upon picture of health service needs, gaps and priorities and by providing essential information to support decision-making and coordination of health sector actors in emergencies. It is a collaborative approach that involves a large range of stakeholders and that has been specifically designed to operate in highly constrained, low-resourced and rapidly changing environments, where access, security and the lack of time and resources impede the use of other traditional health service assessment and monitoring approaches. HeRAMS is a standardized approach supported by a software-based platform.⁹




HeRAMS is articulated around nine information pillars:

1. Master health facility list: this list is the foundation of HeRAMS, combining descriptive data on the point of service delivery and the modality of service delivery (type of point of care, for example health centre or mobile outreach team).
2. Condition: provides information on the state of infrastructure and essential equipment, as well as the main causes of damage.
3. Functionality: provides information on the overall functionality of the modality of service delivery, and the main causes of dysfunctionality.
4. Accessibility: provides information on accessibility to the modality of service delivery and the main causes of inaccessibility.
5. Management and support: provides information on actors managing the modality of service delivery and any form of external support provided.
6. Basic amenities: provides information on the availability and sufficiency (in quantity and quality) of all essential basic amenities.
7. Health information systems: provides information on the contribution of modalities of service delivery to health information systems, including frequency, timeliness and completeness.
8. Availability of essential health services: provides information on services across six subsectors as well as information on the main impediments to service



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

-  [Contents](#)
-  [References](#)
-  [Endnotes](#)

delivery. HeRAMS provides a standard checklist of services. These may be adapted to local contexts as required.

9. Optional module: this pillar is optional and can be activated, depending on need and feasibility, to provide information on the availability of human resources, essential medicines and essential equipment.

HeRAMS requires strong coordination and good integration with other existing health sector coordination mechanisms. The role of the health cluster is to contribute to the implementation of the HeRAMS approach and foster the engagement of cluster partners when relevant. The HeRAMS online platform has been developed to ease field implementation and analysis and to ensure consistency of the approach globally.

WHO Surveillance System for Attacks on Health Care (SSA)

All elements of health care, including medical personnel, health facilities, transport, and patients, are under attack around the world. To understand the extent and nature of the issue and its impact on public health, a single, standardized surveillance system is needed. The information obtained, if made widely available, can inform national and global advocacy efforts and risk reduction interventions to stop attacks and mitigate their consequences for public health, particularly among the world's most vulnerable populations, including those facing public health crises from a wide range of hazards, such as infectious diseases, conflict, natural events, and bioterrorism.

WHO was given the mandate, by World Health Assembly resolution WHA65.20 of 2012, to develop and coordinate a surveillance system to document attacks on health care in emergency settings. WHO consequently developed the Surveillance System for Attacks on Health Care (SSA) to address the need for rapid and accurate information on attacks on health care in emergency settings, taking into consideration the lessons learned from previous experiences (15). The purpose of the SSA is to systematically collect and make available data on attacks on health care, and their impact on public health, in countries facing emergencies.

The objectives of the SSA are the following:

- collect, consolidate, and openly and regularly share reliable data on attacks on health care;
- better understand the extent and nature of the problem of attacks on health care and the consequences for health care delivery and public health;



Information management to support the humanitarian health response

Paragraph 4.1 4.2 4.3 4.4

- Contents
- References
- Endnotes

- produce regular reports with consolidated data and trend analysis;
- provide the evidence base from which to implement advocacy to stop attacks on health care;
- identify global and context-specific trends and patterns of violence to inform and implement risk reduction and resilience measures so that health care is protected and health services are available.

The health cluster is, in many countries, the main vehicle for implementing the SSA and collecting information on attacks on health care in countries with emergencies. The SSA collects primary data from eyewitnesses, victims of attacks, and main informants of such incidents on the ground. They are often the health cluster partners who are implementing health services where an attack occurs.

Once the data about an attack are entered, assigned a level of certainty, and cleared, they are made available in a web-enabled, publicly available, secure global database (15). The information gathered by the SSA is used to generate the evidence needed to inform strategic approaches for safer health care delivery and to support advocacy at country level on protection of the right of access to care (16).

Who, what, where (and when) (3W/4W)

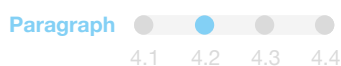
The delineation of health actors throughout the crisis-affected area is a prerequisite for coordinated planning and action. It should be undertaken rapidly at the onset of a crisis, not later than the first cluster meeting, and should be updated continuously during the early stages of response and at regular intervals once the situation has stabilized. It is also important to monitor whether the population has real access to the services being offered and whether those services are being utilized as expected.

The arrangements for delineation must be adapted to the country context but should generally include:

- delineating the services and specific health resources available through different actors in different areas using HeRAMS;
- undertaking a stakeholder analysis by 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;



Information management to support the humanitarian health response



- [Contents](#)
- [References](#)
- [Endnotes](#)

- gathering activity-related information from health actors, including on the following:
 - 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 geographical 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 geographical areas, and when they expect to 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 response to and prevention of sexual and gender-based violence.

Stakeholders may include militias and other non-State actors as well as donors, local political entities, and organizations providing health services.

The combined information is important for assessment and planning purposes but also provides the health cluster coordinator 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 to them).

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

Information from the 3W should be communicated and coordinated with OCHA, as it will feed into the multi-sector 3W.

The health cluster coordinator is responsible for ensuring health sector inputs to the OCHA 3W/4W database. 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. The capacity to monitor is important, including for organizations present for only a limited period, or organizations in the process of expanding their operations and security.

The health cluster coordinator must therefore keep an up-to-date record of “when”, even if this information is not recorded by OCHA.



Information management to support the humanitarian health response

Paragraph 4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

Health cluster coordinator and health cluster action projects and donor support by sector and in relation to defined administrative areas

The following actions should be undertaken by the health cluster, under the aegis of the health cluster coordinator.

- Obtain the area and population data sets (CODs) from OCHA.
- Check what information the ministry of health 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 geographical areas where they are working. Cross-check that information to ensure that it is consistent across organizations and entities.
- Collect information on the health services or service subsectors 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 partners and 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.

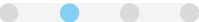
Lessons and practical hints from field experience

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

It has also proved useful to have wallboards or flipcharts posted permanently on a wall in the venue for cluster meetings on which organizations can record – and update as and when necessary – their own data, as well as viewing what others have entered. The information is transcribed into the 3W/4W module, and printouts are distributed periodically by the health cluster coordinator.



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

Partners list

A partners list is simply a list of all health cluster partners and their contact information. While a well maintained 3W/4W database may seem to remove the need to maintain a separate partners list, it is nevertheless usually the case that not all partners contribute to the 3W/4W database in a timely way. Further, partners may not wish their contact information to be shared publicly in the same way that 3W/4W information may be shared, or the 3W/4W database may not be conducive to including contact information (for example, if presented in a map format). A separate partners list should therefore always be created and kept up to date.

4.2.5 Health system performance

A health management information system (HMIS) collects, analyses and reports data from health providers and facilities on causes of consultation and hospitalization, services provided (such as number of antenatal consultations), and (at least in inpatient facilities) patient clinical outcomes.

HMIS data, alone or in combination with catchment population figures, are used to construct a variety of indicators of proportional and absolute morbidity and mortality, service utilization and quality of care. These indicators inform planning, management and decision-making both at the health facility level and at aggregated levels, such as district-level planning by the ministry of health.

An HMIS consists of the people collecting, analysing and acting on data; the standard indicators being monitored; the data collection instruments and procedures; the computing platform and application for data entry, management and analysis; and procedures for data flow, auditing, reporting and action.

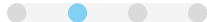
Nearly all countries operate an HMIS, though in most crises these become heavily disrupted or non-functional. Agencies (such as NGOs) that operate direct health services or support existing ministry of health services also need to collect data for reporting purposes, to plan pharmaceutical procurement on the basis of morbidity patterns, and to monitor service utilization and quality. To these ends, they should and often do set up data collection systems that, though with varying complexity and effectiveness, serve some or all of the functions of an HMIS.

The health cluster HMIS service consists of:

- supporting any health cluster partner, including local health authorities, to improve and upgrade any aspect of its HMIS through training (including on-the-job training);



Information management to support the humanitarian health response

Paragraph 
4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

- harmonizing the different HMIS implemented by health cluster partners by introducing a common set of indicators, health facility data sets and catchment population assumptions, and, where possible (rarely), standardized data collection instruments and procedures and software applications;
- regular reporting on HMIS indicators, for example main causes of consultation, through standard channels such as health cluster bulletins or monitoring and evaluation reports;
- making use of such a system to plan activities and identify and respond to large-scale coverage or quality problems;
- helping to develop an emergency HMIS that is interoperable and as consistent as possible with the existing HMIS operated by health authorities, and responsibly handing over emergency HMIS to local health authorities upon cluster deactivation.

Where no prior HMIS is available, the health cluster should support local health authorities and health cluster partners in setting up basic HMIS functionality. Note, however, that an HMIS is not the appropriate instrument for detecting or monitoring epidemics (see EWAR above).

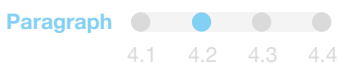
Vaccination coverage estimation

Vaccination, preventive or in response to an epidemic, is a mainstay of public health intervention in an emergency. Vaccination coverage – the proportion of the target population group that has received the correct dosage of a given vaccine – is useful both as a measure of epidemic risk (before any supplementary vaccination campaigns) and as a measure of performance of supplementary vaccination campaigns. When planning campaigns, disaggregated data on vaccination coverage can inform whether remedial vaccination activities are required and what the most efficient strategies would be for such activities (for example, targeted geographical approaches or regionwide enhanced vaccination).

There are two main methods for vaccination coverage estimation: administrative coverage, in which the number of administered doses is divided by the estimated population of eligible recipients; and coverage surveys, which use representative sampling to determine coverage. Both methods have advantages and disadvantages. Vaccination coverage estimation requires specialized expertise and should thus be undertaken in consultation with vaccination experts or epidemiologists.



Information management to support the humanitarian health response



- [Contents](#)
- [References](#)
- [Endnotes](#)

Health cluster bulletin

The health cluster bulletin is a frequent publication that provides an overview of the main public health needs, key health information including trends, and activities of health cluster partners. A typical health cluster bulletin should have the following structure:¹⁰

- cover page with title, crisis name, reporting period, health cluster partners and observers;
- highlights of the previous time period (since publication of the last bulletin);
- information from health assessments during the time period;
- information from different surveillance and monitoring systems during the time period;
- summary needs and gaps during the time period;
- information about or from coordination meetings during the time period;
- agency activities during the time period;
- capacity-building during the time period;
- funds requested and received during the time period;
- useful contact details, including key staff at national or subnational levels (where the humanitarian activities are taking place).

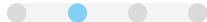
The health cluster bulletin's purpose is mainly to keep all health cluster partners and other stakeholders informed. In the absence of a regular emergency HMIS report, the health cluster bulletin is the main vehicle for reporting on the health response's performance.

Operational indicator monitoring: monitoring and evaluation in emergencies

The operational indicator monitoring service, also commonly referred to as monitoring and evaluation, aggregates and reports a small set of key performance indicators for the health cluster response as a whole. These may include raw input figures (such as number of cholera kits obtained), activity figures (such as number of cholera response workshops held), output figures (such as number of people



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

vaccinated against cholera), outcome figures (such as number of cholera cases), and, rarely, impact figures (such as cholera case fatality rate). Ideally, all indicators are reported against targets.

Operational indicator monitoring does not collect primary data. Rather, it captures data generated by health cluster partners and other systems, such as the HMIS (see above). The process for doing so is necessarily different in every health cluster, depending on available data sources. The purpose of operational indicator monitoring is to supply basic information activity reporting in order to allow for course correction and to improve accountability against commitments made.¹¹

Ad hoc infographics

Infographics refer to any visual representation of information to improve cognition and thus understanding of data patterns and key observations. Infographics for PHIS can include:

- maps
- tables
- graphs
- diagrams
- dashboards.

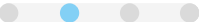
The most important of these, and among the first of all information products needed in a response, is maps. Maps allow all partners to orient themselves to the geographical dimensions of the emergency and its response. Beyond basic geographical information, maps may feature layers showing data on health risks (such as disease cases), resources (such as number of pre-positioned drug kits) or services (such as health facilities by type).

Infographics are typically commissioned by the health cluster coordinator or prepared by an information management officer to complement and help illustrate information arising from other public health services, such as the public health situation analysis, a health cluster bulletin, or an HeRAMS report. Occasionally, they may be presented as a stand-alone information product, or included in presentations for various audiences. While complicated geographical information system (GIS) skills may be beyond the scope of many health clusters, basic mapping (by hand if necessary) is a required competency for any health cluster team.

The PHIS Toolkit offers a variety of resources to support maps and other ad hoc infographics.



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

4.3 Roles and responsibilities in information management

4.3.1 Role of the health cluster coordinator

When a health cluster or sector is activated, it will need to keep up with information demands and disseminate relevant information appropriately. The health cluster or sector should produce and share a number of information management products with the government and the humanitarian country team and its members to inform planning and decision-making. Having a minimum set of information management services in place will ensure the cluster and sector can function effectively. The health cluster coordinator¹² should contribute to the strengthening of existing information systems or the implementation of transitional information systems as required and ensure partners are integrated and contributing to those systems. One of the main roles of the health cluster or sector coordinator is to ensure that this happens, mainly through supporting the information management officer in their work.

Specifically, the health cluster coordinator:

- ensures that information management issues and needs are included in the cluster's strategic planning;
- lobbies for adequate resources for information management;
- establishes relationships with partners and external stakeholders;
- promotes trust and transparency with regard to information management and sharing;
- facilitates the analysis processes of health data and information;
- facilitates information management product development to meet information management demands;
- uses the information generated for a collective, evidence-based health cluster operational response.

More specific tasks and deliverables for the health cluster coordinator are outlined in the PHIS standards.



Information management to support the humanitarian health response

Paragraph ● ● ● ●
4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

4.3.2 Role of the information management officer

The information management officer ensures that the information needs of the health cluster are identified and met. Close collaboration between the health cluster coordinator and information management officer is essential. The respective roles and responsibilities of these two positions should be outlined in clear terms of reference (TOR), including communication lines between the health cluster coordinator and information management officer at national and subnational levels. An example can be seen in the TOR for health cluster coordinator (17, 18) and information management officer.

Generally speaking, an information management officer is in place to perform the following tasks.

- Support the cluster and sector and partners to produce consolidated information management products. These should be produced in a regular and timely manner, and should be user-friendly and informative.
- Participate in multisectoral information management forums and encourage use of appropriate information management tools for the health cluster and sector. Regardless of the inter-cluster working arrangements, information being generated by the water, sanitation and hygiene (WASH), food security, and nutrition sectors is of particular importance to the health cluster or sector because of the links between morbidity and mortality rates on the one hand, and food insecurity and waterborne and vector-borne diseases on the other hand.
- Maintain website and information management-specific databases. These could include 4W information, an assessment database, and a project database.

4.3.3 Role of national authorities in information management

National authorities maintain the overall responsibility for a humanitarian response in emergencies and should be involved from the start, to ensure that emerging information management cluster or sector systems build on existing national data sets and existing systems. It is essential to maximize use of existing data and avoid duplication. However, in many humanitarian contexts, existing information management systems will need to be adapted or at least scaled up in collaboration with the ministry of health to meet the increased information management demands from the various new stakeholders involved in the response.



Information management to support the humanitarian health response

Paragraph ● ● ● ●
4.1 4.2 4.3 4.4

- Contents
- References
- Endnotes

4.3.4 Role of the cluster lead agency in information management

The cluster lead agency at the country level is responsible for ensuring that the need for appropriate information management is provided for an effective and coordinated response within the cluster (intra-cluster). Some of the responsibilities of the cluster lead agency at country level are to:

- allocate the necessary human and financial resources for information management, including through appointment of an information management focal point or team leader, who should have sufficient expertise and ability to work with different partners and clusters as well as within the different sections (including non-emergency) of the cluster lead agency;
- share information management resources and capacities within and across clusters at the country level, where appropriate, to promote harmonization and economies of scale;
- ensure adherence to global – and taking into account national – information management norms, policies and standards;
- if needed, establish a data confidentiality and privacy policy within their cluster, which ensures that sensitive, personally identifiable data sets are suitably anonymized and that information does not cause harm to the affected population (19);
- ensure all information is age- and sex- (and others where relevant) disaggregated, where appropriate (20).

4.3.5 Role of health cluster partners

The role of health cluster partners is to:

- contribute to health data and information exchange;
- agree and adhere to common definitions, indicators and standards;
- contribute to analyses and collectively interpret information and data, for example in the health information management working group (see below);
- contribute to health cluster and sector information management products for dissemination;
- contribute their expertise to the health technical working groups, where relevant.



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

The latter may include a health-specific information management working group, which is set up to provide technical support in streamlining information management and reporting for improved decision-making in emergency preparedness and response. The information management working group is an open forum and welcomes participants from organizations working on humanitarian health issues, including the United Nations, national and international NGOs, volunteer organizations and academia.

4.3.6 Role of OCHA in information management

Providing information products and services to the humanitarian community is an important part of OCHA's coordination role in both new and ongoing emergencies. OCHA provides the overarching framework for pulling together information across clusters. It also suggests standards that allow for data sets and databases to be compatible in order to support data interoperability, including:

- ensuring that sex- and age-disaggregated data are collected and used;
- providing standardized cross-cluster needs and gap analysis, based on information provided by the different clusters;
- supporting clusters in their information management activities, including the promotion of best practices;
- ensuring the development of compatible information management cluster and sector systems, harmonized reporting where appropriate, joint assessments where appropriate, and coordinated cluster-specific assessments to ensure that specific groups or areas are not unnecessarily overassessed;¹³
- providing mapping services and technical support to information management colleagues.

OCHA will allocate appropriate information management resources according to the nature and scope of the emergency. The minimum services to be provided or made available by OCHA to clusters and sectors are:

- a location where the humanitarian community can access information resources;
- maintenance of common data sets that are used by the majority of sectors and clusters;
- geospatial data and analysis relevant to inter-cluster and intersectoral decision-making;



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

- management of the collection and dissemination of all inter-cluster information;
- advocacy with regard to data and information sharing within the humanitarian community as well as the adoption of global data standards;
- provision of technical information management advice to clusters and sectors on survey design for needs assessments or other significant external data collection exercises;
- access to schedules, agendas and minutes of cluster and sector coordination meetings.

OCHA coordination mechanisms for information management at country level include an intersectoral information management working group, which aims to build on existing in-country information management cluster or sector systems and support the national authority's efforts to coordinate and harmonize the information management activities of all humanitarian partners. Members include all relevant information management focal points (information management officers) from existing clusters and the national authority. The information management working group ensures timely sharing of reliable and relevant evidence through joint information systems and supports the development of coordinated information management products.

When an emergency occurs, OCHA's information management officers immediately start working with key partners to produce standard information services and products to support coordination of all the humanitarian organizations. OCHA's information management services and products include the following.

- **Common operational data sets (CODs).** CODs are predictable, core sets of data needed to support operations and decision-making for all actors in a humanitarian response (21). They are proactively identified and maintained prior to an emergency as part of data preparedness activities and are made available by OCHA within 48 hours of an emergency being declared. They should present the best available data for seven key themes: administrative boundaries, populated places, transportation network, hydrology, topography, population statistics, and humanitarian profile (caseloads).
- **Country-specific CODs.** These are data sets that are relevant to specific disaster typologies (for example, earthquake, flood or conflict) and are thus specific to the risk profile in a given country. There may be overlapping data sets where more than one agency or cluster maintains databases with the same information, such as anthropometric survey data in relation to a food insecurity crisis. In this example, the nutrition cluster or sector coordinator and the information management



Information management to support the humanitarian health response

Paragraph  4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

officer should be aware of these overlaps in order to engage agencies and other clusters in determining the most feasible and effective collaboration mechanisms. Such a process will ensure that databases are both complete and accurate, and enable identification and prioritization of one data set as the COD to promote harmonization. Coordination can be undermined if plans and strategies are being developed based on two different understandings of the situation, simply due to gaps in information in one database that are filled in another.

- **HumanitarianResponse.info.** www.humanitarianresponse.info is a central website maintained by OCHA that enables operational responders to collaborate during an emergency. After a humanitarian crisis occurs, the site creates a space for that crisis as a centralizing portal for operational coordination information and information management tools and services. Sections include contacts, events, documents, maps and infographics, data sets, offices, and an assessment registry. Users can register to a particular response to be given access to non-public information, such as contact lists, for that response.
- **Humanitarian Data Exchange.** The Humanitarian Data Exchange (<https://data.humdata.org>) is an open platform for sharing data across crises and organizations. Launched in 2014, its goal is to make humanitarian raw data easy to find and use for analysis. It is managed by OCHA's Centre for Humanitarian Data (<https://centre.humdata.org>) and provides tools to rapidly standardize, refine, and visualize data for interoperability and analysis.
- **Mapping.** Most humanitarian information has a geographical component. Maps are a highly effective means of communicating large amounts of information in a simple form. Mapping can be extremely useful and is an effective presentation tool. However, it can also be resource and time intensive. Quick and simple maps are practical and effective for many types of data, particularly at the onset of an emergency when baseline data are often incomplete or changing rapidly. OCHA also gathers data using satellite imagery, other geospatial information, census data and other tools. It uses these data to create maps on demand. These may be maintained on www.humanitarianresponse.info or elsewhere.
- **Contact lists.** These are searchable databases of basic contact information (organization, names, emails and phone numbers) for individuals and organizations responding to the emergency. They may be maintained on www.humanitarianresponse.info or elsewhere.
- **Meeting schedules.** Meeting schedules provide the time, location and function of all meetings in an operational environment. They are updated daily in the first weeks after a disaster. These may be maintained on www.humanitarianresponse.info or elsewhere.



Information management to support the humanitarian health response

Paragraph 
4.1 4.2 4.3 4.4

- [Contents](#)
- [References](#)
- [Endnotes](#)

- **Humanitarian Dashboard.** The Humanitarian Dashboard is maintained by OCHA. It provides a visual overview of progress towards meeting the needs in a humanitarian response. It allows stakeholders to quickly understand the strategic priorities of a response, the key figures characterizing the crisis, the most important humanitarian needs and the related response per sector or cluster.

4.4 Conclusion

All activated clusters are responsible for keeping up with information requirements. Cluster and sector partners should adhere to commonly agreed definitions and indicators for sector needs and activities, as well as the use of common baseline or reference data, which are disaggregated by age and sex, and consider diversity issues where appropriate. These include humanitarian actors participating in the health cluster or sector as observers, who should be encouraged to share information with the wider humanitarian community.

Other clusters and sectors will be sharing information through inter-cluster mechanisms. This is not only good practice, but also of particular importance to the health sector for an increased understanding of the underlying causes of diseases. The health cluster or sector coordinator will need to ensure health is adequately represented in these by attending or designating an information management officer or partner to attend and contribute on the group's behalf.



Information management to support the humanitarian health response

Paragraph ● ● ● ●
4.1 4.2 4.3 4.4

- Contents
- References
- Endnotes

References

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Information management to support the humanitarian health response

Paragraph ● ● ● ●
4.1 4.2 4.3 4.4

- Contents
- References
- Endnotes

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Information management to support the humanitarian health response

Paragraph ● ● ● ●
4.1 4.2 4.3 4.4

- Contents
- References
- Endnotes

Endnotes

1. Needs assessment and analysis; strategic response planning; resource mobilization; implementation and monitoring; and operational review and evaluation (2).
2. See section 4.4.
3. See also section 4.3.6 Role of OCHA in information management.
4. See the PHIS Toolkit, which contains an up-to-date repository of relevant resources (10).
5. Data are raw, unorganized facts that need to be processed. When data are processed, organized, structured or presented in a given context so as to make them useful, they become “information”. https://www.diffen.com/difference/Data_vs_Information.
6. For more information about these services, please consult the PHIS standards, PHIS Toolkit, and relevant links presented in this chapter.
7. For further information see Chapter 10.
8. SMART: <https://smartmethodology.org/>.
9. HeRAMS: www.herams.org.
10. See template at <https://www.who.int/health-cluster/resources/publications/HC-Bulletin-template.docx?ua=1>.
11. More detail on this service is provided in Chapter 12.
12. The structure of roles in the cluster may vary. Public health officers and epidemiologists often resume activities – see Table 1, PHIS standards (11).
13. See Chapter 10.

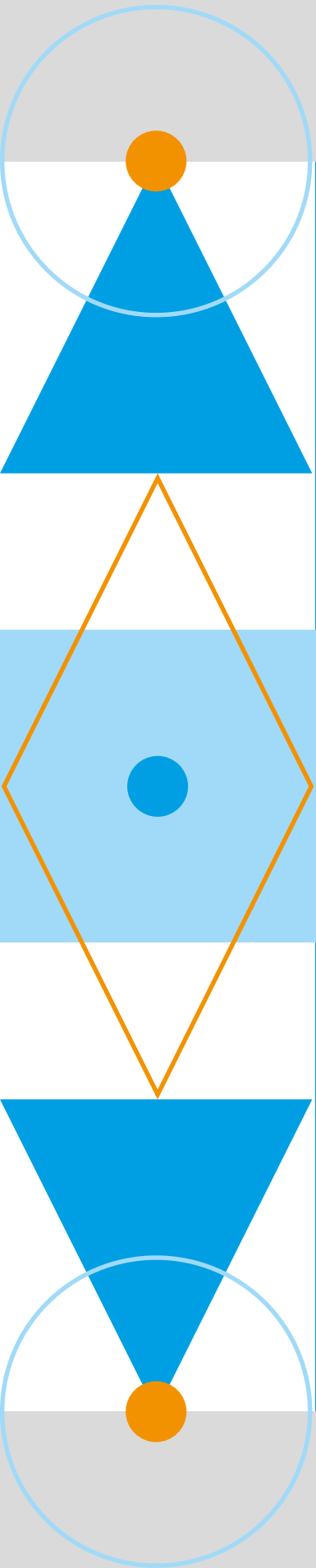


Information management to support the humanitarian health response

Paragraph ● ● ● ●
4.1 4.2 4.3 4.4

- Contents
- References
- Endnotes

Promoting standards for a quality health response



05

Contents

Chapter 5		
Promoting standards for a quality health response		182
5.1 Definition of quality of care		182
5.1.1	Quality of health care in humanitarian settings	183
5.1.2	Challenges to providing quality health care in humanitarian settings	185
5.2 Establishing quality of care processes		188
5.3 Ensuring standards and promoting best practices for a quality health response		191
5.3.1	What are standards and why are they needed?	191
5.3.2	Types of international and national standards	192
5.4 Setting standards		204
5.4.1	Identifying gaps in standards	204
5.4.2	Developing standards in different scenarios	204
5.4.3	Steps to be taken in developing standards	206
5.5 Building capacity to ensure standards and promote best practice		207
References		209
Endnotes		212
Boxes		
Box 5.1	Why is it necessary to promote standards?	192
Box 5.2	Sphere Protection Principles	195
Box 5.3	Health systems standards	198
Box 5.4	Essential health care standards	199
Figures		
Figure 5.1	Domains of quality of care	185
Figure 5.2	The eight elements of national quality policy and strategy (NQPS)	189
Figure 5.3	Successful interventions for quality improvement	190
Figure 5.4	CHS commitments	193
Tables		
Table 5.1	Examples of challenges to delivering quality of care in humanitarian settings	186
Table 5.2	Different scenarios relating to standards for health response in humanitarian settings	205
Table 5.3	Steps in developing standards and roles of key actors	206

Abbreviations

ALNAP	Active Learning Network for Accountability and Performance
CHS	Core Humanitarian Standard on Quality and Accountability
EPHS	essential package of health services
HAP	Humanitarian Accountability Partnership
IASC	Inter-Agency Standing Committee
IFRC	International Federation of Red Cross and Red Crescent Societies
MISP	Minimum Initial Service Package
NGO	nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Co-operation and Development
WASH	water, sanitation and hygiene
WHO	World Health Organization

5. Promoting standards for a quality health response

Improving the health outcomes of a crisis-affected population through provision of a quality health care response is a general goal of any health cluster. For health services to improve health outcomes, it is necessary to ensure not only that the quality of clinical care delivered within a health care setting is of the required standard, but also that the provision of health care adequately meets the needs of the population it is meant to serve.

During the development of the humanitarian response plan, the health cluster strategy will be determined, including definition of the overall objectives of the health cluster response. It is important to define an essential package of health care services – what health care services should be available at each level of health care (1) and what standards should be achieved – in order to allow health cluster partners and stakeholders, including affected populations, to clearly understand what quality of health care is intended to be provided.¹

5.1 Definition of quality of care

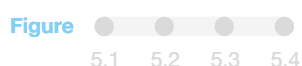
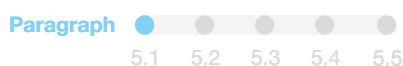
Inadequate quality of care now accounts for between 5.7 million and 8.4 million deaths globally in low- and middle-income countries (2).

The World Health Organization (WHO), the Organisation for Economic Co-operation and Development (OECD) and the World Bank define “quality of care” as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (3). Quality health care has seven interrelated domains:

- **safe:** avoiding harm to people for whom the care is intended;
- **people-centred:** providing health care that responds to the preferences, needs and values of individual service users and communities;
- **equitable:** providing health care that does not vary in quality on account of age, sex, gender, race, ethnicity, geographical location, religion, socioeconomic status, language or political affiliation, or due to social marginalization or stigma;



Promoting standards for a quality health response



- Contents
- References
- Endnotes

- **effective:** providing evidence-based health care services to those who need them;
- **timely:** reducing waiting times and harmful delays for both those who receive and those who give care;
- **integrated:** providing care that is coordinated across levels and providers (and sectors) and makes available the full range of health services throughout the life course;
- **efficient:** providing health care in a manner that maximizes resource use and avoids waste.

Individuals, families and populations should have access to a continuum of quality health care throughout their life course, comprising promotive, preventive, treatment, rehabilitation and palliative care. Quality health care should therefore be provided at all levels – the primary care level (which includes households, the community and primary health care facilities), the secondary level and the tertiary level, as well as during referrals.

Delivery of quality health services across this continuum of care requires action on multiple health system levers: the health workforce; health information systems; medicines and medical supplies; health financing; and leadership and governance. These will be supported by a strong focus on ensuring access to and availability of health care services.

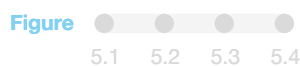
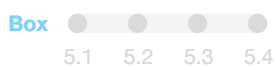
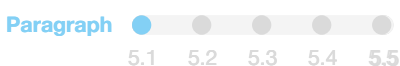
5.1.1 Quality of health care in humanitarian settings

In humanitarian settings the same definition and domains of quality of health care apply, and intersect with and complement key obligations in the humanitarian response (3). Examples follow.

- **Safety** – including the principle of doing no harm – is recognized in the Inter-Agency Standing Committee (IASC) commitment to the centrality of protection in humanitarian action (4) and in the IASC Policy on Protection in Humanitarian Action (5).² Safety relates not only to patient clinical safety, infection prevention and control, and preventing adverse events or health care-acquired infections, but also to ensuring the population is not exposed to harm when accessing care.



Promoting standards for a quality health response



- Contents
- References
- Endnotes

This includes en route to the health care setting (for example, having to journey through insecure areas due to conflict or hazardous areas due to floods) as well as within the health care setting (for example, unsafe buildings due to earthquake damage). The safety and security of patients within the health care setting should also be considered (safe access for those with limited mobility; mitigating the risk of gender-based violence by having appropriate security personnel, adequate lighting and locked toilets; implementing safeguard mechanisms for children to prevent separation from caregivers if kept in isolation during an outbreak; and clear policies and mechanisms to ensure protection from sexual exploitation and abuse).

- **Equity** is highlighted within the four core humanitarian principles of humanity, neutrality, impartiality, and independence (6–8). In humanitarian settings it is important to avoid exacerbating conflict dynamics or power disparities that occur in crises and to provide an impartial response based on need. Neutrality should be promoted, for example in conflict settings. Protection mainstreaming (in the IASC Policy on Protection in Humanitarian Action) requires that all of the population, including groups who are at higher risk (such as children, girls, women and older people), have meaningful access to health care. This requires an understanding of the specific needs of different groups; consideration of how health care should be provided; and monitoring of inequity and discrimination.
- **People-centredness and accountability to affected populations** promotes participation of affected populations in the provision and utilization of health care.³ This entails the involvement of individuals and communities (including those at risk) in programme design, implementation and monitoring, and putting in place functional feedback mechanisms. Protection mainstreaming requires that the dignity of affected populations is ensured through compassionate, survivor-centred care and maintenance of privacy. A people-centred approach engenders appropriate and relevant health care programming, increasing community trust and acceptance (9).

Figure 5.1 shows the domains of quality of care that should be available across all levels of care services defined in an essential package of health services.

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Promoting standards for a quality health response

Paragraph ● 5.1 ● 5.2 ● 5.3 ● 5.4 ● 5.5

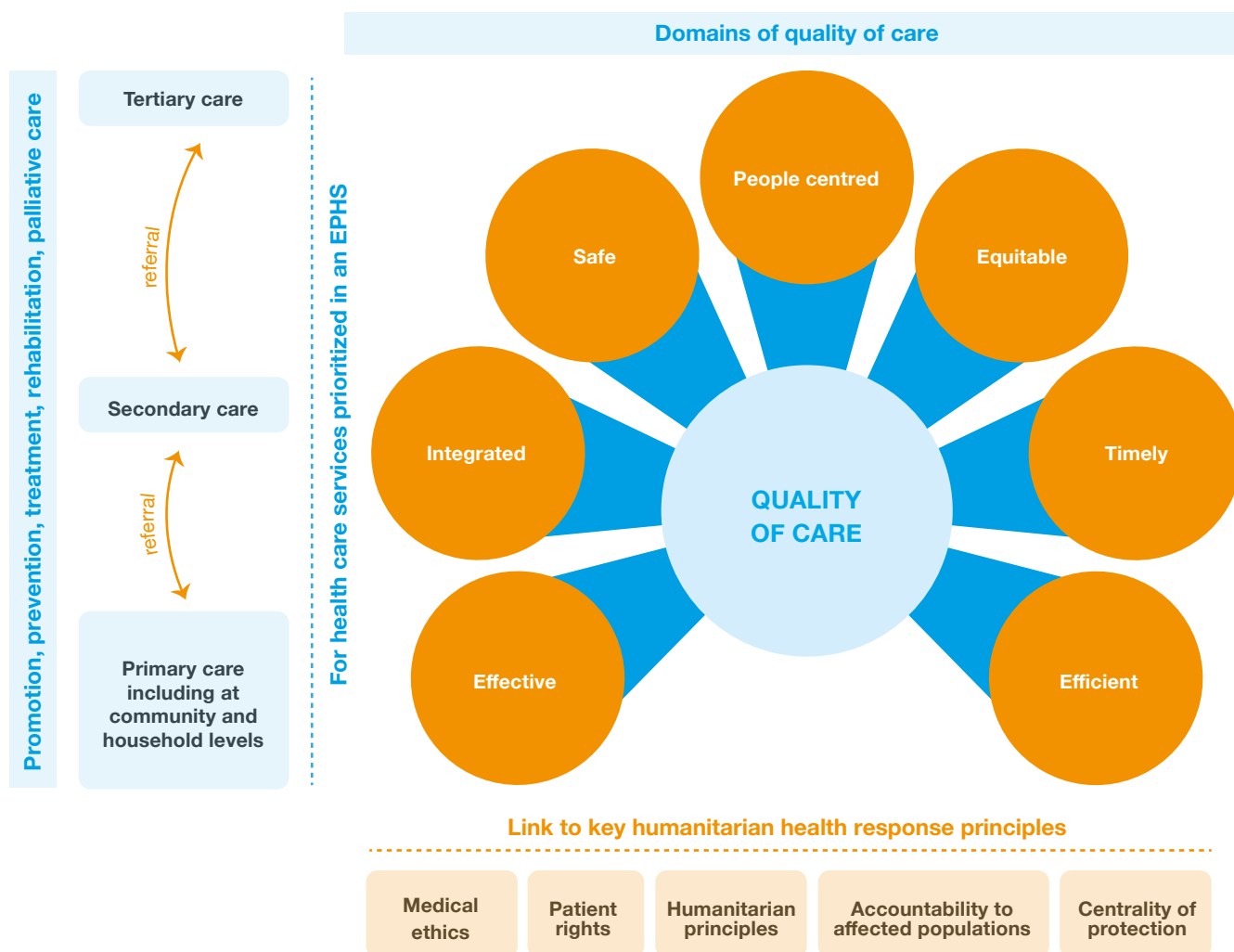
Box ● 5.1 ● 5.2 ● 5.3 ● 5.4

Figure ● 5.1 ● 5.2 ● 5.3 ● 5.4

Table ● 5.1 ● 5.2 ● 5.3

● **Contents**
 ● **References**
 ● **Endnotes**

Figure 5.1 Domains of quality of care



EPHS: essential package of health services.
 Source: Figure adapted from *Delivering quality health services: a global imperative for universal health coverage* (3).

5.1.2 Challenges to providing quality health care in humanitarian settings

The challenges to provision of quality care are multiple and complex in humanitarian crises. In many affected locations health systems are already weak, fragmented and underresourced before the crisis hits, making it very difficult to respond to the increased and changed health needs caused by the crisis. These situations will often be further compounded by many factors, such as impeded

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Promoting standards for a quality health response

Paragraph ● 5.1 5.2 5.3 5.4 5.5

Box ● 5.1 5.2 5.3 5.4

Figure ● 5.1 5.2 5.3 5.4

Table ● 5.1 5.2 5.3

- Contents
- References
- Endnotes

geographical access to health care services, damage to infrastructure or supplies, affected staff and impaired governance (both within a health facility and across the system). A disrupted health system will therefore undermine and challenge efforts to provide quality health care and should be carefully understood and strategically addressed.

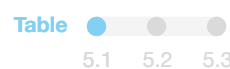
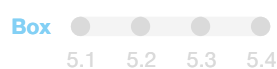
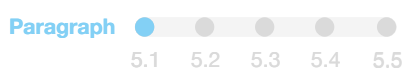
Other challenges are presented in Table 5.1.

► **Table 5.1** Examples of challenges to delivering quality of care in humanitarian settings

QUALITY DOMAINS	CHALLENGES TO DELIVERY OF QUALITY CARE IN HUMANITARIAN SETTINGS
Cross-cutting health system issues	<ul style="list-style-type: none"> • Financing/funding mechanisms that are uncertain and unstable • Poor and eroding infrastructure and facilities • Inadequate and maldistributed resources of all types • Workforce: insufficient numbers of staff with appropriate skills and qualifications • Disruption or lack of systems to ensure knowledge and skills of health professionals • Reduced availability and quality of formal educational and professional development • Insufficient adherence to existing standards of care • Ineffective oversight and governance of health providers • Lack of understanding about health care quality concepts and methods
Effective	<ul style="list-style-type: none"> • Insufficient knowledge and skills of health providers to manage changing health care needs (e.g. injuries from conflict or mental health conditions) • Lack of availability of context-adapted clinical standards, guidelines and protocols • Lack of capacity among providers to implement quality improvement methods • Disrupted or lack of health information and performance measurement systems
Safe	<ul style="list-style-type: none"> • Limited systems to identify and address medical errors • Limited implementation of infection prevention and control measures and lack of or damaged water, sanitation and hygiene (WASH) infrastructure • Culture of safety and security not prioritized • Direct safety of health facility threatened (e.g. by conflict) or facility is in an unsafe environment (e.g. damaged after an earthquake), posing harm and risks to patients and health care workers



Promoting standards for a quality health response



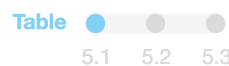
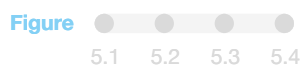
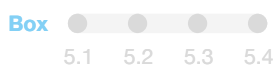
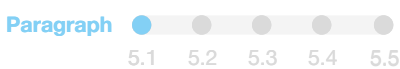
- Contents
- References
- Endnotes

QUALITY DOMAINS	CHALLENGES TO DELIVERY OF QUALITY CARE IN HUMANITARIAN SETTINGS
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People-centred	<ul style="list-style-type: none"> • Lack of systems to engage individuals, families, communities and patients to participate in design, implementation, and monitoring of health services, or providing feedback on services • Challenges in accessibility for the population, including at-risk or socially marginalized groups • Compassionate care or dignity of patients not prioritized • Linguistic and cultural challenges among international health providers
Timely	<ul style="list-style-type: none"> • Reduced service availability due to lack of resources or damaged infrastructure • Increased health needs overwhelming services • Long lead time needed to establish functioning services • Weak referral system, including to other sectors
Equitable	<ul style="list-style-type: none"> • Logistical constraints to providing services in hard-to-reach areas • Increased barriers to access care for marginalized groups (e.g. women and children) • Reduced capacity to pay for services and medicines due to income disruption • Differences in quality of care of services between displaced populations and host community • Challenges in ensuring all sides in a conflict receive similar levels of care
Integrated	<ul style="list-style-type: none"> • Disrupted communication and health information systems • Breakdown of primary care and referral networks • Lack of patient follow-up and continuity of care • Multiple providers, many of which are new to the setting, may not be coordinating with other providers and may have limited knowledge of local systems
Efficient	<ul style="list-style-type: none"> • Difficulties in tracking spending and measuring impact • Increased opportunities for corruption • Multiple funding streams, donors, and providers, often with suboptimal coordination • Often extreme high cost of ensuring safety when transporting patients, staff or supplies



Promoting standards for a quality health response



- Contents
- References
- Endnotes

5.2 Establishing quality of care processes

In humanitarian settings all actors contribute to the provision of quality health care, and different mechanisms may already exist to ensure that it is provided. For example, quality assessments or improvement mechanisms may be already occurring:

- at the facility level, implemented by senior health officers or managers;
- through supervisory or monitoring visits by the humanitarian partner responsible for the management of a number of facilities;
- through the health authority or structure responsible for oversight of humanitarian health services in the affected area;
- through health cluster or third-party assessments;
- through implementation of a national quality of care plan that may already exist or is being developed.

Furthermore, partners may be addressing different sub-elements of quality without necessarily realizing its contribution to overall quality of care, for example by monitoring or ensuring:

- utilization of surgical safety checklists;
- infection prevention and control measures, including personal protective equipment, medical waste management, and provision of WASH infrastructure;
- use of treatment protocols;
- keeping safe and confidential medical records;
- engaging communities in project design;
- providing supportive supervision to health care workers.

It is therefore important that country health clusters and partners have a common understanding of what quality health care entails for their context before agreeing on mechanisms to address or improve it.⁴ The WHO *Handbook for national quality policy and strategy (10)* suggests eight steps to take when developing a strategy for improving quality at a national level.⁵



Promoting standards for a quality health response

Paragraph ● ● ● ● ●
5.1 5.2 5.3 5.4 5.5

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5.1 5.2 5.3 5.4

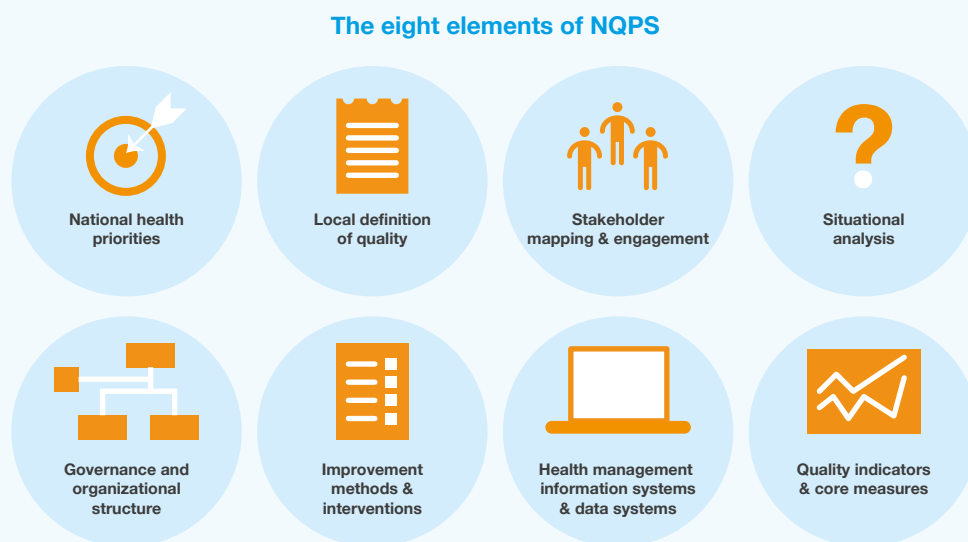
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5.1 5.2 5.3 5.4

Table ● ● ●
5.1 5.2 5.3

- Contents
- References
- Endnotes

Although developing a national policy and strategy may not be the objective for country clusters, key concepts are applicable when country health clusters and partners are establishing a common understanding of the provision, measurement and improvement of quality health care. For example, from planning within a single provider to improve their services, to coordinated multistakeholder planning in an ideal situation, health clusters are likely to have a key role to play in making the case for and coordinating such efforts. The *Handbook for national quality policy and strategy* suggests eight elements (Figure 5.2), which may occur at different stages or simultaneously. The following paragraphs provide further details on those elements.

Figure 5.2 The eight elements of national quality policy and strategy (NQPS)

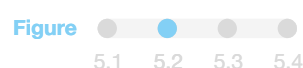
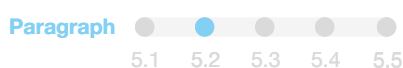


Source: WHO *Handbook for national quality policy and strategy* (10).

- **Health priorities.** Efforts to address quality should align with existing health sector priorities. In humanitarian settings with clusters, health sector priorities should be defined by the health cluster strategy within the humanitarian response plan and essential package of health services (EPHS),⁶ as well as key humanitarian commitments and obligations. Common health service priorities in an EPHS include the following medical needs and clinical conditions: communicable diseases, child and adolescent health, maternal and newborn health, sexual and reproductive health, services to respond to gender-based violence, trauma and injury care, mental health and psychosocial support, noncommunicable disease care and palliative care.



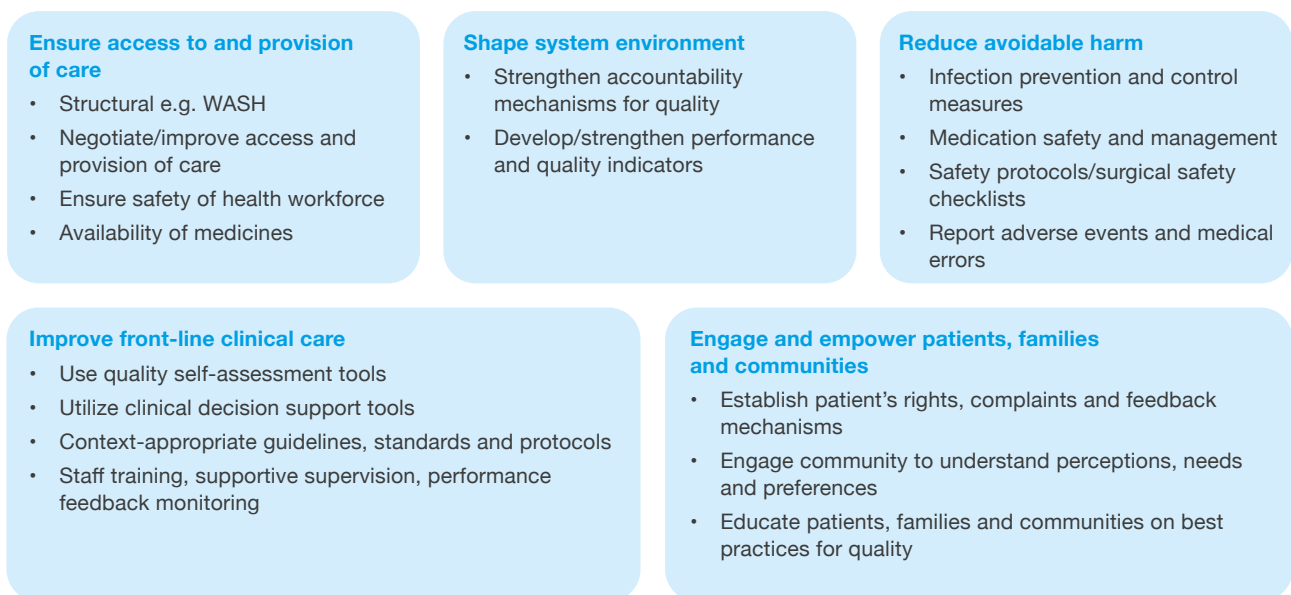
Promoting standards for a quality health response



- Contents
- References
- Endnotes

- **Develop a local definition of quality of care.** Actors should understand and agree on key quality concepts. Within the humanitarian setting, concepts and obligations as described earlier should also be considered.
- **Mapping and engaging stakeholders.** Different actors at different levels will be involved in ensuring quality within the health response and need to be involved.
- **Situational analysis – state of quality.** Current mechanisms to address quality should be understood, such as established practices within health facilities by partners, mechanisms of the local ministry of health, national strategies that have been developed, and an understanding of what health information or assessments exist that provide information on the different domains of quality.
- **Improving governance for quality.** Given the multiple actors involved in the health cluster response, when mapping stakeholders and performing a situational analysis the responsibilities, accountability and governance related to ensuring quality should be mapped and clarified, addressing any gaps.
- **Quality of care interventions.** If a plan is to be developed, it will rely upon effective implementation of a realistic and prioritized package of quality interventions. The evidence for successful quality improvement interventions is still unclear, and continues to be gathered. However, based on expert consensus, examples of successful interventions are provided in Figure 5.3.

Figure 5.3 Successful interventions for quality improvement



Source: Adapted from World Health Organization (10) and Leatherman et al. (11).

C 1 2 3 4 **5** 6 7 8 9 10 11 12 13

Promoting standards for a quality health response

Paragraph ● 5.1 ● 5.2 ● **5.3** ● 5.4 ● 5.5

Box ● 5.1 ● 5.2 ● 5.3 ● 5.4

Figure ● 5.1 ● 5.2 ● **5.3** ● 5.4

Table ● 5.1 ● 5.2 ● 5.3

- **Contents**
- **References**
- **Endnotes**

Health information system and quality assessment. The health information system may already be gathering data on key quality of care indicators. If not, the health information system may be strengthened or discrete quality assessments performed to support implementation of any quality measurement or improvement activity.

Quality measurement. Depending on the services defined in the EPHS, a contextualized definition of standards of quality of health care in humanitarian settings (that is, benchmarks or targets) should be agreed upon and then indicators chosen to measure quality. These should be pragmatic, not adding undue burden to measurement. Development of quality indicators should consider those in the *Sphere handbook* (discussed further below) (12, 13).⁷

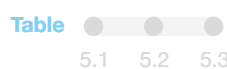
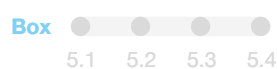
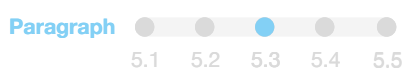
5.3 Ensuring standards and promoting best practices for a quality health response

5.3.1 What are standards and why are they needed?

“Standards” are the policies and technical guidelines that define the way in which health cluster work should be conducted and monitored. They are guides that provide a benchmark of the level of care to be attained. Setting standards is an important part of quality assurance. Quality assurance is the monitoring of established processes against standards to ensure their functionality. This is linked strongly with quality planning, which aims to establish the objectives and requirements for quality; and quality improvement, which is the action of every person working to implement iterative, measurable changes in order to improve health services on all elements of quality. Attention to all three elements within the triad – quality planning, assurance and control, and improvement – can be a powerful catalyst for system-wide change when implemented effectively. Box 5.1 summarizes the reasons why promoting standards is necessary.



Promoting standards for a quality health response



- Contents
- References
- Endnotes

● Box 5.1 Why is it necessary to promote standards?

As a health cluster coordinator or partner, it is important to promote standards for the following reasons:

- to ensure quality in health sector operations for response;
- to ensure that the health response is in line with the health policies and norms of the country, as well as global standards;
- to ensure that a similar level of health care is provided by all health cluster partners;
- to ensure a smooth transition in the humanitarian development nexus to development programmes;
- to ensure accountability, especially to affected populations.

Without standards it would be difficult to measure the impact and effect of the health cluster partners' work in emergency situations.

5.3.2 Types of international and national standards

International generic policies and standards

Core Humanitarian Standard on Quality and Accountability

The Core Humanitarian Standard on Quality and Accountability (CHS) was developed in 2014 following extensive consultation.⁸ It included input and feedback from several hundred nongovernmental organizations (NGOs), networks, governments, and United Nations agencies, and drew upon a number of previously existing standards and commitments.⁹

The CHS places communities and people affected by crises at the centre of humanitarian action. It outlines what good humanitarian action looks like for communities and people affected by crisis, and the staff and organizations involved in a response. The purpose of the CHS is to help organizations design, implement, assess, improve and recognize quality and accountability in assistance and programmes. It outlines the policies, processes and practices that an organization needs in order to deliver quality assistance while at the same time being accountable to communities and people affected by crisis. It is a voluntary and verifiable (that is, measurable) standard.

The CHS includes nine commitments (Figure 5.4), which together form a framework of quality and accountability for good practice that can be easily implemented by all humanitarian actors and in development programmes. It is a standard that reflects key commitments such as accountability to affected populations, centrality of protection and coordination in humanitarian crises (such as the cluster approach), and localization.



Promoting standards for a quality health response

Paragraph ● ● ● ● ●
5.1 5.2 5.3 5.4 5.5

Box ● ● ● ● ●
5.1 5.2 5.3 5.4

Figure ● ● ● ● ●
5.1 5.2 5.3 5.4

Table ● ● ● ● ●
5.1 5.2 5.3

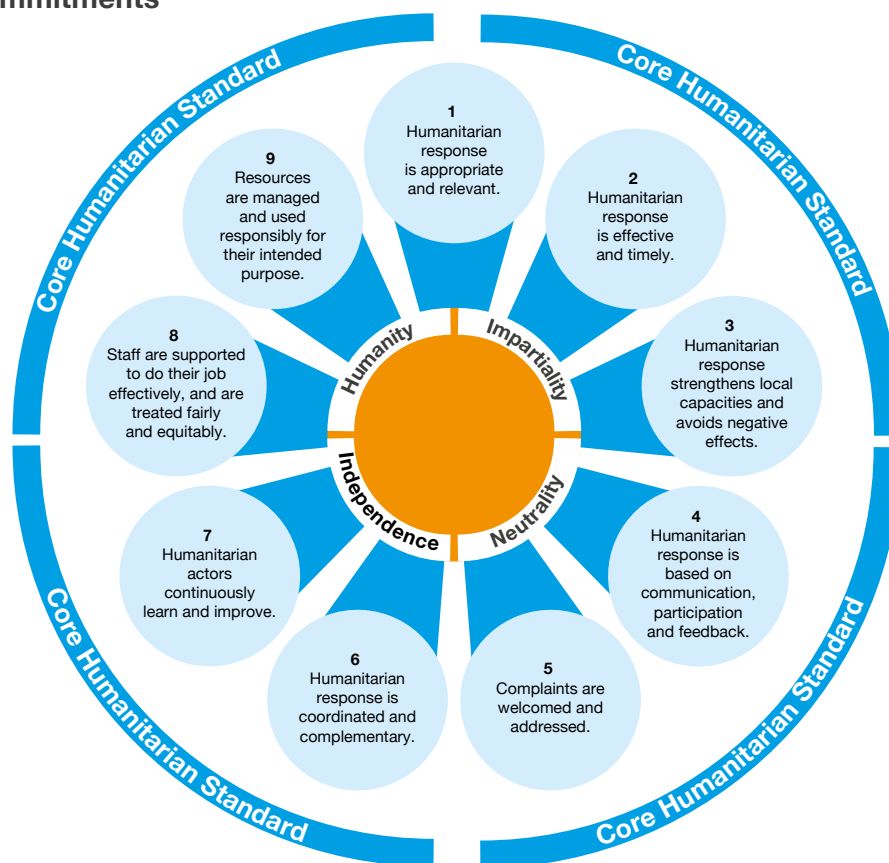
- Contents
- References
- Endnotes

The CHS is structured as follows:

- **nine commitments** to communities and people affected by crisis;
- supporting **quality criteria** to define what should be achieved to fulfil the commitments;
- **key actions** to be undertaken to fulfil the commitments;
- **organizational responsibilities** to support the consistent and systematic implementation of the key actions throughout the organization.

The CHS is supported by Sphere and is a component of the foundational chapters of the *Sphere handbook: humanitarian charter and minimum standards in humanitarian response* (13). Guidance notes, guiding questions and performance indicators to support application of the CHS that had previously been developed are updated within the handbook.

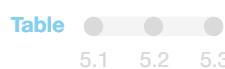
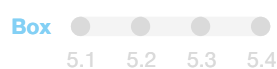
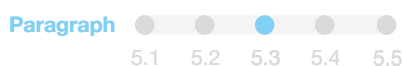
Figure 5.4 CHS commitments



Source: Core Humanitarian Standard on Quality and Accountability (12).



Promoting standards for a quality health response



- Contents
- References
- Endnotes

Who should use the CHS? Over time, the CHS will be recognized and may be used by the majority of humanitarian actors that:

- deliver direct assistance to people and communities affected by crisis;
- provide financial, material or technical support to other organizations, but do not directly take part in providing assistance;
- combine both of these approaches.

The CHS thus encompasses a wide range of actors – individuals, organizations, coordinating bodies, consortiums and other groups undertaking or contributing to humanitarian action, including local, national and international NGOs, the International Red Cross and Red Crescent Movement, the United Nations, donor agencies, national governments, and the private sector.

The CHS should be promoted and implemented by collective humanitarian mechanisms such as the cluster system, humanitarian country teams and pooled funding mechanisms.

CHS Verification Scheme. Managed by the CHS Alliance, the CHS Verification Scheme is a systematic process to assess the degree to which an organization is working to achieve the CHS commitments. This may be done by self-assessment, peer review, independent (third-party) verification or certification. The CHS Verification Scheme applies 62 indicators to determine the extent to which organizations are applying the standard.

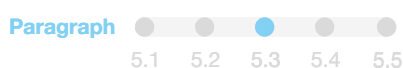
The Sphere handbook: humanitarian charter and minimum standards in humanitarian response

The *Sphere handbook* (13) was first piloted in 1998, with several revised editions published. Each revision process has relied on sectorwide consultations with individuals, NGOs, governments and United Nations agencies. The resulting standards and guidance are informed by evidence and reflect 20 years of field-testing by practitioners around the world. The handbook includes new guidance for working in urban settings, for addressing minimum standards in protracted crises, and for delivering assistance through markets to meet the standards. The Core Humanitarian Standard replaces the previous Core Standards.

The **Humanitarian Charter** is the cornerstone of the *Sphere handbook*, sharing the conviction of humanitarian actors that all people affected by crisis have a right to receive protection and assistance, ensuring the basic conditions for life with dignity. The Humanitarian Charter provides the ethical and legal backdrop to the Protection



Promoting standards for a quality health response



- Contents
- References
- Endnotes

Principles, the CHS and the Minimum Standards. It builds on the 1994 Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief. The Code of Conduct remains an integral component of the *Sphere handbook*.

The **Protection Principles** are a practical translation of the legal principles and rights outlined in the Humanitarian Charter into four principles that inform all humanitarian response. They operationalize and mirror the key commitments of centrality of protection and other IASC guidance on protection (Box 5.2).

● **Box 5.2 Sphere Protection Principles**

Protection Principle 1. Enhance people’s safety, dignity and rights, and avoid exposing them to further harm

Protection Principle 2. Ensure people’s access to impartial assistance, according to need and without discrimination

Protection Principle 3. Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation

Protection Principle 4. Help people to claim their rights.

The **Core Humanitarian Standard** comprises nine commitments that describe essential processes and organizational responsibilities to enable quality and accountability in achieving the Minimum Standards (see above).

The four **technical chapters** include Minimum Standards in key response sectors:

- water supply, sanitation and hygiene promotion
- food security and nutrition
- shelter and settlement
- health.

Each of the Sphere technical chapters outlines standards, key actions, key indicators and guidance notes for the topic in question.

Working with the key indicators. The Sphere key indicators measure whether a standard is being achieved.



Promoting standards for a quality health response

Paragraph ● ● ● ● ●
5.1 5.2 5.3 5.4 5.5

Box ● ● ● ● ●
5.1 5.2 5.3 5.4

Figure ● ● ● ● ●
5.1 5.2 5.3 5.4

Table ● ● ● ● ●
5.1 5.2 5.3

- Contents
- References
- Endnotes

- **Process indicators** check whether a minimum requirement has been achieved. For example, standardized protocols are used to analyse food security, livelihoods and coping strategies.
- **Progress indicators** provide the units of measurement to monitor achievement of the standards. They should be used to determine baselines, set targets with partners and stakeholders, and monitor changes towards those targets. An example is the percentage of households that store drinking water in clean and covered containers. While the optimal target is 100%, practitioners should associate the indicator with the reality on the ground, monitoring improvements against the baseline and progress towards the agreed target over time.
- **Target indicators** are specific, quantifiable targets that represent the quantifiable minimum below which the standard is not being met. Those targets should be reached as soon as possible, as falling short of them will compromise the overall programme. An example is the percentage of children aged 6 months to 15 years who have received measles vaccination on completion of a measles vaccination campaign, for which the target is 95%.

The standards apply throughout the programme cycle. The Sphere standards should be used throughout the programme cycle, from assessment and analysis, through strategy development, planning and programme design, implementation and monitoring, to evaluation and learning.

- **Assessment and analysis.** The Sphere Minimum Standards provide a basis for needs assessment and analysis in each sector, with assessment checklists available in each chapter. At the onset of a crisis, Sphere standards help to identify immediate needs and prioritize activities that will address those needs. Planning figures and minimum assistance levels are outlined globally to help formulate minimum response-wide outcomes.
- **Strategy development and programme design.** The CHS and the Minimum Standards support the planning of responses to provide the right humanitarian assistance at the right time to those most in need. The full participation of the affected population and coordination with national and local authorities is essential to achieve this across all sectors. The key actions and indicators outline the quality of assistance that should be attained. They also provide a basis for conducting a response analysis that identifies the best way to meet identified needs and minimize potential harmful side-effects. The Minimum Standards focus on what must be done, rather than how the assistance should be delivered.



Promoting standards for a quality health response

Paragraph ● ● ● ● ●
5.1 5.2 5.3 5.4 5.5

Box ● ● ● ●
5.1 5.2 5.3 5.4

Figure ● ● ● ●
5.1 5.2 5.3 5.4

Table ● ● ●
5.1 5.2 5.3

- [Contents](#)
- [References](#)
- [Endnotes](#)

- **Implementation.** If the Sphere standards cannot be met for all or some groups from the affected population, it is necessary to investigate why and explain the gaps, as well as what needs to change. The negative implications should be assessed, including protection and public health risks.
- **Monitoring, evaluation, accountability and learning.** Monitoring, evaluation, accountability and learning systems support timely and evidence-based management decisions. All the Minimum Standards have indicators that can be monitored to determine whether they are being achieved, whether they are being achieved equitably for all segments of a population, and how much more needs to be done. Evaluation supports learning to improve policy and future practice and promotes accountability. Monitoring, evaluation, accountability and learning systems also contribute to broader learning efforts related to effective humanitarian action.

Sphere Minimum Standards for Healthcare

The Sphere Minimum Standards for Healthcare comprise three main areas:

- essential concepts in health
- health systems
- essential health care.

Appendices to the Sphere chapter on health include a checklist for health service assessments, sample weekly surveillance reporting forms, sample morbidity and health information forms, formulas for calculating key health indicators, and guidance on poisoning. References and further reading are also provided.

The essential concepts in health affirm that the Sphere Minimum Standards for Healthcare are a practical expression of the right to health care in humanitarian contexts. Health care must be provided without discrimination and must be accessible, meaning that it is available, acceptable, affordable and of good quality. States are obliged to ensure this right during crises. Attacks, threats and other violent obstructions of the work of health care personnel, facilities and medical transport are a violation of international humanitarian law. These protections are derived from the basic obligations to respect and protect the wounded and sick.



Promoting standards for a quality health response

Paragraph

5.1 5.2 5.3 5.4 5.5

Box

5.1 5.2 5.3 5.4

Figure

5.1 5.2 5.3 5.4

Table

5.1 5.2 5.3

- Contents
- References
- Endnotes

The aim of the health care response in a crisis is to improve health outcomes and to reduce excess morbidity and mortality.

The section on essential concepts in health also describes the links to the Protection Principles and Core Humanitarian Standards, and presents examples of protection mainstreaming, safety and security, and ensuring coordination.

Health systems standards highlight the importance of understanding the impact of the crisis on the different aspects of health systems in order to help determine priorities for the humanitarian response. Health systems standards address five core aspects of a well-functioning health system, as shown in Box 5.3.

● **Box 5.3 Health systems standards**

Health systems standard 1.1: Health service delivery

People have access to integrated quality health care that is safe, effective and patient-centred.

Health systems standard 1.2: Health care workforce

People have access to health care workers with adequate skills at all levels of health care.

Health systems standard 1.3: Essential medicines and medical devices

People have access to essential medicines and medical devices that are safe, effective and of assured quality.

Health systems standard 1.4: Health financing

People have access to free priority health care for the duration of the crisis.

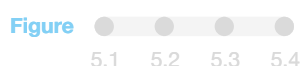
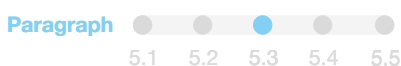
Health systems standard 1.5: Health information

Health care is guided by evidence through the collection, analysis and use of relevant public health data.

Essential health care standards in the *Sphere handbook* apply to the common health care services that should be considered when determining which ones should be prioritized in defining a package of health care in a humanitarian response. These are communicable diseases, child health, sexual and reproductive health, injury and trauma care, mental health, noncommunicable diseases, and palliative care. Box 5.4 shows the standards that should be achieved for each of these.



Promoting standards for a quality health response



- Contents
- References
- Endnotes

● Box 5.4 Essential health care standards

2.1 Communicable diseases

Communicable diseases standard 2.1.1: Prevention

People have access to health care and information to prevent communicable diseases.

Communicable diseases standard 2.1.2: Surveillance, outbreak detection and early response

Surveillance and reporting systems provide early outbreak detection and early response.

Communicable diseases standard 2.1.3: Diagnosis and case management

People have access to effective diagnosis and treatment for infectious diseases that contribute most significantly to morbidity and mortality.

Communicable diseases standard 2.1.4: Outbreak preparedness and response

Outbreaks are adequately prepared for and controlled in a timely and effective manner.

2.2 Essential health care: child health

Child health standard 2.2.1: Childhood vaccine-preventable diseases

Children aged 6 months to 15 years have immunity against disease and access to routine Expanded Programme on Immunization services during crises.

Child health standard 2.2.2: Management of newborn and childhood illness

Children have access to priority health care that addresses the major causes of newborn and childhood morbidity and mortality.

2.3 Sexual and reproductive health

Sexual and reproductive health standard 2.3.1: Reproductive, maternal and newborn health care

People have access to health care and family planning that prevents excessive maternal and newborn morbidity and mortality.

Sexual and reproductive health standard 2.3.2: Sexual violence and clinical management of rape

People have access to health care that is safe and responds to the needs of survivors of sexual violence.

Sexual and reproductive health standard 2.3.3: HIV

People have access to health care that prevents transmission of and reduces morbidity and mortality due to HIV.

2.4 Injury and trauma care

Injury and trauma care standard 2.4: Injury and trauma care

People have access to safe and effective trauma care during crises to prevent avoidable mortality, morbidity, suffering and disability.



Promoting standards for a quality health response

Paragraph

5.1 5.2 5.3 5.4 5.5

Box

5.1 5.2 5.3 5.4

Figure

5.1 5.2 5.3 5.4

Table

5.1 5.2 5.3

● Contents

● References

● Endnotes

2.5 Mental health

Mental health standard 2.5: Mental health care

People of all ages have access to health care that addresses mental health conditions and associated impaired functioning.

2.6 Noncommunicable diseases

Noncommunicable diseases standard 2.6: Care of noncommunicable diseases

People have access to preventive programmes, diagnostics and essential therapies for acute complications and long-term management of noncommunicable diseases.

2.7 Palliative care

Palliative care standard 2.7: Palliative care

People have access to palliative and end-of-life care that relieves pain and suffering, maximizes the comfort, dignity and quality of life of patients, and provides support for family members.

Sphere intersectoral standard for health and WASH

A key new intersectoral standard has been included in the chapter on water supply, sanitation and hygiene promotion of the *Sphere handbook*, as follows:

- **Standard 6: WASH in disease outbreaks and health care settings.** All health care settings maintain minimum WASH infection prevention and control standards, including in disease outbreaks.

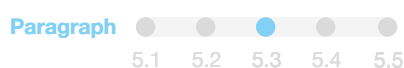
This standard was jointly written by health and WASH experts and reflects the reality that although within a health facility it is the responsibility of health actors to ensure adequate infection prevention and control measures, this often requires significant collaboration with WASH actors.

Standard humanitarian indicators

Standard humanitarian indicators are observable, measurable variables that guide humanitarian actors by indicating the degree to which standards are being attained. The humanitarian indicator registry (14) contains a set of humanitarian indicators for different sectors, as agreed upon by the relevant global clusters. The registry is managed by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and complements the IASC guideline on the implementation of the Humanitarian Programme Cycle (15).



Promoting standards for a quality health response



- Contents
- References
- Endnotes

The humanitarian indicator registry is a standard reference for clusters at country level to select indicators. The registry also lists three indicators related to accountability to affected populations for use by all clusters,¹⁰ and lists the principal baseline, needs assessment and response monitoring (output and outcome) indicators for each cluster. The registry does not capture (long-term) impact or input indicators (as many input indicators can feed into one output).¹¹

Use of standardized key indicators promotes coherence within the clusters and enables comparisons across agencies and geographical areas and countries. Country clusters should use the humanitarian indicator registry for selection of key indicators for humanitarian assessment and response monitoring, selecting the appropriate, relevant key indicators for the context and interventions. The three indicators on accountability to affected populations should be included by all clusters in all responses.

Many indicators have linkages to more than one cluster. These inter-cluster linkages have been highlighted in the registry, with each indicator being tagged to the clusters that it relates to. Identifying “related indicators” will assist with minimizing duplication and fostering synergy across clusters.

The indicators in the list of standard humanitarian indicators are generic, so some adaptation to local context may be necessary based on local standards, if they exist and are applicable.

Health cluster indicators

Currently there are 20 health cluster indicators under six themes (or subdomains) (14):

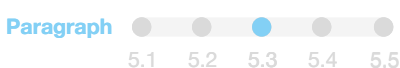
- general clinical services and trauma care
- sexual and reproductive health
- child health
- noncommunicable diseases and mental health
- communicable diseases
- environmental health.

International health policies and standards

Aside from those given above, other standards and policies exist that are often used as a minimum baseline for implementing health activities in emergency situations. The following is a list of some key public health standards. More information on each can be found at the websites identified in the reference list.



Promoting standards for a quality health response



- Contents
- References
- Endnotes

- **WHO Model List of Essential Medicines.** The WHO Model List of Essential Medicines sets out a list of essential medicines that satisfy the priority health needs of a population (16):

Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford (17).

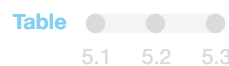
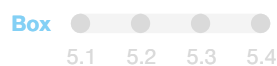
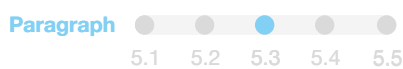
The Model List is a guide for the development of national and institutional lists of essential medicines. It was not designed as a global standard. However, for the past 30 years the Model List has led to a global acceptance of the concept of essential medicines as a powerful means to promote health equity. Most countries have national lists, and some have provincial or state lists as well. National lists of essential medicines usually relate closely to national guidelines for clinical health care practice which are used for the training and supervision of health workers (18).

The list is reviewed and modified every two years by an international group of experts. The Model List of Essential Medicines does not replace the national essential medicines list. However, in cases where there is no standard national list of essential medicines, or issues within the country make it difficult to apply the national list in the country context, the Model List as presented by WHO may be used as a guide for providing drugs to the affected population.

- **Minimum Initial Service Package for reproductive health.** The Minimum Initial Service Package (MISP) for sexual and reproductive health in humanitarian settings is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess maternal and newborn morbidity and mortality; and plan for comprehensive reproductive health services beginning in the early days and weeks of an emergency (19). Additional priority activities of the MISP include making contraceptives available to meet demand, provision of syndromic treatment for sexually transmitted infections to patients presenting with symptoms, and ensuring availability of antiretroviral therapy for continuing users.
- **Essential health package.** An essential package of health services (EPHS) comprises a list of key health services that guarantee the minimum health care to be provided to the population, with the objective of enhancing equity and ensuring the best value for money. The content of the package will vary according to different settings or contexts. The Global Health Cluster has produced guidance for country health clusters on how to develop, implement and monitor an EPHS (1). Work is also continuing to establish a global EPHS that can be used as guidance for ministries of health and countries to establish their own package (20).



Promoting standards for a quality health response



- Contents
- References
- Endnotes

Additional lists of essential equipment and other standards include the following:

- interagency list of priority medical devices for essential interventions for reproductive, maternal, newborn and child health (21);
- newborn health in humanitarian settings: field guide (22);
- core medical equipment (23);
- interagency emergency health kit (24);
- other technical guidelines and guidance notes for humanitarian health action (25).

National health standards, guidelines and policies

National health standards and policies should be adhered to as far as possible. A list of key national health guidelines and standards should be collated and made available to all health partners to ensure adherence.

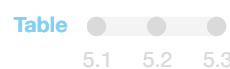
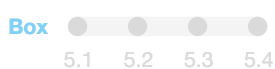
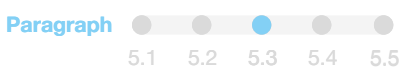
A list of national health technical standards could include:

- basic package of health services
- essential medicines list
- protocols for treatment of specific diseases
- health systems structure
- emergency health policies.

However, the existing national standards and policies may not be adequate to meet the public health needs of the humanitarian crisis, or in line with international guidance, and as such will need to be reviewed (see below).



Promoting standards for a quality health response



- [Contents](#)
- [References](#)
- [Endnotes](#)

5.4 Setting standards

5.4.1 Identifying gaps in standards

If there are obvious differences between national and international standards for humanitarian settings, the national standards should be reviewed together with national counterparts to ensure they are up to date and in line with international guidelines relevant to the context and amended where possible and appropriate. This step should be carried out ideally in the preparedness phase to ensure that national guidelines are adhered to in the disaster response phase.

If there are no national standards, the opportunity can be taken to introduce global standards to the country. Again, this step should ideally be taken in the preparedness phase.

To ensure that standards are met, it is important to first identify what national standards exist to meet the operational needs in a country. After identification of priority health needs, a review should be undertaken of available national policies, standards and protocols addressing priority health needs.

Specifically, a review will first establish the existence of guidance (for each aspect), and then verify whether the guidance is in line with international policy and best practice.

5.4.2 Developing standards in different scenarios

Once gaps have been identified, standards need to be developed quickly and put in place. The standards can be developed by modifying existing national standards so that they are in line with global standards relevant to humanitarian settings, or by formulating new standards based on international or agency-wide standards. The standards need to be appropriate to the local context. It is vital that all health partners adhere to common agreed standards for different elements of the health intervention to ensure quality and facilitate monitoring and evaluation. This will also help with transitioning into sustainable longer-term interventions.

Table 5.2 summarizes the key actions to take in different scenarios. The columns are colour-coded to show the level of urgency of action needed from health cluster partners (see key below table).



Promoting standards for a quality health response

Paragraph ● ● ● ● ●
5.1 5.2 5.3 5.4 5.5

Box ● ● ● ●
5.1 5.2 5.3 5.4

Figure ● ● ● ●
5.1 5.2 5.3 5.4

Table ● ● ●
5.1 5.2 5.3

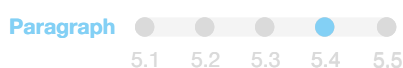
- Contents
- References
- Endnotes

► **Table 5.2** Different scenarios relating to standards for health response in humanitarian settings

National guidelines exist and are in line with the latest global guidance	National standards exist but are not in line with the latest global guidance	National standards do not exist, or technical standards being used by health cluster partners are not harmonized
<p>Focus on ensuring the promotion and use of standards and the linkage to viable monitoring and evaluation systems to support their use. Where guidelines and protocols exist but are not widely implemented or practised at community and facility levels, efforts should be directed towards improving the knowledge and practices of health sector partners, including the government, local authorities, NGOs and health cluster partners, and monitoring the implementation of standards and protocols at facility and community levels.</p>	<p>Focus on consultative development and updating the standards. The health cluster coordinator should facilitate dialogue among all stakeholders to 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 for humanitarian settings.</p>	<p>Focus on identifying, in a consultative manner, the priority standards that are to be developed and that will subsequently facilitate the development process in whichever way is required, given the context and available capacity. At times, interim guidance is required to provide some common understanding while more detailed and consultative standards are developed.</p> <p>Where it is possible to harmonize technical standards between health cluster partners, this should be pursued. Such opportunities can be limited in practice, however, as some agencies are required to use agency-specific technical standards.</p>



Promoting standards for a quality health response



- Contents
- References
- Endnotes

5.4.3 Steps to be taken in developing standards

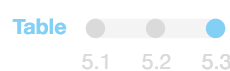
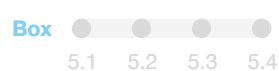
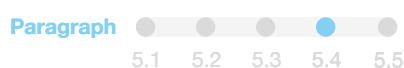
Table 5.3 shows the steps to be taken in developing standards, led by WHO as cluster lead agency.

► **Table 5.3** Steps in developing standards and roles of key actors

STEPS FOR IDENTIFYING GAPS	ROLE OF HEALTH CLUSTER COORDINATOR	ROLE OF HEALTH CLUSTER PARTNERS
1. Develop an appropriate mechanism and activity plan to address priority gaps in standards	Convene a task force among health cluster partners to put together relevant standards	Nominate dedicated focal points as members of the task force
2. Based on gaps identified, conduct a rapid assessment of international standards to see which standards can fill the gaps	Coordinate with partners to identify appropriate international standards	Provide inputs to existing international standards from global platforms or own organization to feed into the process
3. Select relevant international standards that can fill gaps	Discuss with partners and national and local health authorities and select relevant international standards that can help to fill identified gaps In cases where national standards need revision, discuss which need revision and what international standard should be adhered to Modify the standards	Support the process
4. Ensure that standards are owned by the local authorities, disseminated, scaled up and incorporated into appropriate monitoring and evaluation systems and national standards	Ensure all partners are provided with the latest standards using different channels, including an online or offline repository Monitor adherence with national counterparts	Follow standards in all health implementation Where gaps exist, inform the cluster coordinator
5. Ensure that relevant monitoring and evaluation information is gathered and fed into standards and that other standards are addressed as needed	Ensure gaps and issues in standards are addressed in a timely manner	Provide inputs to existing monitoring and evaluation platforms to support the process



Promoting standards for a quality health response



- Contents
- References
- Endnotes

5.5 Building capacity to ensure standards and promote best practice

The health cluster not only has the role of setting and ensuring applications of standards but, where possible and needed, can also assist in building capacity in the country to ensure that the health response is in line with policies and technical specifications. Supportive efforts can take the form of orientation and training on policies and standards, and other forms of dissemination of policies and technical standards and guidance. Capacity-building can help disseminate and promote best practices in specific public health areas of work, especially in cases where there are no specific guidance and standards in place, and where there is insufficient evidence to promote a specific intervention.

Below are some key action points that can be taken by the cluster lead agency (as represented by the health cluster coordinator) and cluster partners to help build capacity.

Role of the health cluster coordinator

- identify the gaps in capacity: overlay with existing humanitarian needs overviews, assessments, and information on health systems;¹²
- understand the capacities within the health cluster to (a) deliver on specific public health areas of work, (b) build local and national capacity on particular health topics, and (c) where needed, support the work to develop or update existing policies and standards;
- identify areas where capacity can be built at both national and local levels, which will require not only a focus on the health sector but also consideration of the capacities among local health volunteers and other networks, as well as capacity within other sectors that may have an impact on delivering the specific public health intervention (for example, ensuring water quality in health facilities);
- identify resources (for example from within the organization, in government agencies, or among health cluster partners) that can provide support in building capacity.



Promoting standards for a quality health response

Paragraph

5.1 5.2 5.3 5.4 5.5

Box 5.1 5.2 5.3 5.4

Figure 5.1 5.2 5.3 5.4

Table 5.1 5.2 5.3

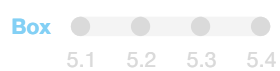
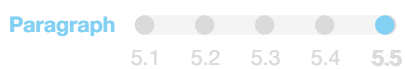
- Contents
- References
- Endnotes

Role of cluster partners

- provide support in identifying gaps;
- collaborate on building capacities based on respective strengths;
- ensure internal capacities are built or in place to provide adequate support to ongoing operations;
- support the process of ensuring ownership of new or updated guidelines by the national and local authorities.



Promoting standards for a quality health response



- Contents
- References
- Endnotes

References

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Promoting standards for a quality health response

Paragraph

5.1 5.2 5.3 5.4 5.5

Box

5.1 5.2 5.3 5.4

Figure

5.1 5.2 5.3 5.4

Table

5.1 5.2 5.3

● Contents

● References

● Endnotes

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Promoting standards for a quality health response

Paragraph ● ● ● ● ●
5.1 5.2 5.3 5.4 5.5

Box ● ● ● ● ●
5.1 5.2 5.3 5.4

Figure ● ● ● ● ●
5.1 5.2 5.3 5.4

Table ● ● ● ● ●
5.1 5.2 5.3

- Contents
- References
- Endnotes

Resources and reference materials

- Sphere: <https://spherestandards.org/>.
- Health cluster guide: http://www.who.int/hac/global_health_cluster/guide/en/.
- Health Cluster knowledge bank: <https://www.who.int/health-cluster/resources/publications/en/>.
- WHO and other technical guidelines on health in emergencies: <http://www.who.int/hac/techguidance/guidelines/en/>.
- Quality of care: a process for making strategic choices in health systems: http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf.
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Promoting standards for a quality health response

Paragraph ● ● ● ● ●
5.1 5.2 5.3 5.4 5.5

Box ● ● ● ●
5.1 5.2 5.3 5.4

Figure ● ● ● ●
5.1 5.2 5.3 5.4

Table ● ● ●
5.1 5.2 5.3

- Contents
- References
- Endnotes

Endnotes

1. See Chapter 11, which describes steps involved when developing the health cluster strategy and humanitarian response plan.
2. See Chapter 1.
3. See Chapter 1.
4. Global Health Cluster guidance to help inform country clusters will be finalized in 2020.
5. A supplement is being developed for fragile, conflict-affected and vulnerable settings.
6. See Chapter 11.
7. Sphere website: <https://spherestandards.org/handbook-2018/>.
8. The CHS consultation was facilitated by Humanitarian Accountability Partnership (HAP) International, People In Aid and the Sphere Project, and drew upon a number of sources.
9. Including the following: the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief, the Sphere Core Standards, the HAP Standard in Accountability and Quality Management, the People In Aid Code of Good Practice, Quality COMPAS, the Active Learning Network for Accountability and Performance (ALNAP) evaluation guidelines, OECD Development Assistance Committee evaluation criteria, the IASC Commitments on Accountability to Affected Populations, the Good Humanitarian Donorship principles, the International Federation of Red Cross and Red Crescent Societies (IFRC) Disaster Law Programme model, and the Global Humanitarian Platform principles of partnership.
10. See Chapter 1.
11. There may be other indicators that some global clusters recommend or that are only locally appropriate, which may not be captured in the registry.
12. See Chapter 4 on information management.



Promoting standards for a quality health response

Paragraph

5.1 5.2 5.3 5.4 5.5

Box

5.1 5.2 5.3 5.4

Figure

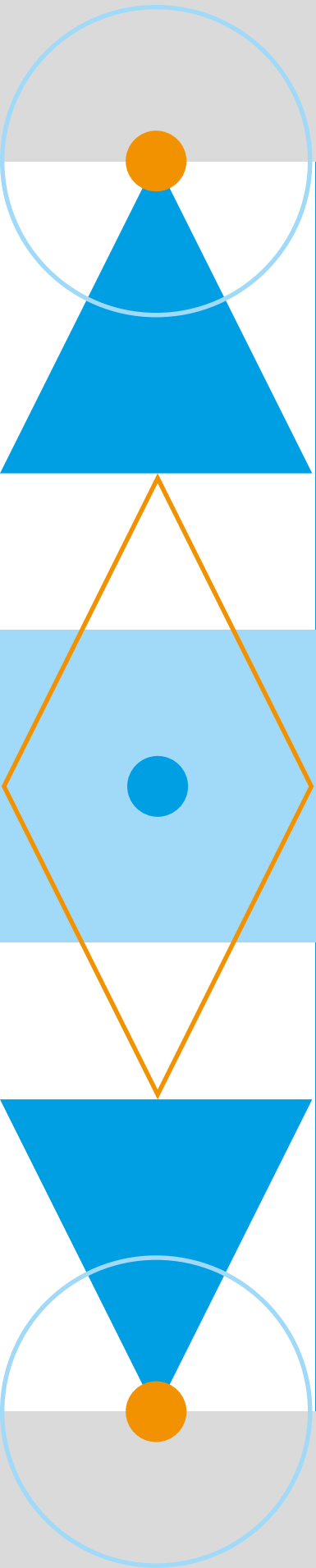
5.1 5.2 5.3 5.4

Table

5.1 5.2 5.3

- Contents
- References
- Endnotes

Humanitarian– development nexus



06

Contents

Chapter 6		
Humanitarian–development nexus		216
6.1 Introduction: the humanitarian–development nexus and its links to peace		216
6.2 Implications of the humanitarian–development nexus for the health sector		219
6.2.1	Influencing collective outcomes	219
6.2.2	Interpreting collective outcomes in the health sector	219
6.2.3	Interpreting joint analysis for the health sector	220
6.2.4	Interpreting joint planning for the health sector	220
6.2.5	Interpreting the link with peacebuilding for the health sector	221
6.3 Typology of context		222
6.4 Health system strengthening, resilience and early recovery		224
6.5 Principles of early recovery		227
6.6 Implementing the humanitarian–development–peace nexus: entry points, health system bottlenecks and approaches		228
6.6.1	Health service delivery: packages and platforms	230
6.6.2	Human resources for health	231
6.6.3	Health information systems	232
6.6.4	Essential medical products and technologies	233
6.6.5	Health financing	234
6.6.6	Leadership and governance	236
6.7 Creating operational links with peacebuilding		238
6.7.1	Social cohesion and peacebuilding: promoting State–citizen and intercommunal cohesion through health	238
6.7.2	Social cohesion and peacebuilding: promoting trust	239
6.8 Initiating and operationalizing the humanitarian–development–peace nexus process		240
6.9 Localization		241
References		243
Annex 6.1	Health system synergies between humanitarian, development and peacebuilding activities	245
Endnotes		250
Figures		
Figure 6.1	Different interventions at different stages of the conflict cycle	222
Figure 6.2	Typologies of response and engagement within the humanitarian–development–peace nexus	223
Figure 6.3	Interlinked elements contributing to universal health coverage and health system resilience	225
Figure 6.4	International approaches to conflict and transitional settings	226

Abbreviations

DG ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
DHIS	District Health Information System
EWAR	early warning, alert and response
HeRAMS	Health Resources and Services Availability Monitoring System
IDSR	Integrated Disease Surveillance and Response
IHP+	International Health Partnership
IHR	International Health Regulations
MIRA	multi-sector initial rapid assessment
mhGAP	WHO Mental Health Gap Action Programme
NGO	nongovernmental organization
SARA	Service Availability and Readiness Assessment
SDG	Sustainable Development Goal
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SPAR	Self-Assessment Annual Reporting Tool
STAR	Strategic Tool for Assessing Risks
TB	tuberculosis
UNSDCF	United Nations Sustainable Development Cooperation Framework
USAID	United States Agency for International Development
WASH	water, sanitation and hygiene
WHO	World Health Organization

6. Humanitarian–development nexus

6.1 Introduction: the humanitarian–development nexus and its links to peace

The New Way of Working calls on humanitarian and development actors to work collaboratively, based on their comparative advantages, towards “collective outcomes” that reduce need, risk and vulnerability over multiple years (1). This notion of “collective outcomes” has been placed at the centre of the commitment to the New Way of Working, summarized in the Commitment to Action signed by the United Nations Secretary-General and eight United Nations Principals at the World Humanitarian Summit, Istanbul, 2016, with the endorsement of the World Bank and the International Organization for Migration (2). Recognizing the need to work differently in protracted crises, several resident coordinators, humanitarian coordinators and country teams, together with a range of partners, embarked on the process of articulating collective outcomes in 2017. A collective outcome is a concrete and measurable result that humanitarian, development and other relevant actors want to achieve jointly over a period of three to five years to reduce people’s needs, risks and vulnerabilities and increase their resilience (1–5).

The New Way of Working and the concept of the humanitarian–development nexus gave impetus to system-wide changes in the humanitarian, development and peacebuilding sectors aimed at transcending long-standing conventional thinking, a “silo” approach, mandates, and other attitudinal, institutional and funding obstacles. Strengthening the nexus involves harmonizing efforts in analysis, planning, programming and coordination among actors in those sectors, as elaborated below.

- **In humanitarian action.** In 2016, at the World Humanitarian Summit, partners agreed on a commitment to action that would transcend the humanitarian–development–peace divide. To this end, the Summit urged the international aid system, including the United Nations, nongovernmental organizations (NGOs) and bilateral donors, to commit to working in a new paradigm marked by three fundamental shifts: (a) reinforce, do not replace, national and local systems; (b) anticipate, do not wait for, crises; and (c) transcend the humanitarian–development–peace divide by working towards collective outcomes, based on comparative advantage and over multi-year time frames.



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

- In the development sector.** The 2030 Agenda for Sustainable Development’s commitment to leaving no one behind and reaching the furthest behind first, and its specific references to people affected by humanitarian emergencies, creates a common results framework under which both humanitarian and development actors can work together to ensure the safety, dignity and ability to thrive of the most vulnerable (6). This meant that development planners could no longer only work on the easier, middling problems but must tackle the most vulnerable and poorest in society – those that might typically be regarded as a “humanitarian” caseload. This agenda was further supported by reform of the United Nations development system, which has empowered the resident coordinator and put the United Nations Sustainable Development Cooperation Framework (UNSDCF) at the centre of joint humanitarian, development and peacebuilding planning.
- In the peace and security sector.** The United Nations General Assembly and United Nations Security Council unanimously adopted identical resolutions on “sustaining peace”,¹ requesting all United Nations entities and the World Bank to mobilize their capacities for mediation and conflict resolution to prevent the “outbreak, escalation, continuation and recurrence of conflict”. This has moved the World Bank and major donors to be more involved in fragile contexts, developing new financing facilities with an overarching objective of building peace and resilience.

At the operational level, these three dimensions – humanitarian action, development and peacebuilding – converge during the process of articulating a joint analysis, jointly planning, and jointly programming to achieve collective outcomes.

The key differences compared to previous efforts to link relief with development is that now both humanitarian and development work streams prioritize areas and populations left behind, and in most need. There is now a broad acknowledgement that there is no sequencing or transition between humanitarian and development programming, but a need to work alongside, managing complementarities between the two.

Violent conflict is increasingly recognized as an obstacle to achieving the Sustainable Development Goals (SDGs) by 2030, given that 80% of the total humanitarian caseload is caused or exacerbated by conflict. In these contexts, all efforts to strengthen the humanitarian–development nexus should be grounded on sound conflict analysis to ensure that programming does no harm and is conflict sensitive. In specific circumstances – and where the necessary preconditions exist² – humanitarian–development programming can even explicitly contribute to improving the prospects for local peace, in line with the United Nations “Sustaining Peace” agenda.



Humanitarian–development nexus



- Contents
- References
- Endnotes

The humanitarian–development–peace nexus is not a straightforward path to development or peace but rather an effort to deliver health services equally, continuously and resiliently to address population needs within a protracted emergency that might last for many years to come and that will have volatile evolutions, but where the needs and the potential gains in terms of the SDGs are more concentrated.

Guiding principles of humanitarian–development programming are as follows.

- From the onset of their response, humanitarian interventions should apply early recovery approaches in the response (early recovery at the onset of acute emergencies, and long-term vision during protracted emergencies), and should seek integration with existing health services and transition of governance to local authorities.
- Development-oriented work streams should target fragile and conflict-affected areas in a more operational manner, addressing key bottlenecks in health system performance that also constrain the humanitarian response, with more flexibility in contracts and adapted management of risks.
- Implementation needs to be supported by predictable and flexible humanitarian and development funding, and coordination and dialogue between all partners. Mapping of financing flows should include non-traditional humanitarian donor groups and development funding.
- In conflict-affected settings, humanitarian and development interventions should be conflict sensitive. That is, they should be designed in such a way that they do not exacerbate the root causes of the conflict and where possible contribute to peacebuilding.



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

6.2 Implications of the humanitarian–development nexus for the health sector

6.2.1 Influencing collective outcomes

Collective outcomes are designed to offer a collective path for prioritizing interventions and funding of humanitarian, development and peacebuilding actors. A collective outcome is “an envisioned result with the aim of addressing needs and reducing risks and vulnerabilities, requiring the combined effort of both humanitarian and development communities and other actors as appropriate” (7).

Health is in many vulnerable contexts among the primary concerns of populations. It can also offer multisectoral entry points to prioritize concrete, achievable and measurable results. When humanitarian and development country teams develop these collective outcomes, and in contexts where health is a primary concern of populations, the health cluster has a responsibility to influence the definition of collective outcomes and to prioritize health in the formulation of these outcomes.

6.2.2 Interpreting collective outcomes in the health sector

Collective outcomes are defined to guide inputs from multiple sectors. Health should be prioritized where relevant, or at a minimum, collective outcomes should integrate in their formulation the contribution of the health sector. The formulation of collective outcomes can take different forms and the contribution of the health sector can also be manifold, but as an overall vision the health sector should support implementation of SDG 3 (on good health and well-being), and should contribute to the overarching goal of universal health coverage by ensuring that people can use essential quality services when they need them without suffering financial hardship, supported by the preparedness of the health system and communities for shocks.

Outcomes such as equitable access to a predefined essential package of health services for affected and host populations, an increased proportion of deliveries assisted by skilled birth attendants, complete vaccination coverage, a functioning early warning and response system, or mortality and morbidity reduction can also be used as collective outcomes for both humanitarian and development health programming. The contribution to peacebuilding will be defined in terms of improved equity, contributions to social cohesion, or enabling of dialogue and reconciliation opportunities.



Humanitarian–development nexus

Paragraph ● 6.1 ● 6.2 ● 6.3 ● 6.4 ● 6.5 ● 6.6 ● 6.7 ● 6.8 ● 6.9

Figure ● 6.1 ● 6.2 ● 6.3 ● 6.4 ● Annex ● 6.1

● Contents
● References
● Endnotes

6.2.3 Interpreting joint analysis for the health sector

For the health sector, joint analysis would bring together the following groups of analysis and assessment information, which should be analysed together to inform joint planning based on complementary investments:

- humanitarian assessments, for example rapid health assessment, multi-agency initial rapid assessment, humanitarian needs overview, Health Resources and Services Availability Monitoring System (HeRAMS);
- health system performance, bottleneck, or capacity assessment (health system assessment, service availability and readiness assessment, health facility survey, district health information system, demographic and health survey, national health accounts, joint annual review) as well as the country capacity assessment, as part of the UNSDCF process;
- all-hazard risk analysis, joint external evaluation under the International Health Regulations (IHR), vulnerability and risk analysis and mapping, Strategic Tool for Assessing Risks (STAR), Self-Assessment Annual Reporting Tool (SPAR);
- context or conflict analysis, recovery and peacebuilding assessment.

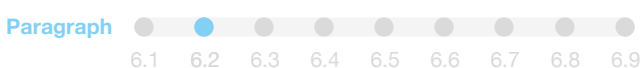
6.2.4 Interpreting joint planning for the health sector

At the multisectoral level, joint planning is currently being implemented in several countries under the UNSDCF (8). For the health sector, this should be considered at both national and subnational levels in the following areas:

- multi-year humanitarian response plan, using the health system analysis framework to identify priorities and opportunities for early recovery to connect with longer-term health system recovery and reforms;
- national development plans and national health strategic plans that prioritize areas and populations in most need, and all-hazard preparedness;
- integrating where possible humanitarian, development and peacebuilding support in the humanitarian operational plans and the national and district development annual operational plans.



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

6.2.5 Interpreting the link with peacebuilding for the health sector

The interlinkages between conflict, health and peace are multifaceted. Armed conflicts and violence have obvious impacts on health. They cause direct, violent deaths among civilians and combatants alike, and lead to physical and mental disabilities. They have long-term public health impacts as they destroy indispensable health facilities, thereby impacting mortality as well as the capacity of the health system to cope with major health problems. Conflicts may accelerate the spread of infectious diseases. Peace is therefore a social determinant of health.

In addition, lack of access, and loss of rights, to basic social services such as health care for specific population groups (for example, ethnic, regional or religious groups) can lead to feelings of exclusion, marginalization, unfair treatment by the government, and inequality vis-à-vis other groups. Often, these grievances at community level boil over into protests, and later violent conflict. Lack of access to health care and other services has also been cited as a reason for joining violent extremist groups.

Against this backdrop, health and health sector programming has the capacity to improve the prospect for peace in two major ways:

- by ensuring health programming is sensitive to specific political contexts, for example by avoiding an inadvertent preference for certain groups or territories over others (do no harm);
- by developing peace-responsive health programming that aims to address some of the root causes of the conflict (do more good).

Through these twin approaches, health care can help to mend horizontal relations between individuals and communities. It can also improve vertical, State–citizen trust relations. Finally, the health sector can provide a platform for parties in conflict to restore contact, dialogue and cooperation.³

Figure 6.1 provides some examples of interventions that link with peacebuilding at different stages of a conflict.

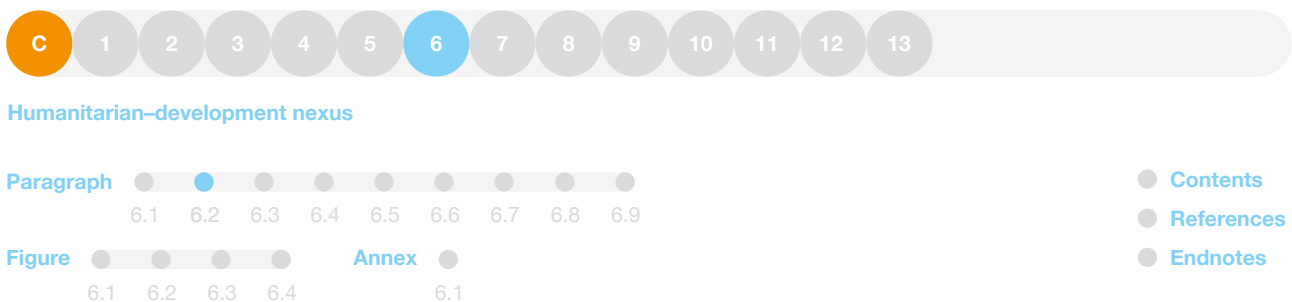
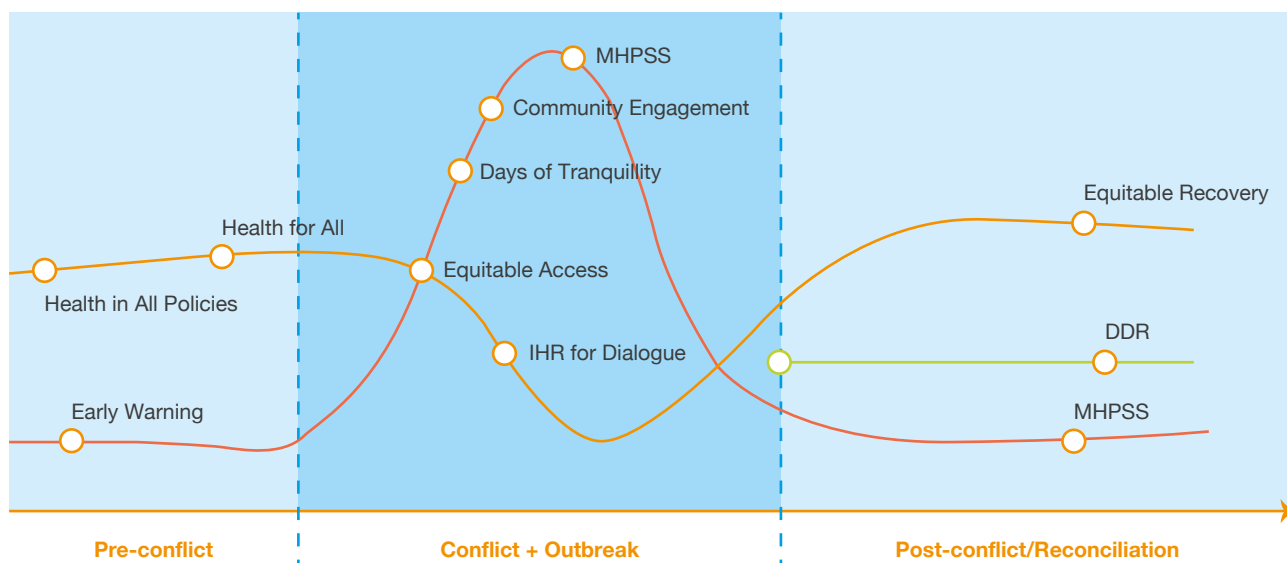


Figure 6.1 Different interventions at different stages of the conflict cycle



- Health diplomacy (Peacebuilding)
- Health systems strengthening (Development)
- Peace process (Governance)
- Emergency response (Humanitarian)

DDR = disarmament, demobilization and reintegration. MHPSS = mental health and psychosocial support services.

6.3 Typology of context

The interpretation of the humanitarian–development–peace nexus depends on the context. Different response scenarios are defined based on three characteristics of the context and the role of the government or local authorities:

- responsibility to protect the population
- capacity to respond
- stability of context: security and access to populations in most need.

These characteristics have implications for joined analysis, planning, and collective outcomes, and they determine the relationship of the international community with the government and local authorities.

Figure 6.2 shows typologies of response and engagement within the humanitarian–development–peace nexus.

C 1 2 3 4 5 6 7 8 9 10 11 12 13

Humanitarian–development nexus

Paragraph 6.1 6.2 6.3 6.4 6.5 6.6 6.7 6.8 6.9

Figure 6.1 6.2 6.3 6.4 Annex 6.1

- Contents
- References
- Endnotes

Figure 6.2 Typologies of response and engagement within the humanitarian–development–peace nexus

Type 1: Constrained

Scenario: Government/authorities unwilling to uphold obligations and responsibility to protect, and limiting the scope of international involvement.

Engagement: Limited joint engagement with government/authorities, with strong emphasis on local capacities, local civil society, and efforts to strengthen social cohesion at community level and focus on lifesaving. Peacebuilding involves advocacy, health diplomacy, and conflict-sensitive programming.

Collective outcomes: Align where possible with national SDG implementation plan, but maintain humanitarian space by developing separate humanitarian plans.

Type 2: Capacity-driven

Scenario: Government/authorities are willing to uphold responsibility, but have little to low capacity to do so, and low ongoing budget support for service delivery.

Engagement: Strong emphasis on capacity-building and localization, significant service delivery in consultation with/request of government and with the view of handing over operations and engagement to government as soon as possible (early recovery). Explore adjusting bilateral mechanisms to finance health sector budget with official development assistance. Peacebuilding includes community engagement, community violence reduction, and working with elites.

Collective outcomes: Align where possible with national SDG implementation plan. Develop common plan with development actors, with anticipated humanitarian caseload. Provide space for protection/human rights issues in separate humanitarian plan.

Type 3: Consultative

Scenario: Strong/capacitated and “responsible” government/authority, recovering or emerging political settlement, but high-intensity or active conflicts/insecure operational contexts persist.

Engagement: Targeted service delivery under leadership of government, relatively limited international operational activity. International expertise used when needed; operational involvement may be requested after consultations with the government or authority in situations of low access or instability with the aim of filling gaps. Peacebuilding involves supporting government in post-conflict peace processes such as disarmament, demobilization and reintegration/returnee settlement and social cohesion and supporting formal reconciliation processes.

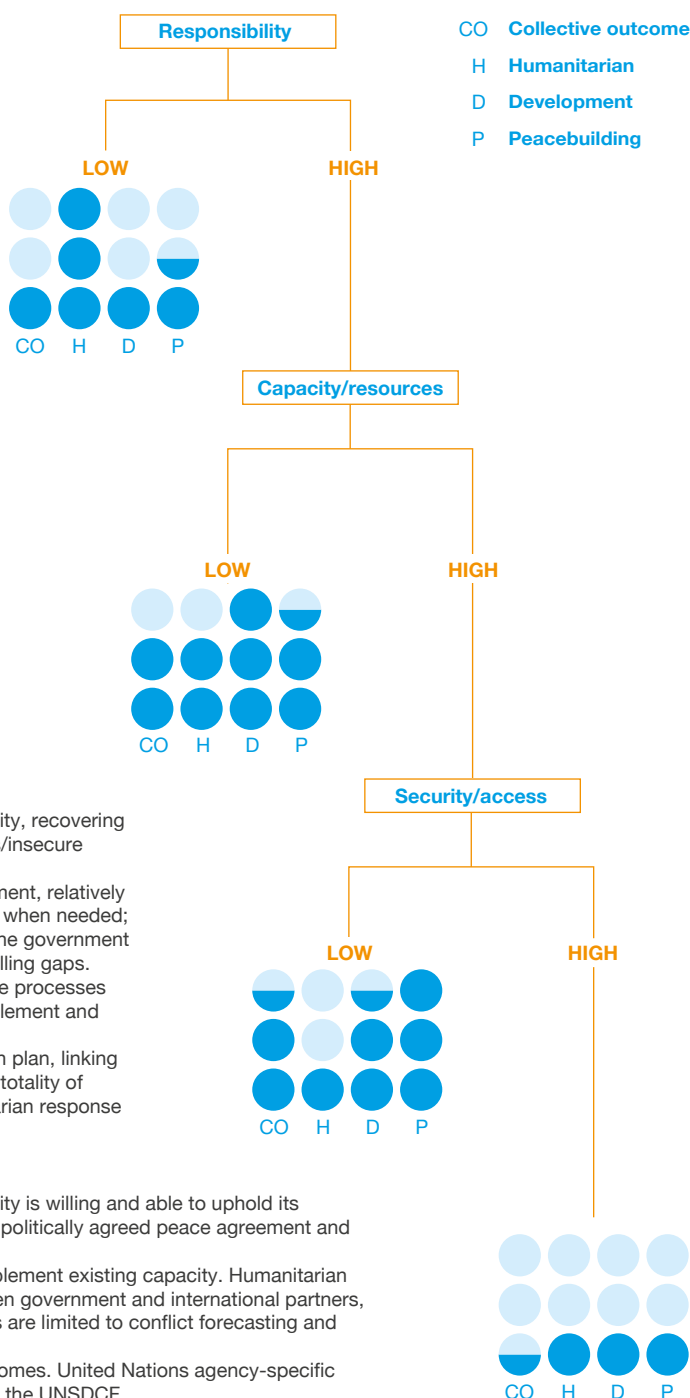
Collective outcomes: Align explicitly with national SDG prioritization plan, linking where necessary with the peacebuilding and recovery plan. Embed totality of humanitarian needs in the UNSDCF, with space for ad hoc humanitarian response plan for pockets of insecurity.

Type 4: Collaborative

Scenario: Strong/capacitated and “responsible” government/authority is willing and able to uphold its obligation and responsibility to protect in a stable situation or with a politically agreed peace agreement and has adequate capacity to respond.

Engagement: Role of international response is to support and complement existing capacity. Humanitarian and development engagement and service delivery is shared between government and international partners, with leadership from relevant line ministries. Peacebuilding initiatives are limited to conflict forecasting and monitoring.

Collective outcomes: Limited need for system-wide collective outcomes. United Nations agency-specific planning engagement should be guided by government as agreed in the UNSDCF.



*Note: The graphics are meant to be figurative. Together, they illustrate the need to adapt the degree of joint humanitarian–development–peacebuilding programming depending on the context. The relevant interpretation should begin with a robust situation analysis.



Humanitarian–development nexus



- Contents
- References
- Endnotes

6.4 Health system strengthening, resilience and early recovery

In addition to facing increased morbidity, mortality and disability, health systems are often severely affected by a crisis. Crises interfere with health service delivery through damage and destruction of health facilities, disruption of supply chains, interruption of health programmes, loss of health staff, and overburdening of clinical and preventive services. Therefore, populations living in these contexts are those most in need of and with least access to services. A single emergency can set back development gains by several years, including progress made on health system strengthening.

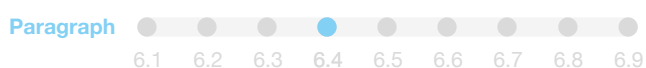
Emergencies may result in severe health system disruptions, depending on:

- the type, scale and length of the emergency
- numbers of people affected
- pre-crisis, existing weaknesses of the health system, including lack of capacity
- the damage and disruption to the health system caused by the emergency.

The interface between health system strengthening and disaster risk management towards the collective outcomes of universal health coverage and health system resilience is depicted in Figure 6.3.

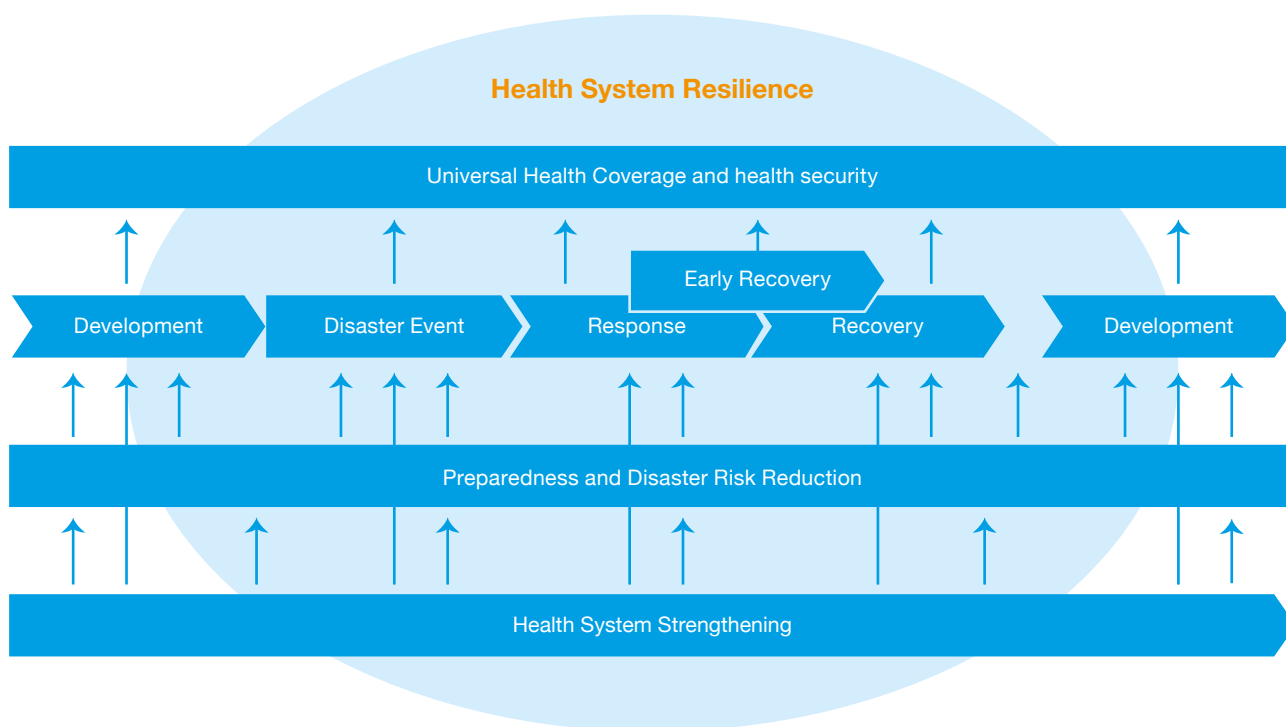


Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

Figure 6.3 Interlinked elements contributing to universal health coverage and health system resilience



Health system strengthening can be defined as (a) the process of identifying and implementing the changes in policy and practice in a country’s health system so that the country can respond better to its health and health system challenges; (b) any array of initiatives and strategies that improve one or more of the functions of the health system and that lead to better health through improvements in access, coverage, quality and efficiency.

Health system resilience can be defined as the ability of the health system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions (9).

Early recovery is the contribution from humanitarian programming towards the humanitarian–development nexus. It is an approach that addresses recovery needs that arise during the emergency, using humanitarian mechanisms aligned with development principles. It enables people to use the benefits of humanitarian action to seize development opportunities, builds resilience, and establishes a sustainable process of recovery from crisis (10, 11).



Humanitarian–development nexus

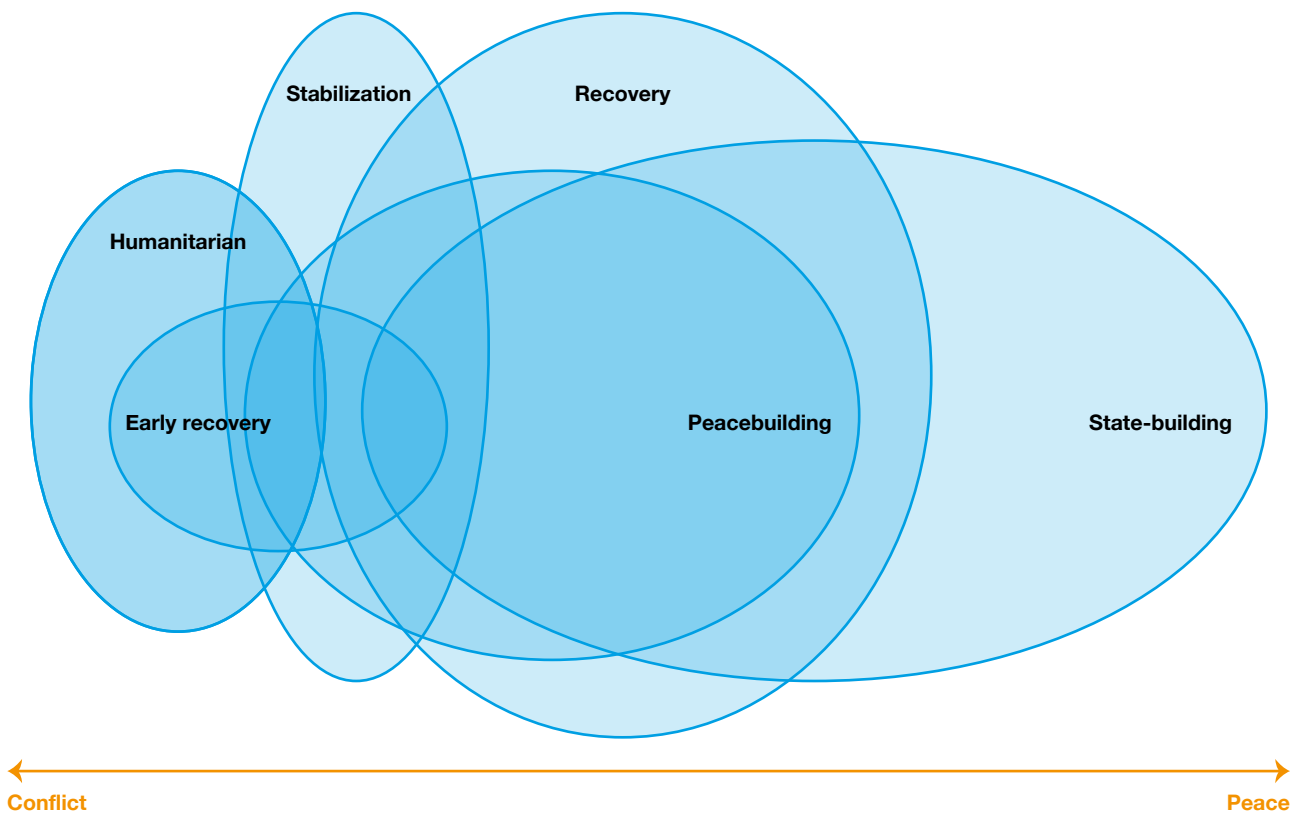
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Figure ● 6.1 ● 6.2 ● 6.3 ● 6.4 ● Annex ● 6.1

- Contents
- References
- Endnotes

Figure 6.4 illustrates the overlap between the spectrum of approaches and programming when moving from conflict to peace.

Figure 6.4 International approaches to conflict and transitional settings



Source: Adapted from Humanitarian Policy Group (12).

Within the mandate and humanitarian imperative to save lives, humanitarian responses can and need to consider the longer-term consequences of their actions, and how interventions interface with and can contribute to building resilience during the crisis and longer-term recovery and development whenever the environment stabilizes. It is important not to wait until a hypothetical end of conflict (the mean duration of protracted crises increased from four years in 2005 to seven years in 2017) (13) but rather to invest early and to the extent possible in delivering services in a sustainable way from the onset of the crisis response.

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Humanitarian–development nexus

Paragraph 6.1 6.2 6.3 6.4 6.5 6.6 6.7 6.8 6.9

Figure 6.1 6.2 6.3 6.4 Annex 6.1

- Contents
- References
- Endnotes

6.5 Principles of early recovery

The following set of principles for the integration of early recovery approaches in emergency health responses is adapted from the general guiding principles for early recovery in the *Guidance note on inter-cluster early recovery*, from the Global Cluster for Early Recovery (10).

- Do not hinder the lifesaving humanitarian imperative

Working towards an aspirational better future and strengthening the existing health system should not come at the expense of attending to emergency-related lifesaving health needs.

- Do not undermine national systems

Emergency interventions that function as a substitution of the local health system may temporarily serve to fill gaps in service coverage for affected populations. However, they may, by their design, undermine ongoing initiatives and future recovery of the health system by fragmenting existing systems, implementing actions that are impossible to sustain with national resources, and disempowering the roles of local and national health authorities. These local health systems may develop dependencies on external actors and become more vulnerable to future shocks, such as outbreaks, ultimately rendering the health of the populations at greater risk.

- Work with national health authorities and partners where and when possible

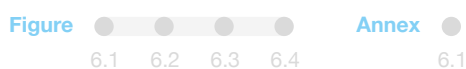
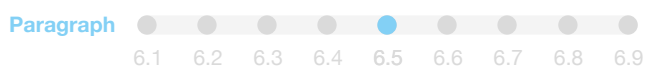
Providers of humanitarian interventions should work with national and local health authorities and partners while respecting humanitarian principles (14). While international humanitarian relief after an acute onset crisis may sometimes establish service delivery capacity and coordination that are parallel to or substitute government provision, most interventions should support service delivery through existing health facilities in collaboration with subnational health authorities. The work of local health workers should be valued, empowered and facilitated to build human resource capacity at the national and local levels.

- Integrate early recovery approaches from the beginning

Early recovery efforts need to be activated and welcomed from the very initial phases of relief. From the early stages of any intervention, consider the foundation for longer-term health system strengthening and resilience, and support health emergency and disaster risk management capacities. Early recovery aims to



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

restore the lead role and ownership of the government and identify opportunities for (re)building the capacity of the local health authorities, where this supports the humanitarian priorities and when this facilitates transition or an exit strategy.

- Create a collaborative environment with peacebuilding and development actors

Welcome development actors and resources and facilitate their engagement in emergencies. Consider how development partners can connect from the earliest phases and lobby for the handover of high and long-term humanitarian action investments in areas that no longer correspond to an acute emergency but that might require long-term support to provide services and attain SDG targets in protracted crises. Supportive actions can include undertaking joint risk analysis and joint needs assessment, followed by seeking complementary planning towards collective outcomes, the alignment of standards and policies in emergency response with those used for development, and joint monitoring and reviews. The comparative advantage of each partner must be evaluated and taken into account. Humanitarian actors should not compromise on their humanitarian mandate when also working towards development goals, but rather aim for complementarity, leading to greater resilience of the local health system while filling gaps where necessary.

6.6 Implementing the humanitarian–development–peace nexus: entry points, health system bottlenecks and approaches

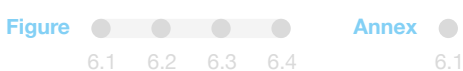
Interpreting early recovery for the health sector means that, building on the initial lifesaving interventions (for those most in need), an approach is taken to strengthen the pillars of the health system, optimizing the quality and coverage (to most of those in need) of health services provided to affected populations collectively by all health actors using all available resources, while laying the foundation for longer-term health system recovery and resilience, including by supporting health emergency risk management capacities.

To implement the humanitarian–development–peace nexus, the following objectives can be used as entry points before, during and after crises:

- strengthen the capacities of the ministry of health, national and international health partners and communities to prepare for, respond to and recover from emergencies arising from all hazards;



Humanitarian–development nexus



- Contents
- References
- Endnotes

- strengthen national and subnational capacity for coordination of humanitarian partners and district health management and create links with health development coordinators and partners;
- strengthen national and subnational capacities to detect and respond to outbreaks of infectious diseases, and build and strengthen community surveillance systems;
- based on conflict analysis, design, adapt and implement interventions that address causes, drivers, and triggers of conflict, in so far as these factors relate to health issues and health care has the potential to tackle the causes;
- use the World Health Organization (WHO) health system analysis framework and its six building blocks (15) to identify priorities and opportunities for early recovery, and identify options to address underlying health system bottlenecks to service delivery;
- progressively expand access to, coverage of and quality of an essential package of health services to populations at risk, with the scope of services and mix of delivery platforms adapted to the various security contexts;
- strengthen supply management systems, seeking efficiencies in joint procurement of quality medicines and shifting from the use of kits to bulk when possible;
- progressively shift to an area- and population-based approach through district health management, supported by community engagement;
- plan towards collective health outcomes to guide humanitarian, development and peacebuilding programming, and clarify synergies or commonalities between humanitarian, development and peacebuilding planning;
- carry out joint monitoring and reviews of operational plans and achievement of collective outcomes informing the next planning cycle.

The following six sections give examples of how the health system building blocks may be affected during crises, either caused by acute natural disasters or during protracted conflicts. Some practical examples are then given for early recovery approaches that can be integrated in the emergency response by humanitarian partners. They also give indications of what needs to be asked from health development partners.⁴ Many of these suggestions can in fact also be part of preparedness planning and should be anticipated prior to a crisis.



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

6.6.1 Health service delivery: packages and platforms

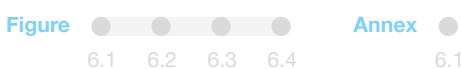
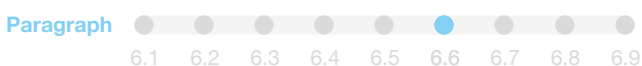
Most natural disasters, such as floods, earthquakes and hurricanes, cause direct damage to the health infrastructure and its physical assets, and thus disrupt service delivery. Often these problems compound health system weaknesses that already existed before the crisis. Insecurity, or deliberate exclusion of or discrimination against population groups, can constrain access to still functional facilities. Health facilities are often targeted during conflict, leading to significant damage and destruction, which can cause services to be interrupted, either temporarily or permanently. Health service delivery can become fragmented when health facilities provide different packages of services, depending on which humanitarian agency provides support. Limited access to health systems can also create intercommunal pressures and tensions. It will be important to define what, where, how, for whom and by whom services can be provided.

Practical early recovery approaches for health service delivery

- map all health service delivery platforms (includes mobile teams, campaigns, community health workers, temporary facilities, private sector facilities) that coexist in the emergency and determine how these are initially funded, staffed and supplied, and how each of these aspects should evolve towards local ownership, governance and coordination in the longer term;
- design and cost a high-priority package of essential services, ensuring that the services in the package and its list of medicines and equipment are aligned with the essential package of health services in the national health plan, guidelines and protocols;
- ensure adaptation of the scope of services and the mix of delivery platforms to the various operational and security contexts and integrate flexibility to respond to rapidly changing conditions;
- establish referral pathways between different levels of the health services and invest in a functional referral system, taking into account functioning health facilities and adapted to changing accessibility;
- include the essential package of health services in a memorandum of understanding between health authorities, agencies and donors, and avoid to the extent possible fragmentation of the essential package of health services by “picking and choosing” based on agency mandate or donor preference;
- avoid establishing parallel service delivery points where there are already facilities and services, unless strictly necessary;



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

- support holistic capacity-building for quality clinical services (such as management of conflict-related trauma) that will support mass casualty management, or investments in the quality of service delivery, focusing on effectiveness of treatment, people-centredness, and patient safety, for example training in infection prevention and control measures, medical waste management and sterilization protocols, water, sanitation and hygiene (WASH) infrastructure and equipment, that can be justified under the lifesaving minimum standards but will have longer-term benefits as well;
- support, when feasible, programmes to be run directly by local health authorities, such as the Expanded Programme on Immunization or programmes for tuberculosis (TB), HIV or blood transfusion, when these overlap with humanitarian health needs;
- with regard to infrastructure, transition as quickly as possible to existing local health facilities and, where no health facilities are available (destroyed or new areas), transition as soon as is feasible from mobile units to temporary structures (tents) and, when security allows, to permanent structures essential to minimum quality standards;
- integrate new permanent infrastructure in national health coverage plans and respect existing standards and specifications;
- invest in health facility security arrangements.

6.6.2 Human resources for health

The health workforce is often significantly affected by crises in many ways, exacerbating the general challenges that already existed before the crisis started. This includes the misdistribution of health workers, the attraction of high allowances from vertical programmes and international NGOs, shortages of providers, fragmented and unaccredited training that international aid agencies may provide to (new) cadres of health workers but without being able to offer accredited diplomas, exposure to infection by epidemic-prone diseases, and attacks on health workers as they become targets of violence or imprisonment.

Practical early recovery approaches for human resources for health

- build capacity through training and supervision and seek consistency in curricula and in post descriptions, and align them to national standards so they can become accredited (this should be done even before a crisis);



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

- second health staff to the ministry of health to fill gaps in coordination or support the delivery of lifesaving interventions;
- harmonize and adapt locally appropriate salary scales or incentive packages with the ministry of health to ensure standardization and consistency, including incentives for arrival or installation, particularly in destroyed villages;
- include all human resources for health policies, and salary and incentive thresholds, in a memorandum of understanding between agencies, donors and health authorities;
- invest in infection prevention and control capacities;
- establish a human resources for health database using HeRAMS as part of the overall mapping of availability of health resources for evidence-based planning and forecasting of workforce requirements, linked to the extent possible with the national health workforce accounts.

6.6.3 Health information systems

Most routine data collection systems will be interrupted during the initial phases of a disaster, or when they remain functional, they are not adapted to inform decision-making for the emergency response. Often the areas where no information comes from are the worst affected.

Practical early recovery approaches for health information systems

- apply the same tools in cases where new systems do need to be introduced to avoid multiple parallel systems and fragmentation of information, and allow aggregation and joint analysis of data across different areas of operations, ensuring that the process is coordinated under the ministry of health, or by the health cluster if it was activated;
- ensure evolution from public health information system for emergencies towards health information management, increasingly owned and operated by the ministry of health;
- agree on and support a standardized disease surveillance system, with an early warning component for diseases that are potentially epidemic;
- build and strengthen community-based surveillance, monitoring and data collection systems;



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

- develop information management tools to collect and report humanitarian–development–peace nexus interventions;
- establish a system for mapping of health facilities, possible levels of damage and functionality, covering the entire affected area and population, including private health service facilities and development partner investments, in addition to facilities run by the public sector, agencies, NGOs and faith-based organizations;
- agree on and use the same sets of geographical and administrative denominators and demographic estimations, leading towards harmonized information that is easier to integrate;
- include the use of national or common standardized data collection and management systems in a memorandum of understanding between agencies, donors and health authorities;
- agree on health facility reporting tools, information technology platforms for uploading data, their interoperability, and processes and incentives for reporting.

6.6.4 Essential medical products and technologies

As infrastructure is damaged by a disaster, medical supplies and equipment may be equally damaged, or power outages may affect the cold chain. Normal supply lines may have been affected due to damage to roads and bridges. Donations of medicines and equipment, as part of the response, may in some cases add additional stress to the system when not compliant with international and national guidelines for drug donations (16). After the war ended in the Balkans in 1995, inappropriate and expired medical supplies had to be destroyed at high cost to the government, as it was classified as chemical waste requiring special incineration.

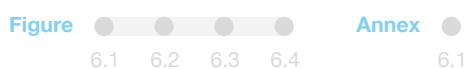
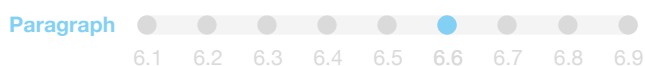
In conflicts, access to quality drugs is usually compromised as centrally led procurement systems are interrupted and the regulatory capacity of the government is weakened.

Practical early recovery approaches for essential medical products and technologies

- shift from the initial use of standard international kits for the supply of medicines and equipment (initial push approach) to bulk procurement of emergency medical supplies based on consumption and caseloads (pull approach);
- align to national standard lists for essential medicines, medical supplies and equipment, known to local health staff and populations;



Humanitarian–development nexus



- Contents
- References
- Endnotes

- invest in rational drug use and prescription behaviour, and patient knowledge, for adherence to prescribed treatment in combination with health promotion;
- where possible, procure these supplies from national or regional manufacturers, provided they comply with international quality standards;
- review the quality and capacity of national supply systems, and if national manufacturers do not comply with international quality standards, invest in their assessment (identification of faults) and improvement for compliance with the WHO Model Quality Assurance System and good distribution practices;
- where possible, carry out bulk procurement by one agency or through a common pipeline for cost savings and efficiency (rather than having each humanitarian partner procure their own drugs for their own projects), which requires yearly planning and clearances;
- explore the use or creation of subnational recognized and compliant central procurement centres if these would fit in with national pharmaceutical policies, as for example the Regional Association for the Supply of Essential Medicines (ASRAMES) in North Kivu, Democratic Republic of the Congo, as well as procurement centres recognized by the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO) and the United States Agency for International Development (USAID);
- if included in their target countries, make use of supplies procured through global health initiatives such as Gavi, the Vaccine Alliance, and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

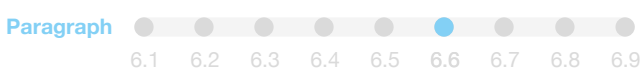
6.6.5 Health financing

Most disasters disproportionately affect poor people. When homes or livelihoods are damaged or lost through a disaster, their overall ability to pay for health services is diminished. In countries whose health financing depends largely on direct out-of-pocket payments, this exacerbates financial barriers for accessing lifesaving services and increases risks for catastrophic health expenditures and subsequent adverse health outcomes.

There is broad consensus in the humanitarian community and among donors that services supported by the international aid agencies should be provided free at the point of delivery (17). However, this may distort the existing public and private health provision, as patients no longer seek care in clinics where they have to pay user fees. As revenues decrease, functioning clinics may have to close, leaving a gap when the humanitarian support ends.



Humanitarian–development nexus



- Contents
- References
- Endnotes

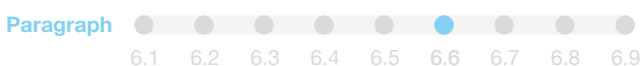
Health financing strategies in support of universal health coverage also aim to ensure financial protection and minimize reliance on out-of-pocket payments (cash) at the point of service use. In countries that have financing largely based on public funding and purchasing through contracting of service providers or health insurance schemes, these services are often disrupted in areas affected by conflict. Nevertheless, the principles of financing, based on public revenues, pooling, and purchasing of a benefit package, should guide models and solutions for financing of services in conflict-affected settings (18).

Practical early recovery approaches for health financing

- employ resource tracking by mapping donors' contributions to the health sector to ensure there is overall equity in the allocation of financial resources;
- reduce fragmentation in funding by establishing pooled funding for health, for example to centralize procurement of medicines or reimbursement of interventions (contracts with hospitals or vouchers for referred patients);
- facilitate partners to gain access to development or peacebuilding funds available through development donors and embassies;
- mobilize support from donors to finance early recovery approaches, or advocate the creation of a hybrid health recovery or transition fund;
- support a policy discussion between humanitarian stakeholders, the ministry of health and development partners when changing user fee practices (including identifying or securing alternative funding where user fees have been abolished or significantly reduced) and in developing more equitable financing mechanisms with the government;
- introduce and monitor any reform related to abolishing user fees carefully, especially in complex situations;
- take note of the growing experience that cash or voucher assistance can be used to cover charges or reduce other indirect financial barriers for patients such as costs for transport, or to incentivize utilization of free services (19);
- explore the creation of health sector pooled funds for supporting free health care when controlling outbreaks (so that financial access does not preclude outbreak containment), joint procurement of medicines, or contracting existing providers to reduce or waive user fees while upholding quality standards;



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

- map all donors and work towards streamlining and reduction of fragmentation by donors and seek flexibility of and between humanitarian and development funding mechanisms, so they can adapt to changes in context and needs;
- empower health authorities so they have ownership of and accountability for the financial management of health service delivery when the local situation is conducive.

6.6.6 Leadership and governance

The offices of the ministry of health at national and subnational levels may also have suffered damage and their staff may have been affected, as mentioned above for other health workers. Where the ministry of health does not yet have procedures in place to establish emergency management systems, it may take time for governing bodies to organize effective coordination and guidance for the response. In the case of large-scale disasters, where often more than 200 international health partners arrive to offer support, the capacity of the existing governing bodies to manage and task partners may be overwhelmed.

In other cases, the governance structure may remain strong but may be compromised by a lack of respect for humanitarian principles or international humanitarian law, for example when governments deliberately exclude populations from services, or put constraints on cross-border or cross-front-line support.

In particular for natural disasters, governments increasingly insist that international emergency medical teams register with and report to them, and expect that partners are able to adhere to international quality standards (20).

Increased ownership by national health authorities can serve several longer-term purposes. First, it can demonstrate the existence and willingness of national agencies who can take on significant roles in the recovery process, and thereby accelerate the shift from dependency on external sources to self-reliance. Second, it enables national agencies and enterprises to fulfil crucial roles in the rebuilding of facilities and services and thereby accelerate the process of national ownership. And third, it can empower the remaining health authorities and foster capacity-building, ultimately leading to stronger leadership and coordination.

Practical early recovery approaches for leadership and governance

- second staff to the ministry of health to support its coordination mechanisms, including registering and tasking international health partners in support of the national response plan;



Humanitarian–development nexus



- Contents
- References
- Endnotes

- align the interventions of partners with national policies, guidelines and standards, unless this would compromise humanitarian principles, and involve national health authorities when there is a need to adapt or update them;
- extend area-based coordination mechanisms to provincial and district levels;
- support the functions of provincial and district health management teams that have a direct relation with the humanitarian programmes, for example with regard to health information systems and early warning, alert and response (EWAR), and supervision and quality assurance of service delivery in their districts;
- establish memoranda of understanding with district or provincial health authorities on such matters as essential packages of health services, incentives paid to health care staff, joint supervision and training, health data management system harmonization, and geographical responsibilities;
- support or create district health committees with stronger community engagement in order to strengthen accountability to affected populations;
- if not set up jointly from the beginning, transfer selected international coordination functions and responsibilities towards national and subnational health authorities;
- include in every project elements of disaster risk management (including preparedness, contingency planning and disaster risk reduction) into the programming, and develop these plans with national health authorities, complementary to the larger national disaster management programme;
- cluster inputs in the recovery planning through a post-disaster needs assessment or recovery and peacebuilding assessment, and where appropriate use these plans to inform humanitarian programmes so they can support recovery;
- connect with global health initiatives, such as Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Stop TB Partnership, Roll Back Malaria, and where relevant use accelerator theme 7 (innovative programming in fragile and vulnerable States and for disease outbreak responses) of the Global Action Plan for Healthy Lives and Well-being for All as a point of entry to strengthen collaboration;
- as an initial measure, create a subgroup on resilience and the humanitarian–development nexus under the humanitarian coordination mechanism, reporting its findings to the larger group, increasing knowledge of approaches to universal



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

health coverage in situations of fragility, conflict and vulnerability, without forcing the whole group away from the humanitarian imperative;

- establish operational links with health development partner coordination mechanisms and develop context-specific solutions for joint coordination of analysis and planning, and addressing key challenges of common concern;
- when there is no development coordination, establish a technical working group on the humanitarian–development–peace nexus under the health cluster to bring together all partners on a common platform;
- invest in and work with multisectoral national coordination mechanisms, especially for determinants of health (nutrition, water, food security, protection) and health emergency preparedness, such as those under ministries responsible for reconstruction and rehabilitation and for humanitarian affairs, the national disaster management agency, and health emergency operations centres.

6.7 Creating operational links with peacebuilding

6.7.1 Social cohesion and peacebuilding: promoting State–citizen and intercommunal cohesion through health

Conflict factors addressed in this area include (a) low level of trust in authorities, health providers and among community members due to a sense of neglect and isolation; (b) poor performance in delivery of social services; and (c) persistence of trauma linked to war-related atrocities. The theory of change postulates that these factors can be reversed: *if* dialogue is facilitated between State authorities, local medical practitioners and communities in conflict zones, *and* authorities and humanitarian actors adapt health reforms and service delivery to address the needs and grievances expressed by the population, *then* satisfaction with the health system will improve and trust towards State institutions and among communities will be reinforced.

Programmatic activities include the following:

- policy dialogue, including recommendations made by WHO to the ministry of health to address the requirements of most dissatisfied populations, and support to implement recommendations;
- outreach to and facilitation of humanitarian NGOs to promote equitable access to an essential package of health services using national systems for affected communities, based on a participatory needs assessment;



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

- facilitated dialogue sessions involving communities, health practitioners and State institutions in conflict-affected areas to understand patients’ needs, grievances and perception of health reforms;
- support for community-based mental health and psychosocial support interventions, including through sociotherapy, group interpersonal therapy and Self-Help Plus interventions;
- assistance with establishment and capacity-building of a strong network of national health NGOs to expand coverage of mental health and psychosocial support services, including through the WHO Mental Health Gap Action Programme (mhGAP), as a transitional solution.

6.7.2 Social cohesion and peacebuilding: promoting trust

The conflict factor addressed in this area is mistrust between conflict parties. According to the theory of change, *if* national health care professionals from across the conflict divide work together to address common health concerns amidst the continuing conflict, *then* mutual understanding can be fostered, steps can be taken towards an inclusive health system, and cooperation and dialogue can be encouraged.

Programmatic activities include the following:

- training performed on technical health aspects jointly targeting health professionals coming from all conflict parties, involving the respective medical associations;
- signing up registered health personnel to provide a national health service during a crisis or humanitarian situation;
- facilitation of health service delivery that requires crossing the front lines (such as patient referrals, delivery of medication), benefiting the local communities affected by the conflict;
- support for front-line health care professionals to deliver quality health care regardless of political, language, religious or community affiliations;
- facilitated dialogues bringing together health professionals belonging to all conflict parties on communicable diseases and IHR to ensure alignment of protocols, methods, planning, and exchange of data.



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

6.8 Initiating and operationalizing the humanitarian–development–peace nexus process

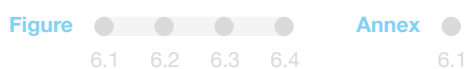
In many crises, some collaboration between humanitarian and development partners and government is already taking place. Often this is informal and normally not explicitly recognized as implementation of the New Way of Working in relation to the humanitarian–development–peace nexus. It is important to formalize this New Way of Working, preferably soon after the onset of the crisis, or before the crisis as part of preparedness.

Depending on the context and the role of the government, the initiative to formalize and invest in the humanitarian–development–peace nexus and the New Way of Working should be taken by the national authorities, the national health cluster or sector partners, or WHO as lead agency for the health sector. The following processes can be used to initiate the humanitarian–development–peace nexus process formally.

- **Preparedness.** It is important to invest in leadership functions and disaster risk management capacities in the ministry of health, and seek links with health system strengthening and development partners for risk reduction, preparedness and contingency plans, and scaling up treatment capacity for response.
- **Joint assessment.** A main first step in this process is to jointly conduct a structured health system assessment with the objective of identifying common challenges to humanitarian and development activities and bottlenecks, and proposing recommendations to address those jointly. Depending on availability of pre-existing health system evaluation resources, such health system assessment will include a desk review and bilateral and group interviews. The assessment could be conducted by a small team of humanitarian–development–peace nexus experts, with combined knowledge of humanitarian and development processes and structures.
- **Joint planning.** Based on the findings and recommendations, government, humanitarian and development partners will jointly develop and commit to a humanitarian–development–peace nexus roadmap consisting of prioritized and costed actions with predictable funding. Normally this process should be led by the government. This roadmap will inform the development of the multi-year humanitarian response plan, the national health strategic plan, the health sector humanitarian operational plan and the national and subnational annual health operational plans. These plans will define the roles and responsibilities



Humanitarian–development nexus



- [Contents](#)
- [References](#)
- [Endnotes](#)

of government and of individual humanitarian and development agencies. The humanitarian–development–peace nexus roadmap, the humanitarian response plan, the national health strategic plan and the operational plans will be accompanied by their monitoring and evaluation frameworks.

- **Coordinated implementation.** Government and humanitarian and development partners will implement the activities defined under responsibilities in a coordinated way. They will use different partner coordination mechanisms, such as the national health cluster or sector, with coordination from the International Health Partnership (IHP+). A special humanitarian–development–peace nexus coordination structure or processes will ensure efficient coordination between humanitarian and development work streams, possibly established and chaired by the ministry.
- **Joint monitoring and evaluation.** In accordance with the monitoring and evaluation frameworks, government, humanitarian and development partners will jointly monitor and evaluate progress and performance of their humanitarian and development activities, as well as indicators specific to the humanitarian–development–peace nexus.

6.9 Localization

Localization, which is a key commitment of the World Humanitarian Summit and the Grand Bargain, aims to create more meaningful partnerships between international and local humanitarian actors, including through more direct and flexible, multi-year, predictable funding, capacity-building, and transfer of technical and contextual knowledge. It does not aim to reduce the involvement of international actors in humanitarian responses, but rather to allow local actors to be effective first responders, supported where necessary by international partners. For example, a roster of local emergency response personnel could be set up, which international partners could complement when needed. Localization is also a means of making humanitarian coordination mechanisms and products – such as the humanitarian country teams, humanitarian response plans, humanitarian needs overviews and country-based pooled funds – more accessible to local humanitarian organizations. Given its interlinkages with approaches such as accountability to affected populations, needs analysis and assessment, and the humanitarian–development–peace nexus, localization is currently being prioritized by major donors, United Nations agencies and international and local NGOs (the former mainly through the Grand Bargain, and the latter most notably through the Charter for Change movement).

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Humanitarian–development nexus

Paragraph ● 6.1 ● 6.2 ● 6.3 ● 6.4 ● 6.5 ● 6.6 ● 6.7 ● 6.8 ● 6.9 ●

Figure ● 6.1 ● 6.2 ● 6.3 ● 6.4 ● **Annex** ● 6.1 ●

● **Contents**
● **References**
● **Endnotes**

A set of six commitments (including two prioritized core commitments) related to localization were agreed by the signatories of the Grand Bargain, focusing on:

- core: a target of at least 25% of humanitarian funding to local and national responders;
- core: a multi-year investment in the institutional capacities of local and national responders;
- removal of barriers that prevent organizations and donors from partnering with local and national responders;
- support to national coordination mechanisms;
- setting a “localization” marker to measure direct and indirect funding to local and national responders;
- greater use of funding tools that increase and improve assistance delivered by local and national responders.

The role of the health cluster coordinator in supporting localization is as follows:

- establish and strengthen partnerships with national health NGOs, and support their capacities to engage in humanitarian response planning and financial and project management;
- ensure that national health NGOs are receiving adequate direct long-term, multi-year, predictable funding through the Common Humanitarian Fund;
- identify key areas of improvement and capacity-building for the health sector, for example through expressing the health needs and elaborating how to address them, mentoring and coaching, one-on-one capacity-building support, and developing a multi-year capacity-building plan;
- advise on humanitarian and development health programming that will result in resilient health systems and ensuring a basic minimum health package free at point of use – before, during and after a crisis;
- engage with local partners and donors to explore the best means to promote localization for health programming and projects and map the geographical areas benefiting from the greatest number of projects.



Humanitarian–development nexus



- Contents
- References
- Endnotes

References

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Humanitarian–development nexus



- Contents
- **References**
- Endnotes

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Humanitarian–development nexus

Paragraph ● ● ● ● ● ● ● ● ● ●
6.1 6.2 6.3 6.4 6.5 6.6 6.7 6.8 6.9

Figure ● ● ● ● Annex ●
6.1 6.2 6.3 6.4 6.1

- Contents
- References
- Endnotes

Annex 6.1

Health system synergies between humanitarian, development and peacebuilding activities

THEME	HUMANITARIAN AND EARLY RECOVERY ACTIVITIES IN EMERGENCY RESPONSE	HEALTH SYSTEM RECOVERY, DEVELOPMENT, RESILIENCE AND PEACEBUILDING
Leadership and coordination	Humanitarian/emergency coordination: <i>Strengthen role of national and subnational health authorities, taking responsibility for the six coordination functions</i>	Health development partner coordination (International Health Partnership for UHC 2030, etc.) Recovery coordination for post-conflict recovery and peacebuilding assessments: <i>Led by health authorities</i>
	Registration and mapping of all health partners: <i>Integrated in mapping of national response capacity, memoranda of understanding with ministry of health</i>	Coordination for the conflict analysis and for the conflict recovery assessment and planning: <i>Led by health authorities</i>
	Subnational emergency coordination: <i>Focused capacity-building of district health management functions in support of delivery of the essential package of health services and lifesaving functions</i> <i>One or two lead NGOs per district to support district health management team</i>	Core functions and capacities for district health management team Decentralization policies, district operational planning
	Accountability to affected populations: <i>Connect with primary health care traditions (district and village health committees)</i>	Guidance for district, community and village health committees
	Emergency preparedness and contingency planning: <i>Strengthen role of national and subnational health authorities, health emergency operations centre, IHR core capacities</i>	Emergency and disaster risk management programme for health (including health emergency operations centre and incident management system) Implementation of IHR core capacities, legislation Integrated in national health sector development policy



Humanitarian–development nexus



- Contents
- References
- Endnotes

THEME	HUMANITARIAN AND EARLY RECOVERY ACTIVITIES IN EMERGENCY RESPONSE	HEALTH SYSTEM RECOVERY, DEVELOPMENT, RESILIENCE AND PEACEBUILDING
Health information system	Simplified morbidity surveillance: <i>Aligned with Integrated Disease Surveillance and Response (IDSR) system</i>	IDSR Set up community-based data collection systems
	Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys	Vital statistics
	Rapid health assessment and multi-sector initial rapid assessment (MIRA), humanitarian needs overview, multisectoral analysis of needs	Emergency response mechanism and IHR capacity assessment
	All-hazard risk analysis	All-hazard risk analysis: <i>Led by health authorities, connected with national disaster management authority</i>
	Early warning, alert and response (EWAR): <i>Aligned with national EWAR network, IHR core capacities</i>	EWAR
	Health Resources and Services Availability Monitoring System (HeRAMS): <i>Baseline links with Service Availability and Readiness Assessment (SARA)</i>	SARA, health facility survey
	Selected health information system indicators: <i>Harmonized with health management information system</i>	Health management information system, District Health Information System (DHIS) 2



Humanitarian–development nexus

Paragraph	● 6.1	● 6.2	● 6.3	● 6.4	● 6.5	● 6.6	● 6.7	● 6.8	● 6.9
Figure	● 6.1	● 6.2	● 6.3	● 6.4					
Annex						● 6.1			

- Contents
- References
- Endnotes

THEME	HUMANITARIAN AND EARLY RECOVERY ACTIVITIES IN EMERGENCY RESPONSE	HEALTH SYSTEM RECOVERY, DEVELOPMENT, RESILIENCE AND PEACEBUILDING
Service delivery	Restore lifesaving services, with special attention to excluded or marginalized groups	Restore equitable access to a minimum package of health services, and address pre-disaster constraints for access and performance
	Minimum or high-priority packages of health interventions and services: <i>Harmonized with essential package of health services and national quality assurance systems (accreditation of national health providers)</i>	Essential package of health services, contracting providers People-centred and integrated health services
	Progressive expansion of coverage and quality	Universal health coverage
	Rapid response mechanism: <i>Role of health authorities</i> Establish temporary treatment centres (e.g. nutrition rehabilitation unit, cholera or Ebola treatment centres): <i>Build capacity of ministry of health in rapid response mechanism and national medical teams</i>	Preparedness to scale up service delivery capacity Safe hospital programme, mass casualty management, national medical teams, mobile clinics and WHO Mental Health Gap Action Programme (mhGAP)
	Infection prevention and control: <i>Aligned with national standards</i>	Risk reduction activities, staff and patient safety, infection prevention and control, etc.
Pharmaceuticals and equipment	List of core lifesaving pharmaceuticals: <i>Aligned with national list of essential medicines</i>	Lists of essential medicines, by level of health facility
	Drug and equipment donation guidelines: <i>Items aligned with national standards</i>	Lists of essential medical equipment, by level of health facility Standards for diagnostics and laboratory services by level
	Stocks of supplies linked with preparedness and contingency plans	Stocks of supplies linked with preparedness and contingency plans: <i>Managed by national health authorities</i>
	Quality control of pharmaceuticals procured by international partners: <i>From kits to procuring bulk items, common logistics through a dedicated procurement partner</i>	Prequalification of suppliers Regulation of private pharmacies Central medical stores for national procurement



Humanitarian–development nexus

Paragraph ● 6.1 ● 6.2 ● 6.3 ● 6.4 ● 6.5 ● 6.6 ● 6.7 ● 6.8 ● 6.9

Figure ● 6.1 ● 6.2 ● 6.3 ● 6.4 ● Annex ● 6.1

● Contents

● References

● Endnotes

THEME	HUMANITARIAN AND EARLY RECOVERY ACTIVITIES IN EMERGENCY RESPONSE	HEALTH SYSTEM RECOVERY, DEVELOPMENT, RESILIENCE AND PEACEBUILDING
Human resources for health	Standardized remuneration and incentives guidelines Staffing standards by level of health facility: <i>Aligned with national standards</i> Mapping available human resources by type through HeRAMS	Human resource for health unit with responsibility for development and monitoring of policies and plans Health workforce registries to track health workforce stock, distribution, flows, demand, supply, capacity and remuneration Established national health workforce accounts Bilateral and multilateral agencies that have integrated in their programming health workforce assessments, support and information exchange
	Scaling up education and employment of integrated teams of primary health care workers, including community health workers: <i>Post description aligned to national human resources for health and community health worker policy and post descriptions</i>	Community health worker policy – task shifting policies that allow community health workers to dispense antibiotics, injectable antibiotics and contraceptives, etc. Standard post descriptions
	Training of health workers: <i>Aligned with national curricula, accreditation of training</i>	Accreditation mechanisms for health training institutions Training curricula for types of health workers, standard post description, licensing Training of health workers on emergency response mechanism and IHR, incident management system, human rights, medical ethics, etc. Training and exercises for emergency response, linked with preparedness plans Standard operating procedures for repurposing health workers for response Preparedness plan and repurposing of registered health personnel for national health service during a crisis



Humanitarian–development nexus

Paragraph	● 6.1	● 6.2	● 6.3	● 6.4	● 6.5	● 6.6	● 6.7	● 6.8	● 6.9
Figure	● 6.1	● 6.2	● 6.3	● 6.4					
Annex						● 6.1			

- Contents
- References
- Endnotes

THEME	HUMANITARIAN AND EARLY RECOVERY ACTIVITIES IN EMERGENCY RESPONSE	HEALTH SYSTEM RECOVERY, DEVELOPMENT, RESILIENCE AND PEACEBUILDING
Financing	<p>Services free at point of delivery, (temporary) waiving of user fees</p> <p>Services financed by humanitarian donors/ resources:</p> <p><i>Purchasing services in national health facilities (public or private) using pooled health risk funds, or other cash-based programming, to access health services based on prepayment and risk sharing</i></p>	<p>Health financing policies, based on public revenue, pooling and purchasing of a benefit package</p> <p>Purchasing services through contracting of services, performance-based financing</p> <p>Financial protection from catastrophic health expenditure</p> <p>Ensuring staff are paid regularly</p> <p>Selective free services (vaccination, antenatal care)</p> <p>Emergency fund to reimburse costs for temporary waiving of user fees during a disaster</p>
	Administration systems connect with national administration for strategic purchasing systems	Financing preparedness and risk reduction



Humanitarian–development nexus

Paragraph	● 6.1	● 6.2	● 6.3	● 6.4	● 6.5	● 6.6	● 6.7	● 6.8	● 6.9
Figure	● 6.1	● 6.2	● 6.3	● 6.4					
Annex						● 6.1			

- Contents
- References
- Endnotes

Endnotes

1. A/RES/70/262 and S/RES/2282.
2. See typologies of response scenarios, section 6.3.
3. For more guiding principles and operational guidance on peace-responsive health interventions see the WHO Health and Peace White Paper (upon request: contact simoniang@who.int).
4. See also Annex 6.1: Health system synergies between humanitarian, development and peacebuilding activities.



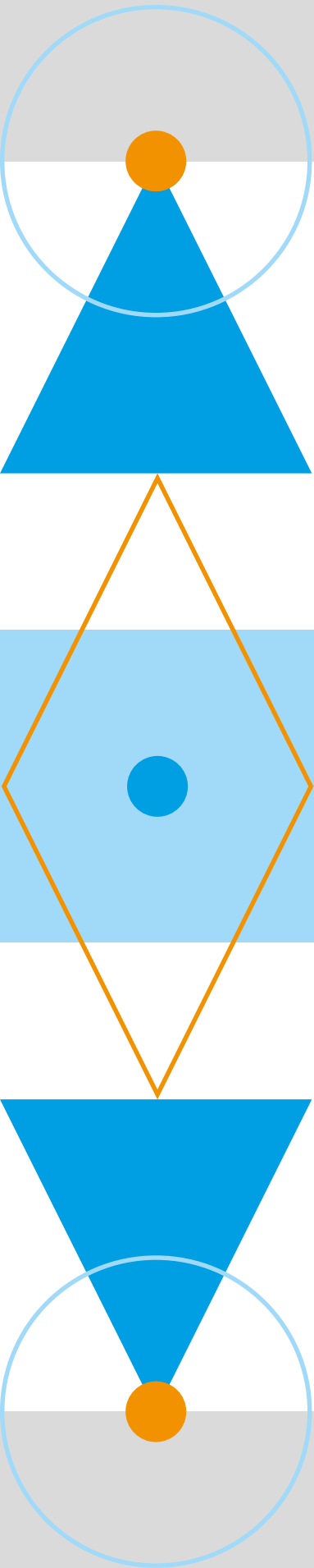
Humanitarian–development nexus

Paragraph ● 6.1 ● 6.2 ● 6.3 ● 6.4 ● 6.5 ● 6.6 ● 6.7 ● 6.8 ● 6.9

Figure ● 6.1 ● 6.2 ● 6.3 ● 6.4 Annex ● 6.1

- Contents
- References
- Endnotes

Effective emergency health advocacy



07

Contents

Chapter 7		
Effective emergency health advocacy		253
7.1 Introduction		253
7.2 What is advocacy?		253
7.3 Humanitarian principles and the right to health as advocacy tools		254
7.4 Health cluster: complementarity between collective and agency advocacy		255
7.5 Steps for effective humanitarian health advocacy		256
Step 1. Identify problems requiring advocacy		257
Step 2. Identify advocacy goals and objectives		257
Step 3. Identify targets, influencers and allies		258
Step 4. Develop key messages		259
Step 5. Select advocacy actions		260
Step 6. Articulating an advocacy action plan		263
Step 7. Carrying out monitoring and evaluation		263
7.6 Respective roles and responsibilities in relation to health advocacy in a humanitarian response		264
References		267
Endnotes		268
Boxes		
Box 7.1	Potential unintended consequences of advocacy actions	260
Box 7.2	Attacks on health care: example of data-supported advocacy	261
Figures		
Figure 7.1	Steps for effective advocacy	256
Tables		
Table 7.1	Useful definitions: advocacy actors	259
Table 7.2	Suggested structure of core messages	260
Table 7.3	Advocacy objective and indicators	264

Abbreviations

ECOSOC	Economic and Social Council
IASC	Inter-Agency Standing Committee
WHO	World Health Organization

7. Effective emergency health advocacy

7.1 Introduction

Advocacy is a core function of a cluster at country level, as stated in the Inter-Agency Standing Committee (IASC) Cluster Coordination Reference Module, and is therefore an obligation for all clusters (1).

Strengthening health cluster advocacy at country level is a strategic priority. The Global Health Cluster provides the framework to support health cluster coordinators, as articulated under Strategic Priority 5 of the Global Health Cluster Strategy 2017–2019 (2–4). Strategic Priority 5 recognizes the critical role that advocacy plays in supporting and enhancing the actions of health cluster partners to prepare for and respond to public health and humanitarian emergencies and ensure better health outcomes in affected populations and contexts. This includes advocacy by the health cluster, as well as the active contribution to advocacy actions by other actors, including the World Health Organization (WHO).

The overall objectives of the Global Health Cluster Advocacy Strategy 2017–2019 (2) are:

- ensure greater protection of health care providers and users of health services in crisis-affected situations;
- ensure greater access to, and equity of, health services across and within crisis-affected populations;
- ensure greater visibility and effectiveness of the health cluster to support advocacy in crisis-affected contexts.

7.2 What is advocacy?

Core function 6 of the country-level health cluster is “to support robust advocacy” (1).

In the context of health in humanitarian emergencies, advocacy involves taking action to influence policies, practices, attitudes and the operational environment to achieve change to improve the health, safety and well-being of the population.



Effective emergency health advocacy

Paragraph ● 7.1 ● 7.2 ● 7.3 ● 7.4 ● 7.5 ● 7.6

Box ● 7.1 ● 7.2 Figure ● 7.1 Table ● 7.1 ● 7.2 ● 7.3

- Contents
- References
- Endnotes

Advocacy should be evidence based and strategic, with clear goals and objectives, and it may be a long-term process.

As advocacy is a core function of the health cluster, it is the responsibility of the health cluster coordinator to ensure that advocacy is appropriately addressed. As part of its typical health-related humanitarian responsibilities, the health cluster would advocate the following:

- appropriate incorporation of the health status and health needs of the affected population into the needs assessment and the humanitarian response plan;
- provision of adequate funding to enable an appropriate, timely and quality emergency health response;
- prioritization of health supplies in supply chain and logistics planning, such as cluster transportation;
- adequate access to health care for the affected population;
- cessation of attacks on health care workers and facilities;
- allocation of adequate resources for health cluster coordination.

7.3 Humanitarian principles and the right to health as advocacy tools

Understanding the four core humanitarian principles – humanity, neutrality, impartiality and independence – is very important for humanitarian advocacy,¹ as is recognition of the right to health, which includes access to safe, timely, acceptable, and affordable health care of appropriate quality (5).

The right to the highest attainable standard of physical and mental health is protected under international human rights law and international humanitarian law, which includes State obligations for the provision of accessible, acceptable and quality health services, as well as interventions to guarantee the conditions of life needed to protect and promote health and well-being for all (6).

The right to health, international humanitarian law, international human rights law and the humanitarian principles address different elements of support for humanitarian work. Various approaches can be adopted, based on the humanitarian context and collective agreement with partners, to enable and support humanitarian approaches.



Effective emergency health advocacy

Paragraph ● ● ● ● ● ● ●
7.1 7.2 7.3 7.4 7.5 7.6

Box ● ● ● Figure ● Table ● ● ●
7.1 7.2 7.1 7.2 7.3

- Contents
- References
- Endnotes

Promoting adherence to the humanitarian principles and the right to health in aid delivery can be a very useful entry point for advocacy in humanitarian contexts, supporting context-specific messages regarding the speed, scale-up and coverage of the relief effort to ensure effective humanitarian and health interventions that are appropriate to people’s needs and rights.

For example, with regard to advocacy in relation to preventing and protecting against attacks on health care, the WHO definition of a health attack is “any act of verbal or physical violence, threat of violence or other psychological violence, or obstruction that interferes with the availability, access and delivery of curative and/or preventive health services” (7).

Continuous reporting on attacks on health care through the Surveillance System for Attacks on Health Care in the West Bank and Gaza Strip has led to a number of recommendations by the Special Rapporteur on the situation of human rights in the Palestinian territories occupied since 1967 and by the United Nations Commission of Inquiry on the 2018 protests in the occupied Palestinian territory, including the following (8).

- Respect for and protection of medical personnel and medical facilities should be ensured, as required by international humanitarian law.
- Regarding attacks on health care, the Commission of Inquiry recommended that Israel “refrain from using lethal force against civilians, including children, journalists, health workers and persons with disabilities, who pose no imminent threat to life”.

In addition, in response to reporting through the Surveillance System for Attacks on Health Care, the WHO Regional Director released a statement expressing concern about the attacks on health care in the Eastern Mediterranean Region, which were contributing to depriving millions of people of the basic human right to health (9).

7.4 Health cluster: complementarity between collective and agency advocacy

Effective humanitarian health advocacy requires a cohesive strategy and plan, with health cluster partners collectively promoting the same advocacy messages, leading to reinforcement of those messages.



Effective emergency health advocacy

Paragraph ● ● ● ● ● ●
7.1 7.2 7.3 7.4 7.5 7.6

Box ● ● Figure ● Table ● ● ●
7.1 7.2 7.1 7.1 7.2 7.3

- Contents
- References
- Endnotes

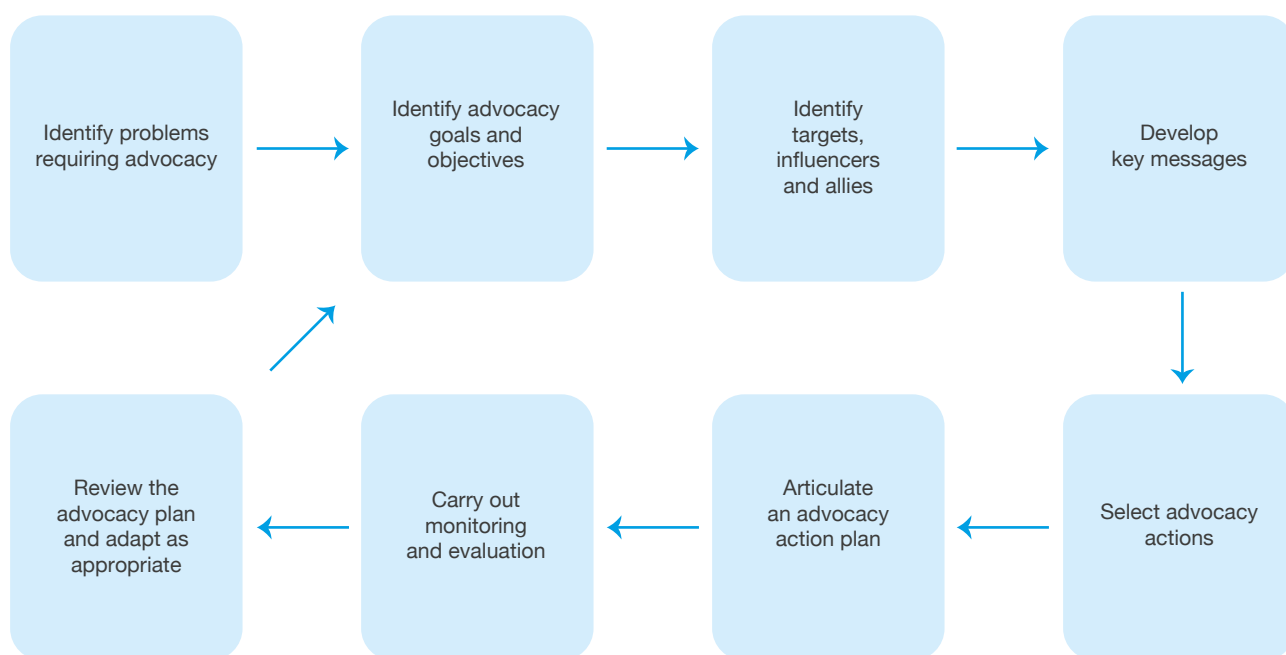
Consultation within the health cluster is required to ensure that health cluster partners are involved in prioritization of key advocacy issues, and subsequently that partners buy into and engage in the process of development and implementation of the health cluster advocacy strategy and plan, through each of the steps outlined below.

Health cluster partners are encouraged to capitalize on opportunities to magnify health cluster messages through their individual organization’s communications and campaigns.

7.5 Steps for effective humanitarian health advocacy

Effective advocacy requires a systematic process to implement a series of sequential steps. Under the direction of the health cluster coordinator and depending on the context, this process may be led by the strategic advisory group or by an advocacy technical working group (Figure 7.1).

Figure 7.1 Steps for effective advocacy



Effective emergency health advocacy



- Contents
- References
- Endnotes

Step 1. Identify problems requiring advocacy

The first step is to clearly identify the problem or problems that require health cluster advocacy. It is important to remember that the health cluster advocacy strategy should not run in parallel with, but should rather underpin, the health cluster response plan and the wider humanitarian response plan or strategy.

Developing an effective advocacy strategy starts by obtaining accurate information on the country-level or local issues to which humanitarian action is responding, and on specific aspects of the response action. This will be done through a situation analysis.² Some of the problems and issues being faced may benefit from advocacy. Advocacy objectives will support the health cluster objectives.

Advocacy must be evidence based.

- Issues should be identified and analysed from an operational perspective and based on the health cluster's collective experience working at both country and global levels.
- The analysis should take into consideration the relevant policy and technical guidance and other evidence related to each problem.
- A proper analysis of each problem provides the foundation for an effective advocacy strategy.

Where one or two key issues are clearly identified as requiring advocacy, the health cluster should proceed to the next step (identifying advocacy goals and objectives).

Where multiple issues are identified as requiring advocacy, the issues with most direct impact on the health of the affected population should be prioritized before proceeding to identifying advocacy goals and objectives.

Step 2. Identify advocacy goals and objectives

An advocacy goal will be formulated as a vision for change.

An advocacy goal may call for policy action and for public awareness-raising to tackle unmet or emerging health needs in relation to a specific event or community. Examples of health advocacy goals include reduction of infant and maternal mortality in a particular community; increased access to contraception; or reduction of high levels of sexual and gender-based violence in instances where there is insufficient protection and response assistance. An advocacy goal will usually target a long-term result.



Effective emergency health advocacy

Paragraph	●	●	●	●	●	●
	7.1	7.2	7.3	7.4	7.5	7.6
Box	●	●				
	7.1	7.2				
Figure	●					
	7.1					
Table	●	●	●			
	7.1	7.2	7.3			

●	Contents
●	References
●	Endnotes

Advocacy objectives contribute to the achievement of the longer-term advocacy goal and should be as specific as possible.

Setting advocacy objectives is similar to the process of setting programmatic objectives. Sound objectives are essential to any planning process and bring clarity and direction to the rest of the process.

The main difference is that while programmatic objectives are activity oriented, advocacy objectives are change oriented. They should describe the desired change in policy or action that is being sought. For example, if the health cluster objective is to promote voluntary HIV testing for refugees at border stations, advocacy could use international humanitarian law and international commitments to advocate national policy change for HIV testing (10, 11). If the health cluster objective is to increase access to health services, and there is evidence of financial barriers negatively impacting population access to services, the health cluster advocacy could use the position paper on *Removing user fees for primary health care services during humanitarian crises* to advocate waiving user fees for poor and vulnerable populations (12).

In another example, specific actions can increase risk and vulnerability related to sexual and gender-based violence, such as having to walk far for water and wood. Advocacy would use data on sexual and gender-based violence to demonstrate the risk arising from the assistance approaches currently being used by national authorities or humanitarian actors and ask for alternative approaches to be adopted to eliminate the risk.

Advocacy objectives may aim to protect robust existing policies from being changed or to ensure a stronger focus on more effective implementation. Alternatively, advocacy objectives may aim to put priority issues on the agenda and get a new policy passed or implemented.

Step 3. Identify targets, influencers and allies

Having defined the advocacy goal and objectives, the next step is to define who has the power to make the desired changes and how the health cluster can influence these decision-makers.

Understanding the different steps in policy-making is essential to know how various groups, departments and institutions engage in decision-making (in government these stakeholders might spread across ministries); who has the power to respond to advocacy demands; and who can support the health cluster's advocacy efforts.



Effective emergency health advocacy



- Contents
- References
- Endnotes

The WHO country office should be able to guide and provide direction on the health policy-making process and the relevant national stakeholders for health-related policy-making.

In humanitarian contexts, health advocacy may target the other clusters, the humanitarian country team, the government, donors and peacekeeping operations. Table 7.1 presents some useful definitions of actors in the field of advocacy.

► **Table 7.1 Useful definitions: advocacy actors**

ENTITIES	DEFINITIONS
Stakeholders	Everybody who can affect or who will be affected by the change being sought.
Targets	Individual decision-makers with the power to respond to the health cluster’s advocacy demands and to move the political process towards addressing the issue.
Influentials	Individuals who may not have the power themselves but have some influence over advocacy targets. It is important to remember that these individuals can use their influence for or against a specific case.
Allies	Individuals or organizations that support an advocacy issue in different ways and to different degrees. These can be potential partners for advocacy efforts.

Step 4. Develop key messages

It will be important to develop a few core messages that clearly summarize the health cluster position and the changes the health cluster is seeking to achieve. These core messages will then guide the development of more specific, tailored messages that will be targeted to different audiences.

Advocacy messages should be:

- clear and direct, using precise language;
- simple: make sure the messages developed can be understood by a non-technical audience, and avoid the use of technical language and abbreviations;
- evidence based: use the operational experience from the in-country health cluster to illustrate the problem and bring in relevant global experience in terms of solutions (see below);
- action oriented: put forward suggested solutions and provide a concrete request to the target audience – “we want you to do this and change that”;



Effective emergency health advocacy

Paragraph	7.1	7.2	7.3	7.4	7.5	7.6		
Box	7.1	7.2	Figure	7.1	Table	7.1	7.2	7.3

- Contents
- References
- Endnotes

- adapted to local context and culturally sensitive.

Table 7.2 presents a summary of how core messages could be structured.

► **Table 7.2 Suggested structure of core messages**

ELEMENT	REASONING
Statement	The central idea of the message – the analysis of the problem
Evidence to support statement	This supports the problem statement – facts and figures using appropriate language for clear communication (good data, credible sources)
An example may be used	This can be useful when communicating the message
The desired action	This is the solution or partial solution, and constitutes the policy request – bring in relevant global experience supporting the desired action

Step 5. Select advocacy actions

Effective advocacy requires implementation of a variety of activities that complement and reinforce each other to influence decision-making and achieve change.

The selection of activities from those presented below will vary depending on the issue, the context and the capacity. It will be important to identify the key strategic opportunities for health advocacy actions (key events) and ensure that the health cluster is appropriately represented and ready to present its position and desired actions. Care should be taken to avoid the possible unintended, negative consequences of advocacy actions (Box 7.1).

• **Box 7.1 Potential unintended consequences of advocacy actions**

When determining advocacy actions, it is important to be aware of the potential unintended consequences of advocacy – including the possibility of reduced access to the affected population or being asked to leave the country in a situation where the national authorities do not like the message – and to forestall unintended consequences.

For example, where the message or issue is extremely sensitive for the national authorities, it may be appropriate to undertake considerable bilateral lobbying and bring in key influentials to support the position prior to dissemination of a press release.

Another possibility is that it may be more appropriate for individual partners that have a strong advocacy mandate to take on the challenge, rather than pursue it through a collective health cluster campaign.



Effective emergency health advocacy

Paragraph	7.1	7.2	7.3	7.4	7.5	7.6
Box	7.1	7.2				
Figure			7.1			
Table				7.1	7.2	7.3

- [Contents](#)
- [References](#)
- [Endnotes](#)

Ensuring an evidence-based advocacy position

Effective use of good data from credible sources is essential to develop an advocacy position supported by robust evidence on a problem, including its causes and solutions. Strong evidence can reinforce advocacy messages and influence decision-makers. In some situations, the health cluster may be required to conduct research to provide this evidence. Box 7.2 presents an example of how data can support advocacy efforts to reduce attacks on health care.

● Box 7.2 Attacks on health care: example of data-supported advocacy

The data on attacks on health care have been used for advocacy at global, regional and national levels. Country health clusters and humanitarian country teams have consistently used data provided by the Surveillance System for Attacks on Health Care to advocate greater protection of both health care and civilian infrastructure, as in the cases of Libya, Syrian Arab Republic and Yemen. At the global level, the evidence has been used in multiple ways, including in United Nations Security Council debates, side events of the United Nations Economic and Social Council (ECOSOC) Humanitarian Affairs Segment, and in quiet dialogue and diplomacy among countries in making political decisions.

Evidence may be presented in different ways:

- position paper: a short paper presenting the health cluster's position on a particular issue;
- thematic report: a longer paper presenting the health cluster's evidence and analysis on a particular issue and recommendations for policy-makers;
- thematic briefing: a shorter paper summarizing the key messages and recommendation of a fuller report (use an easy-to-read format with key messages at the start for busy decision-makers).

Dealing with sensitive information

In some situations (for example, in conflict) information may be highly sensitive and there will be a need for confidentiality, in which case it will be essential that the health cluster establishes and implements solid protocols to ensure anonymity of sources of sensitive information. In line with humanitarian principles, advocacy should never seek to apportion blame or identify perpetrators. Collecting information in the health context can have significant consequences, particularly in the areas of violence (including sexual violence), contraception, abortion, or sex worker activities. Anonymity is sometimes not sufficient, as the information collected can be evidence enough to identify a specific person (for example, a



Effective emergency health advocacy

Paragraph

7.1 7.2 7.3 7.4 7.5 7.6

Box

7.1 7.2

Figure

7.1

Table

7.1 7.2 7.3

- Contents
- References
- Endnotes

14-year-old orphan in location xxx). In highly sensitive contexts data collection could be done through a coded data set, for example identifying children below a certain age as C2, a boy as M2, or an orphan as NA.

Lobbying

Lobbying may be carried out through bilateral face-to-face meetings with decision-makers and those who influence them, and through participation in meetings to address multiple targets simultaneously. In both cases, lobbyists will present the health cluster advocacy position, including the problem, proposed solution, and desired changes, and will seek support for specific actions that will positively impact health outcomes.

Selection of target groups for lobbying will depend on the context and the advocacy issue, but could include other clusters, the humanitarian country team, government, donors and development partners.

In some situations, it may be appropriate to organize an event focusing specifically on the health cluster advocacy issue, inviting all key stakeholders to attend, at which the health cluster advocacy position would be presented, as outlined above.

Media

Dissemination of a press release will help improve the visibility of an advocacy issue with both the public and decision-makers. A press release can be used:

- to inform media agencies about the launch of a new report, campaign or project;
- to influence the agenda of a negotiation or the position of key actors ahead of a relevant event.

As WHO is the cluster lead agency for health, the head of the WHO country office will approve all health cluster statements before release to the media.

Media interviews provide an opportunity to convey an advocacy message, share information and respond to questions on the pertinent advocacy issues. As mentioned above, the head of the WHO country office will represent the health cluster in media interviews.

Social media help to amplify advocacy efforts by potentially reaching more people, in more places, faster than ever before. The purpose of using social media for advocacy is to galvanize supporters to take action. All social media postings should be in line with WHO digital policy.



Effective emergency health advocacy

Paragraph ● 7.1 ● 7.2 ● 7.3 ● 7.4 ● 7.5 ● 7.6

Box ● 7.1 ● 7.2 Figure ● 7.1 Table ● 7.1 ● 7.2 ● 7.3

- Contents
- References
- Endnotes

Generating public awareness

Building public awareness and understanding on an issue will provide a more receptive context for change – it is also a key strategy where change in public behaviours or norms is one of the advocacy objectives.

Use of the media is essential for generating public awareness. Other methods include campaigning (generally to large groups) and community dialogue (generally smaller groups).

Step 6. Articulating an advocacy action plan

Advocacy should be included in the health cluster strategic response plan and workplan. The advocacy goals, change objectives and specific activities should be articulated, including indication of when and where these activities will occur and the lead agency for each activity. It is the responsibility of WHO as cluster lead agency for health to secure sufficient resources for the advocacy activities outlined in the plan.

Step 7. Carrying out monitoring and evaluation

Monitoring and evaluation of health cluster advocacy work should be conducted as part of the routine health cluster monitoring and evaluation process.

Regular monitoring should be undertaken to ensure that advocacy activities are being implemented in line with the health cluster strategic response plan and workplan. The results will be fed into the periodic evaluation of progress towards achievement of advocacy objectives.

Periodic evaluation (for example, biannually) should be undertaken to assess achievement of advocacy objectives and goals. Changes in policy and practice may, in some contexts, take many years; thus it is equally important to capture indicators of significant progress that will ultimately contribute to achievement of advocacy goals and objectives in the longer term (Table 7.3).



Effective emergency health advocacy



- Contents
- References
- Endnotes

► **Table 7.3** Advocacy objective and indicators

ADVOCACY OBJECTIVE	SAMPLE INDICATORS OF PROGRESS	SAMPLE INDICATORS OF CHANGE
Policy practice change	<ul style="list-style-type: none"> • Profile and visibility of issue raised • Dialogue and discussion of the issue raised – “it’s on the agenda” • Changes in key personnel • High-level personnel in charge of implementing roll-out of policy changes • Evidence of strong political will • Increased capacity of health cluster partners to promote advocacy • Presence of advocacy champions within the health cluster • Strong partnerships and alliances working collaboratively on advocacy issues 	<ul style="list-style-type: none"> • Policy or legislation changed • Evidence of wide implementation of policy or legislation and resource mobilization changes

7.6 Respective roles and responsibilities in relation to health advocacy in a humanitarian response

Health cluster coordinator

The health cluster coordinator, with the support of the health cluster coordination team, has a central role to play in:

- leading the development of a health cluster advocacy strategy and plan through a consultative process with health cluster partners (this work may be carried out by the strategic advisory group where one exists or an advocacy technical working group may be established);
- supporting the implementation of the health cluster advocacy plan in line with the activities outlined in the workplan;
- directly conducting health cluster activities, specifically high-level external communications and lobbying in line with the health cluster advocacy plan;



Effective emergency health advocacy

Paragraph ● 7.1 ● 7.2 ● 7.3 ● 7.4 ● 7.5 ● 7.6

Box ● 7.1 ● 7.2
 Figure ● 7.1
 Table ● 7.1 ● 7.2 ● 7.3

- Contents
- References
- Endnotes

- liaising with WHO communications staff;
- liaising with WHO programme staff to ensure coherence and complementarity of the health cluster and WHO advocacy messages;
- liaising with the head of the WHO country office (a) to provide updates on the health cluster position on the various advocacy issues, (b) to get sign-off on advocacy positions to be communicated, and (c) to ensure that the head of the WHO country office is well positioned to effectively represent the health cluster on all advocacy-related issues.

Health cluster partners

Health cluster partners will play key roles by:

- actively participating in the process of identification of advocacy issues and in the development of the health cluster advocacy strategy and plan;
- actively engaging in implementation of the advocacy plan, which may involve taking responsibility to lead aspects of the plan;
- ensuring that their own agency advocacy messages are aligned with health cluster messages as and where relevant.

Head of the WHO country office in cluster lead agency capacity

The tasks of the head of the WHO country office will include:

- ensuring people have access to impartial assistance, in proportion to their needs and without discrimination;
- gathering and consolidating data and establishing national registries on attacks on health care, and documenting the consequences of those attacks for health care delivery and public health;
- engaging with donors to raise funds in line with the strategic objectives of the sector or cluster response plan, in concert with relevant regional offices and headquarters;
- making the case for allocation of resources, in accordance with cluster priorities and perspectives, in a full, fair, and impartial manner, to the humanitarian coordinator and humanitarian country team, donors, government, and other external interlocutors;



Effective emergency health advocacy

Paragraph	●	●	●	●	●	●
	7.1	7.2	7.3	7.4	7.5	7.6
Box	●	●				
	7.1	7.2				
Figure	●					
	7.1					
Table	●	●	●			
	7.1	7.2	7.3			

- [Contents](#)
- [References](#)
- [Endnotes](#)

- assisting the humanitarian country team in designing modalities for the allocation of in-country pooled funds, including Emergency Response Fund, Common Humanitarian Fund, and Central Emergency Response Fund submissions;
- supporting the prioritization of health funding through in-country pooled funds, the Central Emergency Response Fund and inclusion in the flash appeal or strategic humanitarian response plan;
- constantly monitoring budget requirements and funding forecasts for the health cluster to manage the risk that funding shortfalls will affect the provision of service.



Effective emergency health advocacy

Paragraph ● ● ● ● ● ● ●
7.1 7.2 7.3 7.4 7.5 7.6

Box ● ● ● ● ● ● ●
7.1 7.2 7.1 7.1 7.2 7.3

- **Contents**
- **References**
- **Endnotes**

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Effective emergency health advocacy

Paragraph	7.1	7.2	7.3	7.4	7.5	7.6		
Box	7.1	7.2	Figure	7.1	Table	7.1	7.2	7.3

- Contents
- **References**
- Endnotes

Endnotes

1. See Chapter 1.
2. See Chapter 4 on information management.



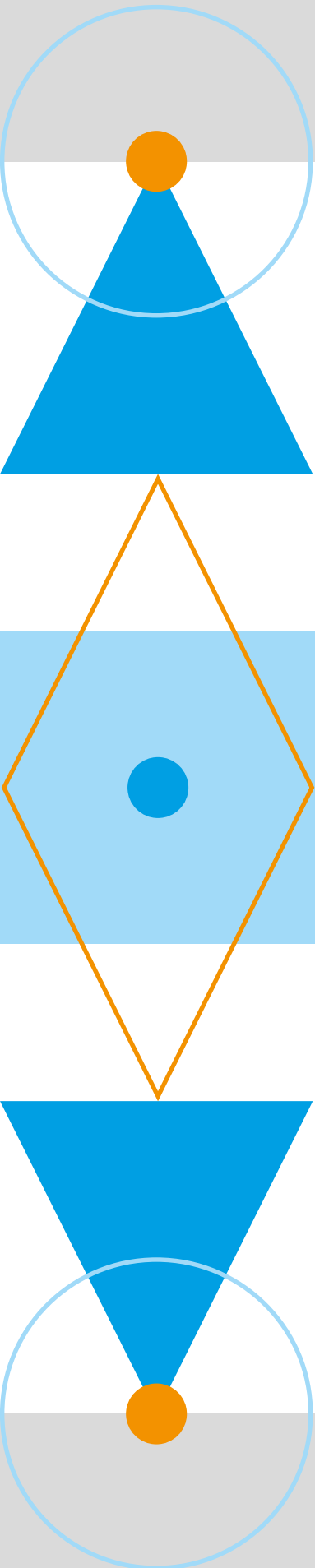
Effective emergency health advocacy

Paragraph ● 7.1 ● 7.2 ● 7.3 ● 7.4 ● 7.5 ● 7.6

Box ● 7.1 ● 7.2 **Figure** ● 7.1 **Table** ● 7.1 ● 7.2 ● 7.3

- Contents
- References
- Endnotes

Integrated programming for better health outcomes: a multisectoral approach



08

Contents

Chapter 8		
Integrated programming for better health outcomes: a multisectoral response		271
8.1 Rationale for integrated programming for better health outcomes		271
8.2 What is integrated programming for better health outcomes?		271
8.3 Applying a multisectoral approach for collective action and better health outcomes		277
8.3.1	Joint assessment and analysis of the situation	278
8.3.2	Planning a multi-cluster response	282
8.3.3	Incorporating advocacy as required	283
8.3.4	Resource mobilization	283
8.3.5	Implementation of a multisectoral integrated programme	284
8.3.6	Monitoring and evaluating a multisectoral response	285
8.4 Principles to enhance a multisectoral integrated response for improved outcomes		285
8.5 Health cluster coordination checklist to ensure a multisectoral, integrated response for collective action and better health outcomes		286
References		287
Endnotes		288
Boxes		
Box 8.1	Common features of humanitarian clusters	272
Box 8.2	Afghanistan and South Sudan: joint assessment and analysis	279
Box 8.3	Cox's Bazar, Bangladesh: joint analysis of gender-based violence services	282
Box 8.4	Joint operational framework for effective cholera preparedness and response	283
Box 8.5	Iraq: integrated programming to combat gender-based violence	284
Figures		
Figure 8.1	Integrated programming for better health outcomes	275
Figure 8.2	Afghanistan Humanitarian Response Plan, 2017: contributions of clusters to strategic objectives	277
Tables		
Table 8.1	Integration approaches: advantages and examples of activities	273

8. Integrated programming for better health outcomes: a multisectoral response

8.1 Rationale for integrated programming for better health outcomes

There is growing recognition that multisectoral integrated programming is essential for a coherent and effective humanitarian response. The 2016 Agenda for Humanity advocates that the humanitarian agencies move towards an approach of working jointly across sectors and mandates and across the emergency–development divide to deliver on collective outcomes (Agenda for Humanity, core responsibility 4c) (1).

The health status of a population is impacted by multiple factors far beyond the provision of preventive and curative health services. Additional factors directly impacting morbidity and mortality of the population in a humanitarian emergency include availability of water, sanitation and vector control, food security, preventive and curative nutrition services, and protection. Availability of adequate shelter and good camp management will also affect health status. Health interventions may be conducted through or in collaboration with schools, while logistic and telecommunications support will also significantly influence the effectiveness of a health response. Consequently, better health outcomes will require collective action from multiple clusters and sectors.

8.2 What is integrated programming for better health outcomes?

Integrated programming for better health outcomes refers to a way of working whereby there is coordination and strategic collaboration across two or more clusters or sectors with the goal of achieving better health outcomes through collective action. Box 8.1 presents some relevant features of humanitarian clusters.



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●

8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●

8.1 8.2 8.3 8.4 8.5

Figure ● ●

8.1 8.2

Table ●

8.1

- Contents
- References
- Endnotes

● Box 8.1 Common features of humanitarian clusters

Clusters should have a common understanding of the humanitarian context, implying agreement upon:

- *where* is it happening? geographical dimensions
- *who* are we talking about? vulnerabilities and other cross-cutting issues
- *what* are we talking about? service deliveries
- *when* will it happen? prioritization of interventions
- *how* can humanitarian actors best deliver as a consulted group? joint planning for common outcomes.

Clusters have common mandates:

- adherence to humanitarian principles and principles of partnership
- accountability to affected populations within a people-centred approach
- protection mainstreaming
- combating gender-based violence
- mental health and psychosocial support services
- cross-cutting issues, including age, HIV/AIDS, gender, disability, diversity
- advocacy.

Clusters may have common modalities for response implementation:

- provision of packages for multisectoral service delivery
- joint planning and integrated multisectoral response
- joint resource mobilization for multisectoral service delivery
- linked emergency response with development-oriented and durable solutions.

Integration, as a concept, has a number of different interpretations. It is therefore important to establish a shared understanding between clusters of what integration means. Different processes may promote the integration of activities and contribute to their implementation. A range of integration modalities may be applied depending on the context, the issues being addressed, and existing systems, policies and approaches. Table 8.1 provides examples of approaches to integration, the associated advantages and related activities.

C

1

2

3

4

5

6

7

8

9

10

11

12

13

Integrated programming for better health outcomes: a multisectoral approach

Paragraph

8.1 8.2 8.3 8.4 8.5

Box

8.1 8.2 8.3 8.4 8.5

Figure

8.1 8.2

Table

8.1

● Contents

● References

● Endnotes

► **Table 8.1** Integration approaches: advantages and examples of activities

INTEGRATION APPROACH	ADVANTAGES	EXAMPLES
Coherence	Duplication is minimized, ensuring that activities in one sector are not counterproductive for activities in another sector	Ensure the health cluster response plan is coherent with plans of other clusters and sectors Consider existing development programmes when planning the humanitarian response
Convergence	Interventions are aligned to achieve a common goal; each sector prioritizes actions with highest potential to contribute to that goal	Agree on common indicators for joint analysis Prioritize humanitarian needs and consequences Identify shared objectives within the humanitarian response plan
Complementarity	Action in one sector complements action in another sector, enabling increased overall effectiveness	Carry out joint assessments Implement joint targeting (for example, most vulnerable households or population subgroups) Develop joint response plan Develop joint preparedness plan
Combined	Combined effect of intervention exceeds the effect if separately implemented	Carry out joint evaluation Develop a comprehensive package of services covering all basic needs while reinforcing existing systems

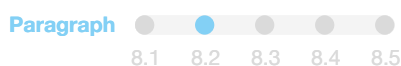
To increase the efficiency of integrated programming, an operational framework could be elaborated between different sectors, activities and beneficiaries, focusing on the same common aim.

Effective integrated programming for better health outcomes requires a number of sequential steps.

1. Carry out joint or harmonized assessment and joint analysis of the health status and vulnerability of the affected population and underlying contributory causes.
2. Jointly prioritize the most vulnerable geographical areas and target populations for a multisectoral integrated response.



Integrated programming for better health outcomes: a multisectoral approach



- [Contents](#)
- [References](#)
- [Endnotes](#)

3. For each geographical area and target population, jointly define the priority health problems and various interventions required to address the problems and their various contributory causes.
4. Define the specific responsibilities of each cluster or sector, and the strategic and operational linkages between the clusters and sectors for collective action.
5. Develop and implement an integrated response plan and budget, for increased cost-effectiveness.
6. Monitor and evaluate the integrated response plan in terms of progress towards the health outcomes, while addressing the potential for double counting in the monitoring and evaluation framework.
7. Ensure that, in most humanitarian contexts, the health cluster works at a minimum as part of an integrated response with the water, sanitation and hygiene (WASH), nutrition, protection, and food security clusters, and with the support of the logistics cluster.

The humanitarian context and the health status and vulnerability of a population, and consequently the goal of the intervention, will affect the level of collective action required with the various clusters. It is the responsibility of health cluster coordinators to reinforce work across clusters and towards collective action and outcomes. An effective multisectoral integrated response requires inter-cluster coordination at national, subnational and operational levels.

Figure 8.1 illustrates how integrated programming can lead to better health outcomes.



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

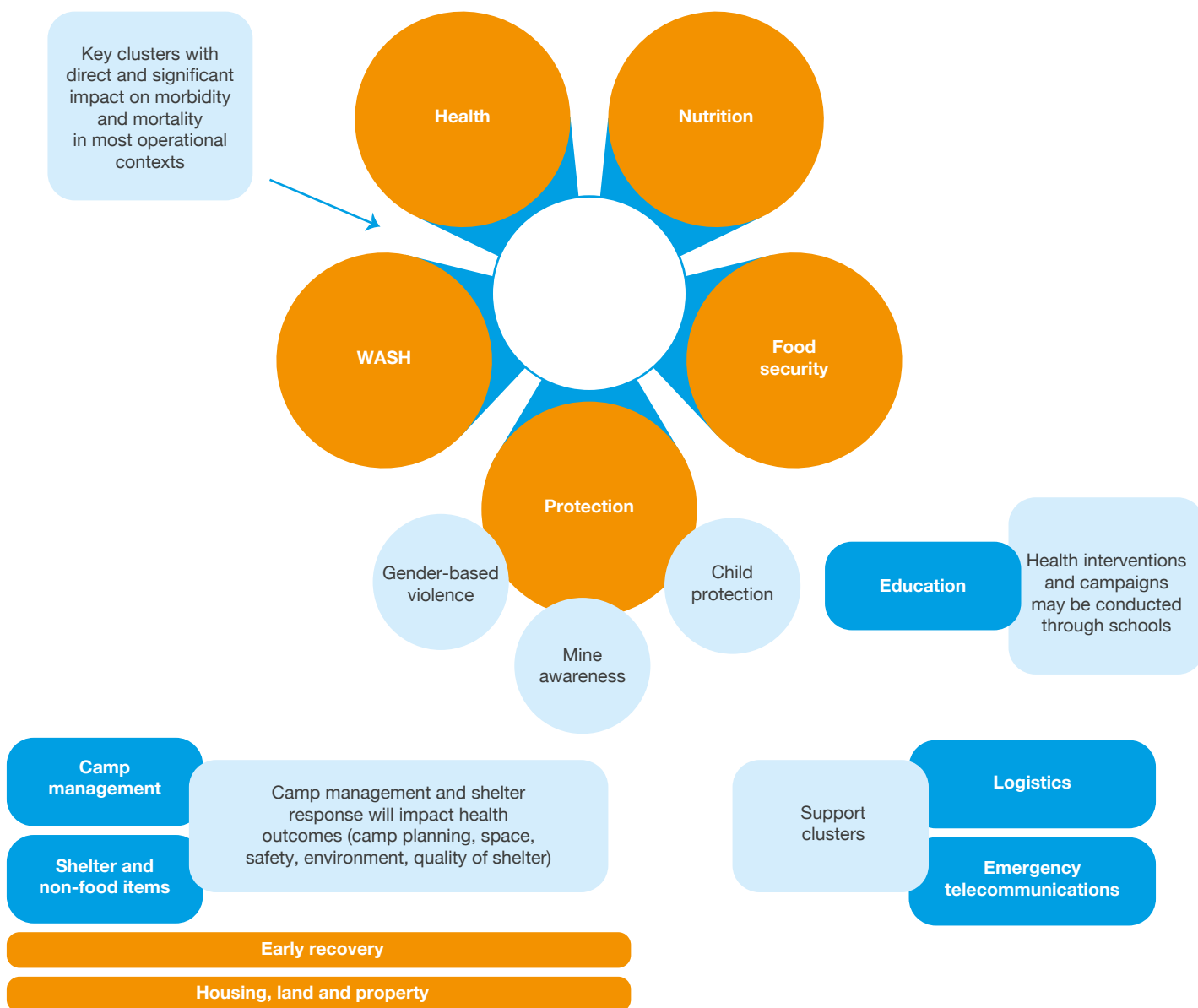
Box ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Figure ● ●
8.1 8.2

Table ●
8.1

- Contents
- References
- Endnotes

Figure 8.1 Integrated programming for better health outcomes



Integrated programming for better health outcomes: a multisectoral approach

Paragraph 8.1 8.2 8.3 8.4 8.5

Box 8.1 8.2 8.3 8.4 8.5

Figure 8.1 8.2

Table 8.1

- Contents
- References
- Endnotes

This figure illustrates the different ways that the various technical and support clusters may impact health outcomes in an emergency context. Some examples follow.

- The health, nutrition, protection, WASH, and food security clusters are key clusters that are likely to directly and significantly impact morbidity and mortality in operational contexts.
- The protection cluster ensures linkages between the psychosocial services provided through the protection cluster partners and mental health services provided by the health cluster partners.¹ Protection cluster interventions promoting safety have clear links to reducing incidence of violence.
- Increasing access to health services for survivors of gender-based violence and relevant referrals between the protection and health clusters will ensure that the health consequences (both mental and physical) of gender-based violence are addressed. The health consequences of violence are mitigated through multisectoral service provision coordinated across the two clusters.
- The shelter and camp management clusters will impact health outcomes. Overcrowded settlements can contribute to an increase in disease, while poor lighting and lack of safety considerations can contribute to risks of sexual violence, and poor site planning for hygiene and sanitation can lead to disease.
- The education cluster may be used as a platform to conduct health interventions and health education campaigns.
- All clusters have some shared objectives and goals and have shared advocacy mandates, for example the health, education and WASH clusters with regard to monitoring attacks on health facilities and schools.
- Ultimately, all clusters will be working towards achievement of one or more of the overarching strategic objectives outlined in the humanitarian response plan.

Figure 8.2 presents an example from the Afghanistan Humanitarian Response Plan, 2017, showing how each of the key clusters with responsibilities for reducing morbidity and mortality relate to the four strategic objectives outlined in the plan.



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

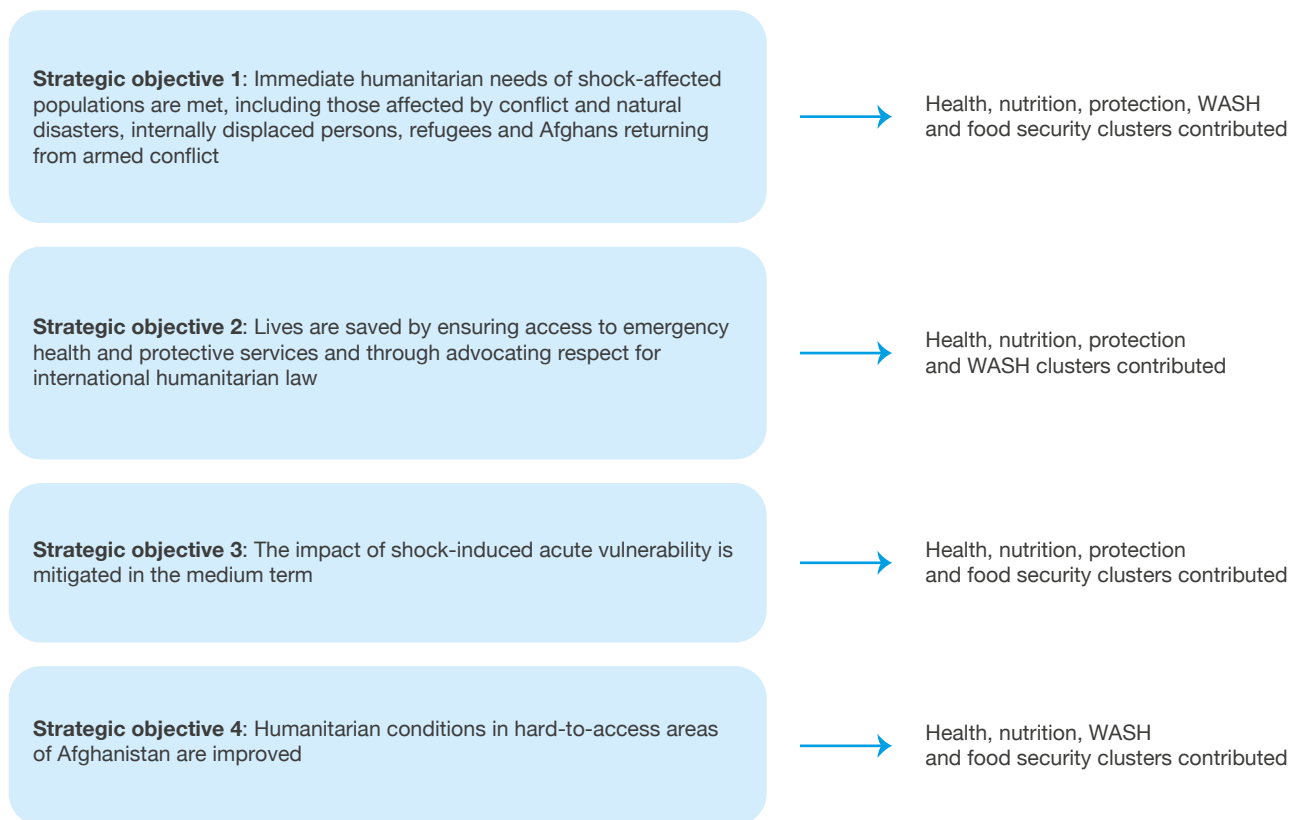
Box ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Figure ● ●
8.1 8.2

Table ●
8.1

- Contents
- References
- Endnotes

Figure 8.2 Afghanistan Humanitarian Response Plan, 2017: contributions of clusters to strategic objectives



8.3 Applying a multisectoral approach for collective action and better health outcomes

Effective integrated programming requires a multi-cluster, multisectoral approach through all stages of the Humanitarian Programme Cycle, including assessment and analysis, strategic planning, resource mobilization, implementation, and monitoring and preparedness.



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
 8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●
 8.1 8.2 8.3 8.4 8.5

Figure ● ● ● ● ●
 8.1 8.2

Table ● ● ● ● ●
 8.1

- Contents
- References
- Endnotes

8.3.1 Joint assessment and analysis of the situation

Joint assessment

Ideally, key clusters directly impacting morbidity and mortality will carry out a joint needs assessment.² However, joint assessments are not always possible, due to such factors as lack of simultaneous availability of key staff from key clusters, or limited opportunities to travel to the assessment area (for example, where air travel is necessary). In such situations, harmonized assessments would be a reasonable second alternative.

Multi-cluster or multisectoral joint assessments require careful planning and coordination. They take more time and involve more negotiation and compromise than a single sector assessment; nevertheless, the data analysis, triangulation and subsequent decision-making are easier when there is a shared experience. Joint assessments are also a good way to learn about the other participating clusters and sectors and discover areas of shared interest.

Joint analysis

After assessments are carried out, the key clusters directly impacting health outcomes should conduct a joint analysis of the situation.

- Where joint assessments have been conducted, the findings of the assessment should be discussed and agreed upon and used to identify priority geographical areas or vulnerable populations and the priority issues to be addressed.
- Where joint assessments have not been conducted for whatever reason, nevertheless, after assessment the key clusters should get together to conduct a joint analysis, during which the findings from each cluster assessment are presented, along with other relevant information (such as geographical displacement figures, availability of health and social services and access to safe drinking-water). The analysis will enable identification of priority geographical areas and vulnerable populations, and the priority issues to be addressed in the response.

Box 8.2 presents examples from Afghanistan and South Sudan of joint assessment and analysis.



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Figure ● ●
8.1 8.2

Table ●
8.1

- Contents
- References
- Endnotes

● **Box 8.2 Afghanistan and South Sudan: joint assessment and analysis**

Afghanistan: development of humanitarian needs overview, 2019

Several sector-specific information sources, as well as a multisectoral whole of Afghanistan assessment, provided a comprehensive evidence base for the 2019 Afghanistan humanitarian needs overview. The supporting data sets covered all provinces of Afghanistan and included health information and insights on hard-to-reach districts. As a nationwide, multisectoral assessment, the whole of Afghanistan assessment enabled the humanitarian needs overview not only to compare sectoral needs, but also to give a better understanding of how these needs interacted in different geographical areas. Various sector-specific assessments, including a specific health assessment, were able to build on this multisectoral foundation and expand on technical information that the whole of Afghanistan assessment was not able to provide. The assessment input was combined and triangulated with sector-specific technical studies, including for health.

South Sudan: joint analysis, 2011/2012

While the health, nutrition, food security and WASH clusters did not undertake joint assessments in South Sudan, these clusters regularly conducted joint analysis of the situation, coming together to share the various cluster assessment findings and analysis, which were then cross-tabulated to identify the priority geographical areas and vulnerable populations. This analysis was then fed into the development of the humanitarian response plan, and prioritization criteria for the key cluster response plans.

During joint analysis, the clusters should determine the status of the priority health problems and identify contributory causes. Examples are as follows.

High levels of diarrhoea in children aged under 5 years caused by:

- poor water quality and quantity;
- poor access to water (articulate why – for example, due to long distances to travel to collect water or high prices to pay for water);
- poor sanitation facilities and practices (articulate the situation – for example, open defecation close to houses);
- poor hygiene practices (articulate what these are – for example, generally limited use of soap for handwashing or poor practice in food preparation);
- poor infant and young child feeding practices (articulate what these are and why – for example, early weaning due to cultural norms or mother's older children caring for younger siblings as mothers go to work);
- poor nutritional status (see below).



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● 8.1 ● 8.2 ● 8.3 ● 8.4 ● 8.5

Box ● 8.1 ● 8.2 ● 8.3 ● 8.4 ● 8.5

Figure ● 8.1 ● 8.2

Table ● 8.1

- [Contents](#)
- [References](#)
- [Endnotes](#)

Increased reproductive health needs due to:

- increased risk of sexual violence during emergencies;
- withholding access to essential goods in exchange for sex;
- poor or no observation of standard precautions, allowing the transmission of sexually transmitted infections, including HIV, to patients or health workers;
- no referral system in place to transfer patients in need of basic or comprehensive emergency obstetric care;
- poor social and sexual behaviours and increased risk-taking behaviours;
- harmful traditional practices;
- stress and malnutrition.

Increased mental health and psychosocial support needs due to:

- pre-existing (pre-emergency) social and psychological problems, such as extreme poverty, belonging to a group that is discriminated against or marginalized, political oppression, severe mental disorder or alcohol abuse;
- emergency-induced social and psychological problems, such as family separation, disruption of social networks, destruction of community structures, resources and trust, increased gender-based violence, grief and non-pathological distress, and depression and anxiety disorders, including post-traumatic stress disorder;
- humanitarian aid-induced social and psychological problems, such as undermining of community structures or traditional support mechanisms, and anxiety due to a lack of information about food distribution (2).

High levels of acute malnutrition in children aged under 5 years due to:

- poor dietary intake (articulate why);
- poor infant and young child feeding practices (outline what these are);
- poor hygiene and care practices (articulate what these are);
- high burden of infectious diseases (articulate the main diseases among children aged under 5 years);



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Figure ● ●
8.1 8.2

Table ●
8.1

- Contents
- References
- Endnotes

- lack of access to affordable quality child health services (articulate why);
- lack of access to adequate quality and quantity of water (articulate why);
- poor environmental health (specify).

Gender-based violence due to:

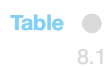
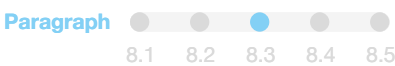
- lack of security, presence of conflict, or inadequate shelter, which can pose safety concerns;
- lack of access to resources to meet basic needs, which can drive sexual exploitation, early marriage and intimate partner violence;
- breakdown of social and protective networks;
- risks related to elements of WASH (water collection, latrine design) if gender-based violence standards are not incorporated;
- lack of protection services for survivors;
- underreporting due to sociocultural barriers, stigmatization, shame, fear of reprisal;
- other issues preventing survivors of gender-based violence from receiving health care to mitigate the consequences of violence (and therefore affecting health outcomes), including unsafe access to facilities, untrained staff, insufficient supplies and equipment, underreporting, lack of availability or awareness of services, and lack of referrals between various sectors (for example, in the areas of gender-based violence, health and child protection) (3).

Articulating the various contributory causes of priority problems facilitates the development of an appropriate multisectoral integrated response plan.

Box 8.3 presents an example from Bangladesh of how joint analysis of gender-based violence services contributed to improved planning to counteract the problem.



Integrated programming for better health outcomes: a multisectoral approach



- [Contents](#)
- [References](#)
- [Endnotes](#)

● **Box 8.3 Cox's Bazar, Bangladesh: joint analysis of gender-based violence services**

In Cox's Bazar, Bangladesh, in 2019, the health sector and the protection sector conducted a joint analysis of the quality of gender-based violence services within primary health care facilities. The health sector working group convened workshops with members from the reproductive health working group, the mental health and psychosocial support working group, the gender-based violence subsector and the child protection subsector to develop an assessment tool, adapted from existing gender-based violence quality assurance tools, that would holistically capture the full range of survivor needs. The joint analysis also assessed selected facilities based on priority standards. By collaborating across clusters, the team members were able to leverage their technical expertise to assess whether the health services met standards for the provision of clinical care, were survivor-centric and child-friendly, and were sufficiently integrated with mental health and psychosocial support services. In taking forward recommendations from this assessment, the health sector was able to ensure that health action plans were fully informed by broader multisectoral concerns.

8.3.2 Planning a multi-cluster response

Based on joint analysis, key clusters should work jointly to:

- prioritize the most vulnerable geographical areas and target populations for a multi-cluster integrated response leading to better health outcomes;
- agree on the priority problems;
- reach consensus on the interventions required by each cluster or sector to address the problems and the various underlying causes;
- formulate a joint operational framework outlining the shared objectives and respective responsibilities of each cluster to fulfil the objectives, and how the key clusters will interact with each other operationally (to be adapted from available global frameworks);
- develop an integrated response plan based on the joint operational framework, including benchmarks, standards, indicators and arrangements to monitor progress towards achieving collective outcomes.

Tools exist to assist with analysis and planning a multisectoral, integrated response for better health outcomes. Box 8.4 presents an example.



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Figure ● ●
8.1 8.2

Table ●
8.1

- **Contents**
- **References**
- **Endnotes**

● **Box 8.4 Joint operational framework for effective cholera preparedness and response**

The joint operational framework defines the responsibilities and accountabilities of the health and WASH clusters during emergency response in areas of potential overlap.

The objectives are to:

- clarify responsibilities and accountabilities between both clusters, especially as they relate to cholera prevention, preparedness and response actions;
- improve coordination and collaboration among health and WASH field staff during emergency operations.

Source: Global Health and Global WASH Clusters (4).

8.3.3 Incorporating advocacy as required

The health cluster may need to carry out advocacy with one or more of the technical clusters to enlist their engagement in integrated response programming, and with the logistics and emergency telecommunications clusters to ensure necessary logistical and telecommunications support for an effective response.³

8.3.4 Resource mobilization

The implementation of collective activities in the health and other clusters may have significant cost implications. Funding the needs assessment and planning components within the humanitarian mechanism is one of the main challenges, especially in protracted crises. Donors are increasingly interested in supporting programmes that bring measurable results for affected populations through joint action and improved service coverage, thereby reducing duplication of effort and increasing the effectiveness of interventions.

Some aspects should be considered for joint resource mobilization.

- Are there any activities to build capacity on technical aspects of the other sectors (for example, WASH providing training to health) included in the funding processes?
- Are there joint funding proposals (including pooled funds)?
- Is there joint advocacy to encourage donors to fund inter-cluster integration initiatives?



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Figure ● ●
8.1 8.2

Table ●
8.1

- **Contents**
- **References**
- **Endnotes**

8.3.5 Implementation of a multisectoral integrated programme

Each cluster and sector will be responsible for implementing activities and coordinating and collaborating with other clusters in line with the joint operational framework and integrated response plan.

There are many forms of integrated programming. For example, the convergence model focuses on the geographical co-location of the emergency response from several clusters, with services targeting the jointly identified beneficiaries and providing a standard agreed minimum package. For defining the package, agreement should be reached on the selection criteria for the beneficiaries and the most affected and vulnerable locations, and on the identification of activities at administrative level, while incorporating relevant protection issues. The Yemen Integrated Programming for Famine Risk Reduction (5) provides an example (6): priority districts were identified using specific selection criteria (evidence-based global acute malnutrition rate and food security contributing factors).

Another approach to integrated programming is results-focused programming,⁴ which is an approach designed to improve programme delivery and strengthen management effectiveness, efficiency and accountability, based on clearly defined and measurable intended results and impact, rather than on planned activities. It supports moving the focus of programming, managing and decision-making from inputs and processes to the *objectives to be met*: for example, reduced mortality due to a reduction in severe acute malnutrition rates and waterborne and communicable diseases. At the planning stage, results-focused programming ensures that relevant interventions are in place to achieve an expected result. During the implementation stage this approach ensures and monitors that all available financial and human resources continue to support the intended results.

Box 8.5 gives an example from Iraq of integrated programming.

● **Box 8.5 Iraq: integrated programming to combat gender-based violence**

In Iraq, the health cluster promoted increased multisectoral coordination on gender-based violence by establishing a focal point for gender-based violence. This focal point was a member of the health cluster but attended the gender-based violence subcluster meetings and was responsible for sharing information between the two and identifying issues that required joint action. This resulted in greater collaboration around the humanitarian needs overview process and better integration of gender-based violence objectives within the health section of the 2019 Humanitarian Response Plan. In 2019, the health cluster also produced an advocacy paper highlighting key messages for the health sector to take forward to better address gender-based violence.



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Figure ● ●
8.1 8.2

Table ●
8.1

- Contents
- References
- Endnotes

8.3.6 Monitoring and evaluating a multisectoral response

Regular monitoring information should be collated from each of the clusters, and the performance and outcome of the whole response and individual interventions in terms of achieving collective outcomes should be analysed jointly on a regular basis (monthly or quarterly), and programming interventions adapted as appropriate.

8.4 Principles to enhance a multisectoral integrated response for improved outcomes

A collective outcome is a jointly envisioned result with the aim of addressing needs and reducing risks and vulnerabilities, requiring the combined efforts of humanitarian, development and peacebuilding communities and other actors as appropriate (7).

- Outcomes should be needs based and target those furthest behind – focus will be on those who are most vulnerable.
- Outcomes should be quantifiable, with clear lines of accountability.
- Outcomes should take into consideration age, gender and diversity.
- Involvement must “do no harm” and be consistent with the norms of accountability to affected populations.
- Involvement of civil society, local communities and beneficiaries in planning and implementation for better health outcomes is good practice.
- Implementation should consider comparative advantage, including that of local actors – health cluster partners’ mandates, capacities and expertise will be analysed for this purpose.
- Joint operational frameworks for common response scenarios should be used to assist with planning multi-cluster responses. These frameworks aim to identify common entry points for integration. They should be used flexibly and adapted to the specific country context.
- Multi-cluster integrated programming is to be incorporated in the humanitarian health response plan, preparedness and contingency plans, and the humanitarian health response monitoring and evaluation framework.



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●

8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●

8.1 8.2 8.3 8.4 8.5

Figure ● ●

8.1 8.2

Table ●

8.1

- Contents
- References
- Endnotes

8.5 Health cluster coordination checklist to ensure a multisectoral, integrated response for collective action and better health outcomes

1. What are the priority interventions (from health and other clusters) for better health outcomes in this specific context?
2. Which clusters are responsible for the various interventions?
3. Have each of these responsible clusters been engaged in:
 - carrying out joint or harmonized assessment and analysis;
 - agreeing on the priority geographical areas and target populations for a multisectoral, integrated response for collective action and better health outcomes;
 - developing an integrated response plan, with budget;
 - agreeing a multi-cluster monitoring and evaluation mechanism (benchmarks, indicators, reporting, monitoring and review process)?
4. What advocacy is required with stakeholders from each of the various clusters to promote multisectoral, integrated programming for collective action and better health outcomes?
5. Is the integrated response plan guiding, and being incorporated into, the emergency health response?
6. Is the multi-cluster monitoring and evaluation plan being used to monitor the emergency health response?
7. Does the health cluster coordinator (or someone representing the health cluster) routinely attend and participate in meetings of each of the clusters that directly impact morbidity and mortality?
8. Do the various coordinators (or their representatives) from each of the clusters directly impacting morbidity and mortality attend and actively participate in the health cluster meetings?
9. Are there other key actions required to enhance multi-cluster and multisectoral integrated programming, and if so, what are they, and are there plans to address these actions?



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●

8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●

8.1 8.2 8.3 8.4 8.5

Figure ● ●

8.1 8.2

Table ●

8.1

- Contents
- References
- Endnotes

References

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Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Box ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Figure ● ●
8.1 8.2

Table ●
8.1

- Contents
- **References**
- Endnotes

Endnotes

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- 2. See Chapter 10 on needs assessment.
- 3. See Chapter 7 on advocacy.
- 4. United Nations Development Assistance Framework Guidance. Key approaches for integrated programming, pp. 13–16: https://procurement-notices.undp.org/view_file.cfm?doc_id=120296.



Integrated programming for better health outcomes: a multisectoral approach

Paragraph ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

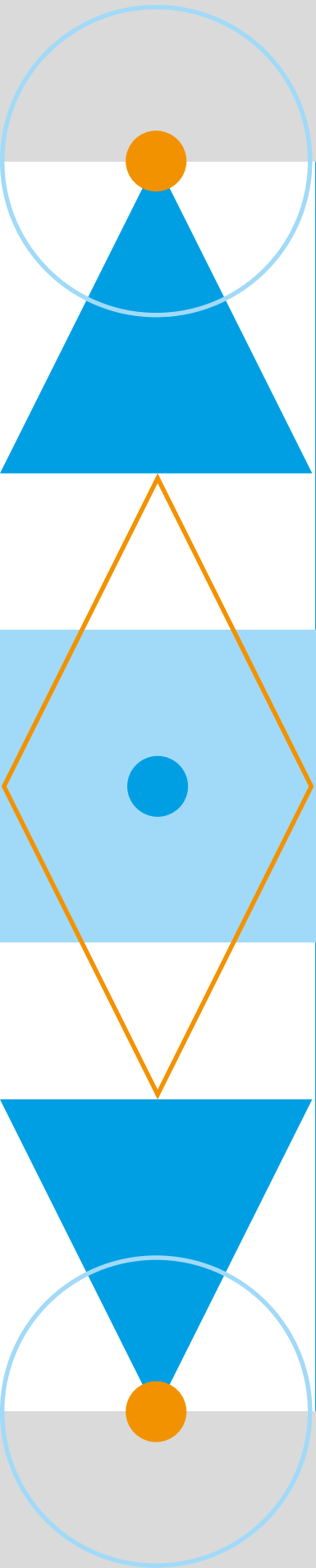
Box ● ● ● ● ●
8.1 8.2 8.3 8.4 8.5

Figure ● ●
8.1 8.2

Table ●
8.1

- Contents
- References
- Endnotes

Health cluster in emergency preparedness



09

Contents

Chapter 9		
Health cluster in emergency preparedness		291
9.1 Role of health cluster in health emergency and disaster risk management		291
9.1.1	What is emergency preparedness and when does it happen?	291
9.1.2	Continuum of health emergency and disaster risk management measures	292
9.1.3	Why should the cluster be involved in emergency preparedness?	294
9.1.4	Role of the health cluster in emergency preparedness	295
9.2 Preparedness activities		300
9.2.1	Emergency Response Preparedness (ERP) and contingency planning	300
9.2.2	Role of the health cluster coordinator	300
9.2.3	Health cluster preparedness activities in support of national emergency preparedness	301
References		308
Resources		309
Figures		
Figure 9.1	Humanitarian Programme Cycle	293
Figure 9.2	Activities enhancing the level of emergency preparedness	298
Figure 9.3	Contingency planning: functions and objective	302

Abbreviations

ERP	Emergency Response Preparedness
HC	humanitarian coordinator
HeRAMS	Health Resources and Services Availability Monitoring System
IASC	Inter-Agency Standing Committee
IHR	International Health Regulations
INFORM	Index for Risk Management
NGO	nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
RC	resident coordinator
SPAR	State Parties Self-Assessment Annual Reporting (tool)
STAR	Strategic Tool for Assessing Risks
WHO	World Health Organization

9. Health cluster in emergency preparedness

9.1 Role of health cluster in health emergency and disaster risk management

Emergency preparedness forms part of broader health emergency and disaster risk management, which covers the wide range of capacities that countries and communities should have in place to manage the health risks and consequences of emergencies. These include risk mitigation, emergency prevention, preparedness (including operational readiness), and response and recovery measures. The health cluster’s contribution to the overall health emergency and disaster risk management in a country will depend on the role that it plays in the country context. The focus of this chapter is on the health cluster’s role in emergency preparedness.

9.1.1 What is emergency preparedness and when does it happen?

In 2016 the United Nations General Assembly adopted the following definition of preparedness:

The knowledge and capacities developed by governments, professional response and recovery organizations, communities and individuals to effectively anticipate, respond to, and recover from, the impacts of likely, imminent or current hazard events or conditions.

The annotation to the definition notes:

Preparedness action is carried out within the context of disaster risk management and aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response to sustained recovery. Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes such activities as contingency planning, the stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises. These must be supported by formal institutional, legal and budgetary capacities. The related term “readiness” describes the ability to quickly and appropriately respond when required (1).

In recent years, the term “operational readiness” has put greater attention on ensuring that countries, communities and organizations are ready to respond to imminent risks, including those that have the potential to cross international borders and spread within a country. For most of this chapter, the term “emergency preparedness” will encompass both “preparedness” and “operational readiness”, except where there is need to give emphasis to operational readiness.



Health cluster in emergency preparedness

Paragraph ● ○

9.1 9.2

Figure ○ ○ ○

9.1 9.2 9.3

- Contents
- References
- Resources

The health sector’s role in emergency preparedness is well articulated in several global frameworks, including the International Health Regulations (2005) (2); the Sendai Framework for Disaster Risk Reduction, which made health a central focus, including for Priority 4: “Enhancing disaster preparedness for effective response and to ‘Build Back Better’ in recovery, rehabilitation and reconstruction” (3); the World Health Organization (WHO) Health Emergency and Disaster Risk Management Framework (4); and the WHO Strategic Framework for Emergency Preparedness (5).

9.1.2 Continuum of health emergency and disaster risk management measures

Emergency and disaster risk management requires a spectrum of measures that enable countries and communities to reduce the health risks and consequences of emergencies. While “disaster management” has often been considered as a cycle with distinct phases, for example, starting from prevention to preparedness to response to recovery, followed by return to prevention and preparedness, the reality is more complex, with many types of measures taking place simultaneously in a given country context. A key point is that recovery is often accompanied by greater stabilization in the emergency-affected area, thus enabling more focus on development work and drawing on lessons learned from emergency response to reduce risks and prepare for future events. This is a key area where the health cluster can support actions in the humanitarian–development nexus.

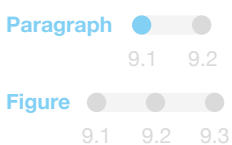
The complexity of emergencies and disasters can be demonstrated by examples, such as the earthquake and resulting tsunami in eastern Japan in 2011, where the tsunami resulted in a nuclear emergency at the Fukushima Daiichi nuclear power plant; Somalia’s protracted emergency, in which conflict is compounded by natural hazards (such as flood and drought) and disease outbreaks (for example, cholera); and the recent Ebola virus disease crises in Africa (2014 and 2018), which have seen simultaneous outbreaks of diseases, including measles, in fragile settings with weakened health systems compounded by insecurity in countries.

In effect, emergency preparedness measures are needed continuously to anticipate and ensure operational readiness in countries and subnational areas, which need to be ready to respond when a new event occurs or there is an imminent risk. Countries need to be prepared for events that may occur during protracted crises, for example, a flood or outbreak in a conflict-affected area. In principle, emergency prevention, mitigation and preparedness measures will reduce hazards and vulnerabilities and mitigate the impact of events on public health and society.

Should these actions be effective, then the likelihood and consequences of events will be reduced, and the time needed to return to development will be shorter. The Humanitarian Programme Cycle (Figure 9.1) also depicts this idea



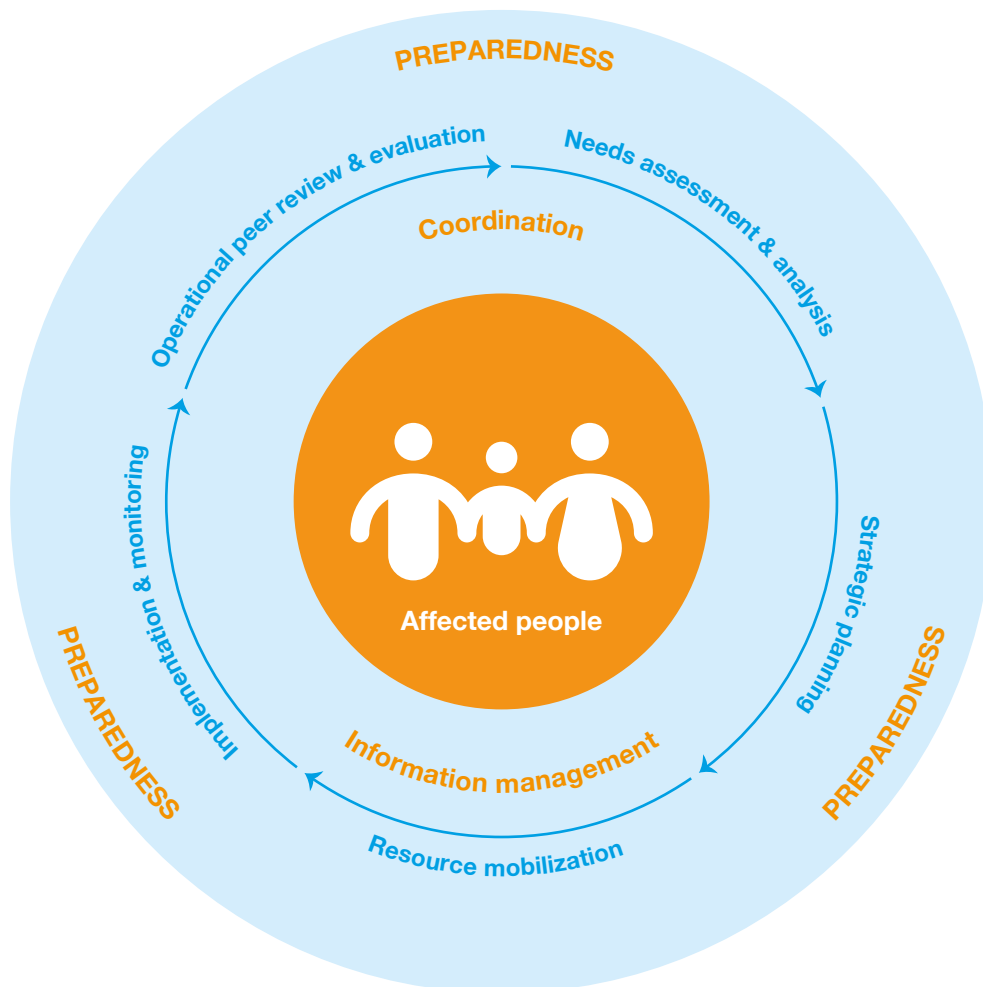
Health cluster in emergency preparedness



- [Contents](#)
- [References](#)
- [Resources](#)

whereby emergency preparedness is a cross-cutting element during all phases of humanitarian programmes. This would then lead into recovery measures for longer-term strengthening of communities, countries and systems to ensure that they are more resilient to future shocks.

Figure 9.1 Humanitarian Programme Cycle



This approach is very much applicable to the health sector. In emergency situations, populations need to have access to adequate health care services for the injuries, illnesses and noncommunicable diseases that are directly and indirectly related to the event. Therefore, health systems need to be prepared to provide a range of health care services to cope with small-scale and large-scale events and to organize an effective response to emergencies, including emergency response plans, emergency operations centres, business continuity plans, early warning systems and mass casualty management. Also, the safety and security of health facilities needs to be factored into health system design to ensure they are



Health cluster in emergency preparedness

Paragraph 9.1 9.2

Figure 9.1 9.2 9.3

- Contents
- References
- Resources

protected from attacks in times of emergencies. Community preparedness and community awareness of the need to protect health care prior to the event could help avoid such attacks, as can be seen in the Democratic Republic of the Congo today. When health systems are unprepared, the health consequences of such crises can be extreme. Effective health emergency and disaster risk management, with a focus on prevention, preparedness and operational readiness, has shown that emergencies and their health consequences can be averted and minimized.

9.1.3 Why should the cluster be involved in emergency preparedness?

The cluster mechanism is a conduit or platform for enacting the Humanitarian Programme Cycle, which recognizes that emergency preparedness happens throughout the cycle (see Figure 9.1).

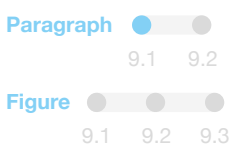
Emergency preparedness is a national responsibility as part of a country's multisectoral emergency and disaster risk management systems. The roles of international partners are often integrated into national multisectoral disaster management strategies. In the health sector, health emergency preparedness should also form part of the national health sector plans, national action plans for health security, and other strategies related to health in emergency and disaster risk management.

The health cluster addresses emergency preparedness under its humanitarian mandate and, within its role in emergency preparedness, can also contribute to and align with the national processes referred to above. The health clusters need to understand the context of the country, discuss relevant issues with the WHO country teams and emergency medical teams, and see how they can link into those processes. In most contexts, the health cluster role focuses on emergency preparedness for other events or risks that can materialize, while the health cluster is active in the response to continuing acute or protracted emergencies. Planning for health emergency preparedness should be based on risk assessments and capacity assessments, which may include voluntary joint external evaluation and annual reporting by States Parties under the International Health Regulations (IHR) Monitoring and Evaluation Framework. As a key stakeholder in the country for health emergency preparedness and response, the health cluster may be approached to participate in risk assessments and contribute information on risks and capacities to these assessments (2).

The Cluster Coordination Reference Module of the Inter-Agency Standing Committee (IASC) (6) describes the different contexts that would decide the preparedness responsibilities of clusters. They are as follows:



Health cluster in emergency preparedness



- Contents
- References
- Resources

- **Countries with a humanitarian coordinator (HC).** Under the HC’s leadership, clusters or sectors should be contributing to implementation of all measures for emergency preparedness and contingency planning and engaging with national structures.
- **Countries with a resident coordinator (RC) at high risk of emergency.** Under the guidance of the RC and in close cooperation with government, sector coordination mechanisms should help to operationalize relevant parts of emergency preparedness and contingency planning.
- **Countries with an RC at low risk of emergency.** The RC and sector lead agencies should promote coordination and preparedness actions in relevant sectors, using the risk profile, and assist government and sectoral counterparts to plan how they will cooperate in the event of a crisis.

In support of national efforts to strengthen preparedness, the health cluster coordinator is responsible for engaging cluster partners in operational readiness, so the cluster is ready and able to provide a timely and effective response to imminent risks and events. The preparedness of the health cluster should also extend to the early recovery phase. In cases where there are no existing health clusters in the country (that is, countries with an RC at low risk of emergency), the global lead health agency should ensure that emergency preparedness measures are in place in support of national authorities such as the ministry of health, and assist in bringing together international and national partners present in the country to strengthen emergency preparedness, as well as identifying potential partners that could become a health cluster standby partner in case of need.

9.1.4 Role of the health cluster in emergency preparedness

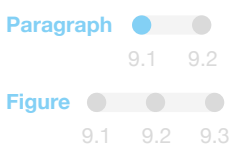
Understanding the context

As the health cluster is one of the key platforms for operationalizing emergency preparedness work in countries, it is important for the health cluster coordinator to understand the country context and where the health cluster’s preparedness work fits within the bigger picture in health and other sectors.

Within the overall framework of emergency and disaster risk management, the health sector aims to increase capacities to manage the risks and consequences of emergencies. It is important to ensure that the work of the cluster is in line with the national and subnational systems and policies in place.



Health cluster in emergency preparedness



- [Contents](#)
- [References](#)
- [Resources](#)

Defining the role of the health cluster

In defining the role of the health cluster, answers are needed to the following questions:

- What policies, strategies and legislation are currently in place in the country?
- What planning and coordination structures are already in place?
 - national disaster management authority and where health sits within this structure;
 - public health emergency operations centre and its linkages with the national incident management system;
 - national disaster management authority;
 - health sector emergency management coordination and structures;
 - subnational-level structures;
 - IHR national focal point and disease-specific task forces;
 - incident management structures in country;
 - coordination structures with international partners and national and civil societies;
 - national- and subnational-level health emergency response plans and contingency plans.
- What other initiatives and efforts are being undertaken by WHO country teams, regional offices, and emergency medical teams (to determine gaps and prioritize health cluster involvement)?
- What is the overall health profile of the country?
 - country health status across a range of indicators;
 - health emergency risk profiles, such as risk assessments, maps, Index for Risk Management (INFORM);
 - existing multi-hazard health emergency disaster risk management capacities in the health sector, including capacities for managing outbreaks and implementing the IHR (voluntary joint external evaluation and annual reporting by States Parties);
 - national health sector response capacities;
 - subnational and community emergency management capacities;
 - human resources;
 - financing for emergency preparedness and response;
 - health infrastructure (including health facilities) and logistics;



Health cluster in emergency preparedness

Paragraph

9.1 9.2

Figure

9.1 9.2 9.3

- [Contents](#)
- [References](#)
- [Resources](#)

- health and related services and the plans for mobilizing these in emergency situations (for example, mechanism for requesting and receiving international assistance);
 - studies of public health determinants, behavioural risk factors, anthropological studies.
- What information management systems are in place for emergencies?

Sources of information

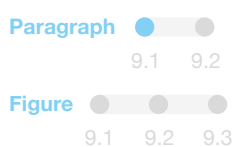
Sources for obtaining such information could include the following:

- national and health sector strategic risk assessment;
- national and health sector country capacity assessment for disaster risk management and core capacities for IHR (voluntary joint external evaluation and annual reporting by States Parties) and Health Resources and Services Availability Monitoring System (HeRAMS);
- national policies, strategies and plans, including for the health sector;
- national health emergency and disaster risk management strategies, national action plans for health security;
- health statistics bureau, health information management system;
- humanitarian country team, United Nations Office for the Coordination of Humanitarian Affairs (OCHA) database, emergency response plans, strategic response plans (where available), and Surveillance System for Attacks on Health Care;
- after-action reviews, simulation exercises (recommendations);
- World Bank database.

Given the health cluster focus on emergency preparedness (including operational readiness), the activities presented in Figure 9.2 are expected to enhance the level of emergency preparedness.

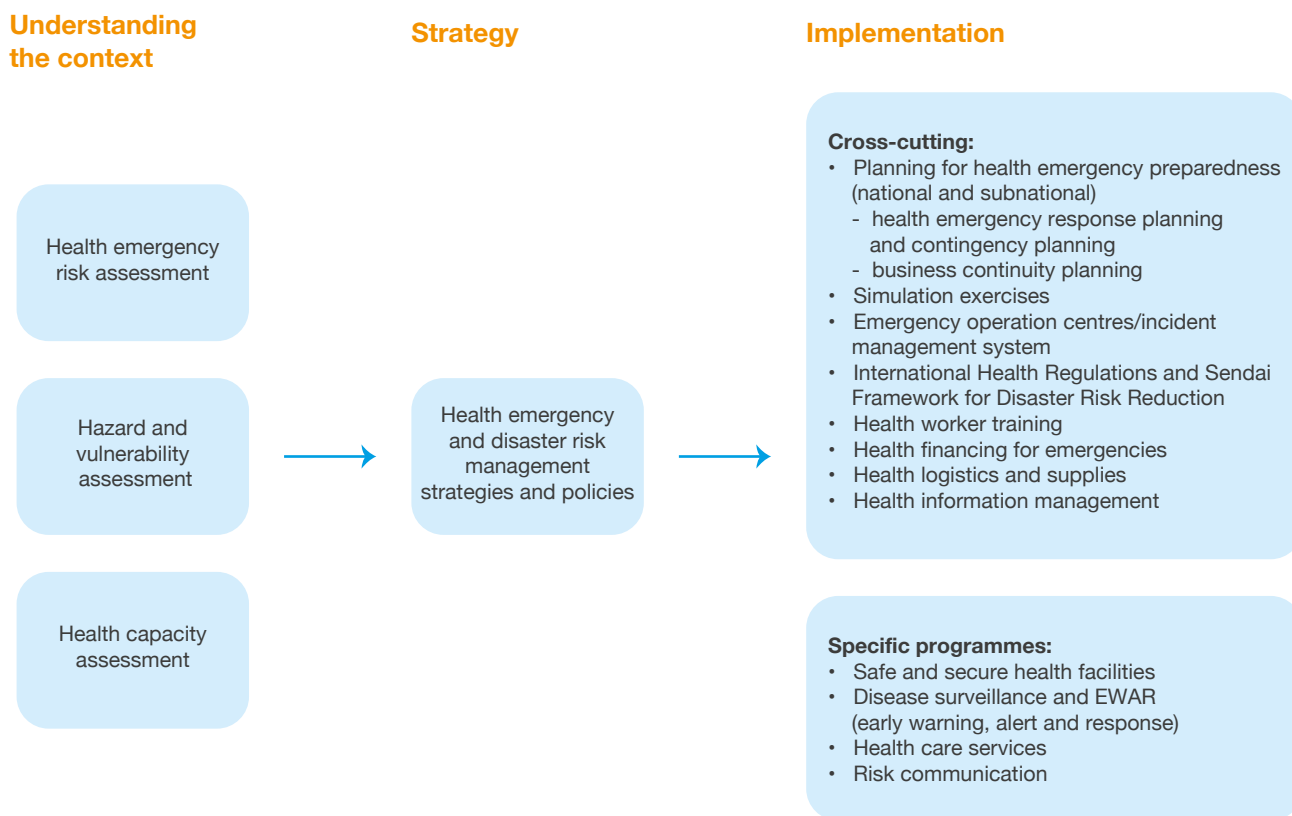


Health cluster in emergency preparedness



- [Contents](#)
- [References](#)
- [Resources](#)

Figure 9.2 Activities enhancing the level of emergency preparedness



Health cluster coordinator’s role in emergency preparedness

The health cluster coordinator’s role in emergency preparedness is as follows:

- identify key elements in the humanitarian programme cycle that require preparation in advance, such as prepositioning of key items and supplies;
- participate in analysing and addressing anticipated risks to countries, populations and operations and represent the health cluster partners;
- ensure that health elements are fully integrated into risk assessments, including biological risks (outbreaks);
- participate in emergency preparedness (and operational readiness) activities, for example capacity assessments (including voluntary joint external evaluations under the IHR Monitoring and Evaluation Framework), response planning, and exercises;



Health cluster in emergency preparedness

Paragraph 9.1 9.2

Figure 9.1 9.2 9.3

- Contents
- References
- Resources

- establish good working relationships with national authorities, accept their leadership where appropriate, and take fully into account their preparedness and response arrangements;
- establish good working relationships with other partners and sectors whose cooperation will be critical in a response, including other sectors and clusters;
- reinforce the coordination structures that will be used during a response and, where appropriate, support the work to ensure that the coordination structure in countries is in line with the cluster approach;
- clarify the roles and responsibilities of different members of the health cluster partners, including responsibilities vis-à-vis national authorities;
- develop and regularly update the 4W Matrix for health partners in the country to have a clear vision regarding as to which organizations (“who”) are carrying out which activities (“what”) in which locations (“where”) and at what times (“when”).

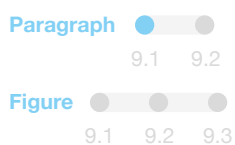
Who should be involved in emergency preparedness?

The following partners should be involved in emergency preparedness:

- national and local partners:
 - national disaster management authorities
 - ministries of health and national health authorities
 - health institutions
 - medical and nursing associations
 - hospitals and health facilities
 - private sector
 - national nongovernmental organizations (NGOs) and civil society
 - communities
 - International Red Cross and Red Crescent Movement
 - army and civil protection agencies
 - relevant sectors such as nutrition and water, sanitation and hygiene
 - other related agencies and bodies.



Health cluster in emergency preparedness



- [Contents](#)
- [References](#)
- [Resources](#)

- international partners:
 - HC/RC and IASC partners
 - international agencies
 - international NGOs
 - regional organizations
 - other related agencies and bodies.

9.2 Preparedness activities

9.2.1 Emergency Response Preparedness (ERP) and contingency planning

One of the main tools in place for preparedness in countries is the Emergency Response Preparedness (ERP) tool (7). The ERP was developed to replace the Inter-Agency Contingency Planning Guidelines for Humanitarian Assistance (8). The ERP is designed to “foresee emergencies that are likely to occur and pre-plan key components of a response”. The ERP has three key components: risk analysis and monitoring, minimum preparedness actions, and advanced preparedness actions and contingency planning. These three components will be discussed further below.

In countries that are at low to medium risk, the ERP process may stop at the level of minimum preparedness actions. In countries that are at higher risk of emergencies, or are currently responding to an event, the advanced preparedness actions and contingency planning may be further developed for immediate to medium-term actions.

9.2.2 Role of the health cluster coordinator

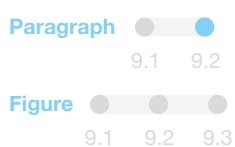
The health cluster coordinator should be involved in all components and ensure that health elements are well reflected in risk analysis and monitoring as well as in the minimum preparedness actions. The contingency planning section allows each sector to come up with a more detailed plan for responding to potential hazards.

Further information about the three key elements of the ERP follows.

Risk analysis and monitoring. Understanding the country- and context-specific risks that may trigger a crisis is a fundamental part of ERP. Analysis helps to identify hazards and create a risk ranking, while monitoring provides an early warning system to trigger early action. This includes providing an overall analysis and monitoring normally conducted by the national disaster management authority or its equivalent with support from the United Nations country team or humanitarian country team.



Health cluster in emergency preparedness



- [Contents](#)
- [References](#)
- [Resources](#)

For the health cluster, the information gained from this exercise can be overlaid with health information to analyse the health vulnerabilities and risks, which will then guide the health cluster’s planning processes.

Minimum preparedness actions. These are a set of general activities implemented by the humanitarian country team and requiring few additional resources. Implementation of minimum preparedness actions provides a baseline for maintaining readiness and flexibility to respond to potential emergencies. The overall process for this is normally conducted under the leadership of the national disaster management authority, with support from the HC and humanitarian country team.

For the health cluster, it is important to ensure that health is part of this process.

Advanced preparedness actions and contingency planning. These are complementary activities initiated concurrently to plan for perceived high-risk situations. Advanced preparedness actions are risk specific and increase readiness in response to early warning, whilst a contingency plan sets out a needs-specific strategy for the first days of an unfolding emergency.

For the health cluster, health sector contingency planning and advanced preparedness actions are critical to ensure the quality of the health response.

9.2.3 Health cluster preparedness activities in support of national emergency preparedness

As indicated above, there are a number of health cluster preparedness activities that can support national emergency preparedness, including assessments, planning, simulation exercises, training, and prepositioning of supplies.

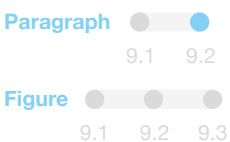
Contingency plan: definition and purpose

What is a contingency plan?

A contingency plan “sets out the initial response strategy and operational plan that would ... meet critical humanitarian needs during the first three to four weeks of an emergency, should a scenario materialize” (6). As the focus of contingency plans is on specific scenarios they should be based on multi-hazard emergency response plans, which are generic in nature and form the foundation of response to any type of emergency.



Health cluster in emergency preparedness

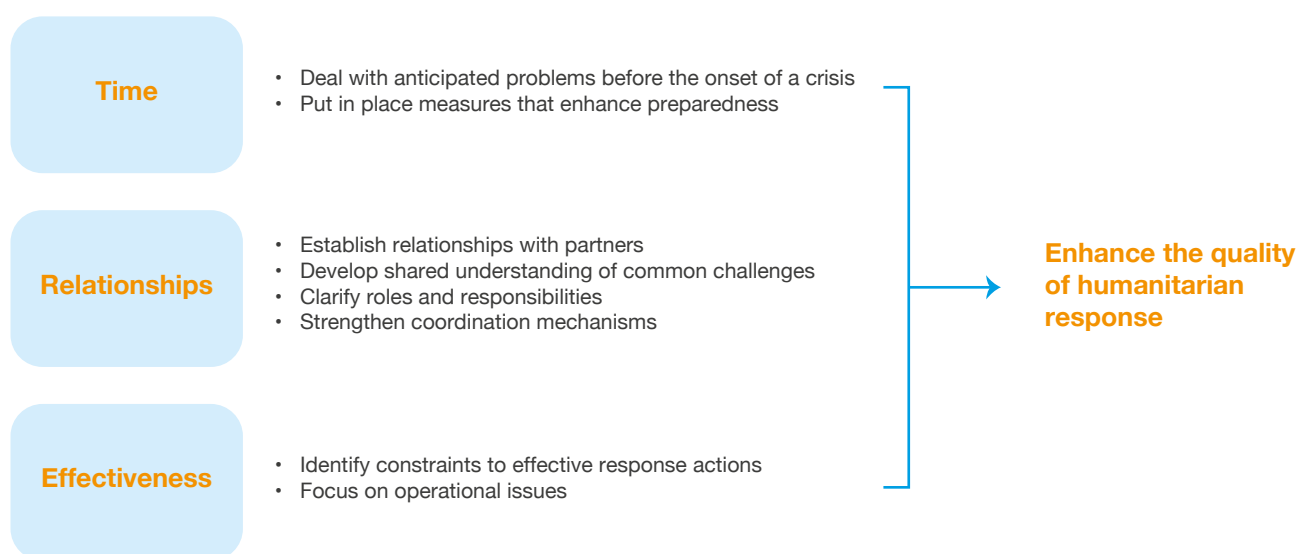


- [Contents](#)
- [References](#)
- [Resources](#)

- Contingency planning is a management tool used to analyse the impact of potential crises and ensure that adequate and appropriate arrangements are made in advance to respond in a timely, effective and appropriate way to the needs of the affected population(s) for specific scenarios.
- Contingency planning is a tool to anticipate and solve problems that typically arise during humanitarian response for specific scenarios.

Figure 9.3 presents the functions and overall objective of a contingency plan.

Figure 9.3 Contingency planning: functions and objective



Why are contingency plans needed?

Contingency plans are needed to ensure a timely response that is conducted effectively within an enabling relationship with relevant partners, including the national and local authorities for specific scenarios. The following are some key steps to be taken by the health cluster coordinator for the development of the health sector contingency plan.



Health cluster in emergency preparedness

Paragraph ● 9.1 ● 9.2

Figure ● 9.1 ● 9.2 ● 9.3

- Contents
- References
- Resources

Content of health sector contingency plans

A. Situation and risk analysis

This section is defined by the United Nations country team and humanitarian country team together. The health cluster coordinator should be involved in the discussion to identify the potential impact on the health of the population from specific hazards. Countries should have a multi-hazard health emergency response plan for all types of hazards (that is, a generic plan), which is complemented by contingency plans for specific hazards. The health cluster will also need to take account of subnational and local emergency response plans. The content would typically have the following structure:

- context;
- summary of risks;
- health consequences, both direct and indirect (for example, linked to the effect on health of other consequences, such as disruption to water supply);
- response and operational capacity;
- gaps and constraints;
- planning figures for humanitarian assistance.

B. Health cluster contingency plan

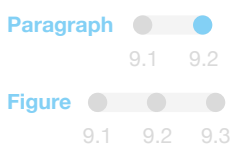
The health cluster contingency plan defines the strategic and operational objectives of the health cluster response based on risks, possible health situation and existing vulnerabilities and capacities of the health sector in the country. It should reflect the health cluster's role in relation to the country's response plan and contingency plans. This section aims to detail the health cluster actions to deal with the potential health situation, the main risk factors, and weaknesses and constraints that could hamper an effective response for a specific risk.

The health cluster coordinator would be responsible for supporting the ministry of health and gathering stakeholders to do the following:

- identify the potential impact of the different hazards, vulnerabilities and existing capacities in the health sector and among health cluster partners, including where capacities are weak or there are gaps;



Health cluster in emergency preparedness



- [Contents](#)
- [References](#)
- [Resources](#)

- develop key interventions for filling the gaps by the health cluster partners, reflecting the comparative advantage of the health cluster;
- identify the main actions to enable the response plan to be activated, including emergency preparedness and operational readiness measures to be taken (such as planning, training, exercises) with key stakeholders, including health cluster partners and the ministry of health.

C. Operational delivery

This section looks at the practical strategy envisioned for responding to a potential emergency in the country. It reflects the health situation and what can be done to better respond under the circumstances. The main questions to answer in this section include the following.

- What could be the main public health issues, taking the public health profile into account?
- What are the potential gaps in response, looking at the current health system structure?
- What needs to be done to address these needs?

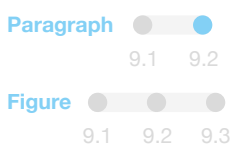
D. Coordination and operational support

This section identifies the different coordination structures the health cluster should engage with to allow delivery of health services to the affected population effectively. This includes coordination with the following:

- health cluster partners
- other clusters
- government
- humanitarian country team
- other sectors
- other related actors.



Health cluster in emergency preparedness



- [Contents](#)
- [References](#)
- [Resources](#)

In terms of operational support, this section informs the health cluster on what it needs as a basis for effective action. This can include needs assessments, information management systems, response monitoring, common services, supplies required, their availability, where they will come from, how will they get to the field locations, as well as ensuring safety and security for those who will deliver the services.

Role of the health cluster coordinator in capacity development

A key role of the health cluster coordinator in emergency preparedness is to understand the strengths and gaps in existing capacities and find means to address such gaps in order to strengthen emergency preparedness and operational readiness.

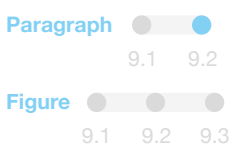
Several tools exist for assessment capacities within the health sector. These include the State Parties Self-Assessment Annual Reporting (SPAR) tool, the IHR joint external evaluation, HeRAMS, and various disaster risk management capacity assessment tools, as well as health system assessment tools, including regular surveys of services, national health sector development plans, and capacity development strategies. Health inequity mapping could also provide a good understanding of the vulnerabilities that at-risk and affected populations can face in emergency situations. It is important to identify the capacity of the various health services to scale up their operations in emergency situations and mobilize further resources to fill critical resource gaps in affected areas.

Countries may already have conducted capacity assessments, which provide a good source for considering the role of the health cluster in future capacity development activities. If that has not been done, capacity assessments should be conducted in the risk analysis phase of the ERP. Capacity assessments of the health cluster among cluster partners should be conducted so that available resources and gaps are identified.

The role of the health cluster in capacity development is expected to focus on strengthening the capacities needed to enhance preparedness for and response to emergencies. The role of the health cluster in capacity-building should be performed in support of and in conjunction with overall emergency preparedness in the country, including health emergency and disaster management strategies and national action plans for health security.



Health cluster in emergency preparedness



- [Contents](#)
- [References](#)
- [Resources](#)

Role of the health cluster coordinator in competency development and training

Building the competencies of key personnel, including health cluster partners and national and local actors, focuses on strengthening both coordination and technical areas of work.

Strengthening coordination includes:

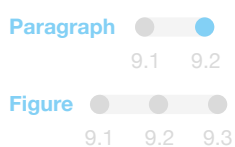
- training on key concepts of coordination of national and subnational authorities and health cluster partners;
- support for the national and local health authorities in setting up coordination structures and platforms, where not existing;
- introducing cluster coordination mechanisms for both government and partners, and establishing a system for linking the cluster with national coordination mechanisms;
- on-the-job training, including direct support to governments during the response;
- emergency response planning and contingency planning;
- simulation exercises.

Strengthening technical public health areas includes:

- risk and capacity assessments, including identifying key health risks and vulnerabilities to identified hazards (for example, management of severe acute malnutrition with medical complications in a drought situation);
- identification of technical resources and ensuring their application and dissemination in the country;
- support for training of relevant personnel on specific technical areas;
- with relevant technical units and agencies, identification and adaptation of relevant guidelines on specific health areas to the country context;
- mobilization of additional resources to provide training and technical support in relevant areas (risk communication, early warning of outbreaks, setting up temporary facilities, mass immunization campaigns).



Health cluster in emergency preparedness



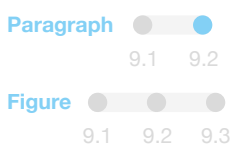
- [Contents](#)
- [References](#)
- [Resources](#)

Resources for capacity-building include the following:

- Trainings:
 - WHO trainings on risk assessment, for example the Strategic Tool for Assessing Risks (STAR), response planning, business continuity planning;
 - IASC trainings on ERP and contingency planning;
 - WHO trainings on surge, incident management systems, emergency operations centres;
 - regional trainings, such as the WHO Public Health Pre-Deployment Course and the Public Health and Emergency Management in Asia and the Pacific programme;
 - trainings in specific public health areas of work (such as early warning systems, infection prevention and control).
- Technical guidelines and standards.
- Tools, manuals, support structures, WHO operational readiness checklists.



Health cluster in emergency preparedness



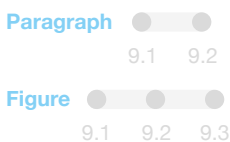
- [Contents](#)
- [References](#)
- [Resources](#)

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Health cluster in emergency preparedness



- Contents
- References
- Resources

Resources

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WHO Guidance for Business Continuity Planning: <https://apps.who.int/iris/bitstream/handle/10665/324850/WHO-WHE-CPI-2018.60-eng.pdf?ua=1>

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Simulation exercise manual. WHO; 2017 <http://www.who.int/ihr/publications/WHO-WHE-CPI-2017.10/en/>

SPHERE: <https://spherestandards.org/handbook-2018/>

WHO and other technical guidelines on health in emergencies: <http://www.who.int/hac/techguidance/guidelines/en/>



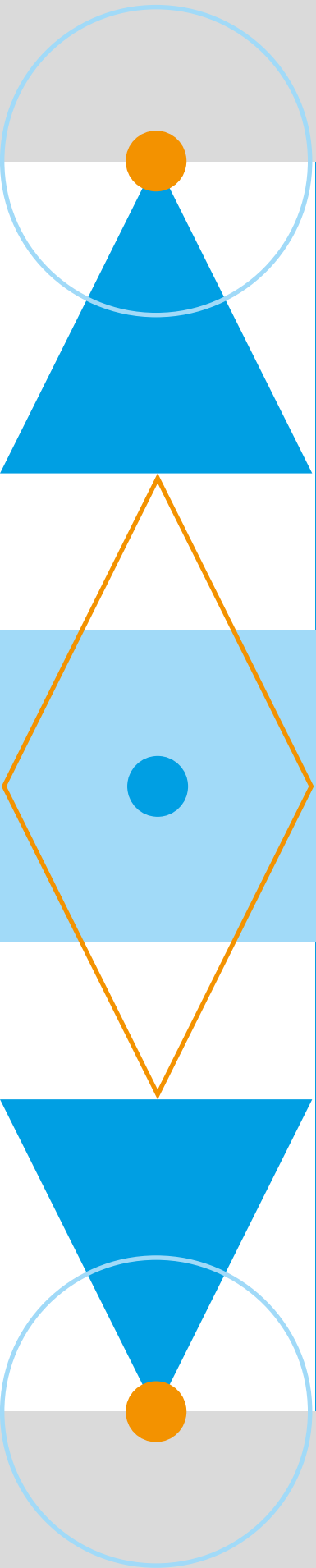
Health cluster in emergency preparedness

Paragraph ● ●
9.1 9.2

Figure ● ● ●
9.1 9.2 9.3

- Contents
- References
- Resources

Needs assessment



10

Contents

Chapter 10		
Needs assessment		314
10.1 General overview		314
10.2 Purpose and definitions		314
10.2.1	Scope of needs assessment	315
10.2.2	Data collection methodologies	315
10.2.3	Secondary data	315
10.2.4	Primary data	317
10.2.5	Measurement levels	320
10.2.6	Sampling	320
10.3 Types of needs assessment		321
10.3.1	Coordinated assessments	323
10.3.2	Health-specific assessments	325
10.4 Roles and responsibilities		327
10.5 When to conduct a needs assessment		327
10.5.1	Humanitarian needs overview (HNO)	328
10.5.2	People in need	328
10.6 Steps for conducting a needs assessment		329
Step 1.	Plan and design	329
Step 2.	Implement	336
Step 3.	Clean and process data	338
Step 4.	Analyse	340
Step 5.	Share findings	342
10.7 Tools		344
10.7.1	Technology and needs assessment	344
10.7.2	Checklist to give affected communities a voice	347
10.7.3	Team checklist (composition, skills, equipment, training)	347
10.8 Basic principles for needs assessment		349
References		352
Endnotes		353
Boxes		
Box 10.1	Enumerator training for data collection	337
Figures		
Figure 10.1	Steps for conducting a needs assessment	329
Figure 10.2	Flowchart to determine most appropriate data collection methods	332
Figure 10.3	Assessment framework: example of information for inclusion	333
Figure 10.4	Assessment framework for question formulation and data collection	334
Figure 10.5	Analytical steps of needs assessment	341
Tables		
Table 10.1	Pre-crisis data and in-crisis data: examples	316
Table 10.2	Types of needs assessment: key features	322
Table 10.3	Roles and responsibilities for actors in a coordinated assessment	327
Table 10.4	Needs assessment: competencies checklist	348

Abbreviations

3W/4W	who, what, where (and when)
EWAR	early warning, alert and response
GIS	geographical information system
GPS	Global Positioning System
HeRAMS	Health Resources and Services Availability Monitoring System
HESPER	Humanitarian Emergency Settings Perceived Needs Scale
HNO	humanitarian needs overview
IASC	Inter-Agency Standing Committee
LGBTI	lesbian, gay, bisexual, transgender and intersex
MIRA	multi-cluster/sector initial rapid assessment
MSNA	multi-sector needs assessment
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PDA	personal digital assistant
PHSA	public health situation analysis
SMART	Standardized Monitoring and Assessment of Relief and Transitions
UNDP	United Nations Development Programme
WASH	water, sanitation and hygiene

10. Needs assessment

10.1 General overview

The purpose of this chapter is to provide an overview on needs assessments in humanitarian settings, with specific focus on assessing health needs and how needs assessments fit within the Public Health Information Services standards.¹ While it seeks to provide some basic information on the purpose of and means for conducting needs assessment, it should not be considered a comprehensive guide. Once a decision has been made to conduct an assessment and the type of assessment has been decided, further research should be done to ensure the information produced is as accurate and relevant as possible.

10.2 Purpose and definitions

Needs assessment is the collection and analysis of information that relates to the needs of affected populations and that will help determine gaps between an agreed standard and the current situation.

The Inter-Agency Standing Committee (IASC) defines people in need as

those members [of a population]:

- whose physical security, basic rights, dignity, living conditions or livelihoods are threatened or have been disrupted, *and*
- whose current level of access to basic services, goods and social protection is inadequate to re-establish normal living conditions with their accustomed means in a timely manner without additional assistance (1).

The primary purpose of needs assessment is to identify which people are in need, disaggregated by different categories of people (for example, all affected persons, pregnant women, children) and different types of needs; determine the severity of their needs; and pinpoint the type of assistance they require to ensure prioritized, focused, response planning. It is triggered by a need to better assess and monitor a particular situation and the conditions faced by populations of concern, whether in the context of a response to a sudden crisis or as an ongoing planning effort during a protracted crisis.



Needs assessment

Paragraph ● ● ● ● ● ● ● ●

10.1 10.2 10.3 10.4 10.5 10.6 10.7 10.8

Box ●

Figure ● ● ● ● ●

10.1

10.1 10.2 10.3 10.4 10.5

Table ● ● ● ●

10.1 10.2 10.3 10.4

● Contents

● References

● Endnotes

10.2.1 Scope of needs assessment

A needs assessment seeks to understand some or all of the following:

- the spectrum of needs and risks
- geographical distribution of needs and severity
- temporal duration of needs (how long each need is expected to continue)
- estimated severity of conditions
- existing capacities and resources
- information available disaggregated by gender, age, minority group, vulnerability
- production of baseline data to measure future progress and inform future assessments.

10.2.2 Data collection methodologies

Any assessment is predicated on the compilation and analysis of data. These data can be either **primary** – data collected within that specific, time delimited, assessment (usually through fieldwork); or **secondary** – data or information existing prior to the specific time-bound assessment, including from prior field assessments. Wherever possible duplication of efforts should be avoided, so it is important to review the pre-existing (that is, secondary) information sources before moving ahead with any primary data collection.

Data are usually classified as either:

- **quantitative** – information that is quantifiable and can be analysed numerically, often presented with the use of statistics in tables or graphs; or
- **qualitative** – produced through exploratory research that results in non-numerical data.

Qualitative research can help to explore intangible factors by capturing feelings, attitudes, intentions or personal experiences, and provides contextual information that may not be clearly demonstrated in the collection of quantitative data.

10.2.3 Secondary data

Classification of secondary data

Secondary data in emergencies can be classified into two groups: pre-crisis and in-crisis. Some examples of each are shown in Table 10.1.



Needs assessment



- [Contents](#)
- [References](#)
- [Endnotes](#)

► **Table 10.1 Pre-crisis data and in-crisis data: examples**

PRE-CRISIS DATA	IN-CRISIS DATA
<ul style="list-style-type: none"> • Population figures • Demographics • Vulnerabilities and minority groups • Socioeconomic data • Morbidity and mortality rates • Existing data on water, sanitation and hygiene (WASH), e.g. water sources • Location of infrastructure (including health facilities) • Environmental and seasonal data, e.g. timing of rainy season to note when vector-borne diseases might become an issue • Legal and political data 	<ul style="list-style-type: none"> • Population estimates (including displacement figures) • Humanitarian access constraints • Geographical area affected • 3W data (who does what and where) showing presence or absence of humanitarian actors • Security considerations

It is important that a secondary data review be conducted prior to any assessment involving primary data collection.

Secondary data review

A secondary data review is an integral component of any assessment. It involves reviewing any and all pre-existing information related to the assessment. Secondary data reviews help to provide the background information critical to understanding the wider context and can ensure all existing data are incorporated before resources are allocated to primary data collection. In the context of the health cluster, the key framework for capturing existing secondary data, and identifying information gaps that may require primary data collection, is the public health situation analysis.²

One component of ensuring a comprehensive secondary data review is maintenance of an assessment repository where any health-related assessment is outlined, along with the organization that conducted it and the methodology used.



Needs assessment



- [Contents](#)
- [References](#)
- [Endnotes](#)

10.2.4 Primary data

Below is an overview of some of the most commonly used methodologies for collecting primary data. In many cases an assessment will employ mixed methodologies, using multiple means for collecting information to fill the identified information gaps.

Direct observation

Direct observation helps to add context and meaning to collected data. It can be collected in one of two ways.

- **Structured** (*looking for*) – where specific behaviour, objects or events are looked for.³ An example is monitoring whether patients are offered the services of an interpreter or translator at a clinic where such services are supposed to be provided. Structured observation is often used for assessing the physical status of items (such as buildings or health care facilities).
- **Unstructured** (*looking at*) – where a situation is monitored to see what issues may exist. An example is monitoring how men and women seek medical assistance at a clinic. A set of questions can be outlined for the observer to answer.

Observation helps provide a snapshot of a given situation and is something that often occurs in the course of collecting data, whether intentionally planned or not. However, observation requires skilled observers to collect data, as they need to understand what to look for (and be informed enough to know when to focus on the unexpected). It is also at high risk of bias, as the observer’s own beliefs will impact what is observed. Furthermore, the presence of an observer can often result in changed behaviour. Even so, observation does not require significant resources and can be used to rapidly collect different types of information in emergency settings. Information can be collected through physical observation on the ground, through windows while driving by an area (drive-by), or by looking over an area from the air (fly-over).

Key informant interview

Key informants are individuals identified for the specific knowledge they have relating to a topic being covered by the assessment. They can provide answers on behalf of a larger community (in which case they are not only answering about their personal experience), also referred to as “lay” key informants, often community or religious leaders; or about a specific technical topic, such as water quality or health care availability (“expert” key informants). Note that the same person may serve as both a key informant and an individual respondent in a survey.



Needs assessment



- Contents
- References
- Endnotes

Key informant interviews are conversations with key informants that can be either *structured* or *semi-structured*.

- **Structured.** A preset list of questions is compiled about a selected topic. The questions may also include answer options. This type of interview ensures collected data can be aggregated and comparisons made. The inclusion of answer options can also help speed up data collection as well as accuracy. Care should be taken, however, not to lead key informants by reading out answer options, and to allow for answers outside the prescribed list. It is important to weigh the benefits of faster analysis provided by structured interviews against the loss of contextual information that can be offered by using a more open methodology. Structured interviews also have the potential of introducing bias by only focusing on topics presumed to be the most relevant.
- **Semi-structured.** Interviews are guided by a set of open-ended questions designed to stimulate dialogue between interviewer and interviewee. Semi-structured interviews have the benefit of providing a richer data set, though interviewers need to be careful not to be judgemental or too rigid in preconceived notions. While this style of interview can provide very rich information, it requires that interviewers are well versed in the topics being covered and know when to push for further information. Beyond the higher degree of skill required in data collection, this type of qualitative data is more time consuming to process and analyse.

Key informant interviews have the benefit of providing a flexible methodology that can allow for exploration of new ideas and issues. They can also be conducted relatively quickly and do not require large teams of individuals. Furthermore, key informant interviews can be useful in collecting information on areas that are remote or hard to reach. However, the data produced are not measurable (quantitative), and the quality of the data collected is heavily reliant on the knowledge and objectivity of the key informant.

Remember: key informant interviews provide a subjective perspective, and all information will have an individual and cultural bias that needs to be taken into account during analysis.

Focus group discussion

Focus group discussions are structured discussions with a small, homogeneous group of people identified by preselected criteria. These are often conducted in the community with a group from the same geographical area. Focus group discussions generally encourage discussion within the group, fostering an air of constructive debate where information can be cross-checked and issues probed. It is important



Needs assessment



- Contents
- References
- Endnotes

to ensure the right dynamic between discussion participants and to be careful that the views of some members are not muted by the presence of others. For example, female residents may not speak openly when in a group with males, or minority representatives may not voice certain issues if they are in a group with community leaders from the majority group. The size of the focus group discussion plays an important role, as enough people are required to ensure a lively discussion, but it should remain small enough that voices are not lost to the group. Where possible these groups should aim at four to eight individuals (though in some crisis settings it may be difficult to avoid the gathering of larger groups). Where focus group discussions are run it is useful to have two facilitators in order to ensure one person is able to take notes while another facilitates the discussion. While it may be necessary to identify potential answer options in a questionnaire to facilitate analysis, it is important that the wider discussion is recorded, and new and unforeseen responses should always be encouraged.

Community group discussion

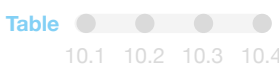
Community group discussions differ from focus group discussions in that they are far less organized. They are characterized by discussions with people from a community and are often larger than focus group discussions without the same level of targeting to identify participants. Community group discussions are used in the earlier stages of a crisis, as they are a useful means of collecting information quickly and have lower logistical requirements than more standard focus group discussions. A community group discussion can still employ a structured tool, but levels of bias should be considered when analysing results, as the mixed grouping of participants may result in certain voices being lost in favour of the views of more dominant individuals.

Survey

Surveys consist of a set of structured interviews with either members of a household (speaking on behalf of their whole household) or individuals for the purpose of gaining information on their direct experiences, perceptions, expectations, and situations or conditions (rather than about the experiences of the broader community, in which case they would be acting in the capacity of key informants). They are often combined with observation (for example, collecting information on household conditions coupled with observations from the enumerator on materials used). It is important to have a degree of contextual understanding prior to undertaking a survey, so that accurate answer options are provided.



Needs assessment



- Contents
- References
- Endnotes

10.2.5 Measurement levels

Data are usually measured at one of the following levels.

- **Community.** Information is collected at the community level (for example, through community group discussions), and is designed to provide an overview of a specific community or key informants reporting on a specific geographical area.
- **Institution.** Information is collected at the level of an institution or facility. This type of data gathering is commonly employed in health assessments, particularly under the Health Resources and Services Availability Monitoring System (HeRAMS).⁴
- **Household.** Surveys will often ask questions that require a respondent to report as a representative of an entire household.
- **Individual.** Surveys can also ask questions at the individual level (requiring the respondent to report on their own opinions, experiences and perceptions). It is also possible to interview at the individual level.

10.2.6 Sampling

A sample is a subset of the population that takes part in the survey and is expected to represent the wider group of affected individuals. Most assessments will use a sample, as there is unlikely to be sufficient time to conduct a full census (surveying all individuals).

Participants can be selected through one of three main sampling methods.

- **Purposive sample.** Specific respondents are sought out for the survey, for example pregnant women or members of an ethnic minority.
- **Convenience sample.** Individuals are interviewed who are easy to reach, for example people first encountered when visiting the affected area.
- **Representative sample.** Statistical methods are used to identify which households or individuals to interview. Representative samples are used to estimate the distribution of opinions, experiences and needs. Simply put, if a properly constructed representative sample is collected it is possible to use the data to determine (within a certain margin) what the wider group (outside the sample) would have answered to each question.



Needs assessment



- [Contents](#)
- [References](#)
- [Endnotes](#)

The choice of selection method is largely dependent on available resources and expertise. Surveys with representative sampling can be time consuming and expensive to implement, as well as requiring specialized skills in sampling methodology and statistical analysis. An expert should be consulted prior to undertaking a representative survey.

10.3 Types of needs assessment

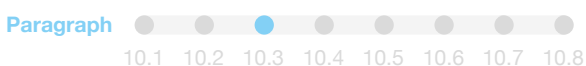
Needs assessments can be classified by when in the crisis time frame they take place, by the focus they have, and by their design. Below is a description of each type.

- **Initial assessments** are undertaken promptly at the outset of a crisis or following a new event or sudden change. They seek to identify whether a response is required and to what scale. Initial assessments are based primarily on secondary data and may include rapid and largely unstructured field visits.
- **Rapid assessments** are conducted following an initial assessment, usually within the first two weeks of the event that sparked the initial assessment. They are based on a combination of primary and secondary data.
- **In-depth assessments** are undertaken when more detailed information is required to inform operations and programme design. These assessments may cover multiple clusters or sectors or may focus on a single cluster or sector. They employ rigorous methodologies adapted to the context.
- **Monitoring assessments** are continuously undertaken, usually tracking one or a few key issues over time. The process of monitoring the situation helps to ensure a timely operational response.⁵ A common example of a type of monitoring assessment is early warning systems.

Table 10.2 presents the key features of each type of assessment.



Needs assessment



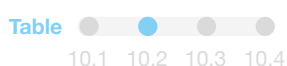
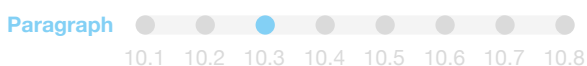
- [Contents](#)
- [References](#)
- [Endnotes](#)

► **Table 10.2** Types of needs assessment: key features

CRITERIA	INITIAL	RAPID	IN-DEPTH	MONITORING
Time frame	24–72 hours	3–14 days	2 weeks +	Ongoing
Assessment duration	3 to 5 days	1 to 4 weeks	1 to 6 months	Varies, but should be relatively swift if conducted regularly
Description	Define scale and severity of the health crisis Identify and locate affected areas Establish key immediate priorities Define access constraints	Define impact of crisis Estimate populations in need Assess severity of needs of affected groups and areas Establish key priorities with affected populations Identify information gaps	Define and quantify needs, including more in-depth sectoral information Provide detailed and statistically representative data Capture representative views of affected populations through joint consultation Establish baseline for needs and response monitoring	Track potential risks and hazards Track existing capacities and resources
Type of decisions to inform	Initial response decisions Rapid assessment design Emergency funding appeals	Initial planning of humanitarian response Define focus for subsequent in-depth assessments Provide recommendations for strategic planning	Inform detailed planning Adjust ongoing response Provide recommendations for programme and operational planning	Identify when a situation becomes concerning or when significant changes are occurring Trigger an assessment (initial/rapid)
Design	Secondary data analysis Small number of field visits, if feasible	Secondary and primary data analysis Primary data are gathered primarily at community level Qualitative research methods	Secondary and primary data analysis Primary data are gathered at community, institution, household or individual level Quantitative and qualitative research methods	Primary data continually reported
Sampling	Convenience or purposive sampling	Purposive sampling (rarely representative)	Representative sampling	Varies, can include a full census



Needs assessment



- Contents
- References
- Endnotes

CRITERIA	INITIAL	RAPID	IN-DEPTH	MONITORING
Data collection techniques	Fly-over Direct observation Key informant interview	Focus group discussion Key informant interview Direct observation Survey	Focus group discussion Key informant interview Direct observation Survey	Reporting system that feeds data into a centralized database can include any type of collection technique
Unit of measurement	Province, district or subdistrict Community or village	Community Institution (Rarely household)	Community Institution Household Individual	Community Institution Household Individual
Health-specific examples	Public health situation analysis (PHSA) (short form) (secondary data component)	PHSA (long form) (secondary data component) Health questions included in multi-cluster/sector initial rapid assessment (MIRA) Health questions included in initial rapid assessment WHO rapid health assessment Others	Humanitarian Emergency Settings Perceived Needs Scale (HESPER) HeRAMS Population mortality estimation (retrospective survey) Vaccination coverage survey Others	Early warning, alert and response (EWAR) system HeRAMS Population mortality estimation (prospective surveillance) Standardized Monitoring and Assessment of Relief and Transitions (SMART) survey Others

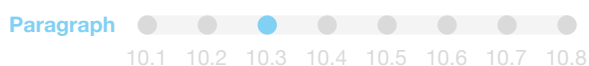
10.3.1 Coordinated assessments

Needs assessments should be coordinated wherever possible in order to ensure efficient use of resources, improve the quality of the output, and promote buy-in by having as many partners involved as is relevant to the assessment. Coordinated assessments can be classified into two groups.

- **Joint.** Assessments are designed and conducted jointly. These can be inter-cluster or inter-sector, such as MIRA or the multi-sector needs assessment (MSNA); or intra-cluster or intra-sector, where many partners may join together to conduct a health assessment.
- **Harmonized.** Assessments are run by individual organizations but adhere to a set of agreed standards (for example, the use of common operational data sets or a set of agreed indicators) in order to facilitate cross-analysis.



Needs assessment



- Contents
- References
- Endnotes

Harmonized assessments can be promoted early on in a crisis by agreeing to use common operational data sets and a set of key indicators. If partner organizations report on assessment activities prior to commencement it should be possible to facilitate sharing of secondary data and avoid duplication of assessment efforts within geographical regions. Funding does not always allow for joint assessments to take place, so the sooner key standards can be agreed upon by the cluster, the greater the chances that all organization-level assessments will be able to feed into wider cluster- or sector-level analysis.

Standardized coordinated assessments commonly used at present include the following.

Multi-cluster/sector initial rapid assessment (MIRA)

MIRA is a commonly used methodology for rapid assessments. It is an agreed interagency framework for conducting a rapid assessment that aims to provide information on the needs of affected populations and identify humanitarian priorities. A MIRA covers multiple clusters or sectors (2).

Initial rapid assessment

This assessment was developed by the Global Health, Nutrition and WASH clusters. It is designed for use by individuals with relevant knowledge but not necessarily a high degree of specialized technical expertise. An initial rapid assessment should be conducted within the first 24–48 hours of the onset of a crisis and include a secondary data review as well as very focused primary data collection. The output is a rapid overview of the emergency situation, identification of the immediate impact of the crisis, initial estimate of needs and an outline of the priorities for the early weeks of the humanitarian response.

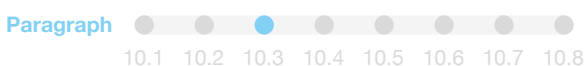
Multi-sector needs assessment (MSNA)

An MSNA⁶ can technically refer to any needs assessment involving more than one sector, but often references a specific type of assessment used to inform the humanitarian needs overview. An MSNA is more in-depth than a MIRA, often incorporating household-level surveys if access is available to affected populations. To be classified as an MSNA, it must meet the following criteria:

- cover all affected population groups in all areas
- be endorsed by the inter-cluster coordination group and humanitarian country team
- include indicators that have been developed with relevant clusters
- be coordinated by the assessment working group (where it is active).



Needs assessment



- [Contents](#)
- [References](#)
- [Endnotes](#)

Post-conflict needs assessment

The post-conflict needs assessment is usually jointly supported by the United Nations and the World Bank. It is led by national authorities and supported by the international community, and aims at identifying long-term needs, actions and outcomes that are necessary to address the consequences of conflict and prevent renewed conflict.⁷ The assessment is usually conducted in the recovery phase.

Post-disaster needs assessment

The post-disaster needs assessment was developed by the United Nations Development Programme (UNDP) along with the World Bank and the European Union. The primary purpose is to assess the impact of a disaster and identify the long-term recovery needs and services as the basis for designing the recovery strategy. The post-disaster needs assessment is forward looking and incorporates restoration of infrastructure, services, systems, and government, as well as basic needs and livelihoods. It also seeks to emphasize disaster risk reduction and increased resilience.

10.3.2 Health-specific assessments

There are a number of assessment types that have been standardized for use in collecting or monitoring specific sectoral needs. In the health domain, the most commonly employed to help assess needs are as follows.

Public health situation analysis (PHSA)

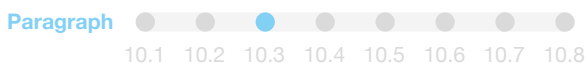
This is a background document that synthesizes previously available data from a wide array of sources in order to provide an overview of epidemiological conditions, existing health needs and possible health threats faced by the crisis-affected population. It is then continuously updated as more information and primary data are collected. Templates are available in both a short form (preliminary PHSA incorporating only secondary data) and a long form (that includes results of primary data collection). The short form is designed for use as an initial assessment, while the long form is more of a rapid assessment. It is important to note that as a situation analysis, the information collected in the PHSA goes beyond the need to cover the wider status of operations, political structure and any other information relevant for informing the situation.

Rapid health assessment

The health cluster is currently updating the rapid health assessment (3) methodology. A rapid health assessment seeks to answer the following questions:



Needs assessment



- Contents
- References
- Endnotes

- Is there a health emergency?
- What is the type, impact and possible evolution of the emergency?
- Who is the most severely affected population and where is the most severely impacted area?
- What are the main health problems?
- What is the existing response capacity?
- What are critical information gaps for follow-up assessments?
- What are the recommended priority actions for immediate response?

Population mortality estimation

Population mortality estimation can be considered the ultimate metric of physical health, and is arguably the single most important measure of health status. However, it requires significant cost, effort and technical expertise to produce. For these reasons, estimation should be attempted only when all three of the following conditions are met.

- It is plausible that findings would improve the health of beneficiaries.
- Quality mortality estimation is feasible given local conditions, and resources and expertise have been secured.
- There is a clear, agreed plan for disseminating and acting upon findings.

Mortality estimation may be performed either on a one-off basis (in-depth assessment) or collected on an ongoing basis (monitoring).

Health Resources and Services Availability Monitoring System (HeRAMS)

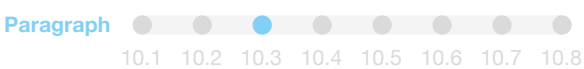
HeRAMS is designed to systematically monitor the availability and functionality of health services to affected populations. HeRAMS helps to ensure service gaps are quickly identified and responded to in a timely manner. It is suggested that interviews and updates become a regular agenda item of cluster and sector meetings, and that HeRAMS not be utilized as a stand-alone survey (in-depth assessment) but rather be continually updated (monitoring). Even so, HeRAMS can serve as a one-off assessment of current capacities and service gaps.

Early warning, alert and response (EWAR)

An EWAR system is often set up in emergency situations when public health surveillance systems may be underperforming, disrupted or non-existent. It is designed to utilize a network of health facilities, with the aim of achieving universal coverage by strengthening the surveillance capacity and resources at all health facilities. Information from the system can help to identify when epidemic-prone diseases are identified and can trigger an initial, rapid or in-depth needs assessment depending on the circumstances and information needs.



Needs assessment



- [Contents](#)
- [References](#)
- [Endnotes](#)

10.4 Roles and responsibilities

Roles and responsibilities for various actors in a coordinated assessment are set out in Table 10.3, as proposed by the IASC (4).

► **Table 10.3** Roles and responsibilities for actors in a coordinated assessment

ACTOR	ROLES	RESPONSIBILITIES
Humanitarian coordinator	Coordinates inter-cluster/sector assessments	Appoints assessment focal point for initial assessment
		Coordinates assessments undertaken by clusters/sectors
		Promotes the use of tools for harmonized assessments
		Shares assessment data across clusters/sectors
		Supports inter-cluster/sector analysis
Cluster/sector coordinator	Coordinates intra-cluster/sector assessments	Prioritizes needs and decides on strategic priorities
		Supports inter-cluster/sector assessments
		Coordinates assessments of cluster/sector members
		Promotes the use of tools for harmonized assessments
		Sets out standards for cluster/sector assessments
Cluster/sector members	Supports and/or implements coordinated assessments	Promotes joint assessments within the cluster/sector
		Shares assessment data within the cluster/sector
		Supports cluster/sector analysis
		Shares information on assessments with clusters/sectors
		Uses tools for harmonized assessments
		Participates in joint assessments at the cluster/sector level
		Contributes to cluster/sector analysis
		Uses key humanitarian indicators and common operational data sets

Source: IASC (4).

10.5 When to conduct a needs assessment

Needs assessments should take place whenever there is likely to be a change in needs. This includes the onset of an emergency, after any developments during a continuing crisis – be they new crises (such as renewed fighting and displacement) or environmental or external factors (such as the onset of winter) – or changes that simply occur over time. Needs assessments not only provide the baseline



Needs assessment

Paragraph



Box

Figure

10.1

10.1 10.2 10.3 10.4 10.5

Table

10.1 10.2 10.3 10.4

● Contents

● References

● Endnotes

information for future monitoring but are the evidence base for strategic planning. For this reason, it is important to ensure needs assessments comprise a continuous process throughout the response. Information may need to be updated as a situation evolves.

10.5.1 Humanitarian needs overview (HNO)

Information on needs is also required for the production of the HNO, which should be produced twice per year to support the humanitarian country team. The HNO is designed to support the development of a shared understanding of the impact and evolution of a crisis and inform the humanitarian response plan. It is the responsibility of the cluster or sector to provide the required information on health needs to inform the intersectoral HNO. Clusters and sectors are required to contribute to the development of the HNO and must provide people in need figures, ideally disaggregated by gender and age group, as well as flagging the most vulnerable groups and factors associated with critical problems related to physical and mental well-being. It is also necessary to quantify the severity of health needs.

Coordinated needs assessments are ideally conducted to help provide for people in need, but funding may not always be available for large-scale needs assessments. If a coordinated needs assessment is not possible, it is necessary to either conduct a sectorwide joint assessment (funding permitting) or pool existing harmonized data from completed assessments to create a concerted picture of need across the crisis-affected area. When producing information for the HNO, it is necessary to clearly document where the information came from and the process used to calculate all provided figures.

In order to facilitate the prioritization of needs, a standardized tool has been developed that provides a method and structure to prioritize needs by categorizing and weighting indicators along geographical areas, sectors, intersectoral aspects and demographics. This tool is available for use but remains optional at present (5).

10.5.2 People in need

People in need refers to the quantification of the number of people presenting needs, disaggregated as appropriate (6). It provides the number of people in need of, for example, health assistance, broken down by geographical region (the administrative level may vary by crisis but is often set around the district level) and often by category of service (such as people in need of reproductive health services). Data are usually disaggregated by women, men, girls and boys, as well as displacement status (refugee, internally displaced person, returnee) and, where possible, the prevalence of people with disabilities.



Needs assessment

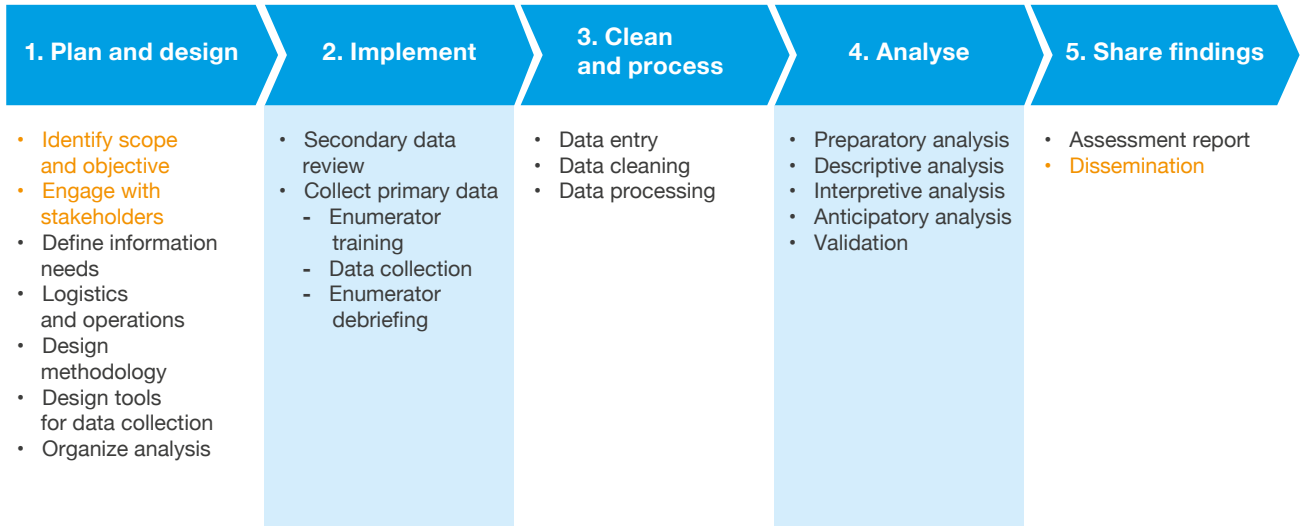


- Contents
- References
- Endnotes

10.6 Steps for conducting a needs assessment

Figure 10.1 shows the steps for conducting a needs assessment. Further information on each step is provided in the following subsections.

Figure 10.1 Steps for conducting a needs assessment



● Tasks in orange are the responsibility of the coordination team

● Tasks in black are the responsibility of the assessment team

Step 1: Plan and design

1. Identify scope and objective

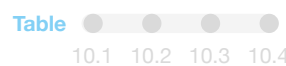
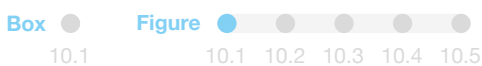
The first step in any assessment is to define the scope and objectives of the assessment. Most needs assessments will seek to answer the following:

- Who is most in need?
- What are the primary needs?
- Where is need most severe?

It is also necessary to identify what the outputs of the needs assessment will inform (for example, to provide information to set key health priorities for the next programme cycle). The scope of the assessment identifies the geographical coverage (for example, is focus only on urban areas? Or perhaps the assessment seeks to compare affected areas to unaffected areas, requiring a much wider geographical area).



Needs assessment



- Contents
- References
- Endnotes

2. *Engage with stakeholders*

It is important that coordination structures be clear throughout the assessment process. This is particularly so in the case of joint assessments, but even outside coordinated assessments it is important to avoid overlap of data collection activities. Once the objectives and scope are identified, stakeholder mapping can take place to identify which organizations may have information to feed into the needs assessment or those that may want to take part.

Where possible, effort should be made to include government in the assessment process. Access to communities and data collection areas requires approval from local authorities, and their engagement early on can help facilitate the coordination process. Engagement with local government can also help ensure a degree of national ownership and buy-in from local authorities.

3. *Define information needs*

Prior to implementing any needs assessment, it is imperative to identify the information needs. This should be done in coordination with any organizations involved in the assessment, along with any potential decision-makers the assessment is designed to inform. These may include any target groups for which specific information is required, and any additional key information that is needed to inform decision-makers. It is important to note that information needs are not the same as indicators or questions used in tools. Information needs will help the assessment team identify what types of tools are required and which questions should be asked.

When defining information needs, focus should be placed on the *minimum* amount of data that is needed to provide evidenced-based analysis, that is, distinguishing *need to know* from *nice to know*.

Some examples of information needs for health needs assessments are:

- What health resources are currently available in crisis-affected areas?
- Are mortality and morbidity rates affected by the crisis? If so, are they impacted evenly across the crisis-affected area or are some locations or groups more affected than others?
- Do minority groups have equal access to health facilities?
- Which areas are likely to have the greatest risk of vector-borne diseases?
- Is vaccination coverage the same in urban and rural areas?



Needs assessment



- [Contents](#)
- [References](#)
- [Endnotes](#)

4. Logistics and operations

As soon as the scale of the assessment is understood, it is necessary to identify the resources available to contribute to the assessment. Whether it be pooling resources or requesting funds, the implementation of the needs assessment cannot sufficiently progress without financial and human resources.

One of the key factors that has been attributed to the success of an assessment is the presence of a single coordinator throughout the process. With a large number of moving parts, it is beneficial to have one person who is involved from start to finish, who can keep their eye on the macro-level picture. With a larger needs assessment, this coordinator would need to be dedicated full time to the assessment, possibly with a team of other individuals who are also dedicated throughout the needs assessment.

The resources that need to be considered for an assessment are:

- needs assessment coordinator
- additional staff
- enumerators (for data collection)
- vehicles (for data collection)
- communication devices (or phone credit)
- per diem (for assessment team)
- mobile phones, tablets, or personal digital assistant (PDA) (if data are to be collected on mobile devices)
- printing facilities (if data are to be collected on paper questionnaires)
- facilities for trainings
- facilities for enumerator debriefings
- translation services (for tools and reports)
- interpretation services (if required for data collection or trainings)
- graphics support for the final report
- publishing services (if distributing hard copies)
- facilities to present findings to affected populations.

It is also useful to make a checklist of the various steps and information that will be required to complete the needs assessment from an administrative point of view, including:

- visa requirements for any assessment staff;
- permissions that might be required of local authorities to access targeted locations (note that formal institutional review board approval is not normally sought or required for needs assessments designed to inform humanitarian operations);
- security updates and any movement restrictions (for example, if travel to assessment sites is time consuming but there are restrictions on movement that limit driving to daylight hours, data collection may require extra time);



Needs assessment



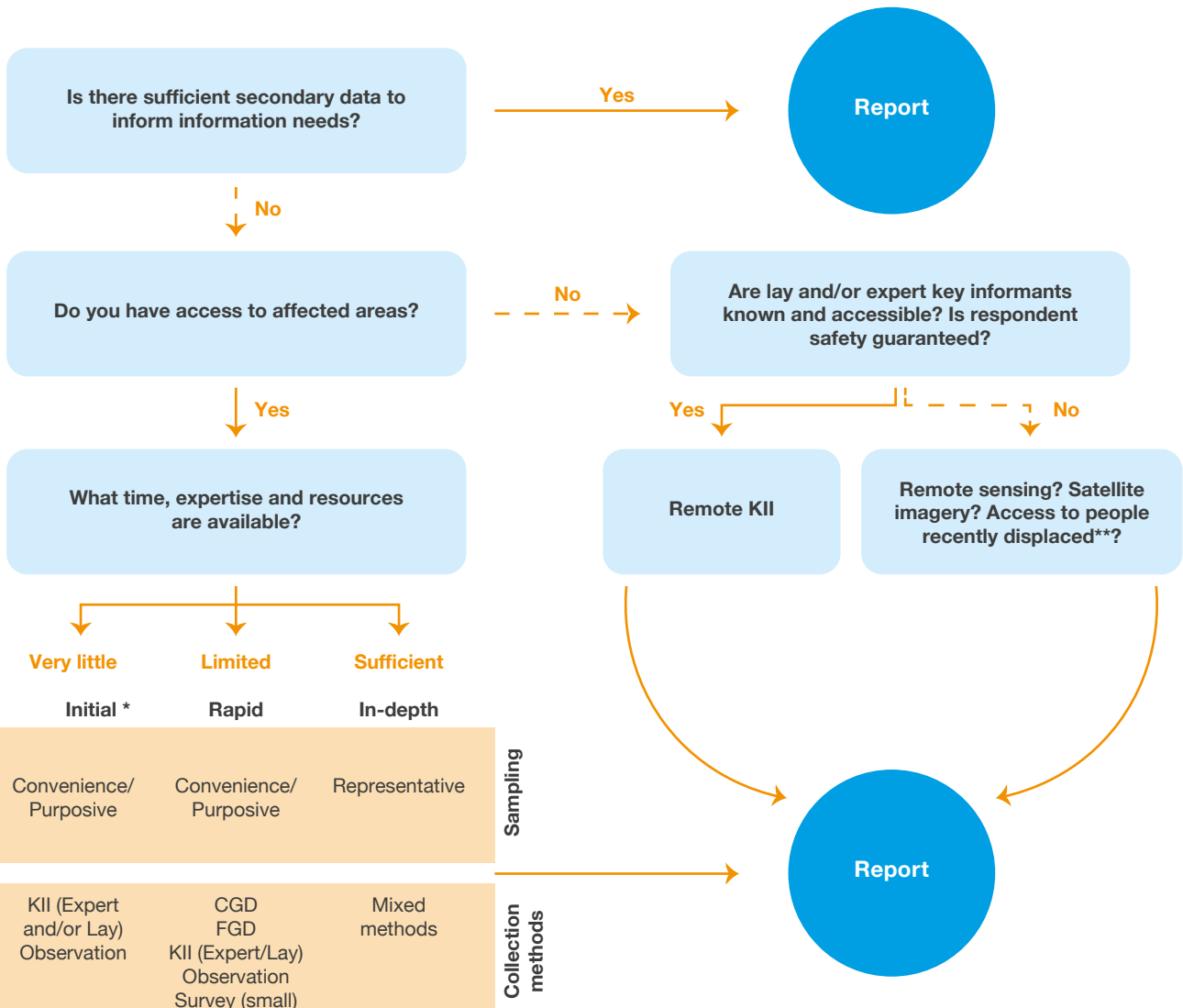
- [Contents](#)
- [References](#)
- [Endnotes](#)

- seasonal calendar – in some locations collecting data at certain times of year (notably the rainy season or winter months) can be very difficult.

5. Design methodology

It is always important to ensure that the data collection methods identified are both appropriate and feasible. Figure 10.2 presents a flowchart that can be used to determine the most appropriate data collection methods to use.

Figure 10.2 Flowchart to determine most appropriate data collection methods



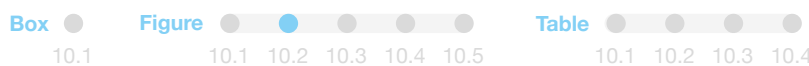
CGD: community group discussion; FGD: focus group discussion; KII: key informant interview.

*Initial assessments should only be run when there is insufficient time to do any other type of assessment. If resources are scarce, but time is available, effort should be put into identifying information gaps and advocating for resources to enable a more appropriate needs assessment.

**When all other options have been exhausted, data can sometimes be collected from people who have recently relocated from the area that cannot be accessed. This is an option of last resort only as information is incredibly hard to verify and often the situation has already evolved rendering collected data obsolete.



Needs assessment



- Contents
- References
- Endnotes

When designing the methodology, it is useful to chart out information needs, broadening them into a list of indicators⁸ that can provide responses to those needs. This *assessment framework* allows for indicators to then be linked to data collection sources. Organizing the design process in such a way improves documentation and reduces the possibility of skipping steps.

Figure 10.3 provides an example to show the sort of information that may be included when drafting an assessment framework.

Figure 10.3 Assessment framework: example of information for inclusion

		DATA COLLECTION TOOLS					
Information needs	Indicators	Key informant interviews	Community discussion group data gathering	Focus group discussions	Survey	Observation	Secondary data review
Have mortality rates been affected by the crisis and are they impacting all groups evenly?	Disaggregated mortality rate pre-crisis						●
	Disaggregated current mortality	●			●		

6. Design tools for data collection

If primary data collection is required, tools will need to be designed to collect the data. Figure 10.4 shows the process that starts by taking the assessment framework and breaking down the relevant indicators (for each data collection method) into more detailed questions with the aim of collecting the data elements (for example, the numerator and denominator) that go into calculating each indicator.

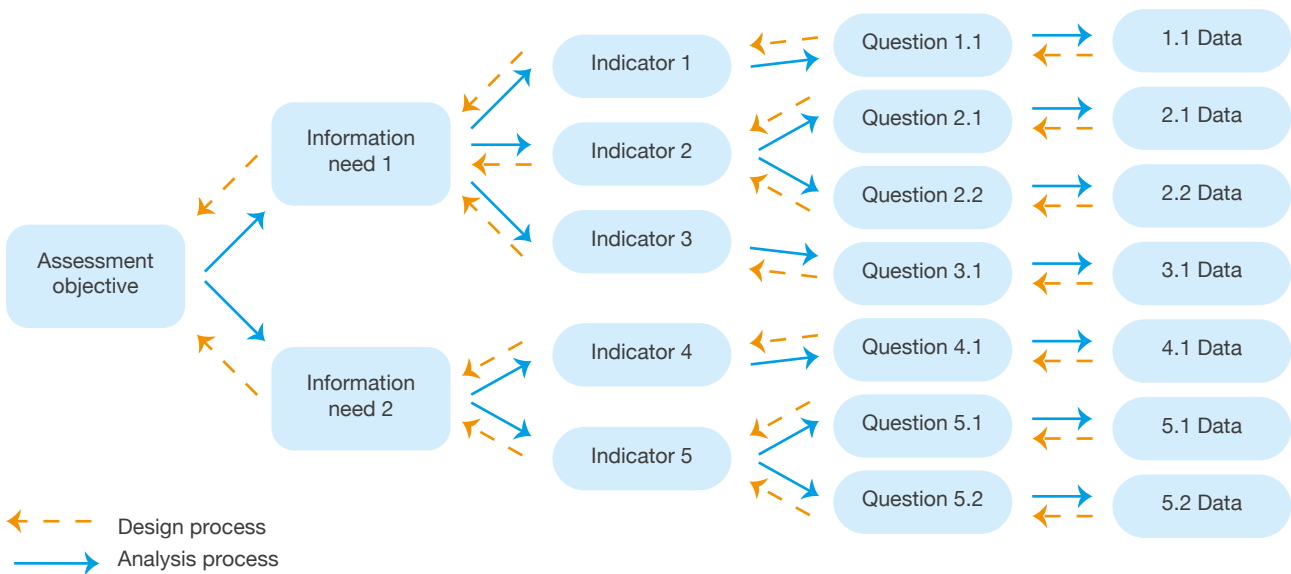


Needs assessment



- Contents
- References
- Endnotes

Figure 10.4 Assessment framework for question formulation and data collection



For example, using the indicator “disaggregated current mortality” (Figure 10.3) would require questions that allow adequate disaggregation levels (such as gender, age, disability status, ethnic group or geographical location). It is advisable to keep the team that designs the tools small and limited to technical specialists with backgrounds in assessment. All questions added in a tool should be clearly linked to an information need in order to ensure only relevant data are collected. It is useful to keep in mind how data will be used when choosing the questions. If, for example, a representative household-level survey is being undertaken and there is a need for data disaggregated by displacement status and for information on distance to health care facilities, then questions will need to be asked on displacement status, and a question on the distance to the health care facility. There are various options for framing the question regarding the nearest health care facility. It can be asked by the amount of time it takes to travel there; a set of options can be given with ranges of time or distance; a number can be requested that measures distance in a set of units; or it can ask to provide the distance and the unit used. If there is a small, dedicated assessment team that will also be responsible for the analysis, and the team members already know they want to run some correlation tests so they can determine if access to health facilities is significantly different for each displacement group, they will choose to collect information in numeric form.⁹

When designing tools for data collection, it is important to remember to use standardized demographic questions in order to facilitate harmonized analysis. For example, the age ranges collected can vary quite significantly, so it is useful to standardize the age ranges to be collected early on during a crisis. It is also

C 1 2 3 4 5 6 7 8 9 10 11 12 13

Needs assessment

Paragraph 10.1 10.2 10.3 10.4 10.5 10.6 10.7 10.8

Box 10.1 Figure 10.1 10.2 10.3 10.4 10.5 Table 10.1 10.2 10.3 10.4

- Contents
- References
- Endnotes

useful to agree on standard geographical data to collect (for example, the various administrative levels and names that will be collected using the common operational data sets).

7. Organize analysis

The process of designing the methodology helps to form the basis for analysis, and if followed systematically does not require much further input. In some cases, for example coordinated assessments, where individuals may support certain components of the assessment and not others, it may be necessary to clearly outline the steps that will be required to combine the data in order to analyse them. Referring back to Figure 10.4, it is possible to see the link between the assessment objective, through the information needs, all the way to the various pieces of data. When organizing the analysis, the process simply runs in reverse, linking data to questions, which then link to indicators and then to information needs. Using the example provided above, when the people designing the questionnaire are also the people who will run the analysis, they will often design questions to fit with that analysis (for example, choosing to collect numeric data in order to be able to run some specific statistical tests to see if there is a correlation between displacement status and distance to health care facilities).

Where the design team does not comprise the entire analysis team, it is necessary to plot out the analysis steps so that those who will later process and analyse the data know what they need to do. This analysis plan should consider the structure of data and how variables may be combined to provide information for specific indicators. It is also necessary to detail what sort of statistical tests might need to be run if the assessment includes a representative sample. Going back to the previous example, it would be necessary to outline that the collected numeric data on distance to health care facilities need to be checked to ensure they are all in the same unit (and converted where they are not) and then run through the identified statistical tests comparing distance with displacement status.

8. Outline data management procedures

It is important to have discussions regarding data ownership, data security and data anonymization. Due to the protection concerns that exist with detailed personal information potentially being collected, information security should be carefully considered.

With large assessments, management of data is a major consideration. Enumerators (individuals collecting interviews on the ground) need to be clear on where to store data and ensure all records (such as recordings, questionnaires and field notes) are properly labelled and stored so data are not lost.



Needs assessment



- Contents
- References
- Endnotes

Data management procedures should also outline the metadata¹⁰ standards that will be in place, and requirements for recording and tracking any changes made to the data in the process of cleaning.

Step 2: Implement

1. Secondary data review

The first step in implementation is collecting all relevant, existing data and reviewing the information provided. It is important that this step take place prior to any data collection exercise to ensure no efforts are duplicated. In situations where no further information is required, the collection and coalition of secondary data comprise the entire implementation step. In cases where primary data are being collected, the secondary data review will help to provide background on the crisis and contextual information that can help during data collection.

Some key data sets and information sources that should be looked for to help inform the needs assessment are:

- population figures;
- location of health facilities;
- pre-crisis morbidity and mortality rates;
- records of any disease outbreaks;
- any health assessments that have been conducted in the area that the needs assessment is targeting (for example, census, Demographic and Health Surveys, and Multiple Indicator Cluster Survey data collected within the prior five years);
- HeRAMS, if it is available;
- PHSA;
- security data and humanitarian access constraints;
- 3W data, if available, showing humanitarian activities that have taken place in the assessment area;
- information produced by other clusters or sectors that may relate to health status (such as nutrition, food security and WASH data);
- information produced by or for the mental health and psychosocial support working group (if activated);
- information on attacks, looting and other threats in affected areas (can be sourced from operational partners, media reports, social media data mining, local human rights associations);
- United States Geological Survey (data for geophysical hazards);
- Famine Early Warning Systems Network (for drought-related crises).



Needs assessment



- Contents
- References
- Endnotes

Where possible, raw data¹¹ should be collected so additional analysis may be conducted. In cases where raw data are being used, it is very important to ensure that the sampling methods and any information on limitations during data collection are included. When looking at time frames for data collection, the date of data collection should be determined, as opposed to the date the research was published (which is often significantly later).

2. Collect primary data

If there is insufficient information through secondary sources to respond to the identified information needs, primary data will need to be collected. To collect data from the field, the following steps should be followed.

Enumerator training

The process followed for collecting data on the ground will vary depending on the methodology. Timing of data collection should be carefully considered, with tools being staggered so they may help inform each other. For example, conducting qualitative focus group discussions may help to provide unforeseen answer options for some of the questions in a household-level survey, so it would help to conduct the focus group discussions first.

Once the time frame has been set, enumerators should be trained on data collection and the tools they will be using. Enumerator training should be as thorough as possible to ensure that all enumerators properly understand the questions they are to ask (Box 10.1).

• Box 10.1 Enumerator training for data collection

Consider a question that asks how many people in a household are chronically ill, and two enumerators who each define “chronic illness” differently:

- Enumerator 1 – any illness at all, including sight issues that require glasses
- Enumerator 2 – severe illnesses that impact ability to work

When analysing the data there is no way to know that the answers to this question are not comparable. It is important that enumerator training be careful and thorough.

Data collection

Once data collection is in the field, the teams should be debriefed each day in order to identify any potential issues as swiftly as possible. Issues that can arise during data collection are numerous and occur often. It is important to stay informed about



Needs assessment



- Contents
- References
- Endnotes

what is occurring and be flexible to find solutions. Some examples of issues that might be faced are:

- bad weather
- sudden change in security situation
- revoked authorization of entry (or different local authorities denying entry)
- community resistance
- transportation issues
- high non-response rates.¹²

While data are being collected, efforts should be made to check the incoming data (the database if mobile collection techniques are being used, or the paper questionnaires if they are in use). As it is often necessary to request field teams to validate certain findings, constantly checking the incoming data can help speed up the validation process and ensure that all necessary information is collected while the field teams are still on site. For example, if an individual reports their age as 105 years, it is useful to follow up with the enumerator and check if that is a data entry error or if the person really is that old. Validation rules on mobile data forms can reduce the number of nonsensical results, such as males that are recorded as pregnant.

Enumerator debriefing

Where possible, debriefing should be a continuous process of collecting feedback from data collection teams. This feedback can form part of the observational data and can help inform the assessment and assist in data validation. If it is not possible to constantly debrief teams, a debriefing session should be organized immediately after data collection is completed.

Doing the debriefing as a group can help bring out more information, as some individuals may not find something relevant until it is mentioned by someone else.

Step 3: Clean and process data

1. Data entry

The ever-increasing use of mobile data collection tools has greatly reduced data entry requirements (as data are entered as they are collected), but where paper questionnaires are utilized, it is necessary to make sure data are entered into a database. This process can be time consuming and can also result in errors.

Where qualitative data are collected, information may be recorded or handwritten in notes and would also need to be transcribed or entered.



Needs assessment



- Contents
- References
- Endnotes

2. Data cleaning

The first step in data cleaning is validating the information. If paper questionnaires were used (and data only entered once), it is necessary to randomly check data against the hard copies of the questionnaires to ensure they have been entered properly.

Where longer answers have been included, or data transcribed, it may be necessary to translate information into the language that will be used during analysis. Translation may also be needed for units collected (for example, distance to the nearest health facility may be collected in a mix of different units, such as kilometres, miles, and local distance units, or there may be a combination of ages in months and years – these would need to be converted into one common unit).

Though cleaning and validation requirements are greatly reduced with mobile data collection, it is still necessary to check each variable and make sure the answers provided make sense. Sometimes the easiest way of achieving this is looking at summaries of the data (minimum, maximum, mean).

Survey questions often include an “other” option, with a request to specify what “other” means. This information needs to be carefully examined to see if it actually fits into a pre-existing category (as perhaps the enumerator incorrectly classified it as “other”) or can potentially lead to the creation of a new category if enough individuals or households reference a similar answer.

Cleaning may also be required for raw data compiled from secondary sources. This is particularly true if multiple data sets are utilized from different sources. The process of compiling data sets can be quite complicated and needs to carefully consider the data collection methodologies used.¹³

When cleaning data, it is imperative that the steps outlined in the data management plan are followed (such as keeping a log of any changes made).

3. Data processing

Data processing is the process of adjusting the data so they can be easily analysed.

With a growing interest in the use of compound indices to help standardize needs classification at the global level, it is possible that such indices will need to be processed. To calculate a compound index, it is often necessary to create a new variable that is calculated from the data collected in other variables. For example, the coping strategies index asks respondents how often they used various coping strategies over the prior seven-day period. The index then multiplies the answer to



Needs assessment



- Contents
- References
- Endnotes

each strategy by a weight (that is provided) and sums them all up into one “coping strategy index”. When these types of questions are included it is important that the new variables be properly calculated prior to undertaking analysis.

Data processing can also be necessary for certain visualizations, as some software or graph types require data to be input in a specific format. In some cases, the data may need to be processed into a pre-identified set of tables so they can be ready for analysis. This type of need should be identified in the analysis plan and implemented during this step.

Where geographical data are collected, it is often useful to incorporate place codes (P-codes) into the data set so information can be easily mapped if required.

Step 4: Analyse

1. Preparatory analysis

The first step involves summarizing the key observations and findings. It can be achieved by systematically working through the analysis plan and ensuring all key variables (questions) are summarized. This may include breaking them down by target groups.¹⁴

2. Descriptive analysis

In the second step, compare results and identify patterns, trends, anomalies, outliers and any stories that may be relevant to the objectives and information needs.

3. Interpretive analysis

Interpretive analysis brings together the various components of the needs assessment (secondary data review along with different sources of qualitative and quantitative data). An effort should be made to seek connections and relationships between observations and across different data sources. Any correlations and links to underlying processes or factors that may help to explain the reason for specific findings should be sought. One of the goals of interpretation is to determine and explain the *why?* of the situation and impart meaning. Arguably one of the most difficult steps in an assessment, interpretation helps to illuminate why certain findings may be seen in data.

Moving beyond explaining the combined findings, interpretation of needs assessment data often seeks to answer the following.



Needs assessment



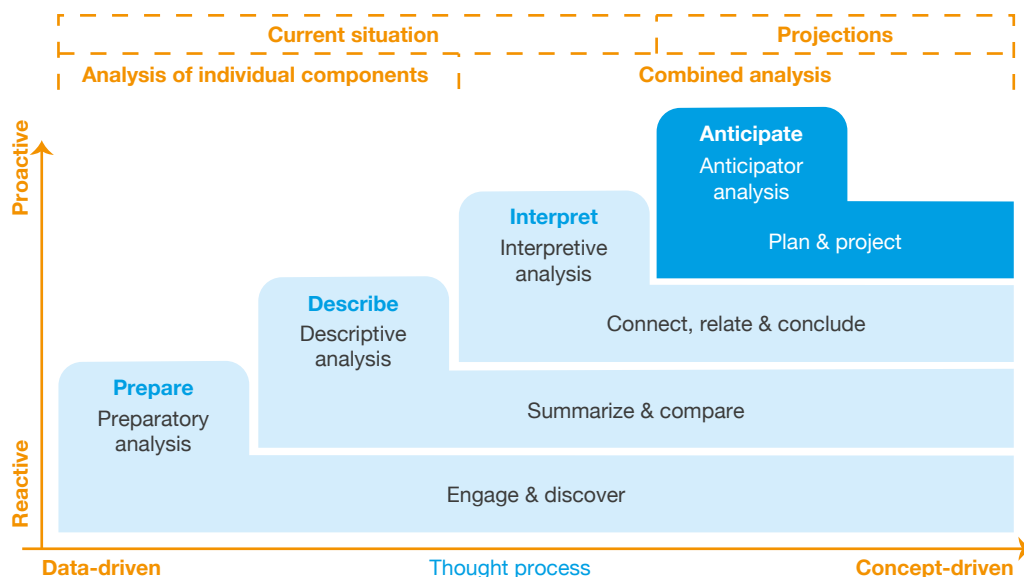
- Contents
- References
- Endnotes

- What was learned?
- What has changed and what has stayed the same?
- What is different or important about a specific group, area, institution or other entity?
- What and where are the most severe conditions?
- How credible are the findings and what are the limitations of the analysis?
- What conclusions can be drawn?
- What are the most important messages?
- What information is missing?
- What are the next steps?

4. Anticipatory analysis

The final stage of the analytical process is to forecast developments and potential outcomes. Anticipation often includes the development of potential scenarios, including projections of how needs might evolve should those scenarios occur. Anticipatory analysis can be greatly facilitated by including forward-looking questions in the assessment – for example, asking what respondents feel their main health issues will be at some specific time in the future (compared with the issues they are reporting currently). Forward-looking questions not only help speed up the process of projection scenarios, they also help to ensure that the voice of the affected population is incorporated in the anticipatory analysis. Figure 10.5 shows how the analytical steps fit together.

Figure 10.5 Analytical steps of needs assessment



Source: Adapted from the chart provided in the *Guidance and toolbox for the basic needs analysis* (7).

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Needs assessment

Paragraph 10.1 10.2 10.3 10.4 10.5 10.6 10.7 10.8

Box 10.1 Figure 10.1 10.2 10.3 10.4 10.5 Table 10.1 10.2 10.3 10.4

Contents
References
Endnotes

5. Validation

It is important that all analytical steps are validated. Group discussions, workshops and meetings can facilitate the validation process. Ensuring a rigorous validation process helps to ensure buy-in once the results of the assessment are released, and also makes certain that a variety of expertise is taken into account in the analysis and interpretation of findings. As objectivity is essential to any needs assessment, a wide variety of discussions during the validation phase are encouraged.

Step 5: Share findings

1. Assessment report

A report should be drafted and structured with the assessment objective and information needs in mind. When drafting reports, it is essential to start by defining the intended audience and ensuring that the writing is targeted at that audience. For example, a report aimed for distribution among health professionals is likely to contain a much higher degree of technical terminology and explanations than one targeted at a wider, non-specialized group.

All reports should contain the following sections (or equivalent).

- **Executive summary** – a short description of key findings and conclusions.
- **Overview of the assessment** (scope) – introductory description of what the objectives and scope of the assessment were.
- **Background** (context) – based largely on the secondary data review, the background should provide relevant information on the crisis context.
- **Methodology** – a detailed description of the design, data collection and analysis process outlining tools used and sampling structure. It is important to be clear about the methodology, as this section is often used during future secondary data reviews to determine both the comparability of contained data and the confidence level in the information provided.
- **Findings** – should provide a breakdown of the analysis and interpretation, being sure to clearly explain all information presented and conclusions drawn.
- **Moving forward** – include any projected scenarios, needs forecasting and next steps.



Needs assessment

Paragraph



Box

10.1

Figure

10.1 10.2 10.3 10.4 10.5

Table

10.1 10.2 10.3 10.4

● Contents

● References

● Endnotes

- **Annexes** – annexes should include the tools used to collect data and, where possible, the actual data.

It is important to balance the need to be thorough against the need to ensure the information is consumed. In humanitarian crises, most needs assessments are designed not only for advocacy but also for use on the ground. Considering that many humanitarians are extremely overburdened, they may not always have the time to read large documents. For this reason, having a concise executive summary that is written in such a way that it may stand alone if required can be very useful. Where possible, use visualizations to expand on points and make the document user friendly.

A note on sharing data

While it can be very useful to share raw data, respondent privacy and risks associated with sharing data must be taken into consideration. Discussions should take place to determine what level of anonymization is required to protect respondents.¹⁵ Anonymization removes all variables that would enable someone to identify the individual or household based on such information. This includes any personal identification numbers, Global Positioning System (GPS) points, names and potentially village and even slightly higher administrative levels, depending on the population in the area. There are a number of options to consider when thinking of sharing data sets:

- sharing data publicly through available platforms, such as the Humanitarian Data Exchange;
- sharing data upon request through a focal point;
- sharing summary tables as opposed to raw data.

2. Dissemination

Findings can be shared in the form of:

- written report
- executive summary
- infographics designed to explain key findings (graphs, charts, etc.)
- PowerPoint presentation
- StoryMaps¹⁶
- dashboard
- briefing notes.



Needs assessment



- Contents
- References
- Endnotes

Methods for disseminating information include:

- email
- workshop
- verbal briefings
- one-on-one discussions
- interpretive dance
- web posting (Humanitarian Data Exchange, ReliefWeb, Global Health Cluster sites)
- hard copy.

Findings should be shared with all relevant stakeholders, including national authorities and affected communities. When sharing with the local population, it is often necessary to ensure that messages are translated into the local language and that any information can be easily understood by all stakeholders. The types of access the affected population has to different information sources should be considered when deciding which methods to use for distribution.

10.7 Tools

10.7.1 Technology and needs assessment

It is important to use the most suitable technology rather than focusing on the best and most advanced technology available.

Mobile data collection

One of the most useful technological advancements for needs assessments in recent years has been the rise of mobile data collection systems. Beyond the environmental impact of reducing paper usage, mobile data collection systems can integrate skips, loops and extended answers far better than paper-based systems (where there is heavy reliance on enumerators to properly read, understand and implement instructions). They also greatly reduce data entry errors by eliminating issues that can arise from having to read illegible notes, not enough space on the paper, and inputting responses in the wrong location.

Even with these benefits, mobile data collection is not always the best option. It may be difficult to quickly enter information into a mobile device in the midst of an interview, and interrupting the respondent repeatedly may compromise rapport. In some circumstances, carrying around devices to collect information is associated with intelligence agencies and can lead to mistrust in the population being surveyed. In certain circumstances, local government may not be comfortable with use of devices that can collect GPS coordinates. In the rare event that data are



Needs assessment



- Contents
- References
- Endnotes

being collected cross-border, there can sometimes be logistical issues relating to sanctions and donor agreements about carrying inputs across borders (and the ability to guarantee their return). In besieged areas, where there may be no physical contact with data collection teams, it may be necessary to use paper surveys if they do not have the tools to use the mobile collection techniques on hand.

Data storage

As data set size and complexity increases, it is necessary to consider how to store data. Many organizations will have policies in place that govern data management. When it comes to needs assessment, *how* data are stored is slightly less of a concern than *that* they are stored. All data should be stored in a secure location that is not susceptible to hacking, particularly when personal data are collected.

Software

There is a wealth of software that can support the needs assessment process. The information below provides an overview of the various software types, with some suggestions for currently used software included. Technology continues to advance and new software is constantly under development; for this reason the software options provided should not be considered exhaustive.

Survey software

Most commonly used for mobile data collection, survey software can also be employed to collect data online. The most common software used to collect data on mobile devices is presently based on XLS forms. In humanitarian settings, KoBoToolbox and Open Data Kit are the most popular options, with SurveyMonkey and LimeSurvey often being used to collect online surveys. The possibilities for remote survey collection are being explored by a number of organizations, but at present no simple solution has been identified. As smart phones are not universally utilized and Internet access can be unreliable (or unavailable) in some areas, most efforts have focused on running surveys through cell phone networks. There are a number of logistical issues that have arisen out of working with mobile phone networks, and this type of data collection has not yet become commonplace. It should only be looked into in circumstances with the most severe access constraints.

Geographical information systems (GIS)

Geographical analysis is very useful to include in the analytical process if a GIS specialist is available. GIS software is not limited to displaying geographical information; for example, it can also be beneficial for calculating a random sample.



Needs assessment



- Contents
- References
- Endnotes

Previously, random samples required a list of potential respondents that could then be used to randomly select a sample. Now, if reasonably updated dwelling information is available (satellite imagery can greatly help in this case), GIS software can be used to select points on the map where interviews can take place. The main GIS analysis software remains Esri's ArcGIS, but use of the open-source QGIS continues to grow.

Statistical software

A variety of statistical software is available to help process data and run statistical tests that can be included in results. SPSS and Stata remain the most popular paid statistical analysis software, with R (an open-source alternative) growing in popularity.

Qualitative data analysis

There is a slowly growing number of applications that can assist in the analysis of qualitative data. A key feature of this type of software is that it enables tagging of key findings through various input documents. The applications usually support a variety of document formats, including voice recordings, pictures, PDFs, quantitative data sets and text documents. While NVivo is arguably the most robust tool for analysing qualitative data available, there are some lower-price alternatives, such as Dedoose, that may be used.¹⁷

Other software

DEEP, currently in its beta edition,

is an intelligent web-based platform offering a suite of collaborative tools tailored towards humanitarian crisis responses. It includes common analysis workflows and frameworks for ... using both structured and unstructured, quantitative and qualitative data (8).

Satellite imagery

Satellite imagery has a number of uses in humanitarian needs assessments. It can be used in combination with sensor technology to conduct remote sensing¹⁸ (for example, in famine-related emergencies, local food availability can be monitored by mapping vegetation growth through analysis of visible infrared light); it can provide an overview of disaster-affected areas by comparing images from before and after the disaster event; it can provide the basis for mapping out areas and understanding settlement locations and population movements; and it can even aid in sampling design. Use of satellite imagery depends on access to images of sufficiently high resolution (with higher-resolution photos often requiring financial investment) and the software and skill sets needed to analyse them.



Needs assessment



- Contents
- References
- Endnotes

Drone technology

Aerial images (which can also be used for remote sensing) can be collected very quickly with the use of drone technology. However, use of drones can be extremely sensitive and proper authorization must always be sought first.

10.7.2 Checklist to give affected communities a voice

The following checklist can provide a guide to ensure participation by affected communities in a needs assessment. It is advisable to incorporate as many options as possible (9).

- ✓ Are all questions being asked in the local language?
- ✓ Are all individuals being interviewed asked to provide informed consent?
- ✓ Are consultations organized for a diverse group of actors (such as women, men, girls, boys, people with disabilities, older persons, youths, LGBTI (lesbian, gay, bisexual, transgender and intersex) persons, and minority groups)?¹⁹
- ✓ Have the assessment findings and conclusions been presented to the affected population in a format the majority can understand, in terms of both medium and language?
- ✓ Have the data from various groups been triangulated to obtain information on the wide variety of experiences, with mention of any outliers?
- ✓ Have you incorporated the potential needs and themes that might be relevant to more marginalized groups in the assessment design (information needs and indicators)?
- ✓ Have you collaborated with specialized nongovernmental and community-based organizations that work with marginalized and isolated groups in order to enhance participation by those groups?
- ✓ Have you engaged with community structures (for example, youth groups, committees for women)?

10.7.3 Team checklist (composition, skills, equipment, training)

Table 10.4 outlines the competencies that may be required for conducting a needs assessment. This table can assist with identifying the correct individuals to participate in the process, and where no single individual possesses all of the necessary competencies, a team can be assembled of individuals with complementary skill sets to ensure a high-quality assessment.



Needs assessment



- Contents
- References
- Endnotes

► **Table 10.4 Needs assessment: competencies checklist**

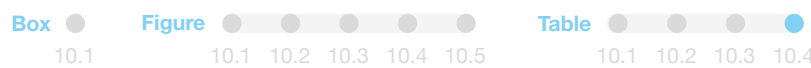
COMPETENCY – THE TEAM MEMBER IS ABLE TO:
Understand current priorities in global health and articulate how the main causes of burden of disease and mortality differ across age groups and regions of the world.
Recognize the different typologies of crisis (armed conflict, displacement, natural disaster, etc.) and the key ways in which humanitarian action differs in these.
Recognize the following generic features of health systems in resource-constrained settings: (a) different levels of care provision (from community to tertiary) and how they connect in a continuum; (b) the difference between preventive and curative health services; and (c) typical challenges, including shortage of skilled health workers, low utilization and financing problems.
Understand the humanitarian aid architecture, the cluster approach and inter-cluster coordination of public health information.
Understand global standards for public health and humanitarian action.
Formulate, select, and interpret appropriate public health indicators. ²⁰
Identify and triangulate already available sources of population estimates and understand the effect of uncertainty in denominators on interpretation of public health information.
Design a survey or assessment questionnaire, applying good practices for question formulation and layout.
Implement a questionnaire in the field, by selecting and implementing the appropriate data collection platform (paper-based or electronic) and carrying out steps for validation and field-testing.
Use available public health information to compose a general picture of risks, gaps and priorities.
Design, implement and analyse population sample surveys, including with complex sampling designs.
Source available georeferenced data sources and set up ad hoc collection of georeferenced data so as to implement geographical information system (GIS) spatial analyses, using appropriate software.
Design, implement and analyse specific field data collection to rapidly estimate population size for planning purposes, when available sources do not appear robust.
Use open-access software solutions to develop and manage simple websites in order to enhance use of information by partners.

Source: Based on the common technical competencies outlined in the *Standards for public health information services (10)*.

One of the most important factors that can contribute to a successful assessment is the presence of one person responsible for coordinating the assessment from start to finish. For larger assessments this person would have to be dedicated to assessment tasks for the duration of the needs assessment.



Needs assessment



- Contents
- References
- Endnotes

For smaller assessments they may be able to undertake additional tasks at certain points, but would need to have sufficient time allotted for completing each task (significant time would be required for the assessment design, debriefing, analysis and writing up the report). Assessment coordinators need to be able to understand the various components of the needs assessment and their relative importance as well as have sufficient knowledge of the sector and cluster system to be able to coordinate across multiple partners. It will be the primary responsibility of the assessment coordinator to interact with government representatives; working with such a broad array of actors requires strong diplomatic skills.

10.8 Basic principles for needs assessment

The following principles should underpin the entire needs assessment process.

- Do no harm.** Information sources should be protected by complying with best practices regarding privacy, confidentiality and seeking informed consent. All primary data collection should start by describing the assessment and data being collected to the person partaking in the interview. That person must then agree to participate before any questions can be asked. It is necessary, when collecting data, to always be mindful of the potential for re-traumatization and vicarious victimization when asking people to relay potentially traumatic information. Assessment teams should have referral information available for when immediate mitigation and remedial health actions are needed. The principles of data responsibility in humanitarian action are meant to serve as a benchmark for the processing of non-personal data, particularly in sensitive contexts that may put certain individuals or groups of individuals at risk of harm (11). They are adapted from the United Nations Principles on Personal Data Protection and Privacy (12), as well as the core humanitarian principles, Sphere, and the Core Humanitarian Standard on Quality and Accountability (13, 14). If an assessment purports to collect anonymous data, it is essential that all data be anonymized before being shared, and that use of any personalized data be limited only to validation procedures (such as examining collected GPS points to compare with sampling plans).
- Coordination.** All stakeholders should know when and where assessments are being carried out. Involving a broad set of actors will strengthen the quality and usability of findings and their impact on the humanitarian response.
- Participation and inclusion.** Action must be taken to ensure that participation of a diverse sample of women, men, girls, and boys – including persons with disabilities, older persons, youths, and LGBTI persons – is adequately captured in a needs assessment. Communities should always be engaged in the needs



Needs assessment



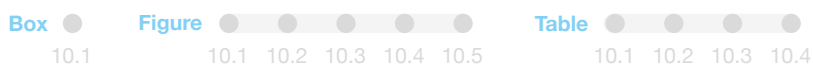
- [Contents](#)
- [References](#)
- [Endnotes](#)

assessment process, and communication techniques should always consider cultural norms (such as language use and cultural practices). In any assessment it is necessary that findings are presented to affected populations as well as other stakeholders in order to avoid situations where people feel that they are constantly being asked for information but nothing comes of it.

- **Validity.** Standardized and rigorous procedures for the collection and analysis of data should be used to ensure credible results and minimize bias. Validation needs to be considered in both the design of the assessment, so that sampling plans and all processes factor in confidence requirements, and during implementation, when cross-checking findings with a variety of stakeholders to obtain buy-in for the conclusions drawn.
- **Relevance.** The purpose of the assessment must be kept in mind, so that only the required data are collected and analysed. Following the step-by-step design process that carefully builds upon information needs will ensure that all questions included in the tool design are relevant to the overall objective.
- **Adequacy.** The scope of the assessment should reflect the extent and nature of the crisis. Assessments are costly procedures and it is often necessary to adjust the design so that the plan is realistic, considering available resources. However, there comes a point when resources may be too limited to provide worthwhile information. This “tipping point” should be carefully considered when working on the assessment design.
- **Timeliness.** The need for accuracy, comprehensiveness and detail should be weighed against the speed with which critical decisions need to be made. While it is necessary to ensure that a needs assessment is adequate for informing the identified information needs, it is also essential that information is produced in sufficient time to be used for its objectives. Timeliness is the main factor that informs the type of assessment used. For example, initial assessments, which are characterized by some of the weakest methodological design but produce the fastest results, should only be utilized when timeliness is most crucial (for example, operations cannot proceed without the needs assessment information).
- **Continuity.** Steps should be taken in the design and implementation of each assessment to maximize comparability between data collected at different points in order to monitor trends.
- **Age, gender and diversity.** Health risks, needs, priorities, capacities, resilience and coping mechanisms are varied, depending not only on age, gender, social roles and other forms of diversity, but also on the extent to which groups are able to participate in finding durable solutions to their situations. It is important to



Needs assessment



- Contents
- References
- Endnotes

include consideration of the dynamics that accompany the interaction of various groups when planning primary data collection. For example, a focus group that has 10 individuals from the same community in it, where two are village leaders, some representatives from minority groups as well as a mix of genders, is unlikely to be of much use, because the information collected will probably reflect only the opinions of the most powerful individuals (village leaders). For this reason, it is often necessary to collect information from specific groups separately (for example, women versus men, dominant versus minority groups, young versus old).

- **Secondary data.** Maximum use should be made of available secondary data. Primary data collection should focus on determining what has changed, validating data, and filling gaps in validated available secondary information. To do this, a secondary data review should always be incorporated into any needs assessment process.

When analysing and sharing data, effort should be made to adhere to the following principles.

- **Impartiality.** A predefined analysis plan will ensure a predictive and objective process and will minimize bias, for example towards preconceived expectations about the severity of health needs.
- **Transparency.** Methodologies and approaches used during an assessment should be made available. This includes any assumptions made during the analysis or any potential limitations on either the accuracy of the data or the sources used.
- **Sharing.** Findings should be shared with other actors, national authorities, and the affected population, while adhering to data-sharing principles and agreed data-sharing protocols or agreements, as relevant. As mentioned above, it is important to consider protection concerns when sharing data and information, and to always share as much as is possible within the frame of “do no harm”.



Needs assessment



- [Contents](#)
- [References](#)
- [Endnotes](#)

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Needs assessment

Paragraph

10.1 10.2 10.3 10.4 10.5 10.6 10.7 10.8

Box

10.1

Figure

10.1 10.2 10.3 10.4 10.5

Table

10.1 10.2 10.3 10.4

● Contents

● References

● Endnotes

Endnotes

1. See Chapter 4.
2. See below and Chapter 4.
3. In some cases it may be the absence of behaviour, objects or events that is being sought.
4. See Chapter 4.
5. This type of monitoring assessment should be differentiated from the more typical programme monitoring that seeks to review programme implementation.
6. MSNAs are usually run through the assessment working group, if one exists. They are often coordinated by a combination of REACH and the assessment working group or REACH and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA). REACH is a leading humanitarian initiative providing granular data, timely information and in-depth analysis from contexts of crisis, disaster and displacement. <https://www.reach-initiative.org/>
7. Note that the post-conflict needs assessment methodology is under review at the time of writing.
8. The IASC defines an indicator as “a specific variable, or combination of variables, that gives insight into a particular aspect of the situation”.
9. Data in surveys can be collected in a variety of formats but are most often classified as numeric (a number) or categorical (can be grouped). Text data can also exist that are not categorical, but they could not be used in statistical tests without first being coded into a numeric or categorical format.
10. Metadata are the descriptions included in a data set that provide guidance on that data set.
11. Raw data have not undergone any processing. They are most often found in the form of a spreadsheet where each column contains a different variable (question or question component) and each row contains a different observation (such as an interview).
12. The non-response rate is the percentage of targeted individuals who refuse to take part in the needs assessment.
13. Data should only be combined into a single data set if they can be disaggregated or aggregated into the same units.
14. Needs assessments will decide early on the level at which data needs to be provided. Usually geographical levels are taken into consideration (for example, allowing for district-level profiles), but it is also beneficial to consider disaggregation by certain vulnerable or minority groups, possibly by gender or age, or other factors that may show differences in health status. It is important to ensure that any criteria intended to be used for disaggregating are factored in during the sample design.
15. For example, there have been instances where health facilities are targeted in aerial attacks, so sharing maps that mark the location of health facilities could have severe consequences. The need to share information should always be weighed against the risks of someone adversely using it.
16. StoryMaps combine various types of information (graphics, images, maps, multimedia content and narrative text).
17. The private sector increasingly relies on qualitative data, and software is constantly under development to assist with analysis. Though data collection may include a slightly different process, the following software should also be considered as potentially useful: HubSpot; MAXQDA; Quirkos; Qualtrics; FreeQDA; and QDA Miner Lite.
18. Remote sensing is defined by the United States Geological Survey as the process of detecting and monitoring the physical characteristics of an area by measuring its reflected and emitted radiation at a distance (typically from satellite or aircraft).
19. It is useful to identify key groups in advance so a separate line item can be included for each group. Remember that all groups should be broken down by gender at a minimum (for example, women with disabilities may have very different experiences to males with disabilities) and possibly by age as well.
20. See Chapter 12.

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7

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9

10

11

12

13

Needs assessment

Paragraph

10.1 10.2 10.3 10.4 10.5 10.6 10.7 10.8

Box

Figure

10.1 10.1 10.2 10.3 10.4 10.5

Table

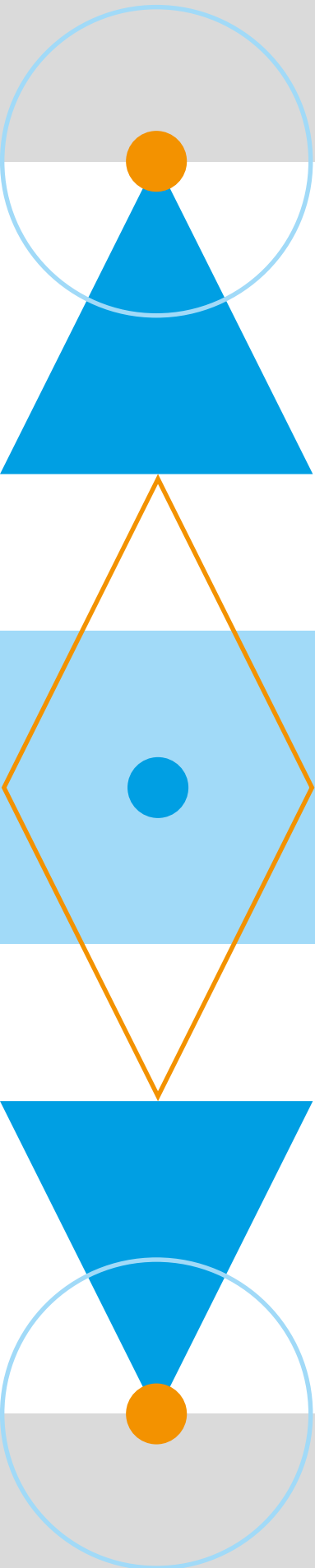
10.1 10.2 10.3 10.4

● Contents

● References

● Endnotes

Health cluster strategic response planning



Contents

Chapter 11		
Health cluster strategic response planning		358
11.1 Introduction		358
11.2 The importance of strategic response planning		358
11.3 Strategic response planning process		359
11.4 Development of a flash appeal and role of health cluster coordinator		361
11.4.1 Flash appeal: definition and purpose		361
11.4.2 Role of the health cluster coordinator in development of a flash appeal		362
11.4.3 Key actions of health cluster coordinator		362
11.5 What is a humanitarian response plan and when is one developed?		363
11.5.1 Country strategy: part 1 of the humanitarian response plan		365
11.5.2 Health cluster response plan: part 2 of the humanitarian response plan		367
11.6 Steps for developing the health cluster response plan		369
11.6.1 Ensuring a consultative process in developing a health cluster response plan		369
11.6.2 Ensuring inter-cluster coordination to support an effective multi-cluster approach for better health outcomes		371
11.6.3 Defining the health cluster response plan		371
11.6.4 Costing of the health cluster response		381
11.6.5 Drafting the health cluster response plan		382
11.7 Coordinated project development: projects for inclusion in the health cluster response plan		382
11.7.1 Tasks of health cluster coordinators		382
11.7.2 Tasks of health cluster partners		385
References		386
Endnotes		388
Boxes		
Box 11.1	Determining number of people in need across all sectors	366
Box 11.2	Comparison of country strategy and health cluster response plan	368
Box 11.3	Main features of the health cluster response plan	369
Box 11.4	OCHA humanitarian indicator registry	373
Box 11.5	Key definitions when determining humanitarian caseloads	374
Box 11.6	Considering environmental concerns	378
Box 11.7	Considering capacity-building issues	380
Box 11.8	Health cluster peer review of partner project proposals	384
Figures		
Figure 11.1	Strategic planning within the Humanitarian Programme Cycle	364
Tables		
Table 11.1	Steps in strategic response plan	360

Abbreviations

3W/4W	who, what, where (and when)
HC	humanitarian coordinator
HPC	Humanitarian Programme Cycle
NGO	nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
RC	resident coordinator
WASH	water, sanitation and hygiene
WHO	World Health Organization

11. Health cluster strategic response planning

11.1 Introduction

This chapter provides an overview of strategic response planning in a humanitarian situation. It addresses the flash appeal (what it is, when it is used and health cluster engagement in its development). It then outlines the process of development of the humanitarian response plan and the health cluster response plan and illustrates the linkages between those plans. The chapter also outlines the respective responsibilities of the health cluster coordinators and health cluster partners in all the processes.

11.2 The importance of strategic response planning

Planning aims to ensure an evidence-based, resource-effective and results-oriented collective response to which clusters and organizations contribute.

Strategic response planning helps the humanitarian community to identify and respond more effectively to the needs of the people affected by a crisis, focusing activities and resources to ensure that organizations are working towards common goals. Strategic response planning also helps in assessing the humanitarian community's response and adjusting it to a changing environment and emerging needs.

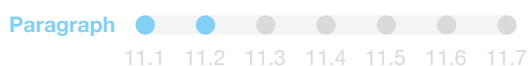
Strategic response planning involves:

- assessing the situation and needs (covered in other chapters);
- setting strategic objectives;
- developing an approach to achieve those objectives;
- prioritization of possible actions, including making the tough decisions about what is critical given limited resources;
- making sure roles and responsibilities are clear.

The development of a strategic response plan is a key step in the Humanitarian Programme Cycle and should be carried out only when needs have been



Health cluster strategic response planning



- [Contents](#)
- [References](#)
- [Endnotes](#)

understood and analysed through the humanitarian needs overview or other joint needs assessment and analysis processes (such as the multi-cluster/sector initial rapid assessment, the multi-cluster needs assessment, or health-specific assessments) (1).

At both the analysis and planning stages, the commitments made at the World Humanitarian Summit, as expressed in the Grand Bargain (2), are emphasized, including the following:

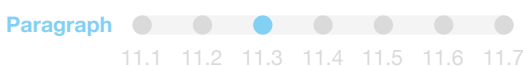
- comprehensive, cross-sectoral assessment of needs;
- risk and vulnerability analysis (including analysis of the status of gender-based violence and sexual exploitation and abuse);
- adoption of a people-centred approach, including mainstreaming accountability to affected populations, protection and diversity in the health cluster;
- integration of people's voices and taking account of their priorities;
- localization of the response;
- use of the risk and vulnerability analysis for consideration of response options;
- ensuring that identification and prioritization of responses is aligned with needs;
- systematic consideration of options for cash transfer programmes and other response modalities.

11.3 Strategic response planning process

The strategic response plan is jointly developed by subnational, national and international stakeholders, including representatives of affected persons. The steps outlined in Table 11.1 are recommended (3).



Health cluster strategic response planning



- Contents
- References
- Endnotes

► **Table 11.1** Steps in strategic response plan

1. CONSOLIDATION OF HEALTH DATA AND INFORMATION	2. STRATEGIC RESPONSE PLAN WORKSHOP	3. INTRA-CLUSTER WORKING SESSIONS	4. USING THE STRATEGIC RESPONSE PLAN
<p>Agree on the scope and focus of the analysis:</p> <ul style="list-style-type: none"> develop a joint analytical framework and plan identify the data, indicators, and other information required as well as the sources define and agree on the roles and responsibilities of agencies, clusters and sectors. <p>Review and analyse data and information, and identify gaps:</p> <ul style="list-style-type: none"> review existing data, indicators and other information related to selected population groups, geographical areas and thematic issues identify critical gaps in data and indicators, and determine how to bridge the gaps conduct joint intersectoral analysis of relevant available data, indicators and other information write the draft analysis results. <p>Review and approve the analysis results and monitoring requirements</p> <p>The humanitarian needs overview is presented to and seeks the endorsement and validation of the humanitarian coordinator (HC).</p> <p style="text-align: center;"> Response analysis</p>	<p>The HC, with the humanitarian country team, convenes a meeting to:</p> <p>Develop a top-line country strategy that includes:</p> <ul style="list-style-type: none"> parameters, boundaries and assumptions of the response strategic objectives, activities and indicators and monitoring requirements. <p>Select priority humanitarian consequences to address and decide on the most appropriate costing methodology for the humanitarian response plan.</p> <p>Relevant clusters work together to agree on how to collaborate in designing an effective and integrated approach to each of the strategic objectives.</p> <p>Ensuring shared ownership of strategic objectives through this process is essential.</p> <p style="text-align: center;"> Country strategy</p>	<p>Health cluster coordinators, together with cluster members, formulate cluster response plans based on the country strategy.</p> <p>Formulate the health activities and estimate the cost of the health response plan:</p> <ul style="list-style-type: none"> identify cluster objectives required to achieve the humanitarian response plan strategic and specific objectives and associated indicators upload and vet projects estimate the cost of the health response write the health response plan. <p>These plans should either be developed at a working session or through regular consultations at cluster and inter-cluster level.</p> <p style="text-align: center;"> Cluster response plans</p>	<p>The strategic objectives, activities and indicators formulated in the strategic response plan are used to:</p> <ul style="list-style-type: none"> inform the development of the joint response monitoring framework inform the development of individual agency programmes. <p>The HC and humanitarian country team share the country strategy, as appropriate, with relevant stakeholders.</p> <p style="text-align: center;"> Monitored and updated humanitarian response</p>

Health cluster strategic response planning

11.4 Development of a flash appeal and role of health cluster coordinator

11.4.1 Flash appeal: definition and purpose

A flash appeal is a concise top-line analysis of the scope and severity of a sudden onset humanitarian crisis (4). It sets out priority actions and preliminary requirements for the response across all clusters and sectors for up to three months, and is used for fundraising purposes.

When is a flash appeal used? A flash appeal is issued three to five days after a sudden onset or emergency, or when the HC and humanitarian country team determine a spike in need or a change in context in protracted or slow onset crises.

Who triggers a flash appeal? The HC or resident coordinator (RC) triggers the flash appeal process in consultation with the humanitarian country team. Aspects of the process include the following.

- Government approval should be sought through all means, and government participation should be encouraged (5). However, government approval is not formally required for a flash appeal to proceed.
- The humanitarian country team establishes the strategic objectives for the plan.
- Cluster and sector leads compile response activity overviews in consultation with partners and the affected population.
- The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) compiles and disseminates the document.

The flash appeal (planning tool) and application to the Central Emergency Response Fund (as the funding mechanism) are developed simultaneously and are part of the same process.¹

Flash appeal resource requirements will be absorbed into the humanitarian response plan when it is developed, within 30 days of the flash appeal (6).



Health cluster strategic response planning

Paragraph ● ● ● ● ● ● ●
11.1 11.2 11.3 11.4 11.5 11.6 11.7

Box ● ● ● ● ● ● ● ●
11.1 11.2 11.3 11.4 11.5 11.6 11.7 11.8

Figure ● Table ●
11.1 11.1

- Contents
- References
- Endnotes

11.4.2 Role of the health cluster coordinator in development of a flash appeal

The HC leads the planning process for a flash appeal and, together with the humanitarian country team, sets out the direction and priorities for the response.

Health cluster coordinators have a responsibility to:

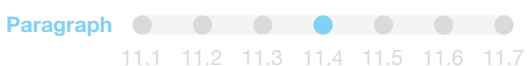
- contribute to the development of the flash appeal, providing inputs to the needs and response analysis and formulation of the overarching strategic objectives for the whole humanitarian response;
- identify priority health needs and priority health cluster interventions;
- provide an estimated figure for the overall cost of the immediate response for the health cluster;
- brief the head of the World Health Organization (WHO) country office on health cluster analysis and priority needs and health cluster interventions, as the head of the WHO country office will also represent the health cluster in humanitarian country team meetings.

11.4.3 Key actions of health cluster coordinator

- The health cluster coordinator should determine the cluster priorities and financial requirements through a consultative process within the health cluster, engaging with the ministry of health, partners and other stakeholders. Consultations should also be carried out with the strategic advisory group where one exists, or with key health cluster partners, along with the local health authorities and other health stakeholders (where the strategic advisory group is not in existence).
- A health cluster meeting should be called urgently to negotiate and agree on health cluster partners' respective responsibilities for implementation of the emergency health response in the initial stages. Such discussions may need to take place online if it is not feasible to bring all partners together within the time constraints. This allocation of responsibility should take into consideration the operational capacity, experience and geographical presence of the various partners in emergency health response and with reference to the health cluster emergency preparedness and contingency plan, as appropriate.
 - The process of mapping of partner activities needs to commence at this stage using the 3W/4W – who, what, where (and when) – matrix, and needs to be updated regularly.²



Health cluster strategic response planning



- [Contents](#)
- [References](#)
- [Endnotes](#)

- A short health cluster response plan should be drafted articulating health cluster priorities (within the confines of the broader flash appeal) and building on the health cluster emergency preparedness and contingency plan, as appropriate (for example, where a health cluster emergency preparedness and contingency plan exists for the type of crisis that has occurred). Where an emergency preparedness and contingency plan does not exist, the health cluster response plan should be drafted based on the initial contextual analysis.

Where a health cluster has not been activated, the health sector and relevant health agencies will provide input to the flash appeal process and development of an emergency health response plan, using the process outlined above. WHO as the cluster lead agency for health will generally take responsibility for the coordination functions in collaboration with the local health authorities. However, in exceptional circumstances it may be another organization that takes on the cluster lead agency role.³

11.5 What is a humanitarian response plan and when is one developed?

The humanitarian response plan is the management tool for country-based decision-makers, primarily the HC and humanitarian country team, but also for use by United Nations agencies and nongovernmental organization (NGO) directors, managers and cluster coordinators. Its purpose is to support an effective and strategic response, based on solid analysis of the humanitarian needs and concerns of the affected population.

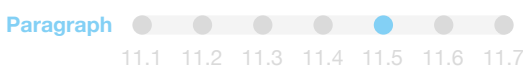
A humanitarian response plan is prepared for sudden onset or protracted emergency situations that require international humanitarian assistance based on a humanitarian needs overview. The plan articulates the shared vision of how all clusters will respond to the assessed and expressed needs of the affected population.

In a sudden onset crisis or where there is a rapid escalation in a protracted crisis, and where a flash appeal has been issued, a humanitarian response plan will normally be produced within 30 days of issuance of the flash appeal, building on the initial planning undertaken.

In a protracted crisis many humanitarian country teams develop humanitarian response plans on an annual basis, usually in the last quarter of the calendar year for the following calendar year. However, the planning time frame is flexible and may start at any point during the year, as determined by the HC and the humanitarian country team.



Health cluster strategic response planning



- Contents
- References
- Endnotes

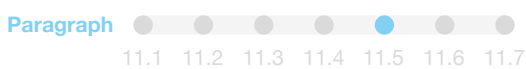
Alternatively, countries may use a multi-year planning process, as promoted by the Grand Bargain (2). The decision to use a multi-year planning time frame is made by the humanitarian country team taking into consideration such factors as the degree of political stability, the likelihood that humanitarian needs continue to exist in the years covered by the plan, the possibility of preparedness and resilience actions, and whether sufficient monitoring methods are in place. Another consideration is the availability of relevant data, including sufficient information on crop cycles, livelihood and market analyses, an iterative contingency planning process, and trends in national capacity (1). The humanitarian country team will often look at the potential availability of multi-year funding and other sources of funding to bridge the humanitarian–development divide.

Figure 11.1 presents stages in the strategic planning process within the Humanitarian Programme Cycle.

Figure 11.1 Strategic planning within the Humanitarian Programme Cycle



Health cluster strategic response planning



- Contents
- References
- Endnotes

The humanitarian response plan has two distinct but interlinked parts:

- a country strategy with a narrative, strategic objectives and identified indicators to monitor the achievement of strategic and specific objectives as well as the response approach and modalities;
- cluster plans with cluster objectives required to achieve the humanitarian response plan strategic and specific objectives and associated indicators, and estimation of the response cost.

11.5.1 Country strategy: part 1 of the humanitarian response plan

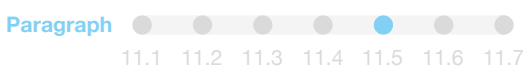
Functions of the country strategy

The country strategy performs the following functions:

- provides an overview of the crisis (contextual analysis);
- establishes the scope and boundaries of the collective humanitarian response (geographical, demographic, sectoral or other measures of vulnerability);
- takes account of needs being addressed by non-humanitarian actors (for example in development programmes);
- establishes intervention criteria (vulnerability analysis, thresholds, crisis factors);
- determines the target population (number, type, population groups and location of people to be assisted, which may be broken down by cluster);
- examines cross-cutting opportunities and incorporates inter-cluster collaboration on targeting and response, where appropriate;
- establishes the parameters of the response, which may be time-bound (for example, now versus later), geographical (for example, west versus east), or seasonal (for example, summer versus winter);
- gives due visibility to accountability to affected populations, protection, diversity (cross-cutting aspects such as age, disability, gender, HIV, mental health), the environment and other issues of relevance to the context;
- incorporates the building of resilience;



Health cluster strategic response planning



- [Contents](#)
- [References](#)
- [Endnotes](#)

- sets overall strategic objectives governed by the needs and priorities outlined in the humanitarian needs overview;
- articulates activities, indicators, baselines and targets for each strategic objective;
- articulates prioritization criteria to be applied, including immediate lifesaving (actions that avert or mitigate direct loss of life or harm to a population), time-critical lifesaving (such as vaccination ahead of epidemics), critically enabling actions (such as logistics, air transport of aid personnel), cost-efficiency, capacity-building, or others as determined by the context;
- explains how the humanitarian community intends to fulfil those objectives.

Box 11.1 presents information on determining the number of people in need across all sectors.

● **Box 11.1 Determining number of people in need across all sectors**

People in need include those whose well-being and living standards are threatened or disrupted, and who cannot re-establish their normal living conditions with their accustomed means in a timely manner without additional assistance.⁴ More specifically, people in need are those who suffer from the humanitarian consequences identified during the joint intersectoral analysis. The estimation of the number of people in need should be disaggregated by relevant population groups, subgroups and geographical areas.

OCHA has the responsibility to facilitate a consultative process to determine the number of people affected by an emergency and break down the data by age and gender across all sectors. OCHA may establish a working group (composed of representatives from some of the clusters and key experts) to carry out this process, which involves liaising with relevant government departments and civil societies in the country, reviewing recent census and other relevant studies and assessments, and calculating population projections based on national standards. The various cluster caseloads should then be developed based on the overarching planning figures.

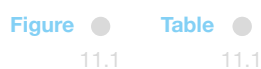
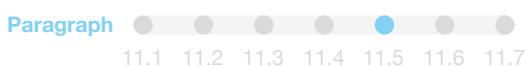
Development of the country strategy for the humanitarian response plan

Based on the humanitarian needs overview,⁵ the country strategy is formulated by the HC and the humanitarian country team in consultation with government, civil society and cluster coordinators and partners.

Often this process is initiated with a consultation workshop with the participation of government, civil society, humanitarian organizations and cluster coordinators. The response analysis will be reviewed and a top-line country strategy developed, outlining boundaries, priorities, and assumptions, and agreeing on strategic objectives.



Health cluster strategic response planning



- [Contents](#)
- [References](#)
- [Endnotes](#)

Health cluster coordinators play a key role in the development of the country strategy. Their responsibilities include:

- representing the health cluster at the inter-cluster coordination group and bilaterally with other key clusters;
- providing inputs to (a) reaching agreement on the scope and focus of the analysis, (b) review and analysis of data and information and identification of gaps, (c) review and approval of the analysis results and monitoring requirements, (d) selection of priority humanitarian consequences to address, (e) analysis of response options and formulation of strategic objectives, and (f) review and approval of the strategic objectives and monitoring requirements;
- reviewing the overall strategic response plan as it is being developed;
- collaborating with other clusters and humanitarian actors to ensure a holistic approach to achieving strategic objectives;
- reviewing guidance, adapting templates and agreeing on time frames for the development of the cluster response plans;
- keeping health cluster partners updated, informed and engaged throughout the process of development of the humanitarian response plan;
- briefing the head of the WHO country office on the health cluster position and priorities, as the head of the WHO country office represents the health cluster in humanitarian country team discussions on the country strategy;
- formulating the activities and estimating the cost of the response plan.

11.5.2 Health cluster response plan: part 2 of the humanitarian response plan

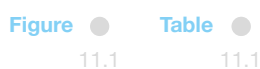
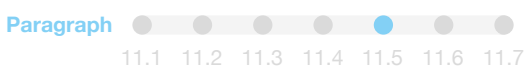
The health cluster response plan is one of the sector-specific response plans that make up part 2 of the humanitarian response plan. The health cluster response plan is:

- the principal tool to facilitate a strategic and coordinated emergency health response;
- the framework for the *collective* response of all health cluster partners.

The health cluster response plan is developed within and aligned with the wider humanitarian response plan for the whole humanitarian response (Boxes 11.2 and 11.3).



Health cluster strategic response planning



- Contents
- References
- Endnotes

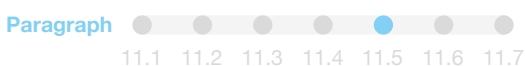
The health cluster response plan will be prepared after the country strategy is developed and will be guided by and aligned with the country strategy. However, this is not a completely linear, sequential process. Health analysis will be incorporated into the country strategy, and development of the health cluster response plan is likely to start as the country strategy is being drafted; thus, the processes may overlap.

● **Box 11.2 Comparison of country strategy and health cluster response plan**

Country strategy	Health cluster response plan
<p>The country strategy:</p> <ul style="list-style-type: none"> • is formulated by the HC and humanitarian country team based on analysis of the humanitarian needs overview and through a consultative process with government, civil society and cluster coordinators; • ensures there is consensus on prioritized needs; • guides development of cluster plans. <p>The humanitarian needs overview is the foundation of the humanitarian response plan.</p>	<p>The development of the health cluster response plan is led by the health cluster coordinator based on the country strategy and humanitarian needs overview, and additional supporting health information.</p> <p>The plan is developed through a consultative process, ensuring active engagement of health cluster partners, health authorities and other key clusters, including food security, nutrition, protection, and water, sanitation and hygiene (WASH).</p> <p>The public health situation analysis is the foundation of the health cluster response plan.</p>



Health cluster strategic response planning



- Contents
- References
- Endnotes

● Box 11.3 Main features of the health cluster response plan

The health cluster response plan:

- defines health cluster prioritization criteria and health cluster priorities;
- defines health cluster objectives and key activities;
- defines health cluster caseloads (number of affected people in need, including number targeted by the health cluster);
- outlines health cluster coordination mechanisms at national, subnational, and field levels;
- defines health cluster indicators;
- determines the total cost for implementation of the plan;
- defines health cluster operational modalities;
- outlines innovative programming;
- describes coordination with key clusters for better health outcomes;
- ensures protection mainstreaming;
- addresses accountability to affected populations;
- addresses cross-cutting issues;
- addresses environmental issues;
- promotes standards, with a focus on quality of care;
- outlines health cluster capacity-building strategies and key activities;
- links the emergency health response to early recovery and promotes the humanitarian–development nexus;
- outlines the transition and deactivation strategy and actions.

11.6 Steps for developing the health cluster response plan

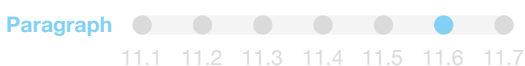
11.6.1 Ensuring a consultative process in developing a health cluster response plan

The health cluster response plan will be developed by the cluster as a collective effort by the cluster coordinator and health partners.

The *health cluster coordinator* is responsible for facilitating the active engagement of international and national health partners and relevant subnational health authorities in the development of the response plan through an effective and transparent consultative process.



Health cluster strategic response planning



- Contents
- References
- Endnotes

The *health cluster partner* actively participates in this consultative process and provides technical input (if part of an existing strategic advisory group).

Health cluster consultation may be conducted through a variety of optional mechanisms.

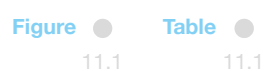
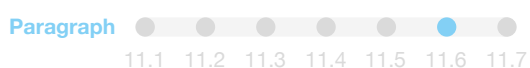
- Where a strategic advisory group is in existence, it should provide direction and guidance on the priorities, objectives and operational modalities for the health cluster response plan.
- A small technical working group may be established to engage in the development of the health cluster response plan. The membership of this group may include members of the strategic advisory group (where in existence), core health cluster partners, and representatives from the national and local health authorities. It is important that those selected for this technical working group have the relevant skills, expertise and capacity to undertake this important task.
- Alternatively, a workshop or series of workshops may be held to develop the plan with participation of health cluster partners and the national and local health authorities, thus ensuring broad input and facilitating consensus.

Tips for engaging partners in the health cluster response plan are as follows.

- ✓ Where the health cluster response plan is developed through the strategic advisory group or a technical working group, it is essential that the health cluster partners be regularly updated on the steps, process and key health needs identified in the public health situation analysis and content of the plan through routine or ad hoc health cluster meetings, in order to obtain wider input and endorsement and to gain consensus.
- ✓ Consultations should be undertaken with specialized agencies and available focal points to ensure that issues related to accountability to affected populations, gender, protection and diversity are appropriately addressed by the health cluster, including prevention of sexual exploitation and abuse. In a situation where the national or local health authorities are not participating in these processes, the health cluster coordinator has the responsibility to engage with the health authorities, as appropriate and depending on the context; to keep the authorities informed and updated on the planning process; to enable input from the authorities into the plan; and to garner an overall consensus.



Health cluster strategic response planning



- [Contents](#)
- [References](#)
- [Endnotes](#)

11.6.2 Ensuring inter-cluster coordination to support an effective multi-cluster approach for better health outcomes

It is the responsibility of the health cluster coordinators to engage with other key clusters to ensure an effective multi-cluster approach for better health outcomes. This coordination will be through the inter-cluster coordination group (facilitated by OCHA) and through communication with other key clusters of relevance to the health response (food security, nutrition, protection, and WASH), bilaterally or through a thematic coordination mechanism.⁶

It will be essential to ensure collaboration and coordination with these key clusters in relation to:

- analysis, building on the humanitarian needs overview;⁷
- defining priority areas geographically (within the scope and boundaries of the humanitarian response plan) and areas of convergence;
- defining the specific strategic and operational linkages with other clusters;⁸
- defining joint indicators, monitoring processes and responsibilities.

✓ **Tip:** It is recommended that representatives of these key clusters be invited to attend relevant health cluster meetings or health cluster workshops when developing the health cluster response plan.⁹

11.6.3 Defining the health cluster response plan

Through the consultative mechanism described above, it is the responsibility of the health cluster coordinators to facilitate discussion and provide direction to determine the health cluster response plan within the confines of the scope and boundaries of the country strategy of the humanitarian response plan. The following elements should be taken into account during this process.

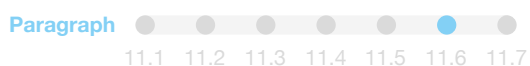
Health situational analysis

Some of the health analyses will already have been fed into the humanitarian needs overview.¹⁰ However, the health cluster may use more detailed, in-depth health analysis for health cluster-specific planning purposes, often elaborated through the public health situation analysis and covering the three domains of health information:¹¹

- health status of and threats facing affected populations
- health resources and services availability
- health system performance.



Health cluster strategic response planning



- [Contents](#)
- [References](#)
- [Endnotes](#)

In the context of health threats, it is important to coordinate with other key clusters (food security, nutrition, protection and WASH) representing key determinants of health to gain an understanding of the capacity of partners, status of infrastructure, available services, and consequent impact on public health.

Health cluster prioritization criteria

Health cluster prioritization criteria need to be determined – immediate lifesaving, time-critical lifesaving, critically enabling, or related to the burden of disease. Alternatively, other criteria related to the context may be used, such as programming in inaccessible areas, or programming through implementation by local NGOs. These criteria need to align with the prioritization criteria of the country strategy (see above).

It is necessary to determine the priority geographical areas and priority health concerns to be addressed in relation to the health status of and risks faced by the population, taking into consideration critical gaps in health service provision and performance of health services.

Priority health interventions need to be agreed, based on the analysis and prioritization criteria (see above).

Health cluster objectives and key activities

Three to five health cluster objectives need to be defined. Each of the health cluster objectives should directly contribute to at least one of the overarching strategic objectives in the country strategy. Health cluster objectives should be specific, measurable, achievable, realistic and time-bound (“SMART”).

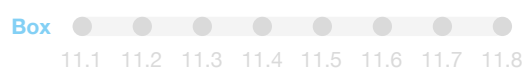
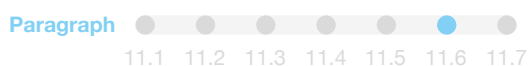
The key activities to be carried out under each health cluster objective should be defined.

Health cluster indicators

The health cluster needs to determine the appropriate indicators to monitor the emergency health response. Output and outcome indicators should be prioritized in the humanitarian response plan, as opposed to process indicators (Box 11.4) (7).¹²



Health cluster strategic response planning



- Contents
- References
- Endnotes

● Box 11.4 OCHA humanitarian indicator registry

The humanitarian indicator registry is a guidance tool for countries to select indicators and, where possible, seek standard definitions and applications of those indicators. It lists the principal needs and response monitoring indicators for each cluster and provides a unique identifier, similar to a place code (P-code), for every indicator. The registry also offers search, filter and export functions.

The reference indicators may be used to track needs over time and to support monitoring along the programme cycle. They can be used for analysis and reporting and may feature in humanitarian needs overviews, strategic planning and monitoring documents, humanitarian dashboards and bulletins.

Scope: The registry is a point of reference for humanitarian country teams and clusters at the country level for indicators that are recommended for monitoring the humanitarian situation, needs and the humanitarian response. The registry does not capture (long-term) impact or input indicators (as many input indicators can feed into one output). There may be some indicators that some global clusters recommend, or other indicators that are only locally appropriate and thus may not be captured in the registry.

Source: OCHA indicators registry (7).

Health cluster caseload

The *health cluster caseload* is the number of affected people in need of humanitarian health assistance, including the number targeted (by geographical location) by the health cluster.

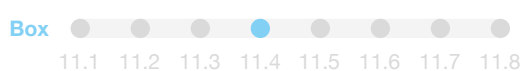
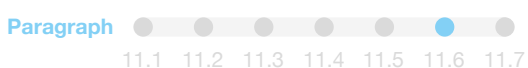
Using the overall planning figures determined by OCHA as a starting point, the health cluster needs to determine:

- the total number of people in need of health services, and their breakdown by age and sex, for each of the specified health interventions or services;
- the health cluster target caseload, that is, the number of people targeted by the health cluster and breakdown by age and sex for each of the specified health interventions or services that will be provided. It is rare that an emergency health response will cover 100% of the population in need, due to security and access issues. The health cluster should use Sphere standards on coverage to define the desired percentage to be covered by the partners as a collective figure (8).

Box 11.5 presents the key definitions used when determining humanitarian caseloads.



Health cluster strategic response planning



- Contents
- References
- Endnotes

● **Box 11.5 Key definitions when determining humanitarian caseloads**

Affected people. Those whose lives have been impacted as a direct result of the crisis. This figure is generally the first available after a sudden onset emergency and often defines the scope or boundary of a needs assessment. It does not, however, necessarily equate to the number of people in need of humanitarian aid. Not all affected people are in need of humanitarian assistance.

People in need.¹³ Those affected people who require humanitarian assistance in some form. People in need represent a subgroup of affected people. This category is further broken down into subcategories or by sector or cluster to provide additional detail about the intensity, severity or type of need.

People targeted. Number of people the humanitarian actors plan or aim to assist. This number is typically smaller than the number of people in need, as (a) it is rare that humanitarian actors can meet all the needs; (b) needs are also being met by those not participating in the joint plan (this may include affected communities, national authorities, the International Red Cross and Red Crescent Movement, and some NGOs); and (c) people in need are not always accessible.

People reached. Those who have received some form of assistance. This figure says nothing about for how long and how well this assistance covers the needs of beneficiaries. A more meaningful picture is provided by the estimate of people covered (see below).

People covered. The number of people whose needs, defined by a humanitarian standard such as Sphere, have been fully met.

There is a significant difference between “people reached” and “people covered”. For example, 1000 people received water (people reached), as opposed to 1000 people received enough water to cover their needs (15 litres per person per day for a certain period of time) (people covered).

Source: Inter-Agency Standing Committee, Information Management Working Group (9).

Health cluster operational modalities

Operational modalities to meet these objectives and targets (implementation strategies) need to be determined, for example use of static versus mobile facilities, use of campaigns, community mobilization, or use of local NGOs and community-based organizations.

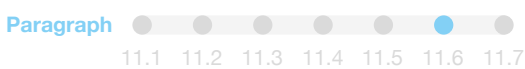
Programming in access-constrained environments

Increasingly, crisis-affected populations are hard to reach, due to access and security constraints in complex conflict environments (10). The lack of unhindered access to communities with high humanitarian needs can prevent aid agencies from applying their standard operating model (“direct operation”). Consequently, alternative modes of operation must be employed.

The key principle behind programming in such access-constrained environments (hereafter referred to as “remote operation”) is that different types of humanitarian actors experience different levels of risk and restriction in insecure or conflict



Health cluster strategic response planning



- Contents
- References
- Endnotes

settings. This means that a programme can sometimes continue in a low-access setting by removing from the operational area personnel who may face high levels of risk or restriction and replacing them with others who can operate more freely.

Remote operation is a reactive solution to the issue generated by the “humanitarian imperative”. Several scenarios can be envisaged in which such a situation applies. An example would be a situation where international NGOs are implementing programmes through partnerships with national or local NGOs rather than through directly recruited staff. International NGO staff might or might not be able to visit the project locations sporadically. Also, governments or authorities may ban international aid workers or organizations from a country or an area of a country, leaving international organizations with the choice of working through local partners.

Remote operation also describes a number of modalities that can be adopted to ensure the start or continuation of response. In the literature, these are arranged into a spectrum that varies according to the depth of roles and responsibilities of the remote agency and the operating agent. The spectrum is typically divided into four modalities: remote control, remote management, remote support, and remote partnership (10).

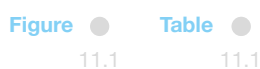
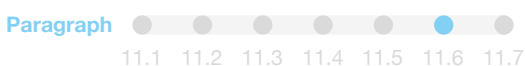
Remote control. The project is run by remote managers, with little or no delegation of authority to operating agents. This operational model is reactive and may be best suited for short-term, highly inaccessible, and rapid onset projects where there is limited staff capacity on the ground.

Remote management. There is some delegation of authority to operating agents and moderate investment in capacity-building, and procedures are in place for better monitoring and quality. This model assumes that remote staff will return to the field and resume decision-making and authority following restoration of access. Such projects are reactive and ideally short term but can be sustained in the medium term. This operational model is considered a contingency during a non-protracted absence of international or senior management staff, with somewhat limited capacity of implementing staff.

Remote support. The remote agency shares authority over programming operating agents (delegating authority while retaining some level of overall accountability and oversight), with significant investment in capacity-building and mentoring. This model is proactive and best suited for longer-term programmes, with experienced staff, limited or some access, and the resources to invest significantly in staff development.



Health cluster strategic response planning



- Contents
- References
- Endnotes

Other kinds of remote operations may operate similarly to those described above but are noteworthy due to the involvement of groups other than traditional humanitarian or civil society actors.

- **Community partnerships** can vary in scope, with implementation ranging from full programmes to aid distribution and monitoring. Community organizations have the benefit of being a stable and familiar presence to the local population, resulting in better targeting of beneficiaries, and are usually more resilient to insecurity. This modality develops community ownership but may also be subject to increased risk of aid being selectively delivered to influential community members.
- **Government partnerships** can promote long-term development and may improve security through increased acceptance. However, this modality might contravene humanitarian principles of neutrality, impartiality and independence, which may undermine acceptance within community factions and may further exacerbate conflict.
- **Outsourcing to commercial contractors** is commonly used for specific services such as supply or third-party monitoring. As with interactions with other partners, it is necessary to do background checks to identify affiliations with terrorist or military groups. Moreover, extensive use of private contractors raises questions of accountability, since there is a risk of unofficial arrangements between different service providers who then share their “cut”. Lengthy chains of contracting and subcontracting lead to high administrative costs and make it difficult to determine the extent to which aid is delivered to intended beneficiaries.

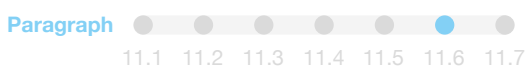
Remote partnership. A remote partnership is one between a remote (international) organization and a (local) operating agent that already has significant internal capacity. The remote partner finances and supports via technical and managerial advice, administration, capacity-building, and advocacy, while the operating agent focuses on context and operations. This model is proactive and best suited to longer-term programmes where aid agencies have lower risk thresholds, fewer resources or lower organizational capacity within the context of implementation.

Most remote agencies adopt a mix of operational modalities, from working through contracted or incentivized staff to working in partnership with national or local organizations, local communities or private enterprises (10).

The Global Health Cluster has developed practical, step-by-step guidance for health actors involved in programming in access-constrained environments. It covers all phases, from inception through programme design and operation to programme closure or return to direct management (10).



Health cluster strategic response planning



- [Contents](#)
- [References](#)
- [Endnotes](#)

Coordination with key clusters for better health outcomes

Strategic and operational linkages between the health cluster and other key clusters (food security, nutrition, protection and WASH) for the emergency response need to be determined in order to identify the respective responsibilities of each of these clusters, referral mechanisms between the health cluster and these key clusters, and potential areas of joint planning and operations.¹⁴

Ensuring protection mainstreaming

Strategies and key actions to ensure protection are mainstreamed and incorporated into the health cluster response plan.¹⁵

Addressing accountability to affected populations

Strategies and key actions to ensure accountability to affected populations need to be determined and incorporated into the health cluster response plan (11).¹⁶

Addressing cross-cutting issues

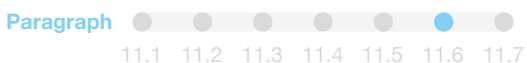
Strategies and key actions to ensure core cross-cutting issues (age, disability, gender, mental health and HIV)¹⁷ should be determined and incorporated into the health cluster response plan.

Addressing environmental issues

Environmental issues should be considered and, where appropriate, strategies to mitigate environmental impacts incorporated into the health cluster response plan (Box 11.6).



Health cluster strategic response planning



- Contents
- References
- Endnotes

● Box 11.6 Considering environmental concerns

The environment is understood as the physical, chemical and biological surroundings in which disaster-affected and local communities live and develop their livelihoods (6).

Key issues in environment and health

Humanitarian operations have a high risk of negatively impacting on the environment, the effects of which may be far reaching and long-lasting, affecting not only the physical environment but also the health, well-being and livelihoods of affected and host communities and increasing the risk for secondary or future disasters (12).

While there are many examples of how humanitarian operations impact the environment, this sentence sums up why humanitarian actors need to ensure that the negative impact on the environment from humanitarian action is minimized.

The impact of environmental degradation on the health of the affected population can be both immediate and long lasting. For example, a sudden high concentration of population in a small area due to displacement from natural disasters can become the source of many environmental health issues and subsequent secondary hazards, including biological and chemical hazards (13). Should this continue, the concentration of population can put further pressure on the environment, which can lead to shortages of food and firewood, thereby having a negative impact on the nutritional status of the affected population. Research also shows that deforestation due to lack of means for collecting firewood can lead to increased vulnerability to gender-based violence, especially among those who are primarily collectors of firewood. Inadequate levels of water and poor sanitation conditions can lead to further pollution of sources of water, including rivers and groundwater reservoirs. This will create a vicious cycle of deterioration in human health due to unsafe water consumption and further pollution of water sources.

Strategies and areas to incorporate environmental considerations into the health cluster response strategy

Factors for incorporating environmental considerations into the health cluster response strategy include the following:

- engage in advocacy with local authorities, other clusters and OCHA to ensure that environmental impacts are considered when planning the location of services;
- in conjunction with specialists from other sectors, ensure safe collection and disposal of health care waste, particularly from hospitals and mobile clinics, and safe transport of biological samples (12);
- ensure strong collaboration with other clusters, especially WASH and nutrition, so that appropriate actions are taken in line with the strategies for limiting negative environmental impacts.

The environment marker (14), developed by the United Nations Environment Programme, can provide guidance on how to incorporate environmental considerations into the health cluster strategy. This marker, although not as rigorously mandated by donors and other humanitarian actors as the gender marker (for example), does provide general means to evaluate health cluster strategies to assess their adherence to addressing environmental issues that could arise from health cluster activities.



Health cluster strategic response planning

Paragraph 11.1 11.2 11.3 11.4 11.5 11.6 11.7

Box 11.1 11.2 11.3 11.4 11.5 11.6 11.7 11.8

Figure 11.1 11.1

Table 11.1

- Contents
- References
- Endnotes

Promoting standards

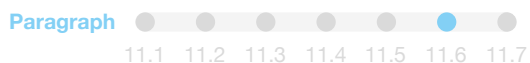
Relevant national technical standards or international standards (where national standards do not exist) to be adhered to should be listed in the plan. International technical standards include Sphere and WHO guidelines (8, 15).

Health cluster capacity-building

The health cluster needs to determine capacity-building needs and incorporate strategies to address capacity-building to enable an effective emergency health response (Box 11.7).



Health cluster strategic response planning



11.1 11.2 11.3 11.4 11.5 11.6 11.7



11.1 11.2 11.3 11.4 11.5 11.6 11.7 11.8



Figure 11.1 Table 11.1

- Contents
- References
- Endnotes

● Box 11.7 Considering capacity-building issues

Capacity-building in this context refers to building the capacity needed to respond in a crisis situation, and not the overall capacity-building of the health sector.

Capacity-building needs to occur largely in two areas:

- coordination
- technical areas of work.

Health cluster coordinators have a key proactive role to play in building capacity and skills in the area of coordination.

A simple analysis of coordination capacity at national and subnational levels should be conducted to determine the levels of coordination capacity and the understanding of the cluster approach.¹⁸

Based on the analysis of coordination capacity, strategies to build additional capacity would include:

- training and orientation on key concepts of coordination for national and subnational authorities and health cluster partners;
- supporting the national and subnational health authorities in establishment of coordination structures, where not already existing.

Health cluster coordinators also have an important role to play in facilitating capacity-building in technical areas.

Through analysis of health resources, service availability and health service performance, critical gaps in health service provision may be identified, and areas where the quality of emergency health services is not of the required standard may be determined.

Having identified the gaps in the quality of services, the health cluster should develop a capacity-building plan or strategy to strengthen the emergency health response. This would include building human resource capacity for assessment and service provision.

Strategies would include:

- identification of technical resources and ensuring wide dissemination in the country;
- working with relevant technical units and agencies to adapt relevant guidelines on specific health issues to country requirements (standards section);
- supporting provision of training for relevant personnel on specific technical areas;
- encouraging relevant agencies with expertise to provide training and technical support in relevant areas (for example, outbreaks, setting up temporary facilities, mass immunization campaigns, international humanitarian law, and protection from sexual exploitation and abuse);
- mobilizing resources to support technical trainings;
- facilitating mentoring of small, local NGOs through partnering with more experienced agencies to transfer first-hand knowledge from expert to less expert partners and organizing cross-project learning visits.

Health cluster partners have an important role to play in capacity-building, for example by taking on aspects of training in their areas of expertise (technical and coordination) and mentoring small, local NGOs.

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1

2

3

4

5

6

7

8

9

10

11

12

13

Health cluster strategic response planning

Paragraph

11.1 11.2 11.3 11.4 11.5 11.6 11.7

Box

11.1 11.2 11.3 11.4 11.5 11.6 11.7 11.8

Figure

11.1

Table

11.1

● Contents

● References

● Endnotes

Linking emergency health response to the humanitarian–development–peace nexus

Early recovery approaches can and should be integrated into humanitarian programming to create connections with, and avoid obstacles to, longer-term health system strengthening. This will contribute to the process of “building back better” and increasing the resilience of communities and the health system.

Early recovery begins in a humanitarian setting, and early recovery activities should not wait for formal, large-scale reconstruction and development programmes. Thus, early recovery needs to be considered at the beginning of an emergency response, while strategies and activities to enhance early recovery and resilience need to be incorporated in the health cluster response plan from the outset (16).

Transition and deactivation

Linked to early recovery and resilience, transition and deactivation of the health cluster also need to be considered from the establishment of the health cluster, and strategies to enhance effective transition and deactivation of emergency health coordination functions need to be incorporated in the health cluster response plan from the outset.

Health cluster coordination mechanisms

The health cluster needs to determine the required emergency coordination needs and agree on the structure, governance and approach to ensure that appropriate coordination functions will be maintained at national and subnational levels and incorporated into the health cluster response plan.¹⁹

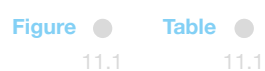
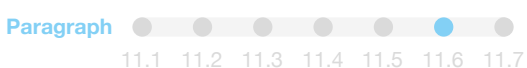
11.6.4 Costing of the health cluster response

The total cost of the emergency health response, reflecting all planned humanitarian activities needed to fulfil the health cluster objectives, needs to be determined (17). There are three options.

- **Project-based costing.** This primarily involves summing the funding requirements for projects submitted by different agencies. Project budgets are either based on standard United Nations or NGO cost categories or are based on activities, outputs or outcomes developed by clusters. Sectors and clusters ensure costs are appropriate and are aligned with activities and outcomes
- **Unit-based costing.** This method identifies a unit cost “driver”, which could be an activity, an outcome or a standard service being delivered at a certain cost. The



Health cluster strategic response planning



- [Contents](#)
- [References](#)
- [Endnotes](#)

unit cost driver in the humanitarian response plan budget is the unit cost that best explains the activity, service or outcome.

- **Hybrid method.** This method applies a combination of both the methodologies described above. It establishes financial requirements using unit-based costing and follows with detailed project planning at a later stage to provide more detail to the initial calculations or to give visibility to participating organizations.

11.6.5 Drafting the health cluster response plan

Having facilitated a consultative process to determine the health cluster response, it is the responsibility of the health cluster coordinators to draft a comprehensive health cluster response plan, reflecting what has been agreed upon along with the cost.

The health cluster response plan will be the overarching guiding document for all health cluster partners and the framework for the collective response of all health partners. A workplan also needs to be developed within the response plan outlining the key activities to be carried out and the time frame for implementation.

The complete version of the health cluster plan should be a detailed document for use by the health cluster partners in planning, implementation and monitoring of the health cluster response, providing additional information for partners on the health cluster vision priorities, operational modalities, strategies and approaches. A shorter version of the health cluster response plan will be submitted to OCHA, to be incorporated into the humanitarian response plan. OCHA at country level will provide the format for the cluster plans for the humanitarian response plan.

11.7 Coordinated project development: projects for inclusion in the health cluster response plan

Coordinated health project development takes place after the health cluster has determined the cluster objectives and key activities, indicators, boundaries and scope of the emergency health response (18).

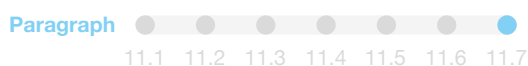
11.7.1 Tasks of health cluster coordinators

Health cluster coordinators have a responsibility to undertake the following tasks.

- *Ensure partners' involvement in drafting the health cluster response plan.*



Health cluster strategic response planning

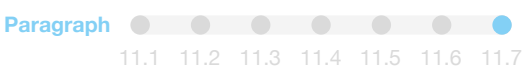


- Contents
- References
- Endnotes

- *Share the draft with all partners.* The partners will then be asked to submit project proposals (a template will be provided) for inclusion in the health cluster response plan.
- ✓ **Tip:** Time is always crucial during the process of development of cluster plans and partner projects for the humanitarian response plan. Therefore, health cluster coordinators need to proactively work to obtain agreement on the overall health strategy and to share project development guidance with partners in a timely manner, in order to ensure that partners have as much time as possible to prepare and submit well designed projects.
- *Gain agreement among health cluster partners on the geographical and technical areas of responsibility for each partner.* It is important to consider and map the activities of those humanitarian agencies that do not register planned actions on the Humanitarian Programme Cycle (HPC) project module to avoid duplication (19). Government health projects supported by NGOs may be included in the plan. While not included in the response plan, it is also important to map the activities of operational government health projects to ensure that service coverage is comprehensive.
- *Establish criteria for the selection and classification of projects with guidance from the HC and humanitarian country team.* Input can also be sought from the health cluster strategic advisory group, as required (for example, with regard to priority geographical areas and interventions, health issues of particular concern, operational and technical capacity and approach of partners, and targeting vulnerable groups, such as elderly people, children, persons with disabilities, pregnant and lactating women, people with chronic diseases, and people with injuries).
- *Provide guidance and support on development of projects.* Guidance may be provided through (for example) health cluster partner workshops or one-to-one mentoring from the health cluster coordination team. National NGOs need more time and guidance from the health cluster coordinator, particularly if they are new to the process. Options for mentorship from more experienced NGOs should be explored.
- *Establish a peer review group to vet partner proposals submitted for inclusion in the health cluster response plan or humanitarian response plan.* This group may consist of strategic advisory group members. Proposals that are in line with the health cluster response plan (strategic aspects) and of a satisfactory technical quality will then be endorsed for inclusion in the health cluster response plan. There may be a need for a process of discussion, negotiation and clarification with some of the partners and for partners to adjust and amend proposals prior to endorsement for inclusion in the humanitarian response plan (Box 11.8).



Health cluster strategic response planning



- Contents
- References
- Endnotes

Box 11.8 Health cluster peer review of partner project proposals

A health cluster peer review should be performed of partner project proposals submitted for inclusion in the health cluster response plan or humanitarian response plan. A peer review group should be established through a transparent consultative process within the health cluster, ensuring representation from United Nations agencies and national and international NGOs, and government where possible.

Some members of the peer review group should be knowledgeable of humanitarian operations and the health cluster strategy and priorities (the “big picture”). It would be appropriate to use members of the strategic advisory group for this function (where such a group exists). Other members of the peer review group should be experts in the various technical aspects of emergency health programming. OCHA could attend as an observer during the peer review of proposals to ensure that the vetting process is in line with the country strategy.

The peer review group will vet the submitted proposals considering both strategic and technical aspects to ensure that:

- proposals are in line with the health cluster plan and country strategy (strategic aspects);
- proposals are of adequate technical standard;
- there is no duplication or overlap between the various projects.

Strategic aspects include:

- strategic relevance
- programmatic relevance
- cost-effectiveness
- management and monitoring
- engagement with coordination mechanisms.

Technical aspects include:

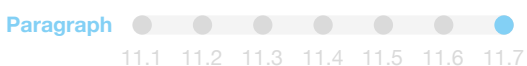
- technical merit and demonstrated technical knowledge of emergency health programming
- appropriateness of budget provisions.

A scoring table may be used to assist the peer review group to assess the proposal against the criteria outlined.

✓ Tip: Where government health authorities are not represented on a peer review group, it will be important for the health cluster coordinator to proactively engage with the health authorities during this process, keeping the health authorities updated and enabling them to contribute to the discussion on selection of agencies.



Health cluster strategic response planning



- Contents
- References
- Endnotes

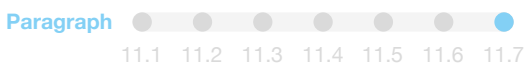
11.7.2 Tasks of health cluster partners

Health cluster partners are required to undertake the following tasks.

- *Design projects based on assessed needs and analysis, response boundaries and scope, and health cluster objectives, priority interventions and approaches.* Each health cluster project proposal will outline proposed geographical areas of intervention, health cluster objectives that the project will contribute to, proposed activities, targets and monitoring indicators, and a clear breakdown of costs. Each health cluster project proposal will be required (by the humanitarian country team) to include a gender marker, and possibly also age and environmental markers, as determined at country level (20, 21).
- *Upload completed project proposals onto the HPC project module and then update amended proposals.*



Health cluster strategic response planning



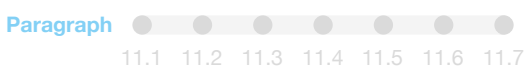
- [Contents](#)
- [References](#)
- [Endnotes](#)

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Health cluster strategic response planning



- Contents
- References
- Endnotes

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Key reference materials

IASC Reference Module for the Humanitarian Programme Cycle: <https://www.humanitarianresponse.info/en/programme-cycle/space/document/iasc-reference-module-humanitarian-programme-cycle>

Prioritization within the Humanitarian Programme Cycle (HPC) – Presentation for STAIT webinar, 15 July 2015: <https://www.humanitarianresponse.info/en/topics/transformational-agenda/document/prioritization-within-humanitarian-programme-cycle-hpc>

Strategic Response Planning: Guidance and Templates: <https://www.humanitarianresponse.info/en/programme-cycle/space/strategic-response-planning-guidance-templates>



Health cluster strategic response planning

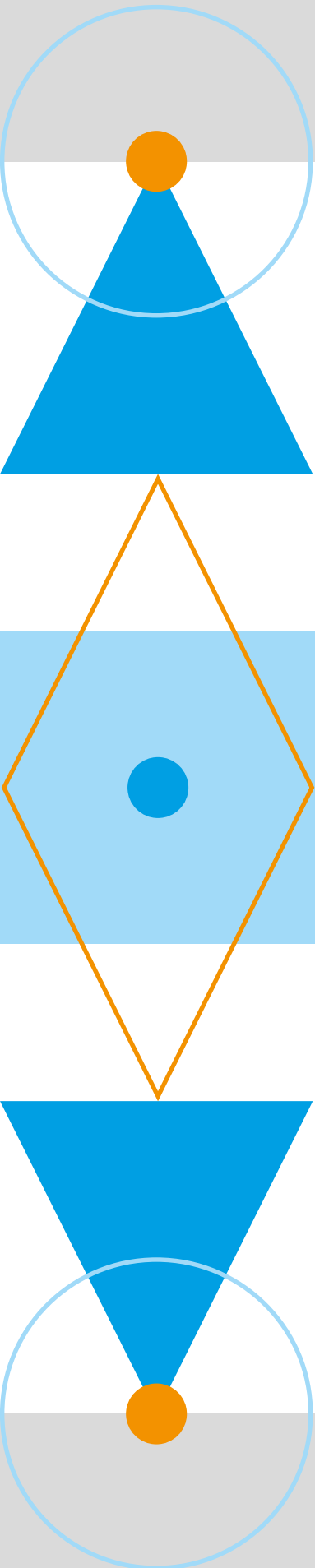
Paragraph ● ● ● ● ● ● ●
11.1 11.2 11.3 11.4 11.5 11.6 11.7

Box ● ● ● ● ● ● ●
11.1 11.2 11.3 11.4 11.5 11.6 11.7 11.8

Figure ● Table ●
11.1 11.1

- Contents
- References
- Endnotes

Monitoring the health cluster/sector response



12

Contents

Chapter 12		
Monitoring the health cluster/sector response		391
12.1 Introduction		391
12.2 What is humanitarian response monitoring and who is involved?		392
12.2.1	Definition, purpose and scope	392
12.2.2	Types of monitoring	393
12.2.3	Relationship between planning and monitoring	396
12.2.4	Humanitarian response monitoring framework	397
12.2.5	Roles and responsibilities	398
12.3 Developing response monitoring frameworks		400
12.3.1	Preparing a humanitarian response monitoring framework	400
12.3.2	Preparing a health cluster response monitoring framework	402
12.3.3	Applying the humanitarian and health response monitoring frameworks along the HRP cycle	407
12.3.4	Reporting: presenting monitoring information	408
References		411
Endnotes		412
Figures		
Figure 12.1	Relationship between planning and monitoring	397
Figure 12.2	Key steps: preparing the monitoring framework	400
Figure 12.3	Ukraine, 2016: example of country-level response monitoring framework	402
Figure 12.4	Example of a monitoring report schedule	402
Figure 12.5	Monitoring levels and examples	403
Figure 12.6	Ukraine, 2016: example of health cluster response monitoring framework	405
Figure 12.7	Key steps: applying the monitoring framework	407
Figure 12.8	South Sudan: example of Humanitarian Dashboard	409
Tables		
Table 12.1	Key monitoring questions for periodic review of the health response	406

Abbreviations

3W/4W	who, what, where (and when)
GBV	gender-based violence
GHO	Global Humanitarian Overview
HeRAMS	Health Resources and Services Availability Monitoring System
HNO	Humanitarian Needs Overview
HRP	humanitarian response plan
ICCG	Inter-Cluster Coordination Group
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
SMART	specific, measurable, achievable, realistic, and time-bound
WASH	water, sanitation and hygiene

12. Monitoring the health cluster/sector response

12.1 Introduction

Key points of note with regard to monitoring the health cluster or sector response are as follows.

- Monitoring requires collecting and analysing information during a humanitarian response and should feed into decision-making about resource allocation and programmatic adjustments.
- The main responsibility for monitoring the overall humanitarian health response rests with the health cluster team. Response monitoring represents one of the required services under the Public Health Information Services standards.
- The inter-cluster coordinator also assists in the regular monitoring of the humanitarian response, supporting the cluster coordinators in all sectors in identifying changing needs and gaps and communicating those to the humanitarian coordinator and humanitarian country team in regular monitoring reports.
- The humanitarian response monitoring framework is an operational tool that supports the humanitarian country team and the clusters to implement activities and ensure effective monitoring of the humanitarian response plan (HRP).
- The main monitoring products include periodic monitoring reports, humanitarian dashboards and mid-year and end-of-year reviews.
- Continuous monitoring and regular joint reviews are essential to ensure that the health strategic plan remains relevant and is implemented to the maximum extent possible with the minimum of gaps and duplications.
- There may be a need to update and revise the strategic response plan during the year to reflect changes in the humanitarian situation and needs that affect the course of the collective operational response.



Monitoring the health cluster/sector response

Paragraph ● 12.1 ● 12.2 ● 12.3

Figure ● 12.1 ● 12.2 ● 12.3 ● 12.4 ● 12.5 ● 12.6 ● 12.7 ● 12.8

Table ● 12.1

- [Contents](#)
- [References](#)
- [Endnotes](#)

12.2 What is humanitarian response monitoring and who is involved?

12.2.1 Definition, purpose and scope

Monitoring is the process of observing and checking the progress and quality of something over a period of time against a specific target or indicator and keeping it under systematic review. It involves the systematic collection of data on specific indicators, and the analysis of this information in a continuous manner (1).

During a humanitarian response, monitoring information is required in line with the Public Health Information Services standards on:

- health status of and threats to affected populations
- availability of health resources and services
- health system performance.

The following can also be monitored:

- the achieved results against the objectives set out in the HRP and health strategic response plan;
- the cluster coordination performance.

Response monitoring has the following purposes.

- The primary purpose of response monitoring is to measure progress towards reaching strategic objectives and cluster objectives, as outlined in the HRP, flash appeal or health-specific strategic plan. It will make use of the findings to develop conclusions about strengths and weaknesses in the response to date and make recommendations for action, to be presented in a periodic monitoring report.
- It provides humanitarian actors, in a timely manner, with an evidence base for making decisions about what actions should be taken to address shortcomings, fill gaps or adjust the HRP, contributing to a more effective and efficient humanitarian response in the short and long term.



Monitoring the health cluster/sector response



- Contents
- References
- Endnotes

- It serves to ensure the accountability of the humanitarian community (to people affected by the crisis, local governments, donors and the public) for the achievement of results committed to in the HRP.
- It serves as a learning process, not just for the emergency but also for future projects.

12.2.2 Types of monitoring

There are three main types of monitoring of relevance to this chapter: situation monitoring, response monitoring and field monitoring.

Situation monitoring

Situation monitoring is the continuous and systematic collection of data on and analysis of the health status of the affected population, the caseloads (people in need and people targeted), public health risks, impact and trends of the disease burden, needs, and capacities in a given humanitarian context. Situation monitoring generates data on emerging or changing health issues in the operational context, informing decisions on whether there is a need to adapt the planned response.

Key components of situation monitoring include use of both primary and secondary data and building on the health information management system in place. Data collected need to be transformed into information that can be acted upon in real time, especially for decision-making. Information management plays a key role in ensuring that this useful information is not lost and is made available to concerned parties in a timely manner.¹ Primary and secondary data should be included in the monitoring plan so that the indicators, methods and regularity of data collection and analyses are clearly identified. Monitoring the response against harmonized health indicators and assessment methodologies enables identification of gaps in the response and guides the coordinated efforts of health actors to fill these gaps.²

Health-specific situation monitoring requires maintaining an inventory of data sources containing information on the humanitarian health situation and analysing the findings, taking regular account of new assessment data. Such data sources include:

- health status threats for affected populations, as indicated by:
 - the public health situation analysis
 - rapid assessments, including multisectoral and health-specific assessments
 - early warning, alert and response systems
 - Surveillance System for Attacks on Health Care



Monitoring the health cluster/sector response



- [Contents](#)
- [References](#)
- [Endnotes](#)

- mortality surveys
- vaccination coverage estimation (as a measure of population immunity)
- assessment reports from other relevant clusters, including water, sanitation and hygiene (WASH), nutrition, food security and protection;
- availability of health resources and services, as indicated by:
 - 3W/4W – who, what, where (and when) matrix
 - list of partners
 - Health Resources and Services Availability Monitoring System (HeRAMS);
- health system performance, as indicated by:
 - health management information systems
 - vaccination coverage estimation (as a measure of the success of vaccination campaigns)
 - health cluster bulletin.

The latter two can also be considered elements of response monitoring.

Response monitoring of the sector and cluster response plan

Response monitoring is a continuous process that tracks the humanitarian assistance delivered to affected populations compared to targets (2). It is a key step in the programme cycle, as it seeks to determine if the humanitarian community is doing what it has committed to do by providing:

- an evidence base to guide practitioners towards a more effective and efficient humanitarian response, in the short and long term;
- reliable data on progress against a strategic response plan and specific subcluster and subsector goals;
- a means of accountability towards affected populations, governments and donors by providing a continuous source of data on achievement of results and quality of programmes outlined in the strategic response plan and subcluster and subsector goals.

Humanitarian response monitoring involves working with cluster and sector partners to keep and maintain an up-to-date database and other sources of information for health programming that are aligned with commitments made during response planning. The information management officer plays a key role in pulling together the key information to support the health cluster and health sector coordinators. This task includes:



Monitoring the health cluster/sector response

Paragraph ● ● ●

12.1 12.2 12.3

Figure ● ● ● ● ● ● ● ●

12.1 12.2 12.3 12.4 12.5 12.6 12.7 12.8

Table ●

12.1

- Contents
- References
- Endnotes

- estimating both geographical and programmatic coverage of programmes and producing coverage maps, humanitarian snapshots and quarterly bulletins;
- supporting the development of indicators that the cluster needs to monitor as a way to track progress of implementation of projects and activities listed in the response plan;
- agreeing on reporting timelines with partners and any follow-up needed;
- undertaking regular monitoring visits to review the responses and providing validation of reporting by partners for quality control purposes;
- maintaining and streamlining monthly (or other timelines as relevant to the response) collection of reports from partners and working with partners to address any reporting issues to enhance timely and quality reporting;
- setting up and maintaining a cluster complaint and feedback mechanism based on the inputs and guidance provided, and giving feedback regularly to cluster partners.

Field monitoring

Field monitoring provides direct appraisal of the quality of the response and the timeliness of delivery, and provides first-hand information on access to services and the perspectives of emergency-affected people, taking diversity into account. Field monitoring can be conducted through visits to implementation sites or through remote exercises. Organizing field monitoring exercises does not fall within the scope of the monitoring framework and is the role of the front-line health cluster partners rather than the cluster coordinators.

It is anticipated that cluster members have some form of field monitoring practice in place, but practices differ and would often benefit from harmonization. Such an approach entails the identification of common health indicators that could be monitored within a health cluster. Health sector or cluster coordination members should agree on and organize how to support the implementation of the response through timely visits. Discussion of this matter should be included on the agenda of coordination meetings (3).

As monitoring data are gathered, it becomes easier to decide when field monitoring visits are needed to obtain more location-specific health information and provide teams with guidance if needed.



Monitoring the health cluster/sector response



- [Contents](#)
- [References](#)
- [Endnotes](#)

Joint monitoring visits should be the responsibility of all humanitarian actors and should focus on supporting the response and finding out what is going well, what gaps exist, and what may require changes. Joint monitoring visits with other clusters or sectors should also be encouraged. Coordinated monitoring approaches are beneficial to the health sector or cluster, in the same way that coordinated assessments are. Beneficial outcomes include improvement of the effectiveness of the health cluster and sector response by enhancing decision-making and prioritization; savings in money and resources; and provision of stronger evidence for reporting to donors and supporters. They also make monitoring seem less like one agency “policing” other agencies, and more of an exercise in collective responsibility. All humanitarian actors should take part in monitoring, building on existing systems.

12.2.3 Relationship between planning and monitoring

Strategic response planning and response monitoring (1) are two distinct elements of the Humanitarian Programme Cycle that have strong linkages at three levels:

- monitoring at the *strategic level* is based on indicators and targets attached to the strategic objectives;
- monitoring at the *cluster level* is based on indicators and targets attached to the cluster objectives;
- monitoring at the *project (or activity or field) level* is based on indicators and targets attached to cluster activities.

Figure 12.1 illustrates the relationship between planning and monitoring.

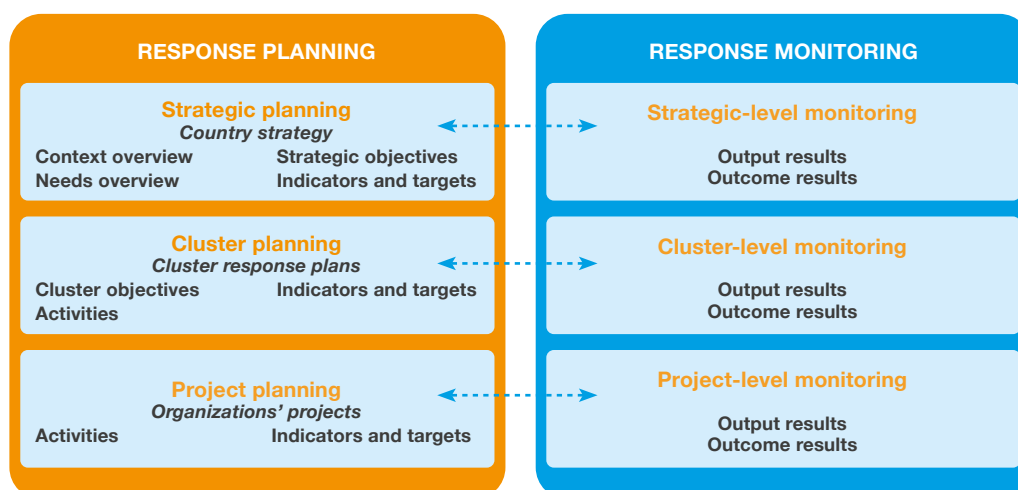


Monitoring the health cluster/sector response



- [Contents](#)
- [References](#)
- [Endnotes](#)

Figure 12.1 Relationship between planning and monitoring



Source: Humanitarian response monitoring: guidance (1).

The preparation for humanitarian response monitoring is therefore done at the time of drafting the HRP and sectoral response plans, and what is agreed upon at that stage will serve as the basis for all health monitoring and reporting efforts throughout the Humanitarian Programme Cycle (4). This can be changed according to needs and the situation on the ground. It is also important to ensure that early recovery planning and transition or exit strategies are reflected in the monitoring programme (5).

12.2.4 Humanitarian response monitoring framework

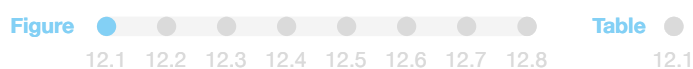
The humanitarian response monitoring framework is a set of practices, performed by all humanitarian actors, for facilitating:

- the collection and analysis of data on the collective humanitarian response throughout the year;
- the production of reports with key findings at scheduled intervals;
- the generation of information for the clusters, inter-cluster coordination group, and humanitarian coordinator and humanitarian country team.

All humanitarian actors should participate in the design and execution of the monitoring framework, and should ensure that they have the capacity to perform their part of the monitoring activities. The framework document should be prepared by the inter-cluster coordination group, with contributions from the clusters,



Monitoring the health cluster/sector response



- Contents
- References
- Endnotes

and endorsed by the humanitarian country team, who will ensure that adequate resources are allocated to the monitoring activities (see subsection 12.2.5 below).

The scope of the humanitarian response monitoring framework will follow the scope of the HRP.

The monitoring framework document should broadly define:

- what will be monitored (coverage and quality of interventions)
- how and when monitoring activities will be undertaken
- who is responsible for monitoring and analysing what
- how and when monitoring information will be reported and disseminated
- what key actions will be taken
- what resources are necessary for successfully monitoring the humanitarian response.

12.2.5 Roles and responsibilities

The application of the humanitarian response monitoring framework (1) relies on a set of predictable steps undertaken by key actors, as outlined below.

Humanitarian coordinator and humanitarian country team

The humanitarian coordinator will oversee finalization and implementation of the monitoring framework, including reaching agreement on ground rules for corrective action in instances where monitoring reveals challenges. The humanitarian country team is responsible for ensuring that the monitoring framework fully measures the prioritized, collective humanitarian response set out in the strategic objectives and will determine the periodicity for reporting. In addition, the humanitarian coordinator and humanitarian country team will:

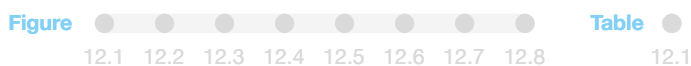
- endorse the humanitarian response monitoring framework;
- ensure adequate financial and human resources to implement the framework;
- endorse periodic monitoring reports and the yearly report;
- decide on the process for dissemination of periodic monitoring reports and dashboards to stakeholders and the general public.

OCHA inter-cluster coordinator

The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) inter-cluster coordinator, with the support, contributions and engagement of cluster members, will:



Monitoring the health cluster/sector response



- [Contents](#)
- [References](#)
- [Endnotes](#)

- facilitate, in the inter-cluster coordination group, the selection (or revision) of indicators and associated targets for measuring strategic objectives, establishing, based on the clusters' decisions, for each indicator, the responsibility for monitoring, the method of monitoring and the frequency of data collection;
- prepare a draft humanitarian response monitoring framework, building on the agreements in the inter-cluster coordination group and submissions from clusters, for review and endorsement by the humanitarian coordinator and humanitarian country team;
- compile information for measuring progress against strategic objectives and interpreting results in the inter-cluster coordination group;
- prepare the periodic monitoring reports, with the inter-cluster coordination group, for the humanitarian coordinator and humanitarian country team;
- disseminate any public monitoring reports, making the reports available online.

Health cluster coordinator

The health cluster coordinator, with the support, contributions and engagement of cluster members, will:

- represent the health cluster in the inter-cluster coordination group for selection of indicators and formulation of targets for strategic objectives, agreeing for each health indicator the responsibility for monitoring, the method of monitoring and the frequency of health data collection;
- engage with health cluster members to determine pertinent indicators for measuring health cluster objectives and activities, methods of monitoring, and the frequency of health data collection for each indicator, securing commitment from member organizations on taking responsibilities for monitoring;
- compile the contributions of cluster members for tracking output indicators and data collected for health cluster outcome indicators, facilitating a review of the data for determining the progress made against health cluster objectives;
- ensure that health cluster contributions are provided for the periodic monitoring report;
- ensure that information on health cluster-level indicators selected for measuring strategic objectives is provided on time;



Monitoring the health cluster/sector response

Paragraph ● ● ●

12.1 12.2 12.3

Figure ● ● ● ● ● ● ● ●

12.1 12.2 12.3 12.4 12.5 12.6 12.7 12.8

Table ●

12.1

- Contents
- References
- Endnotes

- represent the cluster in the inter-cluster coordination group for reviewing and analysing the totality of data collected, in order to measure progress and make any recommendations.

Partners

The role of partners in monitoring is to:

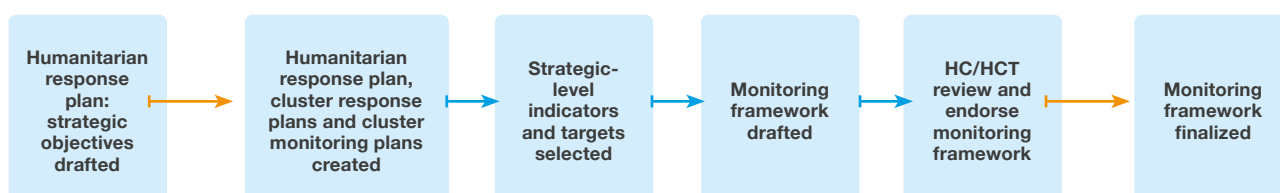
- contribute to the design of the monitoring plan and support the collection and analysis of health data generated;
- appoint monitoring focal points and monitoring and evaluation officers;
- contribute to the development of cluster monitoring plans;
- allocate adequate resources towards field monitoring activities;
- regularly register the results of their activities at output level, using the tools provided by the cluster coordinators.

12.3 Developing response monitoring frameworks

12.3.1 Preparing a humanitarian response monitoring framework

Figure 12.2 shows the key steps in preparing the monitoring framework.

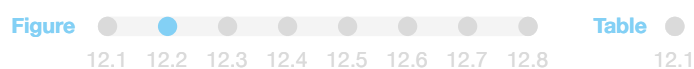
Figure 12.2 Key steps: preparing the monitoring framework



Key: HC = humanitarian coordinator; HCT = humanitarian country team.



Monitoring the health cluster/sector response



- Contents
- References
- Endnotes

At the strategic level, the inter-cluster coordination group (with the contribution of the health cluster coordinator) will:

- define three to five strategic objectives establishing the frame for all detailed planning, and for monitoring;
- define three to five outcome indicators for each HRP strategic objective, with associated targets (and baselines);
- establish responsibilities for collecting data on any inter-cluster-level outcome indicators, determining how the data will be collected, by whom and at what frequency;
- agree whether the data will be collected by individual organizations, by an external agent, or through a joint inter-cluster exercise;
- agree on the methods and tools to use for analysis of inter-cluster data and propose a monitoring report schedule in consultation with clusters;
- estimate the required resources for the monitoring work;
- identify possible challenges to good monitoring (including deficiencies in field data collection, tools for registering results, data storage, analysis skills, resources dedicated to monitoring) and propose solutions to address them (training, improved data tools, advocating provision of better resources);
- compile the inter-cluster group's agreements into a monitoring framework document for presentation to the humanitarian coordinator and humanitarian country team.

Figure 12.3 presents an example from Ukraine of a country-level response monitoring framework, while Figure 12.4 gives an example of a monitoring report schedule.



Monitoring the health cluster/sector response



- [Contents](#)
- [References](#)
- [Endnotes](#)

Figure 12.3 Ukraine, 2016: example of country-level response monitoring framework

Strategic Objectives and Indicators

STRATEGIC OBJECTIVE 1: To advocate for and respond to the protection needs of conflict-affected people with due regard to international norms and standards.						
Indicator	In need	Baseline	Target	Data source/collection method(s)	Organization(s) responsible for data collection	Frequency
Level of access to people in need	3,100,000	-	2,500,000	3W Access map	Partners, Clusters, ICG, OCHA	Quarterly
STRATEGIC OBJECTIVE 2: Provide emergency assistance and ensure non-discriminatory access to quality essential services for populations in need.						
Indicator	In need	Baseline	Target	Data source/collection method(s)	Organization(s) responsible for data collection	Frequency
# of people with access to basic lifesaving service	3,100,000	-	2,500,000	Cluster reports, 3W	ICCG	Quarterly
STRATEGIC OBJECTIVE 3: Improve the resilience of conflict-affected people, prevent further degradation of the humanitarian situation and promote recovery and social cohesion.						
Indicator	In need	Baseline	Target	Data source/collection method(s)	Organization(s) responsible for data collection	Frequency
# of people with access to basic lifesaving service	3,100,000	-	2,500,000	Cluster reports, 3W	ICCG	Quarterly

Figure 12.4 Example of a monitoring report schedule

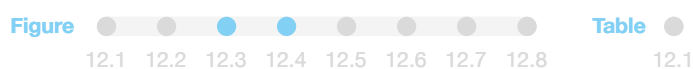
	2016												2017
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN
Humanitarian response monitoring framework													
Humanitarian Dashboard				Jan-Mar			Jan-Jul			Jan-Sep			Jan-Dec
Periodic monitoring report				Jan-Mar				Jan-Jul					Yearly report (Jan-Dec)
						GHO			HNO		HRP	GHO	

12.3.2 Preparing a health cluster response monitoring framework

Beyond the humanitarian response monitoring framework, it is necessary to develop a health cluster-specific monitoring framework to capture more detailed information on the progress of the health-specific response. The health cluster monitoring framework will track the health inputs and outputs resulting from the health interventions provided to the affected populations.³ It maps the outcomes of health cluster activities and measures progress towards the health cluster-specific objectives of the HRP (and any health sectoral plan). This is visualized in Figure 12.5.



Monitoring the health cluster/sector response

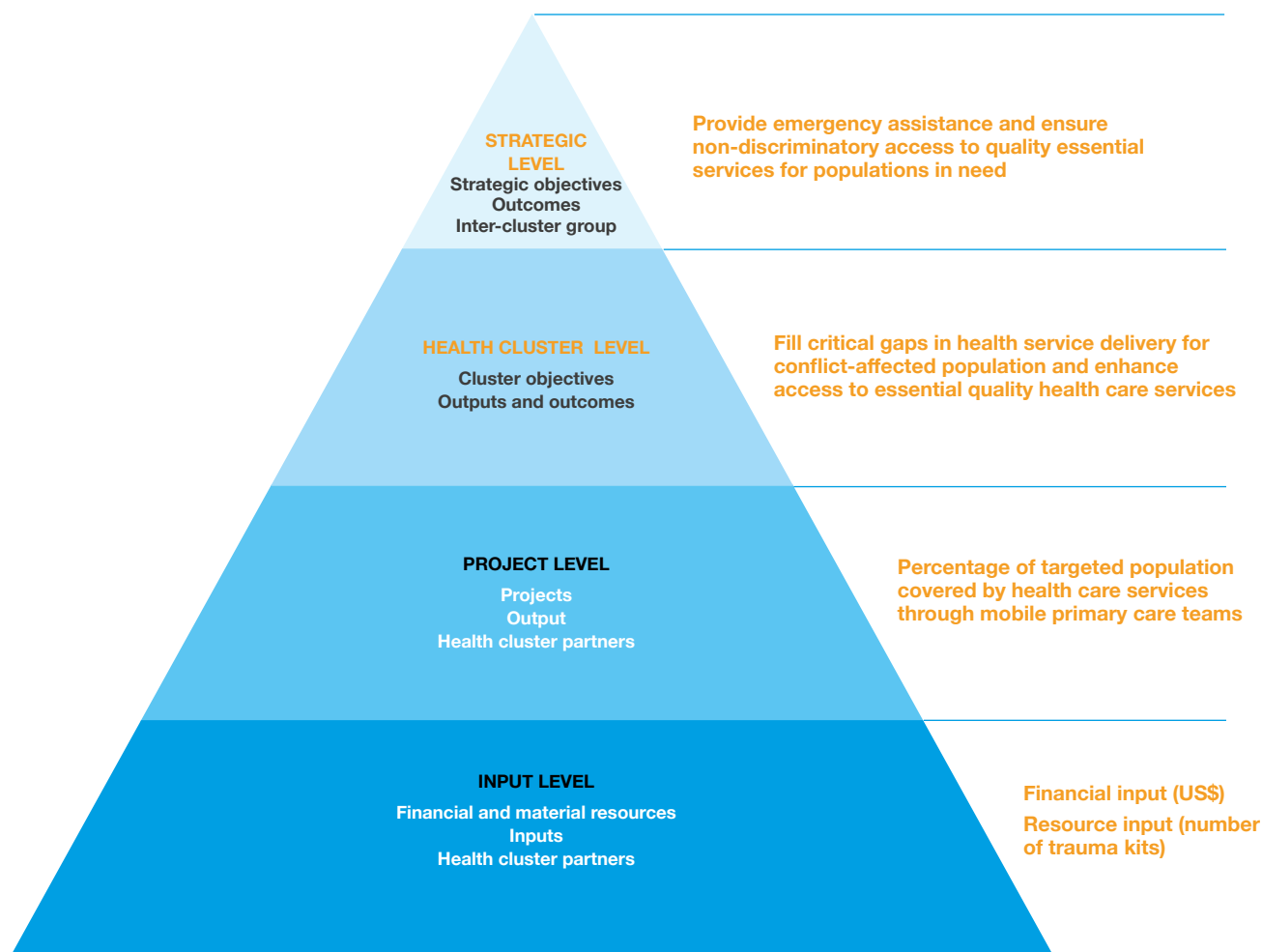


- Contents
- References
- Endnotes

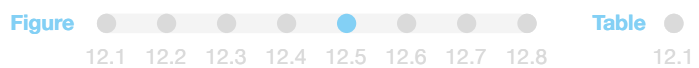
The health project level captures the outputs from the projects of individual health organizations, pertaining to cluster output indicators.

The health cluster level aggregates the results from the projects of cluster members and collects data on the health cluster outcome indicators attached to the health cluster objectives. The overall findings from the indicators are analysed to measure progress towards the health cluster objectives.

Figure 12.5 Monitoring levels and examples



Monitoring the health cluster/sector response



- Contents
- References
- Endnotes

- Members should put in place an internal approach for field monitoring activities, and participate in discussions on harmonization at cluster level of field monitoring and feedback mechanisms from affected populations.
- Members should ensure that adequate resources are budgeted for conducting their part of the monitoring work, including submitting output results at the agreed-upon frequencies and fulfilling any commitments to the collection of outcome-level data.

Figure 12.6 presents an example from Ukraine of a health cluster response monitoring framework.

Figure 12.6 Ukraine, 2016: example of health cluster response monitoring framework

HEALTH AND NUTRITION OBJECTIVE 1: Fill critical gaps in health services delivery for conflict affected populations and enhance access to essential quality health care services.						Relates to Strategic Objective #1, #2 and #3	
Indicator	In need	Baseline	Target	Data source/collection method(s)	Organization(s) responsible for data collection	Frequency	
% of targeted population covered by health care services through Health Facility level and Mobile Emergency Primary Care Units Level of access to people in need	100% (150,000 consultants by mobile teams)	20%	80% ⁴	Epi-EWARN, Field Reports, 3W matrix	WHO and cluster partners	Monthly	
HEALTH AND NUTRITION OBJECTIVE 2: Strengthen and expand disease surveillance and response, including enhance laboratory capacities and technical guidance on priority public health issues and risks.						Relates to Strategic Objective #1, #2 and #3	
Indicator	In need	Baseline	Target	Data source/collection method(s)	Organization(s) responsible for data collection	Frequency	
# of new sentinel sites reporting regularly	100	0	20	Epi-EWARNs	WHO and cluster	Monthly	
# of emergency health kits distributed	100	50	100 emergency health kits	Warehouse data, stock reports, Field Reports, 3W matrix	WHO and cluster partners	Monthly	
HEALTH AND NUTRITION OBJECTIVE 3: Prevent excessive nutrition-related morbidity and mortality of vulnerable groups including acutely malnourished children, pregnant and lactating women (PLW) and elderly.						Relates to Strategic Objective #1, #2 and #3	
Indicator	In need	Baseline	Target	Data source/collection method(s)	Organization(s) responsible for data collection	Frequency	
% of vulnerable groups including children, pregnant and lactating women (PLW) and elderly reached with interventions to support, protect and promote appropriate nutrition	100% (35,000 food baskets)	0	100%	Nutrition Field Reports, 3W matrix	WHO, UNICEF, WFP and cluster partners	Monthly	
HEALTH AND NUTRITION OBJECTIVE 4: Provide technical support through targeted interventions for restoring disrupted health services and basic rehabilitation/restoration of health facilities in the affected areas.						Relates to Strategic Objective #3	
Indicator	In need	Baseline	Target	Data source/collection method(s)	Organization(s) responsible for data collection	Frequency	
# of health facilities supported through basic rehabilitation, provision of supplies and equipment and trainings/capacity building of health care providers	100	15	20	Field Reports, 3W matrix	WHO and cluster partners	Monthly	

Epi-EWARN: Epidemiological Bulletin – Early Warning Alert and Response Network; UNICEF: United Nations Children’s Fund; WFP: World Food Programme.



Monitoring the health cluster/sector response



- Contents
- References
- Endnotes

Setting up a monitoring framework for the health sector or cluster response plan involves the following:

- convening a monitoring task force or technical working group;
- identifying existing mechanisms that can be used for data collection;
- deciding what methods to use and adapt for response monitoring;
- developing and adapting indicators (harmonizing existing indicator sources) (6);
- developing and adapting data collection tools and procedures;
- identifying the appropriate human resources;
- identifying the possibility of field-testing the tools and then finalizing them, to be able to roll out the monitoring system (collect and manage data).

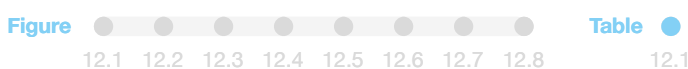
Monitoring should be a continuous (weekly or as appropriate) process to dynamically track progress against individual indicator targets and quickly take corrective action. In addition, more formal periodic health response monitoring framework reviews (equivalent to periodic monitoring reports) should be undertaken, in order to more comprehensively review the progress of the entire health response. The key questions that need to be answered by the health cluster in such reviews are presented in Table 12.1.

► **Table 12.1** Key monitoring questions for periodic review of the health response

NO.	QUESTION
1	Have changes occurred within the emergency context?
2	Have any changes occurred in relation to available human resource capacity to respond?
3	What is the overall progress in relation to response plans and to what extent is this on target?
4	What are the main variations from the response plan and reasons for these?
5	How does the allocation of resources (funds, materials, staff) compare with progress achieved, and are these comparable with similar emergencies in the same country?
6	To what extent do the original assumptions and priorities still apply, e.g. numbers affected, primary needs?
7	To what extent have the expected outcomes or results been achieved, and are these having the required impact?
8	What are the unexpected or negative impacts of health interventions to date?
9	What adjustments to objectives, strategies or inputs are required?

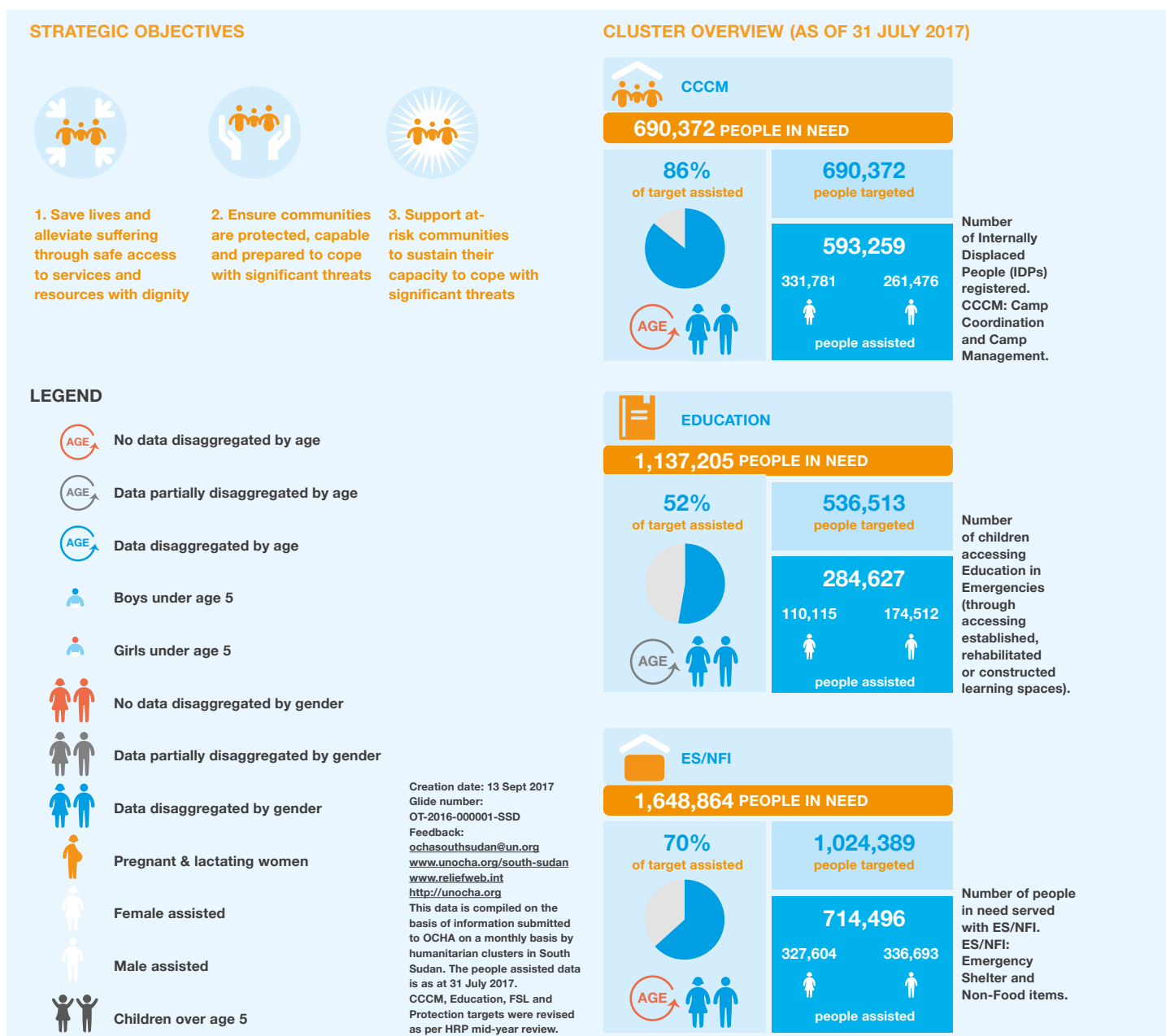


Monitoring the health cluster/sector response



- Contents
- References
- Endnotes

Figure 12.8 South Sudan: example of Humanitarian Dashboard



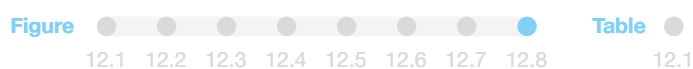
At the level of the health cluster, one type of report should be expected, as follows.

Health response monitoring report

There are no specific templates or required formats for health-specific monitoring reports. Reports should take into account the same principles as for the broader



Monitoring the health cluster/sector response



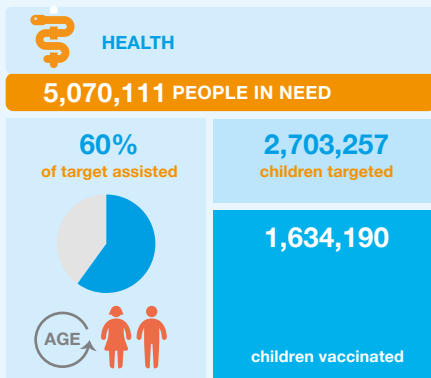
- Contents
- References
- Endnotes



Number of people assisted with food and/or livelihoods and conditional/unconditional cash transfers. FSL: Food Security and Livelihoods.



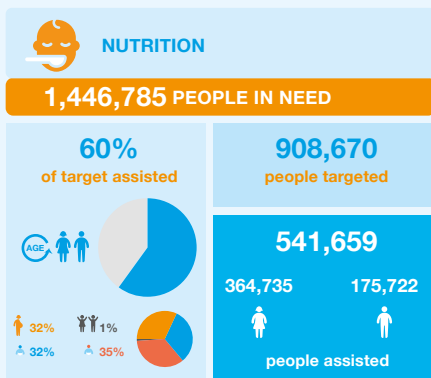
Number of girls, women, boys and men received protection services. Including GBV, child protection and mine action.



Number of children 6 to 59 months receiving measles vaccinations in emergency or returnee situations.



Number of people with access to improved water sources. WASH: Water, Sanitation and Hygiene.



Number of boys and girls aged 0-59 months, children over age 5 and pregnant and lactating women with SAM and MAM admitted for treatment.

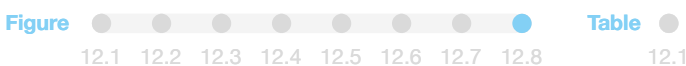
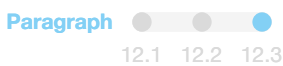


MAM: moderate acute malnutrition; SAM: severe acute malnutrition; UNHAS: United Nations Humanitarian Air Service.

periodic monitoring reports. They should provide updates on progress of indicators against their targets, and address issues outlined in Table 12.1. Examples of good practices can be obtained from the Global Health Cluster.



Monitoring the health cluster/sector response



- Contents
- References
- Endnotes

References

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C

1

2

3

4

5

6

7

8

9

10

11

12

13

Monitoring the health cluster/sector response

Paragraph ● ● ●

12.1 12.2 12.3

Figure ● ● ● ● ● ● ● ●

12.1 12.2 12.3 12.4 12.5 12.6 12.7 12.8

Table ●

12.1

● Contents

● References

● Endnotes

Endnotes

1. See Chapter 4.
2. See Chapter 10 for more information on assessment and analysis.
3. *Inputs* refer to the financial, human and material resources that go into projects; *outputs* refer to the delivery of goods and services to a targeted population; *outcomes* refer to the likely or achieved short- and medium-term effects of an intervention's outputs.
4. See Chapter 11.



Monitoring the health cluster/sector response

Paragraph ● ● ●

12.1 12.2 12.3

Figure ● ● ● ● ● ● ● ●

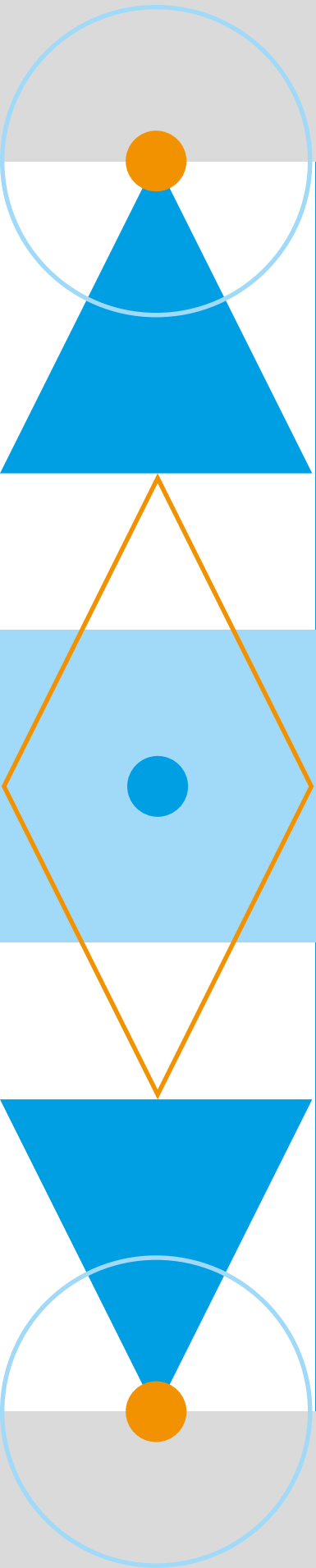
12.1 12.2 12.3 12.4 12.5 12.6 12.7 12.8

Table ●

12.1

- Contents
- References
- Endnotes

Resource mobilization



13

Contents

Chapter 13		
Resource mobilization		415
13.1 Introduction: what is resource mobilization?		415
13.2 Humanitarian funding: the international landscape		415
13.3 Country-level health cluster resource mobilization		416
13.4 Multi-year planning and funding		417
13.5 Monitoring health cluster funding status and determining funding gaps		418
13.6 Engaging and talking to donors		419
13.7 Supporting national and local organizations to access humanitarian funding		422
13.8 Humanitarian pooled funding mechanisms		423
13.8.1 Central Emergency Response Fund (CERF)		423
13.8.2 Country-based pooled funds		428
13.9 Humanitarian funding within the wider context of development funding		434
13.9.1 Country-level humanitarian funding		434
13.9.2 Allocation of humanitarian funding for health within wider context of development funding		434
References		438
Endnotes		440
Boxes		
Box 13.1	Financial Tracking Service	418
Box 13.2	The Start Fund	423
Box 13.3	CERF objectives and funding criteria	424
Box 13.4	Impact of conflict on drug availability and subsequent need for humanitarian support for procurement of essential medicines in Syrian Arab Republic	435
Box 13.5	Examples of development programmes of importance to health cluster	435
Box 13.6	South Sudan: ensuring continuation of service provision despite shift in funding from humanitarian to developmental mechanisms	437
Figures		
Figure 13.1	Resource mobilization within the Humanitarian Programme Cycle	416
Figure 13.2	Steps in the process for CBPF standard and reserve allocations	432
Tables		
Table 13.1	Resource mobilization cycle	421

Abbreviations

CBPF	country-based pooled fund
CERF	Central Emergency Response Fund
HC	humanitarian coordinator
NGO	nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
RC	resident coordinator
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization

13. Resource mobilization

13.1 Introduction: what is resource mobilization?

Resource mobilization involves fundraising for the humanitarian response against humanitarian response plans, flash appeals, or other calls for funding. Successful resource mobilization relies on a strong understanding of the global humanitarian financing landscape together with keen local knowledge based on mapping of donor presence and priorities.

The credibility and accuracy of assessed needs, the strategy and response priorities, and the perceived reasonableness of funding requirements, as well as the perception of the “collectiveness” of engagement under the Humanitarian Programme Cycle, have a crucial impact on donor decision-making.

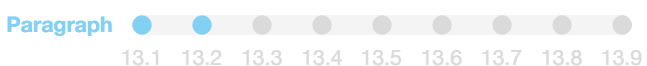
Resource mobilization activities can take place at any phase of the Humanitarian Programme Cycle. However, the top humanitarian donors tend to make their main decisions during the last quarter of the calendar year for disbursement early in the next calendar year, and within 72 hours for sudden onset emergencies.

13.2 Humanitarian funding: the international landscape

Effective humanitarian response and ensuring positive health outcomes for crisis-affected populations require substantial funding. That funding can be raised through multiple sources, including (a) bilateral government contributions; (b) multi-donor pooled funds such as the Central Emergency Response Fund (CERF) and country-based pooled funds (CBPFs); (c) international financing institutions such as the World Bank, Asian Development Bank and African Development Bank; and (d) private contributions from individuals, companies, trusts and foundations. Globally, humanitarian assistance is growing in volume, with total contributions from both government and private donors increasing year on year.



Resource mobilization



- Contents
- References
- Endnotes

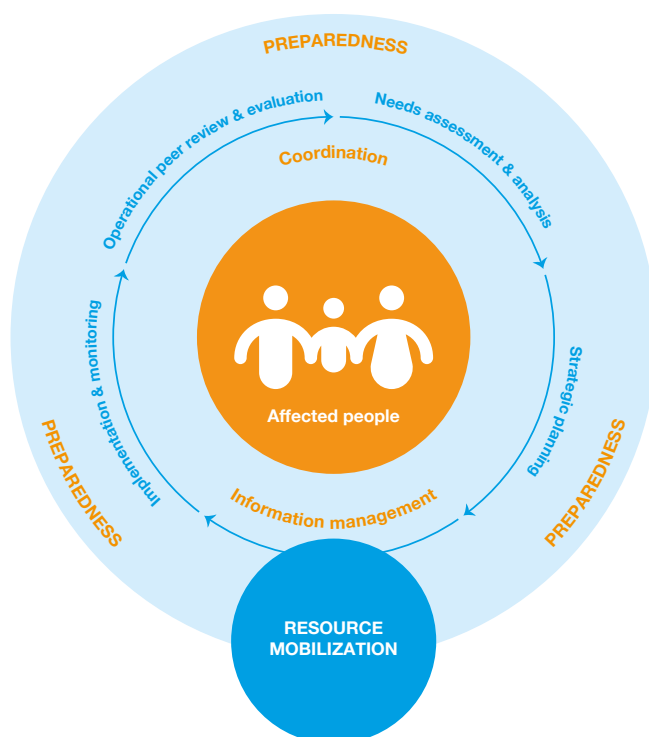
13.3 Country-level health cluster resource mobilization

Operational health organizations have the responsibility to raise funds for their respective emergency response programming.

Only United Nations health cluster partners included in the humanitarian response plan are eligible to apply for United Nations CERF funds existing in a country, in line with health priorities listed in the humanitarian response plan and agreed among United Nations agencies. CBPFs are available to United Nations organizations and international and local nongovernmental organizations (NGOs).

Resource mobilization has its own allocated phase in the humanitarian response plan (Figure 13.1). After the humanitarian country strategy has been developed, the health cluster response plan will be determined and will reflect the total funding requirement for the health cluster. The financial requirements for each cluster and participating agency in the humanitarian response plan are summarized at the end of the humanitarian response plan.

Figure 13.1 Resource mobilization within the Humanitarian Programme Cycle



Source: IASC Cluster Coordination Reference Module (1).



Resource mobilization



- Contents
- References
- Endnotes

Over recent years humanitarian planning and funding has mostly been on an annual basis. For protracted emergencies, while there are exceptions, generally the larger donors make decisions on funding during the last quarter of the calendar year in line with the time frame of the development of the humanitarian response plan, for disbursement early in the following year (as stated above). However, the Grand Bargain promotes the use of multi-year planning and funding processes as viable (2).

13.4 Multi-year planning and funding

Multi-year planning and funding (3) lowers administrative costs and catalyses more responsive programming, notably where humanitarian needs are protracted or recurrent and where livelihood needs and local markets can be analysed and monitored.

Multi-year planning must be based on a shared analysis and understanding of needs and risks as they evolve. Collaborative planning and funding mechanisms for longer programme horizons that are incrementally funded can produce better results and minimize administrative costs for both donors and aid organizations. They can identify results that highlight the linkages between humanitarian, development, stabilization and conflict management initiatives, which are fundamental to decreasing humanitarian needs.

After a sudden onset disaster, the larger humanitarian donors tend to make their main decisions regarding funding within 72 hours of sudden onset emergencies, usually in response to a flash appeal and through bilateral engagement.

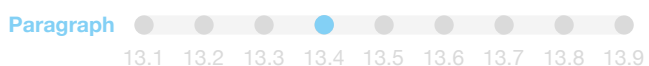
The health cluster coordinator has a continuing role to play in terms of resource mobilization through all phases of the Humanitarian Programme Cycle.

Health cluster coordinator responsibilities include:

- develop a clear picture of the health cluster funding status (requirements and gaps) and monitor this on an ongoing basis;
- undertake a careful analysis of the switch to multi-year planning, including the impact on health cluster funding;
- increase the overall visibility of the health cluster and the financial support requirement to ensure an effective emergency health response;
- proactively encourage humanitarian donors to support the health cluster response in line with the priorities outlined in the health cluster response plan;



Resource mobilization



- [Contents](#)
- [References](#)
- [Endnotes](#)

- proactively support national and local organizations, enabling them to access increased levels of funding;
- mobilize resources for the health cluster through available pooled funding mechanisms and administer the funding mechanism processes.¹

13.5 Monitoring health cluster funding status and determining funding gaps

The financial requirements of the health cluster will be outlined in the humanitarian response plan. The financial status of the cluster (that is, committed and allocated funding against requirements outlined in the humanitarian response plan) can be monitored using the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Financial Tracking Service (Box 13.1).

• Box 13.1 Financial Tracking Service

The Financial Tracking Service is a global online platform established by OCHA to record all reported humanitarian aid contributions. It collects and continuously updates data from:

- contributors wishing to report their humanitarian aid contributions (including government donors and private organizations);
- recipients wishing to report humanitarian aid that has been received (recipient agencies and implementing partners).

Once registered in the system, humanitarian aid contributors and recipients may upload information onto the online Financial Tracking Service at any time.

The Financial Tracking Service enhances the visibility and transparency of humanitarian funding, with a search facility that permits searches by donor, sector, country and recipient agency. The Financial Tracking Service has a specific role in monitoring the funding progress of humanitarian response plans and appeals. The data and information collected and curated by the Financial Tracking Service are regularly used by government and institutional donors, humanitarian coordinators and humanitarian country teams, operational agencies and host country governments, media, researchers, academics and think tanks.

Source: OCHA Financial Tracking Service (4).

It is the responsibility of the health cluster coordinator to monitor the health cluster funding status on an ongoing basis; to have a clear picture of the overall financial status of the health cluster as a collective; and to have an understanding of the financial status of each of the health cluster partners. Then, the health cluster coordinator will be able to lobby donors to allocate additional resources where there are funding gaps.



Resource mobilization



- Contents
- References
- Endnotes

The health cluster coordinator must strongly encourage all health cluster partners to report their financial contributions received against the humanitarian response plan on the Financial Tracking Service to facilitate transparency and more accurate monitoring of the financial status of the health cluster.

It is the responsibility of all health cluster partners to report all financial contributions against the humanitarian response plan on the Financial Tracking Service. Failure of a health cluster partner to keep the Financial Tracking Service updated on the financial status of programmes against the humanitarian response plan may impact future pooled funding allocations.

13.6 Engaging and talking to donors

It is the responsibility of the health cluster coordinator and the World Health Organization (WHO) as cluster lead agency to lobby present and prospective humanitarian donors in the country for funding on behalf of the health cluster as a collective. This includes bilateral and multilateral government donors and private donors.

What do donors want? Not all donors want the same, but in general they appreciate:

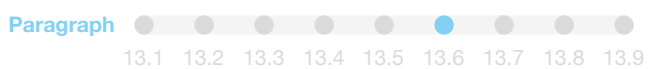
- to be engaged – trust is a constant dialogue;
- information – they want to be informed and consulted;
- good reports that show the impact of their funding;
- value for money – proof that taxpayers’ funds are being used in an efficient and economical manner to achieve their goals, and prioritization of activities and exit strategy are well defined;
- visibility;
- acknowledgement that the donor is not a cash machine!

Main methods for donor engagement include:

- donor mapping;
- interaction in United Nations country team or health cluster meetings;
- information sharing (for example, regular standard health cluster products or quarterly and annual donor reports);
- bilateral or multilateral meetings;
- discussion of concept notes and proposals;
- visits to donor capitals;
- joint field visits to project sites;
- joint donor events.



Resource mobilization



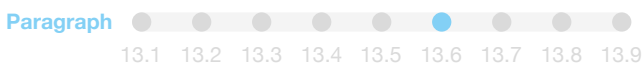
- [Contents](#)
- [References](#)
- [Endnotes](#)

The roles of the health cluster coordinator include the following.

- Always be prepared for meetings with donors, either on a bilateral basis or at health cluster meetings. Always know the current funding status of the health cluster and the priority funding requirements, should there be an opportunity to request additional resources.
- Develop relationships with prospective humanitarian donors present in country.
- Take the initiative to contact donor government representatives, and any potential private donors that are present in country, to explain the health cluster strategy, response priorities and resource needs.
- Encourage current and potential donors to actively participate in the health cluster, including through attending health cluster meetings and participating in health cluster monitoring trips. This will enable these donors to have a better understanding of cluster priorities and processes. Furthermore, many of the humanitarian donor representatives will have significant previous operational experience working in humanitarian situations and will be in a position to make valuable contributions to health cluster discussions and decision-making.
- Understand the particular respective interests of the various donors and keep them informed on a regular basis, through meetings and sharing briefing updates and reports.
- Prepare and regularly update concise, donor-friendly briefing materials and presentations, including graphics for donor briefings. Include information on:
 - health risks
 - gaps in services
 - health cluster strategy
 - health cluster capacity
 - advocacy message
 - health interventions
 - health cluster achievements
 - funding status and gaps
 - health cluster funding priority needs.
- Provide more detailed information to donors if requested by a particular donor.
- Encourage donors to provide funding for specific aspects of the health cluster plan.



Resource mobilization



- Contents
- References
- Endnotes

- Encourage donors to provide funding for specific health cluster partners (key agencies with expertise and capacity).
 - Link potential donors with specific health cluster partners, where appropriate.
 - It is important to maintain an ongoing dialogue with donors on the evolution of needs, results achieved, and funding received. Suggested strategies include the following:
 - develop and maintain a list of health-focused donor contacts for strategic communications;
 - ensure briefing materials (as outlined above) are regularly shared with these donors;
 - organize joint health cluster coordinator and donor programme visits;
 - organize quarterly reviews of the health cluster response with donors and partners;
 - organize a schedule of bilateral meetings with key donors for briefing and updates on the situation.
 - Clearly articulate resource mobilization activities in the annual workplan.
- ✓ **Tip:** In countries where CBPFs are in operation there will be engagement with the humanitarian donors through the CBPF processes, for example, health cluster presentations and briefings as part of an allocation process. However, this does not negate the need for additional bilateral engagement with those donors.

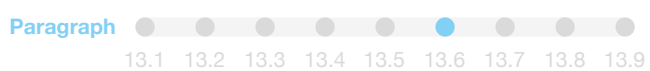
Table 13.1 presents the resource mobilization cycle.

► **Table 13.1 Resource mobilization cycle**

STAGE	ELEMENTS
Positioning	Media, web stories, situation reports, cluster bulletins, country updates, WHO emergency newsletters
Donor engagement	Representation, donor mapping, donor and health sector meetings, bilateral meetings, concept notes and proposals, visits to donor capitals
Implementation	Follow funding conditions, inform donors, ensure visibility, undertake donor field missions
Reporting	Respect reporting timelines, use templates, maintain highest quality standards, provide input to OCHA and other joint reports; good reports are key in securing multi-year funding



Resource mobilization



- Contents
- References
- Endnotes

13.7 Supporting national and local organizations to access humanitarian funding

National NGOs, local NGOs and faith-based organizations play an essential role in supporting the emergency health response. They are often the only agencies working in isolated, hard-to-reach, insecure areas. Despite the recognition of the importance of the role played by these agencies, many national NGOs, local NGOs and faith-based organizations face major challenges in accessing United Nations humanitarian funding. It is interesting to note that one of the Grand Bargain commitments is that 25% of all funding should be channelled to local partners (“localization of aid”).

The health cluster coordinator has an essential role to play in ensuring that these national NGOs are in a position to implement quality health projects in line with international, national and cluster standards and best practice.²

With regard to mobilizing funding, the health cluster coordinator also has a key role to play in enhancing funding opportunities for these agencies. Strategies that may be employed include:

- lobbying donors to support these national NGOs where quality of programming is satisfactory;
- exploring options for development of partnerships between some of the larger agencies so that grants may be channelled through larger NGOs;
- facilitating provision of guidance and mentoring for national and local NGOs and faith-based organizations on all aspects of the Humanitarian Programme Cycle, for example through:
 - the health cluster coordination team running workshops for national NGOs, local NGOs and faith-based organizations;
 - health cluster coordination team members providing one-to-one mentorship for these smaller agencies;
 - some of the stronger health international NGOs providing mentorship and guidance for these smaller agencies.



C

1

2

3

4

5

6

7

8

9

10

11

12

13

Resource mobilization

Paragraph

13.1 13.2 13.3 13.4 13.5 13.6 13.7 13.8 13.9

Box

13.1 13.2 13.3 13.4 13.5 13.6

Figure

13.1 13.2

Table

13.1

- Contents
- References
- Endnotes

13.8 Humanitarian pooled funding mechanisms

There are two main types of pooled funding mechanisms – the global-level Central Emergency Response Fund (CERF) and country-based pooled funds (CBPFs). Other multi-donor funds include the Start Fund for NGOs (Box 13.2) (5).

• Box 13.2 The Start Fund

The Start Fund is collectively owned and managed by Start Network’s members, and supported by the Governments of Belgium, Denmark, Ireland, and the United Kingdom and the European Commission.

Projects are chosen by local committees, made up of staff from Start Network members and their partners, within 72 hours of an alert. This makes the Start Fund the fastest, collectively owned, early response mechanism in the world.

The Start Fund focuses on three types of humanitarian need:

- underfunded small- to medium-scale crises
- spikes in chronic humanitarian emergencies
- forecast and early action for impending crises.

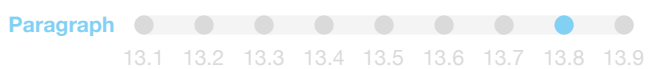
The United Nations Development Programme (UNDP) manages many multi-donor trust funds, including some CBPFs in a joint arrangement with OCHA.

13.8.1 Central Emergency Response Fund (CERF)

CERF is a global funding mechanism that pools the contributions from donors, mainly governments but also private donors, into a single fund. The fund is set aside for immediate use, to jump-start critical relief operations and fund lifesaving programmes not covered by other donors in rapidly deteriorating situations and in underfunded protracted crises (Box 13.3) (6).



Resource mobilization



- Contents
- References
- Endnotes

● Box 13.3 CERF objectives and funding criteria

CERF's objectives are to:

- promote early action and response to reduce loss of life
- enhance response to time-critical requirements
- strengthen core elements of the humanitarian response in underfunded crises.

Essential CERF funding criteria are "golden rules":

- **Lifesaving or core emergency humanitarian programmes** that within a short timespan remedy, mitigate or avert direct loss of life, physical and psychological harm or threats to a population or major portion thereof and protect their dignity. Also permissible are common humanitarian services that are necessary to enable lifesaving activities and multi-agency assessments in the instance of sudden onset disasters.
- **Time-critical response** refers to necessary, rapid and time-limited actions and resources required to minimize additional loss of life and damage to social and economic assets. It relates to the opportunities for rapid injection of resources to save lives either in complex emergencies or after natural disasters.

Health-specific CERF funding criteria apply to activities that have an immediate impact on the health of a population affected by an emergency. Health activities that may be considered for CERF funding are as follows:

- collection, processing, analysis and dissemination of critical health information, including access to and availability of lifesaving health services;
- ensuring equitable and timely access to emergency primary health care;
- provision, distribution and replenishment of quick turnover emergency stockpiles that have been used in an emergency context;
- mass casualty management, including such provisions as first aid centres; in-service, procurement and delivery of essential medicines and medical equipment; and medical evacuation services;
- repair of existing health facilities, including basic, rapid repairs to ensure medical facility functionality and provision of essential emergency medical equipment and medicines to emergency wards;
- addressing life-threatening conditions related to communicable diseases (immunization, outbreak control), including through establishment of emergency early warning and response systems for the early detection of and response to selected outbreaks of communicable diseases, training of health staff, supply of drugs and material, social mobilization and targeted health education, reactive mass vaccination campaign, and preparation of specific ad hoc treatment units (such as cholera treatment centres);
- priority reproductive health emergency interventions, including supply of drugs and material, for example interagency reproductive health kits such as clean delivery kits and midwifery kits, in accordance with the *Inter-agency field manual on reproductive health in humanitarian settings (7)*;
- medical (including psychological) support to survivors of sexual violence, including updating health staff on clinical management of sexual violence protocols, and supply of drugs and material (including interagency reproductive health kits); addressing life-threatening conditions related to chronic diseases that have been interrupted in an emergency context;
- priority responses to HIV/AIDS, including HIV/AIDS awareness information dissemination, provision of condoms, prevention of mother-to-child transmission, post-exposure prophylaxis, and standard precautions in emergency health care settings (emergency awareness and response interventions for high-risk groups, care and treatment of people with HIV whose treatment has been interrupted);
- support for provision of psychological first aid, including protection and care of people with severe mental disorders (suicidal behaviour, psychoses, severe depression and substance abuse) in communities and institutions.

C

1

2

3

4

5

6

7

8

9

10

11

12

13

Resource mobilization

Paragraph

13.1 13.2 13.3 13.4 13.5 13.6 13.7 13.8 13.9

Box

13.1 13.2 13.3 13.4 13.5 13.6

Figure

13.1 13.2

Table

13.1

● Contents

● References

● Endnotes

CERF allocation mechanisms

- **CERF rapid response grants.** These are to be used to respond to the needs of a sudden onset emergency, rapid deterioration of an existing crisis, or time-critical intervention; that is, when it is critical that emergency relief operations get under way and scale up quickly. CERF rapid response grants can be approved in as little as 48 hours.
- **CERF underfunded emergency grants.** These are for use in neglected crises, where a disaster fades from the headlines, or never makes the headlines, and so it is hard to raise donor funds. Twice a year the Emergency Relief Coordinator disburses CERF underfunded emergency grants to selected countries for emergencies that have not attracted sufficient funding. In countries with a humanitarian response plan, the CERF underfunded emergencies window can only fund humanitarian response plan projects.
- **CERF loans.** CERF has a US\$ 30 million loan facility, whereby one-year loans may be provided based on an indication that donor funding will be forthcoming in the future.

CERF recipients

- United Nations agencies, funds and programmes can receive CERF funds for lifesaving activities in emergencies around the world.
- NGOs are not eligible to apply for or directly receive funding from CERF. However, NGOs may be recipients of CERF funding where they are implementing partners of the United Nations agency that is a recipient of the grant (or loan).
- As per CERF’s rules, a United Nations agency cannot have another United Nations agency as its implementing partner, though it can have a government entity or a local or international NGO as its implementing partner. Each United Nations agency has to submit its own proposal.

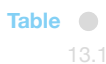
Application for CERF funds

The humanitarian coordinator (HC) or resident coordinator (RC) recommends use of CERF and identifies priority lifesaving needs by consulting the humanitarian country team.

✓ **Tip:** It is essential that the head of the WHO country office proactively engages in the process of discussion and analysis within the humanitarian country team that



Resource mobilization



- [Contents](#)
- [References](#)
- [Endnotes](#)

determines the priorities to be funded by a CERF application in order to ensure that critical health needs are included as a priority intervention.

United Nations organizations jointly apply for CERF funding through the RC or HC, who submits a package of proposals to the Emergency Relief Coordinator for approval. Funds are released immediately if proposals meet CERF criteria (see above) and are based on the priorities established under the leadership of the HC or RC in consultation with the humanitarian country team or United Nations country team.

The CERF application process should be inclusive and transparent and all efforts should be made to engage NGO partners and government. If NGO partners or government are not part of these established coordination forums, efforts should be made to engage them through ad hoc arrangements.

Role of the health cluster coordinator in the health cluster application for CERF

The health cluster application will be facilitated by the health cluster coordinator, transparently and in consultation with health cluster partners.

- The humanitarian country team should prioritize the intervention and decide which agency should intervene in a sector, depending on the context (displacement situation, refugees versus migrants) and the operational capacities, experience, and comparative advantage of the agency. In some contexts, WHO will undertake responsibility for water, sanitation and hygiene (WASH) or reproductive health. In other contexts, the United Nations High Commissioner for Refugees (UNHCR) will implement a multisectoral approach including health interventions for refugees.
- In the case of a rapid response grant at the outset of an emergency, it is likely that the consultation will be with a group of key partners brought together specifically to discuss this requirement.
- Where a health cluster has been in existence for some time, then the health cluster application should be discussed and determined with the strategic advisory group (where one exists) or with a funding review committee.
- The health cluster coordinator will justify and prioritize the health cluster needs.
- The health cluster coordinator will ensure coherence of cluster proposals at the inter-cluster coordination group.
- WHO as cluster lead agency submits the application to the HC or RC on behalf of the health cluster.



Resource mobilization



- Contents
- References
- Endnotes

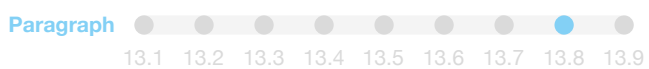
- The health cluster application will then go to the humanitarian country team for approval (along with the other applications), prior to submission to the United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator and CERF secretariat (based in OCHA). This may vary depending on the context, as the dynamics and leadership modalities within the clusters or sectors might vary. Each humanitarian country team has its own way of working. Usually, OCHA or the coordination structure in place will convene a meeting with all clusters and agencies to prioritize interventions.
- Each CERF project proposal must include a budget that details the costs to be funded by CERF and that strictly adheres to the CERF budget template and budget guidelines. The budget should reflect activities described in the project narrative.
- As each United Nations agency prepares its own budget, United Nations agencies cannot pass on CERF grants to other United Nations agencies as implementing partners. Joint projects (where there is more than one agency implementing a project) can have a joint narrative, but must present separate budgets for each agency, as CERF makes separate disbursements to each agency.
- A CERF application usually comprises several projects (at least two and very rarely one). While CERF discourages such an approach, the humanitarian country team might agree to submit three projects or more from three agencies for the same sector. For example, an application covering health sector needs might include interventions from the United Nations Children’s Fund (UNICEF) for immunization procurement activities, the United Nations Population Fund (UNFPA) for reproductive health activities, and WHO for emergency child health activities (WHO might use the vaccines procured by UNICEF for a campaign).
- The final decision on the number of projects, the sectors and the agencies to be submitted to CERF is at the discretion of the HC or RC.

Disbursement of funds

- CERF allocations are designed to complement other humanitarian funding sources, such as CBPFs and bilateral funding (see below).
- CERF rapid response grants are intended to jump-start responses or support the rapid scale-up of current responses rather than fully fund a response or target all the needs of the affected population.
- CERF is not funding a large share of project requirements. Normally, CERF contributes to a limited amount of the total requirement to meet the most time-



Resource mobilization



- [Contents](#)
- [References](#)
- [Endnotes](#)

critical and lifesaving requirements, but this may vary depending on the context and situation.

- **Recipient agencies** have full responsibility for the use of and reporting on all funds disbursed under the fund, and for compliance with the reporting requirements.
- The **RC or HC** ensures that CERF-funded activities are implemented as intended.
- The **humanitarian country team and United Nations country team** are collectively accountable for a CERF allocation and are expected to keep the CERF implementation on their agenda and jointly follow the implementation of CERF projects.
- The **Emergency Relief Coordinator** decides on and announces CERF underfunded emergency country allocations, usually in December for the first round and July for the second round. The total allocation amount per round depends on the resources available for the CERF grant component. The objective is to front-load emergency funding by disbursing a larger proportion of the annual amount set aside for the CERF underfunded emergency window in the first round.

13.8.2 Country-based pooled funds

Country-based pooled funds (CBPFs) play a key role in delivering the Grand Bargain, a set of reforms to improve the humanitarian financing system that was agreed by aid organizations and donors during the 2016 World Humanitarian Summit (8).

CBPF allocations offer fully flexible, in-country support for the highest-priority projects of humanitarian response plans while adhering to humanitarian principles. They incentivize wider inclusion of humanitarian partners in coordination mechanisms and are the largest source of direct funding for national and local actors. They also improve transparency, promote multisectoral cash programming, contribute to better reporting practices and help to minimize transaction costs.

CBPFs are multi-donor humanitarian financing instruments established by the Emergency Relief Coordinator.³ The 17 CBPFs that were active in 2018 received US\$ 957 million and allocated more than US\$ 792 million to 661 partners in 17 countries to support 1365 critical humanitarian projects. The main CBPF donors are Australia, Belgium, Denmark, Germany, Ireland, Norway, Qatar, Sweden, Switzerland and the United Kingdom.



Resource mobilization



- Contents
- References
- Endnotes

CBPFs are under the authority of the HC, with support from OCHA (and in some cases UNDP) for the day-to-day fund management and financial administration. An advisory board, which includes donor, United Nations and NGO representatives, advises the HC on policy and strategic issues and allocations. Government representation on the advisory board may be considered, depending on the country context. In countries where a CBPF is not available, there should be advocacy and agreement reached with the RC and HC and the rest of the United Nations country team to establish one.

CBPFs allocate funds based on identified humanitarian needs and priorities in line with the Humanitarian Programme Cycle and in support of strategic response plans and humanitarian response plans.

To avoid duplication and ensure a complementary use of available funding, CBPF allocations are made considering other funding sources, including contributions from government (bilateral and multilateral) and private donors.⁴

There are two modalities of CBPF:

- **standard allocation** for up to 12 months (projects to be submitted against the humanitarian response plan and allocation strategy or criteria as determined by the humanitarian country team);
- **reserve allocation** intended for rapid and flexible allocation of funds on a rolling basis in the event of unforeseen circumstances, emergencies or contextually relevant, systemic and logistical needs.

The size of each fund (that is, the reserve vis-à-vis the standard) is determined by the specific country context.

- Some CBPFs use the reserve allocation as the main funding modality. In this case, the fund is normally active and open to project proposals submitted on a rolling basis.
- Some CBPFs use the standard allocation as the main modality. In this case, it is up to the HC (in consultation with the advisory board) to activate the reserve allocation to respond to emergency or unforeseen needs.

CBPF recipients

- United Nations agencies, national and international NGOs, and International Red Cross and Red Crescent Movement organizations who are included in the humanitarian response plan are eligible to apply for CBPFs.



Resource mobilization



- [Contents](#)
- [References](#)
- [Endnotes](#)

- All United Nations agencies are eligible to receive funding. International and national NGOs must undergo a capacity assessment process (conducted by OCHA) to become eligible to receive funding from CBPFs (9). Around 25% of all CBPF funding goes to local NGOs.

CBPF application process

Standard allocation. The standard allocation modality outlines a process for consulting with humanitarian partners to ensure the best possible use of available resources (9). Transparency is essential for the fund to function properly. Relevant information should be communicated to key stakeholders in a timely manner and allocation decisions should be rationalized and documented.

Reserve allocation. The reserve allocation modality uses the same principles as for the standard allocation (above). However, the process should be significantly quicker than the standard allocation process (as a number of steps are omitted).

Project review. The CBPF allocation process includes two types of project review:

- a strategic review, which assesses whether the project submission is in line with the strategy and priorities of the cluster;
- a technical review, which assesses the technical soundness and quality of project proposals.

The **cluster strategic review committee** should equitably represent the members of the cluster. Members of the committee should be knowledgeable of humanitarian operations and the health cluster strategy and priorities. It would be appropriate to use the existing strategic advisory group for this function. The committee reviews and scores submitted projects on (a) strategic relevance; (b) programmatic relevance; (c) cost-effectiveness; (d) management and monitoring; and (e) engagement with coordination. Based on the review, a shortlist of prioritized projects will be developed for consideration for CBPF funding.

The **cluster technical review committee** should be made up of technical experts who will review project proposals. Selection of members of the committee should be based on demonstrated technical knowledge of emergency health programming. A small group of experts will allow for detailed deliberation of the technical aspects of project proposals. Additional specialized advisers may be requested to provide support and input into the technical review process. It is likely that some but not all members of the strategic review committee will also be members of the technical review committee. The committee reviews projects on the basis of their technical merit and the appropriateness of the budgetary provisions.



Resource mobilization

Paragraph ● 13.1 ● 13.2 ● 13.3 ● 13.4 ● 13.5 ● 13.6 ● 13.7 ● 13.8 ● 13.9

Box ● 13.1 ● 13.2 ● 13.3 ● 13.4 ● 13.5 ● 13.6

Figure ● 13.1 ● 13.2

Table ● 13.1

- [Contents](#)
- [References](#)
- [Endnotes](#)

To ensure transparency, it is recommended that an agreed-upon scoring matrix be applied.

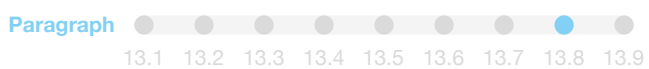
The health cluster strategic and technical review committees should be established through a transparent consultative process within the health cluster. In addition to meeting the criteria outlined above, each committee should ensure representation from United Nations agencies, local NGOs and national NGOs. The Humanitarian Financing Unit (OCHA) will also be represented on both committees. To the extent possible, OCHA will provide additional support for these review committees to discharge their functions and may participate as an observer.

✓ **Tip:** Where the government health authority is not part of these established coordination forums, efforts should be made to engage them through ad hoc arrangements as contextually appropriate.

Figure 13.2 shows the steps in the process for CBPF standard and reserve allocations (9). While the steps and their sequence are mandatory, country-specific approaches can be applied within each of the different steps.

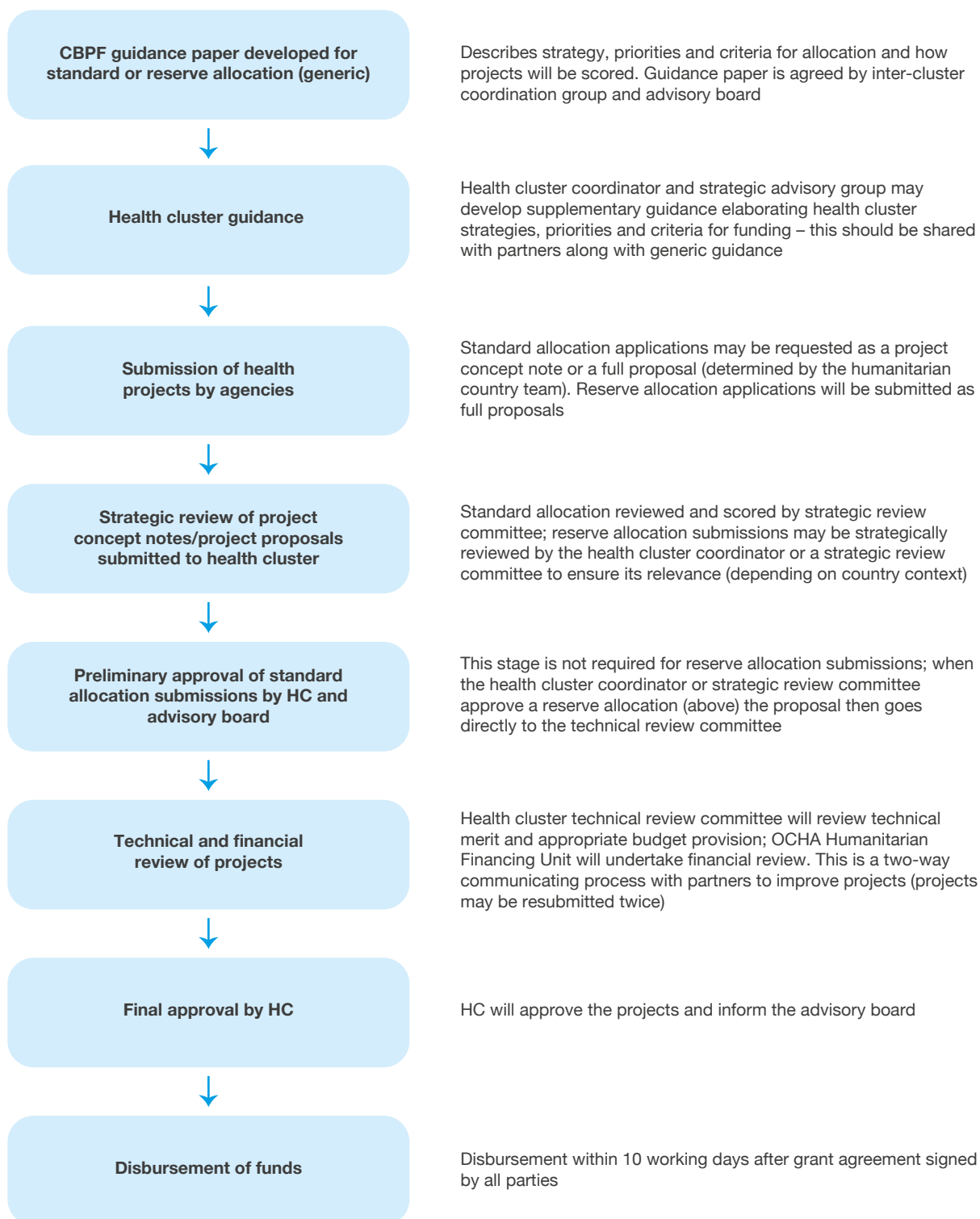


Resource mobilization



- Contents
- References
- Endnotes

Figure 13.2 Steps in the process for CBPF standard and reserve allocations



Resource mobilization

Paragraph ● 13.1 ● 13.2 ● 13.3 ● 13.4 ● 13.5 ● 13.6 ● 13.7 ● 13.8 ● 13.9

Box ● 13.1 ● 13.2 ● 13.3 ● 13.4 ● 13.5 ● 13.6

Figure ● 13.1 ● 13.2

Table ● 13.1

- [Contents](#)
- [References](#)
- [Endnotes](#)

Health cluster coordinator role in CBPF process

Health cluster coordinators have an essential role to play in leadership and coordination of the CBPF allocation process in order to ensure that funding is provided for priority health needs in line with the strategies and priorities outlined in the strategic response plan or humanitarian response plan.

At inter-cluster coordination group or humanitarian country team level:

- engage in analysis and dialogue through the inter-cluster coordination group to ensure that health priority needs are adequately incorporated in the allocation paper or guidance from OCHA;
- ensure that the head of the WHO country office is well briefed and informed on the priority needs and so can further lobby for their inclusion as required at meetings (or related forums) of the humanitarian country team, United Nations country team and CBPF advisory group.

Within the health cluster:

- communicate with health partners, ensuring they understand the allocation process, generic guidance and time frame as determined by OCHA in country;
- provide additional guidance in terms of health cluster strategies and priorities;
- facilitate support for smaller national and local NGOs to submit quality proposals (mini workshops, one-to-one guidance and mentoring from health cluster coordination team or from some of the stronger international NGOs);
- facilitate the establishment of representative strategic and technical review committees (as appropriate for the context) through a transparent consultative process;
- ensure leadership, guidance and support for these review committees (9, 10).⁵

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9

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11

12

13

Resource mobilization

Paragraph

13.1 13.2 13.3 13.4 13.5 13.6 13.7 13.8 13.9

Box

13.1 13.2 13.3 13.4 13.5 13.6

Figure

13.1 13.2

Table

13.1

● Contents

● References

● Endnotes

13.9 Humanitarian funding within the wider context of development funding

13.9.1 Country-level humanitarian funding

Country-level humanitarian funding is provided within the context of wider development funding mechanisms and processes. It is therefore essential that the health cluster coordinator understands the wider development funding environment and specifically the health sector-related funding landscape and mix of financial resources, and that decision-making on allocation of humanitarian funding at country level takes these other resources into consideration.

In some protracted emergency contexts, humanitarian funding may be used to provide basic services where other resources (domestic and international) are not available or are limited. In other humanitarian contexts, international humanitarian funding represents a small fraction of the overall resources provided from domestic public revenues and official development assistance.

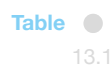
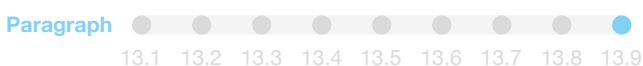
In many situations, as a crisis escalates, development-oriented funding slows down and humanitarian funding increases. While this scaling down of development funds in times of acute crisis can to some extent be expected, there is significant rationale and scope for pooled development funds to remain engaged in many crisis-affected countries. Particularly in protracted and largely predictable emergencies, pooled development funds can be a means of channelling support to address vulnerabilities and build resilience in fragile States where other development modalities may be difficult.

13.9.2 Allocation of humanitarian funding for health within wider context of development funding

The framework of the six building blocks of a health system (11) can be used to conduct a basic mapping of financial support for health, to determine gaps and the potential for disruption, and, consequently, to assess the possible need for humanitarian support (Box 13.4).⁶



Resource mobilization



- Contents
- References
- Endnotes

● **Box 13.4 Impact of conflict on drug availability and subsequent need for humanitarian support for procurement of essential medicines in Syrian Arab Republic**

Prior to the conflict which started in March 2011, 90% of the national drug supply of the Syrian Arab Republic was produced in country. During the first few years of conflict production went down to 10%, so drug supply across the whole country was at a crisis level and humanitarian support was required to fund drug procurement.

The countrywide assessments documented the need for medicines across the country, including in hard-to-reach, besieged areas and territories under the control of the government forces.

The identified needs for essential medicines, supplies and equipment were reflected and articulated in the health sector needs overview and health sector strategy. The main activities related to drugs procurement were:

- annual development of a list of essential medicines;
- a cascade of capacity-building events for pharmacists, logisticians, warehouse managers and staff on procurement, stock management, prescription practices, and supply chain;
- continuous monitoring and supportive evaluation;
- accountability to affected populations, including surveys of end users on availability of free medicines;
- continuous advocacy with authorities, influential stakeholders and donors;
- lifting the importation ban to enable health sector partners to procure and import pharmaceutical products from abroad.

More than 50% of the annual budget of WHO (as leading health sector agency in procurement of medicines) would be allocated to essential medicines, supplies and medical equipment.

Of interest to the health cluster are major developmental programmes that support the health system generally and those supporting the prevention of and response to specific diseases. These would include United Nations multi-donor trust funds, national multi-donor trust funds, stand-alone programmes such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and bilateral donor government funding of the health sector (Box 13.5).

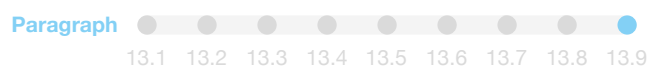
● **Box 13.5 Examples of development programmes of importance to health cluster**

Development programmes of importance to the health cluster include the following:

- donor-funded programmes (European Union Trust Fund, European Neighbourhood Instrument);
- supporting basic health service provision (it is important to know the geographical coverage of each programme or donor);
- multi-donor trust fund for malaria (it is important to know the timing of net distributions and status of drug supply);
- multi-donor trust fund for tuberculosis (it is important to know the status of drug supply and protocols, and practice in situations of conflict or large numbers of internally displaced persons).



Resource mobilization



- Contents
- References
- Endnotes

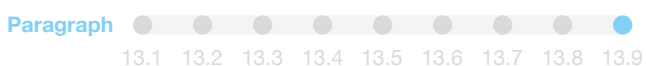
It is the responsibility of the health cluster coordinator along with WHO as cluster lead agency to identify which in-country health funding mechanisms or donors are of relevance to the health cluster. These would potentially include in-country donor coordination bodies and key government donors. The role of the health cluster coordinator will include engagement with and developing working relationships with key mechanisms and donors during the period of existence of the health cluster. The objectives of this engagement would be to:

- share information;
- lobby for the provision of financial resources to support emergency health interventions (see below);
- be aware of the strategy and priorities of each of the key funding mechanisms and donors and the geographical coverage of each, according to any national health sector development plan;
- ensure that efforts to mobilize humanitarian funding for the emergency health response are based on a solid understanding of the wider health financing resource mix;
- ensure that financial allocation through CBPFs are made with due consideration of the wider funding mix, ensuring complementarity of programming rather than duplication.

With regard to funding, in a new emergency the health cluster coordinator along with the head of the WHO country office should encourage development donors to continue to provide development assistance for the health system and, in some situations, to provide additional development support to allow ongoing or increased coverage of health services as required in order to address vulnerability and promote resilience (Box 13.6). As the health cluster transitions and deactivates, the health cluster coordinator along with the head of the WHO country office should encourage development funding to support basic services and coordination functions.



Resource mobilization



- [Contents](#)
- [References](#)
- [Endnotes](#)

● **Box 13.6 South Sudan: ensuring continuation of service provision despite shift in funding from humanitarian to developmental mechanisms**

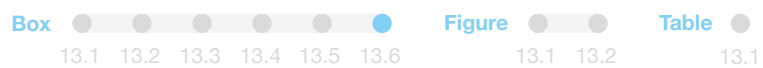
In 2012 health financing for basic services across South Sudan shifted from humanitarian assistance to a development modality, and a health pooled fund was established. As contracts were realigned, the health cluster determined that funding gaps were possible, with the potential for a halt in service provision in many areas.

It was the role of the health cluster coordinator and WHO as cluster lead agency to engage with donors and highlight to the humanitarian country team and HC the concerns of the health sector and to effect a smooth transition, minimizing the diversion of CBPF to maintain services nationally instead of reacting to acute crises.

Furthermore, it was determined that there was a threat of a national drug stock-out, as drug supply funding and mechanisms also changed during the transition. Again, the health cluster coordinator and WHO as cluster lead agency lobbied donors, the humanitarian country team and the HC so that discussion of the issue became prioritized in high-level meetings. An ad hoc emergency fund of US\$ 50 million specifically for drug procurement was established by some main donors, and the gap was averted.



Resource mobilization



- [Contents](#)
- [References](#)
- [Endnotes](#)

Endnotes

1. See sections 13.8.1 and 13.8.2 below for health cluster coordinator responsibility for each process.
2. See Chapter 11, section 11.7.
3. The Common Humanitarian Fund and Emergency Response Fund have now been aligned and harmonized, and both now operate under CBPF policy and operational guidelines.
4. See section 13.5 and Box 13.1 on the Financial Tracking Service.
5. See *Operational handbook for country-based pooled funds (9)* and *CBPF guidelines, Annex 2 (10)*.
6. See Chapter 5 on promoting standards.



Resource mobilization

Paragraph ● ● ● ● ● ● ● ● ● ●
13.1 13.2 13.3 13.4 13.5 13.6 13.7 13.8 13.9

Box ● ● ● ● ● ●
13.1 13.2 13.3 13.4 13.5 13.6

Figure ● ●
13.1 13.2

Table ●
13.1

- Contents
- References
- Endnotes

