National Guidance for Coordination Among Humanitarian Health Partners to Prepare and Respond to Disaster and Public Health Emergencies Following Cluster Approach

Government of Nepal
Ministry of Health and Population

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Summary

Nepal faced significant healthcare challenges during the 2015 earthquake and the COVID-19 pandemic in 2019, necessitating a coordinated response. The Ministry of Health and Population (MoHP) led the health cluster, with the World Health Organization (WHO) as the co-lead for coordination among health partners. However, a gap in coordination was identified as an important area for improvement. A functional simulation exercise in September 2022 highlighted the need for consistent, institutionalized, intra and multisector health coordination and collaboration.

The National Disaster Risk Reduction and Management Act 2074, National Policy for Disaster Risk Reduction, and National Disaster Response Framework 2067 (First Amendment 2076) all mention national and international coordination for effective disaster management. The strategy for coordination of humanitarian health partners aims to reduce need, risk, and vulnerability over multiple years and increase health system resilience.

This guidance document outlines the vision of humanitarian health partners' coordination to save lives and promote dignity in humanitarian and public health emergencies. The objectives include effective coordination, disaster preparedness, identifying roles and responsibilities, mapping partners and support in: developing strategies, monitoring health, analyzing and prioritizing health situations, planning health sector response strategies, ensuring standards of health service delivery, and performance monitoring.

It outlines the strategy for coordination of humanitarian health partners aims to reduce need, risk, and vulnerability and increase health system resilience. This includes support in developing or updating response strategies and work plans for the cluster and ensuring these are adequately reflected in overall coordination mechanism strategies.

Introduction

The year 2015 marked a significant event in Nepal's disaster history with a devastating earthquake that resulted in widespread destruction and loss of life. While the country was recovering from the Earthquake, it faced another major crisis in 2019 with the outbreak of the COVID-19 pandemic. The pandemic posed significant challenges to the healthcare system and required a coordinated and rapid response. Humanitarian coordination was initiated; clusters activated, with the MoHP as the lead and WHO as the co-lead for coordination among health partners both in 2015 and 2019. In regards to the recent 6.4 magnitude earthquake that struck the Jajarkot and Rukum Districts of Karnali Province on November 3, 2023, caused significant damage, resulted in 153 fatalities, and destroyed about 4,000 houses in the hardest-hit areas. In all these disasters, a gap in coordination was identified as one of the important areas for improvement. The coordination mechanism was tested by a functional simulation exercise in September 2022, the key lesson identified was a gap in coordination and communication pathways.[1] International evaluations like the Joint External Evaluation (JEE) in 2022 highlighted the necessity to ensure consistent, institutionalized, intra and multisector and one health coordination and collaboration that is less dependent on the individual.[2]

Underlying rationale/objective of the approach or coordination among humanitarian health partners

Nepal Health Sector Strategic Plan 2023-2030 (Section 3, Sub section 1.6.2 Ga)[3] has mentioned coordination with cluster mechanisms. The health cluster/sector has been activated at the federal and provincial levels at different times; however, there is a lack of a national guiding document for coordination among humanitarian health partners that best suits for national or provincial specific needs. Some provinces have developed the terms of reference for coordination; however, that lacks a comprehensive approach. In this regard, this guiding document aims to bring humanitarian health partners together to support preparedness and response to public health emergencies by following a cluster approach. This document is based on the provision for developing National Guidelines as per Public Health Act 2078. (Section 6, no 48 and 64)

[1] Nepal Health Sector Simulation Exercise, Sep 2022

[2] Joint External Evaluation of IHR core capacities of Nepal, 28 Nov-2 Dec, 2022

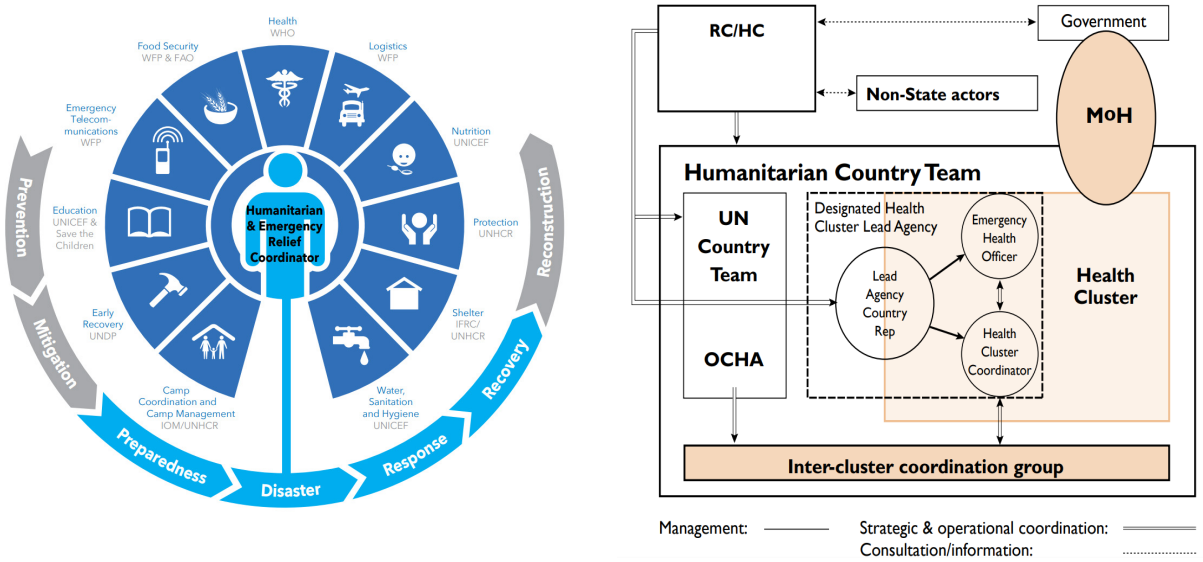
[3] Nepal Health Sector Strategic Planning 2023-2030

Global, national, and subnational background of the humanitarian health partners' coordination mechanism

There are 11 clusters globally, Figure 1.4 Each global cluster is led by one or two United Nations agencies or a United Nations agency and an international NGO. At the country level, clusters are usually co-led by a United Nations agency and an NGO. The cluster leads must be ready to provide services to affected people where other organizations cannot.

Global Health Cluster

In 2005, the Global Health Cluster was established under the guidance of the World Health Organization (WHO). Its primary purpose is to facilitate and endorse collective efforts, both at the global and country levels, to enhance the efficiency, effectiveness, and predictability of humanitarian health interventions. At the country level, the Health Cluster functions as a platform for participating organizations to collaborate and streamline their efforts. The aim is to utilize available resources efficiently while working within the framework of agreed-upon objectives, priorities, and strategies, all geared toward benefiting the affected population(s). This approach aims to prevent gaps and overlaps in the international humanitarian health response, both in terms of human resources and finances.



The National Health Cluster encompasses a range of stakeholders, including UN agencies such as WHO, UNICEF, UNFPA, IOM and IFRC, the national Red Cross/Red Crescent society, international and national NGOs, and representatives of key private-sector health service providers. Additionally, it includes major health-sector donors and other pertinent stakeholders.

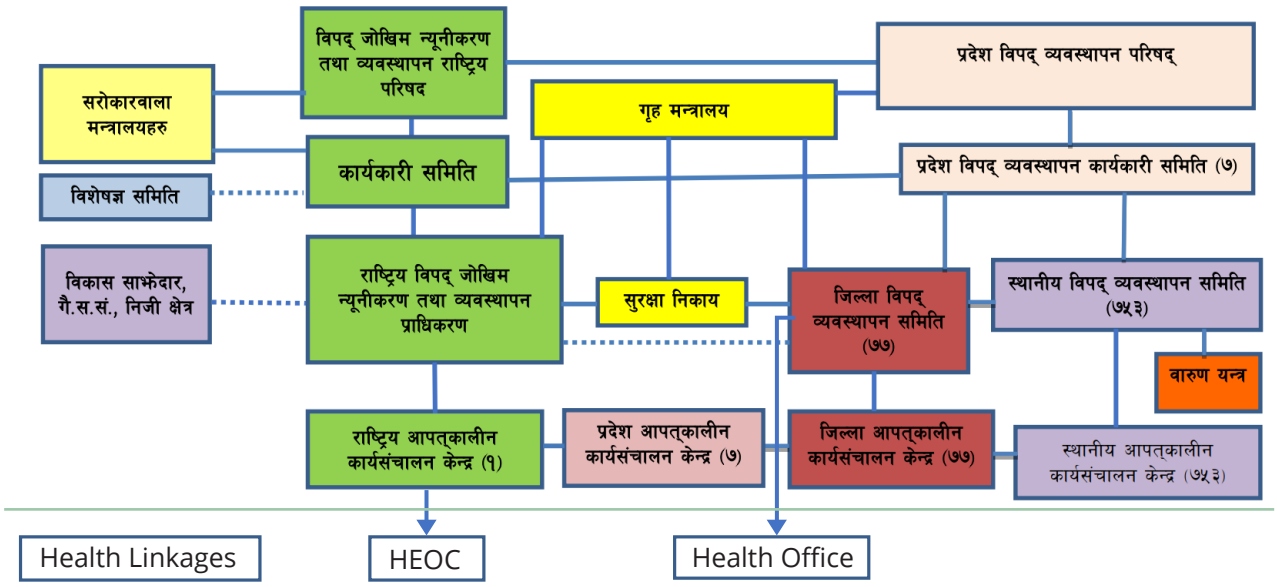
[4] Health cluster guide: A practical Handbook

At the provincial (sub-national) level, Health Cluster groups typically include health agencies active in the area, donor representatives, and other health-related stakeholders. The Health Cluster Lead Agency (CLA) plays a crucial role as a link between national and local health authorities and international and NGO humanitarian health actors. A primary responsibility of the CLA is to ensure that international humanitarian actors leverage local capacities and establish and maintain appropriate connections with relevant government and local authorities and local civil society organizations involved in health-related activities. The relationships among various entities, including the Cluster Lead Agency Representative (CLAREP) of various clusters, the Health Cluster Coordinator, the cluster itself, the Resident Coordinator/ Humanitarian Coordinator (RC/HC), and the government/Ministry of Health and Population, Figure 2.[5]

The Inter-Cluster Coordination Group (ICCG) serves as a pivotal mechanism for different clusters to collaborate, identify humanitarian needs necessitating a multi-sectoral response, and devise strategic plans accordingly. It serves as the platform where cluster coordinators report and discuss how various cross-cutting issues and other humanitarian needs have been integrated and coordinated with other clusters' activities.

National Coordination

To support this National Disaster Risk Reduction and Management Act 2074, there is the provision of a National Council under the chairmanship of Hon Prime Minister, an Executive committee under the chairmanship of the Minister of Home affair and a National Disaster Risk Reduction and Management Authority under the Ministry Home affair to effectively carry out and manage disaster management activities.[6] The committees are in the figure given below, Figure 3.[7]

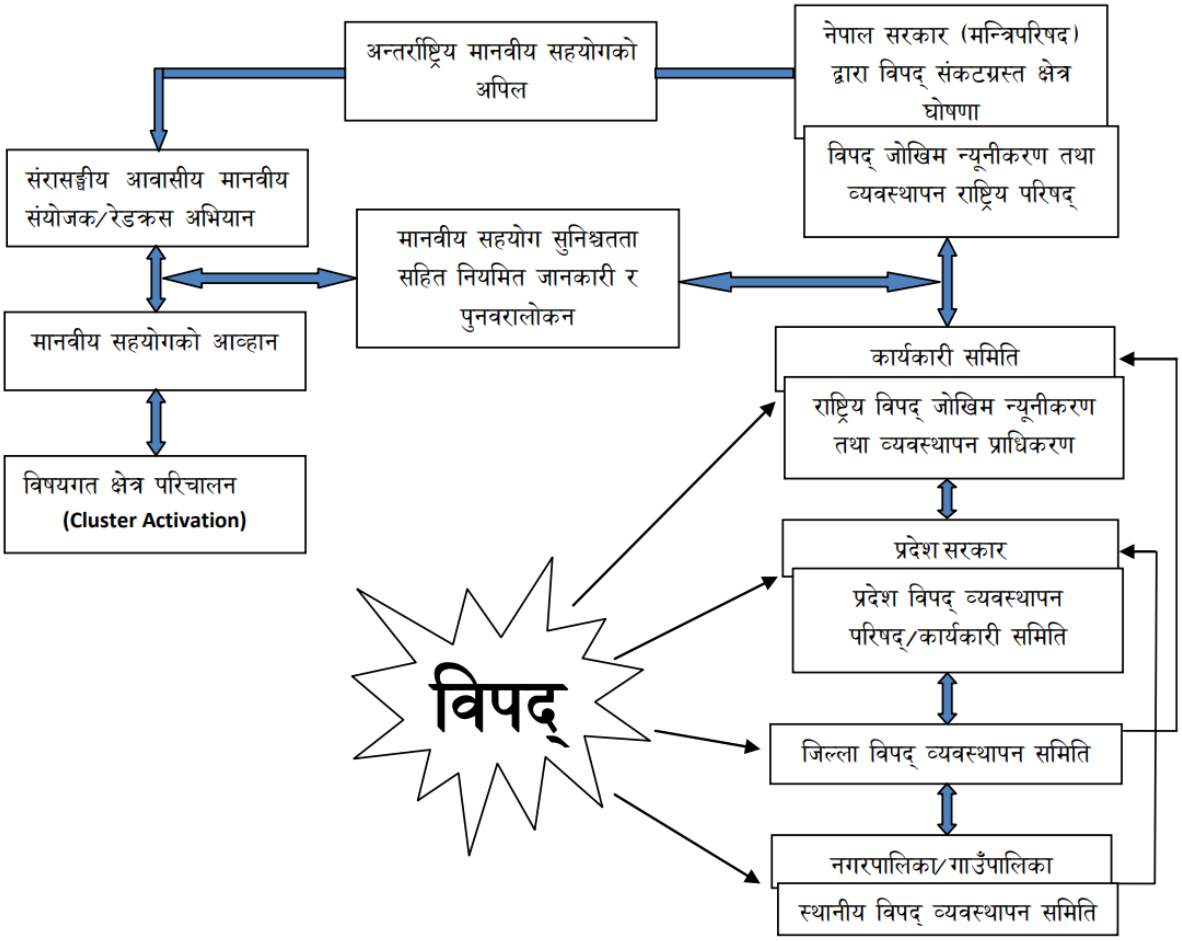


[5] Health Cluster Guide, A practical guide for country level implementation of the Health Cluster, 2019, 2015

[6] Disaster Risk Reduction and Management Act 2074

[7] Disaster Preparedness and Response Plan Implementation Guideline 2076

National policy for Disaster risk reduction, 2075, section 3.5 also mentions the national and international coordination for effective disaster management.[8] National Disaster Response Framework 2067 (First Amendment 2076) has mentioned the cluster mechanism and showed 11 clusters as of the global health cluster.[9]



[8] National policy for disaster risk reduction, 2075

[9] National Disaster response framework, 2076

विषयगत क्षेत्र (Name of the Clusters)	सरकारी निकाय	सहयोगी निकाय
स्वास्थ्य (Health)	स्वास्थ्य तथा जनसंख्या मन्त्रालय	WHO
खानेपानी, सरसफाई तथा स्वास्थ्य प्रबर्द्धन (WASH)	खानेपानी मन्त्रालय	UNICEF
आपत्कालीन आश्रयस्थल (Emergency Shelter)	शहरी विकास मन्त्रालय	IFRC/UN HABITAT
खाद्य सुरक्षा (Food Security)	कृषि तथा पशुपंक्षी विकास मन्त्रालय	WFP/FAO
पोषण (Nutrition)	स्वास्थ्य तथा जनसंख्या मन्त्रालय	UNICEF
शिविर समन्वय तथा शिविर व्यवस्थापन (CCCM)	शहरी विकास मन्त्रालय	IOM
संरक्षण (Protection)	महिला, बालबालिका तथा ज्येष्ठ नागरिक मन्त्रालय	UNHCR/UNICEF/UNFPA
शीघ्र पुनर्लाभ (Early Recovery)	सङ्घीय मामिला तथा सामान्य प्रशासन मन्त्रालय	UNDP
शिक्षा (Education)	शिक्षा, विज्ञान तथा प्रविधि मन्त्रालय	UNICEF/SC
बन्दोबस्ती (Logistics)	गृह मन्त्रालय	WFP
आपत्कालीन सञ्चार (Emergency Communication)	सञ्चार तथा सूचना प्रविधि मन्त्रालय	WFP

Health Sector Coordination

Public Health Service Act 207510, Chapter 2 in alignment with the constitution states that: Every citizen shall have the right to obtain quality health service in an easy and convenient manner; Every health institution shall provide emergency health service as prescribed. Furthermore, chapter 3 of the act states that the Federal, Provincial, and Local Levels may, in order to provide health service, carry out necessary partnerships with private or non-governmental health institutions. This has also been addressed in policy documents in sections 6.6 and 6.11 as following

- Collaboration and partnerships among governmental, non-governmental, and private sectors shall be promoted, managed, and regulated in the health sector and private, internal, and external investments in health education, services, and research shall be encouraged and protected
- Integrated preparedness and response measures shall be adopted to combat communicable diseases, insect-borne, and animal-borne diseases, problems related to climate change, other diseases, epidemics, and disasters

[10] Public Health Service Act

The coordination division under MoHP is entitled to manage international, multisectoral and national health coordination.[11] Similarly, the Health Emergency and Disaster Management Unit under the Ministry of Health and Population is entitled to foresee all activities related to disaster and emergency. The ToR of HEDMU as listed is as follows:[12]

1. To work as a secretariat of the Ministry of Health and Population during health emergencies and disasters
2. To work with the National Disaster Management Center under the Ministry of Home Affairs and other related bodies as a health sector center point.
3. During health emergencies and disasters; coordination with the DoHS and divisions/ Centers for emergency medical teams and rapid response teams.
4. To work as a central communication body at the provincial and local levels during health emergencies and disasters.
5. Operate necessary assistance by coordinating with the affiliated international bodies, non-governmental organizations, and organizations during emergencies and disasters.
6. Necessary coordination with the Hub and satellite hospital networks to facilitate service during emergencies and disasters.
7. Collect, and maintain databases or data relevant to health disasters.
8. To coordinate with the respective divisions and centers and academia at National and Province Level (EDCD / DoHS , National Health Training Center (NHTC),for Standard / Criteria and capacity development.

[11] Coordination division, multilateral coordination unit, MoHP

[12] Terms of Reference, Health Emergency Disaster Management Unit

Vision, mission, and objective for humanitarian health partner coordination

The guidance document defines the ***vision*** of the coordination of humanitarian health partners is to assist in saving lives and promote dignity in humanitarian and public health emergencies; and the ***mission*** is to collectively prepare for and respond to humanitarian and public health emergencies to improve the health outcomes of affected populations through a timely and predictable manner.

The specific objectives are as follows:

1. Effective coordination

a. Supporting with minimum commitments of humanitarian health partners

b. Providing partnership for disaster and health emergency preparedness and response at national and sub-national levels.

c. Identifying roles and responsibilities of lead, co-lead, members, and observers involved in the coordination and their combined responsibilities as a team

d.Developing strategy for coordination of humanitarian health partner

e. Formulating an annual work plan based on the core functions

f. Mapping of the humanitarian health partners at national and provincial

2. Support in assessment of health and situation monitoring

a. Mapping, assessment, documentation, and reporting templates and tools

3. Support in analyzing and prioritizing health situations

4. Support in planning health sector response strategy

a. Preparing health component of common humanitarian health plan

b. Addressing cross-cutting issues

5. Ensuring standards of health service delivery

6. Performance monitoring

a. Monitoring and evaluation framework of the coordination mechanism

Organizational structure and mechanism of humanitarian health partners to perform in cluster approach for disaster and health emergency preparedness and response at national and sub-national level

National level:

At the national level, the health coordination mechanism 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, the International Committee of the Red Cross, or the Red Crescent society, UN agencies (including WHO as a partner as well as other United Nations agencies supporting the health response, for example, the IOM, UNICEF, and UNFPA, representatives of major private sector health service providers (where supporting health services), and the main health sector and humanitarian donors and other important stakeholders.

Provincial level

At provincial 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, professional medical amd public health organizations and other health stakeholders present in the area, Figure 5.13 The humanitarian health partners coordination structure does not necessarily need to mirror the national structure, nor will they necessarily have the same structure across all locations within the country. Provincial-level coordination mechanisms should be adapted to the context of the specific locations where they have been activated. While provincial coordination structures may vary across regions, they should all facilitate decentralized decision-making and shorten response time. Therefore provincial authorities can make their own guidelines bases on this document. Sub-national coordination mechanisms are in a better position 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

[13] Health cluster guide: A practical Handbook

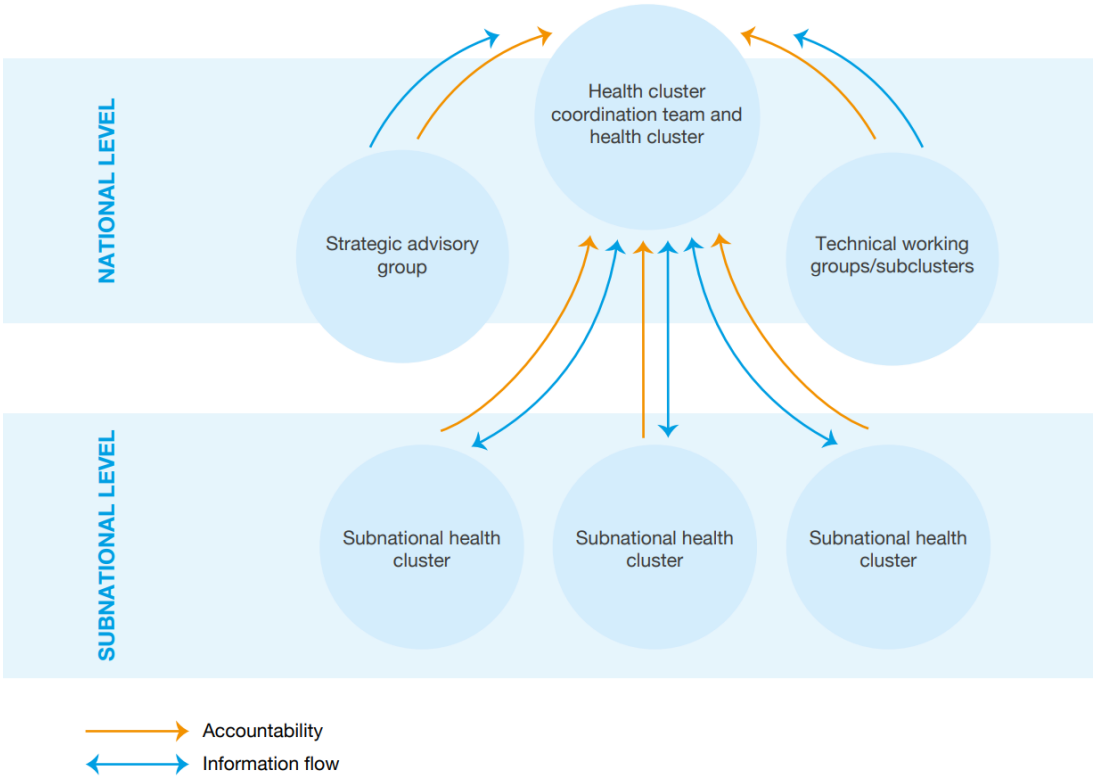


Figure 4. National and Sub Provincial Coordination

Activation of Cluster Mechanism

The cluster mechanism may be activated when the state of emergency is declared and the Incident Command System is activated. During the emergency phase the Government will provide leadership and international partners may reinforce the Government's coordination. During the recovery phase the Government leadership will continue. Humanitarian coordination structures may transition to recovery and to development structures. International actors withdraw or support recovery and help to prepare for future crises.

Map the humanitarian health partners at national and provincial level

Who, what, where (when, for Whom) (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 health partner 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.

Partner's list

A partners list is simply a list of all health cluster partners and their contact information. While a well-maintained 3W/4W/5W 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/5W database in a timely way. Further, partners may not wish their contact information to be shared publicly in the same way that 3W/4W/5W information may be shared, or the 3W/4W/5W 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.

Humanitarian health partners can include a diverse range of organizations, both governmental and non-governmental, that contribute their expertise, resources, and capacities to the overall health response. Some examples of humanitarian health partners include:

1. Government and concerned line ministries
2. United Nations Agencies
3. Non-Governmental Organizations (NGOs/INGO)
4. Red Cross and Red Crescent Movement
5. Academic and Research Institutions
6. Health Development Partner
7. International/ Regional / Intergovernmental Organizations
8. Community-Based Organizations
9. Professional medical and public health associations and societies

Sample of 3W/4W and partner list is in annex 1.

Core functions of humanitarian health partners coordination

The guidance document illustrates how humanitarian and development actors should work together, based on their comparative advantages, towards collective outcomes that reduce need, risk, and vulnerability over multiple years and increase health system resilience.

The core function of health partners' coordination for disaster and public health emergencies will be:

1. Leadership, Strategy, and Coordination:

- Providing overall leadership and direction for health response efforts.
- Developing a clear and comprehensive health strategy that outlines the objectives, priorities, and actions required to address health needs.
- Coordinating the efforts of various health partners and organizations involved in the response to avoid duplication and ensure a comprehensive approach.

2. Assessment and Surveillance:

- Conducting rapid health assessments to gather essential information about the health situation, population health status, and specific health needs.
- Establishing disease surveillance systems to monitor and track the occurrence of diseases and health conditions in the affected area

3. Response Planning and Priority Setting:

- Developing a health response plan that outlines specific activities, targets, and timelines for addressing identified health needs.
- Setting priorities based on the severity and urgency of health issues, available resources, and capacity.

4. Resource Mobilization and Gap Filling:

- Mobilizing the necessary resources, including funding, medical supplies, equipment, and human resources, to support the resilient health response
- Identifying gaps in resources and working to fill those gaps through collaboration with partners and donors.

5.Monitoring, Evaluation, and Quality Assurance:

- Establishing mechanisms for monitoring and evaluating the effectiveness of health interventions and services.
- Ensuring that health services provided meet established quality standards and guidelines.
- Implementing feedback and accountability mechanisms to continually improve the health response.

6. Advocacy and Communication:

- Advocating for the health needs of the affected populations to ensure they receive the necessary attention and support.
- Engaging with relevant stakeholders, including government authorities, donors, and the media, to communicate the health situation, response efforts, and ongoing needs.

7. Accountability to affected population

- By taking account, giving account and being held account for commitments, actions and decisions mad

Roles and responsibilities of lead, co-lead, members, and observers involved in the coordination and their combined responsibilities as a team

In the context of Nepal, the Humanitarian Health Partner Coordination for Disaster and Public Health Emergency lead will be taken by MoHP and the co-lead agency will be WHO. The chief of the coordination division, MoHP will be the coordinator for health partner coordination and the team leader of World Health Organization, Health Emergencies Programme (WHE) will be the co-coordinator for health partner coordination, Figure 4.

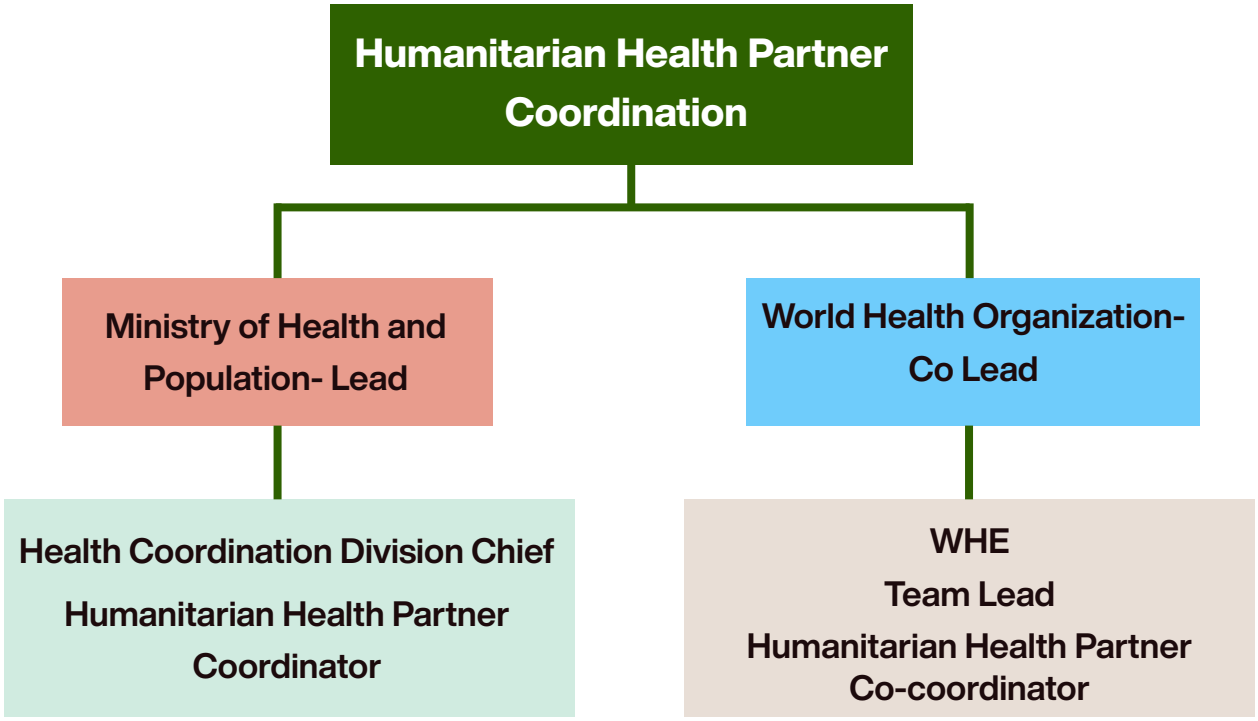


Figure 4. Humanitarian Health Partner Coordination

Humanitarian Health Coordination Partner: Organizations currently providing or supporting disaster or public health emergency services in the affected areas. They can be UN agencies, I/NGOs and relevant technical Ministries.

- They are expected to participate in the Technical Working Group, to have a role in defining the strategic and operational direction of the cluster.
- They will be eligible to participate in health partner-related fundraising efforts, such as the Technical Review Committee etc.

- Health coordination partnership is granted to organizations rather than individuals.
- Each partner organization is responsible for nominating one focal person and one substitute to ensure consistency in representation and facilitate communication within the group.

Humanitarian Health Coordination Observer: Organizations that do not want to be affiliated with the health coordination mechanism regarding their own mandate but do want to share information. Main donors and other important stakeholders fall under this. Active observers can sit on Technical Working Groups or sub-technical working groups and committees.

Humanitarian Health Partner Coordination Technical Working Group (HHPCTwG): HHPCTwG a group of professionals responsible for leading, coordinating, and facilitating health-related activities and interventions in humanitarian and disaster response contexts. The team is led by a Health partner coordination coordinator. This team plays a critical role in ensuring an organized, efficient, and effective health response. The members of the team are as follows:

1.Coordinator

- Chief, Health Coordination Division
- The Humanitarian Health Partner Coordinator supplies overall leadership and strategic direction to the coordination team and ensures effective collaboration among health partners.
- Coordinates the development and implementation of the health response plan.
- Represents the Health Cluster in coordination meetings with other sectors and external stakeholders.
- Advocates for the health needs of the affected populations.

Summary of duties

1. Identify and make contact with health sector stakeholders and existing coordination mechanisms, including national health authorities, national and international organizations and civil society.
2. Hold regular coordination meetings with humanitarian health partners, building when possible on existing health sector coordination and addressing cross cutting issues.
3. Facilitate collection of information from all partners on Who's Where, since and until When, doing What, and regularly feed the database (4W). Provide consolidated feedback to all partners and the other clusters.
4. Mobilize Health Partners to establish partner contribution for early detection of outbreak and regularly report on health services delivered to the affected population and the situation in the areas where they work.
5. Coordinate with humanitarian health partners for joint identification of gaps in the health sector response and agreement on priorities to inform the development (or adaptation) of a health crisis response strategy.

6. Ensure partners' active contribution to and involvement in joint monitoring of individual and common plans of action for health interventions; collate and disseminate this and other information related to the health sector in sit-reps and/or regular Health Bulletins.

7. Lead joint humanitarian health partner contingency planning for potential new events or set-backs, when required.

8. Promote adherence of standards and best practices by all humanitarian health partners taking into account the need for local adaptation.

9. Identify urgent training needs in relation to technical standards and protocols for the delivery of key health services to ensure their adoption and uniform application by all humanitarian health partners. Coordinate the dissemination of key technical materials and the organization of essential workshops or in-service training.

10. In a protracted crisis or health sector recovery context, ensure appropriate links among humanitarian actions and longer-term health sector plans, incorporating the concept of 'building back better' and specific risk reduction measures.

2. Co-Coordinator

- WHE team leader
- Supports the Humanitarian Health Partner Coordinator in their role and responsibilities.
- May take on specific tasks or areas of focus, such as resource mobilization or information management.

Summary of duties

1. The Humanitarian Health Partners Co- Coordinator will work with the Coordinator of the Humanitarian Health partner to lead the coordination meetings at national and sub-national level.

2. The incumbent will coordinate and support Coordinator and technical working groups to provide leadership and strategic guidance to partners on health response and risk mitigation in line with minimum standards and guiding principles.

3. The incumbent will build strategic partnership with relevant government counterparts, UN agencies, I/NGOs, CSOs; support capacity building of the humanitarian health partners, and advocate and influence to strengthen health services delivery where needed.

4. The incumbent will work closely with MoHP and national/sub-national level health authorities and provide strategic guidance and leadership accordingly.

5. Support Humanitarian Health Partner Coordinator in conducting national/sub-national level coordination meeting.

6. Coordinate and support national/sub-national health related mechanisms and technical working groups

7. Coordinate with non-health actors and other clusters and represent the humanitarian health partner coordination mechanisms

8. Coordinate and build rapport with local CSOs to ensure their participation in coordination meetings and coordination structures

9. Provide technical and strategic guidance on health response and programming

10. Coordinate with humanitarian health partners to identify the needs and service gaps on health response and programming

11. Provide technical and strategic guidance to partners in line with Health guiding principles and standards

12. Support Humanitarian Health Partner Coordinator in in response and planning process.

13. Collaborate with humanitarian health partners in order to facilitate implementation of the Response Plan including fundraising

14. Coordination, Representation and Advocacy

15. Support coordination efforts in facilitating the re-establishment and strengthening referral pathways

16. Support on visibility by participation in the work of selected clusters/sectors and other specialized technical working groups

17. Support program goals and Health principles, standards, advocating as necessary with relevant leaders, authorities and humanitarian actors

18. Support Humanitarian Health Partner Coordinator in strengthening M&E framework and ensure accountability to affected people.

3. Information Management Coordinator

- Chief of Health Emergency and Disaster Management Unit (HEDMU)
- Manages health-related data, information, and assessments.
- Facilitates data sharing among health partners and ensures the availability of accurate and timely information for decision-making.
- Supports the development of health-related maps, reports, and dashboards.
- Facilitates in maintaining all the tools applicable for Public health information standards (PHIS).

4. Coordination Officers

- Public health experts appointed by MoHP or WHO
- Coordinated health partner coordination meeting
- Manage specific components of the health response, such as medical services, disease prevention and control, nutrition programs, and more.
- Coordinate and monitor the implementation of health interventions by humanitarian health partners.
- Provide regular updates on progress, challenges, and achievements within their respective areas.
- Maintains all the tools applicable for Public health information standards (PHIS)
- Maintain annual planner

5. Technical Sub working groups

Technical working group can form technical sub working groups if required. Technical sub working groups will work under the guidance of the technical working group according to their area of responsibility and expertise.

The technical sub working groups can be following:

Technical

- Sexual and reproductive health
- Nutrition
- Child health
- Mental health
- Communicable disease
- Non-Communicable disease
- Environmental Health

Roles and responsibilities of humanitarian health partners

Adherence to humanitarian principles twelve minimum commitments14 for humanitarian health partners in the coordination mechanism are as follows:

1. Commitment to humanitarian principles, the principles of partnership, humanitarian health partner-specific guidance, and internationally recognized program standards, including protection from sexual exploitation and sexual abuse
2. Commitment to mainstream protection in program 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
4. Demonstrated understanding of the duties and responsibilities associated with membership of the humanitarian health partner, as defined by TOR and guidance notes
5. Active participation in the humanitarian health partner coordination and a commitment to consistently engage in the cluster's collective work;
6. Capacity and willingness to contribute to the humanitarian 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 humanitarian health partner to fulfill its mission;
9. Commitment to work cooperatively with other humanitarian health 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, MoHP, donors, cluster lead agencies, the media and other audiences;
12. Willingness to ensure that the humanitarian health partners provides interpretation (in an appropriate language) so that all humanitarian health partners are able to participate, including local organizations (and national and local authorities, where appropriate).

[14] Adapted from Cluster Coordination Reference Module (5), page 24.

Others will include:

Protection Mainstreaming

1. **Prioritize safety & dignity, and avoid causing harm:** prevent and minimize as much as possible any unintended negative effects of your intervention which can increase people's vulnerability to both physical and psychosocial risks

2. **Meaningful Access:** arrange for people's access to assistance and services - in proportion to need and without any barriers (e.g. discrimination). Pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services.

3. **Accountability:** set-up appropriate mechanisms through which affected populations can measure the adequacy of interventions, and address concerns and complaints.

4. **Participation and empowerment:** support the development of self-protection, capacities and assist people to claim their rights, including - not exclusively - the rights to shelter, food, water and sanitation, health, and education.

Cross-cutting issues

The responsible partner can work in a sub group to address the cross cutting issue.

Gender and Social Inclusion

Ensure pregnant women, elderly, disabled and vulnerable populations including Dalits and Janajati, including victims of sexual and gender-based violence receive timely access to health facilities. Encourage gender mainstreaming through effective integration with WASH, protection/GBV, including by supporting gender mainstreamed WASH facilities at health units, encouraging training of health workers on GBV screening and referral, and promoting child and female friendly spaces, as well as breastfeeding spaces at health facilities. Promote and advocate for gender equality in both supply (health workforce) and demand (patients, communities) sides through opportunities that encourage equitable promotion of healthcare and that remove social, financial, physical, and cultural obstacles to providing and utilizing healthcare. Ensure the identification and integration of socially excluded and vulnerable groups to enable improved access to health services and for these groups to be reflected in data system in close coordination with Protection Cluster.

Community Engagement and Accountability

Community systems strengthening will engage affected community members on their health and the health of their communities, through promoting sanitation, risk communication, safety and security of women, adolescents, children and elderly. Community members will be encouraged and supported to engage with governance mechanisms at the local and national level in order to communicate areas of priority in their healthcare and health of their communities.

The Cluster will promote strong ethical values among the healthcare workforce in providing health services. Feedback mechanisms at the community level will be strengthened, including comment boxes and bi-lateral communication which will support the understanding of negative experiences and ensuring service delivery meets the needs of affected people.

Prevention from Sexual Exploitation and Abuse

Prevention from sexual exploitation and abuse (PSEA) will ensure that all adults and children have equal rights to protection regardless of any personal characteristic, including their age, gender, ability, culture, caste/ethnic origin, religious belief, and sexual identity. Preparedness will include ensuring all staff involved in response, including partners and UN agencies, receive mandatory PSEA training. Response will include working closely with PSEA focal points to ensure ongoing monitoring and establishment and strengthening of reporting and referral channels, particularly among first responders and program implementers with direct contact to beneficiaries. Following the acute phase, health response actors will identify good practices, lessons learned, and challenges to ensure documentation of PSEA.

HIV and AIDS

Ensure that proposed strategies consider the prevalence of HIV/AIDS and culturally appropriate ways to minimize transmission risks. Evaluate if activities can be adapted to better support individuals with HIV/AIDS and reduce transmission risks. Prioritize the effective implementation of standard precautions across all areas. Establish mechanisms to ensure ongoing treatment for patients already on antiretroviral therapy (ART). Maintain preventive strategies that were in effect before the crisis.

Environment

Ensure that proposed strategies and implementation methods prioritize the protection of the environment and natural resources, avoiding the generation of unnecessary waste. Evaluate if activities can be adjusted to enhance environmental protection measures.

Psychosocial Support

Ensure that the proposed strategies encompass a coordinated, multi-sectoral approach that includes the provision of essential psychosocial support to the population. Facilitate conditions that promote community mobilization, ownership, control, self-help, support, and cultural healing practices. Additionally, the strategies should consider social factors, ensuring dignified and culturally sensitive aid for all while utilizing existing community resources.

Strategy for coordination of humanitarian health partners

The strategy will adopt how humanitarian partners should work together, based on their comparative advantages, towards collective outcomes that reduce need, risk, and vulnerability over multiple years and increase health system resilience. It will include developing or updating agreed response strategies and work plans for the cluster and ensuring that these are adequately reflected in overall coordination mechanism strategies;

Coordination for Preparedness Documents

The coordination for preparedness document will support the existing contingency plans 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 are anticipated. The humanitarian health partner coordinator would be responsible for supporting the MoHP 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;
- Develop key interventions for filling the gaps by the humanitarian health 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).

Frequency of meeting

- During non disaster phase: Once in four months
- During disaster: as needed according to the scale and nature of disaster

Organizing a health partner coordination meeting

- Include all relevant governmental and other national entities.
- Get the MoHP to chair or co-chair the meeting,
- Prepare a realistic agenda, focus on key issues identified and agreed in advance
- Select a venue suitable for accessibility, facilities, space, and ventilation.
- Prepare handouts with new information and maps.
- Prepare formats and/or flip charts to record the information you want to get from others, or cross-check, during or at the end of the meeting.
- Ensure the rapid preparation and distribution of a concise record

Making sure that meetings are productive

- Be clear about the purpose of the meeting and sure that a meeting is the best format.
- Ensure that meetings focus on problem solving, prioritization and planning
- Keep meetings as short as possible and adjust their frequency to the needs of phase of operation.
- Arrange for small sub-groups to work on specific problematic issues and bring recommendations back to the next meeting, when necessary.
- Involve partners in formulating agendas and identifying issues requiring specific work.

Possible agenda for meeting

- Welcome, introductions (if needed); explanation of the purpose of the cluster; agreement on the agenda.
- Short briefing by MoHP on what is known about the situation, health needs, and actions already taken or planned.
- Sharing information: what each participating organization knows, is doing, plans to do (when and where), and the problems and constraints faced.
- Information gaps: identification of any major gaps in information concerning specific areas and/or health aspects; discussion and agreement on how critical information gaps will be filled (who will do what when).
- Priority health problems, risks, service gaps: identification of major, life-threatening health risks and gaps in services to address those risks; discussion and agreement on how those gaps will be filled (who will do what, where, when).
- Arrangements for an initial rapid assessment: possible designation of sub-working group to organize the IRA within an agreed time frame.
- Information clearing house: agreement on an emergency health in- formation focal point to receive and collate information from all partners.
- Bulletin: arrangements for the production and dissemination of an emergency health bulletin.
- Next meeting: date, place, time, agenda items and anything participants are requested to prepare.

Information Management

- Define the types of information to be collected, stored and disseminated for the benefit of health partners and other stakeholders and to support activities. This may include:
    - list of humanitarian health partners and other main stakeholders with contact details
    - sex- and age-disaggregated health data (SADD)

- health-sector situation reports and health bulletins
- health crisis response strategy
- assessment reports
- guidelines on standards and best practices
- press releases and other formal cluster communications
- summary minutes of humanitarian health partners meetings including working groups
- periodic reports, reviews and evaluations of cluster activities and health-sector response

- Background information including reports of previous emergency operations, epidemiological studies and other pre-cri- sis data, health-sector profiles, etc.
- List the tools (standard formats, templates, etc.) for use by humanitarian health partners that should be made available
- Health-related data from all sources (including news media reports) are systematically compiled, stored and reviewed for reliability and relevance.
- Arrange for systematic analysis – including a gender analysis – of all data to generate information for planning, management, evaluation, and advocacy purposes.
- Ensure that information is handled and used responsibly

Humanitarian Health Partners Coordination

At the onset of a crisis

- Establish a basic initial health resource availability and mapping system
- Coordination with humanitarian health partners (and with relevant cross-cutting issues advisors, as necessary) to undertake a joint initial rapid assessment (IRA) in the first 10 to 15 days and produce a joint, initial analysis of priority problems, risks and gaps.
- Establish arrangements with humanitarian health partners to monitor the situation and produce regular reports on the health situation and service usage.

Later and during an ongoing crisis

- Collaborate with humanitarian health partners for in detailed health sector/sub-sector assessments or sample surveys focusing on aspects identified by the IRA as being important and needing more in-depth assessment. Jointly monitor the situation on an ongoing basis.

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

- Collaborate in multi-agency, inter-sectoral “post-disaster” and “post- conflict” needs assessments once the situation has stabilized, focusing on dam- age and related recovery and reconstruction needs. These assessments should benefit from information already available from the PHIS as well as the additional, more detailed and up-to-date information available to cluster partners.

National yearly work plan based on the core functions

An annual plan will be developed following the mechanism listed by disaster preparedness and response planning implementation guideline 2067 BS (amendment 2076 BS).[15]

- To ensure that response plans are in line with existing policy guidance and technical standards;
- To ensure adoption of a people-centered approach in development of the humanitarian health partner coordination strategy
- To promote 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.

The testing of the response plan will be done by table top or functional simulation exercise. The process will be repeated every year. This process will take in account during the preparedness phase of disaster.

Key preparedness activities

- Prepare/update emergency preparedness and disaster response plans for humanitarian health partners coordination.
- Capacity mapping of partners including reproductive health, gender -based violence, mental health and psychosocial support.
- Supporting in Training/capacity building for staff from hospitals, health facilities including municipalities, districts and provinces, on mass casualty management, primary/emergency trauma management, mental health and psychosocial support, Minimum Initial Service Package (MISP) for sexual and reproductive health and clinical management of rape.
- Ensure tools, templates, guidelines, SOPs are in place for risk assessment, risk and media communication.

The sample yearly plan is in annex 2.

[15] Disaster Preparedness and Response Plan Implementation Guideline 2076

To formulate monitoring and evaluation framework of the coordination mechanisms

Monitoring the performance of humanitarian health partner coordination at national and sub-national level is necessary to ensure that health partners are:

- efficient and effective coordination mechanisms
- fulfil the core humanitarian health partner functions
- support efficient delivery of relevant services
- meet the needs of cluster members and demonstrate accountability to affected people

Each Sector thereafter meets to:

- Introduce the CPM: purpose, methodology, process, and follow-up.
- Clarify questions: on process, outcomes, and the language of the questionnaire, including the Core Functions

Sample of Cluster Coordination Performance Monitoring (CPM)16 in in annex 3

[16] Adopted from Cluster Coordination Performance Monitoring Guidance Note, the Global Cluster Coordination Group, updated 2016.

Annex 1. Sample 3W/4W/5W matrix

Table 1. 3w/4w/5w matrix

Type	4W _Phase 1	4W_Phase 2 (example questions)
Who Refers to the partners whose activities are reported in the 4Ws; commonly the first column of the activity reporting template	- The name of the reporting agency	- Name of reporting organization - Name of funding agency - [Optional] Donor Project Code or Appeal Type - Type of organization (UN, LNGO, INGO, Red Cross/Crescent, government, other) - Name of implementing partner (if different from reporting agency) - [Optional] Type of implementing partners
What In 4Ws 'what' is being done or is planned can be quite detailed. Some 4Ws are very specific in the description of the activities undertaken, others are rather generic.	- Health activity description (at the beginning of the crisis when health indicators have not been set yet)	-See the global health cluster indicators guidance note for further information. - [Optional where applicable] Emergency Type – _Depending on the context, it may be useful to differentiate between different response types within the same data collection tool. For example, refugee and IDP responses with similar Health Activities. Alternatively, where different responses involve different activities, for example, Ebola vs. cholera vs drought response.
Where Reports the geographical location of the activities related to a partner. It can make reference to administrative boundaries (region, department or municipality) or point-data (camps, settlements, schools, etc.). The Cluster must decide the detail of geographical information needed for the 4W.	- Name of location (at cluster-agreed administrative level	- Name of location - GPS Coordinates Data collection administrative level 1 - Place Codes (P-Codes)/CODS - - Location Type

When Incorporating this type of information would enable distinguishing between past, present or future activities, and generate time-specific summaries of specific activities, or more detailed trend analyses.	- Usually not collected at the very beginning of a crisis (hence the 3Ws)	- Status – _a column indicating the status of activities is another way to capture the condition of an intervention. Options usually include <planned> or <ongoing> or <completed> - Time frame – _the (planned) start and end date of activities can be captured by adding two separate columns (<start date> and <end date>).
For Whom Incorporating this type of information would enable distinguishing between different target population groups, for example, IDPs in formal camps vs IDPs in informal shelters	- Population covered	-Beneficiary Type Population targeted Population reached

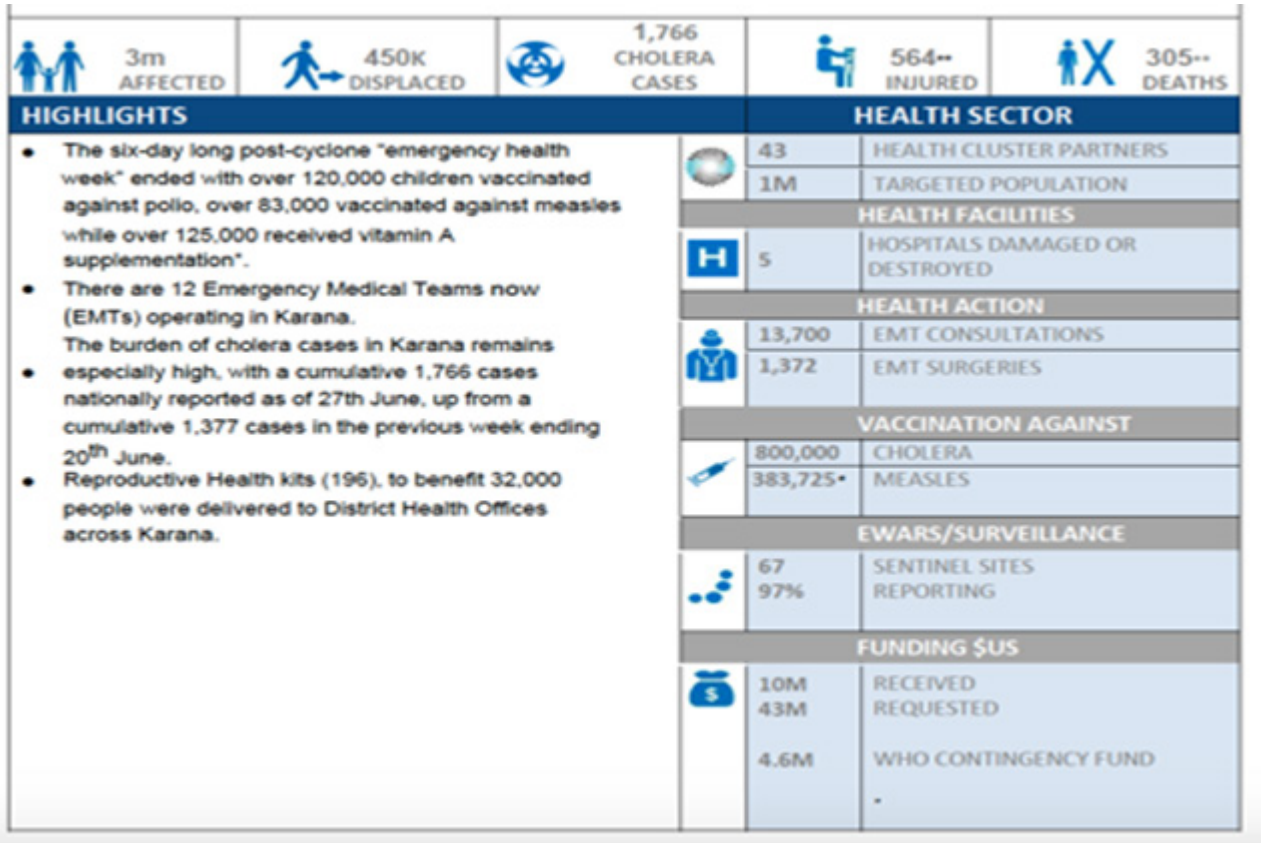
Partner's List (Mapping of Humanitarian Health Partners)

Humanitarian Health Partners will be mapped at the national and subnational level using a excel based mapping which will consist of the name of the organization, and current focal points of those organization along with their emails, phone numbers and location using the following format attached below. This list will include list of organizations, donors, cluster sectors, local organizations, ministry focal points at national and provincial levels.

Organization name	Acronym	Name focal point	Position	Email	Phone	Location
Ministry of Health						
Health coordination division	HCD					
Health Emergency and Disaster Manageme	HEDMU					
Health Emergency Operation Center	HEOC					
Curative Service Division	CSD					
Epidemiology and Disease Control Divisior	EDCD					
National Public Health Laboratory	NPHS					
	NEICC					
Donors						
United States Agency for International	USAID					
European Commission	ECHO					
European Union	EU					
Department for International Development	DFID					
Int Organizations						
World Health Organization	WHO					
International Committee of the Red Cross	ICRC					
United Nations Childrens Fund	UNICEF					
United Nations Population Fund	UNFPA					
International Organization for Migration	IOM					
Sectors/Clusters/OCHA						
WASH	UNICEF					
PROTECTION	UNHCR					
GBV	UNFPA					
UNOCHA	UNOCHA					
Associations						
Nepal Medical Association	NMA					
Nepal Nursing Association	NNA					
Public Health Foundation	PHF					

Fig: Humanitarian Health Partners Resource Mapping tool

Health Cluster Bulletin



3m AFFECTED	450K DISPLACED	1,766 CHOLERA CASES	564** INJURED	305** DEATHS

HIGHLIGHTS

- The six-day long post-cyclone "emergency health week" ended with over 120,000 children vaccinated against polio, over 83,000 vaccinated against measles while over 125,000 received vitamin A supplementation".
- There are 12 Emergency Medical Teams now (EMTs) operating in Karana.
- The burden of cholera cases in Karana remains especially high, with a cumulative 1,766 cases nationally reported as of 27th June, up from a cumulative 1,377 cases in the previous week ending 20th June.
- Reproductive Health kits (196), to benefit 32,000 people were delivered to District Health Offices across Karana.

HEALTH SECTOR	
43	HEALTH CLUSTER PARTNERS
1M	TARGETED POPULATION
HEALTH FACILITIES	
5	HOSPITALS DAMAGED OR DESTROYED
HEALTH ACTION	
13,700	EMT CONSULTATIONS
1,372	EMT SURGERIES
VACCINATION AGAINST	
800,000	CHOLERA
383,725*	MEASLES
EWARS/SURVEILLANCE	
67 97%	SENTINEL SITES REPORTING
FUNDING $US	
10M 43M	RECEIVED REQUESTED
4.6M	WHO CONTINGENCY FUND

Annex 2. Sample annual plan

Table 2. Humanitarian Health Partner annual plan

Activities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Humanitarian health partner meeting for development and consensus of annual plan												
Pre-monsoon meeting												
Post monsoon meeting												
Table top exercise of response plan												
Coordination performance monitoring												
Updating 3W/4W												

Annex 3: Cluster Coordination Performance Monitoring: Preliminary Coordination

Performance Report

Cluster: XX

Country: XX

Level: XX

Completed on: XX

This Coordination Performance Report summarizes the results of questionnaires completed by the cluster coordinator(s) and partners as part of the cluster performance monitoring process undertaken in [country]. The report provides an in-depth assessment of the quality of cluster operations, focusing on the IASC six cluster core functions and an additional component on accountability to affected people. The cluster should meet to review results and identify areas for support and improvement. Following the meeting, the cluster should complete the table included in Annex I of this report and then circulate the completed table to cluster lead agencies, national authorities, the Resident/Humanitarian Coordinator and the Humanitarian Country Team.

Response rate among partners

Response rate among partners			
Partner type	Number partners responding	Total number of partners	Response rate (%)
International NGOs			
National NGOs			
UN organisations			
National authority			
Donors			
Others			
Total			

Results

For more information on the scoring of responses, please see the 'Explanatory Note – Questionnaire and Analysis' at http://clusters.humanitarianresponse.info/how-to/improve-cluster-performance .

Green = Good > 0.75	Yellow = Satisfactory, needs minor improvements 0.51-0.75	Orange = Unsatisfactory, needs major improvements 0.26-0.50	Red = Weak ≤ 0.25

Performance status:

Overall Results:

Category:

Table 4. Partners performance characteristics

IASC core functions	Suggested characteristics of functions	Performance status	Performance status constraints/ opportunities: unexpected circumstances and/or success factors and/or good practice identified	Follow-up action, with responsibilities and deadlines (when status is orange or red), and/or support required
1. Supporting service delivery				
1.1 Provide a platform to ensure that service delivery is driven by the agreed strategic priorities	Established, relevant coordination mechanism recognising national systems, subnational and co-lead aspects; stakeholders participating regularly and effectively; cluster coordinator active in inter-cluster and related meetings.			
1.2 Develop mechanisms to eliminate duplication of service delivery	Cluster partner engagement in dynamic mapping of presence and capacity (4W); information sharing across clusters in line with joint Strategic Objectives.			
2. Informing strategic decision-ma king of the HC/HCT for the humanitarianresponse				
2.1 Needs assessment and gap analysis (across other sectors and within the sector)	Use of assessment tools in accordance with agreed minimum standards, individual assessment / survey results shared and/ or carried out jointly as appropriate.			

2.2 Analysis to identify and address (emerging) gaps, obstacles, duplication, and cross-cutting issues.	Joint analysis for current and anticipated risks, needs, gaps and constraints; cross cutting issues addressed from outset.			
2.3 Prioritization, grounded in response analysis	Joint analysis supporting response planning and prioritisation in short and medium term			
3. Planning and strategy development				
3.1 Develop sectoral plans, objectives and indicators directly supporting realization of the HC/ HCT strategic priorities	Strategic plan based on identified priorities, shows synergies with other sectors against strategic objectives, addresses cross cutting issues, incorporates exit strategy discussion and is developed jointly with partners. Plan is updated regularly and guides response.			
3.2 Application and adherence to existing standards and guidelines	Use of existing national standards and guidelines where possible. Standards and guidance are agreed to, adhered to and reported against.			
3.3 Clarify funding requirements, prioritization, and cluster contributions to HC's overall humanitarian funding considerations	Funding requirements determined with partners, allocation under jointly agreed criteria and prioritisation, status tracked and information shared.			
4. Advocacy				
4.1 Identify advocacy concerns to contribute to HC and HCT messaging and action	Concerns for advocacy identified with partners, including gaps, access, resource needs.			

4.2 Undertaking advocacy activities on behalf of cluster participants and the affected population	Common advocacy campaign agreed and delivered across partners.			
5. Monitoring and reporting				
Monitoring and reporting the implementation of the cluster strategy and results; recommending corrective action where necessary	Use of monitoring tools in accordance with agreed minimum standards, regular report sharing, progress mapped against agreed strategic plan, any necessary corrections identified.			
6. Contingency planning/preparedness				
Contingency planning/ preparedness for recurrent disasters whenever feasible and relevant.	National contingency plans identified and shared; risk assessment and analysis carried out, multi-sectoral where appropriate; readiness status enhanced; regular distribution of early warning reports.			
7. Accountability to affected population				
	Disaster-affected people conduct or actively participate in regular meetings on how to organise and implement the response; agencies have investigated and, as appropriate, acted upon feedback received about the assistance provided			

Technical and Pubication Support

World Health Organization
Nepal

Funded by
European Union
Humanitarian Aid