Implementation report on the health activities in response to the humanitarian crisis in Mali

April 2014
Mali in figures

- 16 586 000 inhabitants
- 9 regions
- 2 500 000 inhabitants in the northern regions
- 703 communes (684 rural and 19 urban)
- 174 129 refugees (Total number of Malian refugees reported by UNHCR at 6 June 2013)
- 450 000 children in need of humanitarian assistance
- 472 000 displaced persons
- 210 000 children at risk of malnutrition

[Yellow: Zone occupied by armed groups
Red: Zone with high concentration of displaced persons
Purple: Zone with low concentration of displaced persons]
# Table of Contents

Summary 4

Introduction 5

Background and justification 6

Objectives 7

Priority needs 8

Main outcomes 9

Lessons learned 24

Constraints and challenges 26

Recommendations 27

Conclusions 27

Outlook 28
Summary

WHO response to Mali crisis

In order to address the impact of the complex humanitarian crisis on the health of the Malian population, the WHO Office in Mali implemented a number of planned emergency and early recovery interventions. Through these interventions WHO was able to:

- provide medicines and other medical supplies for outbreak control and health service strengthening;
- enhance surveillance;
- assess the risk of epidemics;
- respond to epidemics;
- organize preventive immunization and outbreak response campaigns;
- assess health facilities in response to the crisis;
- strengthen health services, including the blood bank;
- strengthen Health Cluster coordination;
- provide capacity building for health staff;
- organize humanitarian missions;
- advocate for partners and support resource mobilization; and
- produce bulletins and situation reports;
- create a Health Cluster website and database.

These interventions have helped to strengthen WHO leadership, facilitate the flow of health information, strengthen the capacity of the health services and ensure continued care in health districts and hospitals in the crisis-affected northern and central regions of Mali.
MANAGEMENT OF THE CRISIS

Introduction

In light of the complex humanitarian crisis, which has had serious consequences for the Malian population, the WHO Representative Office in Mali implemented a set of actions through the Health Cluster, which is under the leadership of WHO.

The health interventions strengthened the capacity of the office and the coordination of health partners. The activities implemented throughout the crisis have also improved access to health care for vulnerable populations in the northern and central regions of Mali and ensured the implementation of disease-control activities. These actions have helped to save human lives at critical moments during the crisis and to reduce overall morbidity and mortality. The results achieved represent a step towards the early rehabilitation of the health system.
Acknowledgments

The World Health Organization would like to take this opportunity to thank the Ministry of Health and the partners of the Health Cluster for their cooperation, which facilitated the implementation of the activities.

We would also like to thank the other Clusters and OCHA which have worked tirelessly to ensure that the interventions were successful.

WHO would like to express its gratitude to the Governments of Finland and the United States of America along with the Central Emergency Response Fund for their highly appreciated contributions to the health humanitarian activities in response to the Mali crisis.

Background and justification

The humanitarian and security situation in Mali

Since January 2012, Mali has been facing a complex humanitarian situation caused by armed conflict, and socio-political and economic turmoil. This situation, which occurred during a food and nutrition crisis due to a drought in 2011, has seriously affected the populations in both the north and south of the country. It has had a particularly severe impact on women and children.

In addition to mass displacement, the population has experienced problems such as:

- limited access to health care due to the destruction and/or looting of facilities, and the interruption of health services (with the departure of staff and non-governmental organizations (NGOs): 94% of community health centres were no longer functional. Most of the health facilities that remained open did not have the qualified staff and medicines required to meet the needs of the population.

- shortages of medicines and medical supplies including blood products;

- overwhelmed health services in the southern regions, which were not prepared to deal with a large influx of people;

- a significant number of dead and war-wounded people brought to health facilities;

- outbreaks of measles, cholera, malaria and anthrax due to overcrowding, deterioration in hygiene and sanitation conditions and poor access to safe drinking water;

- human rights violations and acts of violence, including sexual and gender-based violence;

- many deaths and injuries caused by landmines, explosive devices and bombings, which continue to pose a threat.
Objectives

The aim of the plan presented by WHO is to “ensure the necessary leadership and technical support for the management of health issues related to the humanitarian crisis in Mali”.

The ultimate objective of the Health Cluster is to “speed up the restoration of essential health services in order to save lives among the affected populations and restore and maintain an optimally functioning health system in order to reduce excess morbidity and mortality resulting from the crisis”.

Since the Health Cluster was created in March 2012, it has coordinated various interventions together with the technical services of the Ministry of Health, NGOs, UN agencies and other Clusters in order to ensure an appropriate response to the unprecedented humanitarian crisis in Mali.

It should be noted that:

- Eight humanitarian missions were organized (an eighth mission is under way). Medicines and other medical supplies were provided in order to
**Priority needs**

The health situation analysis carried out by the Ministry of Health and partners during the early stages of the crisis (March – May 2013) highlighted the following needs:

- Resumption of activities in destroyed, looted or vandalized health centres and hospitals are still affected by staff shortages, the lack of qualified staff and the interruption of health programmes. According to the results of the health facilities assessment survey, 70% of the facilities had been partially or completely destroyed in the regions of Kidal, 45% in Timbuktu and 40% in Gao;

- Regular provision of medicines and other medical supplies;

- Strengthening of the health system in the southern regions in order to cope with the influx of internally displaced persons.

- Response to the effects of the “lean season” and epidemics

The interventions undertaken have helped to strengthen WHO leadership, facilitate the flow of information, enhance the capacity of the WHO Office and health services, and ensure continuity of care in health districts and hospitals in the northern and central regions of Mali. WHO has been able to:

- provide medicines and medical supplies to the Ministry of Health and to NGOs in order to control outbreaks and strengthen health services;

- assess the risk of epidemics, respond to epidemics, and organize preventive immunization campaigns for outbreak response;

- assess health facilities in response to the crisis;

- strengthen surveillance;

- strengthen health services, including the blood bank;

- produce bulletins and situation reports;

- provide capacity building for health staff;

- strengthen Health Cluster coordination,

- provide advocacy and support for partners in order to mobilize resources through the Consolidated Appeal Process (CAP) and Central Emergency Response Fund (CERF) projects;

- map NGO interventions and strengthen information sharing at Health Cluster level which has led to the creation of a Health Cluster website and database.

In addition to a summary of the needs and objectives of the humanitarian response plan, this report will provide an overview of the interventions, main outcomes, lessons learned, constraints, challenges and prospects.
Priority needs

- Response to the increase in morbidity and mortality and particularly epidemics resulting from poor living conditions and the vulnerability of the population (measles, cholera, meningitis, malaria, anthrax);

- Restoration of referral mechanisms for medical, obstetric-surgical emergencies, especially where there is a lack of qualified staff, medicines and medical supplies, and where water pumps and electrical installations in health centres have been destroyed.

- Response to the critical nutritional status of children, in particular in the northern regions and also in areas in the south which are hosting internally displaced persons. It is estimated that around 210 000 children are at risk of acute malnutrition and that 450 000 children are at risk of moderate acute malnutrition. Given the conditions of insecurity, this situation may worsen.

- Response to the effects of threats related to explosive devices and bombings.

With regard to the implementation of the response plan, the priorities established according to the urgency of the situation were:

i) coordination of partner interventions, production and sharing of strategic information, provision of emergency care for the population and supply of medicines and health and hygiene products;

ii) capacity building for health facilities and revival of priority health activities and programmes;

iii) epidemic prevention and control;

iv) and Health Cluster coordination.
In the response plan, the priorities established according to the urgency of the situation were: i) coordination of partner interventions, production and sharing of strategic information, provision of emergency care for the population and supply of medicines and health and hygiene products; ii) capacity building for health facilities and revival of priority health activities and programmes; iii) epidemic prevention and control; iv) and Health Cluster coordination.

The health interventions were coordinated by the Health Cluster. The Health Cluster was created in March 2012 and brings together UN agencies, technical services and NGOs under the leadership of WHO and the National Health Directorate.

The Health Cluster operates on the basis of weekly or bi-weekly meetings between partners and technical services.
In terms of results, the coordination activities have:

- Ensured regular monitoring of the humanitarian and health situation, supported needs assessment, planning, identification of strategies, mapping and the implementation of the interventions;

- Contributed to the preparation of Ministry of Health emergency plans, inter-agency contingency planning and inter-agency and Ministry of Health early recovery plans. In addition, Consolidated Appeal Plan (CAP) projects were formulated and updated. Central Emergency Response Fund projects and a priority action plan were prepared.

- Formed working groups in order to hold strategic discussions on specific diseases and problems: HIV/AIDS, malaria, and immunization groups, cholera task force, CAP project selection committee, data manager working group;

- Established and equipped a crisis unit;

- Participated in inter-cluster meetings under the leadership of OCHA.
Coordination outcomes

- Organized a supervisory mission to the Health Sub-Clusters in Ségué and Mopti and provided support for their operations;

- Conducted two missions to strengthen inter-cluster coordination in Timbuktu (19-20 September) and Gao (8-10 October);

- Covered the operational costs of needs assessment missions and epidemiological surveillance missions based on the requests made by the Ministry of Health;

- Conducted a survey to assess the performance of the Health Cluster (August and September 2013) in collaboration with partners and the Global Health Cluster Secretariat. Feedback was given on the results during a workshop at the National Institute of Research in Public Health. A second workshop was held to analyze these results and determine the priority actions required in order to improve performance.
Strategic information

A Health Resources and Services Availability Mapping (HeRAMS) survey was conducted in Mali to investigate the availability of health services and resources. An assessment was carried out of 1581 public, private and community health facilities.

This required a coordinator, a central coordination team, the cooperation of regional health directors, hospital directors, social service managers, district chief medical officers and technical directors from community health centres.
A finalization workshop with the partners and feedback workshop were organized. The results of the assessment were published in eight bulletins designed by the assessment coordination team. The health facility assessment survey provided basic data that were used to:

i) Finalize the codification of health facilities;

ii) Assess needs for the early recovery of the health system (see Ministry of Health and inter-agency early recovery plans);

iii) Map the functional status of health facilities and services using three different figures (availability, coverage and ratio: see examples below).
Around 18.6% (294/1581) of the health facilities have been completely or partially destroyed. In the northern regions, 93% of facilities have been completely destroyed. In all regions, 26.3% (70/266) of facilities have been partially destroyed, including 70% in Kidal, 40% in Gao and 45% in Timbuktu.

Essential health services were no longer available in many health facilities due to staff shortages or lack of qualified staff, lack of training, lack of equipment and poor infrastructure (see map of health services).

i) Create a dynamic database (see table with defined variables);

ii) Establish district health profiles (see Annex 1: health profile for Commune VI in the district of Bamako).
The humanitarian missions were organized to ensure the continuity of health care to the populations in health districts and hospitals in the regions of Gao, Timbuktu, Kidal, Mopti and Ségou.

Each mission had teams comprised of general physicians, specialists such as surgeons, paediatricians, gynaecologists, obstetricians, pharmacists, midwives, hygiene technicians, vaccinators and psychologists.

Over 450 health workers were mobilized in order to carry out these interventions. The teams, selected by the Conseil de l’Ordre des Médecins (French Medical Board) from its list of volunteers, were responsible for ensuring care for the population through one-month rotations in the target health facilities, as needed, and particularly in the health districts and hospitals in northern and central regions.

A meeting between partners was organized beforehand in order to assess needs based on information provided by the National Health Directorate and previous missions.

A three to four day briefing session for mission workers on security, humanitarian principles and guidelines for disease surveillance, prevention and control was also organized by WHO, OCHA, other UN agencies, and the technical services from the Ministry of Health.
In addition to the activities to provide care for the population, the missions contributed to strengthening the capacity of field staff as necessary, enhancing epidemiological surveillance, responding to epidemics and carrying out immunization activities.

To date, eight missions have been carried out by specialized technical staff. The interventions have enabled the following:

i) The reopening of certain health facilities in Douentza and other areas;

ii) The availability of health services for persons affected by the crisis, provided in order to save lives and relieve suffering. Continuity of services was ensured in health districts and hospitals in the regions of Gao, Kidal, Timbuktu, Mopti and Ségou.

Eight humanitarian missions were sent to the northern and central regions to ensure the continuity of health care for the population including immunization.
Provision of health care, medicines and products to affected populations

The provision of emergency medicine kits and other medical and non-medical supplies was ensured in a number of different ways:

i) Provision of medicine supplies to the humanitarian missions in order to deliver care to the population;

ii) Pre-positioning of emergency medicines against malaria and cholera;

iii) Transfer of medical supplies to the Ministry of Health for the purpose of epidemic control and the strengthening of the health services;

iv) Provision of essential medicines to partners (NGOs) on request;

v) Provision of medicines and hygiene products for the purpose of flood response (Ségou, Bamako) and also to the Directorate-General of Civil Defence.

Table 1: Summary of activities during the humanitarian missions carried out in the northern and central regions of Mali in 2012 and 2013

<table>
<thead>
<tr>
<th>Service</th>
<th>1st HM</th>
<th>2nd HM</th>
<th>3rd MH</th>
<th>4th HM</th>
<th>5th HM</th>
<th>6th HM</th>
<th>7th HM</th>
<th>TOTAL 1-7 HM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curative treatment</td>
<td>3268</td>
<td>3297</td>
<td>11,633</td>
<td>3799</td>
<td>16,119</td>
<td>8524</td>
<td>15,953</td>
<td>62,593</td>
</tr>
<tr>
<td>Pre-natal care</td>
<td>426</td>
<td>170</td>
<td>1212</td>
<td>907</td>
<td>1675</td>
<td>1835</td>
<td>2202</td>
<td>8427</td>
</tr>
<tr>
<td>Childbirth</td>
<td>118</td>
<td>178</td>
<td>234</td>
<td>402</td>
<td>411</td>
<td>148</td>
<td>834</td>
<td>2325</td>
</tr>
<tr>
<td>Gynecological consultation</td>
<td>405</td>
<td>200</td>
<td>624</td>
<td>0</td>
<td>1128</td>
<td>469</td>
<td>1746</td>
<td>4572</td>
</tr>
<tr>
<td>Surgery</td>
<td>44</td>
<td>177</td>
<td>82</td>
<td>510</td>
<td>435</td>
<td>343</td>
<td>556</td>
<td>2147</td>
</tr>
<tr>
<td>Caesarian</td>
<td>23</td>
<td>26</td>
<td>9</td>
<td>35</td>
<td>125</td>
<td>149</td>
<td>97</td>
<td>464</td>
</tr>
<tr>
<td>Treatment of road accidents</td>
<td>13</td>
<td>73</td>
<td>53</td>
<td>59</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>254</td>
</tr>
<tr>
<td>Treatment of war-wounded</td>
<td>18</td>
<td>17</td>
<td>2</td>
<td>32</td>
<td>0</td>
<td>6</td>
<td>2</td>
<td>77</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>189</td>
<td>452</td>
<td>1989</td>
<td>459</td>
<td>5870</td>
<td>511</td>
<td>9470</td>
<td></td>
</tr>
</tbody>
</table>
The humanitarian missions also contributed to epidemic management.

Cholera epidemic (see graphs): Despite the crisis, the outbreaks in 2012 and 2013 saw the lowest number of cases and deaths out of all recent cholera epidemics in Mali.

2012: health districts of Gao and Ansongo: 219 cases, 19 deaths.

2013: health districts of Ansongo: 22 cases including two deaths. Two essential factors were the pre-positioning of cholera kits by Médecins du monde Belgique (MDM Belgique) long before the beginning of epidemic and the strengthening of hygiene measures in cholera treatments centres throughout the humanitarian missions.
The weekly surveillance system for epidemic-prone diseases was maintained thanks to the actions of representatives appointed in each health district and region, even though periods of silence were noted. The representatives were health workers who remained on site and were responsible for ensuring the transmission of surveillance data to the national level.

The health and humanitarian situation was regularly monitored and information was shared with the partners. In addition to the weekly data on epidemic-prone diseases, information on activities such as those related to antenatal consultations, childbirth, immunization, malnutrition and war-wounded cases was collected.

### Table 2: Number of cases and deaths related to diseases under surveillance during the 49th week of 2013 in Mali.

<table>
<thead>
<tr>
<th>Diseases</th>
<th>48th week</th>
<th>49th week</th>
<th>1st - 49th week 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
<td>Deaths</td>
<td>Cases</td>
</tr>
<tr>
<td>Meningitis</td>
<td>11</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Measles</td>
<td>3</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Cholera</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suspected cases of yellow fever</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Acute flaccid paralysis</td>
<td>4</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Neonatal tetanus</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pertussis</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bloody diarrhoea</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Guinea worm</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>H5N1 avian influenza</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>H1N1 influenza</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anthrax</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Uncomplicated and severe malaria</td>
<td>42,397</td>
<td>7</td>
<td>45,163</td>
</tr>
</tbody>
</table>
Given the characteristics of the first cholera cases that occurred in Wabaria in the health district of Gao in 2012, and the poor availability of medicines, the health areas along the Niger river had been identified as at risk. Partners were requested to pre-position medicines and strengthen prevention in these health areas.

A cholera risk assessment was also carried out by the Water And Sanitation Hygiene Cluster. A three-year cholera prevention plan was developed.
The WHO risk assessment tool was used to identify the districts that had reached the measles epidemic threshold in Mali. In view of the numbers involved, 26 health districts were identified as being at a high risk of a measles epidemic. An immunization response plan was developed by the Ministry of Health and WHO mobilized partners in order to implement it. An immunization response campaign was carried out in the regions of Kidal and Gao, which had already crossed the epidemic threshold. A campaign to strengthen the routine Expanded Program on Immunization was carried out in the northern regions. An immunization campaign was also conducted in the Bamako district.
Assessment of malaria epidemic risk: The investigations carried out by the working group revealed a high risk in the Timbuktu region, as demonstrated by the graph below. The districts of Diré and Gourma Rharouss were the most affected. The National Malaria Control Programme (PNLP) strengthened the provision of anti-malarials, malaria rapid diagnosis tests and insecticide-treated bednets.

Despite the lack of security and the incomplete data from the weekly surveillance of epidemic-prone diseases in the northern regions, the surveillance system enabled warnings to be issued and ensured a response to epidemics, namely:

i) The measles outbreaks in Douentza in 2012 (an immunization response campaign was organized), and in Gao and Kidal in 2013. Given the lack of security, the immunization response campaign could only be organized in the health districts and certain community health centres.

ii) The cholera outbreaks in Gao and Ansongo in 2012 and in Ansongo in 2013. In addition to the pre-positioning and strengthening of medicine supplies, the humanitarian teams implemented hygiene and sanitation measures in health facilities (cholera treatment centres), which helped to stem the epidemic.

iii) The malaria epidemics that occurred in Diré, Niafunké and Gao in February 2013 during the low-water season of the Niger River. Emergency provisions of medicines, insecticide-treated bednets and other medical supplies were made available. Prevalence of the disease remains high compared with normal fluctuations. The weekly malaria epidemiological situation is being carefully monitored and the results are shared with partners.

iv) As regards epidemic prevention and control, a training module on cholera was developed and a training session was held for staff from the regions of Ségou and Koulikoro in Koulikoro and Fana respectively.

The 2010 WHO/AFRO generic guidelines for Integrated Disease Surveillance and Response were adapted to the situation in Mali in 2012 and the training modules were revised.
LESSONS LEARNED

Information:

1. The return of health workers to health facilities following the alleviation of the crisis (over 200 technical, social and health workers) was funded by WHO.

2. The implementation of a training course on risk and disaster management is under way. In this regard, a briefing workshop on the regional strategy for risk and disaster management was organized for the national authorities on 13-14 September 2013 in collaboration with IST/WA. The requests for the implementation of curricula are being processed, although no funds are available for the organization of this activity.

Planning:

1. The technical support provided by IST/AFRO and Geneva and the consultants contributed significantly to the development of plans for each phase of the crisis: emergency plan, contingency plan and early recovery plan.

2. The establishment of a committee to select and analyze projects improved the quality of the projects and gained around a third of the funding.

Coordination of partners:

1. Despite the difficulties experienced, the approach based on the mapping of the interventions and the 3W (Who is doing What, Where) matrix contributed significantly to the planning and implementation of the interventions and strengthened understanding among partners.
Priority interventions:

- The humanitarian missions (briefing, medical supplies, collaboration with NGOs) helped to open access for humanitarian aid in the northern regions at the beginning of the occupation. The strategy proved to be effective in improving the quality of health services, and the briefing organized before the start of the field mission was an opportunity to strengthen the capacity of staff in the field of humanitarian response and disease control. In addition to the continued provision of services to the population, the interventions could be a springboard for the development of the health system even in times of peace.

Pre-positioning of medicines:

- This was an essential strategy in controlling outbreaks of cholera. In view of the security situation, WHO had given (based on an outbreak in a neighbouring region of Niger) a cholera kit to an NGO (MDM Belgique) to pre-position in the health areas of Gao. This enabled the cholera outbreak in Wabaria to be swiftly contained.

Hygiene and sanitation:

- The lack of hygiene and sanitation in the cholera treatment centres was a factor in the spread and persistence of cholera in the district of Ansongo. The intervention of hygiene technicians during the humanitarian missions enabled the outbreak to be stemmed.

- Needs assessment: The multisectoral assessment missions helped to improve information on the health districts.

- The multisectoral study carried out by WHO, the Ministry of Health and other partners provided information on almost all health facilities. This information was used to develop the Ministry of Health recovery plan.
Although the outcomes were satisfactory on the whole and positive lessons were learned from the implementation of the response plan, there were problems and the following challenges still need to be overcome:

- Continue to strengthen the human resources of the Health Cluster;
- Ensure the continued provision of health services until health facilities are completely restored, in particular the continuation of humanitarian missions;
- Ensure the continued provision of medicines to health facilities;
- Support the health services in order to ensure free health care;
- Strengthen the epidemiological surveillance system;
- Strengthen security in health facilities;
- Ensure the early rehabilitation of health services and the return of health staff;
- Ensure the restoration of vital care systems (infrastructure, blood bank, cold chain, equipment, medicines);
- Ensure the appropriate management of conflicts between health staff (returning members and members who stayed);
- Take into account the uncertainty of future events (legislative elections, outcome of negotiations).
CONCLUSION

The analysis of the outcomes of the WHO response plan shows that it was quite successfully implemented despite the challenges mentioned above, as indicated by the results of the Health Cluster performance assessment carried out this year. The lessons learned during these two years should improve and strengthen the Health Cluster and enhance capacity of staff, including the national authorities and those in the field, with a view to making an effective and sustainable transition to development.

- Improve coordination, information management and operational capacity for the Health Cluster in a sustainable manner;
- Enhance the sustainability of the Health Sub-Clusters by providing them with enough resources to ensure effective coordination in the regions in question;
- Strengthen coordination and cooperation between humanitarian workers and state authorities at both central and decentralized levels.

CONCLUSION

- Build sustainable human resources and different capacities (coordination, information management and operational capacity) for the Health Cluster;
- Enhance the sustainability of the Health Sub-Clusters by providing them with enough resources to ensure effective coordination in the regions in question;
- Strengthen coordination and cooperation between humanitarian workers and state authorities at both a central and decentralized level.
- Strengthen and decentralize the current coordination efforts and continue to gradually improve humanitarian access to the northern regions and the arrival of new humanitarian workers;

- Strengthen the capacities of the authorities and humanitarian workers in order to make the humanitarian action more effective and improve the transition between humanitarian action and development particularly in the affected regions;

- Strengthen cooperation between civilians and the military in order to increase the efficiency of interventions in response to new circumstances related to elections and the upsurge in terrorist acts and bombings;

- Strengthen health information management activities and carry out a follow-up assessment of the Health Cluster’s performance and advocacy actions – update the tools and continue to collect field data and information in order to strengthen the capacities of the workers and institutions involved;

- Make the transition from crisis to development: Early recovery and planning context for the Humanitarian Needs Overview - Strategic Response Plan (HNO-SRP) which has replaced the Consolidated Appeal Process. Cooperation between humanitarian workers, state authorities and technical and financial partners for development and a particular focus on resilience at different levels (individuals, communities, institutions).