

2 EFFECTIVE COORDINATION

Key points:

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

Expected Health Cluster outputs

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

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

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

2.1 ENGAGING PARTNERS – BUILDING AN EFFECTIVE HEALTH CLUSTER

Some basic principles

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

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

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

Identifying potential cluster partners

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

Engaging partners and getting buy-in

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

⁴ Achieving coordination depends heavily on behaviour and interpersonal skills.

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

Engaging with local health actors

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

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

Ensuring coordinated action in specific sub-sectors

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

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

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

A progressive approach to effective coordination

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

As a start, have the partners *sharing information* on:

- mandates, objectives, roles and responsibilities,
- resources and capabilities,
- areas of operations, priorities and projects,
- sources of data and perception of the general context.

As next step, have the partners *working together* at:

- assessing needs, setting standards, and mobilizing external resources,
- ensuring access to the affected populations,
- building local and national capacities, and training their own staff.

In a more advanced phase you will find that partners can *share plans and resources* through:

- joint planning – strategic, operational and contingency planning,
- implementing joint operations,
- sharing their experts, security systems, and logistics arrangements /capacities.

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Where to look for technical and operational support

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





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

Anticipating and overcoming barriers to coordination

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

Common barriers to coordination	Tips to overcome them
<p>Unilateral actions: Individual organizations ignore established coordination processes and do not respect joint decisions.</p>	<p>Discuss with the organization concerned in a non-confrontational manner.</p> <p>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.</p>
<p>“No benefit – a waste of time”: Many partners feel that the process does not provide sufficient benefits to justify the time invested.</p>	<p>Provide useful information and services.</p> <p>Establish a cluster action plan with clear, agreed objectives and concrete, actionable deliverables.</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 the next CAP.</p> <p>Organize periodic participatory evaluations of partners’ satisfaction with cluster processes, activities and decision-making to determine how they might be improved.</p>
<p>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.</p>	<p>Explain the role of the cluster and the reasons for previous decisions and agreements.</p> <p>Encourage all partners to involve senior national staff in the work of the cluster in order to assure continuity in thinking and action.</p>

Additional guidance

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

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2.2 MAPPING HEALTH ACTORS

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

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

- ☑ Mapping the *services* and specific health *resources* available through different actors in different areas using the Health Resources Analysis and Mapping System (*HeRAMS*) – the initial “i-HeRAMS” version in the first instance – see section 3.2.
- ☑ Provide regularly to OCHA the information collected through HeRAMS, in order to feed the Who is where, when, doing what (4W) database.
- ☑ Complementing these “activity-related” data with additional elements such as:
 - the mandate, role, objectives, areas of expertise, and the priorities they want to address;
 - the resources they have, and what they hope to mobilize, and the types and quantities of assistance they intend (or might be able) to provide;
 - the geographic and service areas into which they plan (or might be able) to extend their activities;
 - when they expect to initiate any new activities, or extend activities to new geographic areas, and when phase down and close particular activities;
 - their commitment (or willingness) to collaborate with others and work in partnership, and their interest in contributing to Cluster activities;
 - their commitment to equity and cross cutting issues including gender equality programming and SGBV response and prevention activities.
- ☑ Undertaking a *stakeholder analysis* – systematically examining the interests of each agency, organization, group and individual that has a direct or indirect interest in health, health services, and the activities of the Health Cluster, and whose attitudes and actions could have an

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

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

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

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

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

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

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

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

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HCC and Health Cluster action

- ☑ Get the area and population data sets from OCHA and customize HeRAMS.
- ☑ Check what information the MoH and OCHA already have or are collecting at national and field levels concerning organizations active in the health sector. This might include contact addresses, general information about the organization, and the geographic areas where they are working. Cross-check that information to ensure that everyone is “on the same page”.
- ☑ Collect information on the health services/service sub-sectors that each health actor is providing, or plans to provide in specific areas using HeRAMS:
 - make the data available to OCHA for inclusion in the 3W/4W database health module;
 - work to ensure maximum possible complementarity among the service delivery activities of different that partners/health actors (for example, one partner may provide primary health care services in a particular area while another supports hospital care).
- ☑ Collect information on mandates, objectives, roles, resources, and the types and quantities of assistance each partner can provide, and the areas and priorities they want to address; analyse their respective comparative strengths and look for consistency in the integration of cross-cutting concerns in their activities.
- ☑ Make sure all these data are regularly updated and emphasize (and support, if necessary) the collection of sex- and age-disaggregated data (SADD).


Lessons and practical hints from field experience

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

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

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

Additional guidance

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

2.3 HOLDING SUCCESSFUL CLUSTER MEETINGS

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

Organizing a cluster meeting

- Include all relevant governmental and other national entities.
- Get the MoH to chair or co-chair the meeting, if possible. Otherwise, if a UN agency is the CLA, meetings may be co-chaired with an appropriate NGO.
- Prepare a realistic agenda – see the example in the box below; focus on key issues identified and agreed in advance with the MoH.
- Select a venue that is suitable in terms of accessibility, facilities, space, ventilation.
- Prepare handouts with new information and maps.
- Prepare formats and/or flip charts to record the information you want to get from others, or cross-check, during or at the end of the meeting. (For the early meetings this includes, in particular, information on who is where and providing what kind/level of health care.)
- Ensure the rapid preparation and distribution of a concise record of key items of information shared in the meeting, decisions reached, and follow up actions required with responsibilities.

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

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

Making sure that meetings are productive

- ☑ Be clear about the *purpose* of the meeting and sure that a meeting is the best format.⁵ Specify in advance the outputs to be produced and the decisions to be taken.
- ☑ Ensure that meetings *focus* on problem solving, prioritization and planning, and do not simply become occasions for sharing information. Enforce time-keeping.
- ☑ Keep meetings as *short* as possible and adjust their frequency to the needs of phase of operation.
- ☑ Arrange for small *sub-groups* to work on specific problematic issues and bring recommendations back to the next cluster meeting, when necessary. But avoid a proliferation of meetings. Ask for email feedback on drafts and limit discussion in cluster meetings to the key issues only.
- ☑ *Involve* partners in formulating agendas and identifying issues requiring specific work.
- ☑ During the first month, ask *newly-arrived organizations* to come half-an-hour earlier for a quick briefing on the role of the cluster and what has been discussed and decided at previous meetings. This will avoid time being lost during the meeting itself.

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

POSSIBLE AGENDA FOR A FIRST HEALTH CLUSTER MEETING

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

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

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

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Lessons and practical hints from field experience

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

Additional guidance

-  IASC. *Coordination Meetings*. Cluster-Sector Leadership Training Tip Sheets, Inter-Agency Standing Committee, 2007.
-  Global WASH Cluster. Section 2.4 “Managing and facilitating cluster meetings”, in *WASH Cluster Coordinator Handbook*. Global WASH Cluster Coordination Project, January 2009.



2.4 WORKING WITH OTHER CLUSTERS AND COORDINATING ENTITIES

Coordinating with other clusters/sector groups

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

- ✓ the CLA in the context of the Humanitarian Country Team, chaired by the HC;
- ✓ the HCC through the inter-cluster coordination group⁶ chaired by the OCHA team leader and any other multi-cluster/multi-sectoral groups that may be constituted; and
- ✓ arranging joint activities and attendance at each others’ meetings, as outlined below.

Working with other clusters

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

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

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

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

Working with other coordinating entities

The HCC must work closely with:

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

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

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

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2.5 ENSURING GOOD INFORMATION MANAGEMENT

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

Some basic principles

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

HCC and Health Cluster action

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

- appeals documents (see chapter 7)
 - guidelines on standards and best practices
 - press releases and other formal cluster communications
 - summary minutes of cluster meetings including working groups
 - periodic reports, reviews and evaluations of cluster activities and health-sector response
 - background information including reports of previous emergency operations, epidemiological studies and other pre-crisis data, health-sector profiles, etc.
- ☑ List the *tools* (standard formats, templates, etc.) for use by health cluster partners that should be made available through a suitable web site⁷ together with the above information.
 - ☑ Ensure active participation in *inter-agency initiatives* in information management (HIC, information management working groups) to improve inter-agency sharing of information, get access to information on the potential causes of health problems or risks and initiatives of other clusters that could affect public health (e.g. shortage of water, pollution of sources, lack of sanitation, etc. as well as gender analysis and other contextual information), and participate in establishing inter-agency information management standards.
 - ☑ Ensure that health-related data from *all sources* (including news media reports) are systematically compiled, stored and reviewed for reliability and relevance.
 - ☑ Arrange for systematic *analysis* – including a gender analysis – of all data to generate information for planning, management, evaluation, and advocacy purposes.
 - ☑ Ensure that information is handled and used responsibly, see box below.

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

HANDLING AND USING DATA AND INFORMATION RESPONSIBLY

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

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

Additional guidance

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

2.6 DISSEMINATING INFORMATION – MANAGING EXTERNAL COMMUNICATIONS

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

Some basic principles

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

Health Cluster lead agency

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

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

- ☑ Establish and cultivate contacts with local and international journalists/news-media representatives.
- ☑ Prepare press releases and organize press briefings whenever there is important information to publicize.
- ☑ Organize question-and-answer briefings and field visits for national and international journalists.
- ☑ Establish a photo-library and systematically collect and catalogue photos of the health situation and significant events.

Lessons and practical hints from field experience

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

Additional guidance

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