4

ANALYSIS AND PRIORITIZATION

Key points:

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

Expected Health Cluster outputs

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

4.1 IDENTIFYING AND ANALYSING PROBLEMS, RISKS AND GAPS

Analysis for planning purposes involves two steps:

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

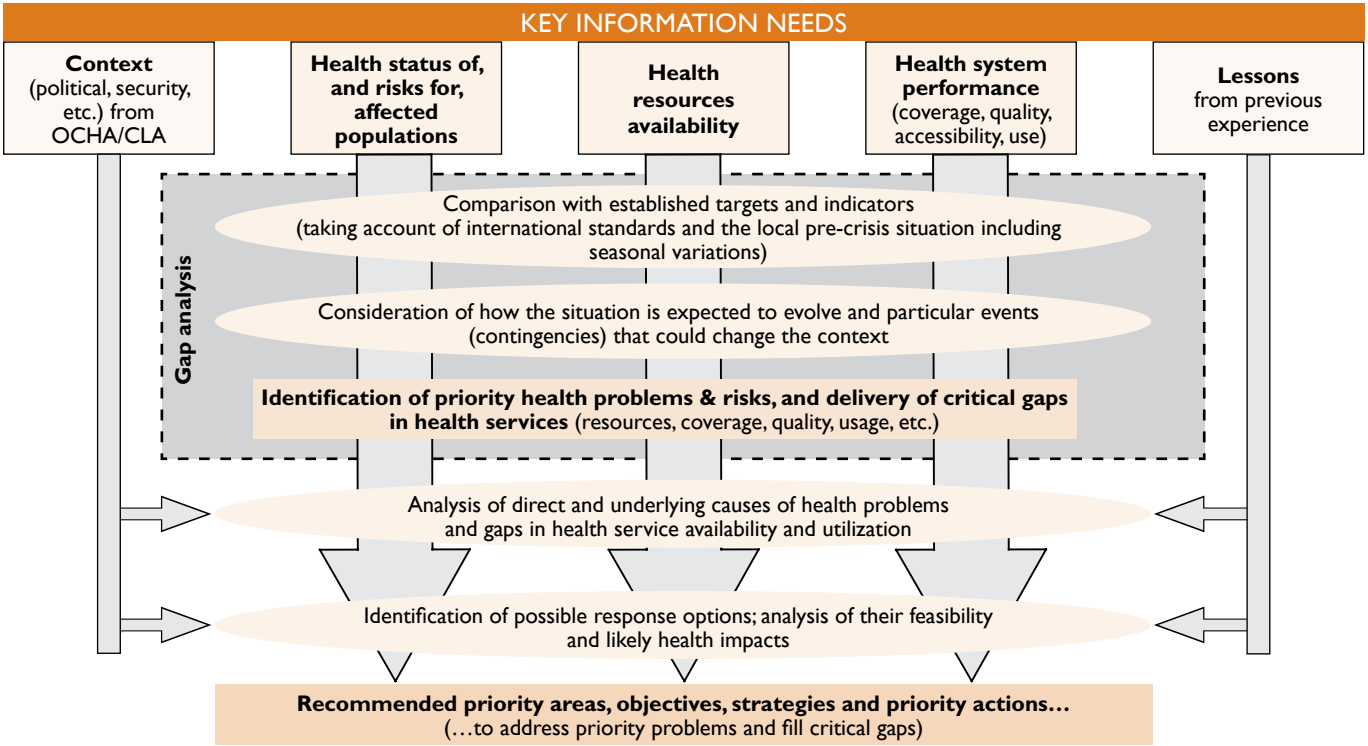
2. An analysis of the *options* available (feasible and acceptable) to address the priority gaps/ problems and the prioritization of health *actions* taking account of the resources that would be required and the health benefits that could be expected in the prevailing local context including security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

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

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

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

Figure 4a Framework for analysing the health situation



Problem and gap analysis

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

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

Some widely accepted benchmarks are provided in section 9.1.

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

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

Context analysis

The context analysis must include analyses of:

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

The analysis tools that can be useful include:

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

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

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

HCC and Health Cluster action

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

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

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

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

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

Additional guidance & tools

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

4.2 PRIORITIZING PROBLEMS AND RESPONSE ACTIONS

The following are some key questions to be answered:

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

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

HCC and Health Cluster action

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

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

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

Figure 4b Sample worksheet for identifying priorities

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

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

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

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