Global Health Cluster
Partners Capacity Survey
2012
# Table of Contents

1. Acknowledgment ........................................................................................................2
2. Introduction ................................................................................................................3
3. Objectives of the Partners’ Capacity Survey .................................................................3
4. Methodology of the survey ..........................................................................................4
5. Overview of Conclusions .............................................................................................5
6. Survey sections .............................................................................................................7
   6.1. Global Health Cluster focal points .................................................................7
   6.2. Composition of the Global Health Cluster ......................................................7
       6.2.1. Survey response rate ..............................................................................7
   6.2.2. Nature of the GHC partners responding to the survey ............................8
   6.3. Field presence of GHC operational partners ...............................................9
       6.3.1. Distribution of GHC operational partners in the 6 WHO Regions and the 66 WHO ERM countries of concern .................................................................9
       6.3.2. Distribution of operational partners in countries in crises .......................9
       6.3.3. Representation of operational partners in Health Cluster countries .........10
       6.3.4. Representation of operational partners in countries with acute crises ......11
       6.3.5. Representation of operational partners in countries with protracted crises .................................................................12
   6.4. Main mission of the Non-Operational GHC partners ........................................12
   6.5. Areas of support from Non-Operational GHC partners ....................................13
       6.6. Expertise of operational GHC partners in the different healthcare levels ..........13
       6.6.1. Current Health projects carried-out by the different entities in the GHC ........13
       6.6.2. Community Healthcare ........................................................................14
       6.6.3. Primary Healthcare ..............................................................................14
       6.6.4. Secondary and tertiary healthcare ..........................................................16
   6.7. GHC partners Human resources Capacities .......................................................17
       6.7.1. Coordination capacities .........................................................................17
       6.7.2. GHC Human resources standby capacities ..........................................17
   6.8. Logistical Capacities .........................................................................................18
       6.8.1. kits prepositioned and available to GHC partners ..................................18
       6.8.2. Logistical hubs used by GHC partners ..................................................19
   7. Recommendations ..................................................................................................19
1. ACKNOWLEDGMENT

The Global Health Cluster Partners Capacity survey was a team effort from its inception until its completion, and was made possible through the collaboration of all the units in WHO Emergency Risk Management and Humanitarian Response Department (ERM), including the Surge and Crisis Support Team (SCT), Policy Practice and Evaluation team (PPE), the Intelligence and Information Management team (IIM) and the Directors Office (DO).

We hereby extend our sincere thanks to the Director of WHO ERM, Dr Rick Brennan for entrusting us with the task of conducting this survey, and for supporting its implementation at various levels including the advocacy with partners for completing the survey. Special thanks are due to Dr Xavier De Radigues coordinator of the Intelligence and Information Management Unit in ERM/IIM, who provided invaluable time and effort during all the phases of the survey, from the conception of the tool until the results analysis and the review of the report. Our sincere thanks are due to Dr Claudine Prudhon, Dr Alice Croisier, Ms. Inga Williams, Ms. Leila Parkkali and Mr Samuel Petragallo all members of the ERM/IIM team who have collaborated for the implementation of this survey at different levels, and provided the technical knowledge for the launching of the questionnaire as well as the data processing and analysis.

We express our gratitude and sincerest thanks to the organizations and partners in the Global Health Cluster, and their focal points who have taken the time to fulfill the laborious task of responding to the survey and duly filling the survey questionnaire despite its length and complexity in certain sections.

Successful completion of the survey was possible largely due to the true efforts of the World Health Organization as the lead of the Global Health Cluster as well as all the partners and organizations members of the Global Health Cluster.

On behalf of the Global health Cluster secretariat

Dr Ahmed ZOUITEN

WHO Emergency Risk Management and Humanitarian Response Department (ERM)
2. **INTRODUCTION**

The Global Health Cluster (GHC) was created in 2005, as part of the humanitarian reform process following the United Nations General Assembly Resolution 60/124. Currently, the Global Health Cluster is made up of 40 international humanitarian health organizations and 5 observers. The Health Cluster is indeed, a partnership that strives to demonstrate optimized cluster performance and health outcomes through timely, effective, complementary and coordinated action preparing for, responding to, and recovering from crises.

The Health Cluster’s Goal during humanitarian crises is to reduce avoidable mortality, morbidity and disability, and restore the delivery of, and equitable access to, preventive and curative health care as quickly as possible and in as sustainable a manner as possible.

The Health Cluster abides by the following Guiding Principles that serve as the foundation for achieving its Strategic Objectives i) Commitment and voluntary cooperation; ii) partnership; iii) community participation and accountability to affected populations; iv) support national authorities’ coordination efforts, priorities and building capacities; v) Adherence to humanitarian principles, reference to the right to health.

At Global Level, partners in the GHC work in close collaboration and strive to build consensus on health priorities and related best practices, and strengthen system-wide capacities to ensure predictability, accountability and effectiveness in the response to health related issues in humanitarian emergencies. It is mandated to build global capacity in humanitarian response in three ways: i) providing guidance and tools and standards and policies; ii) establishing systems and procedures for rapid deployment of the experts and supplies, and iii) building global partnerships to implement and promote this work.

At Country Level, the health cluster should serve as a mechanism for participating organizations to work together in partnership to harmonize efforts and use available resources efficiently within the framework of agreed objectives, priorities and strategies, for the benefit of the affected population(s). This includes avoiding gaps and/or overlap in the international humanitarian health response and resources (human and financial). The cluster should provide a framework for effective partnerships among international and national humanitarian health actors, civil society and other stakeholders, and ensure that international health responses are appropriately aligned with national structures.

Since 2005, the Emergency Relief Coordinator has activated health clusters in a total of 47 countries; 28 of these health clusters are currently still active. In large scale crises, such as those which occurred in Haiti and Pakistan in 2010, more than 300 humanitarian agencies were part of the health cluster, posing enormous coordination challenges.

3. **OBJECTIVES OF THE PARTNERS’ CAPACITY SURVEY**

As part of the GHC coordination role, and in order to ensure predictability and effectiveness in future responses to health related issues in countries faced with the threat of emergencies with public health consequences, the secretariat of the GHC seeks to take stock of the resources and capacities available to different partners in the GHC, and which can be mobilized in the wake of a large scale emergency.

In the spirit of partnership for improved preparedness and planning for response, this survey aims to:

- Document the areas of technical expertise for both operational and non-operational GHC partners;
- Determine the collective capacities of GHC partners for emergency surge;
- Determine the predictable operational response capacity for cluster-wide activation of the GHC partners;
Map the current operational presence of GHC partners in countries affected by emergencies as well as in the 66 countries of concern for WHO ERM work.

Identify capacities of operational agencies to act as Country Health Cluster Lead at national and sub-national levels.

Explore potential synergies and avoiding duplications of efforts especially in the procurement, preposition of drugs, medical supplies and logistics.

4. Methodology of the Survey

The GHC Partners Capacity survey was conducted as Cross-Sectional Surveys through a simple online questionnaire designed for this purpose, and hosted on the WHO website, in the form of a “Lime survey”.

All GHC members were asked to complete the survey as the tool was designed for both operational and non operational partners and comprised a branch question to fit the nature of the different constituents of the GHC. For operational partners, the questionnaire took about 15 minutes, and about 10 for non operational ones, provided that all the information was readily available to the respondent.

The survey questionnaire consisted of 8 sections:

- Global Health Cluster focal points (11 questions)
- Description of the organization member of the GHC (3 questions)
- Mission of the Organization (non-operational organizations) (3 questions)
- Field presence (operational organizations) (2 questions)
- Areas of activities in the health sector (3 rolling menus)
- Coordination capacities (3 questions)
- Human resources stand-by capacities (2 questions)
- Logistics capacities (2 questions)

The Branch question cited above was placed after the section 2 “Description of organization member of the GHC”, then the Non Operational Partners had a set of questions adapted to the support they can provide to the GHC and to the response to health related issues in humanitarian emergencies. The questions focused on; i) the main mission of the organization; ii) the type of support that your organization may be able to provide during emergency response activities and iii) the country or countries where the organization has a physical presence.

GHC partners completing the survey were advised that;

- Each organization member of the GHC could fill only one questionnaire, with the exception when the same organization is represented by more than one section in the GHC. (Ex: Save the children US and UK could complete one questionnaire each).

- The Survey should be completed by the staff member representing the agency in the GHC, or his/her alternate.

- The information will be collected and analyzed once a year, and as much as possible and feasible, the person completing the questionnaire the first time should be the one completing it each time.

The online survey was launched on November 1st 2012, and GHC partners were advised to complete the survey by mid November, but due to a slow response rate, the survey completion deadline was extended to the first week of December, and preliminary results were presented in the annual GHC meeting. Upon the request of some partners, the survey was reopened in early January 2013 for an additional 2 weeks.
5. Overview of Conclusions

The total response rate to the GHC Partners Capacity Survey was 83% with 33 respondents among the 40 GHC partners. The response rate varied between the different constituencies of the GHC and ranged between 100% among the international organizations, donors and academic institutes category, and 50% among the category (others). 79% (26/33) of respondents identified their organization as an operational entity, while 21% (7/33) filled the survey questionnaire as non-operational partner organization.

All the operational GHC partners responding to the survey had field presence in at least 5 countries representing at least 2 WHO regions. The highest representation was among IFRC and UN agencies (WHO, UNICEF and UNFPA), while among the NGO partners the average presence in countries was 19 ranging from 36 Country offices for MDM and 5 for ARC.

With regards to the presence of the GHC partners in the countries with active Health Clusters, IFRC and UN agencies were represented in all the countries, while the NGO partners had the highest representation in DRC, Kenya, Ethiopia, Somalia, Sudan (North and South), Pakistan and Myanmar with an average between 10 and 13 NGO members. While the presence in Mali, Chad, Haiti, Uganda, Yemen, Afghanistan, Nepal, and Bangladesh ranged between 7 and 10. In countries like Mauritania, Niger, Iraq and Djibouti, despite the great need for supporting the humanitarian response in the health sector, the representation was very low and ranged between 0 and 3 NGO partners.

In countries with acute crises, the highest representation among NGO partners was in Pakistan with 13 partners, followed by DRC, Sudan and Somalia with 10 partners. The lowest representation was in Lesotho, Mauritania, Nigeria with 2 NGO partners represented respectively. 3 NGO partners were conducting health projects in Syria (ERA, MDM and Mercy)

The non-operational GHC partners were represented by 4 NGOs, 2 Donors and 1 Academic institute. A part from the 2 donor agencies, the GHC Non-Operational partners, identified the following activities as their main mission statements: Academic/Research, Advocacy, Education and policy programmes. The non operational GHC members could support the GHC in Health technical expertise, Needs assessment Information management and Health Cluster Coordination.

The operational GHC partners (26/33) indicated that had their organization had technical capacity to conduct or support health projects in countries where they were present. 96% (25/26) partners supported or could support community health projects; 92% (24/26) partner supported or could support primary healthcare projects and 53% (14/26) partners supported or could support secondary/tertiary healthcare projects. At the time of the survey, international NGOs were carrying out 30 Community health projects, 446 Primary Health projects and 124 Secondary Healthcare projects.

In the community Health care field; 84% (22/26) GHC operational partners were supporting mobile clinics, and 80% were supporting Village Health work.

With regards to primary healthcare projects, the survey questionnaire identified six areas as follows. The level of expertise of the GHC members in engaging in the six areas varied according to the complexity of services.

i) General Clinical Health Service provision: 57.7% were conducting routine Immunization Programs (EPI), 77% were carrying-out Outpatient Services, 50% had capacity for hospitalization in at least one of their projects and 61.5% were involved in child health projects including under 5 Consultations.

ii) Communicable diseases: 61.5% were supporting Malaria control programs, 50% were operational in the area of the control of Tuberculosis; 53.8% were operational in the area of outbreak
response including the diagnostic and management of epidemic prone diseases, 38.5% were involved in other local communicable diseases like African trypanosomiasis.

iii) The response to HIV: 73.1% of operational GHC partners were conducting projects providing HIV counselling and testing, 50% of partners provided Post-Exposure Prophylaxis (PEP) in their projects, against 57.7% capacity for Prevention of mother-to-child HIV transmission (PMTCT). 65.4% had the capacity to provided Prophylaxis and treatment of opportunistic infections and 69.2% provided Syndromic management of sexually transmitted infections while only 50% provided Antiretroviral therapy.

iv) Management of Malnutrition: 73.1% of the operational GHC partners provided Under/Malnutrition screening with MUAC or Weight/Height; 73.1% of partners supported the management of Moderate and Acute Malnutrition (MAM) and 65.4% supported the management of Severe Acute Malnutrition (SAM)

v) Sexual and Reproductive Health: 57.7% provided Clinical management of Rape survivors; 53.8% provided emergency contraception; 65.4% provided family planning; 69.2% provided prenatal care; 65.4% provided post-partum care; 61.5% provide essential newborn care; and the same percentage of partners provided skilled care for safe deliveries.

vi) Non-communicable diseases: Non-Communicable diseases diagnostic and treatment represents the primary healthcare area that received the least attention from the GHC partners; indeed only 46.2% of partners provided injury and trauma care; 50% of partners provided diabetes and hypertension treatment; and 53.8% provided mental health care.

In secondary and tertiary Healthcare level, the questionnaire focused on 3 areas:

i) Secondary level general clinical services: 38.4% were supporting Out-patient services with surgical triage and inpatients services, 30.7% provided Emergency and elective surgery through at least 1 operating theatre, 30.7% were supporting Blood Bank service, 38.4% were supporting secondary level laboratory services, and 26.9% were providing X-Ray imagery

ii) comprehensive Maternal, New-born and Child health: 46.1% of the operational GHC partners provided Comprehensive Emergency Obstetric Care and 38.4% provided secondary level of pediatric care.

iii) secondary level Non-Communicable diseases: 30.7% of partners provided outpatient psychiatric care and psychological counseling, 19.2% provided acute psychiatric inpatient services and 34.6% provided advanced treatment for injuries’ and disability management and rehabilitation

With regards to the GHC surge capacity for ensuring the coordination of health services in emergencies, 12 operational GHC partners indicated they had trained and available Health Cluster Coordinator who can deploy within 7 days. 13 operational GHC partners could deploy Needs Assessment specialist within 7 days, and Nine operational GHC partners could deploy professionals to perform Information management functions within the Health Cluster Coordination team

The Operational GHC Partners had standby capacity of 1197 staff, 585 among them could be deployed within 72 hours notice and 612 could be deployed afterwards within 7 days (CDC and IMC could deploy 271 and 100 staff within 72 hours respectively). Among the staff available on standby, there are 203 Medical Doctors, 44 Reproductive health specialists, 182 Public health specialists, 125Epidemiologists, 27 Mental health specialists, 121Nurses and midwives and 44 Nutritionists.
6. **Survey Sections**

6.1. **Global Health Cluster focal points**

Partners in the GHC are represented by 1 focal point and 1 alternate focal point as shown in Annex 1. The GHC relies on a steering committee called the “Global Health Cluster Core Group” or Core Group (CG), to provide policy guidance, strategic direction, and to manage the implementation of the GHC work-plan. The CG is comprised of a subset of GHC partners focal points, with no more than one representative per agency, and representatives of WHO as Cluster Lead Agency, including members of the WHO Global Emergency Management Team who are linked to the Core Group as stated in the GHC Strategy.

6.2. **Composition of the Global Health Cluster**

The Global Health Cluster (GHC) was created in 2005, as part of the humanitarian reform process following the United Nations General Assembly Resolution 60/124. Presently, the Global Health Cluster is made up of 40 international humanitarian health organizations, and 5 observers.

The active GHC members are made out of 6 UN agencies, 23 International Non-Governmental Organizations, 4 donor agencies, 3 academic institutes, the International Organization for Migration and the International Federation of the Red Cross and Red Crescent Societies, the CDC and the Public Health Agency of Canada. 5 partners are affiliated as observers (International Committee of the Red Cross ICRC, Medecins Sans Frontières MSF, The Health Protection Agency HPA, Sphere Project and Interaction)

6.2.1. **Survey response rate**

The total response rate to the GHC Partners Capacity Survey was 83%. The response rate varied between the different constituencies of the GHC. It ranged from 100% among the international organizations, donors and academic institutes category, and 50% in the category of others (represented by the CDC and the Public Health Agency of Canada), among the UN agencies and the International NGOs, the response rate was 83% as shown in the table below

<table>
<thead>
<tr>
<th>Cluster Members</th>
<th>N° of respondents</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>International NGOs</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>International organisations</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>UN organisations</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Donors</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Academic Institutes</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Observers</td>
<td>5</td>
<td>NA</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>40 + 5</td>
<td>33</td>
</tr>
</tbody>
</table>
6.2.2. **Nature of the GHC Partners Responding to the Survey**

The GHC survey comprised a filter question separating Operational and Non-Operational partners and their contributions to the Health Sector’s response in emergencies.

Among the respondents to Survey, 79% (26/33) identified their organization as an operational entity, while 21% (7/33) filled the survey questionnaire as non-operational partner organization.

6.2.2.1 **Operational Organizations by category**

Among the operational organizations responding to the survey 58% (15/26) were International NGOs, 19% (5/26) were UN organizations (UNFPA, UNICEF, UNHCR, WHO and WFP while FAO didn’t respond to the survey).

The representation of donors, Academic Institutes and international Organizations and others, ranged between 4 and 7%.

6.2.2.2 **Non-Operational Organizations by category**

Among Non-Operational partners 57% (4/7) were NGOs (WADEM, ICVA, ICN, WRC), 29% (2/7) were Non-operational Donors (DFID and ECHO) and 14% (1/7) Academic institute (Harvard Humanitarian Initiative)
6.3. Field Presence of GHC Operational Partners

6.3.1. Distribution of GHC Operational Partners in the 6 WHO Regions and the 66 WHO ERM Countries of Concern

All the operational GHC partners responding to the survey had field presence in at least 2 of WHO regions.

- IFRC, WHO, UNICEF and UNFPA had presence in most of the 6 WHO regions, with field presence in the countries of concern as follow (66, 66, 65 and 64 respectively).

- Among NGOs; MDM, Save the Children and WVI were the most represented with field presence in 36, 32, 29 WHO ERM countries of concern respectively.

- AFRO region was by far the region that had the highest representation of GHC partners with 23 partners conducting 301 health projects in 26 countries (table 2). GHC partners presence in this region ranged from 1 country (ERA, ARC) to 25 countries (IFRC, WHO, UNICEF and UNFPA).

- EMRO was the second region in terms of partners representation with 177 health projects in 13 countries. IFRC, UNFPA, UNICEF and WHO were represented in all countries of concern of the EMRO region followed by UHCR and IOM with 11 and 9 projects respectively.
Table 2: Field presence of the GHC Operational partners in the 66 WHO ERM countries of concern

<table>
<thead>
<tr>
<th>Organization</th>
<th>AFRO</th>
<th>EMRO</th>
<th>SEARO</th>
<th>WPRO</th>
<th>AMRO/PAHO</th>
<th>EURO</th>
<th>Total countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>IFRC</td>
<td>26</td>
<td>13</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>1</td>
<td>66</td>
</tr>
<tr>
<td>WHO</td>
<td>26</td>
<td>13</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>1</td>
<td>66</td>
</tr>
<tr>
<td>UNICEF</td>
<td>26</td>
<td>13</td>
<td>8</td>
<td>8</td>
<td>9</td>
<td>1</td>
<td>65</td>
</tr>
<tr>
<td>UNFPA</td>
<td>26</td>
<td>13</td>
<td>8</td>
<td>6</td>
<td>10</td>
<td>1</td>
<td>64</td>
</tr>
<tr>
<td>UNHCR</td>
<td>23</td>
<td>11</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td></td>
<td>41</td>
</tr>
<tr>
<td>BPRM</td>
<td>20</td>
<td>13</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td></td>
<td>44</td>
</tr>
<tr>
<td>CDC</td>
<td>20</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>8</td>
<td>1</td>
<td>45</td>
</tr>
<tr>
<td>WFP</td>
<td>17</td>
<td>4</td>
<td>7</td>
<td>2</td>
<td>5</td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>MDM</td>
<td>16</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>SC-UK</td>
<td>13</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Care</td>
<td>13</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>IRC</td>
<td>12</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>Marie Stopes Int</td>
<td>11</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>SC-US</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>WVI</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>IMC</td>
<td>7</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>IOM</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Merlin</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>AHA</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>HelpAge</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Hope World Wide</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>ERA-AMU</td>
<td>1</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>ARC</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Mercy Malaysia</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td><strong>Total number of</strong></td>
<td><strong>301</strong></td>
<td><strong>177</strong></td>
<td><strong>103</strong></td>
<td><strong>68</strong></td>
<td><strong>80</strong></td>
<td><strong>7</strong></td>
<td><strong>736</strong></td>
</tr>
</tbody>
</table>

*Some partners have more than one project/country, however the table assumes that each partner has 1 project/country.

6.3.2. DISTRIBUTION OF OPERATIONAL PARTNERS IN COUNTRIES IN CRISIS

As shown in the map below,

- The countries affected by crises that had the highest representation of GHC members were DRC, Kenya, Ethiopia, Somalia, Sudan (North and South), Pakistan and Myanmar with an average between 15 and 19 members.
- The countries which were receiving an average of 12 - 15 members were; Mali, Chad, Haiti, Sierra Leone, Uganda, Yemen, Afghanistan, Nepal, Bangladesh and the Philippines.
- Countries like Guatemala, Djibouti, Eriteria, Turkey, and North Korea, were the ones receiving support from between 3 and 6 GHC partners.
6.3.3. Representation of operational partners in Health Cluster countries

The representation of operational partners in countries with activated Health Clusters varied from a country to another. The highest representation was in Ethiopia with 22 partners, followed by Pakistan with 21 partners, then Kenya with 20 partners. Guinea was the country with the lowest representation with 7 partners followed by Timor Leste (8 Partners) then Mauritania, Niger, and Iraq with (9 partners each).

While UN representation in country Health Clusters varied between 4 and 5 partners in each country, the NGO representation showed important differences, with the highest representation in Pakistan (12), Ethiopia (11), and the lowest in Guinea with 1 NGO followed by Timor Leste and Mauritania with 2 NGOs.

6.3.4. Representation of operational partners in countries with acute crises

The representation of GHC operational partners in countries in acute crisis or on alert (ref. from week 46 in 2012) varied between countries; the highest representation was in Pakistan with 21 partners (4 UN, 13 NGOs, IOM, IFRC and 2 others), then DRC, Sudan and Somalia with 20 partners. The lowest representation was in Lesotho and Guinea- Bissau with 7 and 8 partners respectively.

Countries like Mauritania, Nigeria and Syria had representation of between 9 and 11 partners which is contrasting with the scale, the scope and the complexity of the crises they were experiencing
6.3.5. Representation of operational partners in countries with protracted crises

The representation of operational partners in countries with protracted emergencies (ref. from week 46 in 2012) likewise varied between the different countries; the highest representation was in Ethiopia with 22 partners (5 UN, 12 NGOs, IOM, IFRC and 3 others), then Kenya with 20 partners, followed by Myanmar and Afghanistan with 19 partners. The lowest representation was in DPRK with 6 partners, followed by Madagascar and Djibouti with 8 and 9 partners respectively.

With regards to NGO representation in countries in protracted crises, Ethiopia, Kenya, Myanmar and Afghanistan had the largest NGO representation with between 10 and 21 GHC NGO partners, while DPRK and Djibouti both had a representation from one NGO partner, followed by CAR, Burkina Faso and Madagascar with 3 NGOs each.

6.4. Main mission of the Non-Operational GHC partners

The GHC survey comprised a filter question separating Operational and Non-Operational partners and their contributions to the Health Sector’s response in emergencies. Among the respondent to the Survey, 21% (7/33) GHC partners identified their organization as a Non-Operational Organization, they were:

- 4 were NGOs (WADEM, ICVA, ICN, WRC)
- 2 Donors (DFID and ECHO); and
- 1 Academic institute (Harvard Humanitarian Initiative).

The main mission statements of the GHC Non-Operational partners, were as follows:

- Donor: 2 (ECHO and DFID)
- Academic/teaching: 2 (HHI, WADEM)
- Academic/Research: 3 (HHI, WADEM and WRC)
- Professional association: 2 (WADEM, ICN)
- Advocacy: 3 (ICN, WADEM and WRC)
- Prehospital and Disaster Medicine: 1 WADEM
- Education and policy programmes: 1 ICN
- NGO network, sharing information and working together: 1 ICVA
6.5. Areas of Support from Non-Operational GHC Partners

Respondents to the survey as Non-Operational GHC partners, identified the following areas of support for cluster work at country level:

- Health technical expertise: 5 partners (DFiD, ECHO, HHI, ICN and WADEM)
- Health Cluster Coordination: 1 partner; ECHO (funding support)
- Logistics: 1 ECHO (funding support)
- Information management: 4 partners; (ECHO, HHI, WADEM and WRC)
- Needs assessment: 3 partners; (ECHO, HHI and WADEM)

6.6. Expertise of Operational GHC Partners in the Different Healthcare Levels

79% (26/33) partners among the respondents to the GHC survey, are operational and had the technical capacity to conduct or support health projects in at least 5 countries in 2 or more WHO regions where they were present (see table 6.3.1)

- 96% (25/26) partners supported or could support community health projects
- 92% (24/26) partner supported or could support primary healthcare projects
- 53% (14/26) partners supported or could support secondary/tertiary healthcare projects

6.6.1. Current Health Projects Carried-out by the Different Entities in the GHC

- At the time of the survey, international NGOs were carrying out 30 Community health projects, 446 Primary Health projects and 124 Secondary Healthcare projects
- UN organizations were supporting 10 Community health projects, 137 Primary Health Projects and 19 Secondary Healthcare projects
- IFRC and IOM were mainly operating at the primary healthcare level.
6.6.2. COMMUNITY HEALTHCARE

The GHC survey questionnaire included two community healthcare activities; Mobile clinics and Village health work and referral system.

- 22 partners out of the 26 were supporting mobile clinics in 1 or more countries. NGOs represent 63% (14) of the partners carrying out mobile clinics
- 21 partners out of the 26 were supporting Village Health work in 1 or more countries in crises. NGOs represent 61% (13) of the partners carrying out Village Health work

6.6.3. PRIMARY HEALTHCARE

6.6.3.1 General Clinical Health Service provision

Among the 26 operational GHC partners;

- 57.7% were conducting routine Immunization Programs (EPI)
- 77% were carrying-out Outpatient Services
- 50% had capacity for hospitalization in at least one of their projects
- 61.5% were involved in child health projects including under 5 Consultations

6.6.3.2 Communicable diseases

The GHC survey questionnaire included 4 different areas pertaining to communicable diseases; i) Diagnosis and treatment of Malaria; ii) Diagnosis and treatment of Tuberculosis; iii) Diagnostic and management of epidemic prone diseases (outbreak response); and iv) Other local relevant communicable diseases

Among the 26 operational GHC partners;

- 61.5% were supporting Malaria control programs
- 50% were operational in the area of the control of Tuberculosis
- 53.8% were operational in the area of outbreak response including the diagnostic and management of epidemic prone diseases
- 38.5% were involved in other local communicable diseases like African trypanosomiasis and others.
6.6.3.3 The response to HIV

The response to HIV in the health sector was identified in the GHC survey as one of the areas included in the Primary Healthcare level. The minimum response package to HIV in Primary Healthcare centers included; i) HIV counselling and testing; ii) Post-exposure prophylaxis (PEP); iii) Prevention of mother-to-child HIV transmission (PMTCT); iv) Prophylaxis and treatment of opportunistic infections; v) Syndromic management of sexually transmitted infections; and vi) Access to Antiretroviral therapy.

- 73.1% of operational GHC partners were conducting or could conduct projects providing HIV counselling and testing
- 50% of partners provided or could provide Post-Exposure Prophylaxis (PEP) in their projects, against 57.7% capacity for Prevention of mother-to-child HIV transmission (PMTCT)
- 65.4% had the capacity to provide Prophylaxis and treatment of opportunistic infections and 69.2% provided Syndromic management of sexually transmitted infections
- 50% provided Antiretroviral therapy

6.6.3.4 Management of Malnutrition

With regards to the management of malnutrition in the health sector,

- 73.1% of the operational GHC partners provided Under/Malnutrition screening with MUAC or Weight/Height;
- 73.1% of partners supported the management of Moderate and Acute Malnutrition (MAM)
- 65.4% supported the management of Severe Acute Malnutrition (SAM)

6.6.3.5 Sexual and Reproductive Health

Among the 26 Operational GHC partners, 62% supported Sexual and Reproductive Health in emergencies;

57.7% provided Clinical management of Rape survivors; 53.8% provided emergency contraception; 65.4% provided family planning; 69.2% provided prenatal care; 65.4% provided post-partum care; 61.5% provide essential newborn care; and the same percentage of partners provided skilled care for safe deliveries.
### 6.6.3.6 Non-communicable diseases

Non-Communicable diseases diagnostic and treatment represents the primary healthcare area that received the least attention from the GHC partners; indeed only **46.2%** of partners provided injury and trauma care; **50%** of partners provided diabetes and hypertension treatment; and **53.8 %** provided mental health care.

### 6.6.4 Secondary and Tertiary Healthcare

14 partners among the 26 operational agencies (53%) supported or could support secondary/tertiary healthcare projects. As described in the survey questionnaire, the list of secondary/tertiary healthcare activities, was based on the agreed list in the HeRAMs format, and include 3 categories; i) Secondary level general clinical services; ii) comprehensive Maternal, New-born and Child health, iii) secondary level Non-Communicable diseases.

#### 6.6.4.1 Secondary level General Clinical Services

Among the 26 operational GHC partners;

- **38.4%** were supporting Out-patient services with surgical triage + Inpatients services (medical, paediatrics and obstetrics and gynaecology wards)
- **30.7%** supported or provided Emergency and elective surgery through at least 1 operating theatre
- **30.7%** were supporting Blood Bank service
- **38.4%** were supporting secondary level laboratory services
- **26.9%** were providing X-Ray imagery

#### 6.6.4.2 Comprehensive Maternal, New-born and Child health

- **46.1%** of the operational GHC partners provided Comprehensive Emergency Obstetric Care (CEmOC) = Emergency Obstetric Care (BEmOC) + caesarean section + safe blood transfusion
- **38.4%** of operational partners provided secondary level of pediatric care and supported the Management of children with severe and very severe diseases
6.6.4.3 Secondary level Non-Communicable diseases

While 50% of operational GHC partners provided Non communicable diseases care as part of a primary healthcare package, only 28.2% of operational partners were able to provide a secondary level comprehensive Non-Communicable package.

- 30.7% of partners provided outpatient psychiatric care and psychological counselling
- 19.2% provided acute psychiatric inpatient services
- 34.6% provided advanced treatment for injuries’ and disabilities’ management and rehabilitation

6.7. GHC partners Human resources capacities

6.7.1. Coordination capacities

With regards to the GHC surge capacity for ensuring the coordination of health services in emergencies, the survey questionnaire focused on 4 functions; i) Health Cluster Coordinator (National level); ii) Health Cluster Coordinator (Sub-national level); iii) Information manager; iv) Needs Assessment specialist

- **Health Cluster Coordinator HCC**: 12 operational GHC partners had trained and available HCCs, 51 could be deployed within 7 days, among them 21 who can deploy within 72 hours.
- At sub-national level, 58 professionals could deploy within 7 days among them 24 than could deploy within 72 hours
- **Needs Assessment specialist**: 13 operational GHC partners could deploy professionals to perform needs assessment activities, 61 GHC partners’ staff could deploy within 7 days and 30 could deploy within 72 hours notice
- Nine operational GHC partners could deploy professionals to perform **Information management functions** within the Health Cluster Coordination team, 34 GHC partners’ staff could deploy within 7 days and 13 could deploy within 72 hours notice

6.7.2. GHC Human Resources Standby Capacities

6.7.2.1 Number of staff available on standby by GHC partner

The Operational GHC Partners respondent to the survey indicated that they had a standby capacity of 1197 staff, 585 among them could be deployed within 72 hours notice and 612 could be deployed afterwards within 7 days.

The number of staff deployable within 72 varies greatly between GHC partners

- 5 operational GHC partners could not deploy any staff within 72 hours
- 4 operational GHC partners could deploy between 1 and 5 staff within 72 hours
- 3 operational GHC partners could deploy between 6 and 10 staff within 72 hours
- 6 operational GHC partners could deploy between 11 and 25 staff within 72 hours
- 5 operational GHC partners could deploy more than 25 staff within 72 hours; CDC and IMC could deploy 271 and 100 staff within 72 hours respectively

The number of staff deployable within 7 days also varies greatly between GHC partners

- 1 operational GHC partners could not deploy any staff within 7 days
- 4 operational GHC partners could deploy between 1 and 5 staff within 7 days
- 3 operational GHC partners could deploy between 6 and 10 staff within 7 days
- 6 operational GHC partners could deploy between 11 and 25 staff within 7 days
- 9 operational GHC partners could deploy more than 25 staff within 7 days; the CDC and IMC could deploy up to 370 staff within 7 days

### 6.7.2.2 Number of staff available on standby by specialty

The Operational GHC Partners indicated that they have a standby capacity of 1197 staff from different backgrounds and different competencies distributed as follows:

- Medical Doctors (203)
- Reproductive health specialists (44)
- Public health specialists (182)
- Epidemiologists (125)
- Mental health specialists (27)
- Needs assessment specialists (102)
- Nurses and midwives (121)
- Nutritionists (44)
- Logisticians (83)
- Other specialities (266)

### 6.8. Logistical Capacities

#### 6.8.1. Kits prepositioned and available to GHC partners

The GHC capacity survey questionnaire included a section on logistic capacities available to the GHC partners. As stated above, the human resources available to support GHC partners’ operations in terms of logistics include 83 logisticians who could deploy within 7 days, among them 45 who could deploy within 72 hours from the onset of an emergency.

With regards to the supplies available to the GHC partners, and which could be deployed in support of an eventual large scale emergency:
- **Interagency Emerg. Health Kits (IEHK):** 48 kits are available to GHC partners and ready to be deployed in case of need, 42 kits are available within 1 week, 5 before the 3rd week and 1 after 3 weeks.

- **Trauma kits:** 22 kits are ready to be deployed in case of need, 12 are available within 1 week, 10 before the 3rd week.

- **Reproductive Health Kits:** 49 kits are ready to be deployed in case of need, 34 kits are available within 1 week, 14 kits before the 3rd weeks and 1 kit after 3 weeks.

- **Diarrhoal Diseases kits:** 58 kits are ready to be deployed in case of need, 45 kits are available within 1 week, 13 kits available after the 3rd week.

6.8.2. **Logistical hubs used by GHC partners**

![Logistical hubs map]

- **Global Health Cluster - Emergency stockpiles**

  - Dubai, Egypt, USA
  - Dubai, Netherlands, Kuala Lumpur, Subang, Netherlands
  - Dubai, Copenhagen, Brindisi, Dubai
  - Panama, Nairobi, Netherlands, Solomon Islands, Panama
  - Shanghai, Accra, Pretoria

7. **Recommendations**