Health cluster strategic response planning
Chapter 11
Health cluster strategic response planning 358

11.1 Introduction 358
11.2 The importance of strategic response planning 358
11.3 Strategic response planning process 359

11.4 Development of a flash appeal and role of health cluster coordinator 361
   11.4.1 Flash appeal: definition and purpose 361
   11.4.2 Role of the health cluster coordinator in development of a flash appeal 362
   11.4.3 Key actions of health cluster coordinator 362

11.5 What is a humanitarian response plan and when is one developed? 363
   11.5.1 Country strategy: part 1 of the humanitarian response plan 365
   11.5.2 Health cluster response plan: part 2 of the humanitarian response plan 367

11.6 Steps for developing the health cluster response plan 369
   11.6.1 Ensuring a consultative process in developing a health cluster response plan 369
   11.6.2 Ensuring inter-cluster coordination to support an effective multi-cluster approach for better health outcomes 371
   11.6.3 Defining the health cluster response plan 371
   11.6.4 Costing of the health cluster response 381
   11.6.5 Drafting the health cluster response plan 382

11.7 Coordinated project development: projects for inclusion in the health cluster response plan 382
   11.7.1 Tasks of health cluster coordinators 382
   11.7.2 Tasks of health cluster partners 385

References 386
Endnotes 388

Boxes
Box 11.1 Determining number of people in need across all sectors 366
Box 11.2 Comparison of country strategy and health cluster response plan 368
Box 11.3 Main features of the health cluster response plan 369
Box 11.4 OCHA humanitarian indicator registry 373
Box 11.5 Key definitions when determining humanitarian caseloads 374
Box 11.6 Considering environmental concerns 378
Box 11.7 Considering capacity-building issues 380
Box 11.8 Health cluster peer review of partner project proposals 384

Figures
Figure 11.1 Strategic planning within the Humanitarian Programme Cycle 364

Tables
Table 11.1 Steps in strategic response plan 360
Abbreviations

3W/4W  
who, what, where (and when)

HC  
humanitarian coordinator

HPC  
Humanitarian Programme Cycle

NGO  
nongovernmental organization

OCHA  
United Nations Office for the Coordination of Humanitarian Affairs

RC  
resident coordinator

WASH  
water, sanitation and hygiene

WHO  
World Health Organization
11. Health cluster strategic response planning

11.1 Introduction

This chapter provides an overview of strategic response planning in a humanitarian situation. It addresses the flash appeal (what it is, when it is used and health cluster engagement in its development). It then outlines the process of development of the humanitarian response plan and the health cluster response plan and illustrates the linkages between those plans. The chapter also outlines the respective responsibilities of the health cluster coordinators and health cluster partners in all the processes.

11.2 The importance of strategic response planning

Planning aims to ensure an evidence-based, resource-effective and results-oriented collective response to which clusters and organizations contribute.

Strategic response planning helps the humanitarian community to identify and respond more effectively to the needs of the people affected by a crisis, focusing activities and resources to ensure that organizations are working towards common goals. Strategic response planning also helps in assessing the humanitarian community’s response and adjusting it to a changing environment and emerging needs.

Strategic response planning involves:

- assessing the situation and needs (covered in other chapters);
- setting strategic objectives;
- developing an approach to achieve those objectives;
- prioritization of possible actions, including making the tough decisions about what is critical given limited resources;
- making sure roles and responsibilities are clear.

The development of a strategic response plan is a key step in the Humanitarian Programme Cycle and should be carried out only when needs have been
understood and analysed through the humanitarian needs overview or other joint needs assessment and analysis processes (such as the multi-cluster/sector initial rapid assessment, the multi-cluster needs assessment, or health-specific assessments) (1).

At both the analysis and planning stages, the commitments made at the World Humanitarian Summit, as expressed in the Grand Bargain (2), are emphasized, including the following:

- comprehensive, cross-sectoral assessment of needs;
- risk and vulnerability analysis (including analysis of the status of gender-based violence and sexual exploitation and abuse);
- adoption of a people-centred approach, including mainstreaming accountability to affected populations, protection and diversity in the health cluster;
- integration of people’s voices and taking account of their priorities;
- localization of the response;
- use of the risk and vulnerability analysis for consideration of response options;
- ensuring that identification and prioritization of responses is aligned with needs;
- systematic consideration of options for cash transfer programmes and other response modalities.

11.3 Strategic response planning process

The strategic response plan is jointly developed by subnational, national and international stakeholders, including representatives of affected persons. The steps outlined in Table 11.1 are recommended (3).
Table 11.1 Steps in strategic response plan

<table>
<thead>
<tr>
<th>1. CONSOLIDATION OF HEALTH DATA AND INFORMATION</th>
<th>2. STRATEGIC RESPONSE PLAN WORKSHOP</th>
<th>3. INTRA-CLUSTER WORKING SESSIONS</th>
<th>4. USING THE STRATEGIC RESPONSE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree on the scope and focus of the analysis:</td>
<td>The HC, with the humanitarian country team, convenes a meeting to:</td>
<td>Health cluster coordinators, together with cluster members, formulate cluster response plans based on the country strategy.</td>
<td>The strategic objectives, activities and indicators formulated in the strategic response plan are used to:</td>
</tr>
<tr>
<td>• develop a joint analytical framework and plan</td>
<td>Develop a top-line country strategy that includes:</td>
<td>• identify cluster objectives required to achieve the humanitarian response plan strategic and specific objectives and associated indicators</td>
<td>• inform the development of the joint response monitoring framework</td>
</tr>
<tr>
<td>• identify the data, indicators, and other information required as well as the sources</td>
<td>• parameters, boundaries and assumptions of the response</td>
<td>• upload and vet projects</td>
<td>• inform the development of individual agency programmes.</td>
</tr>
<tr>
<td>• define and agree on the roles and responsibilities of agencies, clusters and sectors.</td>
<td>• strategic objectives, activities and indicators and monitoring requirements.</td>
<td>• estimate the cost of the health response</td>
<td>The HC and humanitarian country team share the country strategy, as appropriate, with relevant stakeholders.</td>
</tr>
<tr>
<td>Review and analyse data and information, and identify gaps:</td>
<td>Select priority humanitarian consequences to address and decide on the most appropriate costing methodology for the humanitarian response plan.</td>
<td>• write the health response plan.</td>
<td></td>
</tr>
<tr>
<td>• review existing data, indicators and other information related to selected population groups, geographical areas and thematic issues</td>
<td>Relevant clusters work together to agree on how to collaborate in designing an effective and integrated approach to each of the strategic objectives.</td>
<td>These plans should either be developed at a working session or through regular consultations at cluster and inter-cluster level.</td>
<td></td>
</tr>
<tr>
<td>• identify critical gaps in data and indicators, and determine how to bridge the gaps</td>
<td>• conduct joint intersectoral analysis of relevant available data, indicators and other information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• write the draft analysis results.</td>
<td>• write the draft analysis results.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Response analysis | Country strategy | Cluster response plans | Monitored and updated humanitarian response

Health cluster strategic response planning

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>11.1</th>
<th>11.2</th>
<th>11.3</th>
<th>11.4</th>
<th>11.5</th>
<th>11.6</th>
<th>11.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Box</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Figure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Table</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11.4 Development of a flash appeal and role of health cluster coordinator

11.4.1 Flash appeal: definition and purpose

A flash appeal is a concise top-line analysis of the scope and severity of a sudden onset humanitarian crisis (4). It sets out priority actions and preliminary requirements for the response across all clusters and sectors for up to three months, and is used for fundraising purposes.

When is a flash appeal used? A flash appeal is issued three to five days after a sudden onset or emergency, or when the HC and humanitarian country team determine a spike in need or a change in context in protracted or slow onset crises.

Who triggers a flash appeal? The HC or resident coordinator (RC) triggers the flash appeal process in consultation with the humanitarian country team. Aspects of the process include the following.

- Government approval should be sought through all means, and government participation should be encouraged (5). However, government approval is not formally required for a flash appeal to proceed.
- The humanitarian country team establishes the strategic objectives for the plan.
- Cluster and sector leads compile response activity overviews in consultation with partners and the affected population.
- The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) compiles and disseminates the document.

The flash appeal (planning tool) and application to the Central Emergency Response Fund (as the funding mechanism) are developed simultaneously and are part of the same process.1

Flash appeal resource requirements will be absorbed into the humanitarian response plan when it is developed, within 30 days of the flash appeal (6).
11.4.2 Role of the health cluster coordinator in development of a flash appeal

The HC leads the planning process for a flash appeal and, together with the humanitarian country team, sets out the direction and priorities for the response.

Health cluster coordinators have a responsibility to:

- contribute to the development of the flash appeal, providing inputs to the needs and response analysis and formulation of the overarching strategic objectives for the whole humanitarian response;
- identify priority health needs and priority health cluster interventions;
- provide an estimated figure for the overall cost of the immediate response for the health cluster;
- brief the head of the World Health Organization (WHO) country office on health cluster analysis and priority needs and health cluster interventions, as the head of the WHO country office will also represent the health cluster in humanitarian country team meetings.

11.4.3 Key actions of health cluster coordinator

- The health cluster coordinator should determine the cluster priorities and financial requirements through a consultative process within the health cluster, engaging with the ministry of health, partners and other stakeholders. Consultations should also be carried out with the strategic advisory group where one exists, or with key health cluster partners, along with the local health authorities and other health stakeholders (where the strategic advisory group is not in existence).
- An health cluster meeting should be called urgently to negotiate and agree on health cluster partners’ respective responsibilities for implementation of the emergency health response in the initial stages. Such discussions may need to take place online if it is not feasible to bring all partners together within the time constraints. This allocation of responsibility should take into consideration the operational capacity, experience and geographical presence of the various partners in emergency health response and with reference to the health cluster emergency preparedness and contingency plan, as appropriate.
  - The process of mapping of partner activities needs to commence at this stage using the 3W/4W – who, what, where (and when) – matrix, and needs to be updated regularly.²

² Health cluster strategic response planning

<table>
<thead>
<tr>
<th>Paragraph</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>11.2</td>
<td>11.3</td>
<td>11.4</td>
<td>11.5</td>
<td>11.6</td>
<td>11.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Box</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.1</td>
<td>11.2</td>
<td>11.3</td>
<td>11.4</td>
<td>11.5</td>
<td>11.6</td>
<td>11.7</td>
<td>11.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Figure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Table</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• A short health cluster response plan should be drafted articulating health cluster priorities (within the confines of the broader flash appeal) and building on the health cluster emergency preparedness and contingency plan, as appropriate (for example, where a health cluster emergency preparedness and contingency plan exists for the type of crisis that has occurred). Where an emergency preparedness and contingency plan does not exist, the health cluster response plan should be drafted based on the initial contextual analysis.

Where a health cluster has not been activated, the health sector and relevant health agencies will provide input to the flash appeal process and development of an emergency health response plan, using the process outlined above. WHO as the cluster lead agency for health will generally take responsibility for the coordination functions in collaboration with the local health authorities. However, in exceptional circumstances it may be another organization that takes on the cluster lead agency role.3

11.5 What is a humanitarian response plan and when is one developed?

The humanitarian response plan is the management tool for country-based decision-makers, primarily the HC and humanitarian country team, but also for use by United Nations agencies and nongovernmental organization (NGO) directors, managers and cluster coordinators. Its purpose is to support an effective and strategic response, based on solid analysis of the humanitarian needs and concerns of the affected population.

A humanitarian response plan is prepared for sudden onset or protracted emergency situations that require international humanitarian assistance based on a humanitarian needs overview. The plan articulates the shared vision of how all clusters will respond to the assessed and expressed needs of the affected population.

In a sudden onset crisis or where there is a rapid escalation in a protracted crisis, and where a flash appeal has been issued, a humanitarian response plan will normally be produced within 30 days of issuance of the flash appeal, building on the initial planning undertaken.

In a protracted crisis many humanitarian country teams develop humanitarian response plans on an annual basis, usually in the last quarter of the calendar year for the following calendar year. However, the planning time frame is flexible and may start at any point during the year, as determined by the HC and the humanitarian country team.
Alternatively, countries may use a multi-year planning process, as promoted by the Grand Bargain (2). The decision to use a multi-year planning time frame is made by the humanitarian country team taking into consideration such factors as the degree of political stability, the likelihood that humanitarian needs continue to exist in the years covered by the plan, the possibility of preparedness and resilience actions, and whether sufficient monitoring methods are in place. Another consideration is the availability of relevant data, including sufficient information on crop cycles, livelihood and market analyses, an iterative contingency planning process, and trends in national capacity (1). The humanitarian country team will often look at the potential availability of multi-year funding and other sources of funding to bridge the humanitarian–development divide.

Figure 11.1 presents stages in the strategic planning process within the Humanitarian Programme Cycle.

**Figure 11.1 Strategic planning within the Humanitarian Programme Cycle**
The humanitarian response plan has two distinct but interlinked parts:

- a country strategy with a narrative, strategic objectives and identified indicators to monitor the achievement of strategic and specific objectives as well as the response approach and modalities;

- cluster plans with cluster objectives required to achieve the humanitarian response plan strategic and specific objectives and associated indicators, and estimation of the response cost.

11.5.1 Country strategy: part 1 of the humanitarian response plan

Functions of the country strategy

The country strategy performs the following functions:

- provides an overview of the crisis (contextual analysis);

- establishes the scope and boundaries of the collective humanitarian response (geographical, demographic, sectoral or other measures of vulnerability);

- takes account of needs being addressed by non-humanitarian actors (for example in development programmes);

- establishes intervention criteria (vulnerability analysis, thresholds, crisis factors);

- determines the target population (number, type, population groups and location of people to be assisted, which may be broken down by cluster);

- examines cross-cutting opportunities and incorporates inter-cluster collaboration on targeting and response, where appropriate;

- establishes the parameters of the response, which may be time-bound (for example, now versus later), geographical (for example, west versus east), or seasonal (for example, summer versus winter);

- gives due visibility to accountability to affected populations, protection, diversity (cross-cutting aspects such as age, disability, gender, HIV, mental health), the environment and other issues of relevance to the context;

- incorporates the building of resilience;
● sets overall strategic objectives governed by the needs and priorities outlined in the humanitarian needs overview;

● articulates activities, indicators, baselines and targets for each strategic objective;

● articulates prioritization criteria to be applied, including immediate lifesaving (actions that avert or mitigate direct loss of life or harm to a population), time-critical lifesaving (such as vaccination ahead of epidemics), critically enabling actions (such as logistics, air transport of aid personnel), cost-efficiency, capacity-building, or others as determined by the context;

● explains how the humanitarian community intends to fulfil those objectives.

Box 11.1 presents information on determining the number of people in need across all sectors.

**Box 11.1 Determining number of people in need across all sectors**

People in need include those whose well-being and living standards are threatened or disrupted, and who cannot re-establish their normal living conditions with their accustomed means in a timely manner without additional assistance. More specifically, people in need are those who suffer from the humanitarian consequences identified during the joint intersectoral analysis. The estimation of the number of people in need should be disaggregated by relevant population groups, subgroups and geographical areas.

OCHA has the responsibility to facilitate a consultative process to determine the number of people affected by an emergency and break down the data by age and gender across all sectors. OCHA may establish a working group (composed of representatives from some of the clusters and key experts) to carry out this process, which involves liaising with relevant government departments and civil societies in the country, reviewing recent census and other relevant studies and assessments, and calculating population projections based on national standards. The various cluster caseloads should then be developed based on the overarching planning figures.

**Development of the country strategy for the humanitarian response plan**

Based on the humanitarian needs overview, the country strategy is formulated by the HC and the humanitarian country team in consultation with government, civil society and cluster coordinators and partners.

Often this process is initiated with a consultation workshop with the participation of government, civil society, humanitarian organizations and cluster coordinators. The response analysis will be reviewed and a top-line country strategy developed, outlining boundaries, priorities, and assumptions, and agreeing on strategic objectives.
Health cluster coordinators play a key role in the development of the country strategy. Their responsibilities include:

- representing the health cluster at the inter-cluster coordination group and bilaterally with other key clusters;
- providing inputs to (a) reaching agreement on the scope and focus of the analysis, (b) review and analysis of data and information and identification of gaps, (c) review and approval of the analysis results and monitoring requirements, (d) selection of priority humanitarian consequences to address, (e) analysis of response options and formulation of strategic objectives, and (f) review and approval of the strategic objectives and monitoring requirements;
- reviewing the overall strategic response plan as it is being developed;
- collaborating with other clusters and humanitarian actors to ensure a holistic approach to achieving strategic objectives;
- reviewing guidance, adapting templates and agreeing on time frames for the development of the cluster response plans;
- keeping health cluster partners updated, informed and engaged throughout the process of development of the humanitarian response plan;
- briefing the head of the WHO country office on the health cluster position and priorities, as the head of the WHO country office represents the health cluster in humanitarian country team discussions on the country strategy;
- formulating the activities and estimating the cost of the response plan.

11.5.2 Health cluster response plan: part 2 of the humanitarian response plan

The health cluster response plan is one of the sector-specific response plans that make up part 2 of the humanitarian response plan. The health cluster response plan is:

- the principal tool to facilitate a strategic and coordinated emergency health response;
- the framework for the collective response of all health cluster partners.

The health cluster response plan is developed within and aligned with the wider humanitarian response plan for the whole humanitarian response (Boxes 11.2 and 11.3).
The health cluster response plan will be prepared after the country strategy is developed and will be guided by and aligned with the country strategy. However, this is not a completely linear, sequential process. Health analysis will be incorporated into the country strategy, and development of the health cluster response plan is likely to start as the country strategy is being drafted; thus, the processes may overlap.

**Box 11.2 Comparison of country strategy and health cluster response plan**

<table>
<thead>
<tr>
<th>Country strategy</th>
<th>Health cluster response plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>The country strategy:</td>
<td>The development of the health cluster response plan is led by the health cluster coordinator based on the country strategy and humanitarian needs overview, and additional supporting health information.</td>
</tr>
<tr>
<td>• is formulated by the HC and humanitarian country team based on analysis of the humanitarian needs overview and through a consultative process with government, civil society and cluster coordinators;</td>
<td>The plan is developed through a consultative process, ensuring active engagement of health cluster partners, health authorities and other key clusters, including food security, nutrition, protection, and water, sanitation and hygiene (WASH).</td>
</tr>
<tr>
<td>• ensures there is consensus on prioritized needs;</td>
<td>The public health situation analysis is the foundation of the health cluster response plan.</td>
</tr>
<tr>
<td>• guides development of cluster plans.</td>
<td></td>
</tr>
</tbody>
</table>

The humanitarian needs overview is the foundation of the humanitarian response plan.
Box 11.3 Main features of the health cluster response plan

The health cluster response plan:
• defines health cluster prioritization criteria and health cluster priorities;
• defines health cluster objectives and key activities;
• defines health cluster caseloads (number of affected people in need, including number targeted by the health cluster);
• outlines health cluster coordination mechanisms at national, subnational, and field levels;
• defines health cluster indicators;
• determines the total cost for implementation of the plan;
• defines health cluster operational modalities;
• outlines innovative programming;
• describes coordination with key clusters for better health outcomes;
• ensures protection mainstreaming;
• addresses accountability to affected populations;
• addresses cross-cutting issues;
• addresses environmental issues;
• promotes standards, with a focus on quality of care;
• outlines health cluster capacity-building strategies and key activities;
• links the emergency health response to early recovery and promotes the humanitarian–development nexus;
• outlines the transition and deactivation strategy and actions.

11.6 Steps for developing the health cluster response plan

11.6.1 Ensuring a consultative process in developing a health cluster response plan

The health cluster response plan will be developed by the cluster as a collective effort by the cluster coordinator and health partners.

The health cluster coordinator is responsible for facilitating the active engagement of international and national health partners and relevant subnational health authorities in the development of the response plan through an effective and transparent consultative process.
The health cluster partner actively participates in this consultative process and provides technical input (if part of an existing strategic advisory group).

Health cluster consultation may be conducted through a variety of optional mechanisms.

- Where a strategic advisory group is in existence, it should provide direction and guidance on the priorities, objectives and operational modalities for the health cluster response plan.

- A small technical working group may be established to engage in the development of the health cluster response plan. The membership of this group may include members of the strategic advisory group (where in existence), core health cluster partners, and representatives from the national and local health authorities. It is important that those selected for this technical working group have the relevant skills, expertise and capacity to undertake this important task.

- Alternatively, a workshop or series of workshops may be held to develop the plan with participation of health cluster partners and the national and local health authorities, thus ensuring broad input and facilitating consensus.

Tips for engaging partners in the health cluster response plan are as follows.

✓ Where the health cluster response plan is developed through the strategic advisory group or a technical working group, it is essential that the health cluster partners be regularly updated on the steps, process and key health needs identified in the public health situation analysis and content of the plan through routine or ad hoc health cluster meetings, in order to obtain wider input and endorsement and to gain consensus.

✓ Consultations should be undertaken with specialized agencies and available focal points to ensure that issues related to accountability to affected populations, gender, protection and diversity are appropriately addressed by the health cluster, including prevention of sexual exploitation and abuse. In a situation where the national or local health authorities are not participating in these processes, the health cluster coordinator has the responsibility to engage with the health authorities, as appropriate and depending on the context; to keep the authorities informed and updated on the planning process; to enable input from the authorities into the plan; and to garner an overall consensus.
11.6.2 Ensuring inter-cluster coordination to support an effective multi-cluster approach for better health outcomes

It is the responsibility of the health cluster coordinators to engage with other key clusters to ensure an effective multi-cluster approach for better health outcomes. This coordination will be through the inter-cluster coordination group (facilitated by OCHA) and through communication with other key clusters of relevance to the health response (food security, nutrition, protection, and WASH), bilaterally or through a thematic coordination mechanism.6

It will be essential to ensure collaboration and coordination with these key clusters in relation to:

- analysis, building on the humanitarian needs overview;7
- defining priority areas geographically (within the scope and boundaries of the humanitarian response plan) and areas of convergence;
- defining the specific strategic and operational linkages with other clusters;8
- defining joint indicators, monitoring processes and responsibilities.

_tip_: It is recommended that representatives of these key clusters be invited to attend relevant health cluster meetings or health cluster workshops when developing the health cluster response plan.9

11.6.3 Defining the health cluster response plan

Through the consultative mechanism described above, it is the responsibility of the health cluster coordinators to facilitate discussion and provide direction to determine the health cluster response plan within the confines of the scope and boundaries of the country strategy of the humanitarian response plan. The following elements should be taken into account during this process.

Health situational analysis

Some of the health analyses will already have been fed into the humanitarian needs overview.10 However, the health cluster may use more detailed, in-depth health analysis for health cluster-specific planning purposes, often elaborated through the public health situation analysis and covering the three domains of health information:11

- health status of and threats facing affected populations
- health resources and services availability
- health system performance.
In the context of health threats, it is important to coordinate with other key clusters (food security, nutrition, protection and WASH) representing key determinants of health to gain an understanding of the capacity of partners, status of infrastructure, available services, and consequent impact on public health.

**Health cluster prioritization criteria**

Health cluster prioritization criteria need to be determined – immediate lifesaving, time-critical lifesaving, critically enabling, or related to the burden of disease. Alternatively, other criteria related to the context may be used, such as programming in inaccessible areas, or programming through implementation by local NGOs. These criteria need to align with the prioritization criteria of the country strategy (see above).

It is necessary to determine the priority geographical areas and priority health concerns to be addressed in relation to the health status of and risks faced by the population, taking into consideration critical gaps in health service provision and performance of health services.

Priority health interventions need to be agreed, based on the analysis and prioritization criteria (see above).

**Health cluster objectives and key activities**

Three to five health cluster objectives need to be defined. Each of the health cluster objectives should directly contribute to at least one of the overarching strategic objectives in the country strategy. Health cluster objectives should be specific, measurable, achievable, realistic and time-bound (“SMART”).

The key activities to be carried out under each health cluster objective should be defined.

**Health cluster indicators**

The health cluster needs to determine the appropriate indicators to monitor the emergency health response. Output and outcome indicators should be prioritized in the humanitarian response plan, as opposed to process indicators (Box 11.4) (7).
Box 11.4 OCHA humanitarian indicator registry

The humanitarian indicator registry is a guidance tool for countries to select indicators and, where possible, seek standard definitions and applications of those indicators. It lists the principal needs and response monitoring indicators for each cluster and provides a unique identifier, similar to a place code (P-code), for every indicator. The registry also offers search, filter and export functions.

The reference indicators may be used to track needs over time and to support monitoring along the programme cycle. They can be used for analysis and reporting and may feature in humanitarian needs overviews, strategic planning and monitoring documents, humanitarian dashboards and bulletins.

**Scope:** The registry is a point of reference for humanitarian country teams and clusters at the country level for indicators that are recommended for monitoring the humanitarian situation, needs and the humanitarian response. The registry does not capture (long-term) impact or input indicators (as many input indicators can feed into one output). There may be some indicators that some global clusters recommend, or other indicators that are only locally appropriate and thus may not be captured in the registry.

*Source:* OCHA indicators registry (7).

**Health cluster caseload**

The *health cluster caseload* is the number of affected people in need of humanitarian health assistance, including the number targeted (by geographical location) by the health cluster.

Using the overall planning figures determined by OCHA as a starting point, the health cluster needs to determine:

- the total number of people in need of health services, and their breakdown by age and sex, for each of the specified health interventions or services;

- the health cluster target caseload, that is, the number of people targeted by the health cluster and breakdown by age and sex for each of the specified health interventions or services that will be provided. It is rare that an emergency health response will cover 100% of the population in need, due to security and access issues. The health cluster should use Sphere standards on coverage to define the desired percentage to be covered by the partners as a collective figure (8).

Box 11.5 presents the key definitions used when determining humanitarian caseloads.
Box 11.5 Key definitions when determining humanitarian caseloads

**Affected people.** Those whose lives have been impacted as a direct result of the crisis. This figure is generally the first available after a sudden onset emergency and often defines the scope or boundary of a needs assessment. It does not, however, necessarily equate to the number of people in need of humanitarian aid. Not all affected people are in need of humanitarian assistance.

**People in need.** Those affected people who require humanitarian assistance in some form. People in need represent a subgroup of affected people. This category is further broken down into subcategories or by sector or cluster to provide additional detail about the intensity, severity or type of need.

**People targeted.** Number of people the humanitarian actors plan or aim to assist. This number is typically smaller than the number of people in need, as (a) it is rare that humanitarian actors can meet all the needs; (b) needs are also being met by those not participating in the joint plan (this may include affected communities, national authorities, the International Red Cross and Red Crescent Movement, and some NGOs); and (c) people in need are not always accessible.

**People reached.** Those who have received some form of assistance. This figure says nothing about how long and how well this assistance covers the needs of beneficiaries. A more meaningful picture is provided by the estimate of people covered (see below).

**People covered.** The number of people whose needs, defined by a humanitarian standard such as Sphere, have been fully met.

There is a significant difference between “people reached” and “people covered”. For example, 1000 people received water (people reached), as opposed to 1000 people received enough water to cover their needs (15 litres per person per day for a certain period of time) (people covered).

*Source: Inter-Agency Standing Committee, Information Management Working Group (9).*

Health cluster operational modalities

Operational modalities to meet these objectives and targets (implementation strategies) need to be determined, for example use of static versus mobile facilities, use of campaigns, community mobilization, or use of local NGOs and community-based organizations.

Programming in access-constrained environments

Increasingly, crisis-affected populations are hard to reach, due to access and security constraints in complex conflict environments (10). The lack of unhindered access to communities with high humanitarian needs can prevent aid agencies from applying their standard operating model (“direct operation”). Consequently, alternative modes of operation must be employed.

The key principle behind programming in such access-constrained environments (hereafter referred to as “remote operation”) is that different types of humanitarian actors experience different levels of risk and restriction in insecure or conflict
settings. This means that a programme can sometimes continue in a low-access setting by removing from the operational area personnel who may face high levels of risk or restriction and replacing them with others who can operate more freely.

Remote operation is a reactive solution to the issue generated by the “humanitarian imperative”. Several scenarios can be envisaged in which such a situation applies. An example would be a situation where international NGOs are implementing programmes through partnerships with national or local NGOs rather than through directly recruited staff. International NGO staff might or might not be able to visit the project locations sporadically. Also, governments or authorities may ban international aid workers or organizations from a country or an area of a country, leaving international organizations with the choice of working through local partners.

Remote operation also describes a number of modalities that can be adopted to ensure the start or continuation of response. In the literature, these are arranged into a spectrum that varies according to the depth of roles and responsibilities of the remote agency and the operating agent. The spectrum is typically divided into four modalities: remote control, remote management, remote support, and remote partnership (10).

**Remote control.** The project is run by remote managers, with little or no delegation of authority to operating agents. This operational model is reactive and may be best suited for short-term, highly inaccessible, and rapid onset projects where there is limited staff capacity on the ground.

**Remote management.** There is some delegation of authority to operating agents and moderate investment in capacity-building, and procedures are in place for better monitoring and quality. This model assumes that remote staff will return to the field and resume decision-making and authority following restoration of access. Such projects are reactive and ideally short term but can be sustained in the medium term. This operational model is considered a contingency during a non-protracted absence of international or senior management staff, with somewhat limited capacity of implementing staff.

**Remote support.** The remote agency shares authority over programming operating agents (delegating authority while retaining some level of overall accountability and oversight), with significant investment in capacity-building and mentoring. This model is proactive and best suited for longer-term programmes, with experienced staff, limited or some access, and the resources to invest significantly in staff development.
Other kinds of remote operations may operate similarly to those described above but are noteworthy due to the involvement of groups other than traditional humanitarian or civil society actors.

- **Community partnerships** can vary in scope, with implementation ranging from full programmes to aid distribution and monitoring. Community organizations have the benefit of being a stable and familiar presence to the local population, resulting in better targeting of beneficiaries, and are usually more resilient to insecurity. This modality develops community ownership but may also be subject to increased risk of aid being selectively delivered to influential community members.

- **Government partnerships** can promote long-term development and may improve security through increased acceptance. However, this modality might contravene humanitarian principles of neutrality, impartiality and independence, which may undermine acceptance within community factions and may further exacerbate conflict.

- **Outsourcing to commercial contractors** is commonly used for specific services such as supply or third-party monitoring. As with interactions with other partners, it is necessary to do background checks to identify affiliations with terrorist or military groups. Moreover, extensive use of private contractors raises questions of accountability, since there is a risk of unofficial arrangements between different service providers who then share their “cut”. Lengthy chains of contracting and subcontracting lead to high administrative costs and make it difficult to determine the extent to which aid is delivered to intended beneficiaries.

**Remote partnership.** A remote partnership is one between a remote (international) organization and a (local) operating agent that already has significant internal capacity. The remote partner finances and supports via technical and managerial advice, administration, capacity-building, and advocacy, while the operating agent focuses on context and operations. This model is proactive and best suited to longer-term programmes where aid agencies have lower risk thresholds, fewer resources or lower organizational capacity within the context of implementation.

Most remote agencies adopt a mix of operational modalities, from working through contracted or incentivized staff to working in partnership with national or local organizations, local communities or private enterprises (10).

The Global Health Cluster has developed practical, step-by-step guidance for health actors involved in programming in access-constrained environments. It covers all phases, from inception through programme design and operation to programme closure or return to direct management (10).
Coordination with key clusters for better health outcomes

Strategic and operational linkages between the health cluster and other key clusters (food security, nutrition, protection and WASH) for the emergency response need to be determined in order to identify the respective responsibilities of each of these clusters, referral mechanisms between the health cluster and these key clusters, and potential areas of joint planning and operations.14

Ensuring protection mainstreaming

Strategies and key actions to ensure protection are mainstreamed and incorporated into the health cluster response plan.15

Addressing accountability to affected populations

Strategies and key actions to ensure accountability to affected populations need to be determined and incorporated into the health cluster response plan (11).16

Addressing cross-cutting issues

Strategies and key actions to ensure core cross-cutting issues (age, disability, gender, mental health and HIV)17 should be determined and incorporated into the health cluster response plan.

Addressing environmental issues

Environmental issues should be considered and, where appropriate, strategies to mitigate environmental impacts incorporated into the health cluster response plan (Box 11.6).
Box 11.6 Considering environmental concerns

The environment is understood as the physical, chemical and biological surroundings in which disaster-affected and local communities live and develop their livelihoods (6).

Key issues in environment and health

Humanitarian operations have a high risk of negatively impacting on the environment, the effects of which may be far reaching and long-lasting, affecting not only the physical environment but also the health, well-being and livelihoods of affected and host communities and increasing the risk for secondary or future disasters (12).

While there are many examples of how humanitarian operations impact the environment, this sentence sums up why humanitarian actors need to ensure that the negative impact on the environment from humanitarian action is minimized.

The impact of environmental degradation on the health of the affected population can be both immediate and long lasting. For example, a sudden high concentration of population in a small area due to displacement from natural disasters can become the source of many environmental health issues and subsequent secondary hazards, including biological and chemical hazards (13). Should this continue, the concentration of population can put further pressure on the environment, which can lead to shortages of food and firewood, thereby having a negative impact on the nutritional status of the affected population. Research also shows that deforestation due to lack of means for collecting firewood can lead to increased vulnerability to gender-based violence, especially among those who are primarily collectors of firewood. Inadequate levels of water and poor sanitation conditions can lead to further pollution of sources of water, including rivers and groundwater reservoirs. This will create a vicious cycle of deterioration in human health due to unsafe water consumption and further pollution of water sources.

Strategies and areas to incorporate environmental considerations into the health cluster response strategy

Factors for incorporating environmental considerations into the health cluster response strategy include the following:

• engage in advocacy with local authorities, other clusters and OCHA to ensure that environmental impacts are considered when planning the location of services;
• in conjunction with specialists from other sectors, ensure safe collection and disposal of health care waste, particularly from hospitals and mobile clinics, and safe transport of biological samples (12);
• ensure strong collaboration with other clusters, especially WASH and nutrition, so that appropriate actions are taken in line with the strategies for limiting negative environmental impacts.

The environment marker (14), developed by the United Nations Environment Programme, can provide guidance on how to incorporate environmental considerations into the health cluster strategy. This marker, although not as rigorously mandated by donors and other humanitarian actors as the gender marker (for example), does provide general means to evaluate health cluster strategies to assess their adherence to addressing environmental issues that could arise from health cluster activities.
Promoting standards

Relevant national technical standards or international standards (where national standards do not exist) to be adhered to should be listed in the plan. International technical standards include Sphere and WHO guidelines (8, 15).

Health cluster capacity-building

The health cluster needs to determine capacity-building needs and incorporate strategies to address capacity-building to enable an effective emergency health response (Box 11.7).
Box 11.7 Considering capacity-building issues

Capacity-building in this context refers to building the capacity needed to respond in a crisis situation, and not the overall capacity-building of the health sector. Capacity-building needs to occur largely in two areas:

- coordination
- technical areas of work.

*Health cluster coordinators have a key proactive role to play in building capacity and skills in the area of coordination.*

A simple analysis of coordination capacity at national and subnational levels should be conducted to determine the levels of coordination capacity and the understanding of the cluster approach. Based on the analysis of coordination capacity, strategies to build additional capacity would include:

- training and orientation on key concepts of coordination for national and subnational authorities and health cluster partners;
- supporting the national and subnational health authorities in establishment of coordination structures, where not already existing.

*Health cluster coordinators also have an important role to play in facilitating capacity-building in technical areas.*

Through analysis of health resources, service availability and health service performance, critical gaps in health service provision may be identified, and areas where the quality of emergency health services is not of the required standard may be determined.

Having identified the gaps in the quality of services, the health cluster should develop a capacity-building plan or strategy to strengthen the emergency health response. This would include building human resource capacity for assessment and service provision.

Strategies would include:

- identification of technical resources and ensuring wide dissemination in the country;
- working with relevant technical units and agencies to adapt relevant guidelines on specific health issues to country requirements (standards section);
- supporting provision of training for relevant personnel on specific technical areas;
- encouraging relevant agencies with expertise to provide training and technical support in relevant areas (for example, outbreaks, setting up temporary facilities, mass immunization campaigns, international humanitarian law, and protection from sexual exploitation and abuse);
- mobilizing resources to support technical trainings;
- facilitating mentoring of small, local NGOs through partnering with more experienced agencies to transfer first-hand knowledge from expert to less expert partners and organizing cross-project learning visits.

*Health cluster partners have an important role to play in capacity-building,* for example by taking on aspects of training in their areas of expertise (technical and coordination) and mentoring small, local NGOs.
Linking emergency health response to the humanitarian–development–peace nexus

Early recovery approaches can and should be integrated into humanitarian programming to create connections with, and avoid obstacles to, longer-term health system strengthening. This will contribute to the process of “building back better” and increasing the resilience of communities and the health system.

Early recovery begins in a humanitarian setting, and early recovery activities should not wait for formal, large-scale reconstruction and development programmes. Thus, early recovery needs to be considered at the beginning of an emergency response, while strategies and activities to enhance early recovery and resilience need to be incorporated in the health cluster response plan from the outset (16).

Transition and deactivation

Linked to early recovery and resilience, transition and deactivation of the health cluster also need to be considered from the establishment of the health cluster, and strategies to enhance effective transition and deactivation of emergency health coordination functions need to be incorporated in the health cluster response plan from the outset.

Health cluster coordination mechanisms

The health cluster needs to determine the required emergency coordination needs and agree on the structure, governance and approach to ensure that appropriate coordination functions will be maintained at national and subnational levels and incorporated into the health cluster response plan.19

11.6.4 Costing of the health cluster response

The total cost of the emergency health response, reflecting all planned humanitarian activities needed to fulfil the health cluster objectives, needs to be determined (17). There are three options.

- **Project-based costing.** This primarily involves summing the funding requirements for projects submitted by different agencies. Project budgets are either based on standard United Nations or NGO cost categories or are based on activities, outputs or outcomes developed by clusters. Sectors and clusters ensure costs are appropriate and are aligned with activities and outcomes

- **Unit-based costing.** This method identifies a unit cost “driver”, which could be an activity, an outcome or a standard service being delivered at a certain cost. The
unit cost driver in the humanitarian response plan budget is the unit cost that best explains the activity, service or outcome.

- **Hybrid method.** This method applies a combination of both the methodologies described above. It establishes financial requirements using unit-based costing and follows with detailed project planning at a later stage to provide more detail to the initial calculations or to give visibility to participating organizations.

**11.6.5 Drafting the health cluster response plan**

Having facilitated a consultative process to determine the health cluster response, it is the responsibility of the health cluster coordinators to draft a comprehensive health cluster response plan, reflecting what has been agreed upon along with the cost.

The health cluster response plan will be the overarching guiding document for all health cluster partners and the framework for the collective response of all health partners. A workplan also needs to be developed within the response plan outlining the key activities to be carried out and the time frame for implementation.

The complete version of the health cluster plan should be a detailed document for use by the health cluster partners in planning, implementation and monitoring of the health cluster response, providing additional information for partners on the health cluster vision priorities, operational modalities, strategies and approaches. A shorter version of the health cluster response plan will be submitted to OCHA, to be incorporated into the humanitarian response plan. OCHA at country level will provide the format for the cluster plans for the humanitarian response plan.

**11.7 Coordinated project development: projects for inclusion in the health cluster response plan**

Coordinated health project development takes place after the health cluster has determined the cluster objectives and key activities, indicators, boundaries and scope of the emergency health response (18).

**11.7.1 Tasks of health cluster coordinators**

Health cluster coordinators have a responsibility to undertake the following tasks.

- *Ensure partners’ involvement in drafting the health cluster response plan.*
• **Share the draft with all partners.** The partners will then be asked to submit project proposals (a template will be provided) for inclusion in the health cluster response plan.

 ✓ **Tip:** Time is always crucial during the process of development of cluster plans and partner projects for the humanitarian response plan. Therefore, health cluster coordinators need to proactively work to obtain agreement on the overall health strategy and to share project development guidance with partners in a timely manner, in order to ensure that partners have as much time as possible to prepare and submit well designed projects.

• **Gain agreement among health cluster partners on the geographical and technical areas of responsibility for each partner.** It is important to consider and map the activities of those humanitarian agencies that do not register planned actions on the Humanitarian Programme Cycle (HPC) project module to avoid duplication (19). Government health projects supported by NGOs may be included in the plan. While not included in the response plan, it is also important to map the activities of operational government health projects to ensure that service coverage is comprehensive.

• **Establish criteria for the selection and classification of projects with guidance from the HC and humanitarian country team.** Input can also be sought from the health cluster strategic advisory group, as required (for example, with regard to priority geographical areas and interventions, health issues of particular concern, operational and technical capacity and approach of partners, and targeting vulnerable groups, such as elderly people, children, persons with disabilities, pregnant and lactating women, people with chronic diseases, and people with injuries).

• **Provide guidance and support on development of projects.** Guidance may be provided through (for example) health cluster partner workshops or one-to-one mentoring from the health cluster coordination team. National NGOs need more time and guidance from the health cluster coordinator, particularly if they are new to the process. Options for mentorship from more experienced NGOs should be explored.

• **Establish a peer review group to vet partner proposals submitted for inclusion in the health cluster response plan or humanitarian response plan.** This group may consist of strategic advisory group members. Proposals that are in line with the health cluster response plan (strategic aspects) and of a satisfactory technical quality will then be endorsed for inclusion in the health cluster response plan. There may be a need for a process of discussion, negotiation and clarification with some of the partners and for partners to adjust and amend proposals prior to endorsement for inclusion in the humanitarian response plan (Box 11.8).
Box 11.8 Health cluster peer review of partner project proposals

A health cluster peer review should be performed of partner project proposals submitted for inclusion in the health cluster response plan or humanitarian response plan. A peer review group should be established through a transparent consultative process within the health cluster, ensuring representation from United Nations agencies and national and international NGOs, and government where possible.

Some members of the peer review group should be knowledgeable of humanitarian operations and the health cluster strategy and priorities (the “big picture”). It would be appropriate to use members of the strategic advisory group for this function (where such a group exists). Other members of the peer review group should be experts in the various technical aspects of emergency health programming. OCHA could attend as an observer during the peer review of proposals to ensure that the vetting process is in line with the country strategy.

The peer review group will vet the submitted proposals considering both strategic and technical aspects to ensure that:

• proposals are in line with the health cluster plan and country strategy (strategic aspects);
• proposals are of adequate technical standard;
• there is no duplication or overlap between the various projects.

Strategic aspects include:

• strategic relevance
• programmatic relevance
• cost-effectiveness
• management and monitoring
• engagement with coordination mechanisms.

Technical aspects include:

• technical merit and demonstrated technical knowledge of emergency health programming
• appropriateness of budget provisions.

A scoring table may be used to assist the peer review group to assess the proposal against the criteria outlined.

✔ Tip: Where government health authorities are not represented on a peer review group, it will be important for the health cluster coordinator to proactively engage with the health authorities during this process, keeping the health authorities updated and enabling them to contribute to the discussion on selection of agencies.
11.7.2 Tasks of health cluster partners

Health cluster partners are required to undertake the following tasks.

- *Design projects based on assessed needs and analysis, response boundaries and scope, and health cluster objectives, priority interventions and approaches.* Each health cluster project proposal will outline proposed geographical areas of intervention, health cluster objectives that the project will contribute to, proposed activities, targets and monitoring indicators, and a clear breakdown of costs. Each health cluster project proposal will be required (by the humanitarian country team) to include a gender marker, and possibly also age and environmental markers, as determined at country level (20, 21).

- *Upload completed project proposals onto the HPC project module and then update amended proposals.*
References


Key reference materials


Endnotes

1. See Chapter 13 on resource mobilization.
2. The full scope of the minimum Public Health Information Services standards is explained in more detail in Chapter 4.
4. For a definition of people in need, see the Step-by-step practical guide for humanitarian needs overviews (page 19) (3).
5. See Chapter 10 on needs assessment.
6. See Chapter 8 on integrated programming.
7. See Chapter 10 on needs assessment.
8. See section 2.6 (on inter-cluster coordination) of Chapter 2, and Chapter 8.
9. See Chapters 2 and 8.
10. See Chapter 10.
11. See Chapter 4.
12. See IASC Global Health Cluster indicator list (https://ir.hpc.tools/) Also, please refer to the humanitarian indicator registry, which lists standardized generic indicators for accountability to affected populations and standardized health indicators (7). Further guidance on monitoring is provided in Chapter 12.
13. Refer also to Box 11.1.
14. See Chapters 2 and 8.
15. See Chapter 5.
18. See section 2.10.4 in Chapter 2.
19. See Chapters 2 and 3.