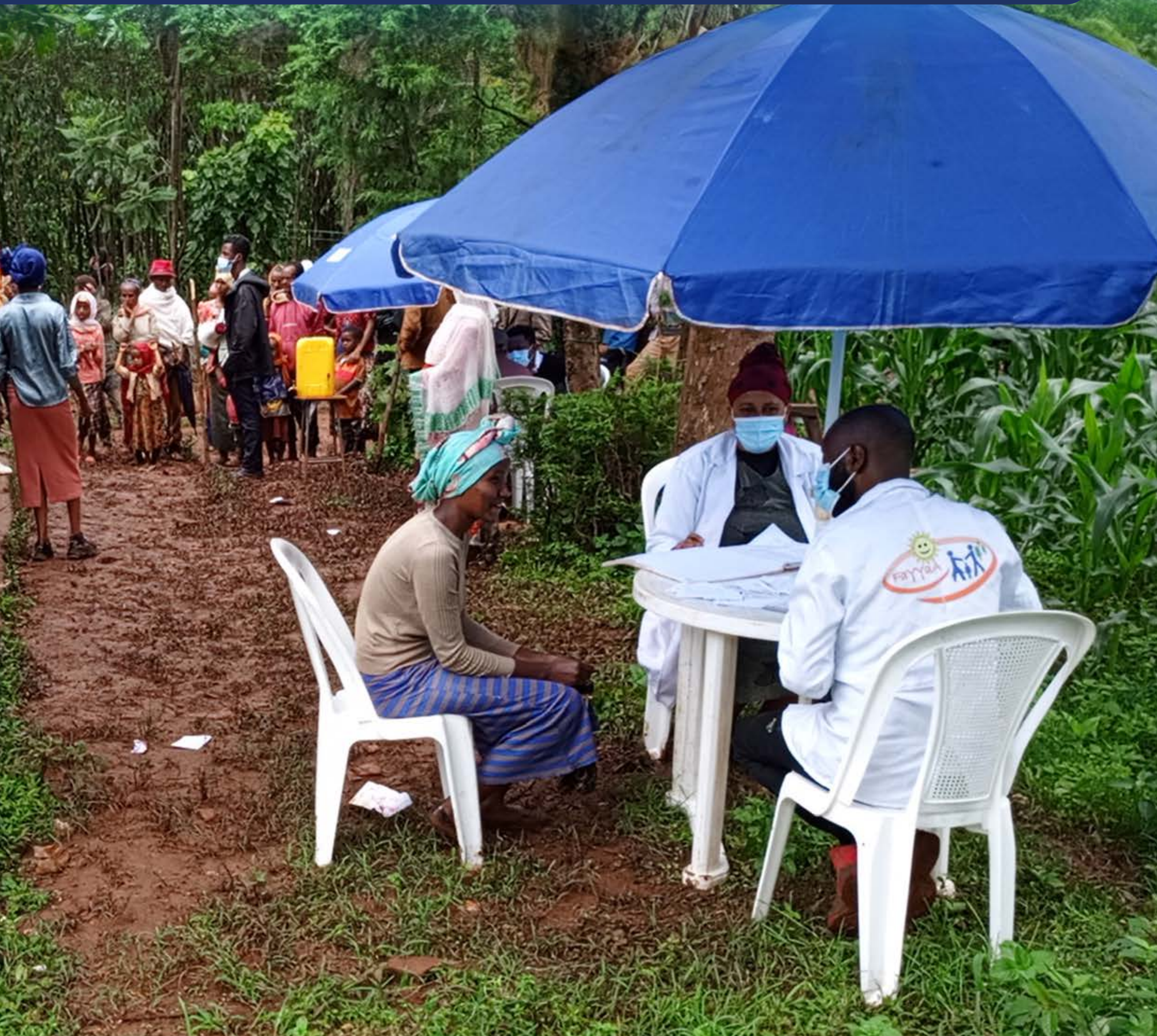
Mobile Clinic Component of the H3 Package

Mobile Clinic as a Service Delivery Platform in the H3 Package



Save the Children

HEALTH CLUSTER

Contents

Acronyms 3

Acknowledgments 4

1 Background 6

2 Objective 7

3 Process and Methodology 8

4 Key outputs and timeline 10

5 Planning assumptions for the Mobile Clinic Component of the H3 Package 11

- Definitions 11
- Context and Rationale 11
- Operational Characteristics 11
- Key considerations for inclusion or exclusion of H3 actions in the Mobile Clinic package 15

6 Annexes 17

- Annex 1: Topline Terms of Reference for Mobile Clinic Human Resources 17
- Annex 2: Cylinder sizes common in health facilities 18
- Annex 3: H3 criteria for core and extended services 18

7 References 20

Acronyms

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
BHA	Bureau for Humanitarian Assistance
CHW	Community Health Worker
EMT	Emergency Medical Team
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunization
FIDO	Fayyaa Integrated Development Organization
GBV	Gender-Based Violence
GHC	Global Health Cluster
GREDO	Gargaar Relief and Development Organization
H3 Package	High-Priority Package of Health Services in Humanitarian Response
HC	Health Cluster
HRP	Humanitarian Response Plan
HIV	Human Immunodeficiency Virus
IEHK	Interagency Emergency Health Kit
IRC	International Rescue Committee
MoH	Ministry of Health
MHPSS	Mental Health and Psycho-Social Support
NCD	Non-Communicable Disease
PHC	Primary Healthcare
SCI	Save the Children International
SPDI	Service Planning, Delivery & Implementation
SRH	Sexual Reproductive Health
TAG	Technical Advisory Group
ToRs	Terms of Reference
QITT	Quality Improvement Technical Team
UNICEF	United Nations Children's Fund
UHC	Universal Health Compendium
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Acknowledgments

The *Mobile Clinic Component of the H3 Package* was developed through the collaborative efforts of humanitarian health partners who generously shared their expertise, time, and experience on a voluntary basis. Their commitment and collective knowledge were instrumental in shaping a resource designed to strengthen the quality of health services in humanitarian settings.

We extend our sincere gratitude to all partners for their valuable contributions and dedication. The World Health Organization Performance, Finance and Delivery Team, Save the Children, and the Global Health Cluster gratefully acknowledge the technical input and contributions of the following individuals:

Authors: Willem Sools and Nureyan Zunong (Save the Children)

Core team members: Ilham Abdelhai Nour, Andre Griekspoor, John Forgati (WHO); Eba Pasha (GHC)

Technical Advisory Group Members

- Hannah Tappis (Jhpiego / JHU Center for Humanitarian Health)
- Mohamud Ahmed (GREDO)
- Kimberly Crunkleton, Trina Helderman, Karin Huster (USAID/BHA)
- Nada Abdelmagid (LSHTM)
- James McQuen Patterson (UNICEF)
- Joy Wright (Medical Teams International)
- Kelly M. Hormez (Samaritan's Purse)
- Mikiyas Girma Demelash (FIDO)
- Cora Nally, Prabu Selvam (Americares)
- Khaldoun Alamire (IRC)
- Andrea Ianthe King (GHC)
- Ilham Abdelhai Nour, Andre Griekspoor (WHO)
- Laura Cardinal (SCI)

Reviewers

Foundations of Care

Ann Fortin (WHO); Bill Clemmer (CORUS INTERNATIONAL); Calvin Oben (SCI); Colleen K.Gallagher Thomas (RI); Erica Bleakley (WHO); Prabu Selvam (Americares); Kathleen Myer, Kimberly Crunkleton, Trina Helderman (Independent/former BHA); Sinead O'Reilly (Concern); Tewodros Gebremichael (Independent/former SCI); Tatek Ayalew (MCMDO); James McQuen Patterson, Rashad Bin Shujaa, Claude Ngabu (UNICEF); Chantal Autotte Bouchard, Sophie MASSOT, Miguel CASTILLO SARABIA, Elisa ROMAGNOLI, Aude MARILLE (PUI)

Reproductive and Sexual Health

Brigitte Tonon (ACF); Nadine Cornier (UNFPA); Tewodros Gebremichael (Independent/ former SCI); Trina Helderman (Independent/ former BHA); Sinead O'Reilly (Concern); M. Cecilia Lopez, Nigisti Belete (MTI); Mikiyas Girma (Action Against Hunger); Tigist Bekele (Independent/former JSI); Sandra Harlass (UNHCR); Sharifa Khan (SCI); Bill Powell (IPAS); Khaldoun Al Amir (IRC); Sonja van Reede (MSI Reproductive Choices); James McQuen Patterson, Rashad Bin Shujaa , Claude Ngabu (UNICEF); Norie Grace Omamalin (Terre de hommes).

Growth, Development, Aging, and Nutrition

Abdi Ahmed (Medair); Bezabih Fentahun Yazie (Amhara RHB, Ethiopia); Bill Clemmer (CORUS INTERNATIONAL); Brigitte Tonon (ACF); Calvin Oben (SCI); Colleen K.Gallagher Thomas (RI); Erica Bleakley (WHO); Tewodros Gebremichael (Independent/ex-SCI); Trina Helderman (Independent/ former BHA); Sinead O'Reilly (Concern); Pil Mohammad Paya (Jhpiego); James McQuen Patterson, Rashad Bin Shujaa, Claude Ngabu (UNICEF); Chantal Autotte Bouchard, Sophie MASSOT, Miguel CASTILLO SARABIA, Elisa ROMAGNOLI, Aude MARILLE (PUI)

Non-Communicable Diseases and Mental Health

Calvin Oben (SCI); Colleen K.Gallagher Thomas (RI); Erica Bleakley, Peter Edwin Skelton, Inka Weissbecker (WHO); Kathleen Myer (Independent/ former BHA); Tewodros Gebremichael (Independent/former SCI); Tehtena Desta (FIDO); Sinead O'Reilly (Concern); Pil Mohammad Paya (Jhpiego); Harnet Adane (Tigray RHB,Ethiopia); Kiran Jobanputra (MSF/WHO); Rachel Coghlan (Melbourne University/JHU); Joy Wright (MTI); James McQuen Patterson, Rashad Bin Shujaa, Claude Ngabu (UNICEF); Chantal Autotte Bouchard, Sophie MASSOT, Miguel CASTILLO SARABIA, Elisa ROMAGNOLI, Aude MARILLE (PUI).

Communicable Diseases

Ann Fortin(WHO); Bezabih Fentahun Yazie (Amhara RHB-Ethiopia); Bilal Saleem(IMC); Colleen K.Gallagher Thomas (RI); Mary Auma Ala (IOM); Tatek Ayalew (MCMDO); Sandra Harlass (UNHCR); Zaza Tsereteli (CORUS INTERNATIONAL); Tewodros Gebremichael (Independent/former SCI); Trina Helderman (Independent/ former BHA); Sinead O'Reilly (Concern); Mikiyas Girma (Action Against Hunger); Pil Mohammad Paya (Jhpiego); James McQuen Patterson, Rashad Bin Shujaa, Claude Ngabu (UNICEF); Chantal Autotte Bouchard, Sophie MASSOT, Miguel CASTILLO SARABIA, Elisa ROMAGNOLI, Aude MARILLE (PUI)

Violence and Injury

Erica Bleakley, Peter Edwin Skelton (WHO); Colleen K.Gallagher Thomas (RI); Sinead O'Reilly (Concern); Tewodros Gebremichael (Independent/former SCI); Trina Helderman, Kimberly Crunkleton (Independent/ former BHA); Pil Mohammad Paya (Jhpiego); Prabu Selvam (Americares); James McQuen Patterson, Rashad Bin Shujaa, Claude Ngabu (UNICEF); Chantal Autotte Bouchard, Sophie MASSOT, Miguel CASTILLO SARABIA, Elisa ROMAGNOLI, Aude MARILLE (PUI)

Neha Misra, Carl Massoneau (WHO) and many other colleagues and partners who shared their time and insights to ensure the relevance, usability, and quality of the tools.

Your collective efforts have been instrumental in bringing this work to life.

Background

The High priority Health Service for Humanitarian Response (H3 Package) has been developed to define a set of prioritized health interventions that can feasibly be delivered to populations affected by humanitarian crises during protracted emergencies. It has been designed to promote the accountability of humanitarian implementers and donors to affected populations and to assist with linkages to national service packages. The H3 Package was developed by the Global Health Cluster (GHC) and the World Health Organization (WHO) in collaboration with humanitarian partners. The H3 Package is a starting point that should be adapted to fit the local burden of disease, service delivery platforms and existing health system capacity. When the H3 package was developed, Mobile Clinics was not added as a service delivery platform since there is no globally acknowledged definition of a Mobile Clinic. In addition, partners felt that the service delivery points from which the Mobile Clinic was operating would have a huge influence on list of services they can deliver. Furthermore, health partners have not agreed on planning assumptions for recommending a list of services that can be safely delivered through Mobile Clinics.

With funding from USAID/BHA,[i] Save the Children International (SCI) has conducted a research project entitled *Identifying Markers of Quality Mobile Clinic Services in Humanitarian Settings, September 2021–June 2023*. This was a landscape analysis to understand how different stakeholders define, utilize and fund Mobile Clinics, and the criteria that define the quality of care provided via Mobile Clinics. Some 28 agencies participated, with key informant interviews, focus group discussions, client exit interviews, and direct observations conducted at Mobile Clinic sites. The agencies also shared proposals, reports, operational manuals and service utilization data associated with Mobile Clinics. The research examined the definition of Mobile Clinics, the quality of care provided and markers of quality from different stakeholders' perspectives, using the seven domains outlined in the Quality of Care in Humanitarian Settings position paper from the GHC Quality Improvement Task Team (QITT), using the WHO Quality of Care in Fragile, Conflict-Affected and Vulnerable Settings as a framework. The research confirmed that multiple modalities of Mobile Clinics exist, and there is no agreed definition across humanitarian partners. Furthermore, there is a consensus among stakeholders that Mobile Clinics can rapidly increase access for hard-to-reach populations in humanitarian contexts who have no access to health services. However, the research also found that the modality comes with inherent challenges that influence the quality of care they can deliver, such as intermittent service delivery, low effective daily operational hours and logistic complexity. Several key stakeholders have therefore suggested that Mobile Clinics proposals for the modality should be temporary and should give way to a more permanent solution as soon as possible. Yet, the research did not identify any partners or coordination bodies using decision-making tools or the existence of these tools to guide decision makers on the relevance and appropriateness of Mobile Clinics, or when and how to exit and scale back from Mobile Clinic services. The research further found no uniform application or definition of quality of care in Mobile Clinics. However, several themes emerged that influence the quality of care Mobile Clinics can provide. These are centred around human resources, supplies, logistics, availability of technical support, infrastructure, service packages, patient privacy, and infection prevention and control. Based on the findings, the research team recommended 24 markers for quality of care in Mobile Clinics, validated by health partners in Afghanistan, Ethiopia and Syria, and GHC partners.

With additional BHA funding, SCI in collaboration with other humanitarian health partners developed a decision-making (support) tool to determine the best feasible and appropriate service delivery modality(s) in any given humanitarian context, along with practical guidance to operationalize the markers of quality to improve quality of care delivered via Mobile Clinics. In addition, SCI in collaboration with GHC/WHO and other humanitarian partners is developing a list of services that can be delivered via Mobile Clinics in humanitarian settings. Once finalized, Mobile Clinic will be added to the H3 Package as a service delivery platform with a list of services that can be safely delivered via mobile clinics.

The list of partners involved in this work includes:

AmeriCares/BHA/BRAC/FIDO/GREDO/GHC/IRC/JHU/LSPHTM/MSF/MTI/Samaritan's Purse/
UNICEF/UNHCR/WHO

i Landscape analysis: "Identifying Markers of Quality Mobile Clinic Services in Humanitarian Settings," 01 September 2021–01 March 2022.

Objective

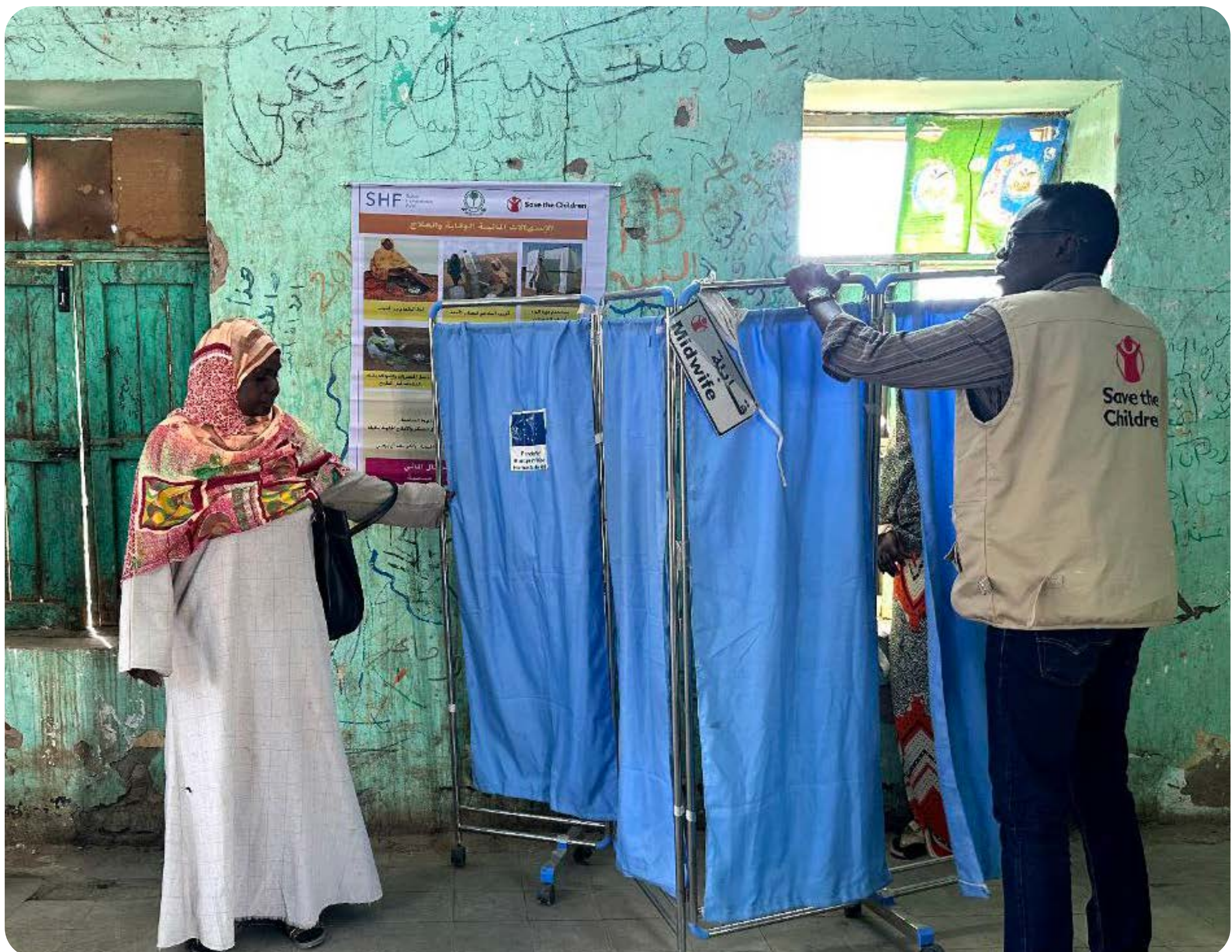
To develop a global set of high-impact, evidence-based health services that can be safely delivered via Mobile Clinics, regardless of where they are set up. The package will be developed in collaboration with humanitarian health partners, and it will be a formal joint publication between the GHC and WHO, acknowledging all partners that contributed to its development.

The Mobile Clinic package will reflect the minimum set of services that humanitarian partners and donors commit to making available to affected populations and against which they can be held accountable. It will function as a red line below which Mobile Clinic service delivery should not go.

The package will take into consideration the inherent limitations of a Mobile Clinic and the absolute minimum a Mobile Clinic should provide in humanitarian, protracted and sudden-onset crises. In settings where more resources are or become available, and when capacities increase, the package can and should be expanded.

The proposed Mobile Clinic package will be the reference for implementation planning and monitoring in the humanitarian response plans (HRPs).

To maximize the sustainability and continuity of packages that will be based on this guidance, we derived the service list from the WHO Universal Health Compendium (UHC) Service Planning, Delivery & Implementation (SPDI) Platform, a global standard for development of packages of services. Utilizing this standardized approach to service formulations and organization will facilitate interoperability and coherence across humanitarian programming and government planning efforts



© Save the Children

Process and Methodology

1. Conduct a mapping and comparison analysis between existing National and Health Cluster (HC) Mobile Clinic packages using the WHO UHC SPDI Platform.

- Supported by SCI, GHC and WHO.
- Collate existing mobile clinic service packages from:
  - » Country HCs.
  - » Ministries of Health (MoHs).
  - » Mobile Clinic service delivery platforms embedded in H3 country packages.
- Map packages to the WHO UHC SPDI Platform.
- Conduct frequency analysis of services provided between existing packages for first analysis.

2. Develop planning assumptions using research and humanitarian minimum standards and conduct a mapping against existing packages.

Using the findings from BHA-funded research project titled *Identifying Markers of Quality Mobile Clinic Services in Humanitarian Settings, September 2021–March 2023*[ii] and the standards from the Emergency Medical Team (EMT) Bluebook,[1] EMT 2030 Strategy,[2] Sphere[3] and UNHCR Emergency Handbook[4] to:

- Agree and finalize the definition and key operational characteristics of a Mobile Clinic.
- Agree on the inclusion and exclusion criteria of Mobile Clinic services.
- Agree on parameters that define the categorizations core and extended in the Mobile Clinic context.

3. Develop an initial Draft H3 Mobile Clinic Service Package.

- Using the mapping and comparison analysis from Step 1.
- Using the planning assumptions from Step 2.

4. Review and validate the initial Draft H3 Mobile Clinic Service Package in Ethiopia H3 Workshop July 2024 by Ethiopia HC partners, Ethiopia MoH and WHO.

- Supported by SCI.
- Discuss the feasibility of the chosen actions in the Draft H3 Mobile Clinic Service Package for Ethiopia context.

5. Conduct a review process with technical experts in the thematic working group.

- Supported by SCI and the GHC QITT.
- Mobile Clinic Project Technical Advisory Group (TAG) and GHC QITT members to agree on the expert validation process terms of reference (ToRs) and identify technical experts for working groups categorized in line with the UHC Compendium list:
  - » Foundations of care.
  - » Sexual and reproductive health (SRH).
  - » Growth, development and ageing.
  - » Noncommunicable diseases (NCDs) and mental health.
  - » Violence and injury.
  - » Communicable diseases.
- Conduct thematic working group meetings with technical experts:
  - » Review the initial Draft H3 Mobile Clinic Service Package (Excel document with all included and excluded actions and their respective categorization: core, extended or conditional).
  - » Identify gaps and categorization changes or propose services to be excluded.
  - » Make recommendations and identify limitations.
- Final review by the WHO TAG for Integrated Clinical Care.

---

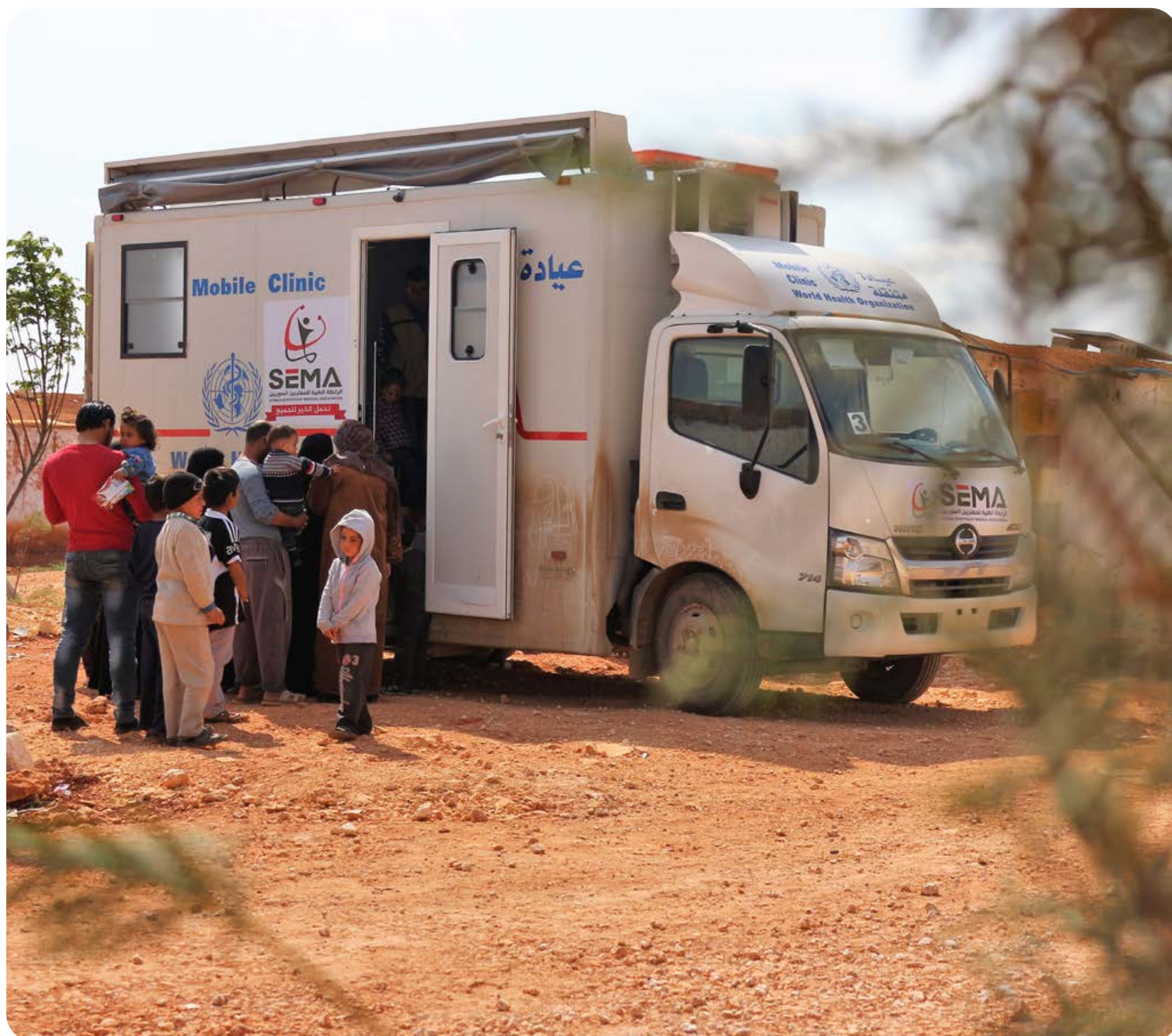
ii Landscape analysis: "Identifying Markers of Quality Mobile Clinic Services in Humanitarian Settings," 01 September 2021–01 March 2022.

6. Finalize guidance document on the initial H3 Mobile Clinic Service Package.

- Supported by SCI and the GHC QITT to compile and analyze recommendations from Steps 4–6 and develop draft guidance.
- Presentation of findings (or review of draft guidance) to the GHC and other key partners.
- Finalize guidance incorporating any further feedback from the GHC and partners.
- Discuss next steps to involve humanitarian partners and to disseminate recommendations more widely.
- Define a process to assess the validity of recommendations.
- Review and update the GHC Essential Package of Health Services (EPHS) Working Paper accordingly as guidance to assist context-specific adaptation and planning for implementation.

7. Utilization of the H3 Mobile Clinic Service Package.

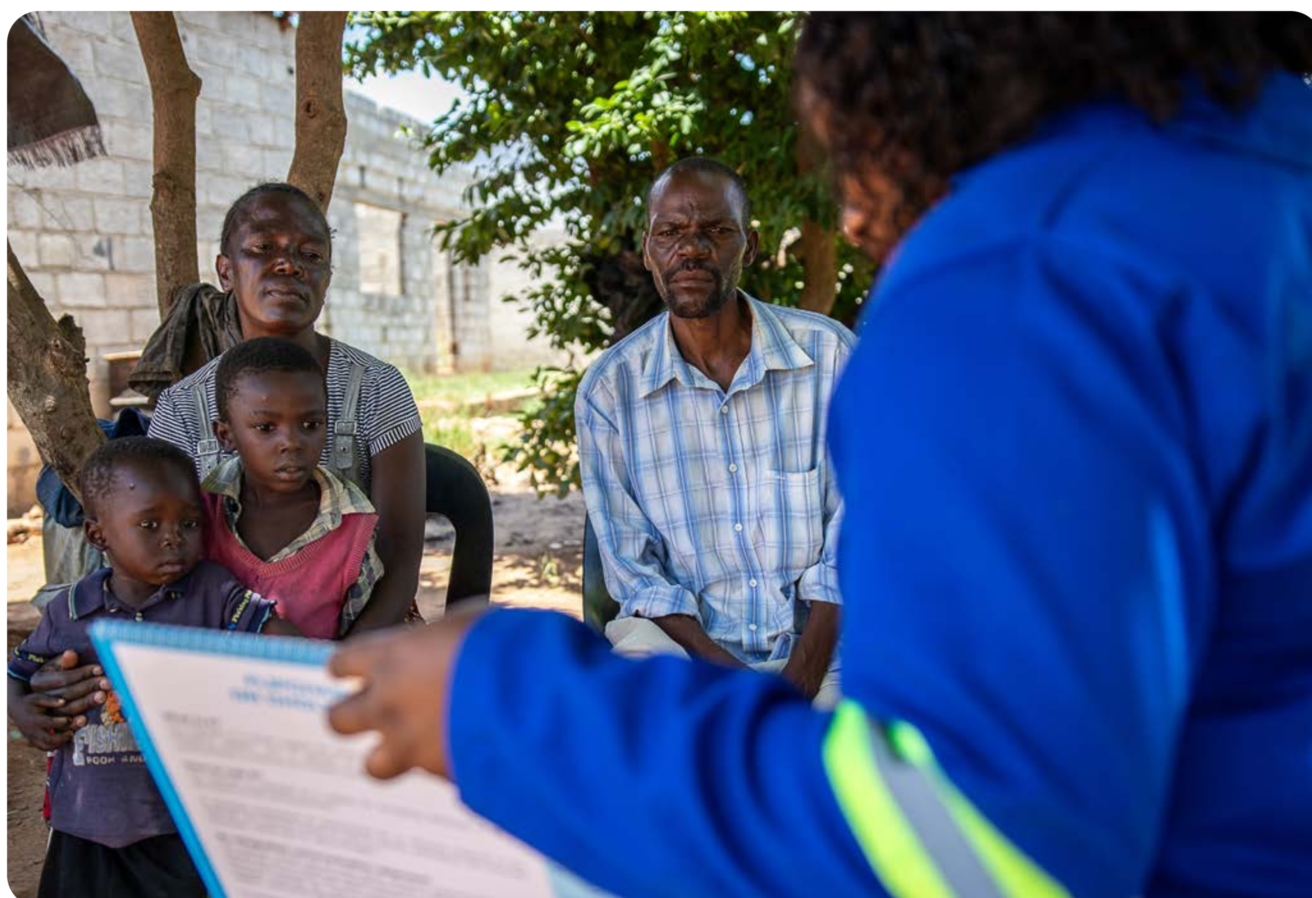
- Supported by the GHC and WHO.
- Review and update the WHO/GHC EPHS Working Paper.
- Work with GHC and other partners to ensure the list is linked with the HRP process and service delivery.
- Work with humanitarian donors to ensure the funding allocation is linked with the delivery of HRP.



© WHO | Mobile clinic in north-west Syrian Arab Republic - 2019

Key outputs and timeline

1.	Scope and methodology finalized with GHC and WHO	31st May 2024
2.	Mapping of existing National and HC Mobile Clinic package and existing humanitarian standards	22nd July 2024
3.	Planning assumptions developed	18th July 2024
4.	Systematic review to select core actions to define the initial Draft Mobile Clinic Component of the H3 Package, ready for validation	30th July 2024
5.	Ethiopia validation workshop	2nd August 2024
6.	Validation and advice from expert groups, through thematic working group meetings	Q3 2025
7.	Review of advice from the expert groups by the core group: decisions on the final version of the Mobile Clinic Component of the H3 Package	Q3 2025
8.	Final document defining Mobile Clinic Component of the H3 Package, published by WHO/GHC	by the end of 2025



© Sacha Myers, Save the Children

Planning assumptions for the Mobile Clinic Component of the H3 Package

This document provides planning assumptions for the baseline H3 Mobile Clinic service package. Included is a definition of the H3 Mobile Clinic service delivery platform with rational operational characteristics and key considerations for the inclusion or exclusion of H3 actions in the package. Furthermore, the assumptions may assist countries to contextualize the package. This package is not influenced by the type of service delivery point/typology (under a tree, tent, fixed building) .

1. Definitions

EMT Type 1 Mobile Health Team: A group of trained individuals who deliver community health services in a manner that is light, portable and adaptable. During or after a health emergency, they extend the range of community interventions and provide basic health (basic treatment and medications) and referral services, particularly to hard-to-reach or vulnerable populations, such as those who are cut off from health services or displaced. These services are usually provided by community health workers (CHWs), paramedics and/or nurses. They may operate from existing structures, temporary structures, such as tents, or specially equipped vehicles (*from the EMT 2030 strategy*).

H3 Mobile Clinic service delivery platform: A self-sufficient, mobile service delivery platform that provides temporary primary care services by a trained multidisciplinary team, often at multiple service delivery points during daylight hours, as per local guidance. May operate from a fixed facility.

The H3 Package outlines a set of essential health services and indicates the lowest feasible level of the health system (service delivery point [SDP]) at which these services should be delivered. It distinguishes between two categories:

- **Core Services** are those that are locally feasible, cost-effective and clinically effective. They can be delivered using existing resources and capacities.
- **Extended Services** require additional investments—such as increased funding, enhanced infrastructure, more material resources, or specialized workforce training—before they can be safely and effectively delivered at the intended level.

2. Context and Rationale

- Ideally temporarily deployed to increase primary health care (PHC) availability and access in crisis-affected areas to reduce excess morbidity and mortality.
- Can increase access (health system gap) in hard-to-reach areas, scattered and nomadic population contexts.

3. Operational Characteristics

Staff

- Core: **1** physician/doctor (anyone who can prescribe as per local policy), with **1** nurse, **1** midwife, **1** dispenser and **1** driver. A physician may be replaced by a lower-level substitute. However, the substitute must be licensed to prescribe and administer or supervise the administration of drugs oral or parenteral. Task shifting may occur in countries with shortages of physicians.

- Optional dedicated mental health and psycho-social support (MHPSS) and/or nutrition staff.
- 1–2 CHWs linked and based at the service delivery point; 3–4 community volunteers for support activities.

See Annex 1 for topline ToRs.
EMT type 1 Mobile bluebook: 4 staff.

EMT Ukraine package has following breakdown:

- *1–2 medical doctors.*
- *2 clinical nurses.*
- *1 midwife.*
- *1 public health officer (field epidemiologist).*
- *1 pharmacy technician.*
- *1 health logistic officer.*
- *1 translator/interpreter.*
- *1–2 community mobilizers from the specific locality to support the team in mobilizing the community for service uptake.*
- *1–2 administration staff for the management of records and patient flow.*
- *Driver/security as per need.*

Vehicle

- One Toyota Landcruiser or minibus type of vehicle.
- Optional second vehicle to increase staff, supply and referral capacity.

Supplies

- Non-medical supplies to ensure self-sufficient/standalone deployment of the mobile clinic.
- Medical supplies; interagency emergency health kit (IEHK)[iii] + Context-specific supplies at an early stage. Ideally international procurement for the long term.
- Cold box for limited cold-chain drugs and vaccines.

Electricity

- No electricity (*EMT Type 1 mobile has 2Kva generator included*).

Water

The relevant requirements for water supply, sanitation and hygiene facilities and service needs to be provided to the same level as if the facilities were permanent structures.[5]
Sphere standard 2018, p 145:

- Mobile Clinic with infrequent visits: 1 litre per patient per day.
- Mobile Clinic with frequent visits: 5 litres per patient per day (equivalent to fixed facility outpatient standard).

Sterilization options

- Sterilization capacity at the service delivery point (autoclave).
- Sterilization capacity at the Mobile Clinic base (autoclave and/or chemical sterilization).
- Outsourcing sterilization to the nearest referral facility.

iii A combination of the IEHK Basic, Supplementary, Malari and PEP kits and IARH Kits 1 - 10.

Oxygen

- Extended service depending on in-country oxygen capacity and supply chain. See Annex 2.

Mobile Clinic visit frequency and # of service delivery points

- **One Mobile Clinic serves multiple service delivery points (±5)** (*EMT Type 1 mobile work in multiple locations; not specified how many*).
- **Short operational hours, ranging from 4–6 hours** (*EMT Type 1 indicates daylight hours, not the exact number of hours*).

Table 1: Number of patients per day based on UNHCR/Sphere standard 50 patients per day (8 hours a day = 0.16 hr or 9.6 min per patient)

Hours	Minutes	Number of patients per clinician	Total number of patients seen by three clinicians
4	240	25	75
5	300	31	94
6	360	38	113
7	420	44	131
8	480	50	150

(EMT Type 1 mobile capable of treating at least 50 outpatients/day).

Target population size

Emergency Standard: Health facility utilization rate: between 1 and 4 new consultations/person/year. UNHCR.

The table and Excel file below analyze the required number of Mobile Clinic visits to service delivery points needed to stay within the Sphere standard displayed in Table 1 considering different target population sizes and service utilization rates. All numbers highlighted in green are within the Sphere standard.

As an alternative to increasing the number of Mobile Clinic visits, the number of teams or clinicians per visit could be increased.

Mobile clinic population size

Analysis of the expected # of patients per population size using a Mobile Clinic frequency of 1–3 visits per week, 8 operational hours and three clinicians

Emergency standard: 50 consultations per clinician per day & a health facility utilization rate: between 1 and 4 new consultations/person/year (C/P/Y). UNHCR.

Population size	1 C/P/Y	Expected # Patients / # MC visits			2 C/P/Y	Expected # Patients / # MC visits			3 C/P/Y	Expected # Patients / # MC visits			4 C/P/Y	Expected # Patients / # MC visits			Average C/P/Y	Expected # Patients / # MC visits		
		1	2	3		1	2	3		1	2	3		1	2	3		1	2	3
1,000	1,000	19			2,000	38			3,000	58			4,000	77			2,500	48		
2,000	2,000	38			4,000	77			6,000	115			8,000	154	77		5,000	96		
3,000	3,000	58			6,000	115			9,000	173	87		12,000	231	115		7,500	144		
4,000	4,000	77			8,000	154	77		12,000	231	115		16,000	308	154	103	10,000	192	96	
5,000	5,000	96			10,000	192	96		15,000	288	144		20,000	385	192	128	12,500	240	120	
6,000	6,000	115			12,000	231	115		18,000	346	173	115	24,000	462	231	154	15,000	288	144	
7,000	7,000	135			14,000	269	135		21,000	404	202	135	28,000	538	269	179	17,500	337	168	112
8,000	8,000	154	77		16,000	308	154	103	24,000	462	231	154	32,000	615	308	205	20,000	385	192	128
9,000	9,000	173	87		18,000	346	173	115	27,000	519	260	173	36,000	692	346	231	22,500	433	216	144
10,000	10,000	192	96	64	20,000	385	192	128	30,000	577	288	192	40,000	769	385	256	25,000	481	240	160

Analysis of the expected # of patients per population size using a Mobile Clinic frequency of 1–3 visits per week, 6 operational hours and three clinicians

Emergency standard: 50 consultations per clinician per day & a health facility utilization rate: between 1 and 4 new consultations/person/year (C/P/Y). UNHCR.

Population size	1 C/P/Y	Expected # Patients / # MC visits			2 C/P/Y	Expected # Patients / # MC visits			3 C/P/Y	Expected # Patients / # MC visits			4 C/P/Y	Expected # Patients / # MC visits			Average C/P/Y	Expected # Patients / # MC visits		
		1	2	3		1	2	3		1	2	3		1	2	3		1	2	3
1,000	1,000	19			2,000	38			3,000	58			4,000	77			2,500	48		
2,000	2,000	38			4,000	77			6,000	115	58		8,000	154	77		5,000	96		
3,000	3,000	58			6,000	115	58		9,000	173	87		12,000	231	115	77	7,500	144	72	
4,000	4,000	77			8,000	154	77		12,000	231	115	77	16,000	308	154	103	10,000	192	96	
5,000	5,000	96			10,000	192	96		15,000	288	144	96	20,000	385	192	128	12,500	240	120	80
6,000	6,000	115	58		12,000	231	115	77	18,000	346	173	115	24,000	462	231	154	15,000	288	144	96
7,000	7,000	135	67		14,000	269	135	90	21,000	404	202	135	28,000	538	269	179	17,500	337	168	112
8,000	8,000	154	77		16,000	308	154	103	24,000	462	231	154	32,000	615	308	205	20,000	385	192	128
9,000	9,000	173	87		18,000	346	173	115	27,000	519	260	173	36,000	692	346	231	22,500	433	216	144
10,000	10,000	192	96	64	20,000	385	192	128	30,000	577	288	192	40,000	769	385	256	25,000	481	240	160

4. Key considerations for inclusion or exclusion of H3 actions in the Mobile Clinic package

Core or extended action selection will follow the H3 selection criteria provided in Annex 3. The operational characteristics of Mobile Clinics will further influence to what extent services and corresponding actions can be implemented and therefore require special consideration.

Mobile Clinic specific considerations

- Due to intermittent service delivery and limited operational hours, rehabilitation services are considered mostly extended except for basic services such as counselling, checking for friction and pressure ulcers/wounds, other complications with prosthetics, or progress on a range of movement. For serious complications, refer.
- Transporting and setting up lab equipment is not feasible. Lab testing is limited to rapid tests only (Malaria [when endemic],[iv] pregnancy test [urinary],[v] urine test[vi]) (*EMT Type 1 mobile includes rapid test)*.
- Patient follow-up is challenging due to intermittent service delivery and often unpredictable security and/or road conditions and weather context.
- Physical examination may be challenging in an open-air setup. However, it is possible but must be well planned to ensure audio and visual privacy.
- Due to the limited number of staff a vehicle can transport, sufficient gender balance may not be possible, which in turn may influence whether a service can be provided and/or will be accepted by the target population.
- Inclusion of medicines and food supplements depends on storage requirements on site, during transport and at base that can be met by Mobile Clinics, such as cold chain, dry and safe storage.
- Referral capacity after Mobile Clinic operational hours is often limited or non-existent. Communities will have to organize and finance their own referrals.

Stabilization and referral

Due to intermittent service delivery, limited operational hours and the inherent constraints of the Mobile Clinic (infra)structure, some core actions are **ONLY** considered core when applied for emergency stabilization and referral support, i.e.:

- Services requiring continuous observation.
- Services that require significant time such as advanced wound care.
- Administration of intravenous medication.
- Services requiring a sterile field are challenging in an open-air Mobile Clinic setup due to exposure to environmental and climatic conditions.
- Signal functions of Basic Emergency Obstetric and Newborn Care (BEmONC) are technically possible but would inherently **focus on stabilization and rapid referral**. Hence delivery and labour services/actions are considered core, but only stabilization and rapid referral (*EMT Type 1 mobile includes BEmONC*).
  a. Administer parenteral antibiotics for treatment of sepsis.
  b. Administer uterotonic drugs (i.e., parenteral oxytocin or misoprostol tablets) for treatment of postpartum haemorrhage and administer intravenous tranexamic acid in addition to standard care for women with clinically diagnosed postpartum haemorrhage.
  c. Administer parenteral anticonvulsant drugs (i.e., magnesium sulphate) to manage severe preeclampsia and eclampsia.
  d. Perform assisted vaginal delivery (e.g., vacuum extraction).
  e. Manually remove the placenta.

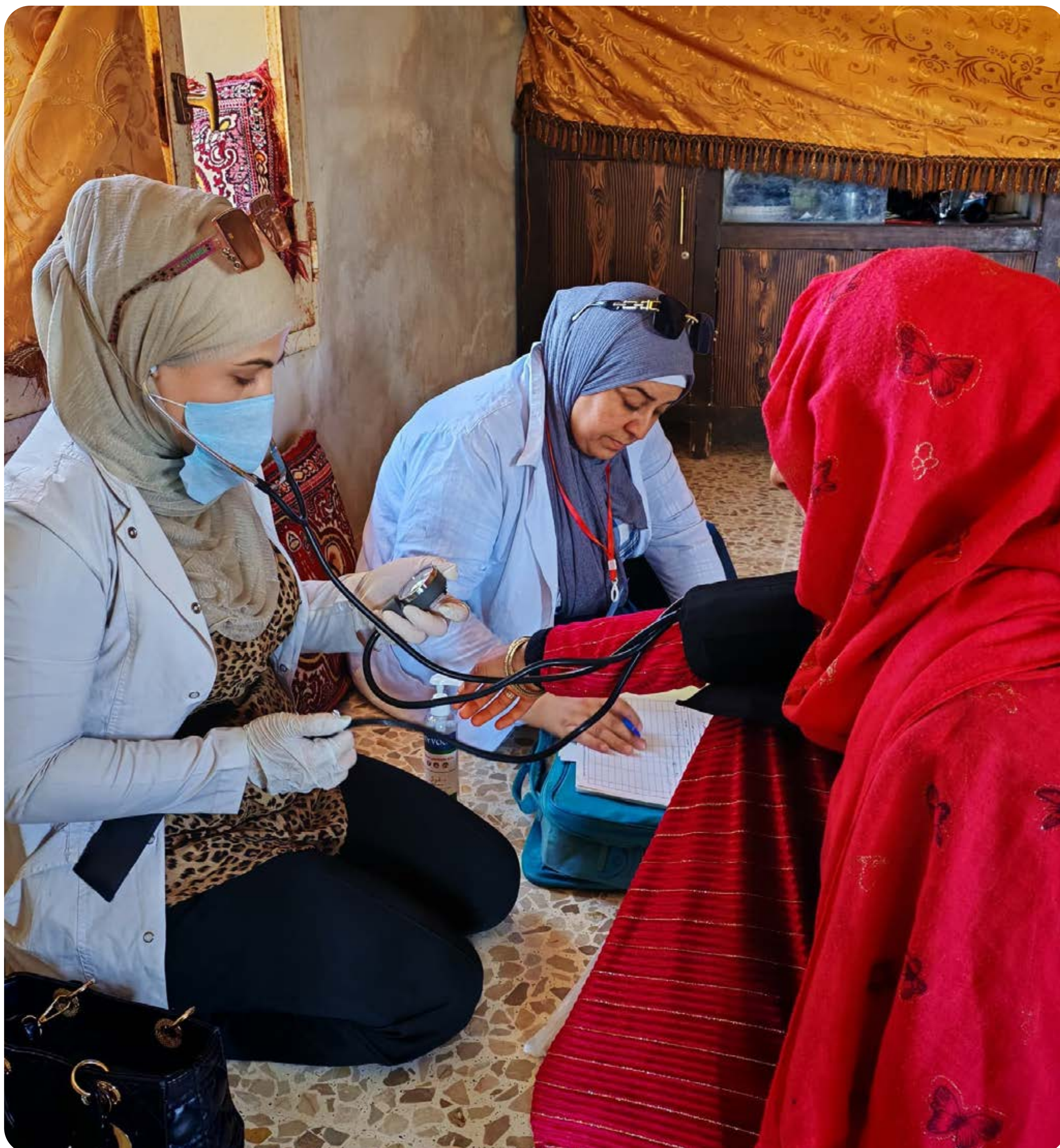
iv Included in IEHK Malaria unit in the basic module.
v Supplementary module—Post-exposure prophylaxis (PEP) unit and IARH Kit 3 Post-Rape Treatment.
vi Supplementary module—Medical devices, renewable and IARH Kit 6B.

f. Remove retained products of conception after delivery or an incomplete abortion.

g. Perform basic neonatal resuscitation (e.g., with bag and mask).

General considerations

- Conservative communities may not be open to certain services such as Expanded Programme on Immunization (EPI), family planning, gender-based violence (GBV), female genital mutilation, or Human Immunodeficiency Virus (HIV) (context specific extended) (*EMT Type 1 mobile can supply tetanus vaccination; however,* **routine vaccination programmes are not an EMT function**).
- Inclusion of neglected tropical and/or infectious diseases depends on the endemicity of the diseases.



© WHO | WHO-supported mobile health team services in Syria

Annexes

Annex 1: Topline Terms of Reference for Mobile Clinic Human Resources

The ToRs provide topline activities that are required to implement the actions of the H3 Mobile Clinic package. Administrative, managerial, supervision, training and other activities focussed on quality of care and management of a Mobile Clinic are not included. Responsibility for actions may vary per country context, inclusion of cadre types and task-shifting policies.

Physician/doctor/medical officer equivalent (1)

- Screening & triage.
- Vital signs.
- Conduct adult outpatient department consultations, manage non- and communicable diseases, including HIV counselling.
- Basic first-line MHPSS counselling.
- Basic rapid tests.
- Injection and basic wound care.
- Lead on all acute and life-threatening illnesses stabilization, and rapid referral.
- Management of infectious disease cases (isolation).
- Prescribe drugs and administer or supervise administration of intravenous or intramuscular injections.

BSc Nurse/vaccination/nutrition (1)

- Under 5 outpatient department consultations.
- Growth monitoring.
- Provide EPI, Vitamin A and deworming activities.
- Provide nutritional screening activities that improve basic preventive health care at a community level.
- Conduct planning and promotion of awareness creation preventative health care issues in the community.

Midwife (1)

- Provide all SRH service (family planning, antenatal care [ANC], Emergency delivery, postnatal care, HIV, syphilis test, pregnancy test.) Identification of high-risk mothers and facilitation of referrals.
- Prevention of mother-to-child transmission counselling.
- Clinical management of GBV and referrals.
- Improving basic preventive health care at the community level in line with public health emergency management with emphasis on health, especially preventing maternal and newborn deaths.

Dispenser (1)

- Daily dispensary as per national dispensary guidance.
- Drug supply management.

CHW (2) *based at service delivery point*

- Support with screening and triage of patients in the waiting area prior to the arrival of the Mobile Clinic and during health service provision.
- Provide health education on identified gaps.
- Set up and maintain hydration corner.
- Screen for infectious disease cases, alert and active case finding.
- Identify pregnant mothers, malnutrition cases, EPI, people with danger signs, disability etc. in the community. Refer to mobile clinic for treatment or follow-up.

Community Volunteer (2–4) *based at service delivery point*

- Control crowd prior to the arrival of the Mobile Clinic and during health service provision.
- Support the Mobile Clinic setup and packing.
- Port water.
- Support with transfer of mobility-compromised patients.
- Link community members who need health service to the Mobile Clinic to seek proper health service.
- Mobilize the community for various awareness creation and health promotion events.
- Support with registration and keep updated demographic data.

Driver (1 per vehicle)
• Responsible for logistics & other support, including transport of referral cases.

Annex 2: Cylinder sizes common in health facilities

Cylinders D and E are suitable for use in Mobile Clinics

Cylinder size	D	E	F	G	J
Nominal content/ oxygen capacity (L)	340	680	1,360	3,400	6,800
Water capacity (L)	2.3	4.7	9.4	23.6	47.2
Dimensions (height × diameter) (mm)	535 × 102	865 × 102	930 × 140	1,320 × 178	1,520 × 229
Approximate full weight (kg)	3.9	6.5	17	39	78
Valve outlet connection (and specification)	Pin index (ISO 407)	Pin index (ISO 407)	Bullnose (BS 341)	Bullnose (BS 341)	Pin index side spindle (ISO 407)
Nominal service pressure (kPa/bar/ psi)	13,700 kPa	13,700 kPa	13,700 kPa	13,700 kPa	13,700 kPa
	(137 bar/1,987 psi)	(137 bar/1,987 psi)	(137 bar/1,987 psi)	(137 bar/1,987 psi)	(137 bar/1,987 psi)
Examples of health facility use	Emergency and ambulance transport	Emergency and ambulance transport	Stand-alone	Stand-alone	Manifold connection and stand-alone
Cylinder Constant	0.16	0.28	0.68	2.41	3.4

Annex 3: H3 criteria for core and extended services

We defined the following set of criteria to select interventions and actions for the H3 package, and to assign actions to the appropriate level of care:

Principal criteria for inclusion as core:

- **Impact on morbidity and mortality:** evidence-based and time-sensitive interventions and actions that have the greatest potential to decrease morbidity and mortality.
- **Affordable/cost-effective:** low-cost and high-impact interventions.
- **Locally feasible:** local capacity can be assumed to be available for the provision of the intervention and its actions.
- **Equitable:** interventions and actions can be made available to the entire population targeted by the humanitarian response.
- **Clinically effective:** specific actions are required as part of an intervention and their absence would render an intervention clinically ineffective (e.g., antibiotics for treatment of pneumonia).
- **Humanitarian imperative:** interventions addressing health needs of small numbers of patients (and thus not ranking high on burden of disease) that result from conflict or violations of human rights (such as health needs of rape victims when rape is used as a weapon of war).

Other criteria for services to be classified as core:

- People-centred:
  - Addressing common symptoms for which people seek care, even if most symptoms are self-limiting (e.g., approach to sore throat).
  - Acknowledging that people seek care with specific symptoms that may not lead to a definitive diagnosis (e.g., abdominal pain).
  - Acknowledging that while certain interventions or actions that are effective for treatment are not in the package, patients will seek care for them nonetheless, and at least require symptomatic diagnosis and treatment (e.g., cancer care).
- Basic skills to deliver a service can be quickly upgraded through a short in-service training and supported through regular supervision and considered part of continuous education.
- Protection of politically sensitive interventions, such as lifesaving abortion care.
- Public and cultural acceptability.

Criteria for services to be classified as extended:

Interventions that are part of a set of extended services:

- Require extensive additional training of personnel.
- Require medicines or equipment currently not available in the WHO and UNFPA kits, or IEHKs, or other kits related to humanitarian minimum service packages (e.g., malnutrition kits, Reproductive Health kits, non-communicable disease [NCD] kits) or the national list of essential medicines.

WHO/GHC—Preliminary guidance for a package of High-Priority Health Services for Humanitarian Response (H3 Package) March 2023, page 13.

References

1 World Health Organization. (2021). *Classification and minimum standards for emergency medical teams*. https://www.who.int/emergencies/partners/emergency-medical-teams

2 World Health Organization. (2023). *Emergency medical teams 2030 strategy*. https://extranet.who.int/emt/content/emt-2030-strategy

3 Sphere Association. (2018). *The Sphere handbook: Humanitarian charter and minimum standards in humanitarian response* (4th ed.). https://www.spherestandards.org/handbook

4 United Nations High Commissioner for Refugees. (n.d.). *UNHCR emergency handbook: Health and nutrition*. https://emergency.unhcr.org/emergency-assistance/health-and-nutrition

5 World Health Organization. (2012). Water, sanitation and hygiene (WASH) in health-care facilities in emergencies. https://www.who.int/health-topics/water-sanitation-and-hygiene-wash#tab=tab_1

Mobile Clinic Component of the H3 Package

Mobile Clinic as a Service Delivery Platform in the H3 Package