

Mobile Clinic Quality of Care Guidance for Humanitarian Settings



Save the Children



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Acronyms

ANC	Antenatal Care
BHA	Bureau for Humanitarian Assistance
CHW	Community Health Worker
CV	Community Volunteer
DEI	Diversity, Equity, and Inclusion
EHR	Electronic Health Record
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunization
FGD	Focus Group Discussion
FIDO	Fayyaa Integrated Development Organization
FSL	Food Security and Livelihoods
GBV	Gender-Based Violence
GHC	Global Health Cluster
GREDO	Gargaar Relief and Development Organization
H3	The High Priority Package of Health Services in Humanitarian Response
HC	Health Cluster
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IEC	Information, Education, and Communication
IEHK	Interagency Emergency Health Kit
IMC	International Medical Corps
IPC	Infection Prevention and Control
IRC	International Rescue Committee
KPI	Key Performance Indicator
MoH	Ministry of Health
MEAL	Monitoring, Evaluation, Accountability, and Learning
MCMDO	Mothers and Children Multisectoral Development Organization
MHPSS	Mental Health and Psycho-Social Support
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
PHC	Primary Healthcare
PPE	Personal Protective Equipment



Acronyms

PSEA	Protection from Sexual Exploitation and Abuse
RH Kit	Reproductive Health Kit
R&R	Rest and Recuperation
SCI	Save the Children International
SDP	Service Delivery Point
SOPs	Standard Operating Procedures
SRH	Sexual Reproductive Health
TAG	Technical Advisory Group
TB	Tuberculosis
ToRs	Terms of Reference
QITT	Quality Improvement Task Team
UN	United Nations
UNICEF	United Nations Children's Fund
UHC	Universal Health Coverage
WASDA	Wajir South Development Association
WHO	World Health Organization



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We thank these collaborators along with many other colleagues and partners who shared their time and insights to ensure the relevance, usability, and quality of the tools. Please note, tools and resources included in this guidance were cited where possible.

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



Background

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Access to timely and appropriate life-saving healthcare is a critical element of humanitarian responses in terms of reducing excess morbidity and mortality and alleviating suffering. However, access to quality health services in humanitarian contexts is often hindered by factors such as insecurity, destruction or damage to health infrastructure, and the unpredictable and rapidly evolving nature of crises.^{1,2} Consequently, Mobile Clinics have been increasingly used to reach affected populations, meet their immediate health needs, and help humanitarian partners achieve the Sphere standards.^{1,3} The term “Mobile Clinic” will be used in this document; other common terms include “Mobile Health Clinic” and “Mobile Health Unit.”

Despite the wide application of Mobile Clinics in humanitarian settings, a 2019 study by Gowan et al. found limited evidence to guide decision-making processes and their use as a service delivery modality.² Accordingly, Save the Children conducted qualitative research funded by the Bureau for Humanitarian Assistance (BHA) from September 2021 to March 2023. The aim of the Identifying Markers of Quality Mobile Clinic Services in Humanitarian Settings research project was to understand how Mobile Clinics are defined, utilized, and evaluated for quality by various stakeholders. The research, which involved key informant interviews, focus group discussions (FGDs), client exit interviews, direct observations, and document reviews across 28 organizations, was structured around the seven domains of the World Health Organization (WHO)/Global Health Cluster (GHC) Quality of Care Framework.^{4,5}

The findings confirmed that Mobile Clinic models vary widely, and that standard definitions, guidance, and quality assurance tools are lacking. While partners consistently acknowledged the value of Mobile Clinics for expanding access to care, many also considered them a temporary solution that would, ideally, be phased out once more permanent service delivery options become feasible. However, few organizations had the formal tools to guide decisions about deploying, adapting, or exiting Mobile Clinics.

This research identified 24 evidence-based quality markers across areas such as staffing, service scope, technical supervision, infrastructure, logistics, patient privacy, and infection prevention and control. These markers were validated by health partners in Afghanistan, Ethiopia, and Syria and globally through the GHC.

Integrated Flow of the Tools for Mobile Clinics

To strengthen the use of Mobile Clinics and improve the quality of care they deliver, Save the Children and its partners have developed five interlinked tools. While each tool is modular and can be used independently, together they form a comprehensive package to support data-driven decision-making, practical implementation, and continuous quality improvement in Mobile Clinic operations. Built-in features such as barrier analysis, exit strategy planning, and centralized monitoring ensure alignment with broader humanitarian health coordination and sustainability goals. Their relationship and connectivity are illustrated in the visual below.

An e-learning course titled [Mobile Clinics and Quality of Care in Humanitarian Settings](#) further complements these tools. This foundational course introduces key quality of care concepts in humanitarian contexts and examines how they apply specifically to Mobile Clinics. It guides users in defining the seven domains of quality of care, exploring how humanitarian settings influence these domains, and recognizing how quality is reflected in the service delivery of Mobile Clinics.



Overview of the Tools to Optimize Quality of Care in Mobile Clinics



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1. Mobile Clinic Planning & Decision-Making Tool

This [KoboToolbox-based tool](#) is the starting point for determining whether a Mobile Clinic is the most relevant and feasible intervention for a given context. It includes:

- Analysis of the humanitarian context and general health service availability at the district level.
- Barrier analysis (Tanahashi model) for any service delivery point (fixed or mobile).
- Evaluation of exit strategy considerations for Mobile Clinic service delivery points (SDPs).
- Context-specific intervention recommendations.

If Mobile Clinics are recommended, users proceed to the other tools below; if not, alternative options are suggested in the *Mobile Clinic Planning & Decision-Making Tool*.

The tool also comes with a video tutorial, presented in short, step-by-step segments, to provide clear guidance on its effective use.

2. Mobile Clinic Component of the H3 Package

The Package of High-Priority Health Services for Humanitarian Response (the H3 Package).

If a Mobile Clinic is identified as a suitable option, the H3 Package¹ guides users on which services can be safely and effectively delivered, in alignment with national or cluster standards.

¹ UHCC

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The H3 Package defines prioritized health interventions for all levels of the health system, including Mobile Clinics that can feasibly be delivered to crisis-affected populations during protracted emergencies. It is designed to:

- Promote accountability of humanitarian implementers and donors to affected populations.
- Strengthen linkages to national service packages.

[The H3 Mobile Clinic Package](#) outlines a core minimum standard of services that should be adapted based on local disease burden, available service delivery platforms, and existing health system capacity. It includes a list of health services that can be safely delivered via Mobile Clinics, regardless of their location or setup.

3. Mobile Clinic Quality of Care Guidance for Humanitarian Settings

Once the service package is confirmed, the [Mobile Clinic Quality of Care Guidance for Humanitarian Settings](#) supports users in coordinating, designing, planning, and delivering quality health services through mobile clinics.

The guidance aims to improve and optimize the quality of care by providing:

- Practical tips, tools, and resources to operationalize quality considerations.
- Support across all stages of implementation: planning, setting up, operating, and monitoring.

It can be used when initiating a new response, launching Mobile Clinic operations, or reviewing and improving ongoing interventions.

4. Mobile Clinic Quality Monitoring Tool

Once a Mobile Clinic is in operation, [the Quality Monitoring Tool](#) can be used to track and improve the quality of services provided. The Kobotoolbox-based tool uses 24 evidence-based quality markers specific to Mobile Clinics to enable structured data collection. This supports teams in systematically assessing, monitoring, and enhancing the quality of care delivered.

Key strengths of the tool include:

- A digital design (Kobo) that enables real-time coordination, oversight, and data use.
- Five complementary data collection sources, each providing a unique perspective on service quality, together offering a comprehensive view of Mobile Clinic performance.

The tool also comes with a video tutorial, presented in short, step-by-step segments, to provide clear guidance on its effective use.

5. Quality Improvement Planning Template

Building on the insights generated by the *Mobile Clinic Quality Monitoring Tool*, the [Quality Improvement Planning Template](#) provides a simple structure for Mobile Clinic teams to develop targeted actions to address service gaps, enhance care quality, and improve operational efficiency.

When used alongside the *Mobile Clinic Quality Monitoring Tool* and the *Mobile Clinic Quality of Care Guidance for Humanitarian Settings*, it completes the quality optimization loop, translating data and recommendations into concrete, actionable improvements.



Structure of the Mobile Clinic Quality of Care Guidance for Humanitarian Settings

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Objective

The objective of the *Mobile Clinic Quality of Care Guidance for Humanitarian Settings* is to improve and optimize the quality of care provided through Mobile Clinics in humanitarian settings using 24 evidence-based markers of quality.

Target Audience

- Coordination bodies (e.g., Health Cluster, Ministry of Health at central and decentralized levels)
- Donors
- Humanitarian health partners staff, including:
 - Technical advisors (for planning, budgeting, and quality assurance)
 - Program managers (for operationalization, recruitment, training, and monitoring)
 - Monitoring, Evaluation, Accountability, and Learning (MEAL) staff (for client engagement, satisfaction, and feedback).

Scope

This guidance supports the planning, setup, operation, and monitoring of Mobile Clinics in humanitarian settings. It applies to both the initial phase of an acute emergency response and situations in which Mobile Clinics are part of a longer-term service delivery model. It provides practical tips, tools, and considerations for delivering the highest possible quality of care. As discussed, the Mobile Clinic Quality Monitoring Tool enables evaluation of service quality, and the findings serve to guide quality optimization and improvement efforts for the assessment of Mobile Clinics.

While this guidance focuses on quality markers specific to Mobile Clinics, it is intended for use in conjunction with broader humanitarian and national quality-of-care standards. Implementers should align Mobile Clinic service delivery with general quality frameworks to ensure comprehensive and context-appropriate care.

Development Process

The first draft of this Practical Guidance for Mobile Clinics was developed based on the key findings and the 24 markers of quality identified through Save the Children's research project titled *Identifying Markers of Quality Mobile Clinic Services in Humanitarian Settings*. The findings and markers provide specific, operational considerations to help implementers deliver the highest possible quality of care through Mobile Clinics.

The development and review of the initial draft were guided by a technical advisory group (TAG) comprising representatives from international and national health partners, academic institutions, the U.S. Bureau for Humanitarian Assistance (BHA), and United Nations (UN) agencies, including the WHO, the United Nations Children's Fund (UNICEF), and the Global Health Cluster (GHC). Members of the TAG contributed to the outline, reviewed content,



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and provided technical inputs. Selected members of the Quality Improvement Technical Team (QITT) and Save the Children's technical staff also contributed to the review process.

The second draft of the guidance was then piloted with eight national and international humanitarian health partners in Ethiopia and Somalia.

- **Ethiopia:** Fayyaa Integrated Development Organization (FIDO), Mothers and Children Multisectoral Development Organization (MCMDO), GOAL Ethiopia, and Save the Children Ethiopia
- **Somalia:** Gargaar Relief and Development Organization (GREDO), Wajir South Development Association (WASDA), Medair, and Save the Children Somalia

The guidance was updated based on feedback collected during the pilot process, which resulted in a third draft. This third draft underwent a second round of review by the TAG, selected QITT members, and members of Save the Children's technical and operational staff. Their inputs were incorporated into the final version of this guidance.

Definitions and Descriptions

Terminology may vary across organizations, institutions, and operational contexts.

This practical guidance is based on research and field experiences from a wide range of humanitarian actors. The following definitions and descriptions are included to provide users with a clear understanding of how key terms are used in this document.

Key Terms and Definitions

Name	Definition proposed by technical authorities and internationally accepted
Quality of Care (QoC)	<p>The WHO^{6,7} defines Quality of Care as "...the extent to which health care services provided to individuals and patient populations improve desired health outcomes."</p> <p>Although there is no one accepted definition for quality of care, there is a commonly shared understanding of interlinked quality domains known as the 7 Domains for Quality Care. Thus, to realize the benefits of quality healthcare, health services must be:</p> <ol style="list-style-type: none">1. Effective: providing evidence-based healthcare services to those who need them.2. Safe: avoiding harm to people for whom the care is intended.3. People-centred: providing care that responds to individual preferences, needs and values.4. Timely: reducing waiting times and sometimes harmful delays.5. Equitable: providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status.6. Integrated: providing care that makes available the full range of health services throughout the life course.7. Efficient: maximizing the benefit of available resources and avoiding waste.
Access (to health services)	<p>The perceptions and experiences of people regarding the ease of reaching health services or health facilities in terms of location, time, and ease of approach.⁶</p> <p style="text-align: center;">or</p> <p>The percentage of a population that can access primary healthcare within one hour's walk from dwellings (minimum 80 percent).⁷</p>
Universal health coverage (UHC)	<p>Situations in which all individuals receive quality health services when and where they need them without incurring financial hardship.⁸</p>
Community Health Worker (CHW)	<p>A trained and supported health worker based in or near a community and working from home or a fixed health post.⁹</p>



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Service Delivery Platform or Modality of Delivery

The way in which resources and services are delivered. The definition of modality, therefore, generally involves describing health facilities but has been developed to accommodate modalities that require a more specific approach, such as field hospitals, mobile clinics, and community-based workers.¹⁰

Primary Health Care (PHC)

A whole-of-society approach to health designed to ensure the equitable distribution and highest possible level of health and well-being by focusing on people's needs (as individuals and as members of families and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care and doing so as close as is feasible to their everyday environment.¹¹

Health Post

A community centre with three key functions: community education, community empowerment, and community services. Enriched activities hosted by health posts include clinical maternal and child health, family planning, nutrition, immunization, diarrhoea control, under-five growth stimulation, and early childhood education.¹²

or

A community centre with no beds that delivers basic community health services.¹³

Health Clinic

A lower-capacity, frontline health facility, typically run by nursing or mid-level personnel, serving basic healthcare needs in under-resourced and frequently remote areas.¹⁴

PHC Unit/facility

A facility staffed by a physician or clinical officer and, often, a midwife that provides basic medical care, minor surgery, family planning and pregnancy services, and safe childbirth for uncomplicated deliveries.¹²

Name	Description
Fixed Facility	A permanent or semi-permanent structure dedicated to providing PHC services, either temporarily or permanently.
Mobile Clinic	<p>A Mobile Clinic is a moving service delivery platform that is self-sufficient (standalone) but can operate from a fixed facility. Mobile Clinics provide temporary, intermittent, preventative, and curative primary healthcare services delivered by a multidisciplinary team of trained health workers at multiple service delivery points during daylight hours in accordance with local guidance.</p> <ul style="list-style-type: none">• Fixed Mobile Clinic: operates entirely in a semi-permanent or permanent structure (public or private) and provides all services without requiring portable infrastructure (unlike a standalone Mobile Clinic).• Annexed Mobile Clinic: provides services from the premises of a permanent health facility (e.g., within the same compound) and utilizes its infrastructure (e.g., water, electricity, and waiting areas); some portable infrastructure may be needed.• Standalone Mobile Clinic: operates independently without reliance on external infrastructure or resources (e.g., under a tree or in a tent).
Service Delivery Point (SDP)	A pre-identified geographical location (e.g., open field, public or private structure, or health facility) agreed on with the target community leadership where fixed, annexed, or standalone Mobile Clinics provide PHC services.
Operating Hours (Mobile Clinic)	The effective patient contact or counselling hours spent by Mobile Clinic service providers at an SDP excluding travel, setup, and packing time.
Non-Users	Individuals living in the catchment area of a Mobile Clinic (i.e., within a 5-km radius or 1-hour walk) who have not visited an SDP or successfully obtained services for themselves or as caregivers since the clinic began operating.
Service Users	Individuals who have visited an SDP of a Mobile Clinic to obtain services for themselves or as caregivers.



Outline of the Practical Guidance

This guidance document supports the optimization of quality care provided through Mobile Clinics in humanitarian settings. The guidance is organized into two parts: Mobile Clinic Markers of Quality and an Operational Checklist for Mobile Clinic Interventions.

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Part 1: Mobile Clinic Markers of Quality

This part guides coordinators, implementers, planners, and MEAL staff in the use of the WHO/GHC Quality of Care framework with 24 quality markers specific to Mobile Clinics across seven domains. Each domain includes definitions, relevance, markers, challenges, links, guidance (Coordination, Proposal/Budgeting, Implementation, Monitoring and Evaluation, and Tools), and resources. The resources originate from various sources and humanitarian health partners.

Domains

1. People-Centred (Markers 1.1–1.3)

- Focuses on community engagement, feedback mechanisms, and addressing barriers to health seeking.

2. Safe (Markers 2.1–2.6)

- Emphasizes patient/staff safety, infection prevention and control (IPC), waste management, and privacy.

3. Equitable (Markers 3.1–3.3)

- Prioritizes access for vulnerable populations through gap analysis and inclusive SDPs.

4. Effective (Markers 4.1–4.3)

- Ensures quality-assured supplies, evidence-based triage, and clear communication of service scope.

5. Integrated (Markers 5.1–5.3)

- Supports coordinated referral systems, CHW engagement, and cross-sector advocacy.

6. Timely (Markers 6.1–6.4)

- Optimizes visit frequency, patient flow, and consultation time to reduce delays.

7. Efficient (Markers 7.1–7.2)

- Maximizes resource use through data-driven planning, surge capacity, and waste minimization.

Part 2: Operational Checklist for Mobile Clinic Interventions

This part provides a checklist for coordination bodies and health partners to manage Mobile Clinic interventions across six phases with prioritized tasks, low-resource adaptations, and equity considerations.

Phases: Assessment, Planning, Preparation, Implementation, Monitoring & Evaluation, Exit/Phase-Out

Additional Elements: Risk Matrix Template and Quick-Reference Summary (contacts, tasks, tips)



Part 1:

Operationalizing the Markers of Quality in Mobile Clinics



Domain 1: People-Centred Care

WHO/GHC Definition

Provides care that responds to individuals' preferences, needs, and values.

Key Considerations

- Healthcare provided is:
 - Dignified
 - Compassionate
 - Appropriate
 - Accessible
 - Relevant
 - Tailored to the specific needs of all, including the members of at-risk groups
- Understand and address barriers to healthcare and health-seeking behaviour.
- Respect and respond to community perceptions of health and desired health responses.
- Ensure community participation in the design of health programs.
- Establish responsive feedback and complaint mechanisms.
- Inform patients of their rights.

People-Centred Care in Mobile Clinics

Achieving people-centred care in Mobile Clinics requires significant investment, time, and targeted efforts, particularly during new crises, when the community may be unfamiliar with the Mobile Clinic team. Building trust is essential. The active inclusion of stakeholders from the affected community in the planning, evaluation, service continuation, and exit phases is crucial for fostering community ownership and enhancing health-seeking behaviours, including for services such as antenatal care (ANC), nutrition, and the control and treatment of non-communicable diseases (NCDs).

Markers of Quality for People-Centred Care in Mobile Clinics

Marker 1.1: Target groups for the Mobile Clinic must be clearly defined, understood by all stakeholders, and involved in planning, evaluation, continuation, and phase-out to enhance acceptance, ownership, and health-seeking behavior.

Marker 1.2: A strong, ideally independent and responsive feedback mechanism with multiple tool options must be established to improve patient and provider satisfaction and support health-seeking behaviour.

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Marker 1.3: Feedback systems must include tools that capture the perspectives of individuals from the target population who have not accessed Mobile Clinic services.

Linkages to Other Domains:

Equitable: Involving marginalized groups and those from areas beyond the immediate SDP in feedback processes helps ensure equitable access.

Integrated: Mobile Clinics are often constrained by the scope of their service packages and the operational guidance set by the Ministry of Health (MoH) or Health Cluster. When target groups are meaningfully engaged in the design of Mobile Clinic services, gaps and unmet needs, particularly in public health areas such as waste, sanitation, and hygiene (WASH), food security and livelihood, and shelter as well as referral support during non-operational hours, are likely to surface. To achieve a higher standard of care, it is essential to pursue integrated and coordinated solutions that address these broader needs.

Safe: The travel and setup time for Mobile Clinics impacts staff performance and patient safety, which, in turn, affects service quality and community trust.

Effective: When services are delivered in line with standard procedures and are accepted by the target population (e.g., ANC, nutrition, and the Expanded Programme on Immunization [EPI]), they are more likely to result in effective care and increased client satisfaction.

Practical Guidance to Enhance People-Centred Care in Mobile Clinics

Coordination (Cluster, Local Health Authorities)

- Use the Mobile Clinic Planning & Decision-Making Tool to determine suitable service delivery interventions.
- Engage local health authorities and community stakeholders in Mobile Clinic planning. Ensure that representation includes marginalized populations and those from areas beyond the immediate SDP.
- Clearly define and agree on the Mobile Clinic's target groups to prevent coverage gaps.
- Establish centrally managed and accessible complaint and feedback mechanisms early in the response.
- Provide early guidance for operationalizing the Mobile Clinic service package to all responding health actors. Ensure that service planning takes into account key operational factors that may affect implementation, quality of care, and patient satisfaction, including:
 - Logistical constraints
 - Travel time, curfews, and time to set up and pack the Mobile Clinic, which reduce effective service hours and consultation time
 - Physical and environmental access barriers
 - Poor road conditions caused by disasters (e.g., floods, earthquakes, and conflicts) or broken bridges
 - Challenging terrain (e.g., mountainous areas, dense forests, and deserts)
 - Adverse weather conditions (e.g., extreme heat, heavy rainfall, and cold)
 - Insecurity or ongoing conflict
 - Transportation and financial limitations
 - Lack of transport options (e.g., no access to cars, bicycles, or public transport)



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- Long distances or travel times to the SDP for patients as well as Mobile Clinic teams
- High out-of-pocket costs (e.g., user fees, medicine, and transport) that limit affordability
- Sociocultural and systemic barriers
 - Disparities based on age, sex, gender, ethnicity, religion, geography, language, or political affiliation
 - Community mistrust because of perceived low quality, discrimination, or stigma
 - Cultural or religious norms that restrict access to health services
- Refer to the **H3 Package** ([The High-Priority Health Services for Humanitarian Response](#)) as a service planning reference.

Proposal and Budgeting

- Include regular community engagement meetings to incorporate feedback into service adjustments.
- Include confidential and appropriate feedback mechanisms to gather input from service users and non-users. Consider a variety of channels to ensure accessibility, inclusivity, and safety, such as:
 - Feedback/suggestion boxes
 - Hotline or toll-free number (by call or SMS)
 - Patient exit interviews
 - Focus group discussions (with both users and non-users)
 - Community leadership or complaint and feedback committees
 - CHWs and volunteers
 - Health workers stationed onsite or designated focal points
 - Management structures for refugee camps and internally displaced persons (IDPs)
 - Local (health) authority representatives
 - Visitors' logbooks
- Allocate sufficient MEAL staff for feedback handling and reporting.
- Include risk assessments and community walks to identify accessible SDPs.
- Include a (Tanahashi) Barrier¹⁵ analysis to assess service availability, accessibility, and acceptability barriers of the SDPs incorporated into the proposal.
- Plan for inclusion of host communities where applicable (e.g., in refugee and IDP contexts).
- Include communication costs, such as equipment and airtime, in the budget. These costs may include radios, mobile phones, or satellite phones to maintain contact with local authorities, referral facilities, emergency services, and headquarters.

Pre-Implementation and Implementation

- Hold project kick-off meetings and SDP selection involving diverse stakeholders, including women leaders, marginalized groups, and IDP/refugee camp management.
- Conduct a barrier analysis, community transect walks,² or risk assessments. Evaluate barriers, including conflict and insecurity, access constraints (e.g., ethnicity and other social factors), movement of nomadic populations, blocked or damaged roads, communication challenges, availability of WASH and shelter at SDPs, and sufficient

2 A transect walk involves walking through the community to observe and discuss the daily activities, the surroundings and the risks and resources (<https://preparecenter.org/wp-content/uploads/2023/08/Transect-walk.pdf>).

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space to accommodate patients.

- Avoid locating SDPs on private property or religious sites unless equitable access is assured.
- Communicate clearly with target populations about:
 - o Services provided (and not provided)
 - o Free of charge
 - o Frequency and duration of Mobile Clinic operations hours and exit plans
 - o Roles of CHWs/volunteers in information dissemination
 - o Ensuring that those from areas beyond the immediate SDP receive all relevant information regarding the Mobile Clinic
 - o Providing appropriate and acceptable complaint and feedback options
- Recruit staff from within the target community when feasible to increase trust and reliability.

Monitoring and Evaluation

- Regularly engage communities to review feedback and resulting changes.
- Share community feedback with Mobile Clinic team members and include them in response planning.
- Use multiple, context-appropriate feedback methods (e.g., exit interviews, focus group discussions [FGDs], and hotlines). Suggestion boxes may be less feasible because of mobility.
- Engage non-users proactively to capture broader community input.
- Categorize feedback by urgency and set clear timelines for response (e.g., 24–72 hours, next clinic visit, weekly reviews).

Domain 1: People-Centred Care - Tools and Resources

- [The High-priority Health Services for Humanitarian Response \(the H3 package\)](#)
- [A toolkit for advancing women’s and girls’ empowerment in Humanitarian Settings, Tool 5: Safety Mapping \(IMC, IRC\)](#)
- [Client Exit Interview Questionnaires](#)
- [Focus Group Discussion Guides](#)
- [Patient Safeguarding Guide \(IMC\)](#)
- [Site Selection Key considerations \(IMC\)](#)
- [Creating and Managing Feedback and Accountability Mechanism \(Care\)](#)





Domain 2: Safe Care

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WHO/GHC Definition

Safe care avoids harm to the people receiving care and those providing it.

Key Considerations

- Healthcare is:
 - Physically and emotionally safe for patients and staff
 - Delivered in secure, well-designed environments
 - Supported by safe treatment protocols and practices
- Ensure safe access, infrastructure, and patient movement.
- Uphold patient rights, including informed consent, privacy, and confidentiality.
- Prevent harm, including violence or abuse from healthcare providers.
- Maintain staff safety and well-being.
- Implement effective IPC and WASH measures.
- Practice safe medication management.
- Use quality assurance and risk management tools.
- Procure and manage medical equipment and consumables safely.



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Safe Care in Mobile Clinics

Ensuring the safety of patients and providers in Mobile Clinics is inherently challenging because of the non-permanent, open-air, or semi-structured nature of these setups. Environmental factors such as dust, rain, heat, and wind severely impact IPC measures.

Water and sanitation access is often inadequate, affecting both IPC and general service quality. Mobile Clinics operating in areas with limited potable water may exacerbate local shortages. As a mitigation, water is often transported to sites for hand hygiene, hydration, and child health interventions. However, handwashing stations are typically few because of vehicle transport limitations. This scarcity, combined with the universal challenge of hand hygiene in healthcare settings, is magnified in mobile service delivery.

Mobile Clinics may benefit from existing WASH infrastructure when hosted in permanent community buildings, but the frequently insufficient cleaning and decontamination after operations pose risks of healthcare-associated infections.

Due to the lack of time, space, equipment, electricity, and water, onsite sterilization and waste disposal are usually not feasible. Instead, reusable equipment and infectious waste must be safely packed and transported to equipped static facilities. The transmission risks increase during handling and transit.

Other compounding safety risks include:

- Exhausting travel conditions
- Long setup times
- Overcrowded SDPs
- High caseloads with limited consultation time

Moreover, many Mobile Clinics lack systems for reporting and managing medical errors and incidents.

Markers of Quality for Safe Care in Mobile Clinics

Marker 2.1: All components of patient safety must be upheld, with regular sensitization and training for all staff.

Marker 2.2: WASH and infrastructure must support core IPC measures.

Marker 2.3: Outsourced infectious waste management must follow strict standard operating procedures (SOPs) for handling and transport, with close monitoring and support of the treatment sites.

Marker 2.4: For setups in public or communal buildings, robust decontamination SOPs must be in place.

Marker 2.5: Visual and audio privacy must be ensured through effective crowd control, space allocation, and adequate shelter.

Marker 2.6: Mobile Clinics should advocate for broader community WASH support and integration with public health activities.

Linkages to Other Domains

People-Centred: Limited infrastructure and higher potential for errors reduce service user satisfaction and trust in care delivery.

Integrated: To effectively reduce disease burden, Mobile Clinics must be complemented by preventive public health measures. While the clinics provide health education, limited

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community infrastructure often hinders implementation. Positioned within communities, they can advocate and coordinate to address basic health needs. Without broader infrastructure investment, they remain a symptomatic response. Sustainable transition requires the rebuilding of public health systems, with Mobile Clinics continuing to serve as key health education platforms.

Equitable: Cultural practices must be respected in patient flow to prevent access barriers. Gender-segregated spaces and ensured privacy are critical, especially for conducting essential physical exams like antenatal checks. Without privacy, patients, particularly women, may avoid care or be restricted by family members. Placing Mobile Clinics on private property may also lead to monopolized or politicized access that excludes vulnerable groups in areas with no alternative services.

Effective: The services included in Mobile Clinic packages must be safe and feasible in the mobile context. Not all standards from fixed facility service packages can be met. To ensure effectiveness, service selection should account for limitations of Mobile Clinics such as intermittent schedules, short operating hours, limited transport capacity, lack of after-hours (referral) care, and constrained referral options because of limited vehicle availability and infrastructure challenges.

Timely: The intermittent frequency and limited hours of Mobile Clinics increase the time pressure and workload for health workers, often resulting in rushed consultations. This situation increases the risk of errors, missed diagnoses, incomplete history-taking, skipped physical exams, and inadequate patient communication, thereby compromising safety and satisfaction. As an example of the challenges associated with short and infrequent service windows, a patient experiencing an adverse reaction after a clinic has left cannot receive follow-up.

Practical Guidance to Enhance Safe Care in Mobile Clinics

Coordination (Cluster, Local Health Authorities)

- Develop a supervision schedule and organize joint supportive supervision visits to Mobile Clinics by various health actors.
- Support and coordinate infectious waste management and sterilization through existing health facilities (e.g., health centres or referral hospitals).
- Consolidate unmet public health needs of populations targeted by Mobile Clinics and advocate for additional public health interventions and resources.
- Ensure that a Protection from Sexual Exploitation and Abuse (PSEA) policy is in place, known, and understood by all staff members, partners, and community members. Establish clear, accessible mechanisms for reporting and managing PSEA cases in line with organizational and inter-agency protocols.

Proposal and Budgeting

- Include staff (refresher) training and orientation on patient safety, treatment protocols, and guidelines.
- Include the provision of Mobile Clinic-friendly (laminated/weather-proof, easy to carry, etc.) guidelines, tools, job aids, and treatment protocols.
- Include regular technical supportive supervision by clinical, pharmaceutical, and IPC/WASH staff.
- Include a robust medical incident management system.
- Include a WASH component and WASH support staff.



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- Consider including a gender/protection specialist or their time in the budget to plan staff training on PSEA.
- Budget for
 - o Incentive payments to daily labourers or volunteers for non-clinical tasks (e.g., water transport, clinic set-up)
 - o Support costs at the final treatment site (e.g., fuel, personal protective equipment [PPE], equipment, materials)
 - o Rehabilitation of waste management infrastructure at the treatment site
 - o Safe transportation of infectious waste
 - o Mentoring, training, and supervision of waste management operators
- Budget for IPC with attention to decontamination when using public or private buildings.
- Budget for an extra set of reusable medical equipment to allow for sterilization rotation.

Pre-Implementation and Implementation

Preparing Staff

- Recruit supervisory staff for clinical, pharmaceutical, and IPC/WASH components.
- Consider full-time roving IPC/WASH supervisors or integrate into staff job descriptions.
- Integrate PSEA into staff recruitment and vetting processes and ensure that all staff members have reviewed, understood, and signed the PSEA policy before deployment.
- Engage community members and conduct joint safety assessments when selecting Mobile Clinic SDP locations to ensure security, community acceptance, and accessibility.
- Acknowledge the demanding Mobile Clinic work environment, which includes high caseloads, long travel times, outdoor exposure, and, often, insecure conditions. Consider introducing a timely rest and recuperation (R&R) package, including for local staff, to maintain staff well-being and performance.
- Orient/train staff members on SOPs, setting up an SDP, referrals, medical waste transportation, patient safety, conducting physical examinations in a mobile clinic, incident management, IPC, treatment protocols, recording and reporting, and their roles and responsibilities.
- Provide each team with treatment protocols, tools, and job aids (printed and laminated).
- Establish a no-blame incident management system that is linked to feedback mechanisms. Hold regular case review sessions with service providers or incorporate incident discussions into routine management meetings. Ensure that a mechanism is in place to communicate corrective actions and follow-up plans regularly to all staff members based on reported incidents.
- Orient all staff members on the code of conduct and safeguarding policies.

Guidance for SDP Setup

- Ensure one-way patient flow when possible.
- Use existing shelter (e.g., trees, canopies, and communal shelters) for waiting areas or construct shelter with local materials and support from the community if necessary.
- For privacy, ensure that there is distance between the waiting and consultation areas.
- Provide sufficient seating with adequate spacing.
- Plan for surge capacity to manage (unpredictable) crowding.
- Include an isolation/holding area for reportable diseases.

IPC and Infectious Waste Management



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- Develop and implement SOPs for waste management and transport to treatment sites.
- Ensure rigorous decontamination protocols for public and communal buildings after use.
- Assess the functionality of (outsourced) waste treatment sites, infrastructure, and devices (e.g., incinerators and crushers).
- Support the rehabilitation of waste treatment sites in accordance with national or international standards.

Supplies

- Designate a person responsible for daily packing and supply checks.
- Procure and provide all necessary medical and IPC items, equipment, furniture, and tools.
- Pre-package medication in various dosages.

Water Supply

- Ensure the water supply for staff members and patients. The Sphere standards for Mobile Clinics should meet outpatient WASH standards, including access to safe water and toilets.
- Water needs: 1 L per patient per day for infrequent visits; 5 L per patient per day for frequent visits.¹⁰
- Engage community volunteers or porters for water transport.

Security and Operational Safety

- Assess geographic, road, and security conditions in all areas to be served by the Mobile Clinic.
- Pre-plan safe travel routes, including alternative routes in case of blockage, lack of security, or hazardous conditions.
- Define a phased deployment approach that incorporates security and safety checks at each stage.
- Establish a clear staff communication protocol, especially for emergencies such as extreme weather, civil unrest, and restrictions to access.

Monitoring and Evaluation

- Plan regular supportive supervision visits with IPC/WASH supervisors.
- Conduct joint visits with local authorities and health clusters.
- Include visits to final waste treatment sites.
- Ensure that the Mobile Clinic Quality Monitoring Tool is available and staff members are trained.



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Domain 2: Safe Care - Tools and Resources

- [Supply lists \(furniture, equipment \(SCI\)\)](#)
- [Checklist for Mobile Clinic Operation \(SCI\)](#)
- [Mobile Clinic setup and patient flow outlines \(SCI/IRC/International Medical Corps \[IMC\]\)](#)
- [Safety and Security checklist for Mobile Clinic and Security Plan template](#)
- [Mobile Clinic Daily Operating Reminder List](#)
- [Guideline Healthcare Waste Management](#)
- [Dispensing Standard Operational Procedure \(SOP\)](#)
- [Medical incident management tools \(SCI\)](#)
- [Infection Prevention and Control \(IPC\) Guidance](#)
- [IPC posters: Ambulance Decontamination](#)
- [IPC Poster: hand hygiene](#)
- [IPC Poster: donning and doffing Gloves](#)
- [Waste Segregation and Treatment for Mobile Clinics](#)
- [Policy: Conducting Intimate Physical Examinations of Female Patients \(IMC\)](#)
- [Child Safeguarding in Health \(SCI\)](#)



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Domain 3: Equitable Care

WHO/GHC Definition

Provides health care that does not vary according to age, sex, gender, race, ethnicity, geographical location, religion, socioeconomic status, linguistics, or political affiliation etc.

Key Considerations

- Healthcare is
 - fair, inclusive, and impartial,
 - culturally and linguistically appropriate, and
 - responsive to the needs of vulnerable and underserved groups.
- Ensure equitable access across all population groups and locations.
- Communicate in local languages using accessible formats.
- Avoid reinforcing social, political, or conflict-related divisions.
- Use disaggregated data to track and improve inclusion.
- Identify and address barriers limiting access.

Equitable Care in Mobile Clinics

Mobile Clinics are designed to increase healthcare access for marginalized, remote, and vulnerable populations by reaching areas underserved by static health facilities. However, achieving equitable care depends on thoughtful planning of SDPs and overcoming the inherent limitations of Mobile Clinics.

Mobile Clinics operate within a fixed radius to allow same-day return to base. Closer SDPs are less resource-intensive and easier to implement in a manner consistent with quality standards. Conversely, distant, hard-to-reach areas often require long travel on poor roads in cramped vehicles, which impacts the well-being of staff and patient care time, potentially lowering service quality. As a result, the most vulnerable communities' risk being deprioritized if travel costs and logistics dominate the selection of SDPs.

During the early response phase, Mobile Clinic locations may be based on limited data. Reaching more difficult areas requires detailed planning and complicates eventual handover or exit, especially in protracted crises during which pre-existing health systems may be limited.

Distance also affects community awareness of the schedules of Mobile Clinics and the services that they provide, and physical access particularly impacts individuals who have limited mobility or acute illnesses.

In IDP or refugee contexts, Mobile Clinics may be hosted in local communities, but their focus is often on displaced populations. To ensure equitable care, host communities must also be considered in the target population.

Markers of Quality for Equitable Care in Mobile Clinics

Marker 3.1: Service delivery point selection must be based on context-specific healthcare access gap analyses to prioritize vulnerable populations and identify additional unmet needs.



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Marker 3.2: All stakeholders must understand the target population, selection criteria, and procedures for escalating communities without access to care.

Marker 3.3: Systems must be in place to identify and assist individuals unable to access the Mobile Clinic, including people with disabilities.

Linkages to Other Domains

Timely: Increasing frequency can improve quality but reduce geographic coverage and, thus, poses ethical dilemmas regarding equity.

People-Centred: Equitable care reinforces people-centredness by ensuring that services meet the needs of all subgroups.

Integrated Care: Work hand in hand with Equitable Care by ensuring inclusive and comprehensive service delivery. Equitable Care focuses on removing barriers that prevent marginalized and underserved groups from accessing services, while Integrated Care ensures that, once individuals do access services, the full range of their health and related needs, both medical and non-medical, is addressed through coordinated referrals, cross-sector collaboration, and strong community-based links.

Practical Guidance to Enhance Equitable Care in Mobile Clinics

Coordination

- Coordinate with health authorities and partners to ensure access to current healthcare coverage gap mappings.
- Use the Mobile Clinic Planning & Decision-Making Tool and joint assessments (e.g., FGDs) to identify barriers, especially for non-users.
- Mobile Clinic partners can conduct and use joint rapid needs assessments to coordinate their responses, thereby avoiding duplicative individual assessments.
- Advocate for the placement of IDP sites near operational areas to ease Mobile Clinic deployment.
- Update health service and barrier mappings regularly (e.g., every 3–6 months) to adjust service strategies.

Proposal and Budgeting

- Budget for community-level kick-off meetings at each SDP to clarify target populations and selection criteria.
- Include ongoing community engagement (e.g., monthly meetings) to identify underserved areas.
- Plan for risk assessments and community “transect walks” for SDP identification.
- Allocate resources for sub-offices and staff accommodations near SDPs to reduce travel and extend service hours.
- Budget sufficient staff based on the package of health services offered and consider ethnicity, language, and gender.
- Budget for the support or strengthening of CHW networks to reach people with disabilities, older adults, and other vulnerable populations unable to access clinics independently.



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- Plan for inclusive access to SDPs for persons living with disabilities. This planning includes considering adaptive equipment (e.g., ramps, seating) and temporary structural elements (e.g., wide pathways, accessible consultation areas) that accommodate diverse mobility and functional needs.

Pre-Implementation and Implementation

Target Groups:

- Ensure that all stakeholders (e.g., community leaders, health authorities, and camp management) understand the target population criteria.
- Equip staff members to manage cases from outside the target group and escalate missed communities.
- Include strategies for capturing the voices of populations distant from SDPs.

SDP Identification:

- Involve community representatives and authorities in SDP location planning.
- Choose accessible sites by considering terrain, road damage, disability inclusion, and conflict dynamics.
- Prioritize the safety of the target population. Specifically, ensure that sites are cleared and accessible by safe routes and provide alternate SDPs if there are ethnic tensions.

SDP Setup:

- Use non-functional health facilities that are structurally sound; otherwise, set up in central community spaces (e.g., markets and schools) familiar to the target population.
- Ensure that sites are cleared of hazards and child-safe.

Community Engagement & Communication:

- Provide all information in local languages and accessible formats.
- Ensure ongoing dialogue with both users and non-users to adjust service delivery.

Staff Recruitment:

- Prioritize hiring providers who speak local languages; if it is not feasible to hire such providers, ensure that translators are available (and consider their gender).
- Ensure a balanced ratio of female and male service providers, particularly in conservative settings.
- Recruit qualified staff locally where possible and explore guesthouse options to reduce commute times and increase consultation hours, ideally, at the proposal stage, or negotiate realignment.

Monitoring and Evaluation:

- Track disability and other diversity, equity, and inclusion (DEI) metrics to assess service reach.
- Ensure non-users' voices are included in feedback mechanisms by using tools such as the Mobile Clinic Quality Monitoring Tool.

Domain 3: Equitable Care - Tools and Resources

- [FGD Guide for Non-Users](#)
- [Mobile Clinic Quality Monitoring Tool](#)
- [A step-by-step guide to conduct transect walks \(IFRC\)](#)





Domain 4: Effective Care

WHO/GHC Definition

Provides evidence-based health care services to those who need them.

Key Considerations

- Healthcare is:
 - Evidence-based and context-adapted
 - Delivered in line with national guidelines, standards, and SOPs
 - Supported by timely and complete health information
- Ensure the availability of:
 - Core services (e.g., Essential Package of Health Services [EPHS] or the H3)
 - Essential medicines, devices, and consumables
 - Qualified staff with the appropriate skills and in the appropriate ratios
- Provide regular training, supervision, and performance support for health workers.
- Ensure that providers offer accurate advice and patient counselling.

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Effective Care in Mobile Clinics

Mobile Clinics rely heavily on emergency health kits, such as the Interagency Emergency Health Kit (IEHK), that offer standardized, prequalified pharmaceuticals and equipment suitable for rapid response.¹⁶ While IEHKs provide timely access and ease of logistics, they are not tailored for use in Mobile Clinic service packages and do not meet all national or Health Cluster requirements, particularly for immunization, reproductive health, human immunodeficiency virus (HIV)/tuberculosis (TB), NCDs, and malnutrition. This mismatch leads to the rapid depletion of some items, the underuse of others, and limited ability to



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provide comprehensive care. In some countries, Mobile Clinics define kits specifically aligned with the service package and contextual needs.

Effectiveness is further impacted when stock shortages, lack of triage protocols, or overworked staff compromise service quality. Members of communities may expect every visit to result in treatment, placing pressure on health workers to dispense unnecessary medications or supplements.

Markers of Quality for Effective Care in Mobile Clinics

Marker 4.1: Mobile Clinics must maintain sufficient quantities and types of quality-assured medical supplies aligned with the service package throughout the project duration.

Marker 4.2: Evidence-based triage protocols must be in place, preferably conducted by trained community members before Mobile Clinic arrival.

Marker 4.3: Mobile Clinics must communicate clearly which services are available, manage expectations of the community, and advocate with partners for uncovered health needs.

Linkages to Other Domains

Safe: High-quality supplies are essential for patient safety. Stock shortages or limited pharmaceutical options can compromise care, such as when full treatments are unavailable or dosages must be split (e.g., for children). Again, cultural expectations of receiving medication at each visit may pressure health workers to prescribe unnecessarily. Additionally, high caseloads and limited time in Mobile Clinics often reduce the quality of patient counselling, thereby increasing the risk of inappropriate or avoidable prescriptions.

People-Centred: High-quality supplies attract service users, while repeated shortages may deter them, thereby reducing trust and continuity of care.

Practical Guidance to Enhance Effective Care in Mobile Clinics

Coordination

- Provide clear guidance on Mobile Clinic service packages, essential drugs, and supply lists.
- Ensure quality control for local procurement.
- Coordinate the procurement and delivery of emergency kits (e.g., IEHKs and reproductive health [RH] kits) in the first 3–6 months of an emergency.
- Coordinate and redistribute under-utilized medicine and medical supplies to avoid shortages.
- Simplify customs and importation procedures in coordination with MoHs and government bodies.
- Engage donors to support stock replenishment and buffer supplies.
- Specify the minimum required documentation for patient care.



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Proposal and Budgeting

- Budget beyond IEHKs for additional medicines and long-term supply needs.
- Plan and fundraise or pre-position buffer (virtual) stocks for rapid deployment.
- Consider local seasonal disease trends when estimating pharmaceutical and medical supply needs.
- Anticipate unpredictable needs, specifically in areas where health services are not free or the surrounding facilities have stock-outs of medications.
- Establish framework agreements with vetted suppliers.
- Allocate medical supply chain staff.
- Include a dedicated dispenser on the team to ensure proper counselling and reduce clinicians' workloads.
- Plan for CHWs and supervisors in all Mobile Clinic catchment areas.

Pre-Implementation and Implementation

- Pre-position supplies where possible and start procurement early.
- Establish memorandums of understanding (MOUs) with partners such as the MoH, United Nations Population Fund (UNFPA), UNICEF, and the WHO for medical supplies and resources.
- Ensure adequate buffer stocks to accommodate unpredictable patient loads during the early stages of a response.
- Initiate procurement early, identify and prepare storage space, and recruit qualified supply chain staff or assign responsibilities accordingly.
- Develop and train staff regarding supply chain SOPs for Mobile Clinics.
- Implement triage protocols, ideally with CHWs or trained volunteers, before opening hours.
- Train CHWs at each SDP in screening and triage procedures.
- Communicate the scope of service and eligibility to communities before and during operations.
- Educate communities on the appropriate use of medicines and supplements.
- Map nearby partners and sectors and establish referral systems for non-covered services.

Monitoring and Evaluation

- Monitor supply consumption and produce regular reports.
- Track referrals and their outcomes to ensure follow-through and service continuity.
- Provide supportive supervision and technical support for all Mobile Clinic staff on adherence to guidance and SOPs.

Domain 4: Effective Care - Tools and Resources

- [Medical Supplies Consumption Monitoring Report \(SCI\)](#)
- [Medical Supply Chain for Mobile Clinics \(SCI\)](#)
- [Interagency Integrated Triage Tool](#)
- [Emergency Triage Assessment and Treatment \(WHO\)](#)





Domain 5: Integrated Care

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References

WHO/GHC Definition

Provides care that is coordinated across levels and providers (as well as sectors) and makes available the full range of health services across the life course.

Key Considerations

- Healthcare is:
 - Coordinated across health system levels and sectors
 - Delivered through functioning referral systems with clear pathways and protocols
- Ensure:
 - Functional and responsive referral systems (including medical and non-medical)
 - Mapping of actors, services, and resources
 - Integration with other sectors (e.g., WASH, nutrition, protection, education)
 - Regular monitoring and follow-up of referrals

Integrated Care in Mobile Clinics

Mobile Clinics serve as a crucial entry point for healthcare in remote, underserved areas and play a key role in bridging communities to higher levels of care through timely referrals. Their presence within communities also gives them unique insight into broader public health and social needs such as food insecurity, lack of protection services, and inadequate WASH infrastructure. Accordingly, Mobile Clinics are positioned not only to deliver clinical care but also to trigger cross-sector responses and advocate for holistic, people-centred support.

Integration also enhances patient outcomes and health provider satisfaction by ensuring that essential services across the life course are coordinated and accessible.

Markers of Quality for Integrated Care in Mobile Clinics

Marker 5.1: All partners must jointly plan and support a coordinated referral system covering logistics, financial costs, and follow-up during and beyond Mobile Clinic hours.

Marker 5.2: Mobile Clinics must strengthen CHW systems to support referrals, especially when the Mobile Clinic is not operating.

Marker 5.3: Given their direct community presence, Mobile Clinics must advocate for unmet needs beyond health such as WASH, food security, and protection.

Linkages to Other Domains

Timely: Integration with health and non-health sectors enables faster access to essential services, improving quality and coverage.

Effective: Addressing foundational needs (e.g., WASH, food, and safety) supports better health outcomes and makes treatments more effective.



Practical Guidance to Enhance Integrated Care in Mobile Clinics

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References

Coordination

- Collect and share 4W (who, what, where, and when) mapping across partners.
- Consider a centralized referral mechanism to maximize resource use.
- Advocate for donor support to expand referral services and higher-level care.
- Facilitate cross-sector coordination (e.g., with WASH, Nutrition, Protection, Mental Health and Psycho-Social Support [MHPSS], Food Security and Livelihoods [FSL], and Education) to create functional referral pathways.
- Establish partnerships with GBV, mental health, and social service organizations to strengthen referral pathways, ensure appropriate follow-up, and provide access to specialized care when needed.

Proposal and Budgeting

- Design integrated, multi-sector responses (Health, WASH, Nutrition, and MHPSS) when possible.
- Budget for all referral-related costs: transport (return trip), escorts, follow-up, and patient support.
- Consider a dedicated referral vehicle, especially for remote or high-traffic SDPs.
- Include mechanisms and staff time for follow-up after referrals.

Pre-Implementation and Implementation

Monitoring and Evaluation

- Track all referrals, follow-up actions, and outcomes using standardized tools.
- Identify and map both medical (e.g., complications, deliveries) and non-medical referral services.
- Develop referral SOPs, including eligibility, contact details, and cost coverage procedures.
- Budget for communication channels (mobile and satellite phone, airtime) to coordinate for referrals.
- Print, laminate and distribute referral contact sheets to Mobile Clinic teams.
- Ensure financial systems can handle direct support for referrals (e.g., travel and treatment).
- Include CHWs in referral pathways especially for off-day support and screening of nonurgent cases.
- Attend coordination meetings with other sectors and advocate for unmet needs observed during Mobile Clinic operations.
- Integrate follow-up responsibilities into CHW or relevant staff roles.
- Train Mobile Clinic teams on referral SOPs during onboarding and regular meetings.

Domain 5: Integrated Care - Tools and Resources

- [Mobile Clinic Referral of Medical Care SOP](#)





Domain 6: Timely Care

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References

WHO/GHC Definition

Reduces waiting times and harmful delays for both those who receive care and those who give care.

Key Considerations

- Healthcare is:
 - Delivered promptly with minimal delays in access or treatment
 - Structured to optimize patient flow and reduce overcrowding
- Ensure:
 - Timely access to consultations and clinical decision-making
 - Functioning referral pathways and after-hours support
 - Efficient operational programming and resource allocation
 - Effective complaint and feedback mechanisms
 - Timely collection and use of health data to inform public health decisions

Timely Care in Mobile Clinics

Mobile Clinics are designed to provide rapid access to essential health services, especially in emergencies and underserved areas. Their mobility allows for fast deployment in crisis contexts. However, the intermittent nature of Mobile Clinic operations, which are often limited to one day per week per location with 4–6 hours of service, results in significant gaps in access. During most of the week, no services are available, so there are barriers to timely care, particularly during emergencies such as childbirth, trauma, or acute illness.

High patient volumes build up while the Mobile Clinic is not at the SDP during the week, and short consultation windows lead to long wait times, overcrowding, and rushed care. Patients may leave without being seen, and health providers may have limited time for proper examination, diagnosis, and counselling. Additionally, unpredictable turnout and caseloads make it difficult to manage resources efficiently, thereby increasing the risk of stockouts and compromised care.

Markers of Quality for Timely Care in Mobile Clinics

Marker 6.1: Mobile Clinics must optimize visit frequency and operational hours to maximize care quality and access.

Marker 6.2: Travel, setup, and takedown time must be minimized to maximize patient consultation time.

Marker 6.3: Mobile Clinics must establish effective crowd control and patient flow systems to maximize operational efficiency and consultation time.

Marker 6.4: Mechanisms must be in place to manage patients who are not seen during operational hours.

Linkages to Other Domains

Equitable & Efficient: Increasing frequency may improve care quality but reduce geographic reach, potentially affecting equitable access and overall efficiency.



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References

People-Centred: Overcrowding and long wait times negatively affect patient experience and satisfaction.

Safe & Effective: Rushed consultations and unmanaged crowds increase the risks of clinical errors, cross-infection, and inadequate treatment. Unpredictable patient numbers make it difficult to accurately forecast daily supply needs, thereby increasing the risk of stockouts and untreated conditions.

Integrated: Without after-hours support, timely referrals and access to emergency or follow-up care are severely limited.

Practical Guidance to Enhance Timely Care in Mobile Clinics

Coordination

- Develop guidance on the optimal frequency of visits and the optimal number of SDPs per Mobile Clinic tailored to the context. Avoid a blanket approach.
- Assess factors including:
 - The size and distribution of the target population
 - Referral options and affordability after hours
 - Availability and integration of CHWs
 - Consultation time per patient compared with available operating hours
 - Impact of travel and setup time compared with service delivery time

Proposal and Budgeting

- Plan for offices and accommodations close to SDPs to reduce travel time.
- Design realistic team compositions based on local needs (e.g., mental health, nutrition, and IPC). Consult the H3 Mobile Clinic Service Package.
- Include dispensers, registrars, community volunteers (CVs), and CHWs to reduce the burden on clinicians and support crowd management and patient flow.
- Budget for surge capacity and backup team members for leave coverage and emergencies.
- Include operational and administrative support staff (supply chain, administration, logistics).
- Link each SDP with sufficient CHWs or CVs for triage, mobilization, and follow-up.

Pre-Implementation and Implementation

- Clearly define roles and distribute workload across team members.
- Recruit, reactivate, or engage CHWs and CVs for each SDP and involve them in mapping and identifying service delivery points.
- Engage CHWs and CVs in SDP mapping, triage, and client follow-up.
- Train staff on patient flow organization and designate someone to oversee it.
- Implement CHW-managed triage systems for early arrivals and patients missed in prior visits (e.g., ticketing or a card system).
- Train CHWs regarding danger signs and referral pathways.



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References

- Strengthen support for referral facilities and explore staff accommodation hubs to increase operational time.
- Clearly communicate Mobile Clinic schedules, services, and any changes to the community.
- Schedule fixed weekly visits to each SDP to support follow-up care, especially for services such as Expanded Programme on Immunization (EPI) and ANC.
- Conduct regular supportive supervision and mentorship for Mobile Clinic teams.
- Strengthen links with referral facilities and explore joint planning, surge support, and training opportunities.
- Support Community Committees to facilitate and fund local referral pathways.
- Establish a system for administrative and support staff to provide operational support, including replenishing supplies and completing paperwork.

Monitoring and Evaluation

- Use client exit interviews to track waiting times, missed consultations, and patients' experiences.
- Monitor and adjust clinic operations based on crowd size, consultation time, and follow-up needs.

Domain 6: Timely Care - Tools and Resources

- [Mobile Clinic setup and patient flow outline \(SCI\)](#)
- [Mobile Clinic Quality Monitoring Tool \(SCI\)](#)
- [Mobile Clinic Estimation for consultation time and visit frequency \(SCI\)](#)



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Domain 7: Efficient Care

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References

WHO/GHC Definition

Maximizes the benefit of available resources and avoids waste.

Key Considerations

- Healthcare is:
 - Evidence-based and cost-effective
 - Delivered through optimized logistics, staffing, and service models
- Ensure the availability of:
 - Efficient use of human, technical, and financial resources
 - Strong logistics and stock management systems
 - Coordinated planning and resource sharing across partners and sectors
 - Flexibility to respond to variable caseloads and service demand
 - Environmental and operational sustainability

Efficient Care in Mobile Clinics

Mobile Clinics operate within tight logistical and resource constraints. Efficiency affects nearly every aspect of service delivery, from staffing, supply chain planning, and setup time to operational hours, visit frequency, and coordination.

While inherent limitations exist, efficiency can be significantly improved through careful forecasting, the strategic deployment of staff, cross-clinic coordination, shared resource hubs, and the use of digital tools. Additionally, Mobile Clinics must minimize waste, reduce duplication, and proactively adapt to unpredictable patient flows in order to maintain quality while reaching as many people as possible.

Markers of Quality for Timely Care in Mobile Clinics

Marker 7.1: Mobile Clinics must anticipate and plan staffing, supply types, and quantities for unpredictable high caseloads, especially when operating with low visit frequency and limited hours.

Marker 7.2: Mobile Clinics should use service utilization and operational data to continually refine resource allocation, identify bottlenecks, and minimize waste.

Practical Guidance to Enhance Efficient Care in Mobile Clinics

Coordination

- Provide early guidance for service packages (the H3 package), staffing structures, and operational models.
- Coordinate resource-sharing among Mobile Clinic partners, including:
 - Human resources (e.g., specialists and health staff)
 - Technical resources (e.g., SOPs, tools, and guidelines)
 - Operational support (e.g., logistics, referral systems, and stock management)



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- Advocate with donors and authorities for:
 - o Flexible funding
 - o Pre-positioned or buffer stocks
 - o Streamlined importation and procurement pathways
- Coordinate shared technical roles or pooled resources across nearby Mobile Clinics (e.g., pharmacists and cold chain technicians).

Proposal and Budgeting

- Budget for surge capacity: additional supplies and backup staff to manage peaks in demand.
- Budget for transition to routine service delivery.
- Include support staff (supply chain and administration) and role-specific team members (e.g., registrars and crowd managers).
- Plan for more frequent visits to high-volume SDPs if feasible.
- Budget for strategically located sub-offices or guesthouses to reduce travel time and maximize consultation hours.
- Include low-emission solutions where possible (e.g., solar energy systems and fuel-efficient cold chains).
- Incorporate digital tools for stock tracking and service documentation to reduce duplication.

Pre-Implementation and Implementation

- Analyse daily patient load data and community trends to forecast turnout and adjust staff and supplies accordingly.
- Collaborate with other partners to share logistics, supply systems, and specialist roles.
- Integrate lower-volume tasks into other job descriptions when full-time roles are not needed.
- Implement quarterly internal “efficiency reviews” to assess workload distribution, stock usage, and consultation time.
- Introduce simple crowd control tools (e.g., ticketing or card systems) to manage patient flow and prevent congestion.
- Develop systems for triage and crowd management led by CHWs before the arrival of Mobile Clinics to improve consultation flow.
- Use digital platforms (e.g., KoboToolbox and DHIS2) for real-time stock, patient, and referral tracking when feasible.

Monitoring and Evaluation

- Track service utilization by date and SDP to identify inefficiencies and guide adjustments in visit frequency and team composition.
- Monitor stock consumption and forecast supply needs based on actual trends

Domain 7: Efficient Care - Tools and Resources

- Daily Service Utilization Tally Sheet
- Digital Tools for Real-Time Data Collection (e.g., Kobo, DHIS2) SCI Ethiopia



Part 2:

Mobile Clinics Quality Assurance Operational Checklist

Purpose

This checklist supports Coordination (e.g., MoH and Health Cluster) and Health Partners in the planning, implementation, and phasing out of Mobile Clinic interventions in humanitarian settings. It follows the project management cycle (assessment, planning, preparation, implementation, monitoring and evaluation, and exit) with detailed, prioritized tasks, timelines, and considerations for resource-constrained contexts.

Tasks are marked as:

Critical (must-do),

Recommended (high-impact and context-dependent), or

Extended (flexible based on resources).



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Assessment



Coordination

Task	Priority	Notes
Use existing assessment tools (e.g., Mobile Clinic Planning & Decision-Making Tool) to identify suitable service delivery modalities.	Critical	Align with the MoH and Health Cluster. Use tools such as the H3 package or EPHS to define the service scope.
Coordinate with other sectoral assessments (e.g., Shelter, WASH, and Protection) to align health responses.	Critical	Share findings to avoid duplication. Map cross-sector resources (e.g., shared vehicles and WASH infrastructure).

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Map legal and regulatory constraints (e.g., MoH approvals, import restrictions, and non-governmental organization [NGO] mandates).	Critical	Engage the MoH early to streamline approvals. Document restrictions (e.g., curfews and medicine import bans).
Conduct stakeholder power analyses, particularly in conflict-affected settings.	Recommended	Identify influencers, alignment risks, and coordination gaps. Use local informants in low-resource settings.
Map PHC modalities, referral pathways, CHW networks, and transportation options.	Critical	Include cross-agency resource sharing (e.g., vehicles and CHWs). Map other mobile interventions to avoid overlap.
Engage the national/sub-national Health Cluster to validate assessment findings.	Critical	Ensure strategic alignment with national health strategy (e.g., the EPHS).
Coordinate with donors and authorities to understand geographic/population priorities and funding constraints.	Critical	Clarify funding ceilings and operational restrictions.



Management

Task	Priority	Notes
Conduct health service access gap mapping using (Tanahashi) barrier analysis.	Critical	Availability gaps and barriers to access and acceptance. Analyse demographic, epidemiological, and utilization data. Use paper forms if digital tools are unavailable.
Engage affected communities to understand service expectations and barriers (e.g., cost, discrimination, and distance).	Critical	Use participatory tools (e.g., FGDs and community mapping). Prioritize marginalized groups (e.g., disabled individuals, women, and ethnic minorities).
Conduct baseline evaluation to support monitoring and impact measurement.	Recommended	Collect baseline data on access, utilization, and outcomes. Use simple surveys in low-resource settings.
Identify contextual barriers (e.g., insecurity, terrain, weather, infrastructure, and inequality).	Critical	Assess terrain (e.g., mountainous, desert), weather (e.g., rain and cold), and inequality (e.g., gender and disability).
Assess community preferences for service delivery (e.g., mobile compared with outreach or static).	Extended	Use surveys, FGDs, or verbal feedback through CHWs. Prioritize accessibility for remote populations.
Review existing service utilization data to triangulate access barriers and gaps.	Recommended	Use MoH or Health Cluster data. Cross-check with community feedback.
Assess supply chain feasibility for essential medicines and consumables.	Critical	Pre-identify suppliers, buffer stock, and storage. Explore local suppliers in low-resource settings.



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Map security risks along Mobile Clinic routes and at SDPs.

Critical

Develop contingency plans (e.g., alternate routes and evacuation). Use a risk matrix (see Additional Elements).

Pre-identify surge/outbreak risks (e.g., disease seasonality and displacement patterns).

Recommended

Plan for increased demand (e.g., cholera or measles outbreaks). Stockpile emergency health kits.

Low-Resource Adaptations

- Use paper-based forms for gap mapping and digitize later if connectivity is limited.
- Leverage local leaders and volunteers for stakeholder analysis in insecure areas.
- Use bicycles and/or porters for supply transport if vehicles are unavailable.

Equity Considerations:

- Engage women, youth, and disability representatives in assessments.
- Identify service gaps in GBV/sexual reproductive health (SRH) and plan referral pathways.

Planning



Coordination

Task	Priority	Notes
Assess patient contact time to ensure quality of care (excluding travel, setup, and teardown).	Critical	Aim for approximately 10 minutes per consultation as recommended in the Sphere Standards (50 patients per 8-hour day). Adjust for standalone models with high logistical demands.
Define Mobile Clinic service package with MoH and partners.	Critical	Based on H3 package or national standards. Include GBV/SRH services. Account for travel time, terrain, curfews, and insecurity.
Determine SDP frequency and coverage based on the size, density, and needs of the population.	Critical	Consider CHW presence, referral options, and community preferences (e.g., scattered or concentrated populations).
Establish coordination mechanisms with other Mobile Clinic actors (e.g., schedule sharing and referral tracking).	Critical	Avoid duplication and gaps. Share schedules through Health Cluster.
Align with Health Cluster and sectoral priorities and national health strategies.	Critical	Ensure compliance with EPHS and emergency response frameworks.
Plan periodic access gap mapping (every 3–6 months).	Recommended	Use baseline data to track changes. Use paper-based tools in low-resource settings.
Coordinate pre-positioning of supplies and donor support.	Critical	Secure framework agreements with suppliers for rapid procurement.



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Coordinate with MoH for approvals (e.g., SOPs, medicine import, movement permissions). **Critical** Start early to avoid delays. Document approval processes.

Engage broad stakeholder representation, including marginalized groups. **Critical** Include communities more than an hour's walk from SDPs. Use local languages and accessible formats.



Management

Task	Priority	Notes
Human Resources, Team Composition, & Capacity Building		
Plan team composition (clinicians, dispenser, registrar, CHWs, and WASH/IPC staff).	Critical	Include a backup team. Add specialties (e.g., MHPSS for trauma and nutrition for food insecurity).
Budget for incentive payments for volunteers (e.g., water porters and crowd control).	Recommended	Ensure fair compensation consistent with local norms.
Budget for staff training on SOPs, clinical protocols, IPC, referral, and data collection.	Critical	Include CHWs and volunteers. Use laminated job aids. Train on GBV/SRH case identification.
Plan supervision time for WASH, Nutrition, and MHPSS staff.	Recommended	Integrate supervision into existing roles if full-time staff are unavailable.
Community Engagement, Social Mobilization, & Feedback		
Plan project kick-off meetings at the community level.	Critical	Clarify target population, services, and feedback mechanisms. Use local languages and accessible formats.
Budget for community engagement (e.g., FGDs, hotlines, and exit interviews).	Critical	Use low-cost methods (e.g., megaphone announcements and noticeboards) in resource-constrained areas.
Develop information, education, and communication (IEC) materials (e.g., visual aids and radio messages).	Recommended	Field test for cultural relevance and accessibility (e.g., braille and visuals for low literacy).
Service Delivery, Referral, & Infrastructure		
Budget for referral costs (e.g., medical, transport, and staff accompaniment).	Critical	Ensure financing for the full referral cycle, including GBV/SRH referrals.
Plan Mobile Clinic typology (e.g., vehicle-based, tent-based, or hybrid).	Critical	Assess terrain and infrastructure. Consider disability access (e.g., ramps).
Budget for WASH infrastructure (e.g., handwashing stations, water trucking, and emergency latrines).	Recommended	Rent local storage tanks or partner with WASH actors if tanks are unavailable.
Plan local construction of waiting areas or shade.	Recommended	Use local materials (e.g., mats and tents) in low-resource settings.



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Supplies, Logistics, & Mobility

Procure waterproof clinical guidelines, job aids, and protocols.	Recommended	Laminate for durability. Distribute to all teams.
Pre-position (virtual) stock and establish supplier agreements.	Critical	Include buffer stock. Use local suppliers when quality assurance systems are available and if possible.
Budget for IPC measures and medical waste treatment (e.g., incineration and PPE).	Critical	Assess outsourced waste management facilities for safety.
Establish base operations (e.g., offices, warehouses, and accommodations).	Extended	Ensure secure, accessible locations.
Plan transportation logistics (e.g., vehicles, boats, fuel, and spare parts).	Critical	Include contingency options (e.g., back-up vehicles and security escorts).

Systems, Data, M&E, & Risk Communication

Plan data systems (paper/ Electronic Health Record [EHR]), data protection, and informed consent tools.	Critical	Use offline paper forms in low-connectivity areas. Offer training in data protection.
Develop risk communication strategies to counter misinformation.	Recommended	Use trusted messengers (e.g., CHWs and religious leaders).
Budget for baseline data collection tools (e.g., tablets and translated forms).	Recommended	Use paper forms if digital tools are unavailable.
Ensure patient confidentiality during (digital) registration in crowded settings.	Critical	Secure data storage on paper-based or mobile devices and provide protocols for data transfer in low-connectivity areas.

Low-Resource Adaptations

- Train volunteers for non-clinical roles (e.g., crowd control and triage) if there are staff shortages.
- Use megaphone announcements or noticeboards for IEC in areas without radio or phone access.
- Partner with local NGOs or WASH actors to share vehicles/infrastructure.

Equity Considerations

- Include women's groups and disability representatives in stakeholder engagement.
- Budget for SRH kits and GBV referral training.



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Preparation for implementation



Coordination

Task	Priority	Notes
Define and agree on the target populations for Mobile Clinics, including marginalized groups.	Critical	Include populations more than an hour's walk from SDPs. Avoid overrepresentation of central areas.
Engage local health authorities and diverse community representatives.	Critical	Use local languages and accessible formats. Include women, youth, and disability groups.
Recommend a context-appropriate standard service package.	Critical	Align with H3 package or MoH standards. Include GBV/SRH services.
Coordinate medical waste management and sterilization through existing facilities.	Critical	Ensure oversight and compliance with national standards.
Influence IDP site selection or relocation near accessible Mobile Clinic areas.	Recommended	Advocate for proximity in order to reduce travel barriers.
Facilitate the procurement and distribution of emergency health kits (first 3–6 months).	Critical	Prioritize acute emergencies. Coordinate with Health Cluster.
Explore centrally managed referral mechanisms for large-scale responses.	Recommended	Optimize resource use and streamline referrals.
Advocate with donors and partners for specialized services and referral support.	Extended	Support advanced care (e.g., surgery and diagnostics).
Clarify coordination structures (e.g., clinical supervision and incident escalation).	Critical	Define roles for decision-making and operational changes.



Management

Task	Priority	Notes
Community Engagement and Feedback Mechanism		
Ensure communication materials are in local languages.	Critical	Include braille or visuals for accessibility.
Establish/test community feedback channels (e.g., hotline, FGDs, and anonymous boxes).	Critical	Test channels before launch. Use noticeboards if needed.
Clarify how feedback will be analysed and acted on.	Critical	Develop systematic feedback review process.
Disseminate service information (eligibility, frequency, and complaint mechanism).	Critical	Use radio, megaphones, or CHWs in low-resource settings.
Ensure that visual, audio, and printed materials are locally relevant and field-tested.	Critical	Test for cultural appropriateness and accessibility.



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Human Resources, Training, and Technical Supervision

Integrate IPC/WASH responsibilities into existing roles if full-time staff members are unavailable.	Recommended	Reduce staffing costs in low-resource settings.
Assign a team member to manage daily supply packing.	Critical	Ensure that supplies are ready before deployment.
Recruit and/or assign staff to lead medical supply chain management.	Critical	Prioritize local hires fluent in local languages.
Prioritize hiring service providers from the target population.	Recommended	Provide translators if needed.
Recruit roving supervisors for clinical, pharmaceutical, and IPC/WASH components.	Critical	Ensure supervision across all SDPs.
Recruit CHWs for each SDP and train in screening and triage.	Recommended	Reactivate existing CHW networks if available.
Provide orientation on roles, SOPs, patient safety, IPC, waste management, and referrals.	Critical	Include GBV/SRH case identification training.
Train staff about audio and visual privacy, patient rights, and special considerations (e.g., gender and disability).	Critical	Ensure sensitivity to marginalized groups.
Train staff about population selection criteria and managing non-catchment patients.	Critical	Encourage identification of underserved groups.
Validate staff rosters, workflow plans, and roles with a dry run.	Critical	Simulate operations to identify gaps.

Medical Supply Chain Management

Procure essential supplies (medicines, furniture, and job aids) consistent with MoH/Cluster standards.	Critical	Align with national guidelines.
Activate and transport pre-positioned stock.	Critical	Ensure stock availability before launch.
Prepare storage facilities for supplies.	Critical	Ensure secure, temperature-controlled storage.
Develop SOPs for supply management, consumption tracking, and stock control.	Critical	Train teams on SOPs.
Create emergency restocking and fast-track procurement procedures.	Recommended	Pre-identify fallback suppliers for stockouts.

SOPs and Technical Tools

Establish medical incident management system with no-blame culture.	Critical	Integrate with community/facility feedback.
Develop referral SOPs (medical and non-medical pathways, eligibility, and transport).	Critical	Include GBV/SRH referral protocols (see the flowchart in Additional Elements).
Develop SOPs for CHW engagement during non-coverage periods.	Recommended	Support triage and referrals between visits.
Develop SOPs for medical waste transport and supervision.	Critical	Ensure compliance with national standards.
Develop SOPs for environmental cleaning of public and private buildings.	Critical	Include IPC measures for safety.

Service Delivery Readiness



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Ensure that stakeholders understand population selection criteria.	Critical	Train staff to manage or escalate non-catchment cases.
Involve stakeholders in SDP identification.	Critical	Confirm accessibility (roads, bridges, and disability inclusion).
Ensure that SDPs and routes are secure and conflict-free.	Critical	Consider separate SDPs for equitable access in high-risk areas.
Map WASH infrastructure at SDPs (latrines, water, and handwashing).	Critical	Budget for water trucking if unavailable.
Pre-test tent or temporary shelter setup for timing and patient flow.	Extended	Ensure protection from rain and sun.
Use safe, non-functional facilities or central public spaces (e.g., markets and schools).	Critical	Ensure child-safe, accessible setups.
Plan signage and crowd control materials for setup day.	Recommended	Use local volunteers for crowd control.
Identify and document medical and non-medical referral pathways.	Critical	Laminate contact info for referral facilities.
Ensure that referrals are fully financed (transfer to return).	Critical	Align with organizational policies.
Validate referral functionality through test referrals or simulations.	Critical	Identify bottlenecks (e.g., after hours transport).
Assess outsourced waste treatment equipment (e.g., incinerators and PPE).	Critical	Support upgrades to meet standards.
Validate route security and contingency access plans.	Critical	Establish check-in/check-out procedures.
Set up paper and digital data collection systems and train users.	Critical	Use offline paper forms in low-connectivity areas. Ensure backup power (e.g., solar chargers).

Low-Resource Adaptations:

- Use volunteers for crowd control and waste transport to reduce costs.
- Store supplies in local facilities if dedicated warehouses are unavailable.
- Conduct verbal training if written materials are limited.

Equity Considerations:

- Ensure disability-accessible SDPs (e.g., ramps and wide entrances).
- Train CHWs to identify and refer GBV cases.



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Implementation



Coordination

Task	Priority	Notes
Organize joint supportive supervision visits with health actors.	Recommended	Promote cross-learning and service quality.
Oversee medical waste management and sterilization through referral facilities.	Critical	Ensure oversight and compliance with standards.
Monitor health service access gaps through FGDs with non-users.	Recommended	Adjust strategies based on feedback. Use CHWs for outreach in remote areas.
Procure and distribute emergency health kits (first 3–6 months).	Critical	Prioritize sudden-onset emergencies.
Consider centrally managed referral mechanisms for large-scale responses.	Recommended	Streamline referrals and maximize efficiency.
Participate in cross-sectoral coordination (e.g., Nutrition, WASH, and Protection).	Recommended	Establish integrated referral pathways.
Share resources (e.g., SOPs, logistics, re-referral systems) across Mobile Clinic partners.	Recommended	Avoid duplication and waste.



Management

Task	Priority	Notes
Community Engagement and Feedback Mechanism		
Conduct kick-off meetings with diverse stakeholders (e.g., leaders and camp man-agers).	Critical	Clarify services, days, hours, and exit strategy. Use local languages.
Provide transparent information on the scope and eligibility of Mobile Clinics.	Critical	Use accessible formats (e.g., braille and visuals).



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Inform populations more than an hour's walk from SDPs about services.	Critical	Use CHWs or volunteers for outreach.
Display banners and distribute feedback hotline cards at SDPs.	Recommended	Ensure visibility and accessibility.
Engage non-users and remote communities for feedback.	Critical	Use FGDs or CHW visits.
Hold regular community engagement meetings to report on the use of feedback.	Critical	Share adaptations to build trust.
Human Resources, Training, and Technical Supervision		
Assign staff to pack supplies daily before deployment.	Recommended	Ensure readiness for each SDP visit.
Distribute responsibilities across all cadres of staff with clear terms of reference (ToRs).	Critical	Clarify roles for triage, patient flow, and reporting.
Appoint a team member to manage patient flow and triage.	Critical	Use CHWs for early triage.
Conduct regular supportive supervision and mentoring.	Critical	Use supervision checklists.
Hold routine learning sessions (e.g., case studies and incident reviews).	Recommended	Share lessons learned internally.
Equip teams with waterproof treatment protocols and job aids.	Critical	Ensure durability in field conditions.
Rotate staff on high-burden routes and ensure rest days.	Critical	Mitigate burnout.
Provide psychosocial support check-ins and conflict debriefs.	Recommended	Support staff wellbeing post-deployment.
Ensure administrative and operational support (e.g., logistics and paperwork).	Critical	Streamline operations for staff.
Service Delivery and Referrals		
Expand access to host communities, marginalized groups, and remote areas.	Critical	Use community walks and risk mapping to identify underserved groups.
Avoid private and religious and/or politically sensitive SDP locations.	Critical	Prevent exclusion or monopolization.
Rent guesthouses near SDPs to reduce travel time.	Recommended	Use local accommodations if budget allows.
Set up hubs and/or sub-offices central to multiple SDPs.	Recommended	Enhance efficiency in scattered areas.
Use shaded, safe, and accessible waiting areas with surge capacity.	Critical	Ensure audio privacy and disability access.
Organize patient queues and manage expectations.	Critical	Use volunteers for crowd control.
Include holding areas for suspected infectious disease cases.	Critical	Align with Early Warning, Alert, and Response System protocols.
Use safe, non-functional health facilities or central public spaces.	Critical	Ensure child-safe, accessible set-ups (e.g., markets and schools).
Conduct early triage using CHWs or trained volunteers.	Critical	Start triage before Mobile Clinics arrive.



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Provide health education about medication and nutrition supplement use.	Critical	Use visual aids for low-literacy populations.
Reactivate CHW networks to support patients with disabilities.	Recommended	Ensure mobility assistance.
Use card systems and CHW follow-up for missed consultations.	Recommended	Track patients awaiting care.
Refer clients based on SOPs with communication means (e.g., mobile phones).	Critical	Ensure reliable communication (see flowchart in Additional Elements).
Assign referral follow-up to CHWs or designated staff.	Critical	Ensure accountability for referral completion.
Ensure that after-hours referral options are affordable and accessible.	Critical	Address affordability barriers.
Support community committees with referral logistics.	Recommended	Provide financial and logistical support.
Build relationships with referral facilities.	Critical	Support surge or training needs.

Supplies and Infection Prevention Control (IPC)

Equip Mobile Clinics with MoH-standard supplies, furniture, and reporting tools.	Critical	Align with national guidelines.
Implement SOPs for environmental cleaning of public/private structures.	Critical	Ensure IPC compliance.
Ensure proper medical waste disposal and assess outsourced providers.	Critical	Verify equipment safety (e.g., incinerators).
Provide adequate water supply (1–5 litres/patient/day in accordance with the Sphere standards).	Critical	Engage volunteers and/or porters for water transport.

Contingency Planning and Continuity

Establish contingency protocols for service interruptions (e.g., insecurity and weather).	Critical	Include alternate service options.
Pre-inform communities about alternate services during suspensions.	Critical	Use CHWs or noticeboards for communication.
Assess accessibility/security of SDPs and routes.	Critical	Adjust for ethnic- and conflict-related access issues.

Documentation and Accountability

Maintain logbooks for referrals, safety incidents, and community feedback.	Critical	Ensure accurate record-keeping.
Document lessons learned monthly and share with coordination structures.	Critical	Inform future planning.

Low-Resource Adaptations:

- Use volunteers for crowd control, water transport, and triage.
- Rely on verbal health education if IEC materials are limited.

Equity Considerations:

- Ensure disability-accessible waiting areas and referral transport.
- Train staff to handle GBV cases sensitively and refer promptly.



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Monitoring and evaluation



Coordination

Task	Priority	Notes
Use triangulated data (client exit interviews, CHW feedback, and direct observation).	Recommended	Inform coordinated improvements. Use paper forms in low-connectivity areas.
Organize FGDs with users and non-users to capture feedback and service gaps.	Critical	Include marginalized groups (e.g., disabled and remote populations).
Monitor equity and inclusion indicators (e.g., access by gender, disability, and ethnicity).	Extended	Ensure that data are disaggregated by age, sex, disability, and distance.
Share feedback trends and adaptations with communities and coordination bodies.	Critical	Promote transparency and trust.
Align M&E indicators with national HMIS or DHIS2 systems.	Critical	Contribute to national reporting.
Share key findings, lessons learned, and performance data.	Critical	Use reports or dashboards for donors and MoHs.
Conduct exit interviews with clients and direct observation using structured tools.	Critical	Assess satisfaction and quality.



Management

Task	Priority	Notes
Conduct routine quality assessments using the Mobile Clinic Quality Monitoring Tool.	Critical	Benchmark against standards.
Monitor key performance indicators (KPIs) through internal dashboards.	Critical	Track consultations, referral uptake, stockouts, and service reach.
Establish alert systems for declining quality or increased demand.	Critical	Use CHW reports or consultation surges.
Conduct endline evaluation to compare with baseline.	Critical	Measure impact on access and outcomes.
Track staff performance and supervision coverage.	Critical	Use supportive supervision checklists and logs.
Hold regular review meetings to assess data and implement improvements.	Critical	Adapt based on findings.
Document lessons learned, success stories, and adaptation areas.	Critical	Guide scale-up or transition strategies.
Monitor patient satisfaction using rating scales or open-ended prompts.	Recommended	Conduct during and after visits.



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Track Mobile Clinic-specific metrics:

- Aim for approximately 10 minutes per consultation, consistent with the Sphere Standards (50 patients per day for 8 hrs).
- Time spent on travel, setup, and teardown
- Number of SDPs visited per week or month
- Proportion of scheduled visits completed (>95%)

Use dashboards for real-time tracking.

Critical

Promote mobile/digital data collection (e.g., KoboToolbox and CommCare).

Recommended

Use paper forms in low-connectivity areas.

Low-Resource Adaptations:

- Use paper-based exit interviews and FGDs if digital tools are unavailable.
- Train CHWs to collect verbal feedback from remote communities.

Equity Considerations:

- Disaggregate data to monitor access for women, disabled persons, and minorities.
- Include GBV/SRH service uptake in indicators.



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Exit or Phase Out

Mobile Clinics play a vital role in increasing access to care in humanitarian settings, particularly when fixed health services are unavailable. However, they come with intrinsic limitations that constrain the quality and continuity of care and cannot be fully mitigated because of the nature of the modality. While their benefits are evident, their constraints are equally significant, so Mobile Clinics are a temporary, last-resort solution. Transitioning to semi-permanent or permanent service models is strongly recommended as soon as conditions allow.

A. Limitations That Underscore the Need for Exit

Intermittent Service Delivery: Mobile Clinics typically visit each SDP once every week to maximize their geographic reach. This scheduling leads to patient accumulation between visits and may discourage individuals from seeking alternative care. On visit days, high patient volumes often overwhelm staff, compromising consultation quality and potentially delaying urgent care.

Short Operational Hours: Long travel distances, poor road conditions, curfews, and the time required for setup at SDPs reduce a clinic's effective operating time. This reduction shortens patient-provider interactions and limits the feasibility of services such as assisted deliveries, laboratory diagnostics, continuous vital sign monitoring, and emergency referrals outside clinic hours.

Space Constraints: Mobile Clinics are restricted in terms of the number of staff members, the volume of supplies, and the type of infrastructure that they can transport because of the vehicles' capacity. Accordingly, it is difficult to maintain service quality while managing logistical and financial efficiency.

Climatic and Environmental Challenges: Exposure to weather conditions such as rain, heat, wind, and cold affects both service quality and safety. Limited shelter at SDPs can compromise the prevention and control of infections, patients' privacy, and the wellbeing of staff members. Furthermore, environmental barriers such as difficult terrain can delay travel or restrict access altogether, disrupting service continuity.

Despite these known challenges, Mobile Clinics are often used over extended periods. It is, therefore, essential to acknowledge from the outset that this model is temporary, assess the achievable level of quality within these constraints, and plan actively for a sustainable exit strategy, as detailed throughout this guidance.

At the same time, contingency planning must account for scenarios in which a Mobile Clinic may be unable to implement its exit strategy fully, including:

- **Funding shortfalls** that necessitate early withdrawal.
- **Escalation of conflicts** requiring temporary or complete suspension or evacuation.
- **Sudden displacement or relocation** of affected populations beyond the reach of a Mobile Clinic or its partners.

Exit Implementation & Documentation

Task	Priority	Notes
Develop a time-bound exit strategy early in the project.	Critical	Ensure PHC access post-exit (e.g., EPHS compliance).
Engage stakeholders (MoHs, community leaders, and donors) early.	Critical	Include national/local MoHs, traditional and religious leaders, and women's and youth groups.

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Map post-exit service access and communicate with communities.	Critical	Clarify alternative care options. Use CHWs for outreach.
Prepare communities for transition by mapping service changes.	Critical	Ensure awareness of new access points.
Track implementation progress using the Mobile Clinic Planning & Decision-Making Tool indicators.	Critical	Monitor PHC accessibility post-exit.
Document transition mechanisms (e.g., CHW scale-up and PHC handover).	Critical	Ensure clear records for sustainability.
Ensure that continued technical supervision, supply chain support, and community engagement mechanisms are in place post-exit.	Critical	Particularly important when CHWs or local PHC actors assume service delivery roles.
Formalize asset handover (e.g., tents, supplies, and patient registers).	Critical	Document handover to MoH or PHC facilities.
Plan and conduct final meetings with stakeholders and community members.	Critical	Share transition plans and gather feedback.
Conduct post-exit evaluation (3–6 months after closure).	Critical	Assess sustainability and remaining gaps.
Report on sustainability, quality impact, and access gaps.	Critical	Share the report with MoH and Health Cluster.
If exit is not feasible, document the constraints (e.g., conflict or no PHC).	Critical	Outline interim measures (e.g., hybrid models and CHW outreach).
Ensure alignment with national health recovery plans.	Critical	Integrate with strategic MoH frameworks.
Transfer patient registers, referral records, and health data.	Critical	Use digital or paper formats for successor services.

Stakeholders to Engage in Exit Planning

- 1. Ministry of Health (MoH):** National and local representatives.
- 2. Community Leadership:** Traditional and religious leaders, women and youth leaders, and community-based organizations.
- 3. Health Cluster:** National and subnational coordination.
- 4. Health Workforce:** Healthcare workers, registered nurses, and CHWs.
- 5. Relevant Partners:** Health, Nutrition, WASH, Protection, and Refugees.
- 6. Donors:** Primary funding agencies and subcontracting donors.
- 7. Local Government/Camp Admin:** Camp managers and municipal representatives.

Transition Options

1. Hand over to an existing PHC modality

- E.g., the nearest functioning PHC facility.
- Includes restocking, HR reallocation, or infrastructure support.

2. Rehabilitate a non-functional health facility

- Repair and restock for operationalization as a permanent or semi-permanent service point.



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3. Hand over Mobile Clinic operations to the MoH

- Includes direct absorption of staff, vehicles, and/or infrastructure.
- Transition early (3 months prior to exit when feasible).
- Start incorporation of joint supervision and joint management as soon as possible.

4. Construct a new fixed PHC facility

- Where permanent health infrastructure is lacking.

5. Construct a temporary or semi-permanent structure

- To phase out the mobile team while maintaining services.

6. Recruit local staff to run a new or existing facility

- Building sustainability with community-based workforces.

7. Build capacity and expand the role of CHWs

- Training, supervision, and resource allocation to CHWs to sustain basic care.

8. Intensify outreach services from nearby PHC modalities

- Regularly deployed outreach teams replace the mobile team.

9. Strengthen referral systems

- Cover costs and logistics for referrals (transport, accompaniment, medication, etc.).

10. Introduce cash or voucher support for healthcare access

- Enable patients to afford care at nearby public or private facilities.
- Before opting for cash and voucher support, consult the GHC working paper for considering cash transfer programming for health in humanitarian contexts.¹⁷

11. Set up early warning systems and emergency preparedness

- Build community and facility capacity for future health shocks.

12. Phase-out due to reduced need

- The Mobile Clinic is no longer required because of normalization or improved access.

B. When Exit Is Not Feasible

Clearly document the reasons why exit cannot proceed, which may include:

- Lack of accessible fixed PHC delivery point for the affected population that meets national standards (e.g., within 5–10 km or one hour's walk).
- Mobile or displaced populations (e.g., nomads, IDPs, and refugees).
- Ongoing insecurity or conflict prevent normalization.
- Escalating crises (e.g., new outbreaks, floods, or droughts).
- Delays in infrastructure, staffing, or funding.
- Slow implementation of exit options.

When exit is delayed, clearly outline the interim measures to maintain care quality and continuity. (e.g., hybrid models, CHW outreach).

Final Note

Exit and transition should never reduce access to essential health services. The ultimate goal is to ensure that all populations previously served by Mobile Clinics continue to receive equitable, safe, and high-quality primary healthcare through more sustainable service delivery models. Post-exit strategies must proactively identify and reach marginalized groups such as persons with disabilities, remote populations, and minorities to prevent the emergence or widening of access gaps.



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Low-Resource Adaptations:

- Train CHWs to sustain basic services post-exit.
- Use local NGOs to manage interim operations if the MoH's capacity is limited.
- Document constraints verbally if resources for documentation are scarce.

Equity Considerations:

- Ensure post-exit services reach marginalized groups (e.g., disabled or remote populations).
- Include GBV and SRH services in transition plans.

Risk Matrix Template

Risk	Likelihood (1-5)	Impact (1-5)	Mitigation
Insecurity on Mobile Clinic routes	3	5	Use alternate routes, security escorts, or satellite phones for communication.
Medicine stockouts	2	4	Pre-position buffer stock, establish local supplier agreements, and fast-track procurement.
Weather disruptions (e.g., rain or heat)	3	3	Provide shaded waiting areas, adjust schedules, and use waterproof materials.
Community mistrust or low uptake	2	3	Conduct community engagement, use trusted CHWs, and field-test IEC materials.
Referral bottlenecks (e.g., after-hours transport)	4	4	Finance full referral cycle, validate pathways, and assign CHW follow-up.

Notes:

- Rate likelihood and impact on a 1-5 scale (1=low, 5=high).
- Prioritize risks with high impact and/or likelihood for immediate mitigation.
- Update matrix monthly or after incidents.
- Assign a responsible party to address the risks.

Quick-Reference Summary:

- **Emergency Contacts:** MoH Approval Desk, Health Cluster Coordinator, Security Focal Point, Local Suppliers, and referral facility focal point(s).
- **Critical Tasks:** Map legal constraints, engage communities, define service package, secure approvals, ensure referral financing, and pre-position supplies.
- **Low-Resource Tips:** Use paper forms, local volunteers, shared transport, and/or megaphone announcements.
- **Equity Focus:** Prioritize marginalized groups (e.g., disabled persons, women, and remote populations). Train on GBV and SRH case identification.



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Notes:

- Align with national health strategies (e.g., EPHS and H3).
- Document lessons learned monthly and share with Health Cluster.
- Ensure that there is no reduction in PHC access post-exit, with a focus on sustainability.



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- 1 World Health Organization. (2019). *Delivering health in some of the world's worst crises through mobile clinics and medical teams*. <https://www.who.int/news-room/feature-stories/detail/delivering-health-in-some-of-the-worlds-worst-crises-through-mobile-clinics-and-medical-teams>
- 2 Gowan, C., Baxter, L., Deola, C., Checchi, F., & Cummings, R. (2019). Mobile clinics in humanitarian emergencies: A systematic review. *Conflict and Health*, 14, Article 4. <https://doi.org/10.1186/s13031-020-0251-8>
- 3 Global Health Cluster. (2025). *Health Cluster countries and regions*. <https://healthcluster.who.int/countries-and-regions>
- 4 World Health Organization. (2020, June). *Quality of care in humanitarian settings*. <https://www.who.int/publications/m/item/quality-of-care-in-humanitarian-settings>
- 5 World Health Organization. (2020). *Quality of care in fragile, conflict-affected and vulnerable settings: Taking action*. <https://iris.who.int/bitstream/handle/10665/337842/9789240015203-eng.pdf?sequence=1>
- 6 World Health Organization. (2018). *Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care*. <https://iris.who.int/bitstream/handle/10665/272357/9789241565561-eng.pdf?sequence=1> (see p. 67)
- 7 Sphere. (2018). *Sphere handbook*. <https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf>
- 8 World Health Organization and International Bank for Reconstruction and Development. (2021). *Tracking universal health coverage: 2021 global monitoring report*. https://cdn.who.int/media/docs/default-source/world-health-data-platform/events/tracking-universal-health-coverage-2021-global-monitoring-report_uhc-day.pdf
- 9 Jamison, D. T., Alwan, A., Mock, C. N., Nugent, R., Watkins, D. A., et al. (2018). Universal health coverage and intersectoral action for health. in D.T. Jamison, H. Gelband, S. Horton, P. Jha, R. Laxminarayan, C.N. Mock, & R. Nugent, *Disease control priorities: Improving health and reducing poverty* (Annex 1A). World Bank. <https://www.dcp-3.org/sites/default/files/chapters/Annex%201A.%20All%20Essential%20Packages.pdf>
- 10 World Health Organization. (2009). *HeRAMs: Approach & roles and responsibilities of the cluster*. <https://www.medbox.org/pdf/5e148832db60a2044c2d1ead>
- 11 World Health Organization and the United Nations Children's Fund. (2018). *A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals*. <https://www.who.int/docs/default-source/primary-health/vision.pdf>
- 12 Blas, E., Sommerfeld, J., & Kurup, A. S. (Eds.). (2011). *Social determinants approaches to public health: From concept to practice*. World Health Organization. <https://dssbr.ensp.fiocruz.br/wp-content/uploads/2011/09/Social-determinants-approaches-to-public-health.pdf>
- 13 World Health Organization. (n.d). *Indicator metadata registry list*. <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/3348>
- 14 Watkins, D. A., Jamison, D. T., Mills, A., Atun, R., Danforth, K., et al. (2018). *Universal health coverage and intersectoral action for health. Chapter 3: Universal Health Coverage and Essential Packages of Care*. https://www.dcp-3.org/sites/default/files/chapters/DCP3%20Volume%209_Ch%203.pdf
- 15 Tanahashi, T. (1978). Health service coverage and its evaluation. *Bulletin of the World Health Organization*, 56(2), 295-303. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2395571/>
- 16 World Health Organization. (2024). *Interagency emergency health kit 2024: medicines and medical devices for 10,000 people for approximately three months*. <https://www.who.int/emergencies/emergency-health-kits/interagency-emergency-health-kit-2017>
- 17 Health Cluster. (2018, March 15). *GHC working paper for considering cash transfer programming for health in humanitarian contexts*. <https://healthcluster.who.int/publications/m/item/working-paper-for-considering-cash-transfer-programming-for-health-in-humanitarian-contexts>



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