Health Cluster 3/4W Tool

Contents

Purpose of this document

This document is intended to inform Health Cluster Coordinators (HCC), Health Information Managers, Senior Managers, and other interested professionals on the purpose of response monitoring, with a specific focus on the use of 3/4/5W matrix tools (as part of the Public Health Information Services - PHIS) to report on health related activities and operational presence. The 3/4/5W Tool is one of the PHIS tools used for measuring and monitoring Health Resources and Services Availability, namely providing information on preventive and curative health services, infrastructure, personnel and supplies provided by health authorities or other actors, as well as the degree of access that affected populations actually have to those services.

What is Response Monitoring?

Response monitoring is a continuous process that tracks the humanitarian assistance delivered to affected populations compared to targets set out in the humanitarian response plan (HRP). According to the IASC Humanitarian Programme Cycle (HPC) Reference Module, the aim of response monitoring is to establish whether aid is actually delivered to affected people as intended and to analyze how and why any gaps, if any, have occurred; in order to inform corrective actions.

Monitoring tracks the inputs, and the outputs resulting from interventions to affected populations, charts the outcomes of cluster activities, and measures progress towards the strategic objectives of the HRP. It is a key step in the programme cycle as it seeks to determine if the humanitarian community is doing what it has committed to doing in the HRP. In addition, response monitoring provides an evidence base for taking decisions about the future direction of the response; and support resource mobilization.

What is a 4W

A 4W (who, what, where, when) is a tool to collect information on operational presence of and emergency response activities by cluster partners. It allows the mapping and reporting on health inputs, activities and outputs, thus serving as one of the tools in the suite of services necessary to support response monitoring; it supports (but not replace) performance monitoring tools (i.e. Operational Indicator Monitoring, OIM) and the monitoring of health resources and mapping of health services' availability (HeRAMS).

According to the IASC Scale-up Activation timeline, there are many variants of the 4W tool depending on the emergency phase, reporting requirements, detail collected, cluster, country/operation, and IMO.

A 3W (who, what, where) tool collects the most basic of information on who is doing what and where. It is usually rolled out at the beginning of an emergency (phase 1) and allows Health Emergency Senior Management (Cluster Coordinators, Incident Managers, Pillar Leads) to obtain a broad understanding of the response.

A standard 4W (who, what, where, when) builds on the 3W with the addition of noting the duration of the activity, collecting more detailed sectoral information at a higher resolution. It is good practice to collect data on the activities reflective to the HNO including population type, SADD, this can be referred

to as a 5W (inclusion of Whom). Indicators can be directly linked into the tool (see 'GHC Core Indicators Guidance Note'). 4W matrix tools are most commonly deployed in the second phase of an emergency, after adequate time has allowed for the establishment of a 4W template as well as step-by-step guidance on the setup, compiling, and analysis of 4W data.

Additional Ws (*Why? for Whom?*) may be added according to information needs and resources available, expanding the tool to 5 and 6Ws. However, it's important to keep in mind that, especially when a response starts, only basic 3W information is required for coordination and reporting purposes. This type of information should be prioritized to ensure timeliness and effectiveness of the tool as its primary purpose is retained.

For the purposes of this document, both Phase 1 and Phase 2 monitoring tools are called 4W, with the distinction being made by the Phase indicated.

IMO Responsibilities

As part of their support to coordination and the efforts of the HCC, information managers usually play a central role in the design and development of 4W templates, tools, and information products given their technical expertise. IMO responsibilities vary depending on the stage of an emergency and include:

- Creating/amending Partner Card and Phase 1 - 4W template and tool to meet the needs of the response until the HRP/Health indicators are defined (not all IMOs will have to do this, they may deploy in the later stages of an emergency)
- Helping the HCC identify realistic indicators (output and outcome) and targets for the Humanitarian Response Plan and Health Monitoring Framework (via analysis of PHIS data, assessments and needs, capacity and caseload exercises).
- Creating/amending the Phase 2 - 4W template and tool to interlink with the reporting needs of the Humanitarian Response Plan, Health Monitoring Framework, and partner information needs
- Determining the best software solution for the emergency response (Excel, ActivityInfo, Report hub, DHIS2, Survey123, KoBo, other systems) in coordination with other Clusters/OCHA
- Consolidating and cleaning 4W data from Health Cluster Partners while probing erroneous entries and promoting 4W data quality
- Developing 4W information products and dashboards
- Analyzing 4W data and identifying relevant insights on need gaps and partner overlaps

In some cases, when IMOs are not present, support on customization of the matrix might also be provided remotely, whereas it is always more advisable to perform data collection and entry at field level.

4W Audience

	Audience	
	In-country responders	Global/headquarter based responders and experts
Who are they?	Incident managers, Ministry of Health, Pillar Leads, Partners involved in the response, field-based donors, etc.	HQ IMST, Regional Office Senior Managers, GHC, Donors, Academia etc
Purpose	Obtain a broad understanding of the ongoing response Support operational decision making and planning of health activities Support Activity monitoring and planning Identify gaps, overlaps, and needs against funds Identify potential partners Ensure transparency with government and donors Advocate for the implementation of activities in inaccessible affected areas	Obtain a broad understanding of the ongoing response Identify gaps, overlaps, and needs against funds Promote response activities and need for additional funding Ensure transparency with government and donors
Level of Analysis	Detailed	Summary/ General Overview of the response
Analyses/ reports	Detailed Dashboards/ Reports	Summarized Dashboards/ Reports

The Humanitarian Response Plan (HRP) and the 4W Process

At the beginning of an emergency, health IMOs are recommended to use the Phase 1 – 4W template usually shared by OCHA for collecting data on health partners, their operational presence, and activities. A basic health template could also be used if aligned with the OCHA shared matrix. Health IMOs should in turn consolidate and disseminate 4W information internally and to partners. In case no template is available in the very first few days of an emergency, a simple Partner List can be used to collect contact/ potential area information until a template is developed.

During the initial phases, the IMO should focus on analyzing available data to flag gaps and maximize initial coverage of known needs. In addition, the IMO should ensure coordination and collaboration with other sectors and OCHA via the Information Management Working Group (IMWG), should one be established. The IMO should not spend time setting up a comprehensive 4W at the start of an emergency response. This effort in time can be unproductive, as there is a likelihood that the Health indicators will not be

confirmed in the first few weeks until both the emergency and affected population needs become better understood (and the HRP and Health Monitoring Framework are developed).
While the HRP and Health Monitoring Framework are being finalized, the Health IMO should, in tandem, be developing the Health Phase 2 - 4W template and tool. The system is critical to the coordination of a response. The system will track the progress of the Cluster against the targets that have been agreed.

Once designed, the 4W template is sent to partners on a regular basis: weekly inthe early stage of a sudden onset response, monthly when the humanitarian situation is stabilized. The coordination team must train partners to properly fill the 4W-matrix and encourage timely reporting of their data. Regular updates based on the agreed reporting timeline should be sent to cluster partners to ensure timely reporting. A schedule with reference to clearance and dissemination plans for the 4W should be implemented, to allow partners to provide and receive information regularly according to needs.

Partners send back the filled 4W matrix with their activity data (activity location, type of activities, +/- number of beneficiaries reached etc.) to the IMO. The IMO compiles and analyses the data and produces infographics to illustrate results of analysis and feed the various response monitoring reports.

For developing the Phase 2- 4W Health Template:

1. Start from the OCHA (or other coordinating partner) template if shared.
2. Involve partners in the design of the 4W template and tool. They will need to be familiar with the template and information requirements as they will be responsible for collecting and reporting on indicators. Involving partners at the beginning also helps raise their sense of ownership and motive to collaborate.
3. Agree on a list of definitions of activities, sub activities and output indicators in collaboration with health partners to report on. This list should be similar to the one from the Humanitarian or Strategic Response Plan in the country and its monitoring framework.
4. Agree with focal points for 4W from partners on all information needs (see Table 1 below).
5. Agree on the appropriate frequency of data collection according to context, need and evolution of the situation.
6. If using 5W (for Whom), agree on reporting on beneficiaries/people reached according to a common methodology. Although a universal definition for counting people reached by a health response does not exist due to the challenge to establish exactly what could be the inclusion and exclusion criteria, some clusters have worked on a composite measure-based system (such as treatment courses, medical procedures, medical procedures etc.) which might lead to a calculation
7. Identify and adopt a 4W data collection tool based on the operating context. (This is an extensive topic discussed separately within this document under the “Data Collection Tools” section)
8. After customizing the 4W template based on activities and health related indicators, it is advisable to re-harmonize the 4W template, to the most possible extent, with the shared and coordinated by OCHA matrix, if available, or any used at inter cluster/sectoral level would be advisable.

Normally, response monitoring using 4Ws follows a pre-agreed duration (one year, six months, 3 months, etc.). At the beginning of an emergency or humanitarian planning year, a blank 4W is sent to all Health Cluster partners to enter or modify their projects based on what they are planning and have funding secured for.

Regular monitoring of the response (through the agreed indicators/targets) can provide evidence towards the Cluster achievements, highlighting critical gaps in the response. The information gathered can be used to write Cluster Bulletins and other types of reports and evaluations. Temporal analysis of 4W data from previous responses could also help develop assumptions and estimations for future planning. Done well, the response monitoring system, including 4Ws, can aid in transparency and accountability to Health partners, donors, public and most importantly, the affected population.

9.

Type	4W – Phase 1	4W – Phase 2 (example questions)
Who Refers to the partners whose activities are reported in the 4Ws; commonly the first column of the activity reporting template	- The name of the reporting agency	- Name of reporting organization - Name of funding agency - [Optional] Donor Project Code or Appeal Type - Type of organization (UN, LNGO, INGO, Red Cross/Crescent, government, other) - Name of implementing partner (if different from reporting agency) - [Optional] Type of implementing partners
What In 4Ws, 'what' is being done or is planned can be quite detailed. Some 4Ws are very specific in the description of the activities undertaken, others are rather generic.	- Health activity description (at the beginning of the crisis when health indicators have not been set yet)	- See the 'Global Health Cluster Indicators Guidance Note' for further information. - See also, Table 2 below - [Optional where applicable] Emergency Type – Depending on the context, it may be useful to differentiate between different response types within the same data collection tool. For example, refugee and IDP responses with similar Health Activities. Alternatively, where different responses involve different activities, for example, Ebola vs. cholera vs drought response.
Where Reports the geographical location of the activities related to a partner. It can make	- Name of location (at cluster-agreed	- Name of location - GPS Coordinates

reference to administrative boundaries (region, department or municipality) or point-data (camps, settlements, schools, etc.). The Cluster must decide the detail of geographical information needed for the 4W.	administrative level)	- Data collection administrative level [1] - Place Codes (P-Codes)/CODS - these resolve the basic issue of what we all call a place. Using place-names as identifiers can easily lead to confusion over spelling, different languages or scripts as well as duplication. Spatial data standards agreed by all agencies provide a single, unified system for referring to locations, allowing the free exchange of data between participating agencies. If a P-Code system is in use, OCHA can normally provide the lists. - Location Type – to allow partners to indicate if the intervention has taken place in a specific facility. In some emergencies the analysis of this type of information may be critical. Examples are a community/ collective center, Primary/Secondary health facility, mobile clinic, detention center, camp, school, disembarkation point, etc.
When Incorporating this type of information would enable distinguishing between past, present or future activities, and generate time-specific summaries of specific activities, or more detailed trend analyses.	- Usually not collected at the very beginning of a crisis (hence the 3Ws)	- Status – a column indicating the status of activities is another way to capture the condition of an intervention. Options usually include <planned> or <ongoing> or <completed> - Time frame – the (planned) start and end date of activities can be captured by adding two separate columns (<start date> and <end date>).
For Whom Incorporating this type of information would enable distinguishing between different target population groups, for example, IDPs in formal camps vs IDPs in informal shelters	- Population covered	- See section below: Common challenges faced when compiling Health 4Ws - Beneficiary Type – a column indicating the type of population / institution to capture the target of the intervention. (Such as IDPs, Refugees, Returnees, Host Communities, Migrants, and others) (If not doing a 5th W, this can be part of the What)

[1] **Important**: Once agreed, normally the chosen administrative level to collect data is not supposed to change and should be maintained for all future data collection.

		- Population targeted – captures the target population - Population reached – captures the population reached to date - Disaggregated population figures by sex and age preferably when possible

Table 2 *The 'What' in Phase 2 of the 4W*

Field	Description
Health Domains	[Optional] The Sphere standards disaggregates health into the following sub-domains which might prove useful when collecting and reporting on health activities: **Health Systems** addressing the core aspects of a well-functioning health system. **Essential Health Care** addressing the major causes of mortality and morbidity in a crisis-affected population: ● Communicable diseases ● Child health ● Sexual and reproductive health ● Injury and trauma care ● Mental health ● Noncommunicable diseases ● Palliative care
Activity /Input Description	To avoid a proliferation of activities, distinctions can be made by using other columns e.g. beneficiary type, location type, emergency type. Activities must be clearly defined and mutually exclusive, and each must have a standard unit that fits to the activity definition.
Health Indicator	The definition of the activities / units must be able to feed relevant information into the indicators as chosen for the HRP/Health Monitoring Framework. ***For this reason, the Phase 2 – 4W should not be finalized until the HRP and Health response monitoring indicators are chosen. It is critical that the Health IMO and Cluster Coordinator work together with health cluster members to choose the indicators.*** See the 'Global Health Cluster Indicators Guidance Note' for further information.
Unit	The units must fit to the activity definition and allow for the calculation of indicators. Examples include: consultation, referred case, session, delivery, health facility, health worker, etc.
Modality	Captures how assistance was provided: In-kind/service vs Cash/Voucher.
Quantity Planned	(For planned activities) Captures the unit quantity intended
Quantity Achieved	Captures the unit quantity provided to date

Target/Planned population	(For planned activities) The number of people targeted by the intervention.
Population reached	The number of people reached by the intervention.

Some fields are essential for the analysis and reporting on Health-related activities but are omitted from the 4W health template to make it lighter and easier for Health Cluster partners to fill.

The following fields are auto-filled based on the selected indicator/ activity:

- Objective
- Output indicator
- Unit

Admin pCodes in addition to population figures are auto-filled based on the selected location and type.

Common challenges faced when compiling Health 4Ws

Target vs. Reached Beneficiaries

Unlike some other humanitarian clusters, counting and reporting on Health beneficiaries and target populations as a result of health interventions can sometimes be challenging and vary by context and emergency. For example, the Food Security cluster usually sets a target population for food assistance and can (depending on resources, access, and safety measure) reach their target population with the planned assistance. In the case of Health assistance, the target is usually set based on the vulnerability of the population and taking into account multiple factors such as an epidemic, expanding conflict, protracted crisis, etc. The number of people reached with Health assistance however varies; for example, one person can get sick from zero to many times and could therefore be double counted. The use and implementation of 4Ws for Health response monitoring thereby requires additional guidance from the emergency's Health Cluster to clarify beneficiary inclusion and counting methodologies the earliest possible to ensure consistent, standard, and accurate reporting from Health Cluster partners. One method to avoid or reduce double counting is to take the maximum number of beneficiaries reached by a Health activity and reported through the 4W.

Other common challenges and alternatives suggested by Health Cluster IMOs based on their experience include:

Reporting on the number of people vaccinated vs. Total Beneficiaries

Herd immunity is a form of indirect protection from infectious disease that occurs when a large percentage of a population has become immune to an infection, whether through previous infections or vaccination, thereby providing a measure of protection for individuals who are not immune.[2] While the number of people vaccinated seems simple to report on, even then the number of beneficiaries could be considered larger if herd immunity is the goal.

Medical staff provided vs. Number of people reached with Health Services

When providing medical staff, it is important to clarify if Health beneficiaries are the number of people medical staff actually reach per month, or how many people X doctors can cover (e.g. number per 10,000).

Number of people reached vs. Number of Consultations

The number of consultations represents the number of times a patient has been attended to by Health workers. A patient within a month can visit a hospital more than once depending on their ailments. Health workers usually record each consultation, hence the risk of double counting. This poses a challenge to estimating the real number of unique people reached with Health services.

Without the use of case management systems, it remains challenging to identify the actual number of unique people reached with Health services. This consequently impacts the calculation of other estimates such as the forecasted number of people in need and target population for the Health Cluster's strategic planning and monitoring framework.

[2] Fine, P.; Eames, K.; Heymann, D. L. (1 April 2011). "'Herd immunity': A rough guide". Clinical Infectious Diseases. 52 (7): 911–16. doi:10.1093/cid/cir007. PMID 21427399.

How to address issues when a project covers more than one of the outlined objectives in the response plan

Reporting on activity indicators is ultimately linked to reporting on relevant HRP Objectives. Some activities are well defined within a project and therefore have their indicators contributing to a specific HRP objective. In other cases, an activity within a project could be contributing to more than one Health cluster objective - hence the possibility of double counting. One way around it is to simply pick one objective to report the indicator under.

Double Counting

Beneficiaries receiving assistance over time (for example training) make reporting on the unique number of beneficiaries difficult - if not impossible - without double counting. This is a common problem across all humanitarian clusters. There is no "one size fits all" solution unfortunately. One solution would be to report on the new number of beneficiaries that have never been assisted before within a programming year. Data quality in addition to collecting and reporting on the data become more challenging however.

Important note: Always make sure to disclose in a disclaimer within your response monitoring products about the possibility of double counting when uncertain or in doubt that beneficiaries are counted more than once for a single indicator or across a series of indicators.

Another issue is the agreed time for counting and reporting of beneficiaries; when planning an assistance vs. when they actually receive assistance. Make sure you pick and clarify a relevant methodology to all partners for consistent reporting.

Recommendations: Reporting on COVID-19 / other major outbreaks

Humanitarian emergencies are susceptible to outbreaks of infectious diseases such as the most recent COVID 19 outbreak and could require new interventions/response activities. The following principles should be applied when reporting on COVID-19 (equally applicable to other major outbreaks that occur during a humanitarian response):

1. **Do not** set up a separate response monitoring template to report on COVID-19/ other infectious diseases.
2. Discuss with partners and Health experts the development of the situation and the additional activities/ reporting requirements.
3. Agree on an additional list of definitions of units, activities, sub activities and output indicators related to COVID-19. This list should be complementary to the one from the Humanitarian or Strategic Response Plan in the country and its monitoring framework.
4. If not done already, share newly developed definitions and terminology with Health and other Cluster members. Establish new linkages on activities with other clusters.
5. Agree on the appropriate frequency and means of data collection according to context, need and evolution of the situation. Depending on the severity of the outbreak and resources available, some activities might require more frequent monitoring to ensure a practical response.

6. Update the existing 4W template:
    a. Incorporate new activities into the existing 3/4/5W template. The updated template should include previously planned HRP activities in addition to COVID-19 response activities.
    b. Add a "status" field to indicate if there is a disruption of existing activities ("ongoing", "postponed", or "cancelled" due to COVID-19).Keep track of the reporting start date on new activities for future reference.
    c. Add a "COVID-19 Specific" field to indicate if an activity is specific to "COVID-19" or "non-COVID-19". Entities submitting data may determine which option to select according to the funding for their project, if earmarked for COVID-19, or see point 35 in the HRP Q&A.
    d. Add other relevant proposed fields/modifications recommended by the WHO Country/Regional Office, IMWG, etc.
7. Share the newly developed template with Health Cluster partners and confirm that all partners are using the new template.
8. Train Health Cluster partners on the new list of activities and indicators.

Data Collection and Reporting Tools

Prior to selecting/developing a 4W data collection tool, it is important to note that coordination, regular communication, and maintaining a good working relationship with Health Cluster partners are equally crucial in determining the success of the Health cluster's response monitoring. IMOs should proactively provide training on and populate Health 4Ws through networking (in meetings, humanitarian briefings, sectoral working groups), informal contacts, and the monitoring work of field staff.

Identifying and/or developing a 4W data collection tool depends on the operating context. Online 4W tools might support the entire process of response monitoring from data collection to reporting and analysis. Some of the available products are presented below. However, it is advisable to always keep a 'paper based' version of the 4W ready to be used in case of power and internet cuts.

Traditional 4W (Spreadsheet)

4W tools are generally created in Microsoft Excel (see GHC 4W Template) or Google Sheets, though some basic 4Ws can be created in Microsoft Word format or by using online survey forms (Survey Monkey, Google Forms etc.). The layout of the matrix is generally constructed with the following structures:

> 1 row = 1 activity conducted by 1 implementing partner at a chosen administrative level in 1 month, with each column in that row giving data about that activity/location

This approach gives a detailed listing of activities, locations and beneficiaries for each activity – it can be more time-consuming for agencies to complete, and care must be taken when defining activities and

analyzing the data to avoid double-counting of beneficiaries in the same location (if conducting 5W). A SUM of MAX beneficiaries per location avoids double-counting activities but may under-represent the response.

Mobile Data Collection

KoBoToolbox is a suite of tools for field mobile data collection for use in challenging environments. It is open source and free to all humanitarians. KoBo includes an online form builder and data management platform in addition to a mobile application that enables users to collect data and report on activities while outside the office with no access to connectivity.

Mobile data collection tools such as KoBo have paved the way for information to be gathered quickly while maintaining better data quality thanks to data validation rules. Location data can also be gathered using a mobile device's GPS feature, ensuring reporting accuracy and adding credibility. Developing a 4W template for KoBo is easy through its online form builder, however the IMO should be cautious about the data validation criteria and response constraints as they could lead to data entry bottlenecks or erroneous entries if not well-designed. The form should also be tested extensively before deploying it to Health Cluster partners as form updates can be challenging when many users are using the offline form on their mobile application. To learn more about KoBo click here.

Activity Info and Report Hub

Online platforms such as ReportHub (supported by IMMAP) and Activity Info (supported by BeDataDriven B.V.) have been designed specifically to address humanitarian response monitoring and evaluation needs. Both tools have an online form builder in addition to advanced data management and visualization features that do not require advanced information management expertise to set up. Such tools are usually agreed upon and implemented by the emergency operation's IMWG (usually led by OCHA) and cluster IMOs depending on the operation, context, and available funding. The advantage of such tools is in making data available in real-time for timely monitoring and reporting.

Activity Info

Pros	**Cons**
User management utilities	Account expiry limitation
API to link with Microsoft Power bi	Data entry case by case (no data copying from other cases)
Provide M&E support	Difficulties in variable mapping with other data sources
Ability to design custom reports/ dashboards	Requires platform experience
Supports online and offline (mobile) data collection	User needs more time to input data

Supports geodatabase	Expensive
Supports multilingual interface	Not many validation criteria in the form design
Ability to lock the database/forms to prevent submission of old data.	Not able to delete many records at the same time.
Maintenance service and technical support available	No calculation operation between two fields in two separate forms.

Report Hub

Pros	**Cons**
Provide real time reporting	Difficult to add such detailed data by health facility
Can be linked with HPD tool for HRP reporting	Suitable for static HFs but not suitable for mobile HFs
Secure and independent software	Does not support mobile data collection
Supports dashboard design	Heavy to open with weak internet
Supports geodatabase	Weak maintenance service

Operational Dashboards

A regularly updated summary and situation analysis of 4W data should be prepared, disseminated, and referred to for information requests from OCHA, government representatives, donors, and other agencies.

Preparing and visualizing data could be extremely time consuming without the use of the right data tools. Using software such as Tableau, Microsoft Power BI, and Microsoft Power Query, IMOs are able to create and store recurrent data preparation steps as well as visualization dashboards that make the process easily reproducible whenever new (cleaned) data arrives. Such software enables the creation of dynamic dashboards facilitating cross analysis between response monitoring indicators and other information, generating smarter insights faster and easier than going through traditional PDF documents. Dashboards in turn are shareable online and facilitate access to information for partners and donors using a link.

If the Health Monitoring Framework/ HRP objectives are in place, the summary dashboard should present quantitative progress against the key indicators. Consistent reporting of these key indicators, with explanations of the nature of the information being reported, is important in presenting a clear picture of a nuanced response and should reduce the chances of over-simplifying data to “Health beneficiaries”.

See “Sample Health 4W Products” for examples on 4W online dashboards and static PDF reports.

Data Collection Tips

As specified earlier in this document, Health Cluster partners and their staff are central to accurate and timely reporting on health activities in an emergency. Setting up a 4W tool, regularly communicating with partners, and providing regular training on the filling of Health 4Ws equally play an important role in ensuring better data quality. However, It is also important that the process takes into account the available capacity of partners when deploying a data collection template and solution:

1. Do not collect more than the essential (i.e. if it is not used, it should not be collected). Keep it simple and easy to use especially by local partner staff.
2. Make sure to have a data analysis plan, expanding on the Health Cluster’s monitoring framework and detailing how the Health Cluster intends to use and report on data being collected. This helps keep Health Cluster partners abreast of the relevance and importance of collecting such data.
3. Design must be done to minimize burden for partner's reporting:
    a. Consider internet connection availability and speed amongst partners. Choosing an online 4W data collection tool could end up limiting data collection and entry activities in places with no or limited connectivity.
    b. Language could be a data entry barrier for some national partner staff, hindering data entry efforts and affecting data quality. Consider developing the form in all languages used in the emergency operation to facilitate data entry. Most online and offline solutions (Activity Info, Report Hub, KoBo) offer the ability to develop a single multilingual form.
    c. Some partners might already have a database or tool in place to help them collect data on their activities. Health partners could also be engaged in multi-activity projects covering more than 1 cluster. Where feasible, investigate the possibility of exporting the 4W format directly from partner databases. Data manipulation tools such as Power Query available within Excel and Power BI and can help automate the preparation of partner 4W data to transform it into the Health Cluster’s 4W template.
4. Automate and make accessible basic analyses that are informed by partner feedback. This also liberates time consumed with recurrent tasks.
5. Develop SOPs including reporting mechanisms and share with reporting partner IMOs to ensure consistent and standard data collection, quality, and reporting.
6. Apply data quality procedures (timeliness, completeness, consistency etc.) throughout feedback with reporting agencies. Engage with reporting staff on erroneous or ambiguous records.
7. Analyze trends for each indicator and seek justifications from reporting partners in case of significant variations.
8. Share and discuss findings of 4Ws with response leadership to ensure findings are used to inform evidence-based operational decision-making
9. Conduct regular Information Management meetings with Health partners to discuss 4Ws issues. Ensure constant communications and engagement are in place to support and promote the adoption, update, and continued use of the tool.

10. Response monitoring using 4Ws requires continuous followup with the partners as well as maintenance and updates to ensure the tool remains easy to use and relevant over time.
11. Assign a 4W focal point (usually the Health Cluster IMO) for helping out or providing users with proactive support.