Global Health Cluster

Survey to establish a baseline for all-hazard preparedness in health cluster operations

Survey Findings

June 13, 2024

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Background

The COVID-19 pandemic revealed immense needs, as well as the enormous potential and thrust with which cluster operations were scaling up the humanitarian health response to the pandemic. The GHC commissioned several studies to examine the response to the COVID-19 pandemic in humanitarian settings. These studies identified good practices how health clusters and humanitarian partners addressed needs, challenges and closed gaps in the pandemic response.

In line with other evaluations such as the Inter-Agency Evaluation of the COVID-19 Humanitarian Response these studies also lay open weaknesses of the humanitarian system to be adequality prepared and ready to respond timely and to scale to high-impact hazards and large public health events.

Phase 2 of the GHC commissioned impact analysis of COVID-19 on humanitarian response conducted in November 2023 furthermore gives evidence of health clusters using gains and learnings from the COVID-19 response to to prepare for future health risks and hazards. Resource limitations and funding gaps, however, bear risks of losing such momentum.

Objectives

The GHC is aiming to support health clusters in the post-pandemic phase to transition from response to strengthening health emergency preparedness and readiness. To tailor this support to the needs of clusters and built targeted support interventions, the GHC conducted this survey to establish a baseline of the state of preparedness planning and readiness to multiple hazards, including high-impact epidemics and pandemics.

Specific objectives were to:

- Map existing preparedness priorities
- Assess the level of integration of preparedness and readiness within the humanitarian coordination platform and national preparedness planning processes
- Identify needs for improved preparedness planning and readiness capacity
- Identify gaps and priorities for support and capacity building

Methodology

An online questionnaire was designed using Microsoft Forms. The questionnaire contained 39 single-choice, multiple-choice and text input questions. Most questions were mandatory, some contained skip logics. The questionnaire was tested for functionality and question logic.

The survey was online from March 7, initially for two weeks, extended to four, until April 4, 2024. The analysis was done in Microsoft Excel, using the data set compiled in Microsoft Forms.

Survey Response

This survey was directed at health cluster coordinators, at national and sub-national levels. Respondents did not need to identify themselves by name; only the country and function were asked.

A total of 42 responses were received from 22 of 31 cluster operations (71%), including 1 regional cluster. Of the 42 responses, 22 were national level respondents, 20 sub-national. Multiple responses were received from Ethiopia (10; 4 natl, 6 sub-natl), Afghanistan (7; 1 natl, 6 sub-natl), Burkina Faso (3 sub-natl), Yemen (2 natl), Nigeria (2; 1 natl, 1 sub-natl) and oPt (2; 1 natl, 1 sub-natl). Respondents from Syria were designated as Syria – cross-border Türkiye, Syria Damascus and Whole of Syria. Syria North-West did not submit a response. Respondents from Burkina Faso and Lebanon identified only as sub-national coordinators.

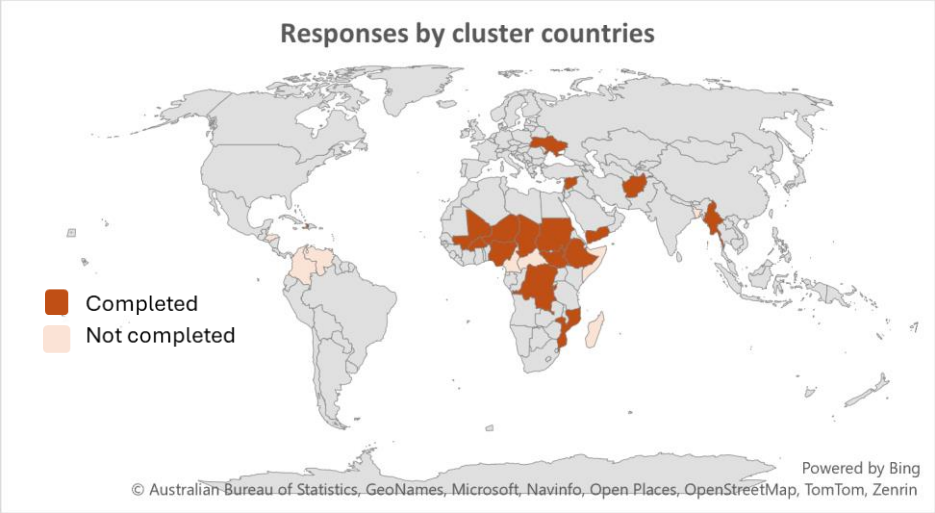


Figure 1 Cluster countries that participated in the survey

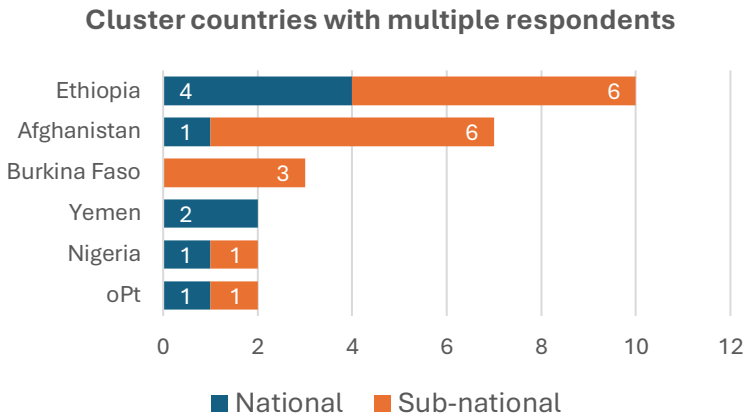


Figure 2 Cluster countries with multiple respondents, disaggregated by national, sub-national

Findings

Scenarios

Survey respondents were asked for which scenarios they are preparing. This was a multiple-choice question with the following pre-set choices: Epidemics; Pandemics; Natural disaster (earthquake, floods, drought); Conflict; Civil unrest; Displacement; Attacks on health care. In addition, respondents were able to select 'other' and enter a scenario of their own.

Natural disaster was selected by 38 respondents, followed by epidemics (36), displacement (35), conflict (34), attacks on health care (25), pandemics (16) and civil unrest (12). Two respondents defined 'Others' with acute malnutrition (1) and returnees (1).

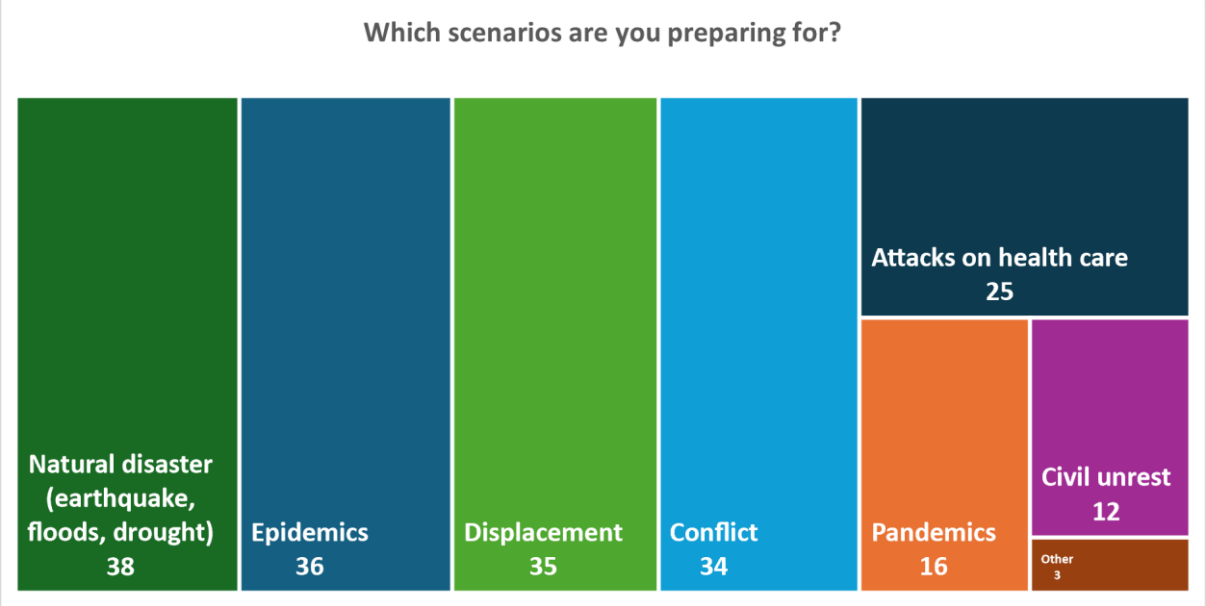


Figure 3 Scenarios being prepared for by respondents

The list displays the number of scenarios, respondents indicated are being planned for in their cluster operation.

Of note is that Burundi has selected natural disasters only, while Lebanon and Ukraine chose conflict related hazards only.

Cluster	Number of scenarios
Afghanistan	9
Burkina Faso	7
Democratic Republic of the Congo	7
Ethiopia	7
Syria	7
Haiti	6
occupied Palestinian territory	6
Chad	5
Mali	5
Myanmar	5
Niger	5
Nigeria	5
Sudan	5
Pacific	4
South Sudan	4
Yemen	4
Mozambique	3
Lebanon	2
Ukraine	2
Burundi	1

Figure 4 Numbers of scenarios planned for by country

Survey respondents were asked if health clusters are or will be developing contingency plans for specific scenarios. Among the 22 cluster operations, 17 (77%) confirmed this with yes; 1 (5%) with No and 4 (18%) were not sure.

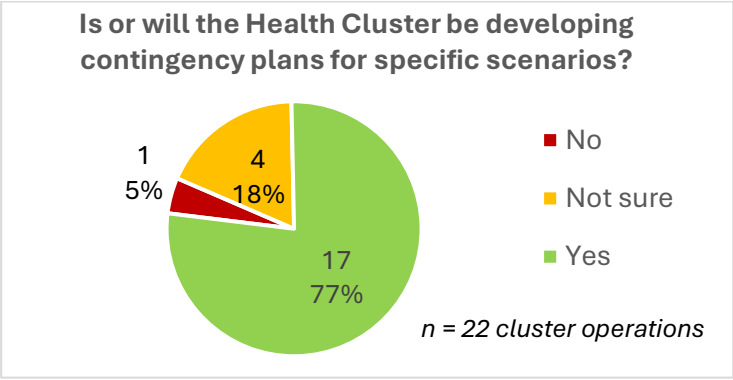


Figure 5 Number and percent of respondents developing contingency plans

Asked to select key components contained in these contingency plans, 15 respondents chose 'coordination and information management', 13 chose 'resource availability/ mobilisation', 13 chose 'emergency response procedures', 11 chose 'human resources capacity' and 10 chose 'roles and responsibilities'.

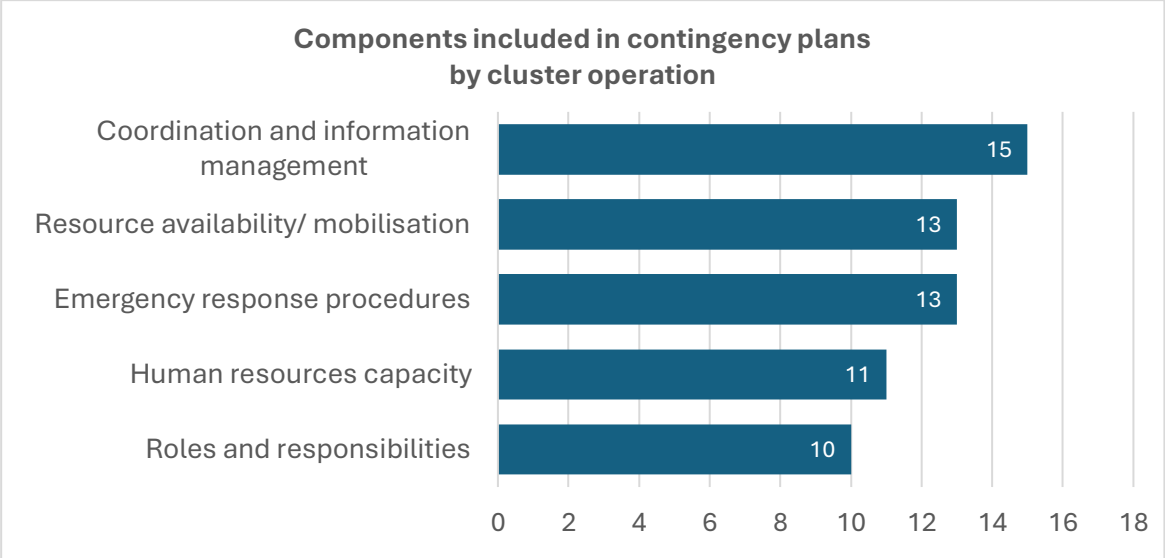


Figure 6 Components included in contingency plans

Assessments

Asked whether respondents recently assessed risks, hazards, vulnerabilities, particularly since the end of the COVID-19 pandemic, 30 (71%; n=42) responded with yes, 12 (29%) with no.

Twelve respondents used the Joint and Intersectoral Analysis Framework (JIAF), 11 used Public Health Situation Analysis (PHSA), 7 used the Strategic Tool for Assessing Risks (STAR) and 6 used each the Multi-Cluster/Sector Initial Rapid Assessment (MiRA), Rapid Risk Assessment (RRA) and Rapid Health Assessment (RHA). Multiple choices were possible. Fourteen respondents confirmed using multiple assessment methods.

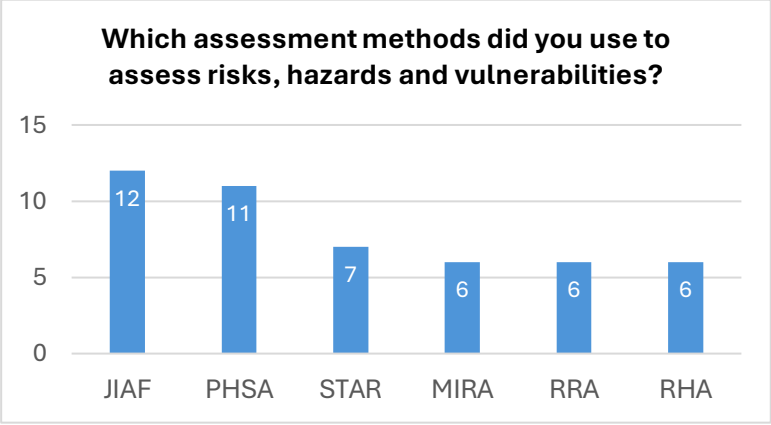
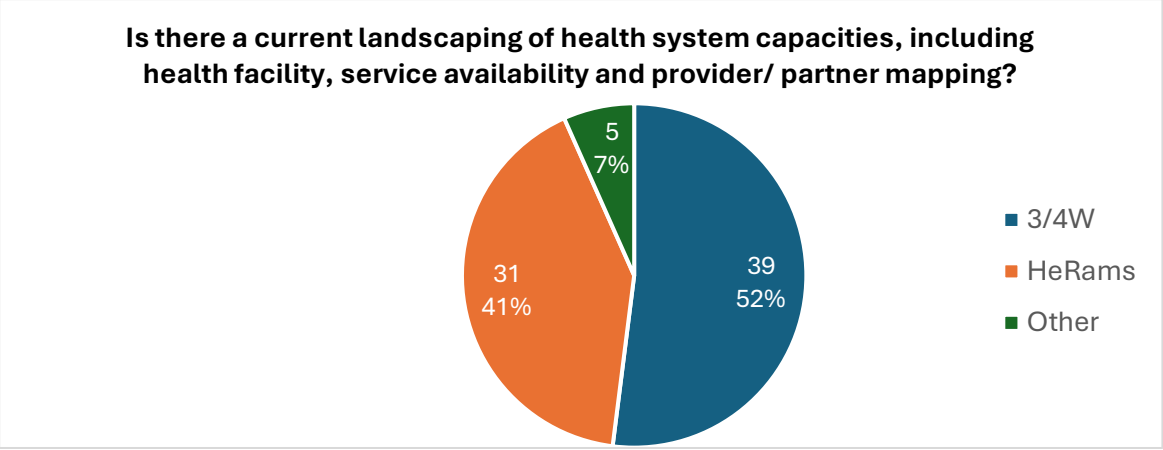


Figure 7 Assessment methods used to assess risks, hazards and vulnerabilities

Thirty-three respondents were aware of recent assessments by WHO, 17 by the government, and 9 by 'Others', which included multisectoral assessments by NGO partners and UN agencies, UNOCHA/UNDRR and other clusters.

Asked if there is a current landscaping of health system capacities, including health facility, service availability and provider/ partner mapping, 39 (52%) of respondents confirmed the presence of a current 3/4W, 31 (41%) Health Resources and Services Availability Monitoring System (HeRAMS) and 5 (7%) selected 'Others'. The respondent from Mozambique noted: *"multiple mapping tables of clusters, government, OCHA… a lot of duplication."*



n = multiple responses per survey participant

Figure 8 Number and percent of types of landscaping of health system capacity

Asked whether crisis-affected populations are included in national risk registers, 25 (60%) respondents from 15 cluster operations confirmed this with yes, 2 (5%) responded with no (Gaza, Mozambique) and 15 (36%) from 8 cluster operations did not know (Afghanistan, Burkina Faso, Haiti, oPt, Pacific, Sudan, South Sudan, Ukraine).

Humanitarian Coordination

Thirty-three (79%) of respondents confirmed that there is a coordinated multisectoral approach to preparedness planning, whilst 9 (21%) agreed that the approach is fragmented and that there are parallel work.

Respondents were asked to provide details as to the types of workstreams in their operation. Analysing these descriptions, responses were categorised into three broad types of approaches: by hazard, by emergency preparedness and response component and by coordination mechanism.

Workstreams by hazard	Workstreams by EPR components	Workstreams by coordination mechanism
Population displacement Disease outbreaks Floods Food insecurity Conflict Insecurity Winter (Ukraine) Earthquake contingency plan (northwest Syria)	Multisectoral assessment Needs analysis Disease Surveillance and Early Warning Emergency Medical Care Health Systems Strengthening Risk Communication and Community Engagement Coordination and Partnerships Access and accountability	Multisectoral preparedness guided by PHEOC Needs assessment and contingency planning through ICCG Preparedness and response plan included in HRP

Health Cluster Coordination

In terms of integration of preparedness into health cluster coordination, 22 (52%) of respondents indicated that they have preparedness specific working groups or other work streams, 10 at national, 12 at sub-national level. Twenty (48%) confirmed not having specific WGs or workstreams, 14 at national level, 6 at sub-national level.

Asked if respondents were able to plan for and budget specific preparedness actions in the 2024 HRP, 21 (50%) responded with Yes; 11 (26%) with No, and 10 (24%) with Partially. Those that responded Yes and Partially were asked if these preparedness actions included a specific focus on strengthening continuous delivery of essential health

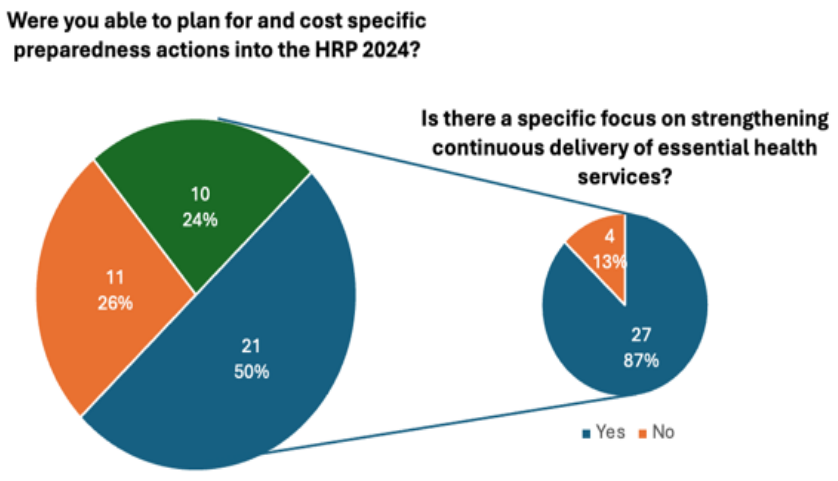


Figure 9 Number and percent indicating focus on continuous delivery of health services

services: 27 (87%) responded yes, 4 (13%) with no.

As perception, rather than an objective measure of the actual capacity, health cluster coordinators were asked to rate the capacity of their cluster partners, as a collective, to be ready, at this point in time, to respond to an emergency in these following response components:

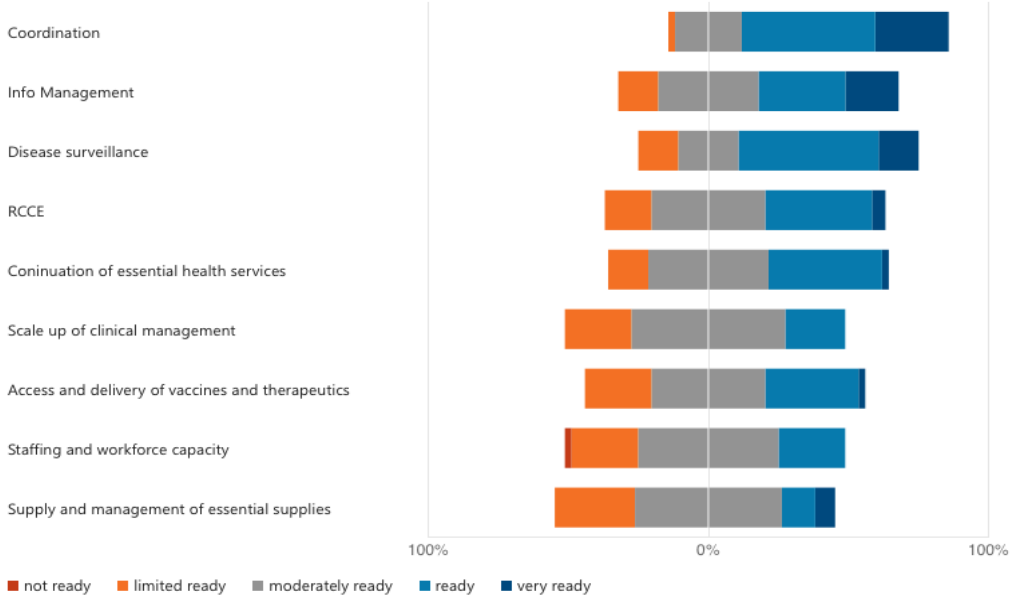


Figure 10 Capacity rating of health cluster partners to respond to an emergency

Whereas coordination, information management, disease surveillance, risk communication and community engagement and continuation of essential health services were assessed predominantly in the positive range of readiness, they were mainly in the negative range for scaling up clinical management, access and delivery of vaccines and therapeutics, staffing and workforce capacity and supply and management of essential supplies.

Explanatory note on rating scale:

- ***Not ready*** (a response would not be possible at this moment)
- ***Limited ready*** (even a limited response would require extensive resources and time)
- ***Moderately ready*** (a response is possible but with limitations and delays)
- ***Ready*** (a response can be mounted with available resources within an appropriate time)
- ***Very ready*** (an effective response can be mounted, additional resources can be acquired without delay)

Survey participants were asked whether the number of partners in their health cluster operation increased, decreased or remained stable since the end of the COVID-19 pandemic. Fifty-five percent of respondents 23 indicated that the number of partners increased, while 9 (21%) saw it decrease, and 10 (24%) remain the same.

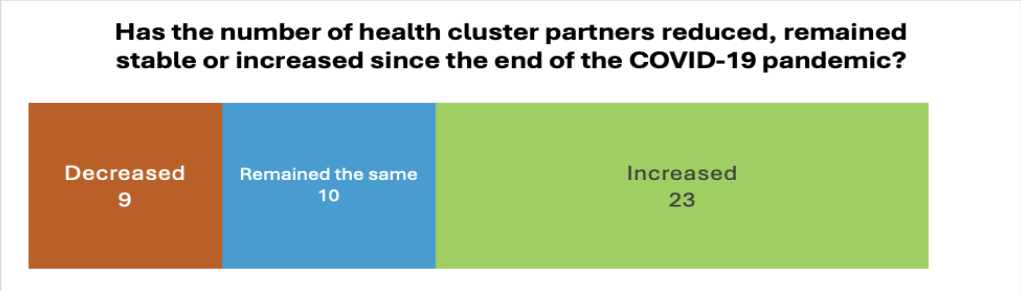


Figure 11 Change in number of partners in health cluster coordination since COVID-19

Coordination with Governments

Responses from the same cluster country/ operation were grouped for the question if national authorities have or are in the process of developing preparedness plans. Fifteen (68%) confirmed this with yes, 2 (9%) with no, and 5 (23%) did not know. A vast majority of respondents (28 of 29, 97%) indicated that the health cluster is actively engaged with the national authorities on the development of preparedness plans. Furthermore, 33 of 42 respondents (78%) confirmed that there is a dedicated coordination platform for national preparedness, including information management.

Public Health Emergency Operations Centres

Public Health Emergency Operations Centres (PHEOCs) are the backbone of national health authorities to monitor, prepare for and respond to health emergencies. The response to the COVID-19 pandemic in humanitarian settings has proven that these are an important counterpart and resource for the health cluster. [1]

Respondents from 14 cluster operations (64%) indicated that there is a functioning PHEOC. In 5 (36%) cluster operations it was confirmed with yes that the PHEOC extend to the sub-national level, 6 (43%) clusters could not confirm this. Respondents from Afghanistan, Burkina Faso and Ethiopia gave conflicting replies.

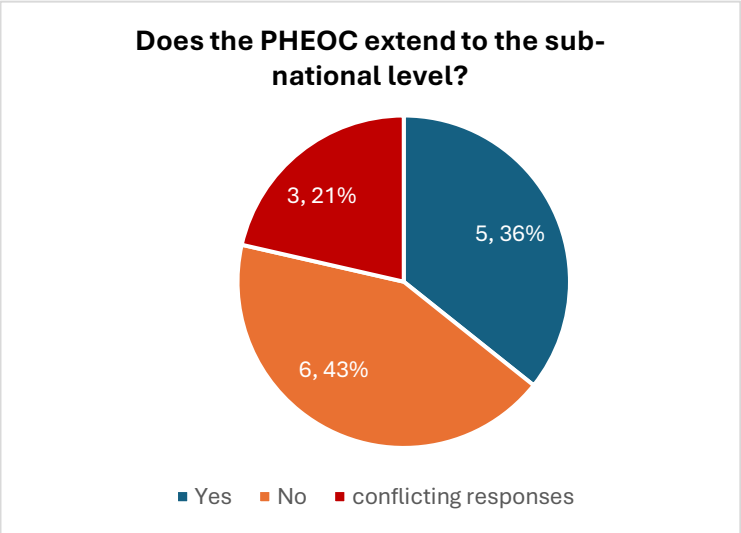


Figure 12 Number and percent of PHEOCs extending to sub-national level

[1] Study to examine the coordination of COVID-19 response in humanitarian settings https://healthcluster.who.int/publications/m/item/study-to-examine-the-coordination-of-covid-19-response-in-humanitarian-settings

Funding

The Pandemic Fund, launched in 2022 is a new global financing mechanism to enhance pandemic preparedness in low- and middle-income countries. The first call for proposals resulted in 19 grants being approved for a total of 37 countries. Six proposals in countries with active health clusters were approved for funding: Colombia, Haiti, both as part of regional grants, Burkina Faso, Ethiopia, oPt and Yemen as single-country proposals. A second call for proposals has been open from December 22, 2023, to May 17, 2024.

Survey participants were asked to indicate whether their country/ operation has applied for funding from the Pandemic Fund. Fourteen cluster operations have confirmed this: Afghanistan, Burkina Faso, Burundi, Chad, Democratic Republic of the Congo, Ethiopia, Haiti, Mali, Niger, Nigeria, occupied Palestinian territories, South Sudan, Syria[2], Yemen. Myanmar, Sudan and Ukraine have indicated that their countries have not applied. Respondents from Lebanon and Mozambique did not know.

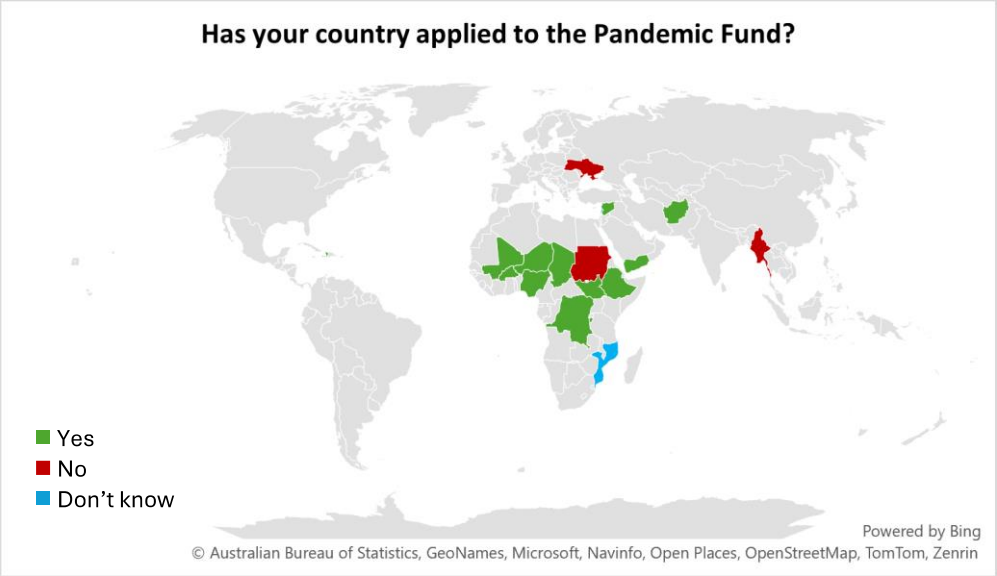


Figure 13 Countries indicating applications to the Pandemic Fund

Eleven respondents from the 14 countries that have an active health cluster and which applied for PF grants indicated that health cluster partners are recipients of funding for projects that explicitly target crisis affected populations: Afghanistan, Burkina Faso, Burundi, Chad, Democratic Republic of the Congo, Ethiopia, Niger, Nigeria, occupied Palestinian territories, Syria, Yemen.

Survey participants were asked to list other sources of funding for preparedness planning. Twenty respondents replied to this question, however, only 10 provided details of other donor sources: the World Bank (4), ECHO (4), USAID (3), BHA (3), Germany (2), Japan (1), Global Fund (2), NHF (2), WHO Contingency Fund for Emergencies (CFE) (2), Afghanistan Trust Fund (1).

[2] The Health Clusters in Syria are grouped as one operation in this map. Syria has four active health cluster operations: Syria Cross-Border North-East, Syria Cross-Border Türkiye, Syria Damascus, and Syria Whole of Syria as the umbrella coordination platform.

Tools and Resources

Survey participants were asked which tools and resources they use. This question was divided into two categories: tools for (a) risk, hazard and vulnerability assessments and (b) preparedness and response planning.

(a) Risk, hazard and vulnerability assessments:

Overall, 64% of respondents indicated to use assessment tools sometimes (21%) and very often (43%), 17% rarely and 19% never. Figure 14 depicts this by assessment tool.

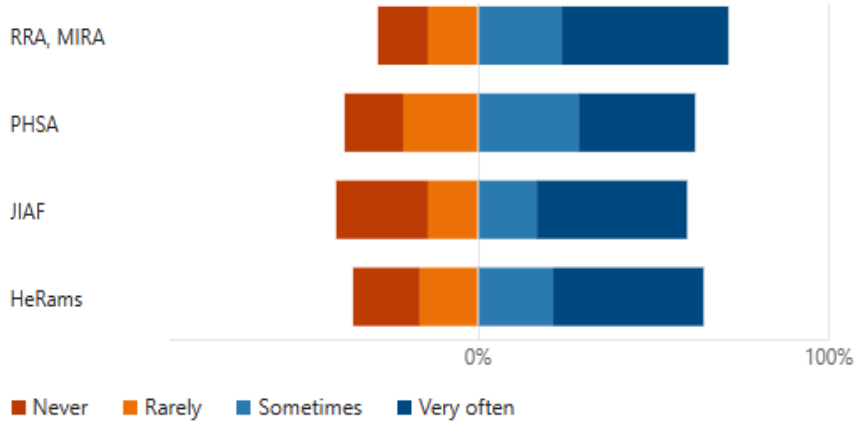


Figure 14 Tools used for risk, hazard and vulnerability assessments

(b) Preparedness and response planning:

Most respondents confirmed to be using the listed OCHA, IASC, WHO and Health Cluster tools very often (41%) and sometimes (31%). Outliers here are the Ready Initiative tools, which 62% respondents indicate using rarely or not at all.

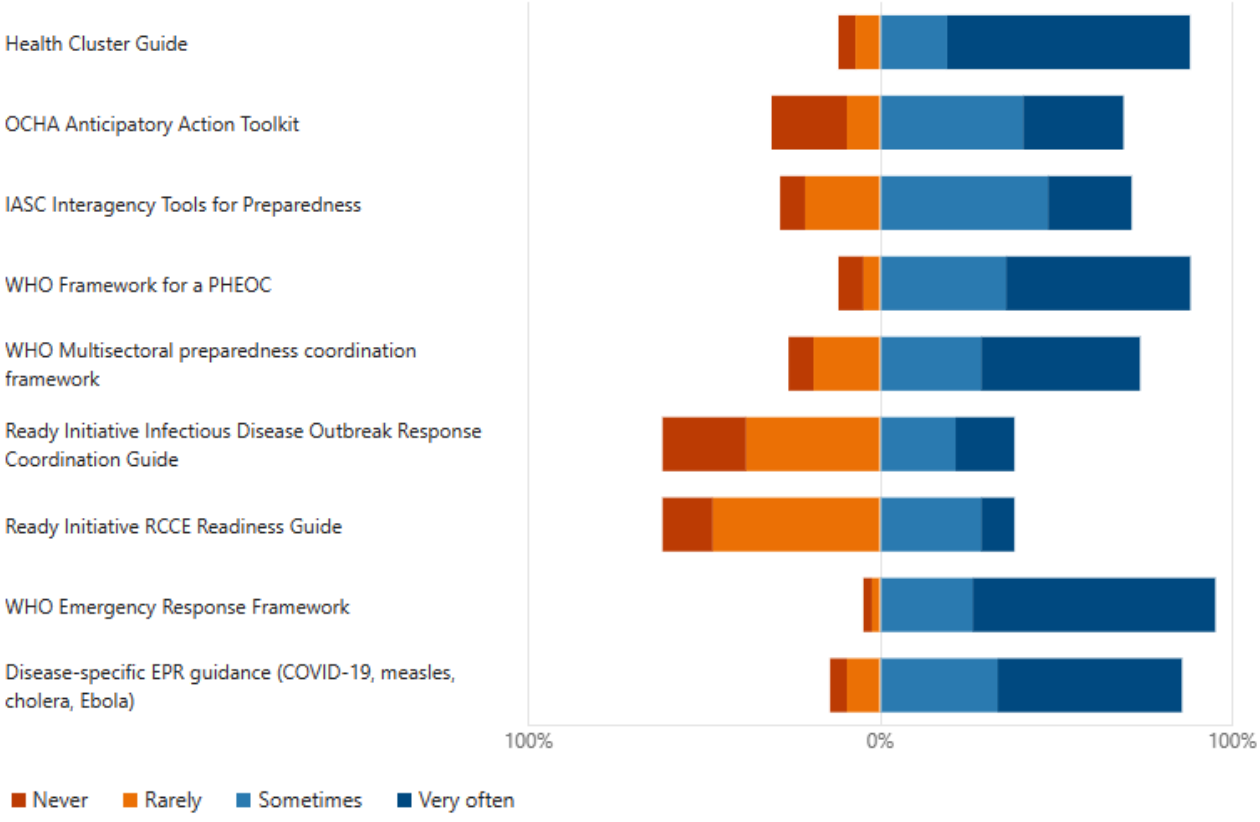


Figure 15 Tools used for preparedness and response planning

Contextualisation

Survey respondents were asked to describe the guidance and tools they were able to contextualise to their specific operational context. Twenty-five respondents completed this question, 19 of which gave a description of tools that they have adapted. Multiple entries were possible.

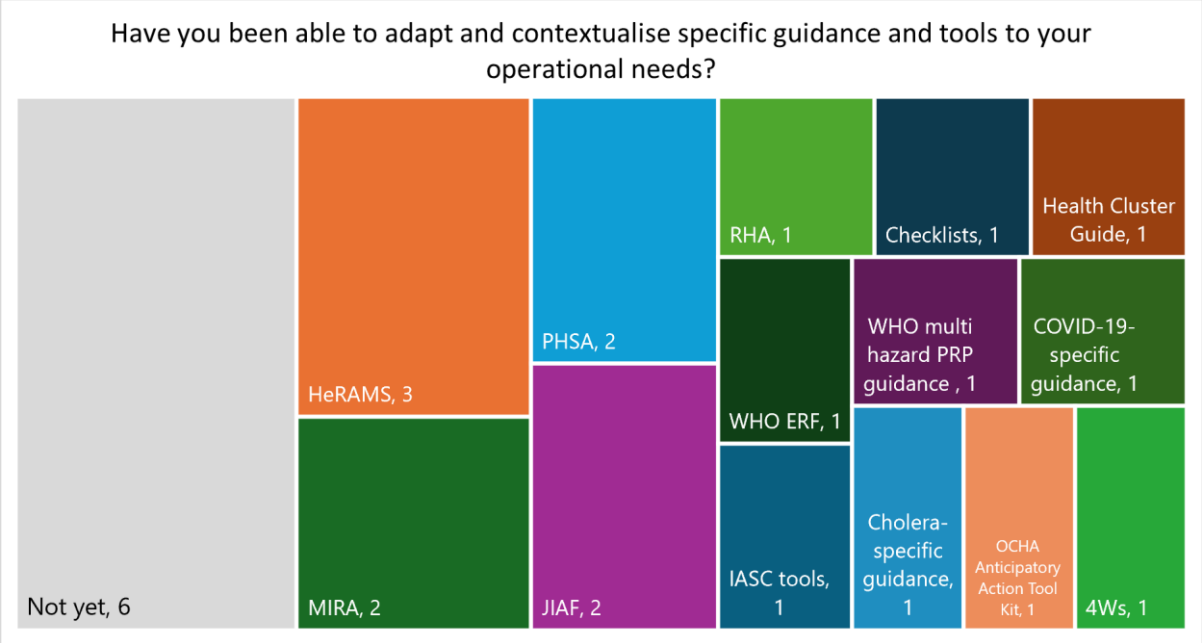


Figure 16 Adaptation and contextualisation of tools and guidance

Capacity Building

To better understand the needs for targeted training and capacity building on preparedness and readiness, survey respondents were asked to describe which hazard-specific or generic training is already being provided. Inputs from respondents display a variety of trainings from disease-specific to assessments, surveillance, project management and proposal writing.

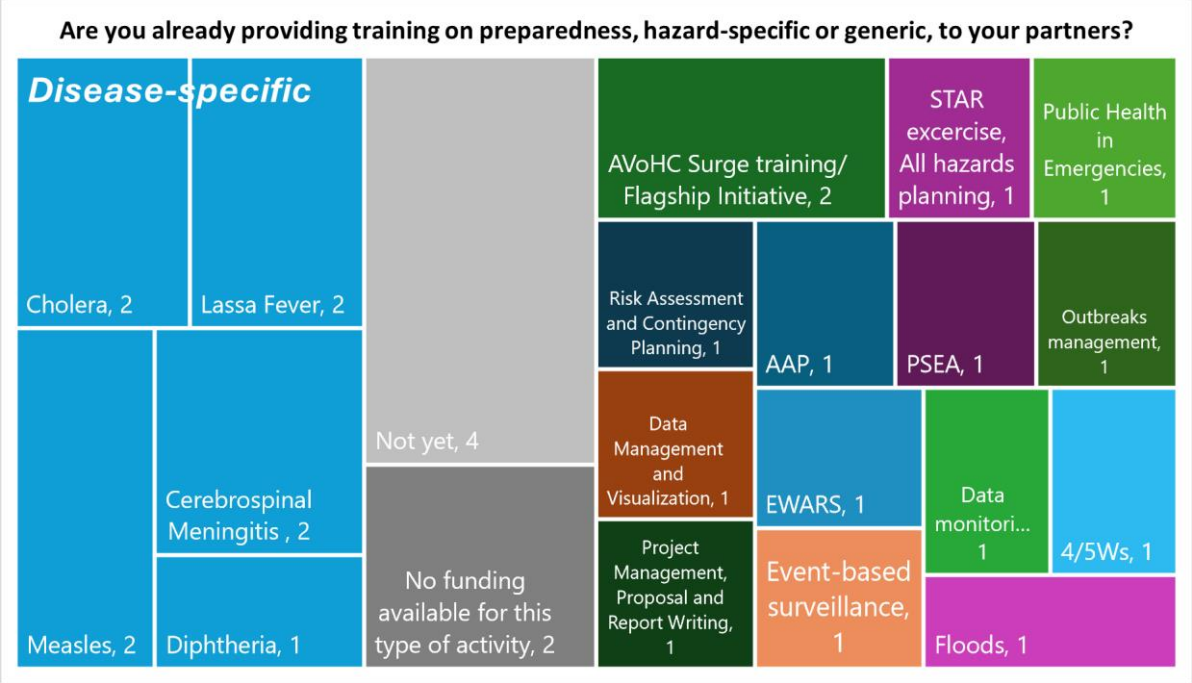


Figure 17 Types of trainings on preparedness being provided to partners by respondents

One respondent from Yemen summarised existing training options available to health cluster partners:

- **World Health Organization (WHO):** The WHO provides training programs and materials on various aspects of health emergency preparedness and response. They offer courses on topics including pandemic preparedness, health risk assessment, and emergency response operations.
- **International Federation of Red Cross and Red Crescent Societies (IFRC):** The IFRC conducts preparedness training programs for its partner National Red Cross and Red Crescent Societies. These programs cover a wide range of hazards, including natural disasters, health emergencies, and conflict-related crises.
- **United Nations Office for the Coordination of Humanitarian Affairs (OCHA):** OCHA offers training courses and resources on humanitarian coordination and response. Their training programs cover areas such as emergency response planning, cluster coordination, and humanitarian principles.
- **Non-governmental Organizations (NGOs):** Numerous NGOs specialize in providing training on emergency preparedness and response. Examples include the ***International Medical Corps, Save the Children, and the International Federation of Environmental Health***. These organizations often offer hazard-specific training tailored to the areas where they operate.

Study participants were asked to select from a predefined list of learning methods that are being used in their cluster operation. Multiple selections were possible. Trainings were the most frequently selected by 33 (32%), followed by workshops, selected by 28 (27%). Online self-learning was chosen by 20 respondents (20%), webinars by 15 (15%). Six (6%) selected 'Other', three of which were further described with "simulation exercises, "on-job training" and "regular information sharing".

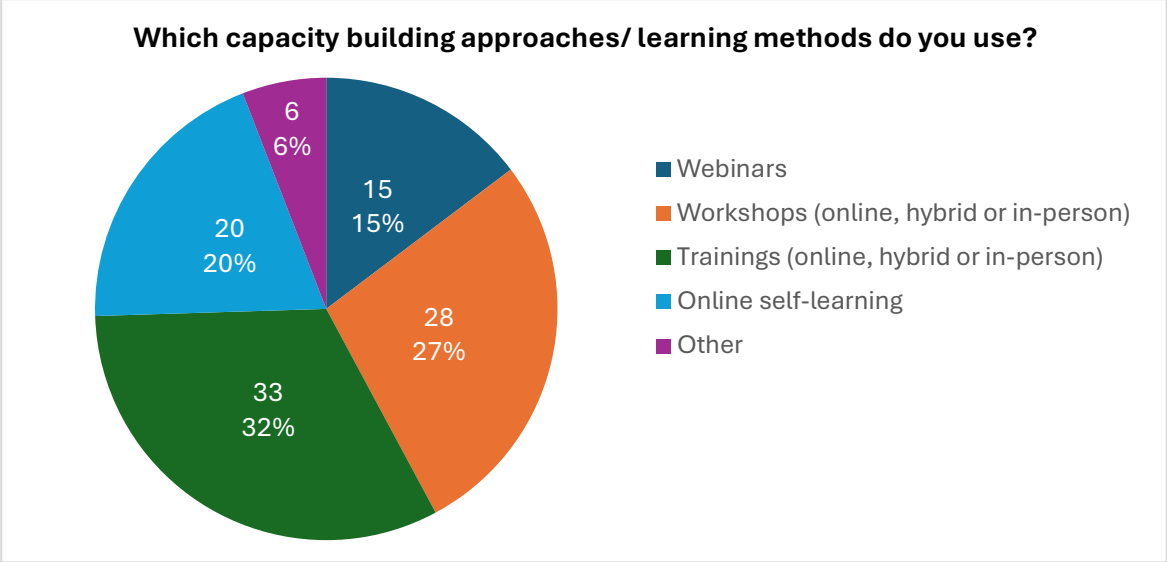


Figure 18 Number and percent of capacity building methods used

Training Needs

Participants were asked to select their five topmost priorities from a predefined list of 14 EPR priorities. Disease surveillance and public health data management was selected by 31 respondents, followed by coordination (28), information management (26), health services capacity (21) and continuation of essential health services (17). Trauma and mass casualties were mentioned under 'Other' by one respondent.

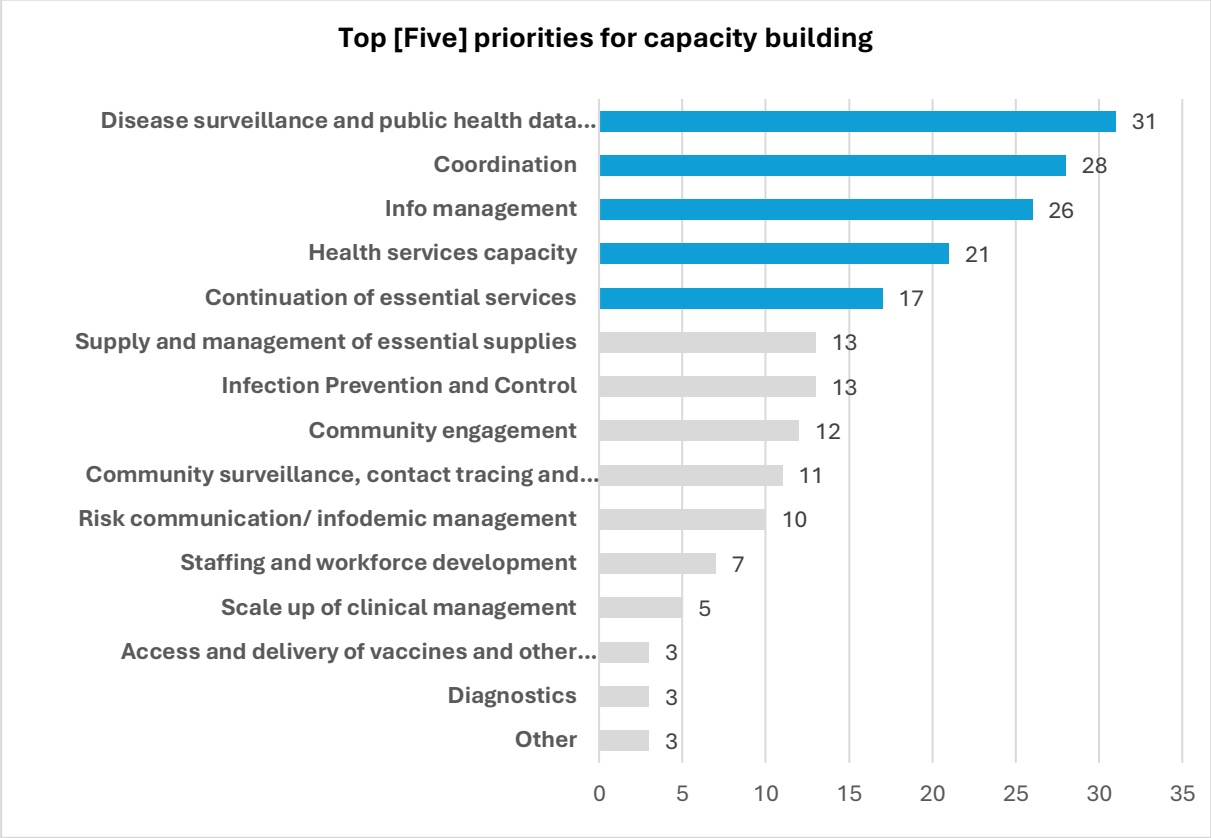


Figure 19 Rated priorities for capacity building

Concluding the survey, participants were asked to describe which support they need in their operation. The below list is the extract of the qualitative analysis of the free-text entries.

- Funding for training
- Training on funding (resource allocation, flexibility)
- Establishment of a mentoring system to support subnational coordinators
- Online preparedness training
- On-site training
- Technical capacity for providing trainings
- Support to local NGOs (project development)
- Training on Health Cluster Coordination for partners
- Contextualising of guidance and tools
- Support to improve quality

Conclusion

Reading the results of this survey in conjunction with the findings of the four GHC studies on the COVID-19 response in humanitarian settings[3] it is evident that substantive learning and good practices is being transitioned into the post COVID-19 pandemic preparedness planning.

Health clusters are preparing for a range of scenarios, from disease outbreaks to natural disasters and conflict and displacement. Clusters also prepare adaptive to their contexts. The survey also reveals that health clusters use and adapt to their context a range of assessment methods, from rapid assessments for acute events (RRA, RHA, MIRA) to preparedness and readiness specific assessments like STAR to integrated assessments which feed into the humanitarian program cycle (JIAF). Seventy percent of respondents confirmed that they have assessed risks and hazards since the end of the COVID-19 pandemic.

Respondents rated the capacity of partners to respond to an emergency at present overall positive for aspects of coordination, information management, disease surveillance, continuation of essential health services and RCCE. This can be an outcome of the lessons learnt from the COVID-19 pandemic. It will be important to maintain this momentum and strengthen the aspects that were rated less positive, namely workforce capacity and scale up of clinical management. Those are aspects of health system strengthening that require sustained inputs and resources.

In this regard it is positive that 50% respondents indicated that they were able to integrate and cost preparedness actions in the 2024 HRP, a further 26% partially. Engagement and coordination with governments and inclusion of crisis-affected populations into national risk registers and preparedness planning has been identified as priority.

Integration into national health systems, where possible, synergies with development partners, engagement with global donors focusing on health system strengthening (e.g. World Bank, Global Fund, GAVI) should be prioritised.

This links to the opportunities to integrate crisis-affected populations into proposals to the Pandemic Fund. This survey indicates that several countries with active health clusters have done so for the second round of calls for proposals. It needs to be seen, and observed, to which extend these proposals receive funding. The Health Cluster needs to stand ready to engage with the PF to ensure this integration materialises into concrete action.

About two thirds of respondents are using and adapting key inter-agency and technical tools and guidance on preparedness. The survey did not, however, determine the effectiveness of this for building and maintaining preparedness and readiness capacity within the health cluster. Follow up at country/ cluster level is needed to determine gaps and explore opportunities for capacity strengthening.

This applies as well to existing trainings on preparedness. Participants indicated using different trainings, from disease-specific to assessments, surveillance, project management and proposal writing. Yet, respondents expressed their needs for more support on training and technical capacity building.

[3] https://healthcluster.who.int/resources/covid-19-resources-and-guidance

Recommendations

Health clusters need to be supported in their efforts to sustain and expand preparedness planning, prioritisation in the HRP, integration into national plans and funding proposals and in supporting health cluster partner capacity development.

The emphasis should be on targeted and contextualised support to partners. The GHC can achieve this with capacity building support and adaptation of trainings to specific needs. Instead of using webinars to reach a broad audience, localised trainings or workshops (online) may be better suited. The GHC should use the capacity of technical units in HQ to tailor and collaborate on trainings to health clusters.

The development of tools, specifically checklists, is an effective means of drawing focus to multisectoral aspects and integration with national, regional and global initiatives. These checklists are already under development. An advantage here is that the GHC has engaged with other units in WHO HQ who are developing preparedness and readiness checklists for other audiences, such as governments, health authorities, WHO country offices. Linking and aligning these will ensure synergy and broadened utility.

Key actions for partners

- Review their own capacities for readiness to multiple hazards
- Review the status of preparedness actions in workplans, strategies
- Identify gaps and define needs.

Key actions for health cluster coordinators

- Assess the status of readiness of partners (i.e. simulation exercise)
- Collate information on the status and integration of preparedness actions in partners' workplans (tabletop review, HRP review)
- Collate and review gaps and needs identified by partners.
- Develop a priority workplan for capacity building. Focus on maximum 5 priorities
- Apply this through a multisectoral approach, and joint planning:
    - Increase engagement with other clusters
    - Identifying joint needs, jointly prioritizing (population, geography),
    - Develop joint monitoring mechanisms.

Key actions for the Global Health Cluster

- Support HCCs to deliver trainings targeted to their specific needs
    - Review and integrate preparedness specific components of existing trainings
    - In collaboration with technical units in WHO develop tailored training modules, either as direct trainings, or ToT
- Finalise, test and roll out the preparedness checklist currently under revision by the GHC.
- Ensure integration of specific humanitarian aspects of preparedness and readiness in tools for other purposes and audiences, especially for those supporting governments in assessing and developing national preparedness plans or funding proposals (Pandemic Fund, Global Fund, others) and include hazard-specific tools as they are being updated or developed

List of Figures

List of Acronyms

AVoHC	[Africa CDC] African Volunteer Health Corps
BHA	[United States] Bureau of Humanitarian Affairs
ECHO	European Civil Protection and Humanitarian Aid Operations
ERF	[WHO] Emergency Response Framework
EWARS	[WHO] Early Warning, Alert and Response System
GHC	Global Health Cluster
HCT	Humanitarian Country Team
HeRAMS	Health Resources and Services Availability Monitoring System
HRP	Humanitarian Response Plan
IASC	Inter-Agency Standing Committee
ICCG	Inter-cluster Coordination Group
JIAF	Joint and Intersectoral Analysis Framework
MIRA	Multi-Cluster/Sector Initial Rapid Assessment
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
PF	Pandemic Fund
PHEOC	Public Health Emergency Operations Centre
PHSA	Public Health Situation Analysis
PSEA	Protection against Sexual Abuse and Exploitation
RCCE	Risk Communication and Community Engagement
RHA	Rapid Health Assessment
RRA	Rapid Risk Assessment
SAG	Strategic Advisory Group
STAR	Strategic Tool for Assessing Risks
SURGE	WHO's initiative: Strengthening & Utilizing Response Groups for Emergencies
ToT	Training of Trainers
UN	United Nations agencies
UN OCHA	UN Office for the Coordination of Humanitarian Affairs
UN DRR	UN Agency for Disaster Risk Reduction
USAID	United States Agency for International Development
WHO	World Health Organization