Health Cluster International Partners' Capacity Survey 2018

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ACRONYMS

AAP Accountability to Affected Populations
AIDS Acquired Immunodeficiency Syndrome
BEOC Basic emergency obstetric care
CC Cluster Coordinator
CHS Core Humanitarian Standards
CLA Cluster Lead Agency
CCPM Cluster Coordination Performance Monitoring
CMAM Community-based Management of Acute Malnutrition
EMT Emergency Medical Team
EWARS Early Warning, Alert and Response System
GBV Gender Based Violence
GHC Global Health Cluster
GOARN Global Outbreak Alert and Response Network
HCC Health Cluster Coordinator
HCCT Health Cluster Coordinator Team
HCP Health Cluster Partners
HCT Humanitarian Country Team
HIV Human immunodeficiency virus
HPC Humanitarian Programme Cycle
HRP Humanitarian Response Plan
IASC Inter-Agency Standing Committee
ICC Inter Cluster Coordination
ICCG Inter Cluster Coordination Group
IMO Information Management Officer
INGO International Non-Governmental Organization
NGO Non-Governmental Organization
NCD Non-Communicable Disease
OFDA Office of Foreign Disaster Assistance
SAG Strategic Advisory Group
SBP Standby Partnerships
WASH Water, Sanitation and Hygiene
WG Working Group
WHO World Health Organization

ACKNOWLEDGEMENTS

The Global Health Cluster gratefully acknowledges strategic inputs to the survey development and implementation from the Strategic Advisory Group, the Task Team on Public Health Information Services, and colleagues in the WHO Health Emergencies Programme in particular, the Health Information Management Department, the Global Outbreak Alert and Response Network, the Emergency Medical Teams and the Standby Partnerships.

We express our gratitude and sincere thanks to the Health Cluster international partners, and their focal points who have taken the time to fill in the survey.

We finally thank the United States Agency for International Development's Office of Foreign Disaster Assistance (USAID/OFDA) for its financial support to this project.

INTRODUCTION

1. Introduction

The Health Cluster[1] is a vital operational partnership network that galvanizes the collective capacities of 700 partners at country level, of which 55 engage strategically at the global level, to achieve better health outcomes in humanitarian and public health emergencies. In 2018, 27 Health Clusters / Sectors worked to meet the health needs of approximately 75 million people worldwide. WHO is the IASC designated Cluster Lead Agency and provides coordination and secretariat support.

The Health Cluster aims to accelerate collective action, as locally as possible and as internationally as necessary, to ensure crisis affected communities receive immediate life-saving support and continued access to essential health services.

Health Cluster partners engage at the global level to deliver the GHC Strategic Priorities for 2017-2019:

1. Strengthen the coordination, technical and operational capacity of national-, regional- and global-level actors to prevent, prepare for, respond and recover from public health and humanitarian emergencies;
2. Strengthen inter-cluster and multi-sector collaboration to achieve better health outcomes;
3. Strengthen our collective and respective health information management;
4. Address strategic and technical gaps; and
5. Strengthen health cluster advocacy at country and global level.

At the country level, the Health Cluster serves as a mechanism for partners to harmonize efforts and use available resources efficiently within the framework of agreed objectives, priorities and strategies, for the benefit of the affected population(s). This includes addressing gaps, avoiding duplication, and resisting the establishment of parallel structures, wherever possible. The cluster should provide a framework for effective partnerships among

[1] The Health Cluster was created in 2005, as part of the Inter-Agency Standing Committee (IASC) Cluster System. The Cluster approach was developed by IASC to address gaps and to increase the effectiveness of humanitarian response by building partnerships. Read more on the IASC Reference Module for Cluster Coordination at Country Level (July 2015). https://www.who.int/health-cluster/about/cluster-system/cluster-coordination-reference-module-2015.pdf?ua=1

international and national humanitarian health actors, civil society and other stakeholders, and ensure that international health responses are appropriately aligned with national structures. In a sector of increasing needs and diminishing resources it is paramount that intensified efforts are made to address critical gaps in the Health Cluster response by strengthening partner capacities, collaborating with new actors and diversifying services.

2. Scope and objectives of the Health Cluster Partners' Capacity Survey

As part of Strategic Priority 1, the Health Cluster Partners' Capacity Survey aims to capture information on partners' technical, operational and coordination capacities, including surge. Previous surveys completed in 2012 and 2015 did not survey all international partners only global. The first phase of this survey conducted between July and August 2018 targeted the international partners of the Country Health Clusters. The second phase to be conducted in 2019 will target national partners.

The result of this exercise will help to more effectively identify critical gaps in global health response capacity and inform future partner engagement for the Health Cluster. The information collected through the survey will:

- Document partners' presence and capacity in areas affected by emergencies with public health consequences;
- Identify critical gaps in global health response;
- Inform and secure surge capacity requirements from technical and operational partners and networks in response to emergencies with public health consequences;
- Create strategic partnerships with current and potential partners/donors to support the implementation of the Global Health Cluster Multi-Year Strategy 2017-2019;
- Inform the development of a Global Health Cluster partners' recruitment strategy.

3. Methodology and response rate

1) Questionnaire

The questionnaire was developed by the GHC unit in collaboration with the GHC Strategic Advisory Group, the Public Health Information Services Task Team, the WHO Health Emergencies Programme - Health Information Management Department, the Global

Outbreak Alert and Response Network, Emergency Medical Teams and Standby Partnerships. The questionnaire was uploaded in Dataform, a version of LimeSurvey provided by WHO.

2) Pilot

The survey was piloted between 9 July 2018 and 30 July 2018 with a sample of Health Cluster international partners representative of the international NGO, donor and UN agency category. A few changes were implemented before the survey was finally launched.

3) Respondent Identification

The GHC unit collated 711 partners who were listed as being part of a Country Health Cluster as of June 2017. From this list, the GHC unit identified 216 international partners, confirmed their focal point and invited them to participate in this survey. Of the 216 partners identified, invitations were sent to a final total of 190 partners to undertake the survey; 26 partners did not have functional email addresses and were therefore unable to be reached.

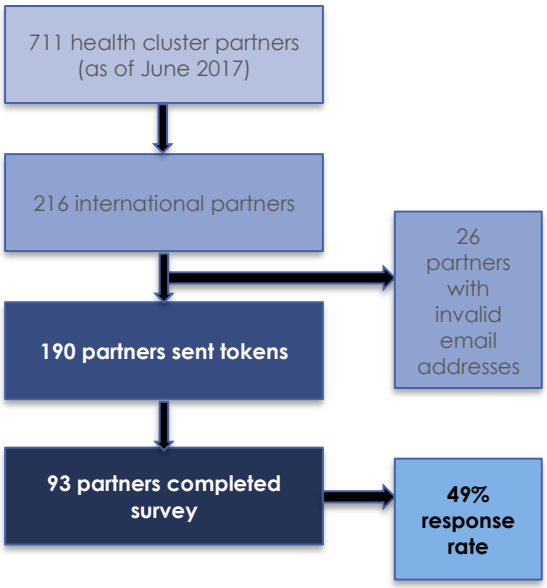


Figure 1. Breakdown of survey respondent identification and respondent rate

4) Launch

The survey was launched on 18 July 2018 and was closed on 30 August 2018. Regular reminders were sent throughout this period.

4. Survey results

1) Response Rate

The overall response rate was 49% (93 completed responses) among 190 international health cluster partners who were sent an invitation. Normally, the expected response rate for an external-facing online survey ranges between 10% and 20% on average. The response rate from previous surveys performed only among global level partners was higher (70%) due to their familiarity with this mapping exercise. It should be noted that 3 organizations left incomplete responses and 6 organizations explicitly opted out of the survey.

2) Survey respondent breakdown by organization

Organizations were asked to indicate their organizational type. Globally, the majority of respondents were NGOs (78%), followed by UN agencies, academia, specialized agencies, donors, and other. The 'other' category includes public-private partnership.

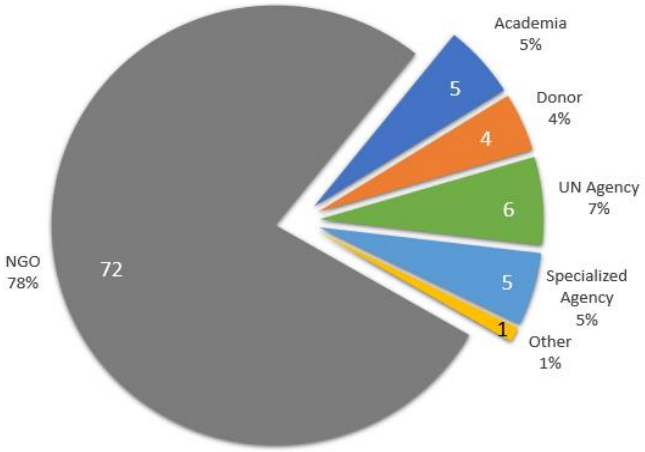
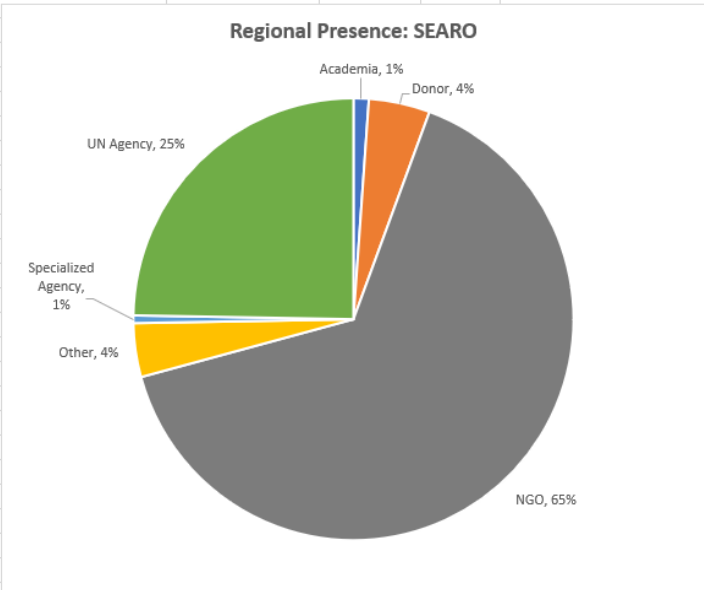
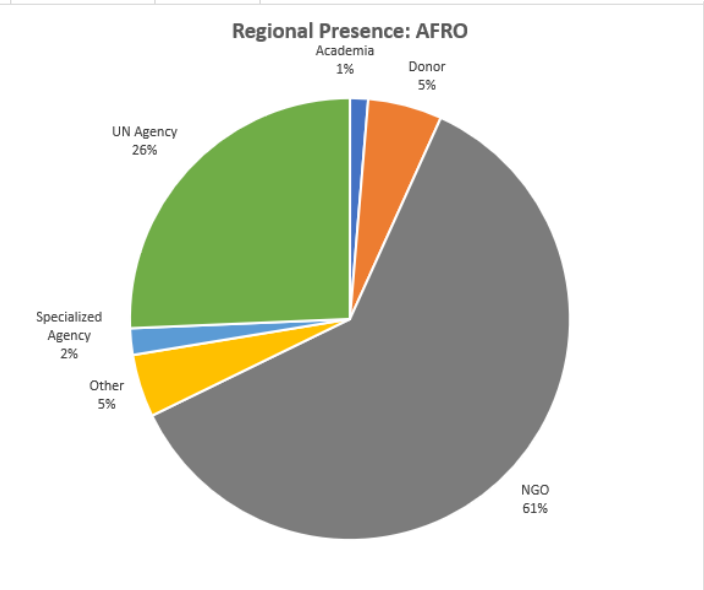


Figure 2. Global breakdown of respondent by organizational type

3) Organizational presence

Organizations were asked to indicate the country where their headquarters are located. Most of the respondents' headquarters were in the United States (21), United Kingdom (13), Switzerland (12), and Germany (5). Organizations were also asked to indicate in which countries they are operating (Figure 5). The top 5 health cluster countries with the highest organizational presence were as follows: South Sudan (39), Ethiopia (37), DR Congo (35), Bangladesh (34), and Nigeria (32). The Pacific Regional Cluster (Fiji, Solomon Islands, Tonga, Vanuatu) had a combined total of 36 organizations present. The Pacific Health & Nutrition Cluster works regionally in the Pacific as a Coordination and surge mechanism. The national health clusters in these countries are run by national Ministries of Health only.





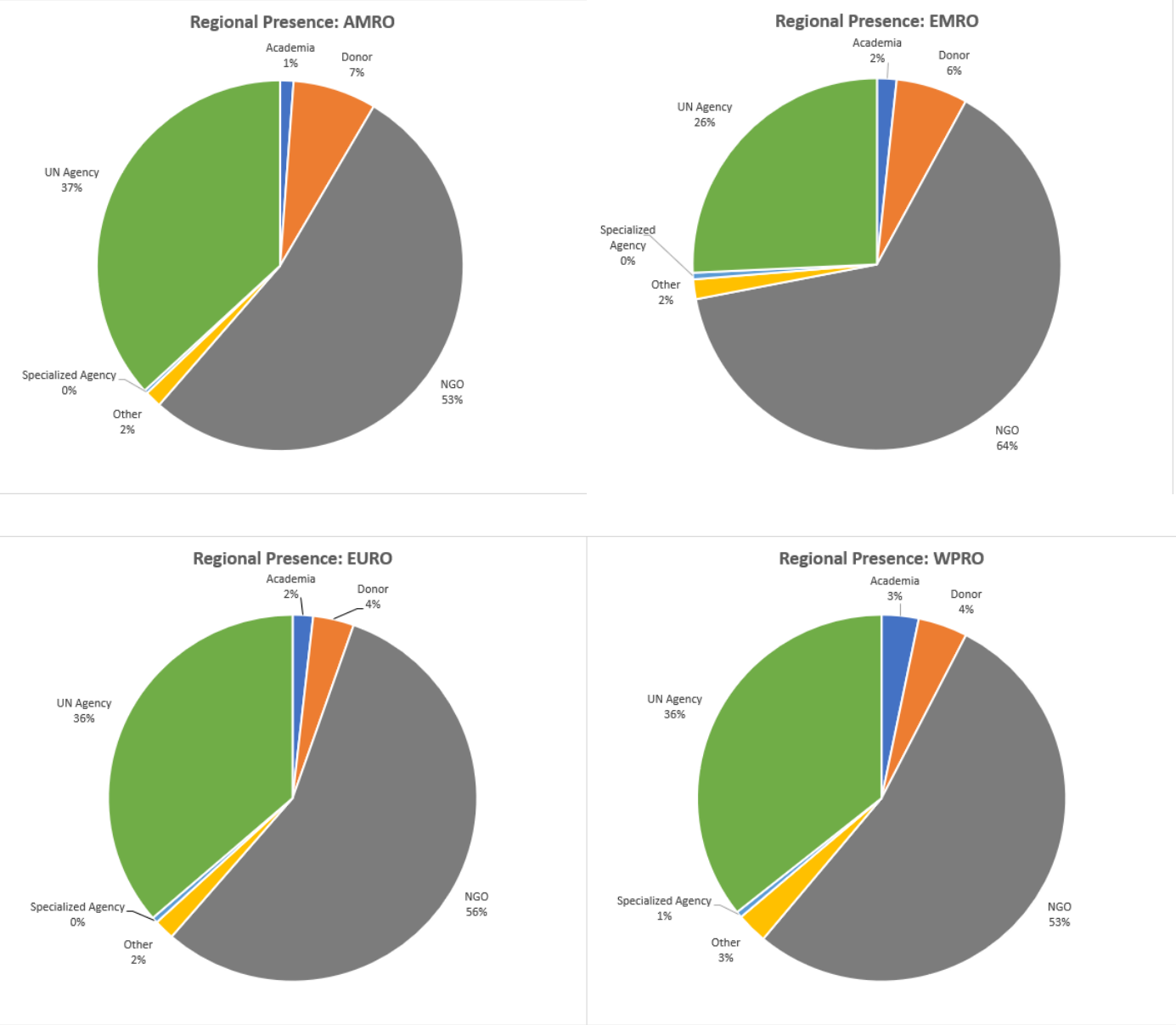


Figure 3. Types and percentages of organizations operating in each WHO region

4) Affiliations to other emergency networks and sectors

Organizations were asked to indicate their affiliations to other emergency networks and sectors. Only a minority of the international health cluster partners identified themselves as being affiliated with other health emergency networks (Figure 4) such as Emergency Medical Teams (21%) and Global Outbreak Alert and Response Network (19%).

In terms of other sector activities, more than half of the respondents reported to be involved in other sector activities closely related to health, such as WASH (55%), nutrition (57%) and food security (51%) (Table 1).

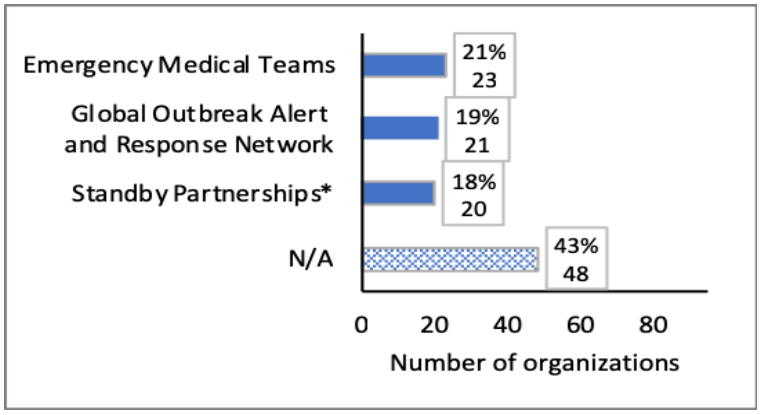


Figure 4. Affiliations to other emergency networks.

* Standby Partnerships (SBP) include the official 9 WHO SBP partners and other forms of stand-by partnership agreements, such as organizations' own surge/standby arrangements.

Other sectors	Education	Food Security	Logistics	Nutrition	Protection	WASH	N/A
Organizations	46	47	24	53	41	51	15
% of total respondents	49%	51%	26%	57%	44%	55%	16%

Table 1. International partner presence in other sectors

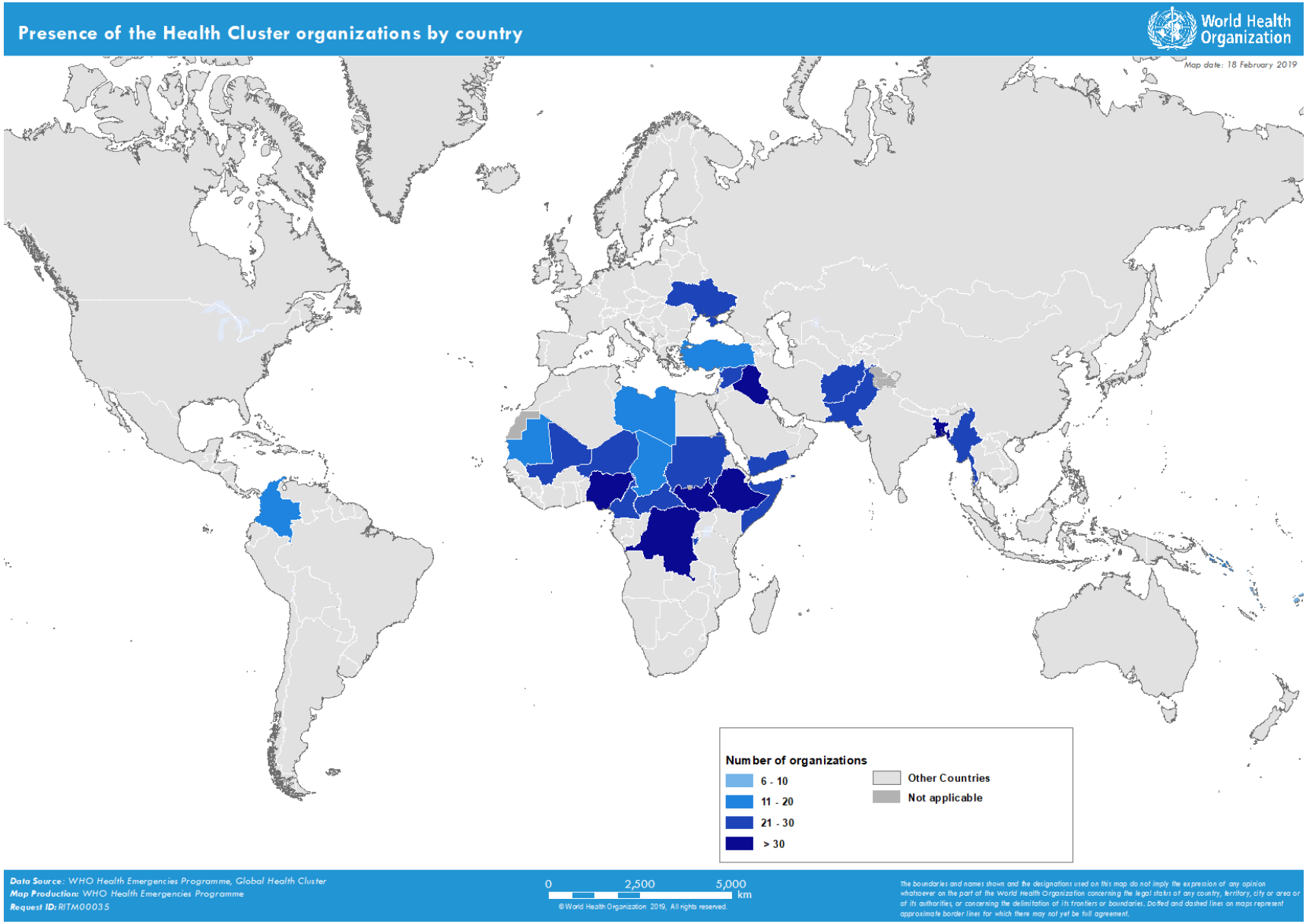


Figure 5. Presence of Health Cluster Organizations by country

5) Organizational expertise

Organizations were asked to indicate the areas of their organizational expertise. Overall, the collective organizational expertise is concentrated among communicable diseases, general clinical services, maternal and newborn health, and child health (Figure 6). There are concerning gaps in areas which require higher technical specialization.

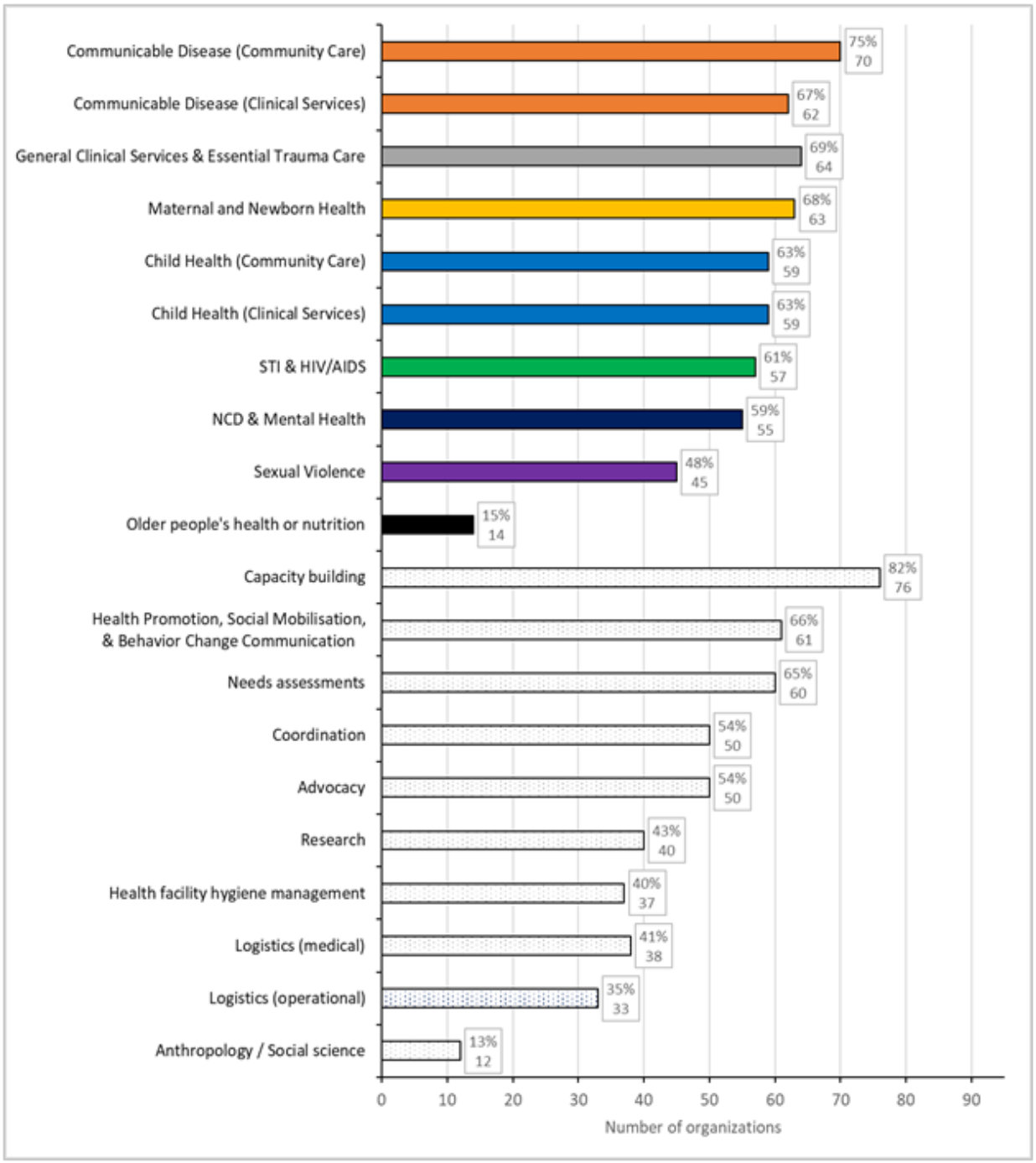


Figure 6. Organizational expertise, overall

a. Communicable disease (community care).

Organizations were asked to indicate the areas of their organizational expertise in communicable disease. The majority of organisations have capacity in community mobilisation, IEC and vector control.

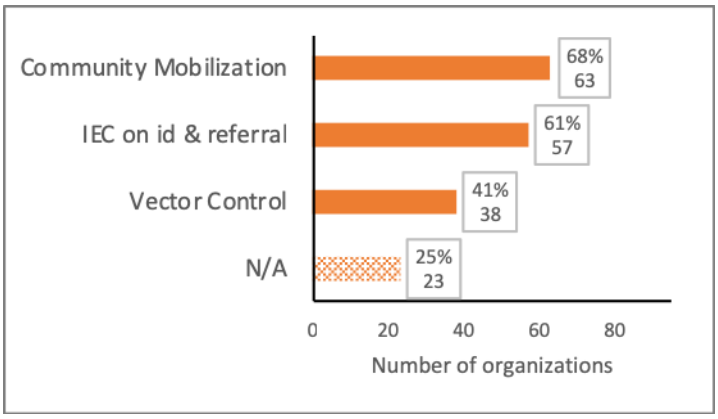


Figure 7. Organizational expertise: communicable disease (community care)

b. General clinical services & essential trauma care

Many respondents claimed technical capacity for basic services such as outpatient services (59%) and primary injury care (44%). However, a concerning 25% of the respondents reported having capacity for services related to surgical care, ranging from capacity to perform surgery and provide post-surgical care to intensive care and blood bank services (Figure 8).

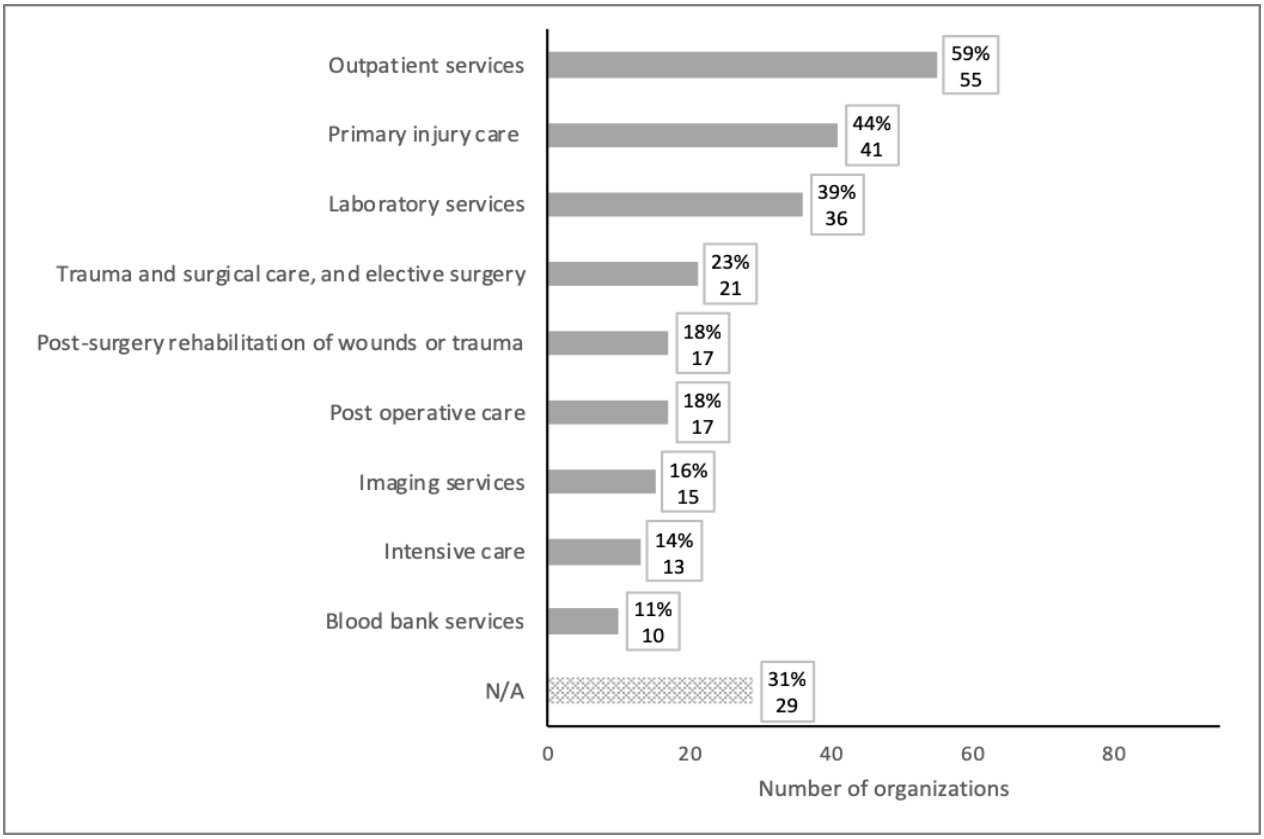


Figure 8. Organizational expertise: general clinical services & essential trauma care

c. Maternal and newborn health

Close to half of the respondents reported having technical capacity in the essential elements of maternal and newborn health (Figure 9). Respondents reported capacity in antenatal care (55%), family planning (47%), essential newborn care (47%), skilled care for skilled delivery (44%), basic emergency obstetric care (42%), and post-partum care (46%). However, reported capacity in comprehensive emergency obstetric care (31%) and comprehensive abortion care (20%) are concerningly low and require immediate attention.

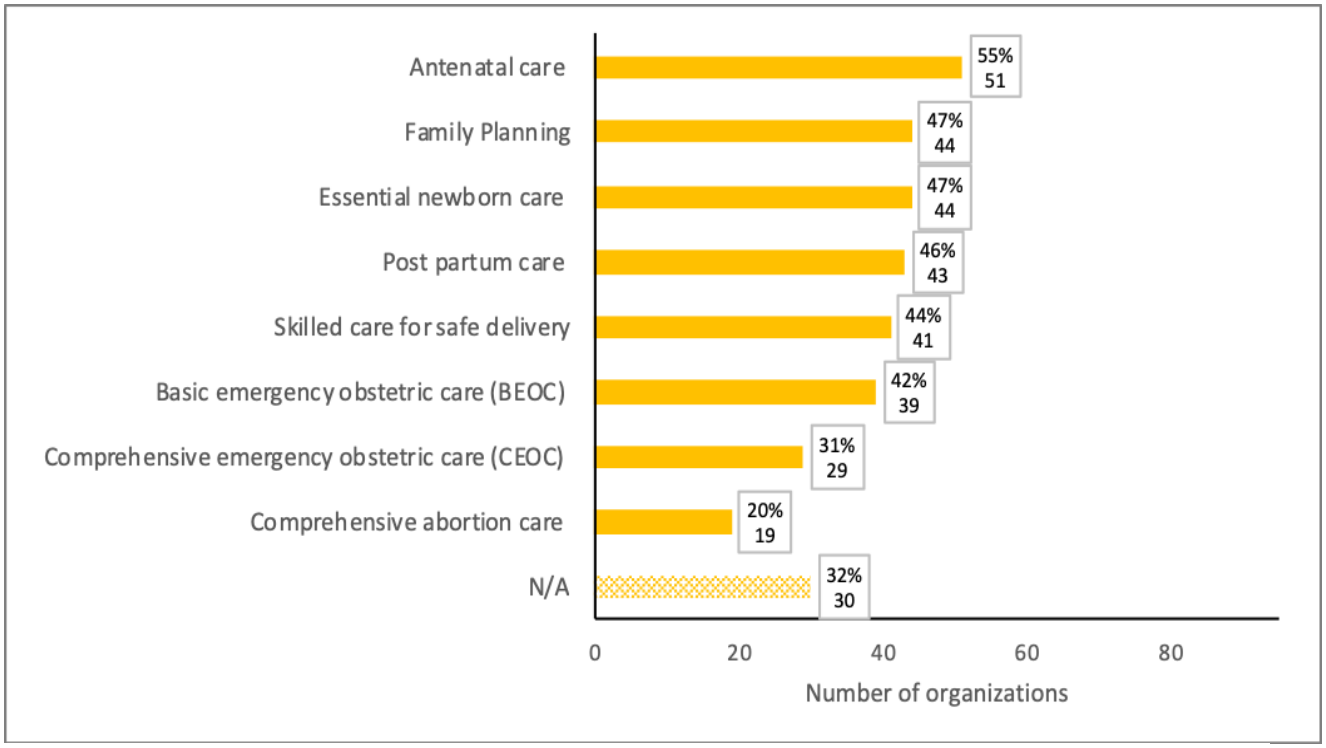


Figure 9. Organizational expertise: maternal and newborn health

Communicable disease (clinical services)

Many partners reported technical capacity for the Early Warning, Alert and Response System (EWARS) (49%), as well as responding to malaria (49%), cholera (42%) and tuberculosis (40%). It is concerning only a quarter of respondents (26%) reported having capacity to respond to viral haemorrhagic fevers, which includes diseases caused by viruses such as Ebola, Lassa, and Marburg (Figure 10).

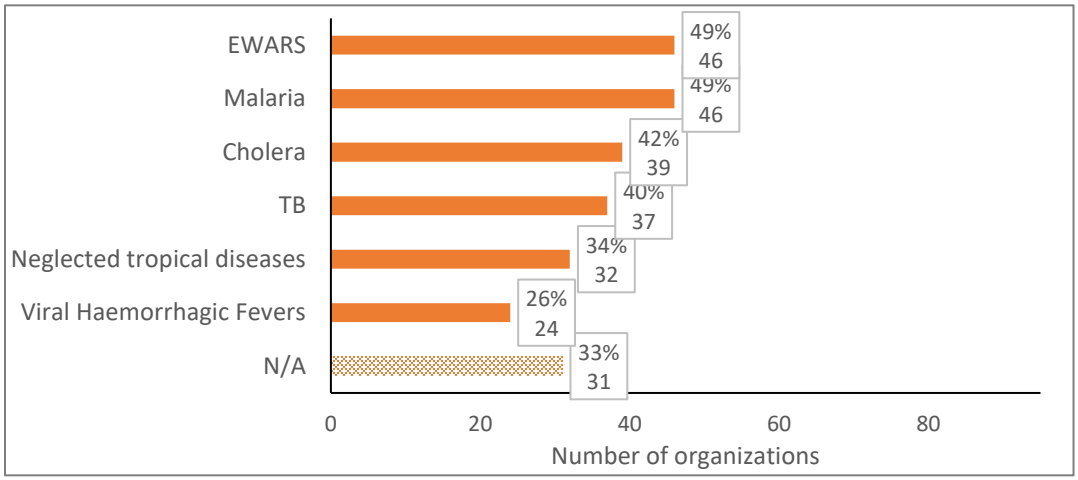


Figure10. Organizational expertise: communicable disease (clinical services)

d. Child health (community care)

Over half of the respondents reported having capacity for integrated community case management (54%) and screening of acute malnutrition (52%) (Figure 11).

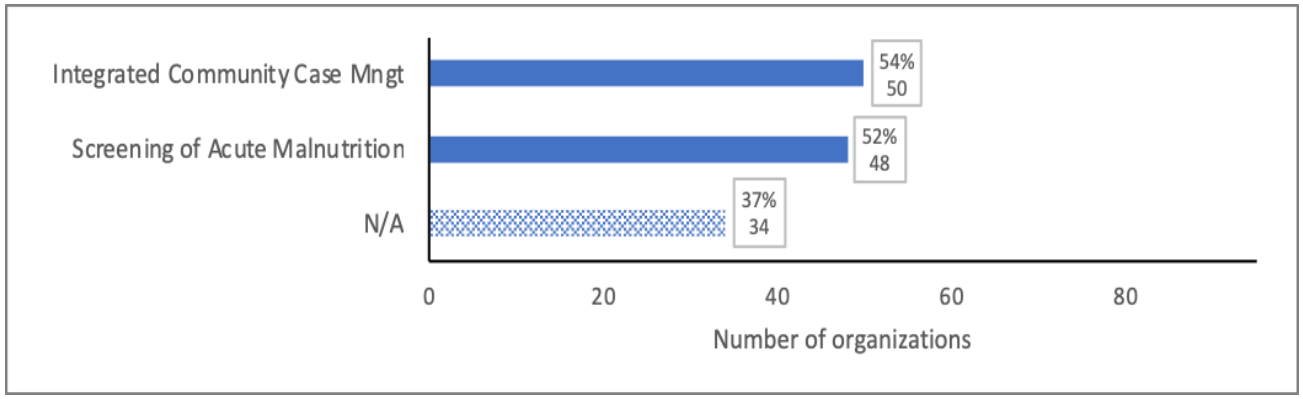


Figure 11. Organizational expertise: child health (community care)

e. Child health (clinical services)

Around clinical services for child health (Figure 12), about half of the respondents reported having technical capacity for basic child care (52%), screening of acute malnutrition (51%), outpatient treatment of acute malnutrition (48%), and for vaccination (45%). However, concerning gaps requiring immediate attention were found in managing children with severe illnesses (37%) and severe acute malnutrition in inpatient stabilization centers (34%).

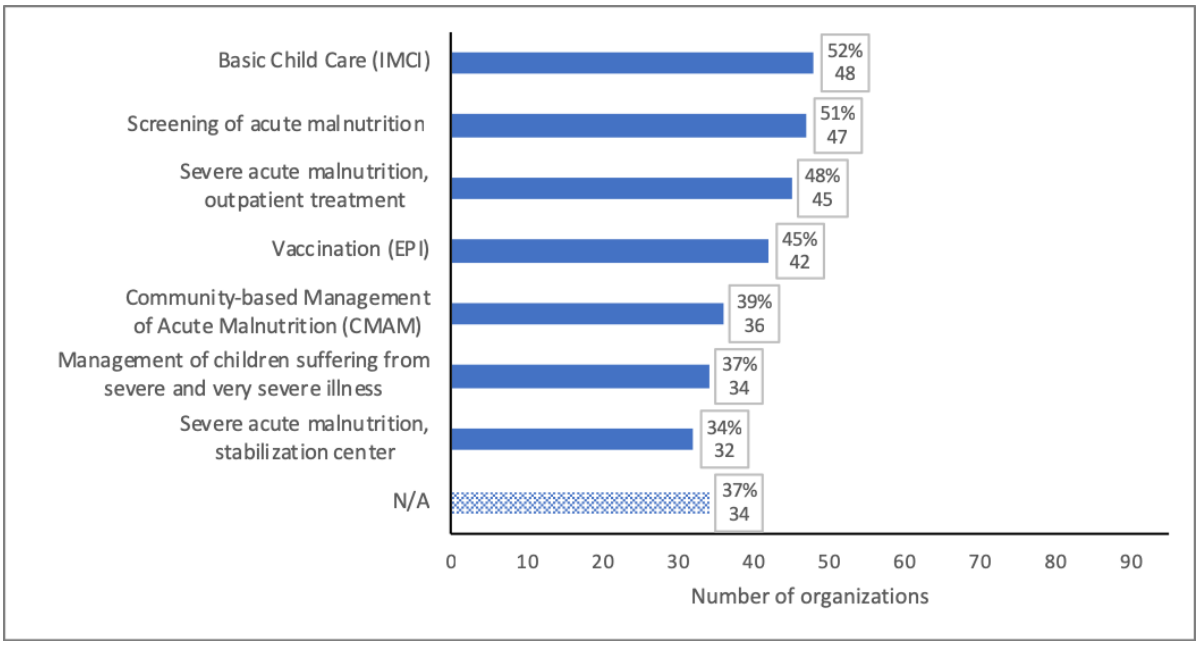


Figure 12. Organizational expertise: child health (clinical services)

f. STI and HIV/AIDS

Almost 50% of partners reported having capacity for HIV counselling and testing. It is concerning that only half of them say they are able to provide antiretroviral treatment (ART).

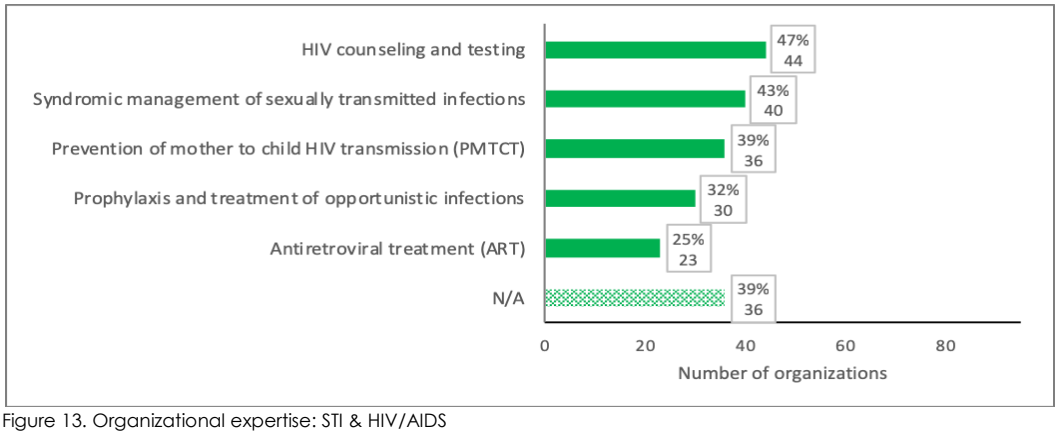


Figure 13. Organizational expertise: STI & HIV/AIDS

g. NCD and mental health

Organizations were asked to detail NCD and mental health capacity. There is a concerning gap highlighting potential limited capacity with mental health care, diabetes treatment, disabilities rehabilitation and response for Thalassemia.

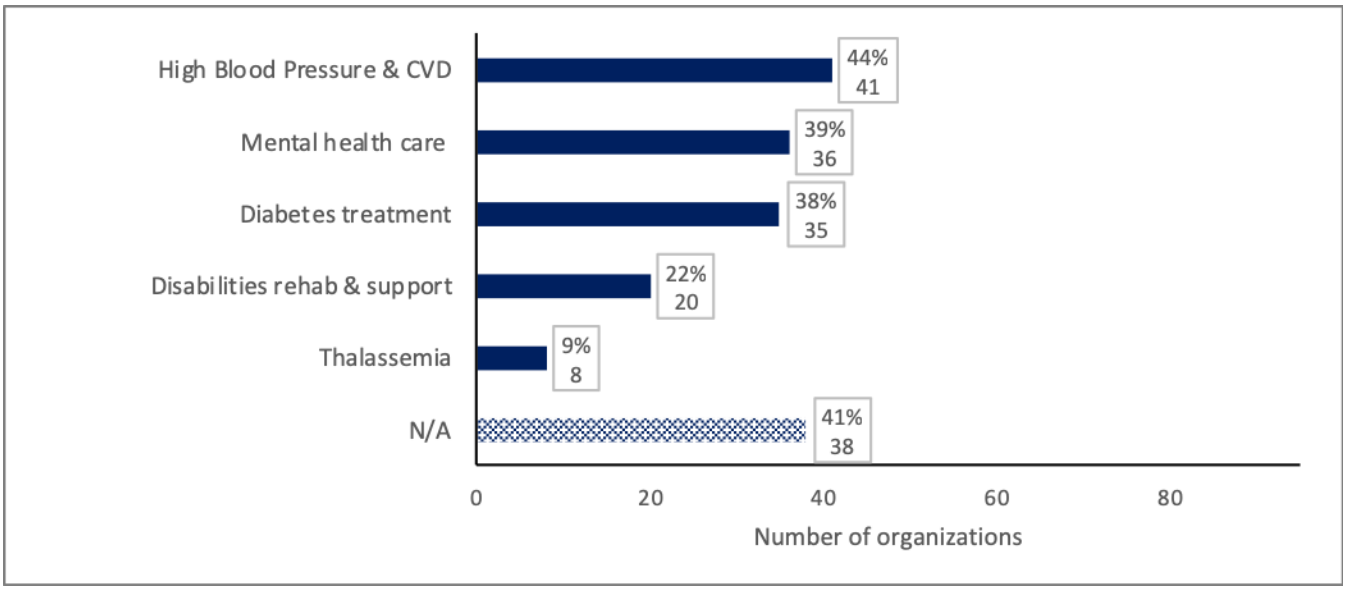


Figure 14. Organizational expertise: NCD & mental health

h. Sexual violence

While 40% of the partners reported having capacity for clinical management of rape, only just over half of them say they are able to provide emergency contraception (Figure 15). This is a concerning figure and requires immediate attention.

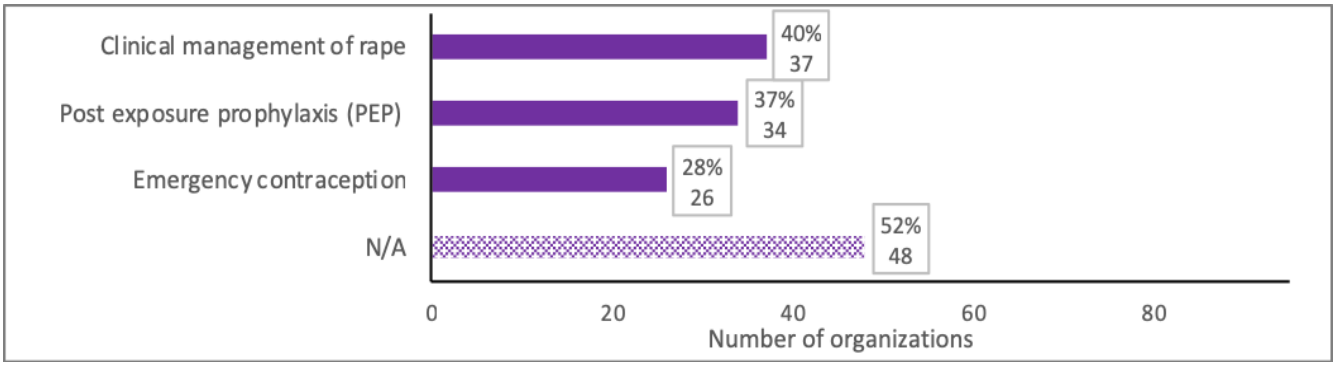


Figure 15. Organizational expertise: sexual violence

i. Other areas

Many partners reported having capacity for frontline work such as capacity building (82%), health promotion, social mobilization, behavior change communication (66%) and needs assessment (65%). The collective capacity for logistics, on the other hand, was comparatively low (41% for medical logistics, 35% for operational logistics). Older people's health and nutrition has a concerningly low number of partners responding as having capacity. (Figure 16).

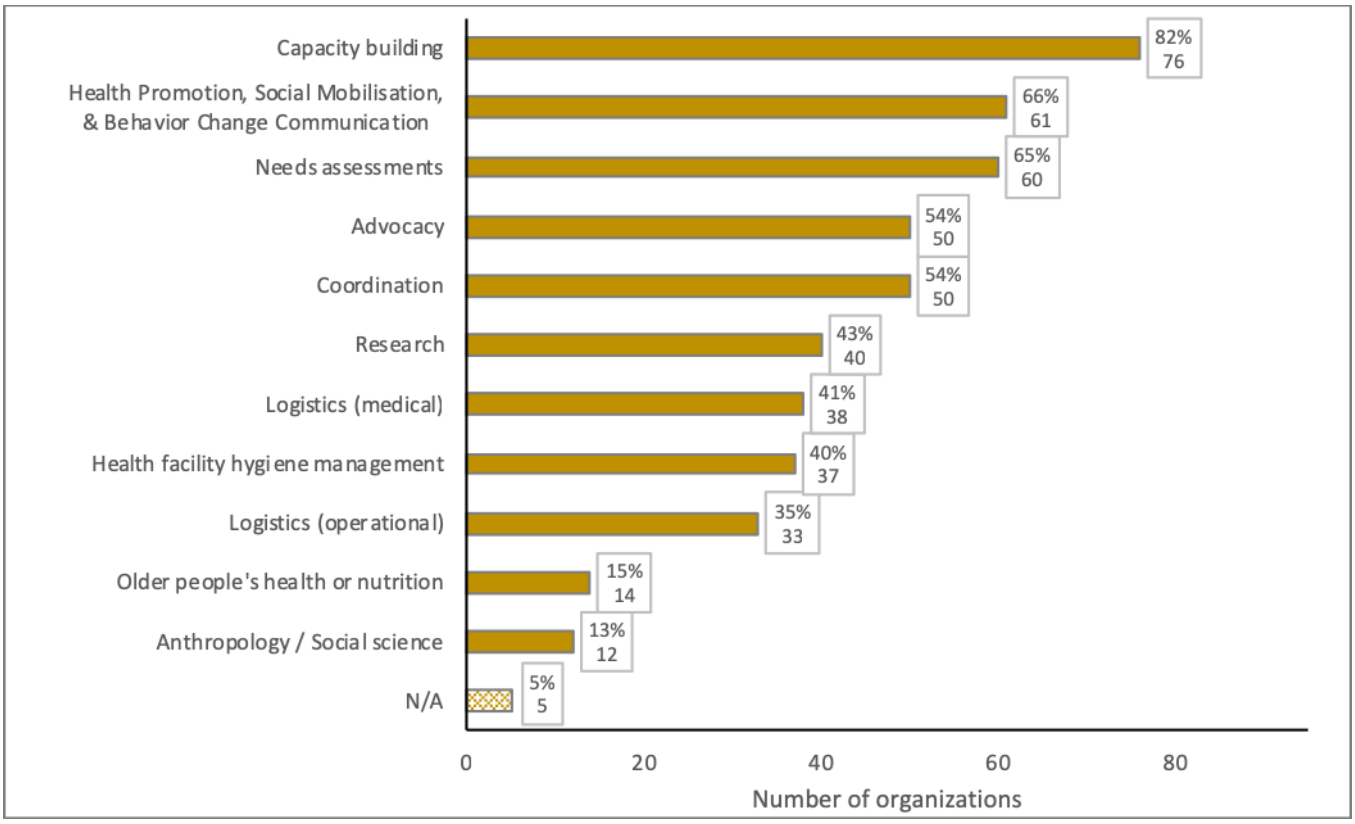


Figure 16. Organizational expertise: other areas

6) Level of health system organization: current and expandable

Organizations were asked to indicate the current and expandable level of health system organization at which they operate. The majority of respondents reported operating mostly at the community care and primary care levels and would scale up their operations at levels of health system organization where they already operate (Figure 17). There is a limited amount engagement in secondary and tertiary levels.

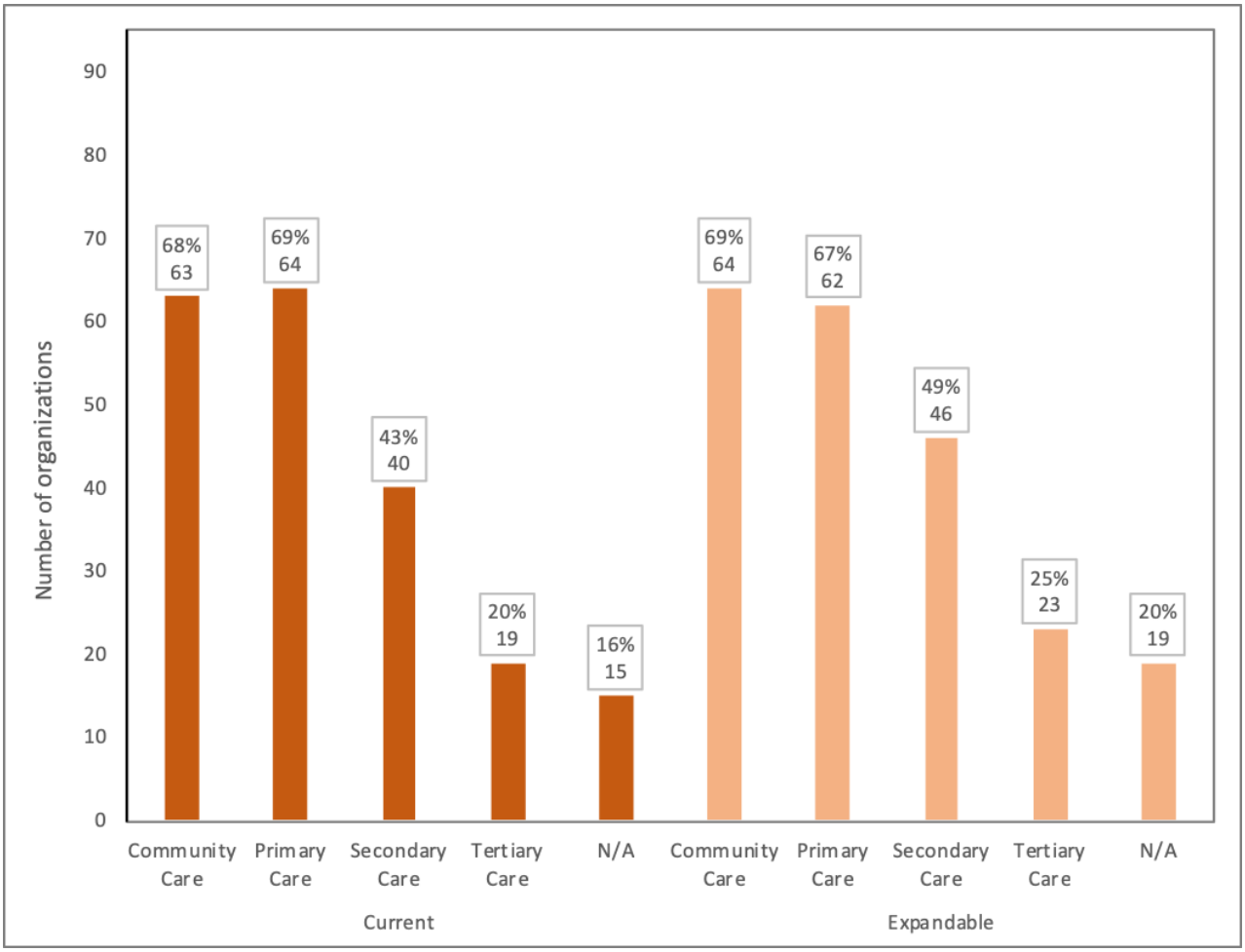


Figure 17. Level of health care system organization

7) Services offered

Organizations were asked to indicate the types of health services they offer across community care, primary care, secondary care, and tertiary care with corresponding details.

a. Community care

The majority of respondents reported to offer community care services (Figure 18). There are concerning gaps in more specialized services such as vector control (Figure 19) and screening of acute malnutrition (Figure 20).

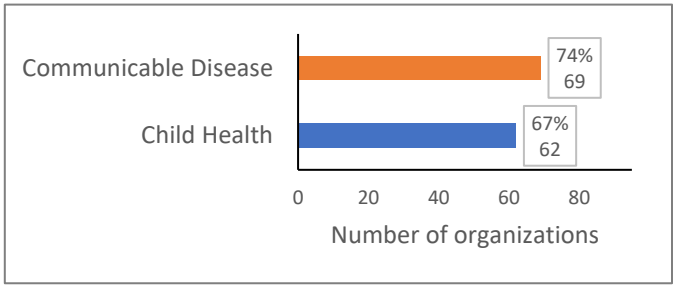


Figure 18. Services offered: community care, overview

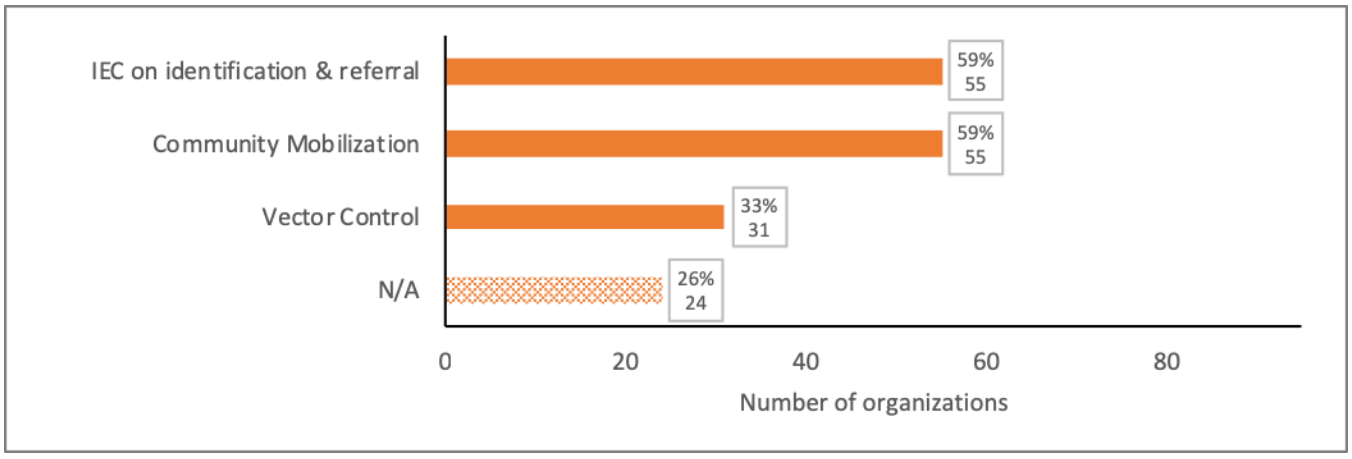


Figure 19. Services offered: communicable diseases (community care)

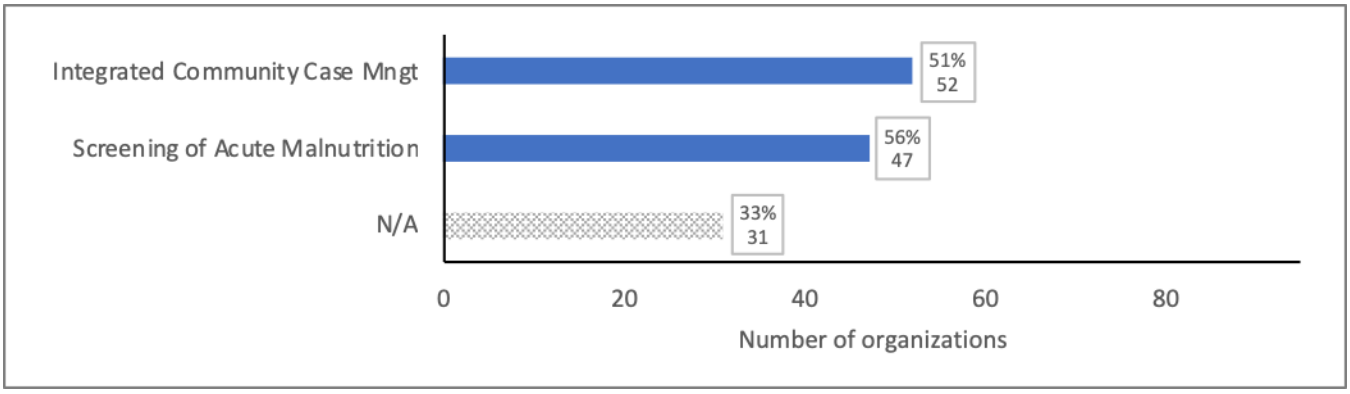


Figure 20. Services offered: child health (community care)

b. Primary care

The top services offered from the respondents were related to communicable diseases (71%), maternal and newborn care (66%) and child health (65%) (Figure 21). Services offered to older people is concerningly low.

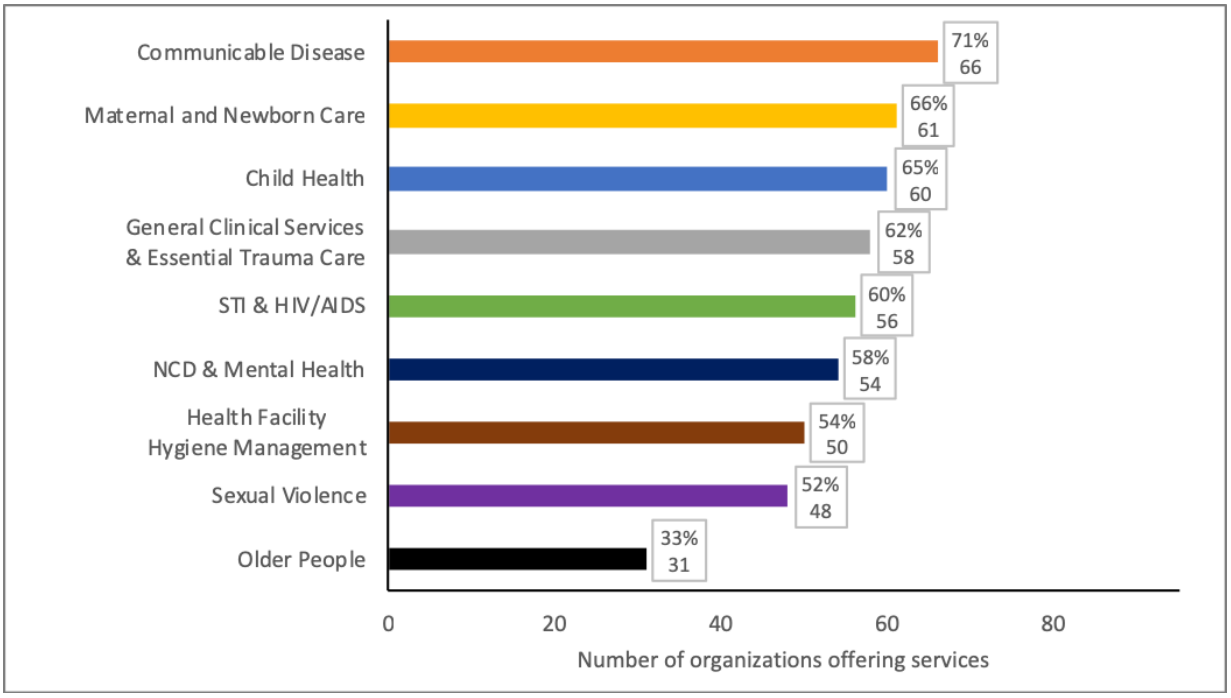


Figure 21. Services offered: primary care, overview

While many partners participate in EWARS (47%) and offer services for malaria (49%), cholera (42%) and tuberculosis (40%), only 22% of the respondents offer services for viral hemorrhagic fevers, which includes diseases caused by viruses such as Ebola, Lassa, and Marburg *(Figure 22)*.

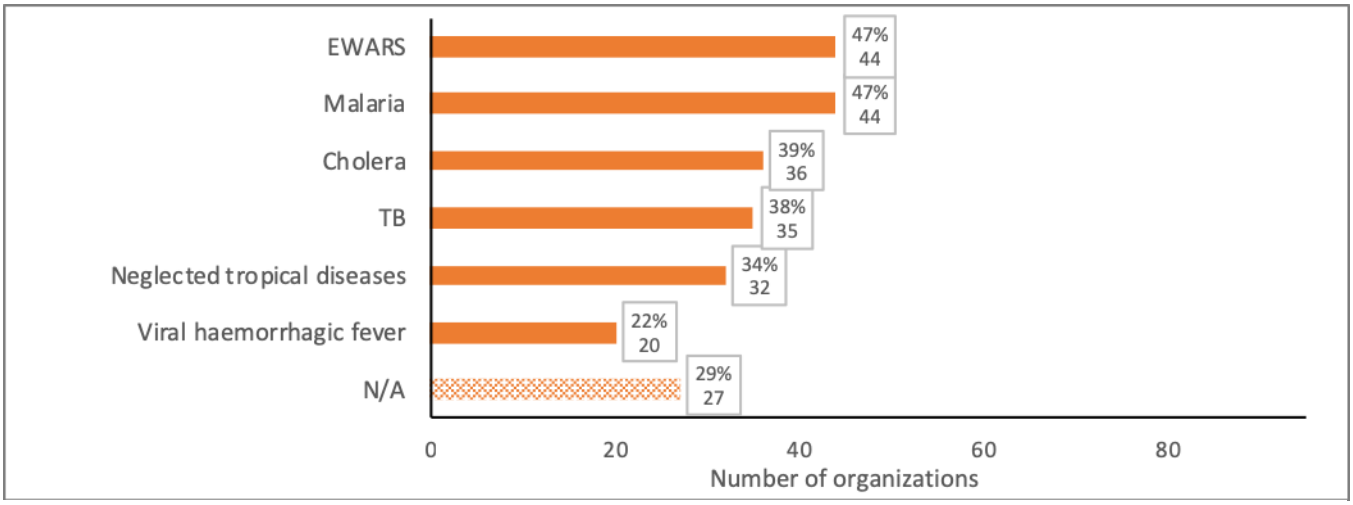


Figure 22. Services offered: communicable disease (primary care)

Around maternal and newborn care, just over half of the respondents offer antenatal care (54%), and less than half of the respondents offer family planning (48%), skilled care during childbirth (44%), postpartum care (43%), and essential newborn care (42%). Basic emergency obstetric care (BEOC) is concerning with only 38% offering services. The proportion of partners offering comprehensive abortion care remains very low (20%) and requires strengthening to ensure wider access to a full range of sexual and reproductive health services for women (Figure 23).

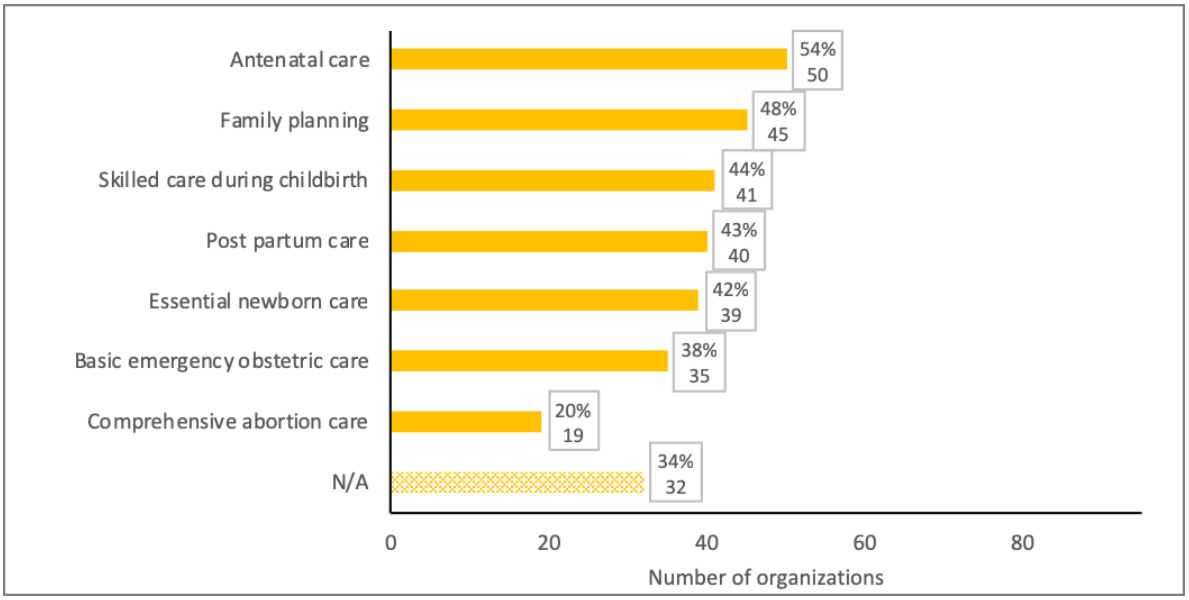


Figure 23. Services offered: maternal and newborn care (primary care)

For child health close to half of the partners offer screening of acute malnutrition (46%) and outpatient treatment (44%). A concerning 35% of the respondents offer stabilization centers for inpatient treatment of severe acute malnutrition (Figure 24).

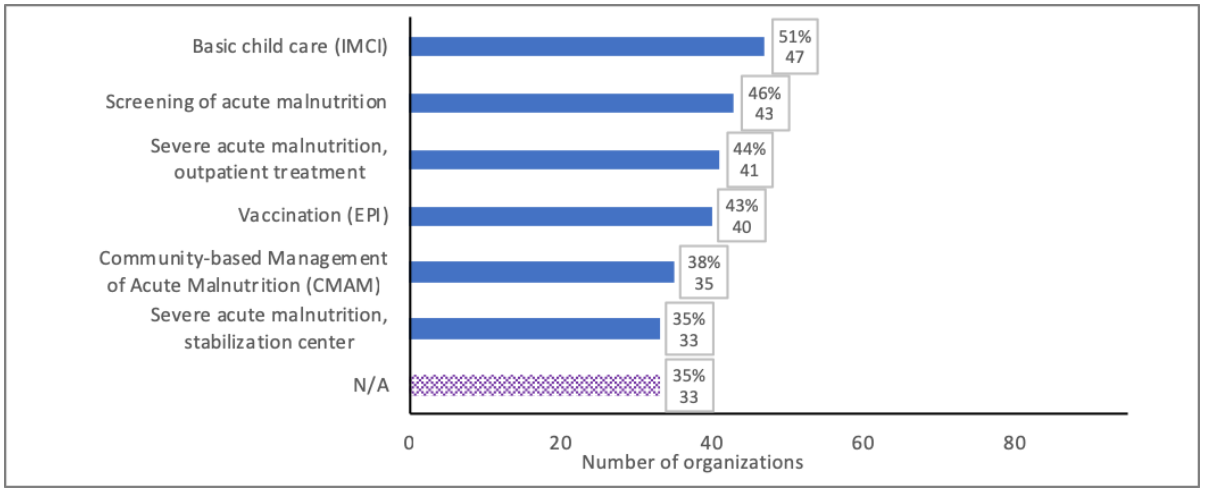


Figure 24. Services offered: child health (primary care)

For general clinical services at the primary care level, only 40% of the respondents reported providing laboratory services, which is a cornerstone of accurately diagnosing and controlling communicable diseases (Figure 25).

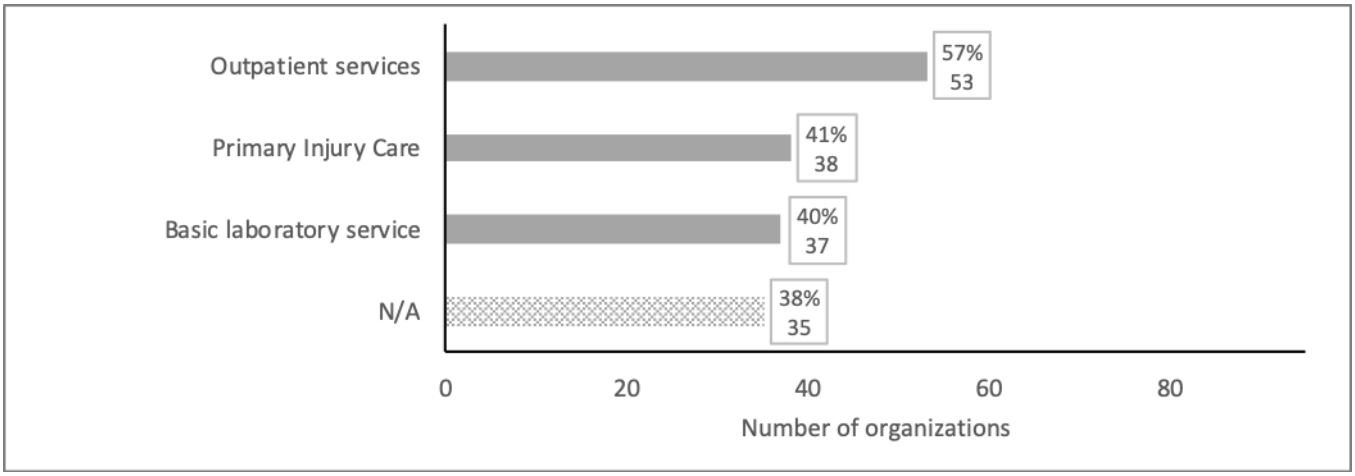


Figure 25. Services offered: general clinical services & essential trauma care (primary care)

While close to half of the partners provide HIV testing services (44%), there is a concerning gap of just over half of them offering antiretroviral treatment (24%) (Figure 26).

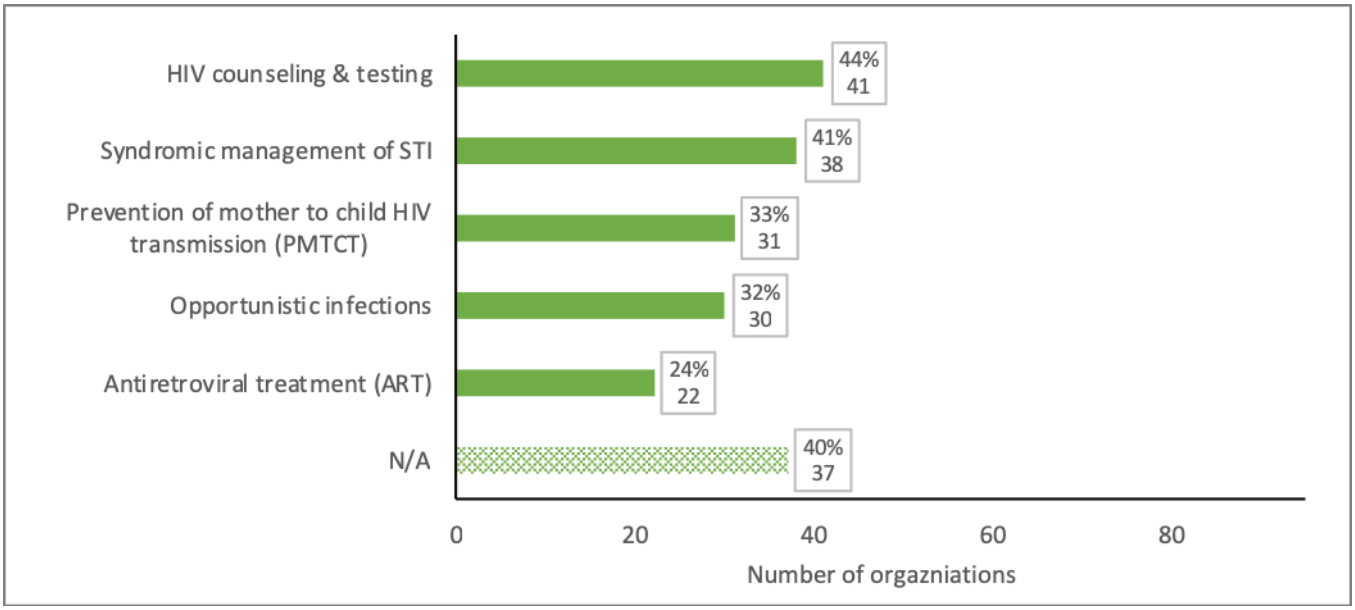


Figure 26. Services offered: STI & HIV/AIDS (primary care)

For NCD and mental health care at the primary care level, it is concerning only 39% of the respondents reported providing mental health care services. (Figure 27).

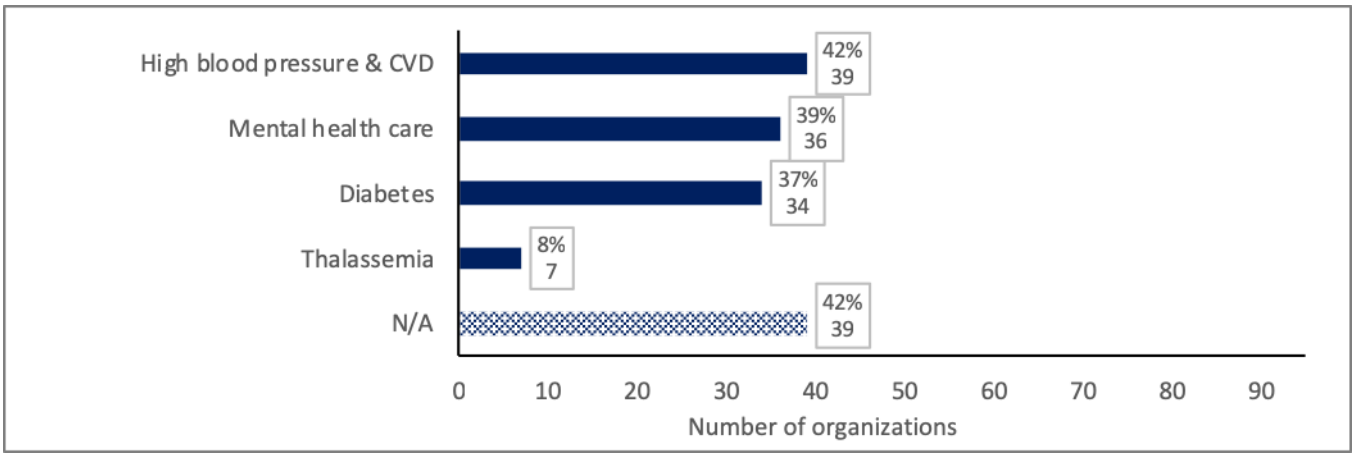


Figure 27. NCD & mental health (primary care)

About half of the partners (48%) offer safe waste disposal and management services (Figure 28). This raises an area of concern on the quality of care.

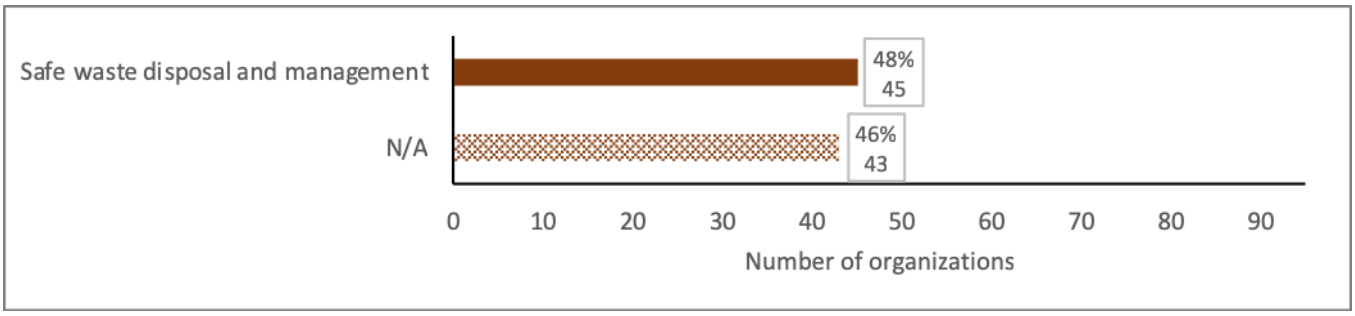


Figure 28. Services offered: health facility hygiene management (primary care)

There is a concerning gap between the proportion of partners providing services in clinical management of rape and the provision of emergency contraception which requires immediate attention (41%). (Figure 29).

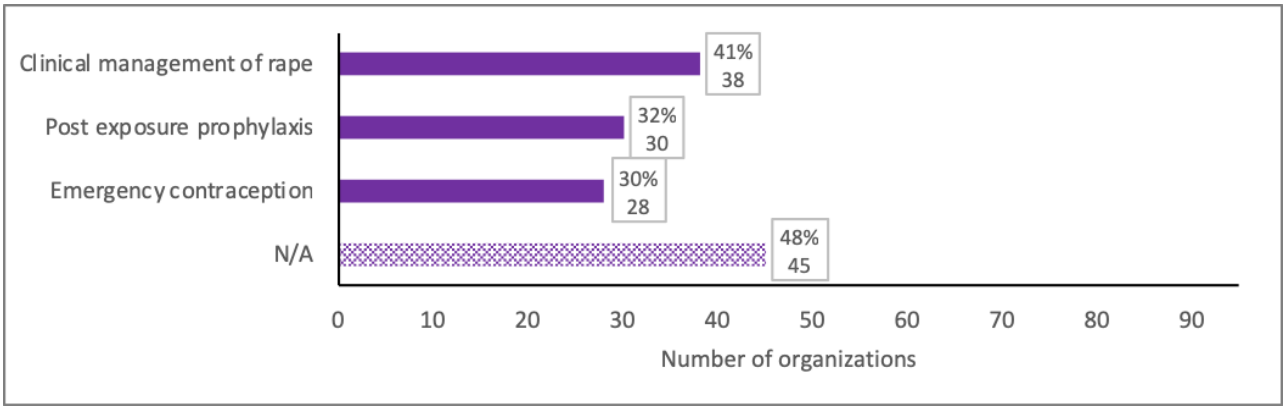


Figure 29. Services offered: sexual violence (primary care)

Less than a quarter of partners (22%) offer services for older people's health and nutrition (Figure 30). This may be due to limited available data on the needs of older people and requires further attention.

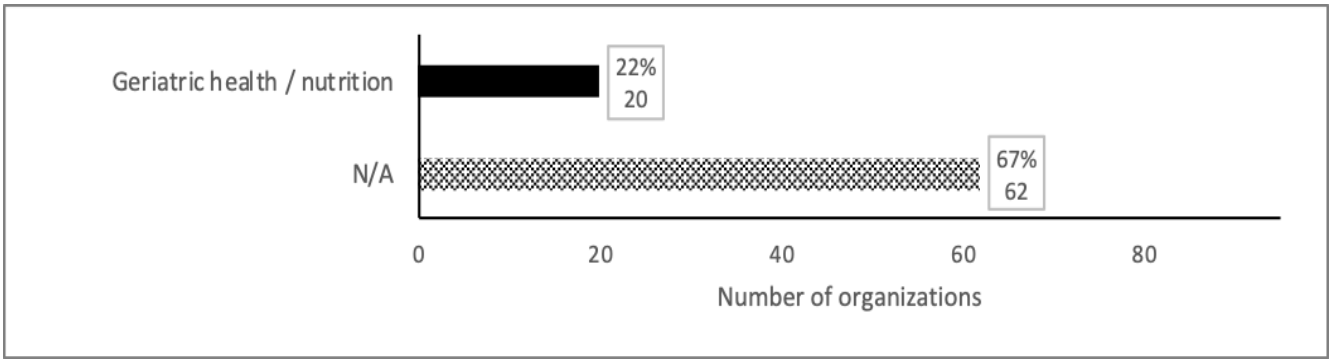


Figure 30. Services offered: older people (primary care)

c. Secondary care

Close to half of the respondents reported providing general clinical services and essential trauma care (53%), followed by child health (46%), and maternal and newborn care (32%) at the secondary care level (Figure 31). Only 8% provided services for NCD and Mental Health.

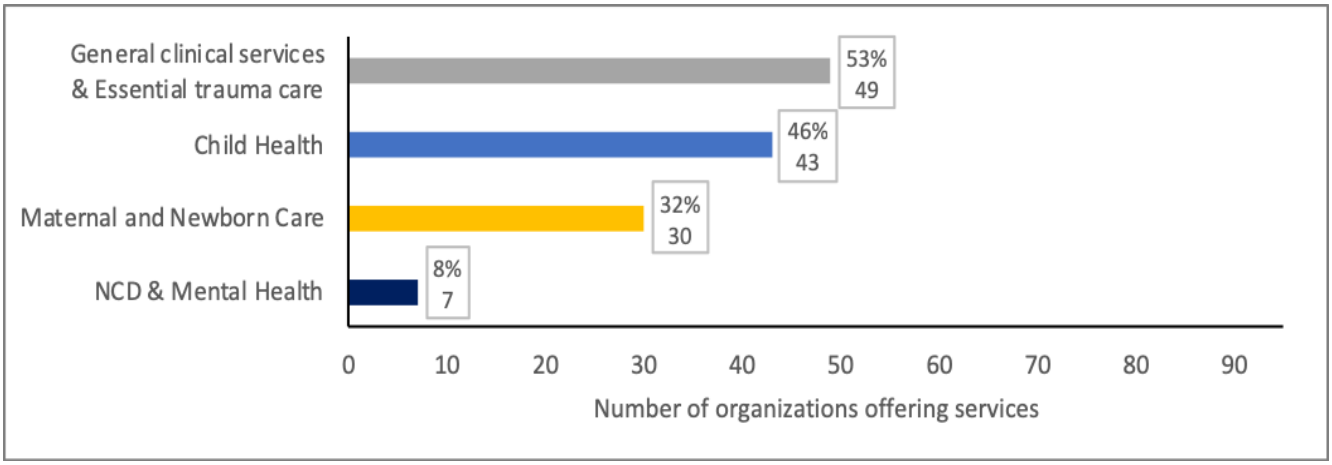


Figure 31. Services offered - secondary care, overview

While one third of the respondents reported offering inpatient services (32%) and laboratory services (30%), only 18% of the respondents reported providing trauma and surgical care, 19% providing post-operative care and post-surgery rehabilitation, and 13% of the respondents reported providing blood bank services. These results indicate the majority of demands for surgery in emergencies continue to fall upon a small number of organizations.

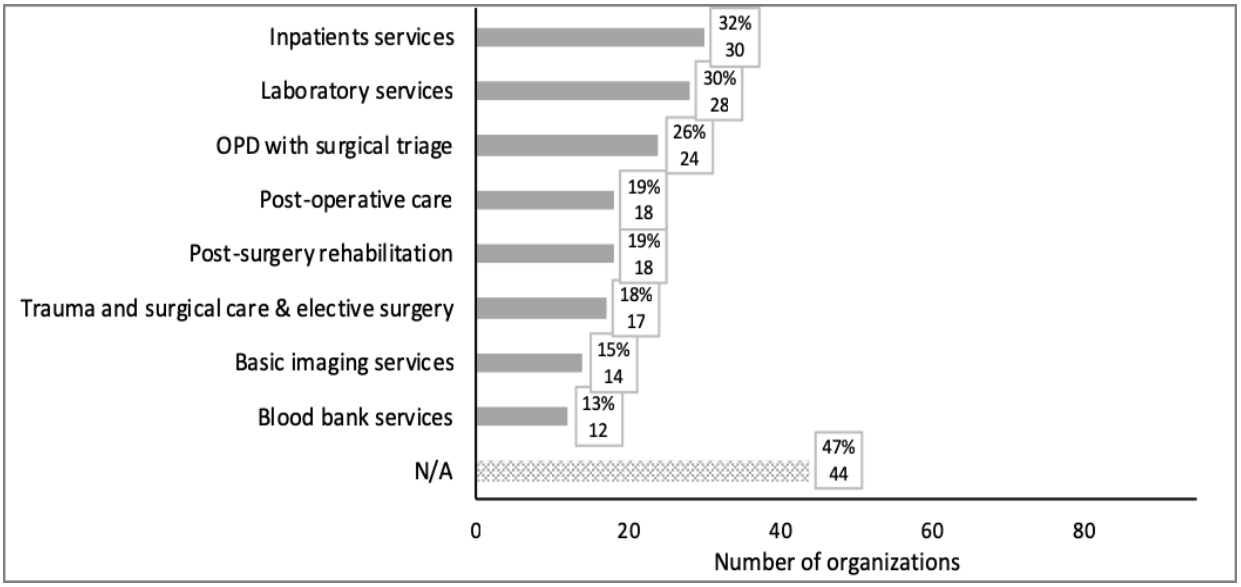


Figure 32. Services offered - general clinical services & essential trauma care (secondary care)

For child health services, less than half of the respondents (38%) reported offering services to manage severe and very severe child illnesses. One third (33%) reported offering stabilization centres for inpatient management of severe acute malnutrition (Figure 33).

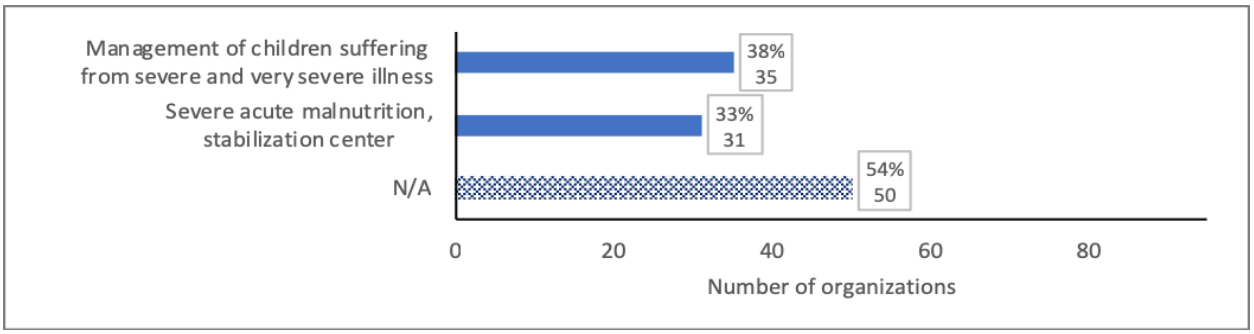


Figure 33. Services offered: child health (secondary care)

It is concerning less than one third of the respondents (29%) reported offering comprehensive emergency obstetrics care (Figure 34).

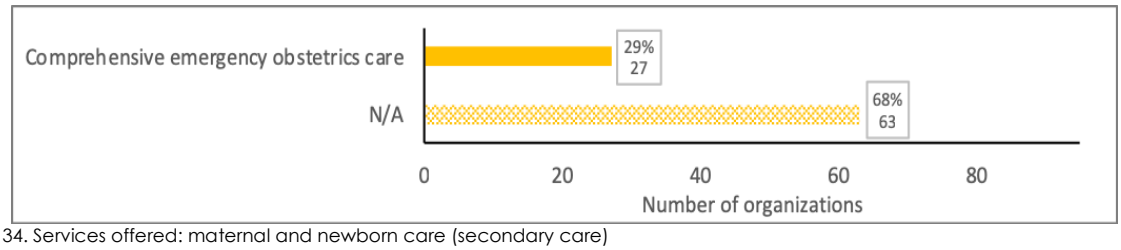


Figure 34. Services offered: maternal and newborn care (secondary care)

While 30% of the respondents offer outpatient psychiatric care and psychological counseling, only 8% of the respondents offer acute psychiatric inpatient care (Figure 35).

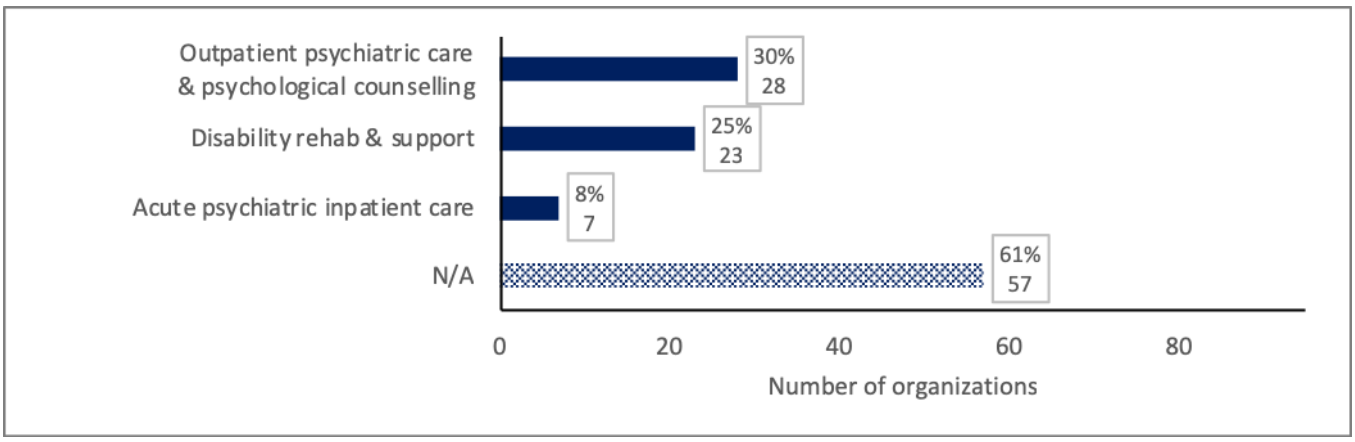


Figure 35. Services offered: NCD & mental Health (secondary care

d. Tertiary care

A small number of the respondents reported providing tertiary care services: higher-level surgical care (11%), intensive care unit (9%), advanced imaging (6%), and reconstructive procedures (6%) (Figure 36).

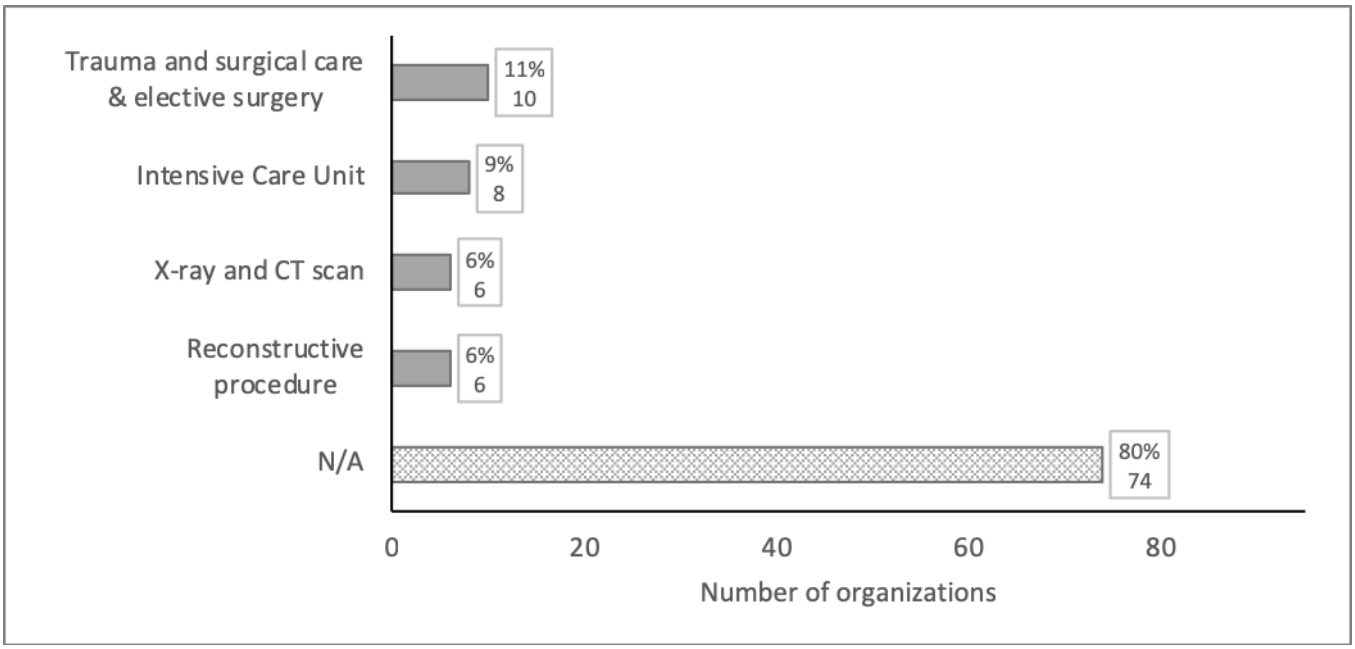


Figure 36. Services offered: tertiary care

8) Surge Deployment Capacity, by Specialty

Organizations were asked to indicate their surge deployment capacity by specialty. The graph below (Figure 37) shows the combined, estimated surge deployment capacity by specialty, cumulative over response timeline in accordance with the WHO Emergency Response Framework (2013). Note that these figures indicate the overall estimated emergency deployment capacity and are not limited to the international partners' capacity to deploy to WHO.

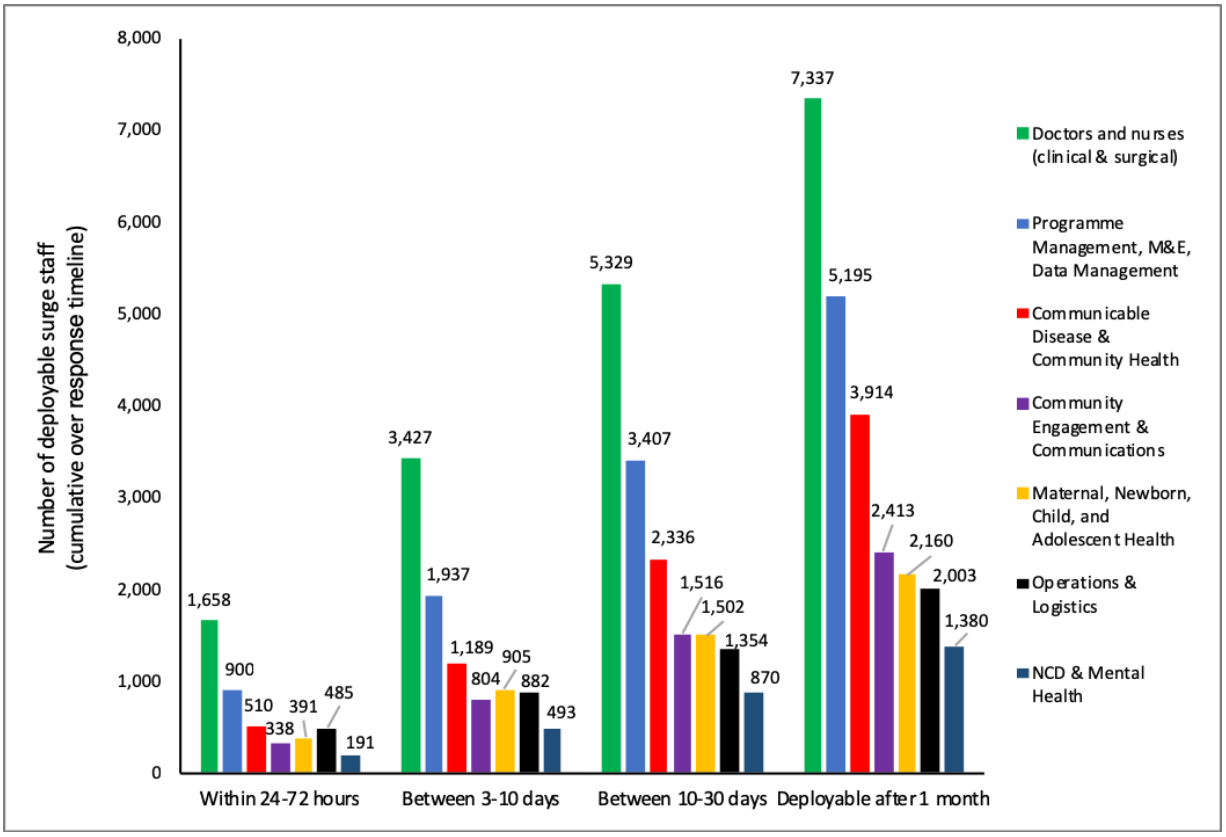


Figure 37. Surge deployment capacity by specialty (cumulative over response timeline)

The results show a combined total of 7,337 deployable doctors and nurses (clinical and surgical) up to the initial 30 days and beyond. Over the response timeline, the rates of scaling up deployment for maternal and newborn health, operational support, and NCD & mental health are much slower than those for clinical staff, programme staff, and communicable disease and community health staff. The relatively small number of surge-deployable staff for NCD and mental health remains a persistent capacity gap here as well.

9) Surge deployment, to support Health Cluster coordination

The results show that a cumulative total of 334 national level coordinators, 265 sub-national coordinators, and 226 Information Management Officers could be deployed within the initial 30 days and afterward to support Health Cluster coordination roles. (Figure 38).

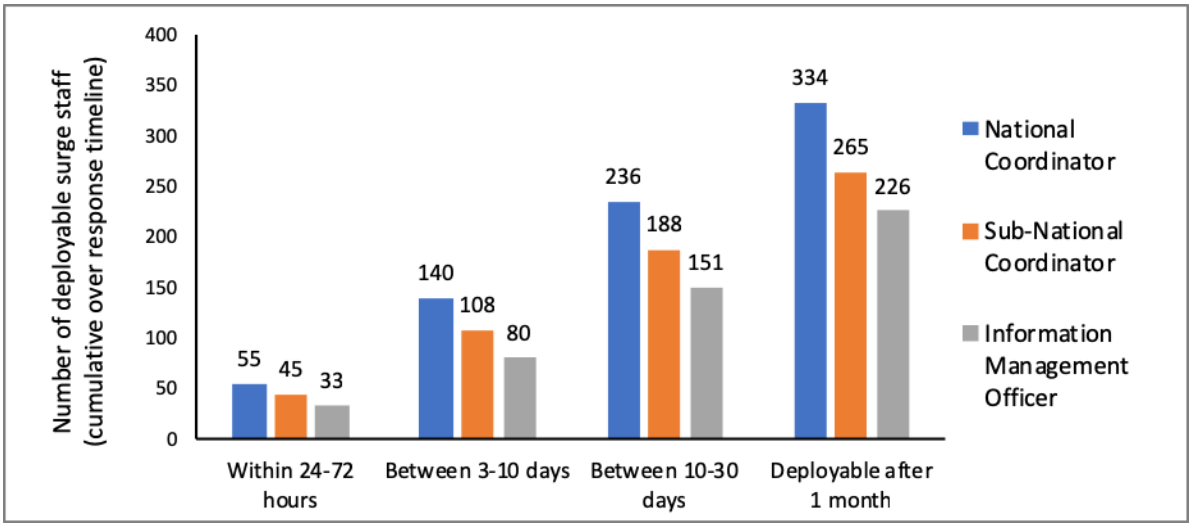


Figure 38. Surge deployment capacity to support Health Cluster coordination (cumulative over response timeline)

10) Organizational surge capacity type

Organizational Surge Capacity Type Includes…	(Yes)		(No)	
Surge Capacity - Individual staff				
• Internal roster	**72**	organizations	**19**	organizations
• Standby partnership †	**33**	organizations	**58**	organizations
• Global Outbreak and Alert Response Network (GOARN)	**17**	organizations	**74**	organizations
Surge Capacity - Teams				
• Public Health Rapid Response Team (PHRRT)	**26**	organizations	**65**	organizations
• Emergency Medical Team (EMT)				
EMT Type 1: Outpatient Emergency Care	**25**	organizations	**66**	organizations
EMT Type 2: Inpatient Surgical Emergency Care	**11**	organizations	**80**	organizations
EMT Type 3: Inpatient Referral Care	**8**	organizations	**83**	organizations
Specialist team	**13**	organizations	**78**	organizations
None of the above / Not applicable	**2**	Organizations	**89**	organizations

EMT Type 1 Provides outpatient initial emergency care of injuries and other significant health care needs

EMT Type 2 Provides inpatient acute care, general and obstetric surgery for trauma and other major conditions

EMT Type 3 Provides complex inpatient referral surgical care including intensive care capacity

† Standby partnerships include the official 9 WHO standby partners and organizations' own surge/standby arrangements.

11) Estimated population that can be helped over response timeline

Organizations were asked to indicate the size of estimated population they can help over the response timeline in accordance with the WHO Emergency Response Framework (2013).

Within 72 hours, only 5 organizations could assist over 100,000 people increasing to 32 organizations able to assist over 100,000 people within a month.

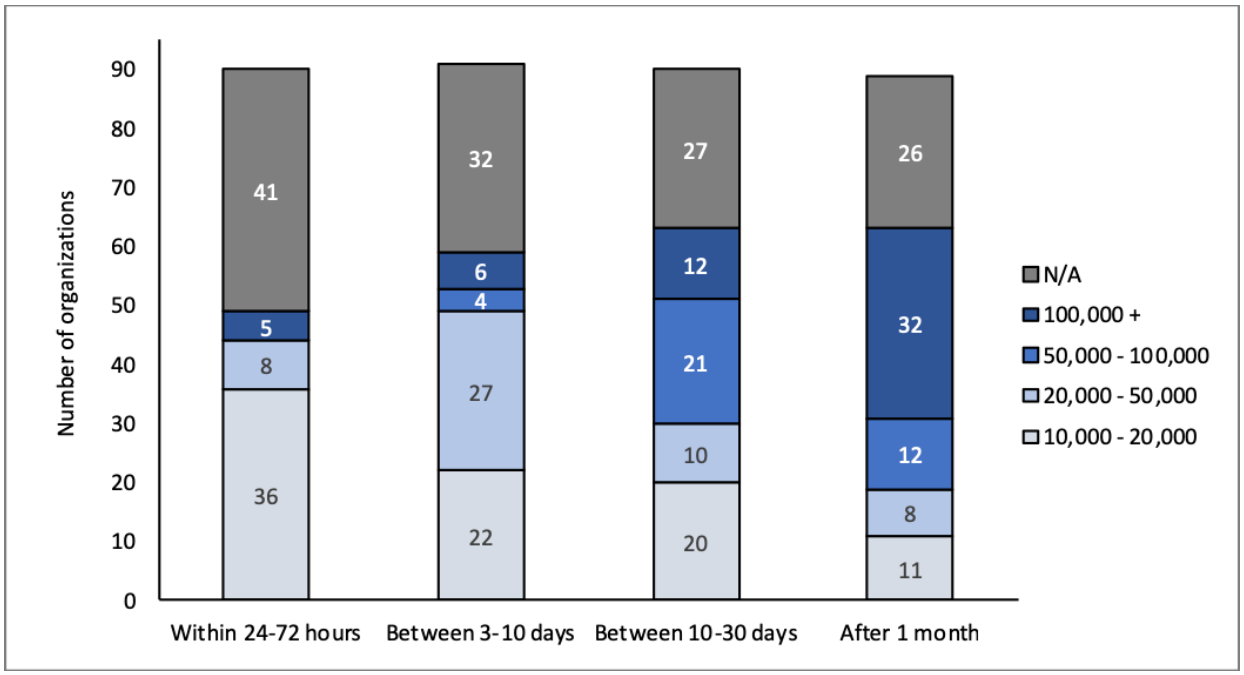


Figure 39. Estimated population that can be helped over response timeline

12) Intervention modalities

Respondents were asked what level of emergency funds they had. Most of the respondents (58%) reported that they did not have their own unrestricted emergency funds (Figure 40). It explains the gradual population reach in the first 30 days of emergency response discussed above. It may also partly explain why the surge deployment capacity for clinical, programme, as well as communicable disease and community health staff is prioritized over other specialties with limited rate of scale-up in the absence of unrestricted emergency funds which enables rapid initial response.

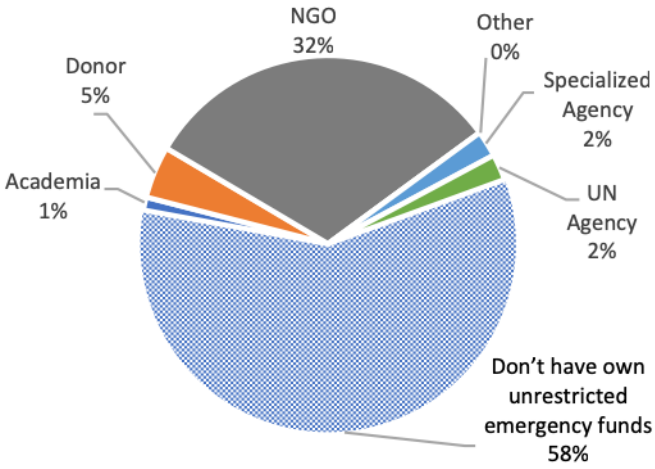


Figure 40. Organizations with their own unrestricted emergency funds

On average, the respondents allocated 31% of their humanitarian health funding toward direct service provision, followed by technical and material assistance (28%) and health personnel capacity building (22%). Notably, on average partners allocated 9% of humanitarian health funding portfolio toward remote management (Figure 41).

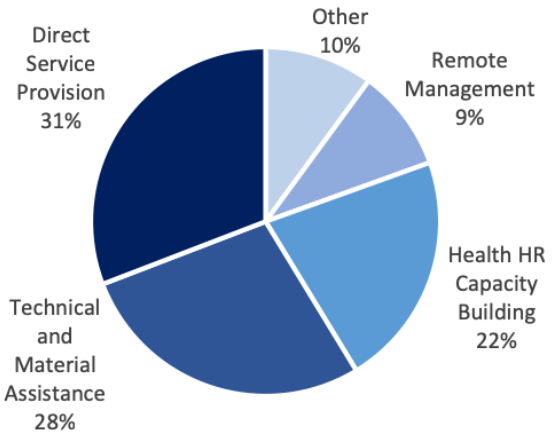


Figure 41. Proportion of humanitarian health funding portfolio

13) Logistic support

Respondents were asked to indicate the locations of main emergency stockpiles. 24% of international partners reported a combined total of 55 emergency stockpiles stored among 30 supply hubs around the world. Many of the emergency stockpiles were concentrated in Western Europe, East Africa, and Middle East (Figure 42). Such geographical pre-positioning may leave a logistic gap or response delay for the emergencies occurring in the regions of South Asia, South-East Asia, West Pacific, and Latin America.

In terms of virtual stock, 14 partners reported having virtual stocks through IDA, MEG and IMRES as well as through their own bilateral agreements with various national and international suppliers.

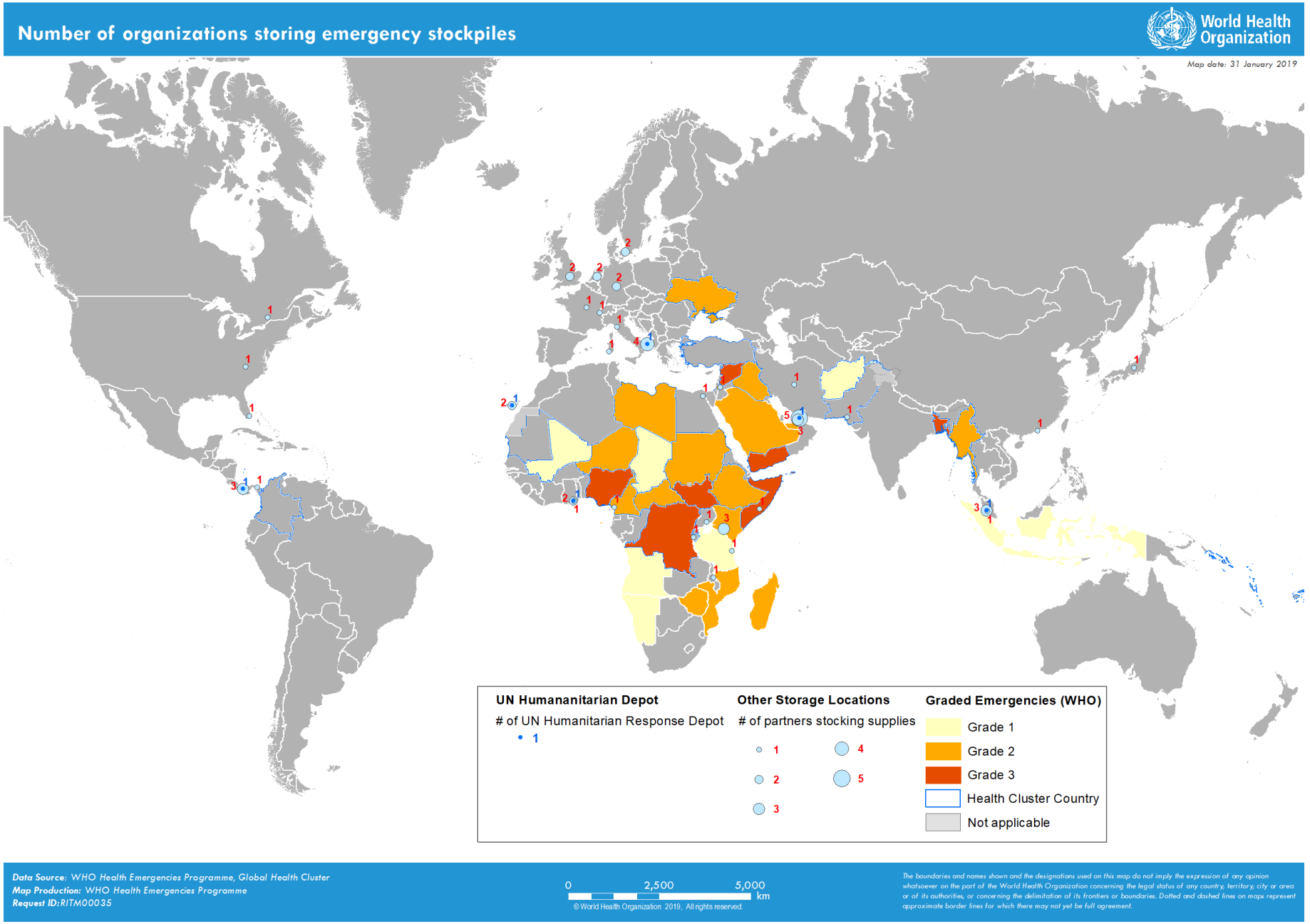


Figure 42. Location and number of emergency stockpile locations

14) Barriers to intervention

Organizations were asked to describe barriers that may impact on their ability to respond to health emergencies (Figure 43).

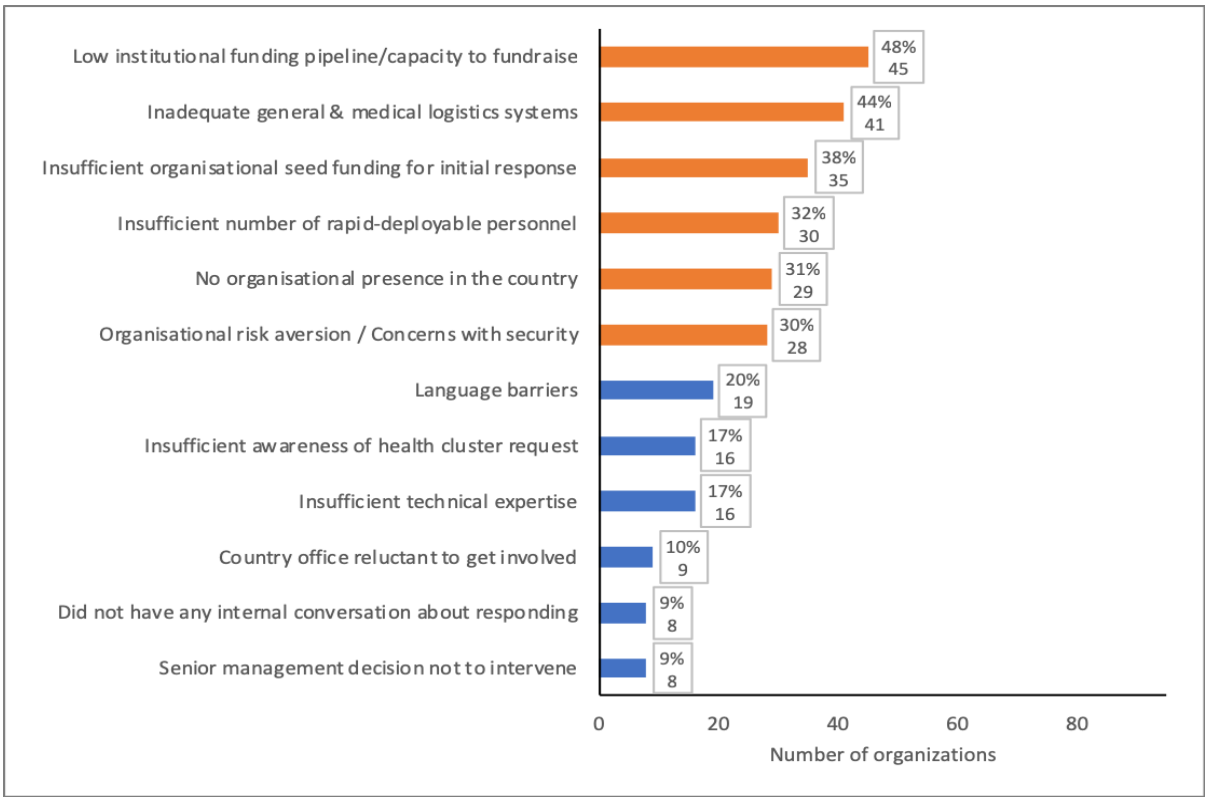


Figure 43. Barriers to intervention

Key comparisons to the 2015 survey are as follows:

- Funding issues ranked 5th in 2015, however, in this survey, funding issues was found to be the top barrier.
- Inadequate logistics remains on the 2nd place for barriers to intervention.
- Insufficient number of rapid-deployable personnel, went down from the 1st to the 4th place.
- Organizational risk aversion went down from the 3rd to the 6th place.

Other notable barriers to intervention were also identified: visa issuance delays for surge deployment and for certain activities not having the organizational mandate or policy for emergency response.

Conclusion

The spectrum of international partners' presence, according to the survey results, reflects the location and severity of ongoing emergencies. The gaps in highly technical areas continue to persist, such as vector control for communicable diseases, managing severe acute malnutrition for child health, comprehensive emergency obstetric care for maternal and newborn health, and surgical care capacity for general clinical services.

While some more traditional emergency services seem to be provided to a satisfactory level concerning gaps within thematic areas raise alarms about quality of service provision and overall response. Given the increasing frequency and duration of humanitarian emergencies worldwide, it may be beneficial to allocate more resources toward increasing the diversity of services offered by current actors and diversifying the number and type of actors. Increasing capacity and network of local actors and investing further in health systems will provide more comprehensive sustainable health care for those in need.

In terms of specialty, the collective surge deployment capacity for clinical, programme, and communicable disease staff remained large and quick to scale up over response timeline. However, the surge staff capacity and rate of scaling up for maternal and newborn health, operations and logistics, as well as NCD and mental health remained weak in comparison. This finding is aligned with the gaps found in services offered.

In terms of surge capacity for Health Cluster coordination the availability of deployment-ready Information Management Officers lags behind that of national and sub-national coordinators, signaling the need to invest in securing these skills and capacity so as to improve data collection, analysis, and use it to inform evidence-based response action.

The responses show that the partners may take some time to expand their population reach in the first 30 days of emergency response, revealing the need to strengthen the capacity for immediate response in support of National First responders.

Agency specific funding for rapid health response identified limited capacity for immediate response, as well as for scaling up certain services and surge staff. This may be because the majority of international partners surveyed reported having no unrestricted emergency funds.

Many emergency stockpiles were located around Europe, Africa, and Middle East. Such geographical pre-positioning may leave a gap for crisis response in South Asia, South-East Asia, and Latin America.

The survey identifies concerning gaps in the provision of essential health services by international actors and requires immediate attention. In the face of increasing complex crises an effective response will require an increase and diversity in partner capacity, further resourced improved health systems and more local actors.