Strengthening public health information for the response to the crisis in Somalia

First Technical Visit Report

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Acknowledgments

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Acronyms

AFP	Acute Flaccid Paralysis
AWD	Acute Watery Diarrhoea
eDEWS	Electronic Disease Early Warning System
EPI	Expanded Program of Immunisation
HeRAMS	Health Resources and Services Availability Mapping
HC	Health Cluster
HCSO	Health Cluster Support Officer
HRP	Humanitarian Response Plan
IM	Information Management
IMO	Information Management Officer
MIRA	Multi-sectoral Initial Rapid Assessment
PHIS	Public Health Information Services
PHSA	Public Health Situation Analysis
TOR	Terms of Reference
WCO	WHO Country Office
WR	WHO Representative

1. Background

Since the drought in 2015, and by ongoing conflict and widespread insecurity, the humanitarian situation in Somalia has deteriorated significantly. Currently, an estimated 5.7 million people are in urgent need of access to primary healthcare services, and 14.7% of children under 5 years are suffering from acute malnutrition. The population in susceptible to outbreaks, as evidenced by the 2016 – 2017 cholera outbreak and the ongoing measles outbreak.

In 2017 – 2018, the Public Health Information Services (PHIS) Task Team of the Global Health Cluster is rolling out new global standards and related software for PHIS in activated clusters and other coordination mechanisms. In collaboration with WHO's Health Emergencies Program, the PHIS Task Team is planning to deliver dedicated PHIS technical support to level 3 or high-priority crises, including Somalia.

The first support trip to Somalia occurred between 16th and 24th of October 2017. The main objectives of this visit were to:

1. Review of Information Management (IM) products (including 3W, Health Cluster Bulletin and dashboards) against PHIS standards;

2. Undertake the first Public Health Situation Analysis (PHSA) with support from PHIS, Cluster and WCO country colleagues through secondary data review and analysis;

3. Support PHIS team in the planning of Health Resources and services Availability Mapping (HeRAMS) through review and development of tools, methodology, implementation and analysis plan;

4. Review of Health Cluster section of 2018 HRP to ensure alignment with PHSA as well as review of indicators to ensure harmonization with PHIS standards.

The report is structured around the 4 objectives of the visit, with a description of findings and recommendations/planned next steps for each of the objectives.

The trip will be followed up with remote support through emails, phone conversations and review/input into documents. A second trip is tentatively planned prior to the end of 2017.

2. Visit Schedule and Activities

The table below describes all activities undertaken during the visit to WHO's Country Office (WCO) in Mogadishu.

Date	Activity
16 October	Arrival Review of ToR and discussion on priorities during visit Briefing on IM team structure + IM products (with Information Management Team Leader) Brief discussion on HeRAMS (with IM TL and HC IMO)
17 October	Mapping of PHIS services and IM products Meeting with Consultant Epidemiologist Meeting with Information Management Team Leader and WHO IMO on IM products and PHIS services Review of IM products HeRAMS Concept Note
18 October	HeRAMS Concept Note
19 October	HeRAMS Concept Note Meeting with EPI Medical Officer Meeting with Information Management Team Leader, WHO IMO and Health Cluster IMO on PHIS Services + IM Products + HeRAMS design
20 October	HeRAMS Concept Note Meeting with Nutrition Deputy Cluster Coordinator HeRAMS assessment tools Mapping/review of IM products
21 October	HeRAMS assessment tools Interview with International Focal Point for Polio, South Somalia Mapping/review of IM products
22 October	Visit to Drought Operations Coordination Centre (UNOCHA) Mapping/review of IM products
23 October	HeRAMS budget Debriefing to team and WR
24 October	Departure

3. Review of PHIS and Information Management Products

3.1 Overview

In view of the protracted nature of the crisis in Somalia, WHO and the Health Cluster have established and ongoing Public Health Information Services (PHIS) and Information Management (IM) products. The health cluster has been activated since 2006 and currently has 66 active members.

The Information Management team consists of an Information Management Team Lead (IM TL) and 2 Information Management Officers (IMOs) – one dedicated to the health cluster and another responsible for WCO PHIS and IM. The IM team members are fully aware of the PHIS Standards and have had preliminary discussions about their PHIS priorities going forward, prior to the visit.

The cluster team also includes 3 Health Cluster Support Officers (HCSOs) [2 in Somalia and 1 in Nairobi] who assist with collection and compilation of data and information from cluster members.

The Epidemiology Team consists of 2 epidemiologists and a data manager. The team works closely with the MoH on disease surveillance and outbreak response, including the production of outbreak-related IM products.

The WCO also includes an EPI/Polio team which oversees an AFP/fever and rash surveillance system, and produces EPI, Polio and Measles surveillance IM products which are shared with the cluster.

Coordinated by the IM TL, the IM team also input into WCO Communications products, and produce ad hoc products for WCO office and in response to donor requests, requests from UNOCHA and requests from governmental line ministries.

General observations

- There is a competent and fully-staffed team of information management and epidemiology specialists in Mogadishu. However, most are on short-term contracts or on secondment from standby partners.
- Multiple teams have information management functions related to the WCO or health cluster. The different teams fall under different line management structures within the WCO, but, for the most part, work collaboratively together on joint PHIS or IM products.
- The IM team is under-resourced as it does not have an allocated activity budget or WHO-owned software and tools to facilitate robust PHIS.
- There are numerous ongoing core and additional PHIS, and the majority are informative. The quality and timeliness of information in the products varies, and is significantly impacted by insufficient cluster member engagement.
- The health response in 2017 has been dominated by the cholera outbreak, and to a lesser extent by the measles outbreak. This is clearly reflected in the 2017 IM products, as there is insufficient information on other health sector subthemes (maternal, newborn and child health, sexual and reproductive health, mental health, etc…)

- The health cluster website is comprehensive and informative. Although it is populated well with PHIS and IM products, it requires more frequent updating.
- There is a cluster-wide agreement on population baseline estimates, geographical administrative levels and codes, and a 2016 comprehensive list of health facilities with codes[1]. This is an excellent baseline that is essential for most PHIS services.

A number of key core PHIS are absent, such as HeRAMS and information on key health risks. This has partly been because of the response focus on the cholera outbreak during 2017. The health cluster and IM teams are fully aware of the need and committed to rolling out additional core PHIS, and have prioritised the PHSA and HeRAMS for completion by the end of 2017.

The information contained in this overview section and Table 2 may not be complete as a few key people were not present in Mogadishu at the time of the visit, including the Health Cluster Coordinator, and the principal Epidemiologist. In addition, an acting Incident Manager arrived in Mogadishu during the visit, and the post was vacant for a few months prior to that. The Cluster Co-Lead and many cluster members are based in Nairobi, and there was no opportunity to meet with them before or after the trip to Somalia. Finally, there was no health cluster meeting held during the mission, which would have been an opportunity to understand some of the perceived PHIS and IM needs of the cluster members.

Table 2 below shows a brief description of the current PHIS and IM products produced by the health cluster and WHO in Somalia. Detailed feedback for improvement of specific IM products is available in Annex 1.

[1] Developed for a 2016 Service Readiness and Availability Assessment (SARA)

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HEALTH CLUSTER

Table 2: Current PHIS and IM Products

PHIS Service	Characteristics (frequency, content)	Owned by	Related Products (frequency, content)	Main challenges noted or mentioned
Health status and threats for affected populations				
Rapid Assessment *(MIRA, rapid health assessment)*	No MIRA or similar large scale rapid assessment conducted. A series of different assessments carried out across Somalia, mostly localised. Can be found at: https://www.humanitarianresponse.info/en/operations/somalia/assessments Most recent multisectoral assessment: OCHA and REACH - Joint Multi-Cluster needs assessments for 45 districts (JMCNA) - July-September 2017 Health assessments: No large-scale health assessment carried out by health cluster. Small scale rapid health assessments carried out by cluster members Health cluster team have a registry of assessments done by cluster members.	Various health cluster members		- As can be seen in HNO 2018 draft, most information on needs is related to outbreaks. This is because of the health response focus on outbreaks in 2017. There is little data available on other health and nutrition risks, and lack of assessments is one of the obstacles to this. - The lack of health cluster funding is also an obstacle to coordinated cluster assessments. Partners carry out local assessments to inform their own programming. - The lack of engagement of cluster members contributes to lack of information sharing on assessments.
Electronic Disease Early Warning System (eDEWS)	Rolled out in week 32 2017 to strengthen surveillance (pre-existing Communicable Disease Surveillance and Response system (CSR) was only covering parts of the country and had many challenges). eDEWS was not rolled out earlier in the year because of the ongoing cholera outbreak and introducing a new system in the middle of the outbreak could have disrupted reporting. By week 32, the outbreak was subsiding and eDEWS was introduced. Sentinel surveillance system, currently 265 facilities reporting, 13 notifiable conditions/diseases. Planning to expand to all facilities doing AFP surveillance by the end of 2017. Data is triangulated with line lists from cholera and measles outbreaks, and with AFP/measles surveillance systems. Paper-based reporting from facilities, and data is compiled and entered online at regional level. eDEWS	WHO (shared with health cluster)	**Epidemic Bulletin** Weekly. Developed jointly by Epidemiology Team and IM Team. Note: Figures for suspected polio and measles are obtained from AFP/measles surveillance systems as they have wider coverage.	**eDEWS:** - Inconsistencies in reported numbers when triangulated with line lists. - Disputed areas between Somaliland and Puntland can lead to confusion in totals, as possibility of missed data or double-counting. - Lack of shared data repository with EPI/Polio team for regular and timely cross-sharing of information. **Epidemic Bulletin** *(detailed feedback in Annex 1)*: - Delays in producing bulletins as rely on AFP/measles surveillance data being compiled and submitted on time. - No information on timeliness of reporting. - Repeats a lot of the information in the AWD weekly sitrep.

PHIS Service	Characteristics (frequency, content)	Owned by	Related Products (frequency, content)	Main challenges noted or mentioned
	is hosted on EMRO's EWARN Platform. The extent of integration between eDEWS and CSR is not clear. *(Insufficient information on this system was obtained during the visit due to the absence of the principal Epidemiologist, Dr. Mutaawe)*	WHO and FMOH (shared with health cluster)	**Acute Watery Diarrhoea (AWD) Situation Report** https://www.humanitarianresponse.info/en/operations/somalia/document/awdcholera-week-41-sitrep Weekly Numbers extracted from eDEWS and line lists.	**AWD Situation Report:** - Numbers of cases reported by MoH are extracted from line lists, but do not include Somaliland (separate jurisdiction) and therefore can be misleading. - Repeats a lot of the information in the epidemic bulletin. - Now that the outbreak has subsided, the rationale for continuing to produce it is not clear.
AFP and measles surveillance system http://www.somaliapolio.org/surveillance/	AFP surveillance has been running in Somalia since 1998, in a partnership between MoH, WHO and UNICEF. The structure extends from village to district to zone to national level. The district teams collect data from communities and facilities, compile and share to zonal levels. For the past 3 years, the AFP surveillance system has been used for fever and rash surveillance - data is compiled in the same manner. Case-based measles surveillance will commence before the end of 2017.	WHO UNICEF FMOH (shared with health cluster)	**EPI/Polio situation report** http://www.somaliapolio.org/2017-week-1-13/ Weekly Now including a section on fever and rash surveillance for ongoing the measles outbreak. Produced by EPI/POL team, and aggregate data shared with Epidemiology/IM teams for epidemic bulletin. Sitrep is shared with health cluster members	System not assessed. However, a few challenges related to the eDEWS and Epidemic Bulletin: - Delays in sharing AFP and measles numbers with Epidemiology/IM teams for production of Epidemic Bulletin. - Raw data is not consistently shared with Epidemiology/IM teams who sometimes require it for graphs/maps. - There are three parallel surveillance systems: CSR, eDEWS and AFP surveillance and it is not clear the extent to which they are integrated with each other. Multiple paper forms exist at facility level thereby reducing effective reporting.
Population mortality estimation	Biannual Food Security and Nutrition Analysis Unit (FSNAU) food security, nutrition and livelihood assessments (January and August) publish estimates of crude and under-5 mortality rates in surveyed areas. Methodology used is SMART survey methodology, and mortality estimation is retrospective using recall method. The MoH and WHO are currently discussing the possibility of rolling out a birth and death registration system, to measure mortality rate and to identify causes of death (using a collapsed ICD-10 system).	FSNAU (publicly available reports)		WHO and the Health Cluster are not involved in the FSNAU surveys, so this system was not assessed.

PHIS Service	Characteristics (frequency, content)	Owned by	Related Products (frequency, content)	Main challenges noted or mentioned
Health Resources and Services Availability				
Who, What, Where, When (4W)	A standard (Excel) 4W matrix is used to collect information on the health cluster member activities. It is updated on a monthly basis. Data is shared with OCHA for overall 3W humanitarian response reporting.	Health Cluster	**4W Matrix** Monthly Excel sheet with dropdown lists for some columns **Health Cluster 3W Operational Presence Map** Ad hoc	**4W Matrix** *(detailed feedback in Annex 1):* - Inconsistent engagement of health cluster members, leading to variations in reporting and inaccurate representation of cluster activities. - Even health cluster members who engage do not consistently use the template, leading to missing data.
Health Cluster Partners List	A standard (Excel) template for partners list is maintained by the health cluster team. It is updated on an ad hoc basis.	Health Cluster	**Health Cluster Partners List** Ad hoc	**Health Cluster Partners List** *(detailed feedback in Annex 1):* Difficult to keep track of membership (new joiners and leavers) due to lack of engagement of members and parallel meetings in Nairobi and Mogadishu.
Health System Performance				
HMIS	In 2016, the health information management switched from a Microsoft Access database to the DHIS2, an online open source software. Regional HMIS officers started entering facility level data into DHIS in January 2017. DHIS2 is being rolled out with support of The Global Fund and UNNICEF. The WHO IM TL supported the MoH with the development of a HIS strategy in September 2017.	UNICEF FMOH		WHO and the Health Cluster are not involved in the HMIS, so this system was not assessed.
Vaccination coverage estimation	Only administrative estimates of EPI coverage have been available since 2006. A multi-antigen coverage survey is planned by WHO in early November 2017. Rapid convenience monitoring is planned after the nationwide mass measles vaccination campaign (outbreak response) in November/December 2017. No information on cholera vaccination coverage was obtained during the visit.	WHO FMOH		System not assessed as no current activities.
Operational Indicator Monitoring	Only one operational health indicator is being reported on by cluster members which is: Number of people receiving primary and/or basic secondary health care services (versus target in HRP)	Health Cluster		It is good practice to have only one or a few operational indicators to report on. However, the definition of primary and/or basic secondary health care services needs to be defined to avoid inaccurate reporting by partners.

PHIS Service	Characteristics (frequency, content)	Owned by	Related Products (frequency, content)	Main challenges noted or mentioned
	Mass vaccination reach is not included in these reports. Data is collected from cluster members on a weekly basis and shared with OCHA. Reports can be found here: https://data.humdata.org/organization/ocha-somalia			
Health Cluster Bulletin	Issued monthly, and compiled from health cluster partner inputs in weekly partner reports, monthly partner reports and other information shared with cluster team. Data is compiled by subnational clusters and shared with cluster IMO. When first started, there was good partner engagement, but large amounts of text and inputs shared, which is difficult for the health cluster team to filter and use.	Health Cluster	**Health Cluster Bulletin** Monthly Shared with all health cluster partners	**Health Cluster Bulletin** *(detailed feedback in Annex 1):* - Health cluster partner engagement has declined. A handful of active NGOs submit regularly and therefore their news tends to dominate the bulletin. - The bulletin is being issued almost a month later – largely due to delayed inputs from partners. - Health cluster members do not adhere to template for information sharing. - The bulletin content is very much focused around the outbreak response, with insufficient information in other sub-thematic areas (PHC, SHC, SAM, SRH, mental health, etc…).
Ad hoc Infographics	Most requests come from: - donors (through donor liaison at WHO) - WHO communications team - UNOCHA - Somalia's Ministry of Humanitarian Affairs and Disaster Management	Some are WHO Some are Health Cluster	**Ad hoc infographics** Ad hoc	- Significant workload, usually at short notice - Disaggregated data sometimes not available, and this is problematic for maps in particular.
Health Cluster partners' summary report	A Word template is used to collect information. It includes numerical data on the operational indicator and narrative updates. It is shared weekly with all cluster partners and UNOCHA.	Health Cluster	**Health Cluster partners' summary report** Weekly	**Health Cluster partners' summary report** *(detailed feedback in Annex 1):* - Partner engagement is poor, and requires active outreach by HCSOs. - The template is lengthy for a weekly basis – particularly that more information is requested on a monthly basis for the health cluster bulletin.
Health Cluster activity calendar	The calendar is an Excel-based tool that lists planned cluster meetings at national and sub-national level, as well as key report submission dates for cluster partners.	Health Cluster	**Health Cluster activity calendar** Update frequency?	None

In addition to the services and products in Table 2, the IM team provides regular inputs into several PHIS and IM products owned by others:

- Health cluster inputs into OCHA Humanitarian Bulletin (monthly): inputs required are cluster funding overview, top-line response activities on key events like outbreaks.
- Health cluster inputs into OCHA Humanitarian Dashboard (monthly): inputs required are health cluster reach in numbers, cluster funding overview, and a summary of needs, response and gaps.
- Health cluster inputs into OCHA'S 3W (monthly): inputs required are health cluster 3W.
- WHO HQ famine response monitoring framework (monthly): inputs required are information for top-line health indicators.
- Health cluster response updates into OCHA's weekly drought sitrep: inputs required are information in weekly health cluster partner summaries
- Interagency Emergency Response Team (IERT) Reports: inputs required are quantitative data on IERT activities carried out by health cluster partners.

3.2 Recommendations and Next Steps

a) **Ways of Working:**
   - There is an urgent need for a shared drive on which all data and products are stored. The shared drive should be accessible by the IM, Epidemiology, EPI/Polio, Health Cluster teams, at a minimum. This is particularly important for institutional memory in case of staff turnover. Incoming staff have struggled to obtain old records and data.
   - A fixed schedule should be agreed for data sharing through the shared drive between teams, e.g. AFP and measles data sharing with IM and Epidemiology teams.

b) **Capacity enhancement:**
   - IM team members need to be on longer-term contracts (at least 6 months, preferably 1 year) to ensure continuity and consistent quality of PHIS services.
   - The IM teams requires an allocated annual budget to enable them to plan their activities in advance and facilitate rolling out of new PHIS. In collaboration with the health cluster team, it is recommended that the IM team develop an annual workplan (which includes activities such as assessments, HeRAMS, etc…) on the basis of which a budget estimation can be made.
   - The IM team members require WHO-owned hardware and software to facilitate their work and ensure continuity in case of staff turnover. Examples include a dedicated health cluster IMO laptop, ArcGIS and analytical software (SPSS, STATA, etc…).

c) **Automation of PHIS:** the workload created by data entry and cleaning is considerable. To free up some of the IM team members time and ensure maximum and effective use of their skills, a number of PHIS can be automated, such as health cluster partner list, partner activity reporting, and 4W. Granting cluster members access to WHO's PRIME platform or ActivityInfo will allow them to take ownership in sharing data and information and reduce the workload on the IM team members. This will ensure timely analysis of data and production of IM products.

d) **Where possible, merge similar IM products:** some products repeat information in others e.g. AWD sitrep information is repeated in Epidemic bulletin and both products target the same audience. The health cluster, IM and Epidemiology teams should jointly explore where comparable products can be merged to ensure efficiency.

e) **Where possible, synchronize timing of products:** some products require similar information but are issued at different times – the different periodicity means that the data is not similar for both products. For example, information needed for the cluster bulletin and for OCHA's humanitarian bulletin and dashboard is similar, but they are produced at different times of the month. The IM and health cluster team should see where they can synchronize the timing of their products to ensure similar data can be used concurrently for both.

f) **Engage cluster partners in PHIS:** the IM and Epidemiology teams are currently shouldering the entire burden of cluster-related PHIS and IM products on behalf of the cluster. There is an opportunity to share the burden, by activation of an IM sub-group, or time-limited establishment of cluster sub-groups for IM functions (e.g. HeRAMS, health needs assessment, etc…).

4. Public Health Situation Analysis (PHSA)

A Public Health Situation Analysis (PHSA) has been prioritised by the Somalia IM team. Given the cyclical nature of the food insecurity crisis in Somalia, the team is keen on using the PHSA as a way of highlighting health risks that occur in different cycles to enable better prediction of spill over health effects, and use the PHSA as a way to advocate for and guide emergency preparedness by the health cluster in 2018.

During the visit, interviews were held, and key data sources were collected. The first edition will be developed by the Public Health Information Strategist by the mid-November 2017, and updated on a quarterly basis by the health cluster and IM teams in-country.

Given that the crisis is protracted in Somalia, for the purposes of the PHSA, it was agreed with the team that the starting point of the crisis will be the November 2015 drought.

5. Health Resources and Services Availability Mapping (HeRAMS)

Rolling out Health Resources and Services Availability Mapping (HeRAMS) has been prioritised by the Somalia IM team. Since the completion of the 2016 Service Availability and Readiness Assessment (SARA), there has been significant population displacement, an increased burden of acute malnutrition, and two large outbreaks of cholera and measles. These events have undoubtedly had an impact on the capacity of health service delivery points, and, by default, the availability of health services to the affected population.

The proposed first cycle of HeRAMS will be conducted in all districts of 4 states in Somalia, where there are active state-level health coordination mechanisms. Data will be collected at health facility level, compiled at state level, cleaned and entered online at regional level, and analysed and interpreted at national level.

During the visit, a HeRAMS concept note, HeRAMS assessment tools (for 4 levels of service delivery) and a budget template were developed. These are currently under review by the health cluster and IM teams.

5.1 Recommendations and Next Steps

a) The first round of HeRAMS needs to be **prioritised for funding** in 2017. The lack of service availability information is hampering the health response, particularly now that the cholera outbreak is subsiding.
b) Engage the **health cluster to lead implementation** by activating working groups at regional, state and national levels. The IM and health cluster team should step into a technical advisory role. This will ensure continuity of HeRAMS as a monitoring system rather than as a one-off survey.
c) **Automate** HeRAMS by using the PRIME platform. This will ensure a simplified data entry and analysis, but also allow state-level clusters to see real-time graphics and information on service availability.
d) Take an **opportunistic approach** to the first round of HeRAMS in terms of geographical.
e) Given that this is a food insecurity crisis, mapping of nutrition and EPI services has been included in the design of HeRAMS. It is recommended to engage the nutrition cluster and WCO EPI team during analysis and reporting, and ensure **wide dissemination across clusters.**

6. Health Cluster Contribution to Somalia HRP 2018

At the time of the visit the final draft of the Humanitarian Needs Overview (HNO) had already been completed, with health inputs. The HRP 2018 planning process had not yet started. Once the process kicks-off, a remote review of the health cluster section of the HRP 2018 will be conducted remotely.

Annex 1: Suggestions for improvement of specific IM products*

<table>
<tr><th>Product</th><th>Suggestions for improvement</th></tr>
<tr><td>Epidemic Bulletin</td><td>
In highlights/cumulative figures section: report proportions (e.g. completeness, timeliness, CFR, attack rate, proportion of true alerts from cumulative cases) with whole numbers, as whole numbers are difficult for the reader to interpret.

Tables: good content, but difficult to interpret (especially Table 4). Suggest adding a column in the tables that shows proportions/rates (such as Cholera CFR in Table 2)

Maps: good content, but difficult to read. Suggest to resize/focus.

For ongoing outbreaks such as measles and cholera, suggest adding as annexes rather than core sections of the bulletin.

Additions:
- A table/chart on eDEWS system performance: showing timeliness, completeness, number of sentinel sites. For example:
<table>
<tr><td rowspan="2">State or Regional Level</td><td rowspan="2">Total number of sentinel sites</td><td colspan="2">Current reporting period</td><td colspan="2">Cumulative since reporting started</td></tr>
<tr><td>Timeliness</td><td>Completeness</td><td>Timeliness</td><td>Completeness</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
- A table/chart on new alerts in the reporting period: location (aggregate at state or regional level), investigation information and outcomes. For example:
<table>
<tr><td>State or Regional Level</td><td>Number of alerts</td><td>Number (proportion) of true alerts</td><td>List causative agents (confirmed or suspected)</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>
- Reminder of case definitions and alert thresholds, and immediate notification channels
</td></tr>
<tr><td>4W Matrix</td><td>
Suggest automating on PRIME whereby partners can enter their own data through their account.

Suggestions for template:
- Group columns under Who, What, Where, When
- Who: suggest changing to: partner name, partner type (directly provides services, supports service delivery, provides funding for service delivery), funded by SHF (or other cluster funding – Yes/No). No need for donor.

- What: Level of care and activity description options are not mutually exclusive and are overlapping. Having both results in partners having to enter a large number of rows to capture the breadth of their work. Suggest simplifying by gathering data on activities by subtheme rather than level of service delivery. Suggest to also include activities other than frontline service delivery e.g. funding, donation of items, training, etc…. This will help capture the diversity of cluster members (donors, MoH, etc…). For example:
<table>
<tr><td>Subtheme (consider using Yes/No format</td><td>Activities</td></tr>
</table>
</td></tr>
</table>

rather than dropdown list)	
Maternal, new-born and reproductive health	Community-based health promotion Community-based distribution of items/kits Sexual and reproductive health care (STI, family planning, SGBV) BeMONC CeMONC
Child Health	Community-based health promotion Community case management of common illnesses Community-based distribution of items/kits Mass vaccination EPI Delivery of/support to vaccines and cold chain
Primary care	Primary outpatient care for communicable and non-communicable disease Disease surveillance at primary level Referral system
Maternal, infant and young child nutrition	Supplementary feeding program Outpatient treatment for acute malnutrition Stabilisation centre
Specialised services: HIV, TB, Cholera	Community-based health promotion Community-based distribution of items/kits TB diagnosis and treatment CTU/CTC
Mental Health	Mental health and psychosocial support (MHPSS) (other than for SGBV)
Inpatient clinical services	Secondary or tertiary medical care (other than CeMONC) Surgical and trauma care Disease surveillance at secondary/tertiary level
Funding	Provide funding for service delivery
Training and technical support	Provide training and/or technical support to service delivery actors
Coordination	Coordination of the health response
Other (specify)	

- **Where**: no suggestions.
- **When**: Format project duration to calculate automatically based on start and end columns (to minimise errors). Remove project status.
- No need for number of beneficiaries, or date updated (especially if automated on PRIME).

Health Cluster Partners List

- Suggest automating on PRIME with partners updating their information, subscribing and unsubscribing from mailing list.
- Suggest adding name and contact information of focal person in each partner.
- Suggest adding type of membership (member, observer, etc…)
- Suggest adding type of partner (national NGO, MOH, international NGO, donor, UN agency, etc…)

Health Cluster Bulletin	- Cover page and highlights: suggest adding number of active cluster members to cover page, and diversify topics of highlights (too focused on outbreak response, should aim to cover other topics). - Summary of Humanitarian Situation: suggest condensing to 1 short paragraph, and focus on the health situation in the reporting period, drawing from health needs assessments during the time period. - Service updates: Overall, the bulletin content is very much focused around the outbreak response, with insufficient information in other sub-thematic areas. A lot of this information is already available in the epidemic bulleting and AWD sitrep. Suggest using sub-headings to service updates along thematic lines rather than geographical areas (Maternal, new-born and reproductive health - Child Health - Primary care - Nutrition - Specialised services: HIV, TB, Cholera - Mental Health - Inpatient clinical services), and writing a brief paragraph on important updates for each. Focus information on agency activities during the time period. - Gaps and Challenges: suggest keeping them focused on reporting period rather than generic/chronic problems. - Human interest/success stories: aim for 2 per bulletin and set criteria for partners for submission (e.g. word count, must include relevant photo, etc…). - Add fixed sections for capacity building (key activities during reporting period) and coordination (information about/from coordination meetings during the time period)
Health Cluster partners' weekly reporting template	Suggest automating this process to use PRIME or ActivityInfo. Suggest adapting template as follows: divide into 2 sections: 1. Weekly: collect quantitative information on health indicators for HRP monitoring. Suggest automating this on PRIME to ensure consistency in interpretation and reporting. Currently, there is only one indicator (number of people reached), and suggest adding age and gender disaggregation. The difference between people and consultations should be made explicit to partners to ensure adequate reporting. In addition, partners can share urgent updates or challenges (optional). 2. Monthly: collect information to feed into the health cluster bulletin, and that is not available through 3Ws, HeRAMS or other PHIS. The following are suggested headings for the monthly section: - New activities by sub-thematic area: - Planned/completed health assessments in reporting period (location, objective, dates, thematic scope, key findings if available) - Planned/completed capacity building activities in the reporting period (location of training, title of training, number and gender breakdown of participants) - Key challenges faced during reporting period. - Human interest/success stories (with specific criteria)
WHO Bulletin (internal, monthly)	- Cover page and highlights: suggest condensing to half page - Due to monthly frequency, important to keep summary of humanitarian situation and health needs, but suggest condensing to 2 brief paragraphs. - Updates: suggest structuring around WCO operational plan objectives, briefly describing outputs, challenges and recommended action/planned next steps. - Although WHO is cluster lead, minimize information on cluster actions which can be obtained from the health cluster bulletin, and focus more on WHO activities.

**** Public Health Information Strategist available for remote support with revision of templates and implementation of suggestions for improvement.***