Health Cluster National Partners' Capacity Survey 2019

Email - healthcluster@who.int

Website - www.who.int/health-cluster/

TABLE OF CONTENTS

Click on your section of interest to directly access the relevant page.

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 Information Management, and colleagues in the WHO Health Emergencies Programme (WHE), in particular the Health Information Management Department, Humanitarian Policy & Guidance Team in the Emergency Operations Department, the Emergency Medical Teams, and the Standby Partnerships.

We express our gratitude and sincere thanks to the Health Cluster national partners and their focal points for having taken the time to fill in the survey, to the Health Cluster Coordinators and Co-Coordinators that have facilitated the process within their own country health clusters, as well as to the Partnership Officers and Programme Area Managers for Emergency Operations within the WHE Programme in the regions that have been supportive of this exercise.

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.

I. INTRODUCTION

1. The Health Cluster

The Health Cluster[1] is a vital operational partnership network that galvanizes the collective capacities of over 900 partners at country level[2], of which 56 engage strategically at the global level, to achieve better health outcomes in humanitarian and public health emergencies. In 2019, there were 29 Health Clusters/Sectors, of which 2 were regional coordination mechanisms working to meet the health needs of approximately 65 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,

[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

[2] The number of Health Cluster partners globally is estimated based on the number of partners that were invited to respond to the international partners survey in 2018 and the national partners survey in 2019.

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 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. The Health Cluster Partners' Capacity Survey

As part of Strategic Priority 1 of the GHC Strategy 2017-2019, the Health Cluster Partners' Capacity Survey aims to capture information on partners' technical, operational and coordination capacities, including surge. A survey of international partners' capacity was previously undertaken between July and August 2018. This report – which focuses on national partners – represents the second phase.

As part of this exercise, the National Partners' Capacity Survey was conducted between April and May 2019. For the first time ever, this survey targeted national partners and, in particular, national non-governmental organizations, local non-governmental organizations[3] and National Red Cross / Red Crescent Societies, that are recognized as first responders in emergencies with public health consequences.

The result of this exercise will help to more effectively identify critical gaps in 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 strengths and gaps in national health response capacity;

[3] For the purpose of this survey the following definitions from the Grand Bargain Localization Stream were adopted: **National NGOs** - Organizations with the head office in the capital city and working in more than one state or region within the country; **Local NGOs** - Organizations engaged with the head office located in a state or region with projects only within that area.

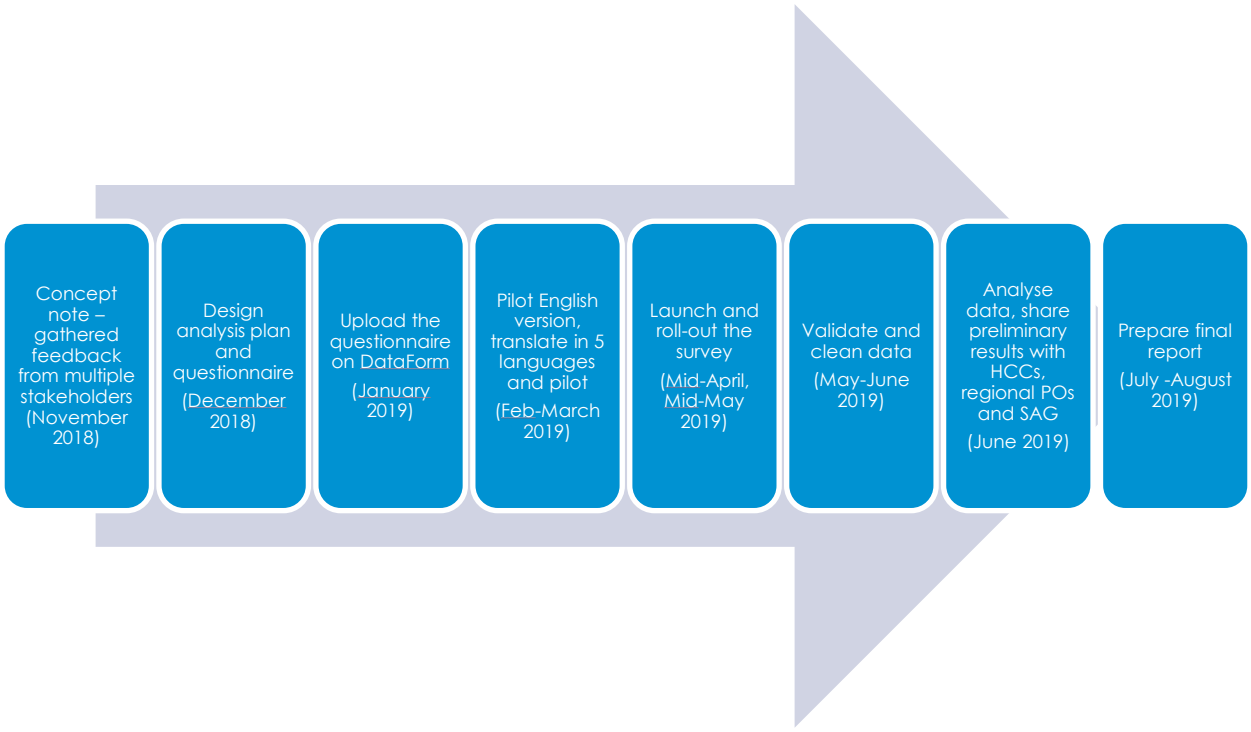
- Inform and secure surge capacity requirements from technical and operational partners and networks in response to emergencies with public health consequences;
- Provide evidence to support ways in which to deepen and strengthen engagement with current and potential partners.

II. METHODOLOGY & RESPONSE RATE

1. Process and timeline

The process was led by the GHC unit and entailed the following steps:

- Gather feedback on process from Health Cluster Coordinators, Regional Partnership Officers, GHC Strategic Advisory Group, Information Management Task Team, WHO Health Emergencies Programme relevant departments and teams, including the Health Information Management Department, the Humanitarian Policy and Guidance Team Emergency Medical Teams and Standby Partnerships in the Emergency Operations Department (November 2018).
- Design an analysis plan and questionnaire with the above-mentioned stakeholders (December 2018).
- Upload the questionnaire in DataForm/LimeSurvey (WHO hosted platform for survey) (January 2019).
- Pilot the questionnaire in English, translate it and pilot it in other 5 languages (French, Arabic, Russian, Spanish, Bengali) with a sample of national partners selected by the Health Cluster Coordinators (February-March 2019).
- Launch the survey through Health Cluster Coordinators that presented the project at the partner meeting or through their listserv (mid-April/mid-May 2019). The survey was sent both through individual tokens addressed to partners' focal points and generic links.
- Validate the data internally and with Health Cluster Coordinators (May-June 2019).
- Analyse the data, share preliminary results with HCCs, regional POs and SAG (June 2019).
- Prepare the final report in collaboration with Health Cluster Coordinators, Regional Partnership Officers and GHC Strategic Advisory Group (July-August 2019).



2. Respondent identification

Overall, 256 national partners (n = 256) completed the survey. In January 2019, the GHC Unit collated a list of national partners from 25 country clusters (Table 1) using information provided by Health Cluster Coordinators. First, 995 invitations were sent via individual DataForm tokens to identified partners. To ensure access to those not included in the original list, generic links were used to disseminate the survey on Country Health Clusters listservs. A total of 698 partners have received individual tokens or opened one of our generic links. These constitute the population (N = 698) of our survey.

3. Launch

The survey was launched on 17 April 2019 and was closed on 24 May 2019. Regular reminders were sent throughout this period through Health Cluster Coordinators and with the DataForm system.

4. Assumptions

The following assumptions should be taken into consideration in the analysis and interpretation of data:

- Possible bias with self-reporting by NGOs
- Harmonisation of different contexts when aggregating results (e.g. Ethiopia and Libya have a very small number of NGOs compared to Somalia)
- Partners may have ticked on expertise / service provision of a particular area / service based on expertise of just one component of the service packages

III. SURVEY RESULTS

1. Response rate

The overall response rate was 37% (256 completed responses) among 698 national health cluster partners.

Country	Tokens	Organizations	Completed	Rate
Afghanistan	34	23	3	13%
Bangladesh	115	42	6	14%
Burundi	6	4	2	50%
Cameroon	55	40	14	35%
Central African Republic	35	31	7	23%
Chad	7	7	2	29%
Colombia	15	6	4	67%
DR Congo	77	54	41	76%
Ethiopia	5	3	2	67%
Iraq	20	13	10	77%
Libya	5	3	0	0%
Mali	9	7	1	14%
Myanmar	18	9	5	56%
Niger	2	2	0	0%
Nigeria	16	16	6	38%
occupied Palestinian territory	62	32	13	41%
Pakistan	35	35	14	40%
Somalia	146	103	32	31%
South Sudan	49	28	12	43%
Sudan	39	23	7	30%
Syria	93	91	37	41%
Turkey	49	49	24	49%
Ukraine	14	9	3	33%
Yemen	31	28	5	18%
Whole of Syria (NE Syria)	58	40	6	15%
Total	**995**	**698**	**256**	**37%**

Table 1. Response rate by country

2. Survey respondent breakdown by organization

Organizations were asked to indicate their organizational type (Figure 1). Globally, the majority of respondents were national organizations (70%), followed by local organizations and the Red Cross/Crescent. It is to note that only 5 Red Cross / Red Crescent Societies participated in this survey.

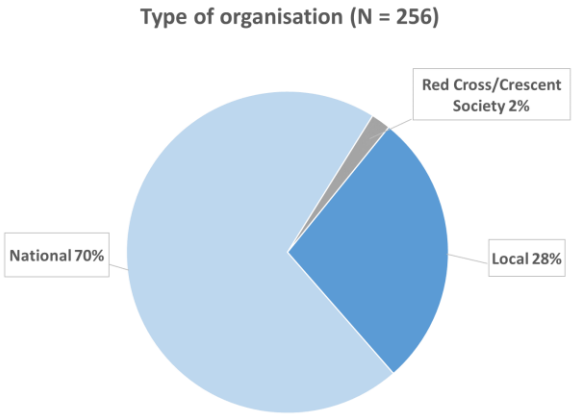


Figure 1. Global breakdown of respondent by organizational type

3. Affiliations to other sectors

They were then Organizations were asked to indicate their affiliations to other sectors (Figure 2). The most common affiliation is with the nutrition sector (69%) followed by WASH (66%) and protection (63%). A limited number of organizations have ties to the logistics sector (23%) and very few have no affiliations to other sectors (9%).

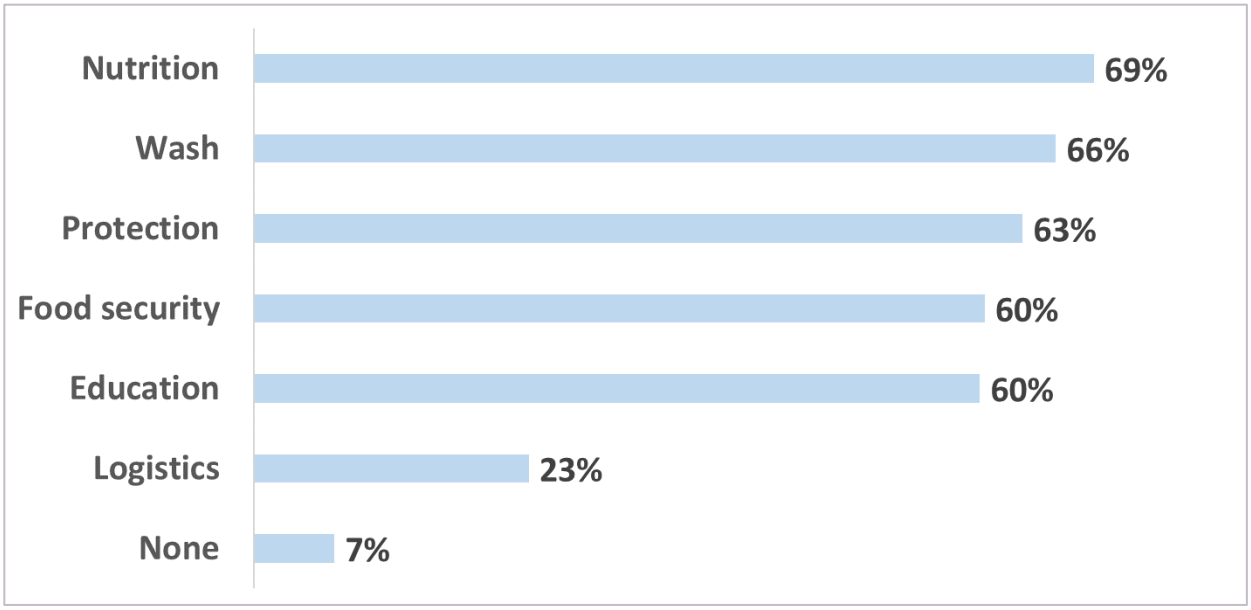


Figure 2. National partner presence in other sectors. (n = 256)

4. Organizational expertise

Organizations were asked to indicate the areas of their organizational expertise (Figure 3). The most common areas of expertise are clinical services for non-communicable diseases and mental health (87%), child health (87%) and services pertaining to communicable diseases (84%) offered at the community care level. Clinical services for sexual violence and STI & HIV/AIDS have the lowest rate with only 64% of respondents having the expertise to offer such services. It is important to highlight that a large majority of respondents (95%) declare having expertise in areas not included in this survey. A breakdown of these areas is available in section 4.10.

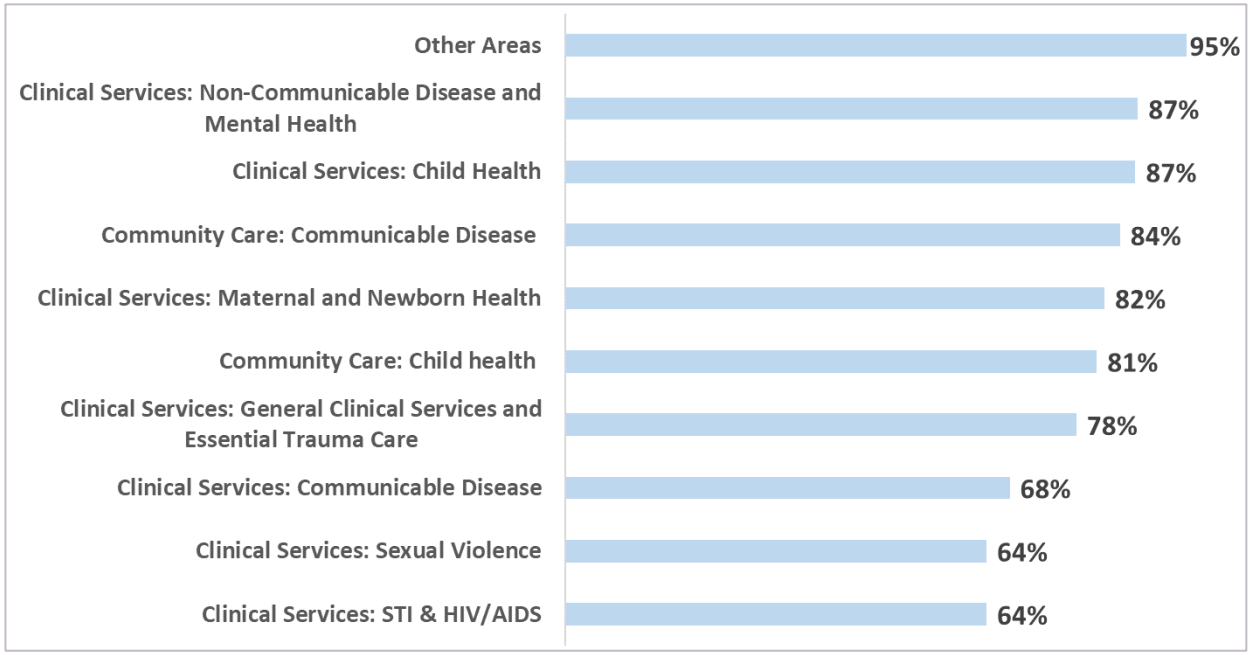


Figure 3. Organizational expertise, overall

4.1 Child health (community care)

Over half of the respondents (Figure 4) reported having expertise in screening of acute malnutrition (66%) and integrated community case management (65%). Overall, these results are encouraging.

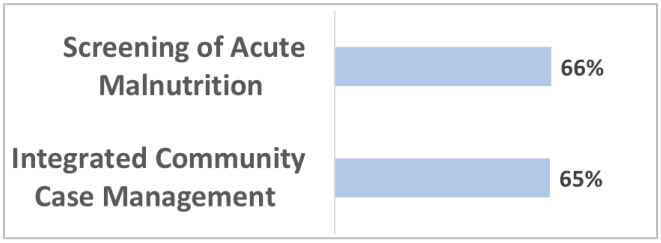


Figure 4. Organizational expertise: child health (community care)

4.2 Communicable disease (community care)

In terms of organizational expertise in communicable disease (Figure 5), it is encouraging that the majority of respondents have the expertise on community mobilization (79%) followed by IEC on early identification and referral of locally priority disease[4][5] (e.g. malaria, acute watery diarrhoea, dengue, others) (63%). However, it is concerning that only 39% declare having expertise in vector control.

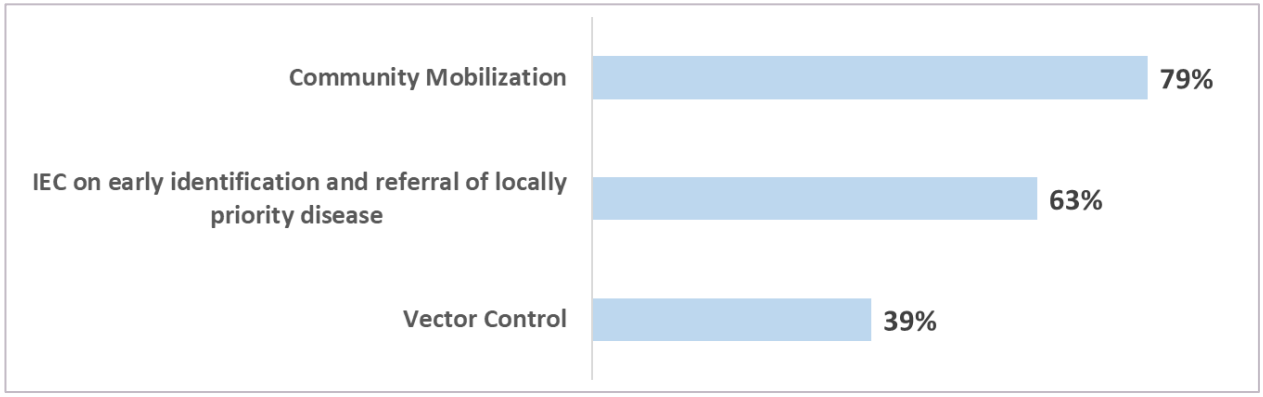


Figure 5. Organizational expertise: communicable disease (community care)

[4] World Health Organization, 2016. Health Resources Availability Mapping System (HeRAMS).
[5] Diseases that pose a public health risk because of their epidemic potential. Source: https://www.who.int/blueprint/priority-diseases/en/

4.3 General clinical services & essential trauma care (clinical services)

More than half of respondents (Figure 6) declare having the expertise to provide essential services such as outpatient services (67%) and primary injury care (59%), while just under a third have expertise in more specialised services related to surgery. It is concerning that only 12% of respondents declare having the necessary expertise to provide blood bank services.

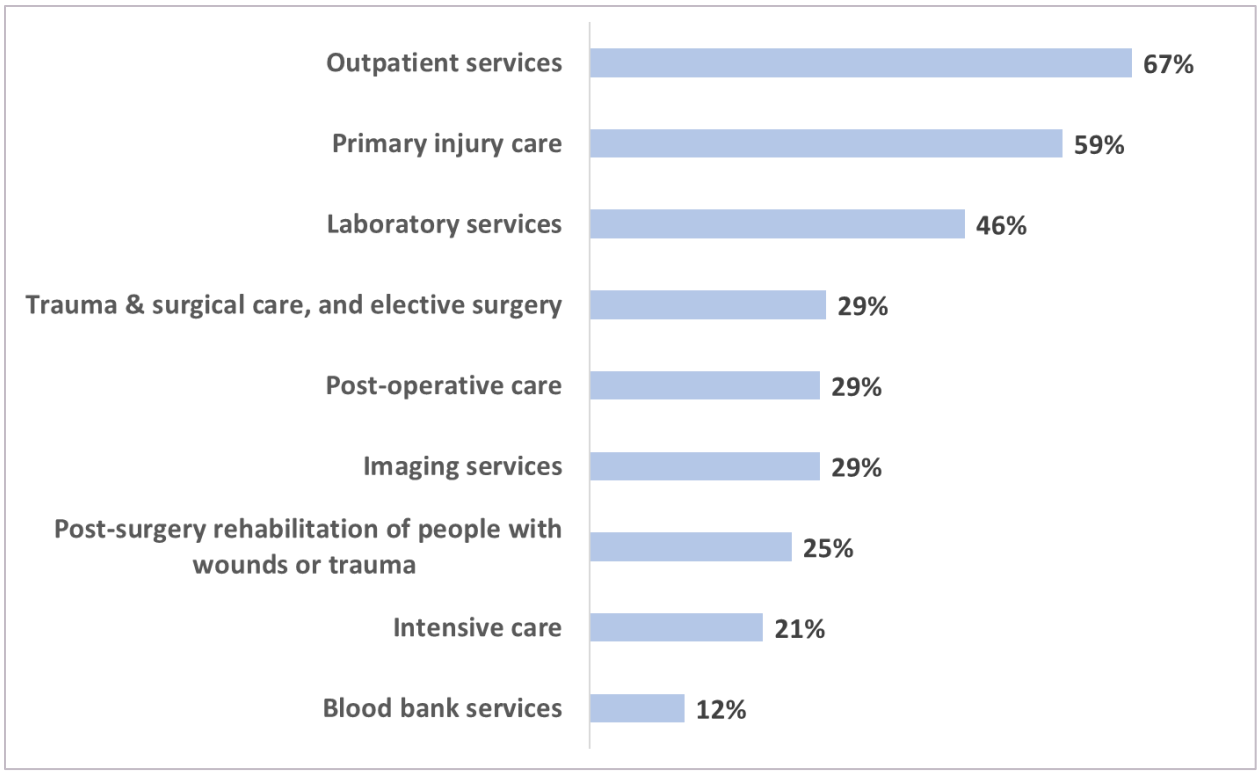


Figure 6. Organizational expertise: general clinical services & essential trauma care (clinical services)

4.4 Child health (clinical services)

Most organizations have the expertise to screen for acute malnutrition (68%) and provide CMAM outreach activities (65%). On the other hand, it is concerning that their expertise in management of children suffering from severe illness (37%) and use of stabilization centers for the management of severe acute malnutrition (28%) remains comparatively low (Figure 7).

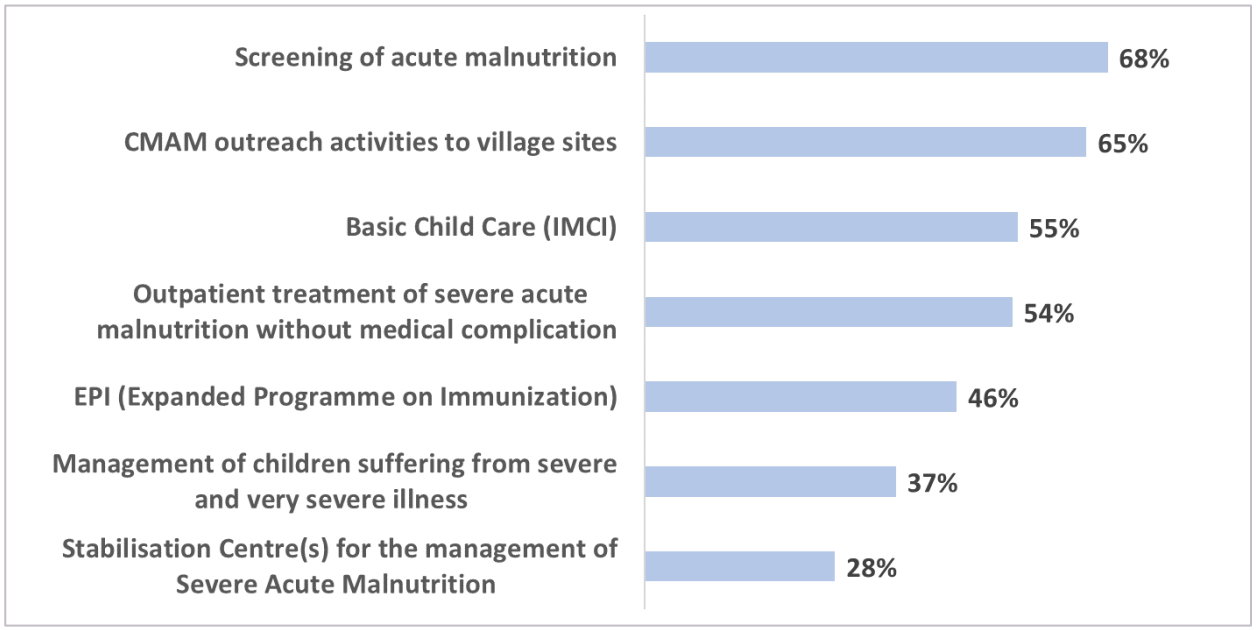


Figure 7. Organizational expertise: child health (clinical services)

4.5 Communicable diseases (clinical services)

Just over half of respondents (Figure 8) reported technical expertise for the Early Warning, Alert and Response System (EWARS) (55%). Expertise remains limited in diagnosis and treatment of malaria (45%), cholera (37%), tuberculosis (23%) and NTDs (20%). Similarly, as little as 19% of respondents declared having the expertise to diagnose and treat viral hemorrhagic fevers. These results are unsatisfactory and require immediate attention.

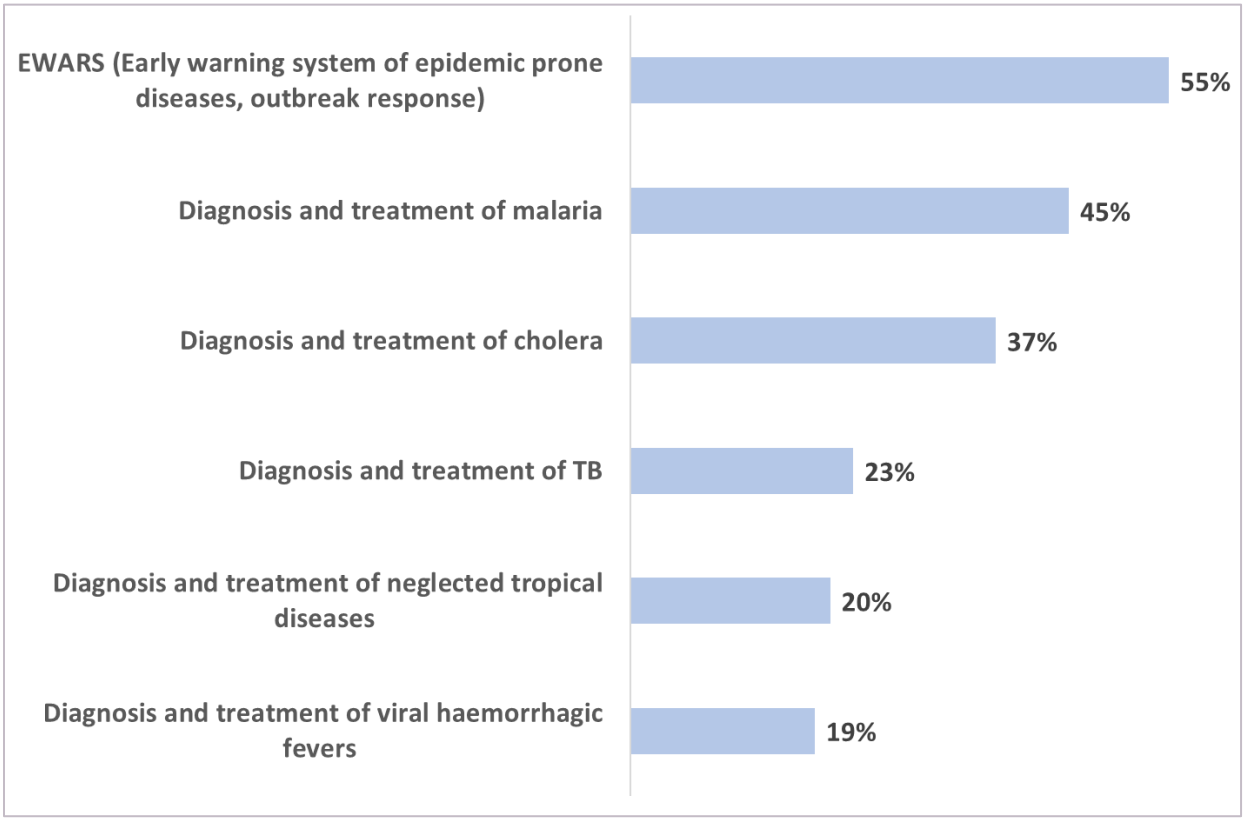


Figure 8. Organizational expertise: communicable disease (clinical services)

4.6 STI and HIV/AIDS (clinical services)

Nearly 50% of partners (Figure 9) reported having capacity for HIV counselling and testing. On the other hand, capacity to treat HIV through antiretroviral treatment (18%) remains low. Overall, these results are unsatisfactory and require immediate attention.

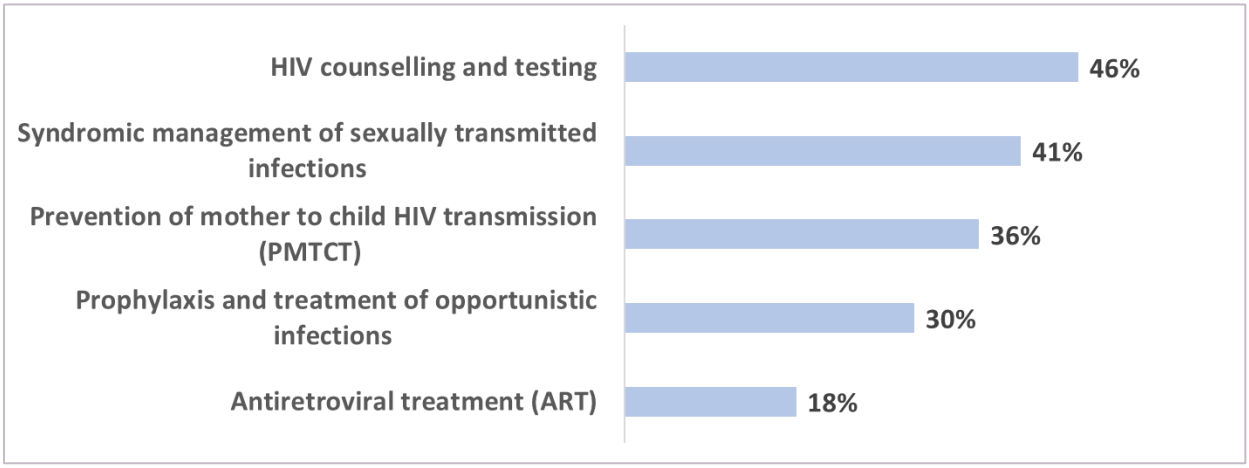


Figure 9. Organizational expertise: STI & HIV/AIDS (clinical services)

4.7 Maternal and newborn health (clinical services)

Close to half of the respondents have some expertise in the essential elements of maternal and newborn health (Figure 10). National partners reported having expertise in family planning (72%), antenatal care (66%), skilled care for safe delivery (51%), essential newborn care (50%), and post-partum care (46%). However, expertise in basic emergency obstetric care (41%), comprehensive emergency obstetric care (30%) and comprehensive abortion care (22%) remains low. These results are unsatisfactory and require immediate attention.

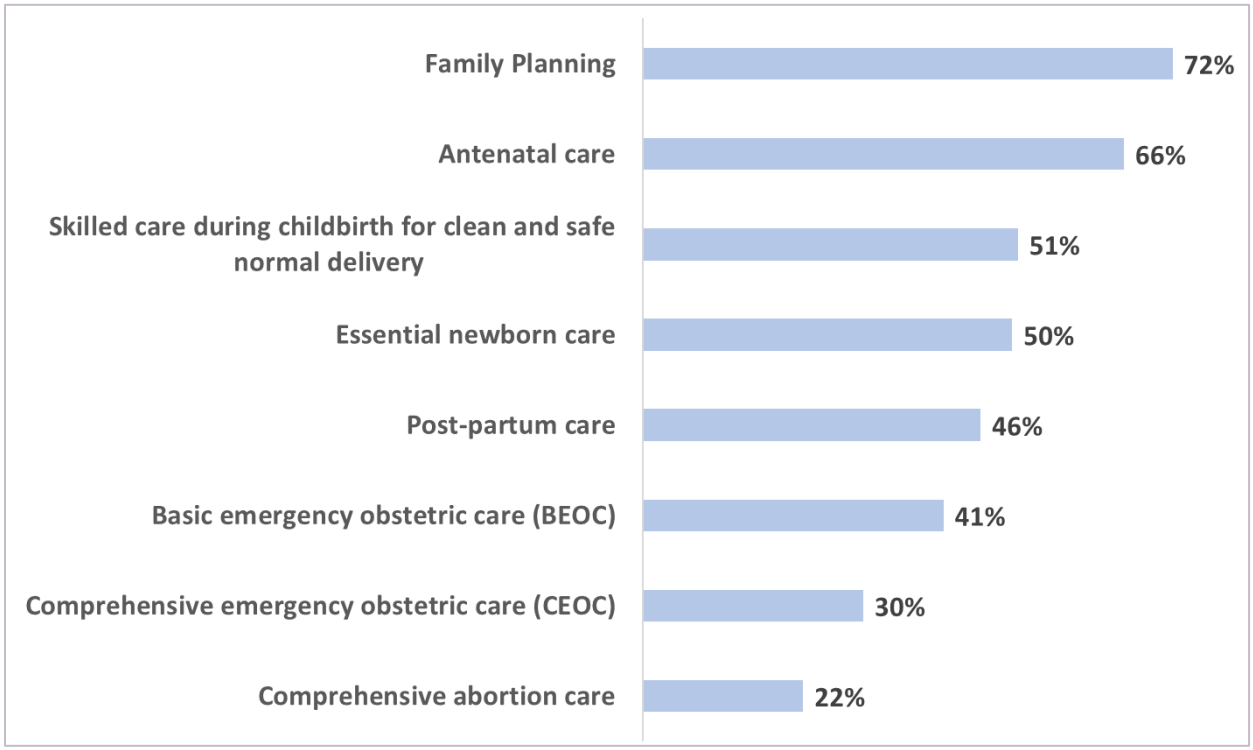


Figure 10. Organizational expertise: maternal and newborn health (clinical services)

4.8 Sexual violence (clinical services)

Just over half of respondents have the expertise to offer services for the clinical management of rape survivors (52%). 42% of national partners have expertise in emergency contraception and 30% have expertise in post exposure prophylaxis (PEP). Overall, these results are unsatisfactory and require immediate attention.

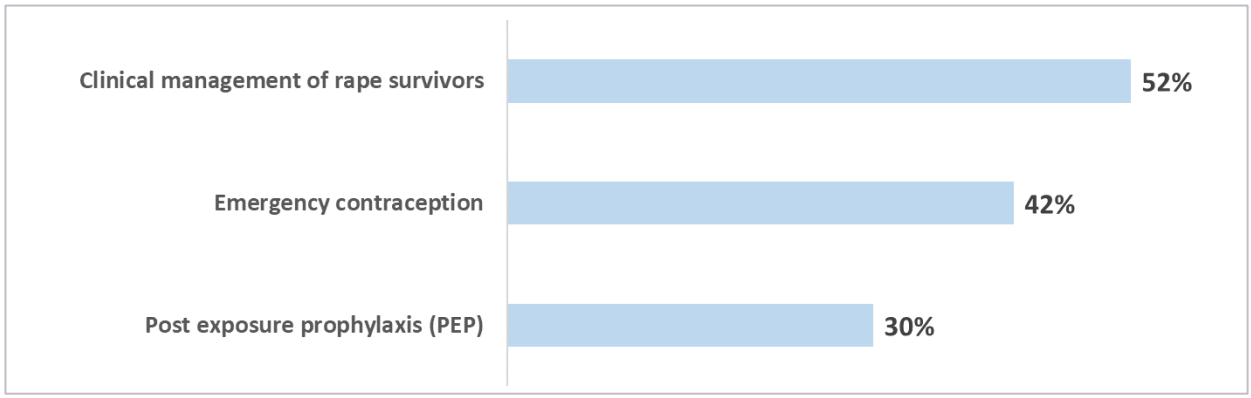


Figure 11. Organizational expertise: sexual violence (clinical services)

4.9 NCD and mental health (clinical services)

Organizations were asked to detail NCD, psychosocial and mental health expertise (Figure 12). It is encouraging that a large majority of respondents declare having the capacity to provide psychosocial support (76%) and that more than half have the expertise to provide treatment of high blood pressure (51%). However, it is concerning that the level of expertise in treatment of thalassemia (25%) remains comparatively low.

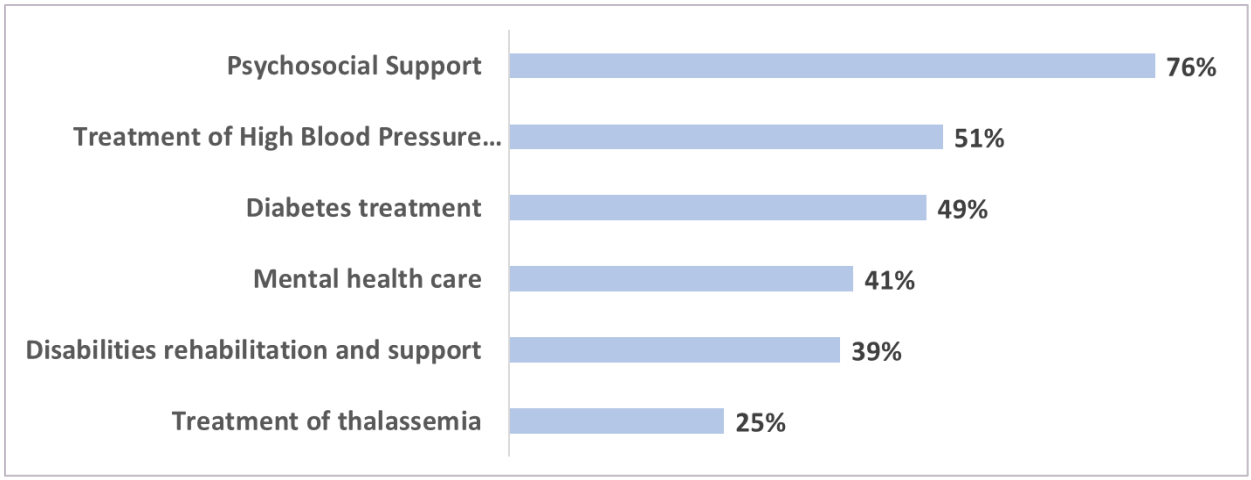


Figure 12. Organizational expertise: non-communicable disease and mental health (clinical services)

4.10 Other areas

The majority of respondents (95%) declared having expertise in areas un-specified in this survey. Many reported having expertise on capacity building (74%), health promotion, social mobilization, behavior change communication (71%) and needs assessment (70%). It is, however, notable that only 18% have expertise in anthropology and social sciences in general (Figure 13).

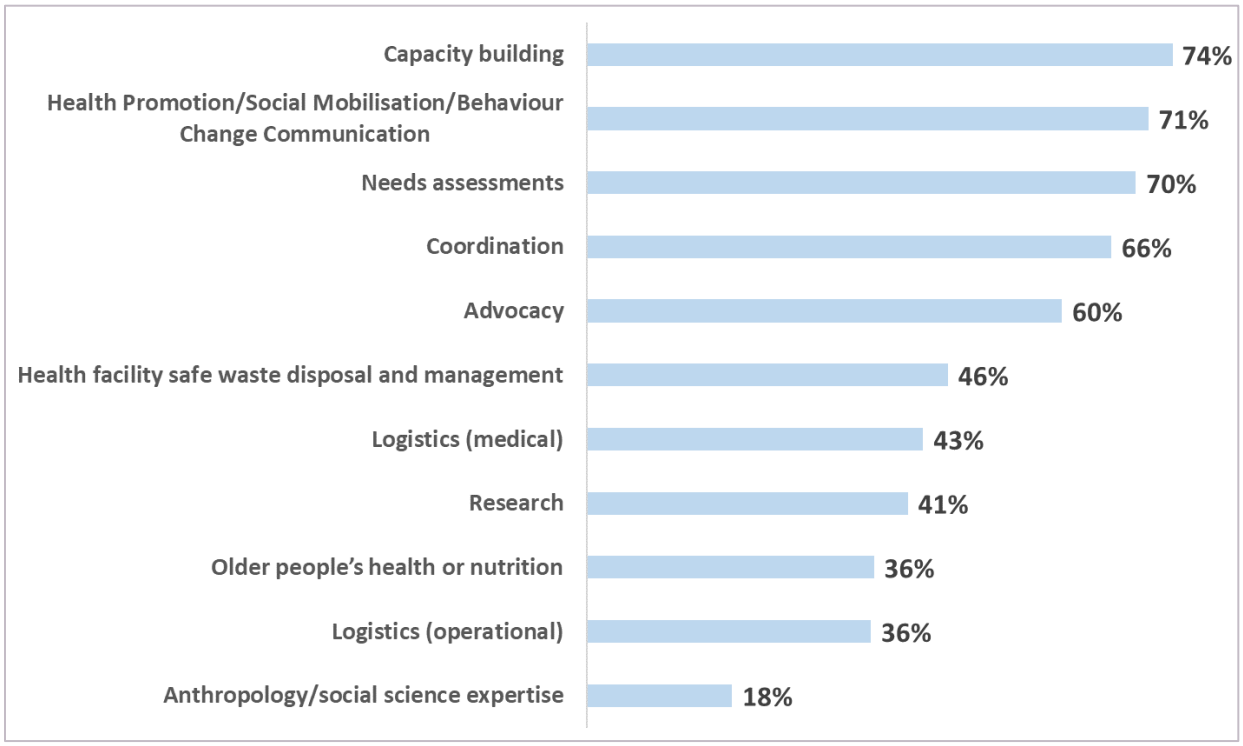


Figure 13. Organizational expertise: other areas

5. Health system organization: current & expandable

Organizations were asked to indicate the current and expandable level of health system organization at which they operate. Most national partners work at the community care and primary health care levels, which is more aligned with the nature of these organizations.

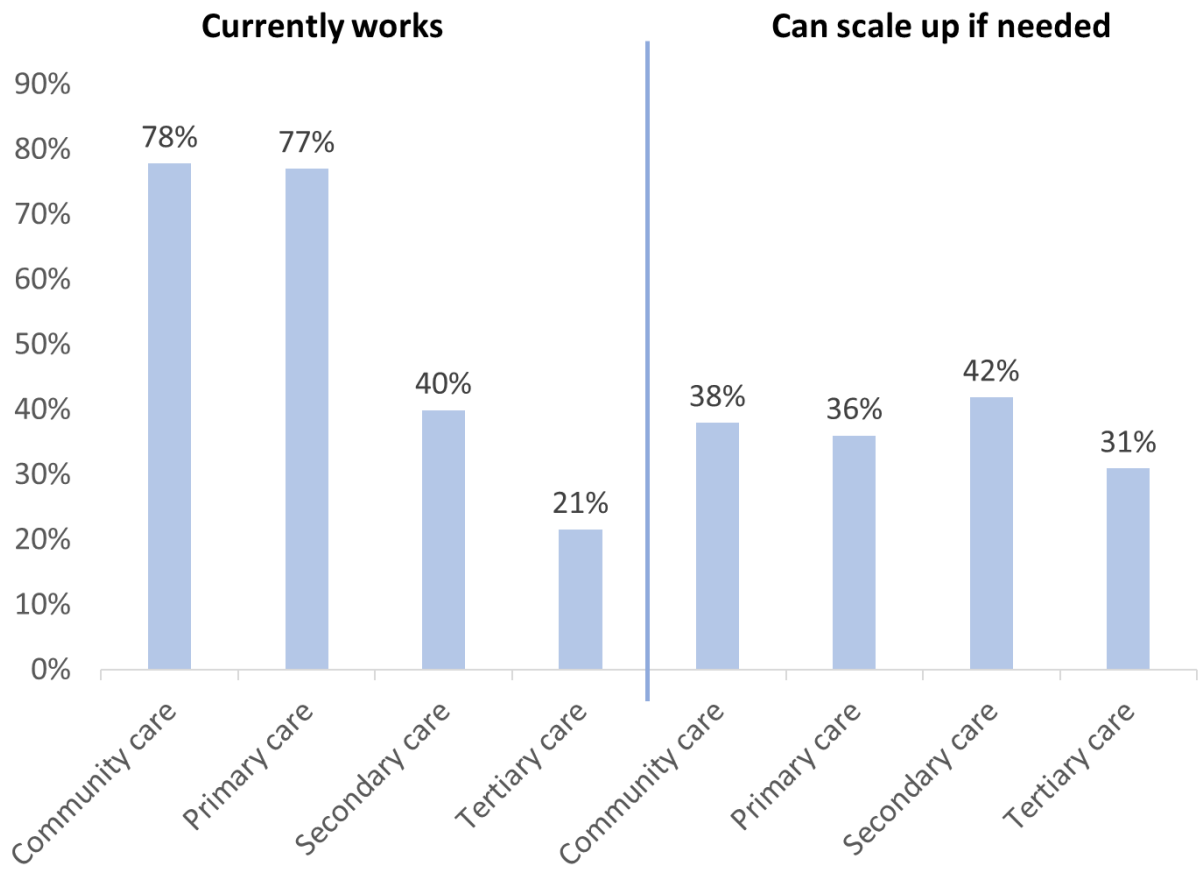


Figure 14. Level of health care system organization

6. 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.

6.1 Community care (overview)

The majority of respondents reported offering community care services (Figure 15) pertaining to communicable diseases (77%) and child health (75%).

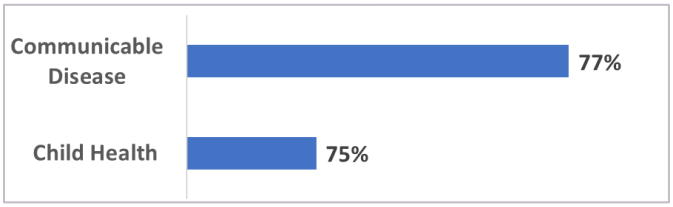


Figure 15. Services offered: community care, overview

a. Child health (community care)

Within child health related services, 63% of national partners offer screening of acute malnutrition and 60% offer integrated community case management (ICCM). It remains concerning that only 60% of respondents provide ICCM given the importance of community work to reduce mortality of under-fives [6].

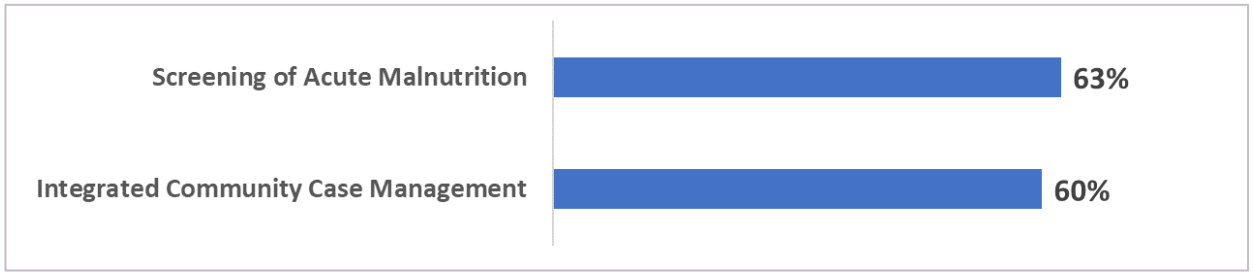


Figure 16. Services offered: child health (community care)

[6] World Health Organization, 2012. WHO/UNICEF Joint Statement Integrated Community Case Management (iCCM). *An Equity-Focused Strategy to Improve Access to Essential Treatment Services for Children. Geneva and New York: iCCM*, pp.1-7.

b. Communicable diseases (community care)

Over two-thirds of respondents offer community mobilization services (69%) and 60% provide IEC on early identification and referral of locally priority disease[7,8]. With 39%, the proportion of partners offering vector control services is concerning.

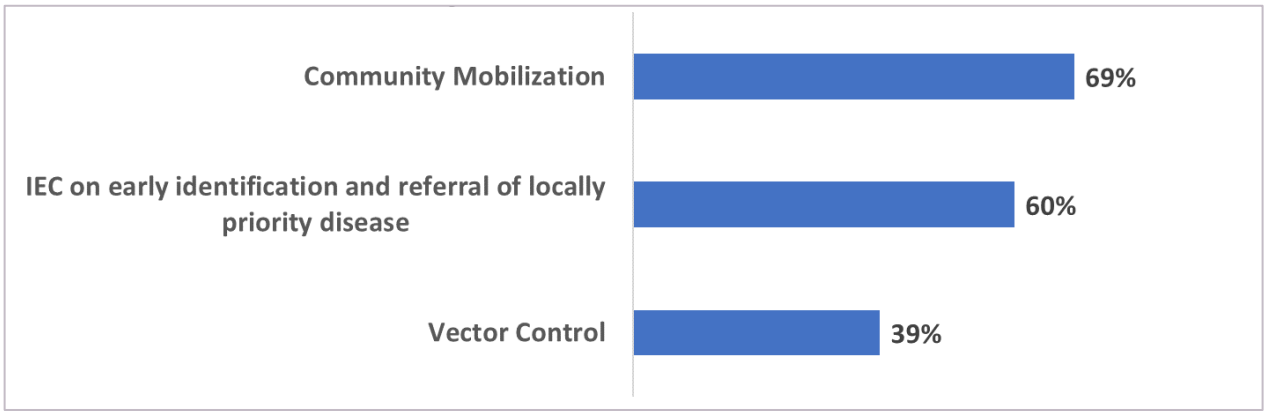


Figure 17. Services offered: communicable disease (community care)

[7] World Health Organization, 2016. Health Resources Availability Mapping System (HeRAMS).
[8] Diseases that pose a public health risk because of their epidemic potential. Source: https://www.who.int/blueprint/priority-diseases/en/

6.2 Primary health care (overview)

The top services offered by the respondents are related to child health (80%), maternal and newborn health (79%) as well as general clinical services and essential trauma care (75%). On the other hand, services related to STIs & HIV/AIDS (56%), sexual violence (55%) and environmental health (52%) are only provided by about half of the respondents. Furthermore, a concerningly low proportion of partners offer services specifically addressed to older people (32%).

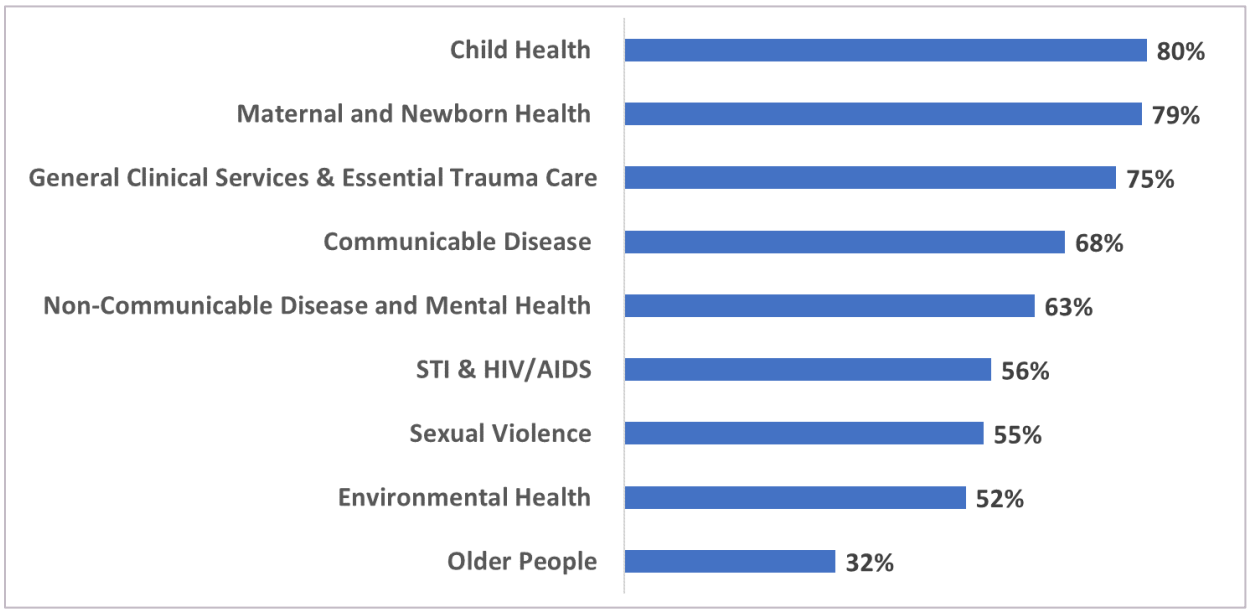


Figure 18. Services offered: primary care, overview

The following chart provides a breakdown of services at the primary health care level by type of organization. The provision of services represented in Figure 19 seems to be evenly distributed across types of organizations. That is to say, the proportion of types of partners offering these services is consistent with the proportion of national, local and Red Cross/Crescent NGOs represented in our sample (Figure 1).

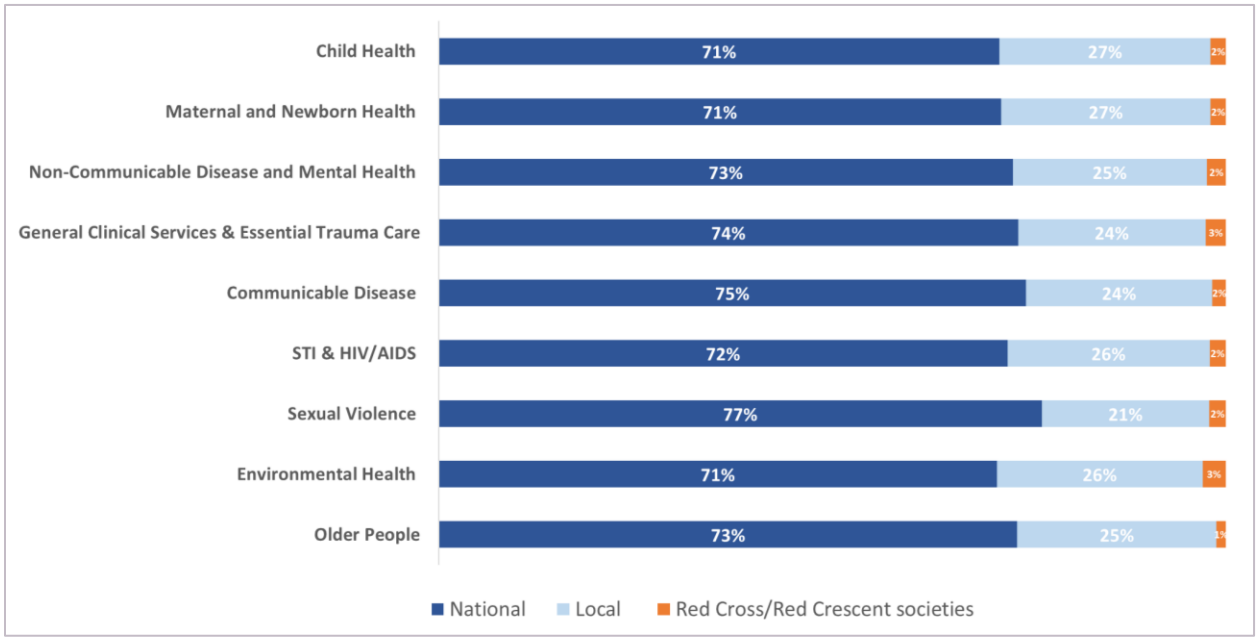


Figure 19. National, local and Red Cross provision of services (primary care)

a. General clinical services & essential trauma care (primary care)

For general clinical services at the primary care level, just over half of the respondents (53%) reported providing laboratory services. This is particularly concerning because it is a cornerstone of accurately diagnosing and controlling communicable diseases.

Figure 20. Services offered: general clinical services and essential trauma care (primary care)

b. Child health (primary care)

For child health services, over half of the partners offer screening of acute malnutrition (64%), CMAM outreach activities to village sites (60%) and outpatient treatment (52%). Less than half of respondents offer Basic Child Care (IMCI). There is a concerning gap between capacity for the latter and Integrated Community Case Management (ICCM) (Figure 16).

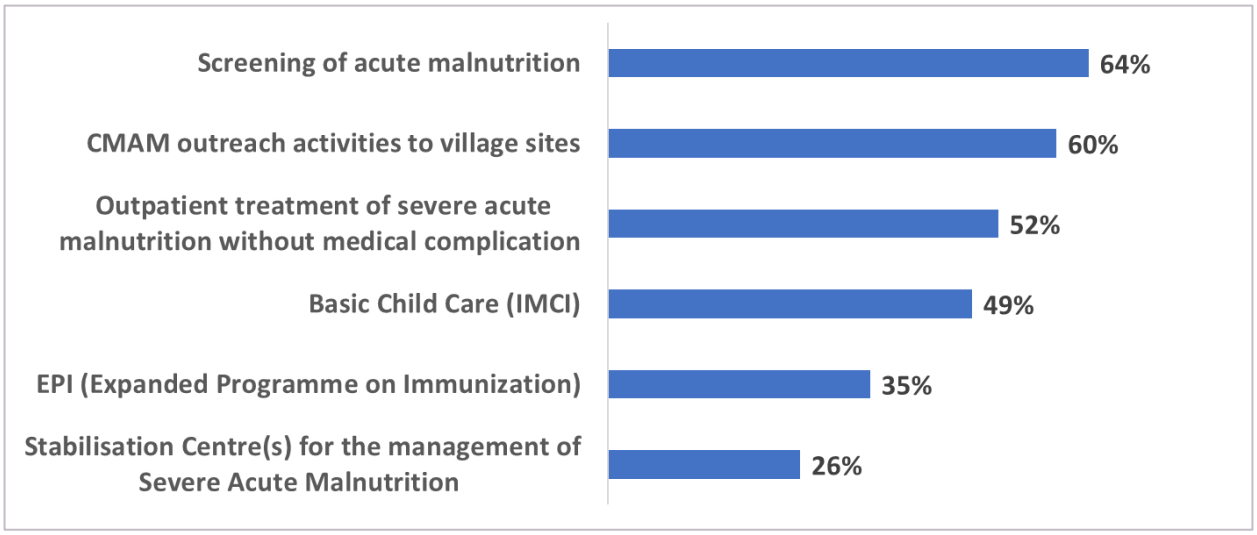


Figure 21. Services offered: child health (primary care)

c. Communicable diseases (primary care)

Overall, the provision of services pertaining to communicable diseases at the primary health care level is unsatisfactory and requires immediate attention. Although 77% of respondents reported offering primary health care services, only 56% participate in EWAR. Nearly half of respondents offer diagnosis and treatment of malaria (45%), but fewer offer services for cholera (34%), tuberculosis (21%), neglected tropical diseases (20%) and viral hemorrhagic fevers (18%).

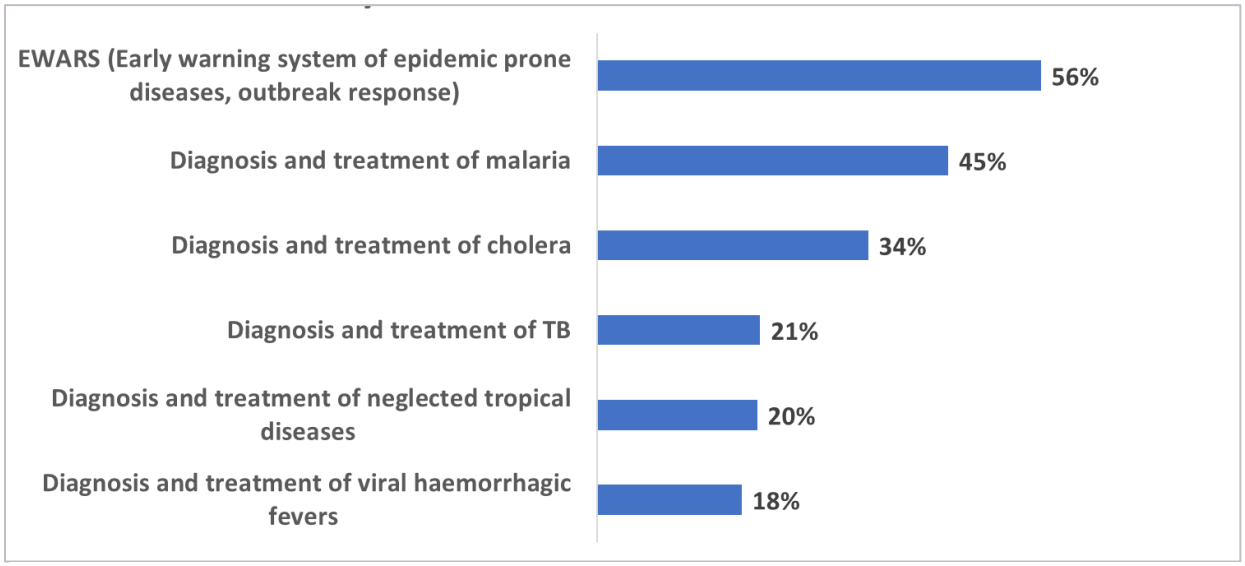


Figure 22. Services offered: communicable disease (primary care)

d. STI & HIV/AIDS (primary care)

While close to half of the partners provide HIV counselling and testing services (42%), just over a quarter of them offer antiretroviral treatment (14%). This considerable gap along the HIV testing and treatment cascade requires immediate attention as the WHO strongly recommends the testing and treatment of patients to be closely linked[9]. However, it is important to highlight that a UNAIDS report on HIV/AIDS[10] has also observed this pattern at a global level. The unavailability of drugs in emergency settings may have further exacerbated this gap.

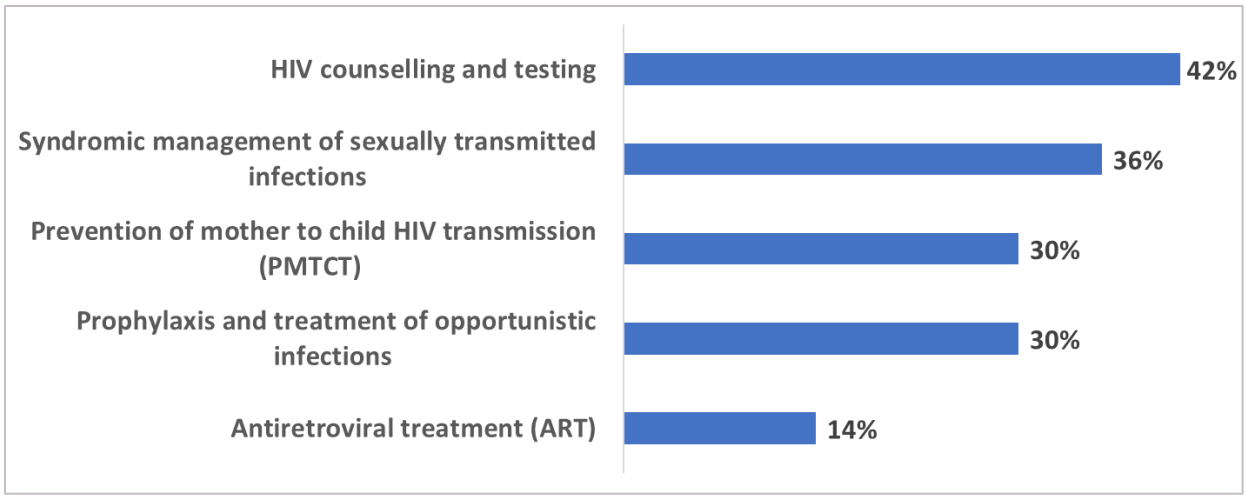


Figure 23. Services offered: STI & HIV/AIDS (primary care)

[9] Sphere Project, 2011, *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response,* Belmon Press Ltd, Northhampton.
[10] UNAIDS, 2018. *Knowledge is power - Know your status, know your viral load*. Geneva. Available at: https://www.unaids.org/sites/default/files/media_asset/jc2940_knowledge-is-power-report_en.pdf [Accessed 5 Sep. 2019].

e. Maternal and newborn health (primary care)

In maternal and newborn care, over half of the respondents offer family planning (67%) and antenatal care (64%). Half of the respondents offer essential newborn care (50%) and skilled care during childbirth (50%). Only 48% of respondents provide post-partum care and 43% provide basic emergency obstetric care (BEOC), despite the importance of these services in reducing maternal and newborn mortality rates[11]. Furthermore, only a quarter (25%) of respondents provide comprehensive abortion care, which may reflect influencing factors including the legal status of abortion in respective countries and cultural taboos[12]. Overall, these results are unsatisfactory and require immediate attention.

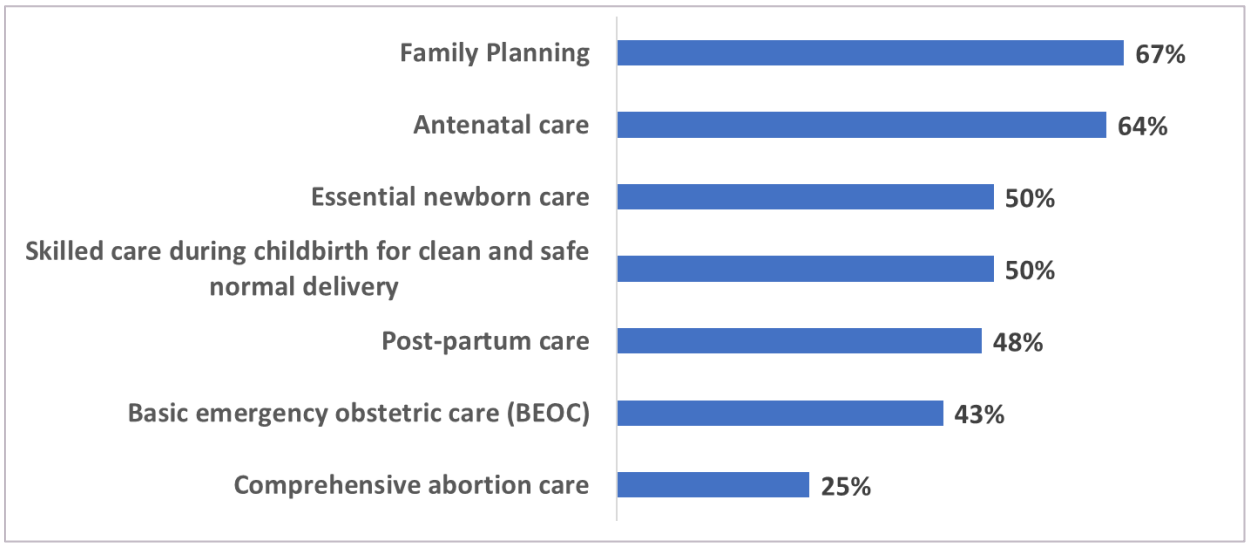


Figure 24. Services offered: maternal and newborn health (primary care)

[11] IAWG, Inter-agency Working Group on Reproductive Health in Crises, 2018. 'Maternal and Newborn Health', in IWAG (ed.) *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. Geneva: United Nations.
[12] IAWG, Inter-agency Working Group on Reproductive Health in Crises, 2018. 'Comprehensive Abortion Care', in IWAG (ed.) *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. Geneva: United Nations.

f. Sexual violence (primary care)

There is a concerning gap between the proportion of partners providing services in clinical management of rape (CMR) (43%) and those who provide emergency contraception (36%) and post-exposure prophylaxis (PEP) (30%). This requires immediate attention.

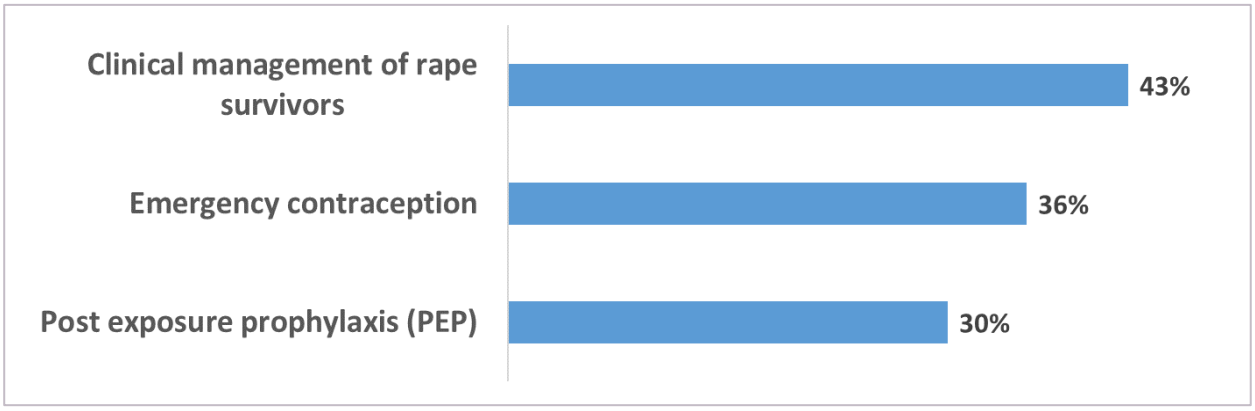


Figure 25. Services offered: sexual violence (primary care)

g. Non-communicable diseases and mental health (primary care)

Two thirds of respondents provide psychosocial support (66%), about half provide treatment for high blood pressure and cardiovascular diseases (52%), 48% provide diabetes treatment and 39% provide mental health care. The rates of provision for psychosocial treatment (66%) and mental health are concerning.

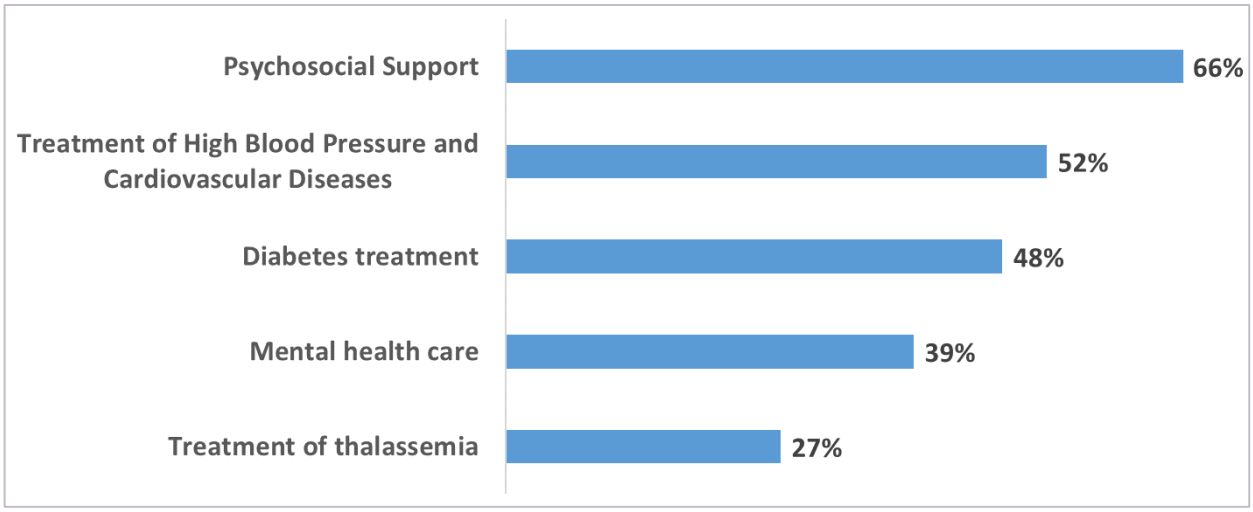


Figure 26. Services offered: non-communicable disease and mental health (primary care)

h. Environmental health (primary care)

Just over half of the respondents offer health facility safe waste disposal and management (52%). This is particularly concerning and raises important questions on quality of care in humanitarian settings.

Figure 27. Services offered: environmental health (primary care)

i. Older people's health (primary care)

As previously stated, a concerningly low proportion of national partners offer services specifically addressed the needs of older people (32%).

Figure 28. Services offered: older people's health (primary care)

6.3 Secondary health care (overview)

At the secondary health care level, over half of the respondents (66%) reported providing non-communicable disease and mental health (66%), followed by general clinical services and essential trauma care (63%), child health (48%) and maternal and newborn care (31%) (Figure 29).

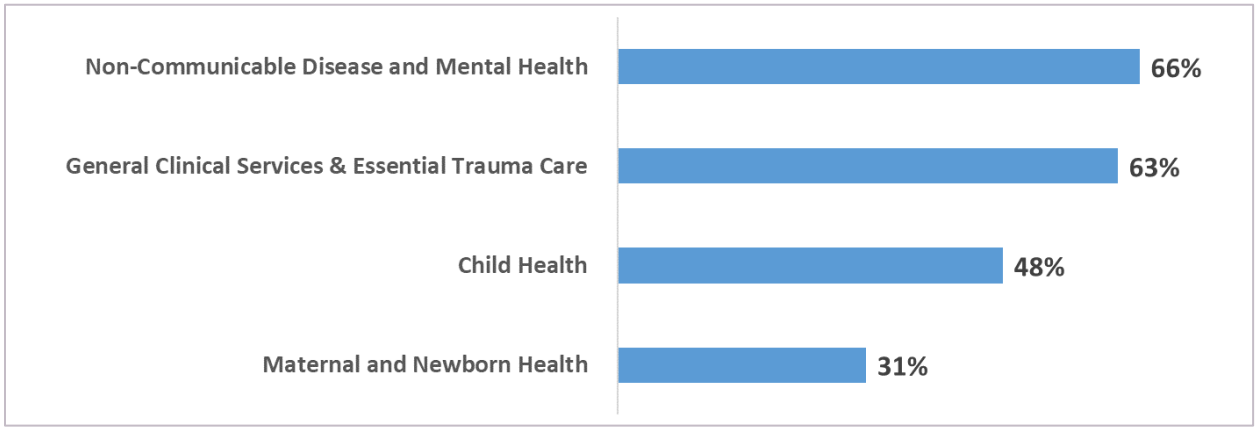


Figure 29. Services offered: secondary care, overview

The chart below provides a breakdown of these services by type of organization. The provision of services represented in Figure 30 seems to be evenly distributed across types of organizations. In fact, the proportion of types of partners offering these services is consistent with the proportion of national, local and Red Cross/Crescent NGOs represented in our sample (Figure 1).

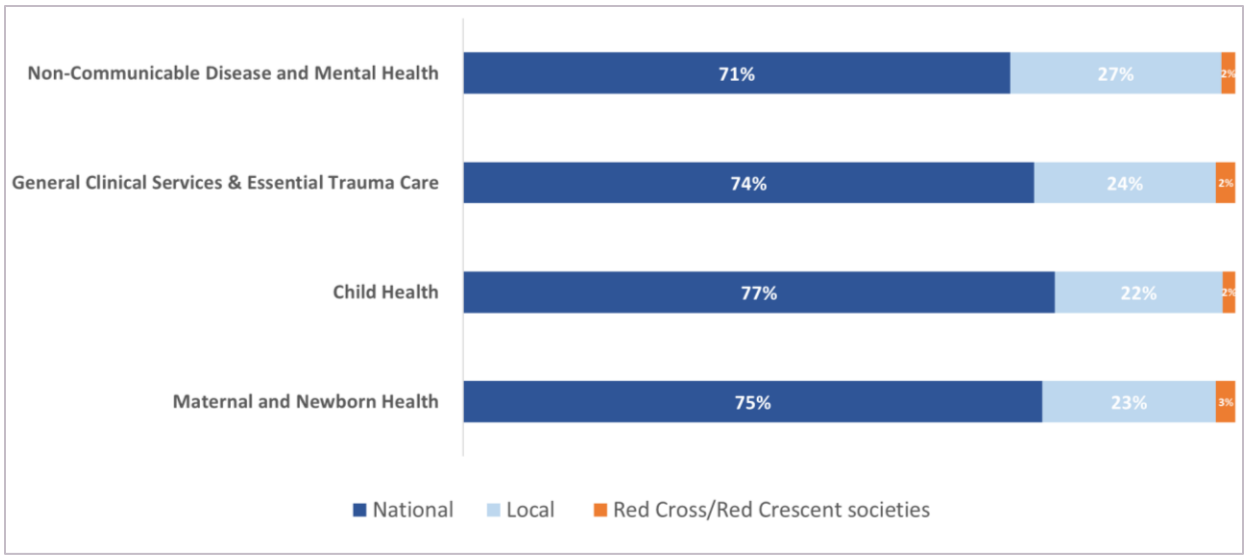


Figure 30. National, local and Red Cross provision of services (secondary care)

a. General clinical services & essential trauma care (secondary care)

It is encouraging that nearly half of the respondents reported offering laboratory services (43%) and inpatient services (41%). However, blood bank services remain strikingly low (13%). Furthermore, the low rates of service provision for post-operative care (27%), trauma and surgical care (25%), as well as post-surgery rehabilitation (25%) indicate that the majority of demands for surgery in emergencies may continue to fall upon a limited number of national NGOs and the national health system.

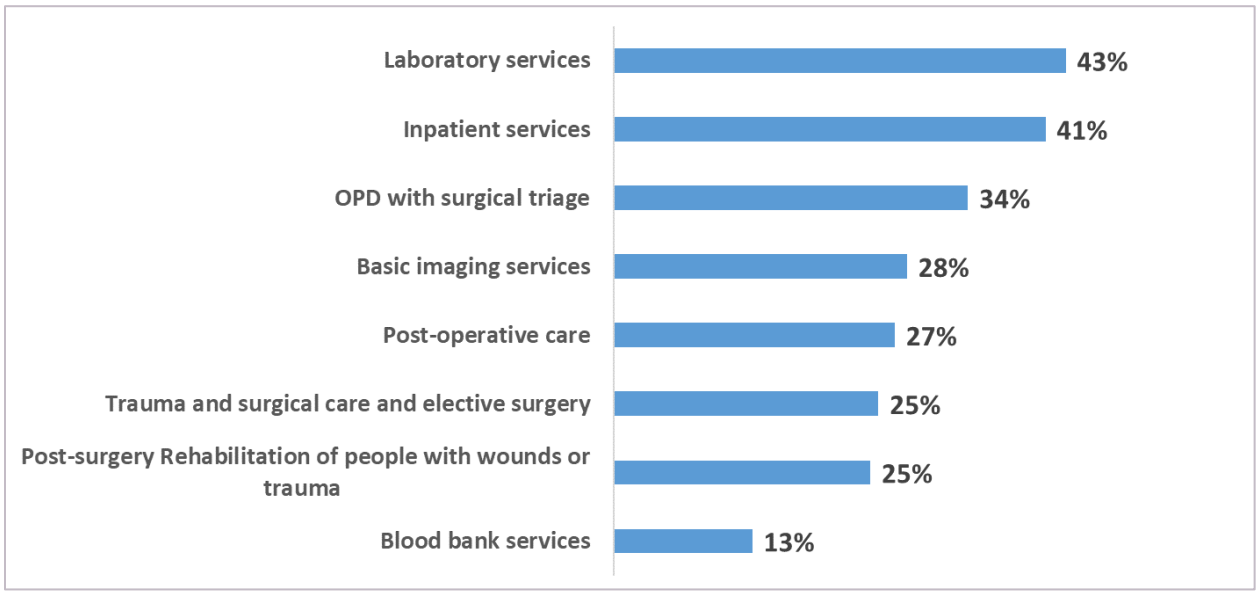


Figure 31. Services offered: general clinical services and essential trauma care (secondary care)

b. Child health (secondary care)

Rates of provision of secondary health care pertaining to child health are concerningly low. For child health services, less than half of the respondents (41%) reported offering services to manage severe and very severe child illnesses. A quarter (25%) reported offering stabilization centers for inpatient management of severe acute malnutrition (Figure 32). As mentioned in assumptions, further investigation is required to determine whether these rates may have been caused by the presence of partners not requiring this type of services in the pool of respondents.

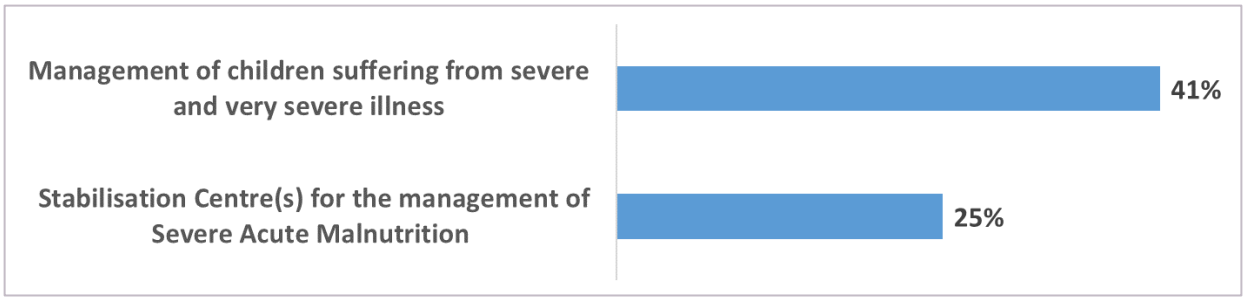


Figure 32. Services offered: child health (secondary care)

c. Maternal and newborn health (secondary care)

It is concerning that just over a third of respondents (31%) reported offering comprehensive emergency obstetric care. This result is concerning as it is essential to provide these interventions to women experiencing complications during child birth to reduce maternal and neonatal death[13]. This requires immediate attention.

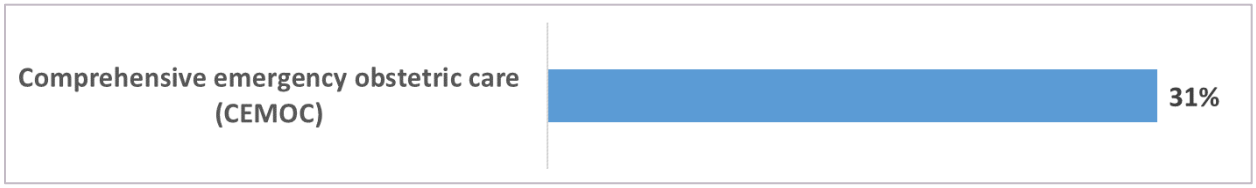


Figure 33. Services offered: maternal and newborn health (secondary care)

[13] World Health Organization and UNICEF, 2009. *Monitoring emergency obstetric care: a handbook*.

d. Non-communicable diseases and mental health (secondary care)

Overall, it is concerning that provision of services at the secondary care level for NCDs and mental health remain low. It is also alarming that while 66% of respondents provide psychosocial support at the primary health care level, 38% of psychiatric care pertains to outpatient services and only 9% to inpatient services at the secondary health care level. This requires immediate attention.

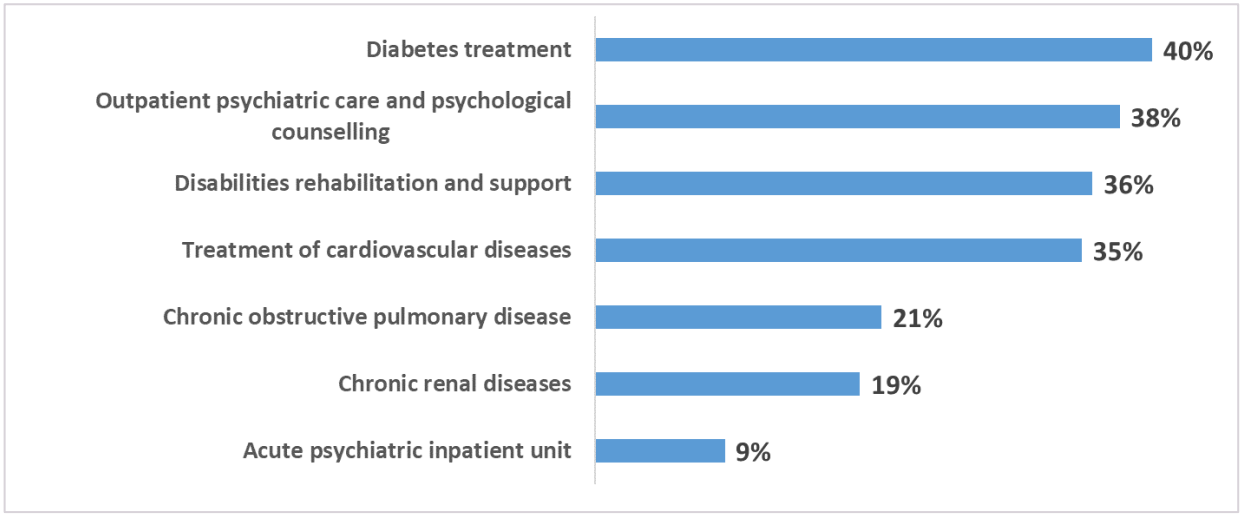


Figure 34. Services offered: non-communicable disease and mental health (secondary care)

6.4 Tertiary health care

A third of respondents reported providing some type of tertiary care services, revealing relatively high rates. It is important to highlight that these results may have been influenced by national variations in classification between primary, secondary and tertiary health care services.

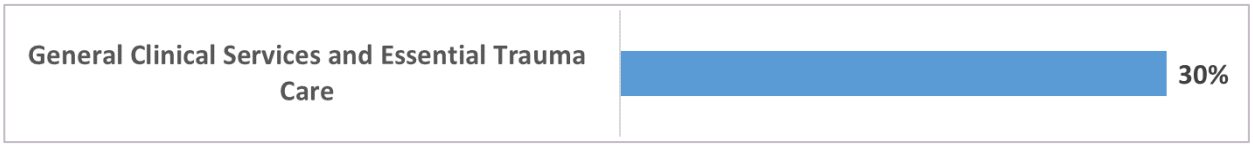


Figure 35. Services offered: tertiary care, overview

The following chart provides a breakdown of services offered at the tertiary health care level by type of organization. The proportion of types of partners offering these services mirrors the proportion of national, local and Red Cross/Crescent NGOs represented in our sample. However, it is noticeable that there is a slight reduction in the involvement of national NGOs at the tertiary level compared to the primary and secondary levels.

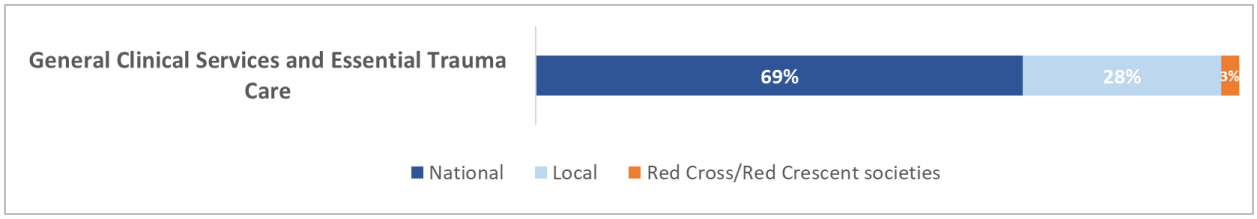


Figure 36. National, local and Red Cross provision of services (tertiary care)

Trauma and surgical care, and elective surgery is the most common service (19%) provided as part of tertiary health care, followed by intensive care unit (18%) and X-ray, echography and RMG (17%). Few organizations declared providing specialized trauma and surgical services (14%).

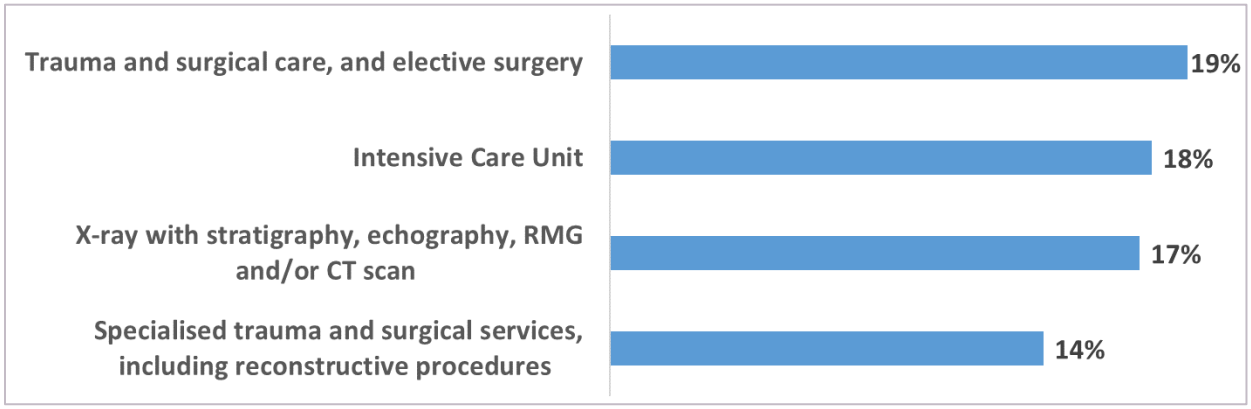


Figure 37. Services offered: general clinical services and essential trauma care (tertiary care)

7. Organizational surge capacity, by type and specialty

Partners were asked to provide an estimate number of people available to be deployed. A majority of the national surge capacity is provided by the Red Cross/ Red Crescent society (923), followed by national (601) and local partners (307).

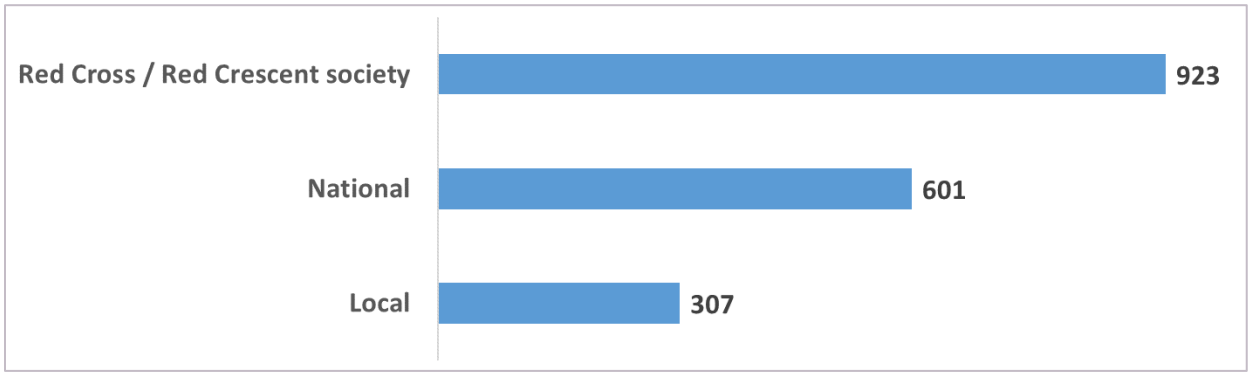


Figure 38. Average surge capacity by type of organization

Organizations were also asked to indicate their surge deployment capacity by specialty. The graph below (Figure 39) shows the combined, estimated surge deployment capacity by specialty, cumulative over response timeline in accordance with the WHO Emergency Response Framework[14].

The results show that, during the first 24-72h, surge capacity is the highest in Programme Management, M&E and Data Management. Beyond 72h, Community Engagement and Communications is the specialty with the greatest surge capacity. It is notable that Clinical staff and Operational support have comparatively low surge capacities, which may indicate difficulties in finding medical staff and resources.

Results should be read against the background of the data represented in Figure 38, which indicates that national Red Cross/Red Crescent societies carry a large proportion of the national surge capacity. Surge capacity may seem high at first glance because the surge capacity of the Red Cross/Red Crescent, national and local partners have been aggregated.

[14] World Health Organization, 2017. *Emergency response framework (ERF)*. 2nd ed. Geneva: World Health Organization

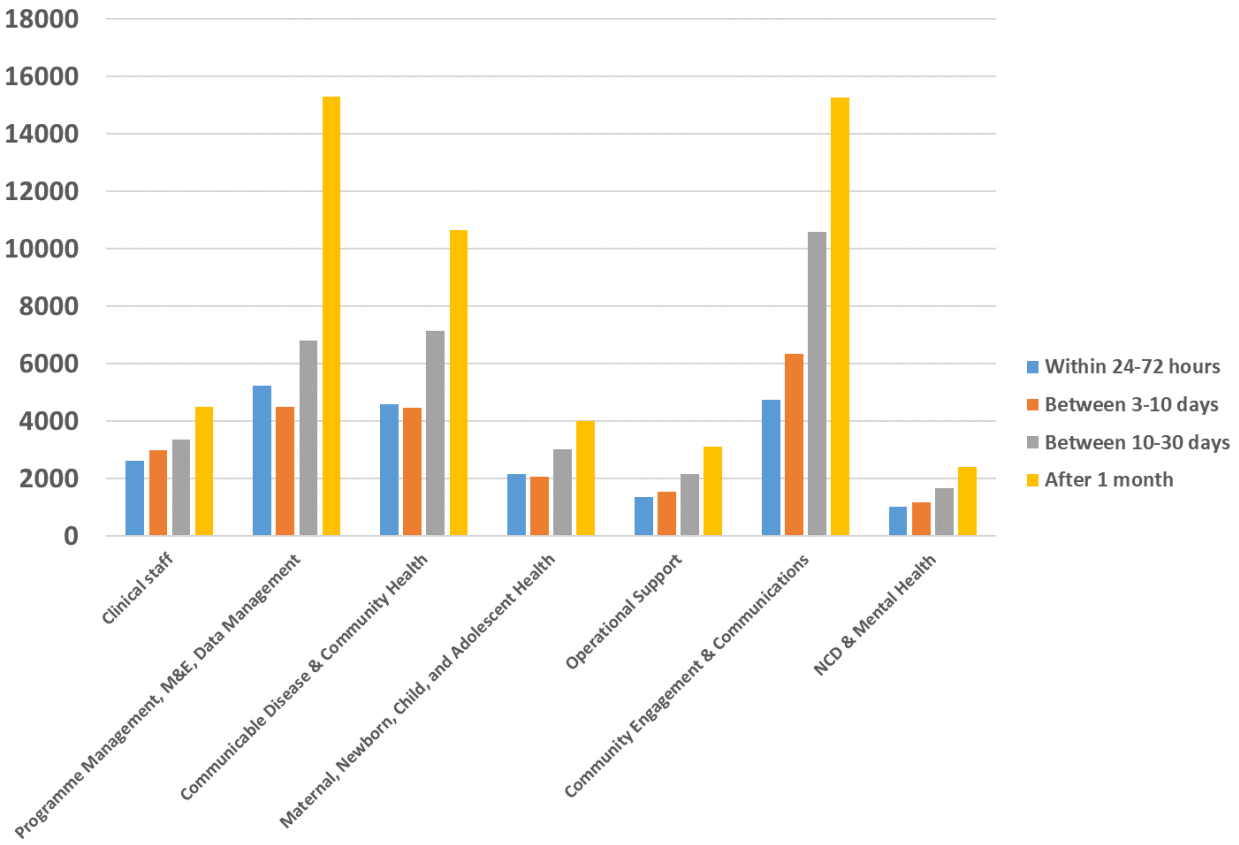


Figure 39. Surge deployment capacity by specialty over response timeline

8. Organizational surge capacity type

Partners were asked to provide information about the type of surge capacity within their organizations. Table 1 below identifies the number of organization for each organizational surge capacity type.

Organizational Surge Capacity Type	Number	Percentage
Individual staff deployed through your organization internal roster	205	80%
Stand-by partner	129	50%
Willing to collaborate with WHO's Standby Partnerships[15] based on the national/local capacity	126	49%
Willing to collaborate through the SBP Agreement[16]	126	49%
Organizational surge capacity include emergency medical teams (EMTs)[17]	165	64%

Table 2. Organizational surge capacity by type.

With reference to the surge capacity provided through EMTs, partners were then asked to specify their level of capacity and specialism (Table 3). 29 national NGOs, 7 local NGOs and 1 Red Cross / Red Crescent Society responded to the question pertaining to types of specialist EMTs within organizations. It is noticeable that when emergency medical teams are included in organizations' surge capacity most are Type 1 teams (85%) and the majority tackle maternal, newborn and child health (86%).

[15] The term Standby Partnership (SBP) refers to a network of bilateral agreements between organizations and United Nations (UN) agencies. The partnership commenced in 1991 in response to the humanitarian crisis in Iraq where it was necessary for the United Nations (UN) to rapidly increase its human resources at short notice. Today it comprises a range of partners which provide support to UN agencies responding to humanitarian emergencies throughout the world via the secondment of gratis personnel. Each Standby Partner maintains its own roster of humanitarian experts who are called upon to fill staffing needs and gaps in UN operations.

[16] Standby Partnership (SBP) agreements enable an organization to partner with WHO and deploy through their internal/external roster during an emergency (preparedness and response). The costs for these deployments, which are for a duration typically for 3-6 months, are borne by the partner organization, while WHO provides for logistical support on the ground to facilitate the deployment. For more details, log on to https://www.who.int/hac/standby_partnerships/en/ and/or contact Ms Indu Ahluwalia at ajaygautami@who.int.

[17] Emergency Medical Teams (EMTs) are groups of health professionals providing direct clinical care to populations affected by disasters, outbreaks and/or other emergencies as a surge capacity to support the local health system

Level of capacity	Number	Percentage
Organizational surge capacity includes emergency medical teams (EMTs)	165	64%
Capacity of EMTs (N = 165)		
None of the below/Not applicable	16	10%
Type 1: fixed or mobile Outpatient Emergency Care (initial emergency care of injuries and other significant health care needs)	141	85%
Type 2: Inpatient Surgical Emergency Care (inpatient acute care, general and obstetric surgery for trauma and other major conditions)	49	30%
Type 3: Inpatient Referral Care (complex inpatient referral surgical care including intensive care capacity)	55	33%
Specialist team	37	22%
Types of specialist EMTs that organizations operate (N = 37)		
Dialysis and care for crush syndrome	7	19%
Maxilla-facial surgery	4	11%
Ortho-plastic surgery	7	19%
Burns care team	17	46%
Intensive Rehabilitation	14	38%
Maternal, newborn and child health	32	86%
Outbreak clinical care team	18	49%
Other type of specialized clinical care, please specify	7	19%

Table 3. Organizational surge capacity involving emergency medical teams

9. Estimated population 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[18]. Within 72h, a large majority of respondents could only assist between 10,000 and 20,000 people. Over time, the number of people that organizations can help grows exponentially.

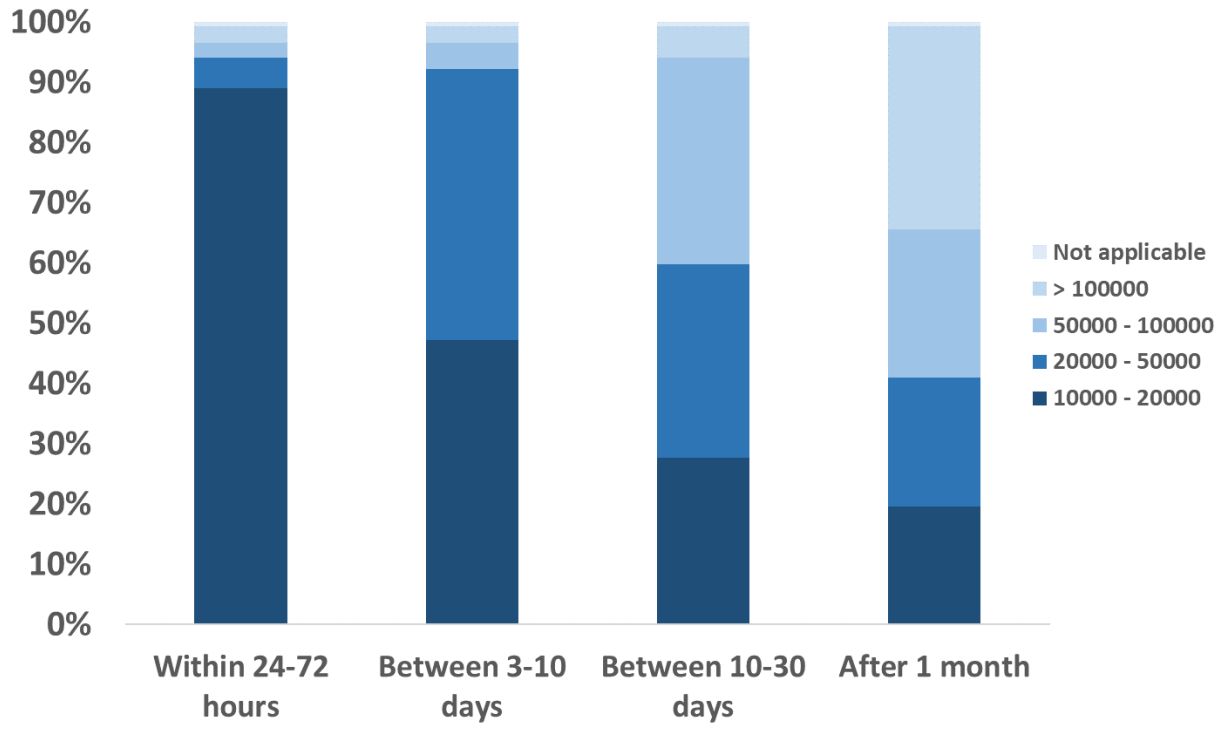


Figure 40. Estimated population that can be helped over response timeline

[18] World Health Organization, 2017. *Emergency response framework (ERF)*. 2nd ed. Geneva: World Health Organization

10. Surge capacity in support of Health Cluster coordination functions

Respondents were asked whether they ever supported Health Cluster Coordinator functions at national or subnational level. Nearly two thirds of our total sample (68%) indicated having previously supported a Cluster Coordinator function, while just over half (58%) supported an Information Management function.

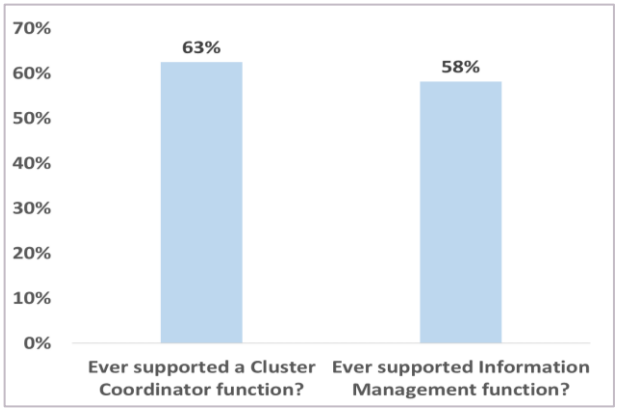


Figure 41. Support of Health Cluster Coordination functions

These results appear inconsistent with other available data, such as the Health Cluster Dashboard as of June 2019. This may be due to varying interpretations of the terms "surge" and "support", which may have been understood as meaning proactive engagement with the Health Cluster rather than actual support of a Health Cluster Coordinator or Information Management function.

11. Logistic support

Respondents were asked to indicate ownership of material and supplies needed for response. It is concerning that nearly half (47%) of respondents do not have their own stock of material and supplies to respond to emergencies.

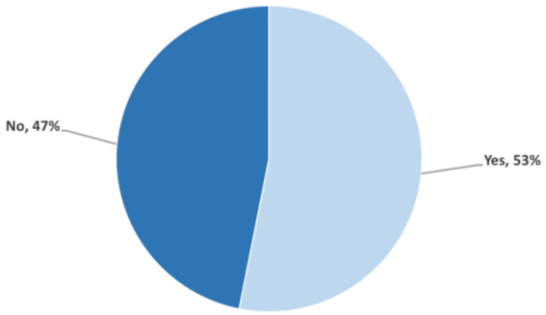


Figure 42. Proportion of respondents owning material and supplies

12. Intervention modalities

Respondents were asked what proportion of their funding is allocated to a variety of emergency health activities. On average, the respondents allocated 45% of their funding to direct service provision, followed by communication with the community (21%) and capacity building (19%).

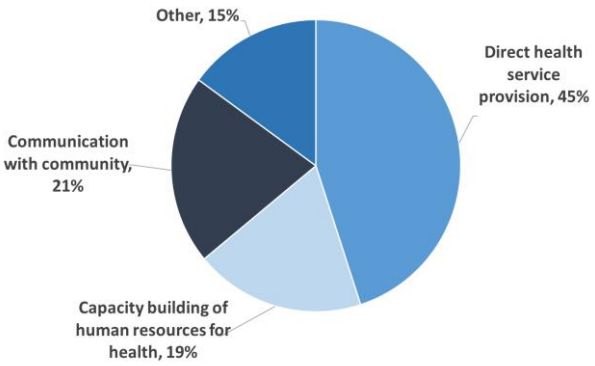


Figure 43. Proportion of funding by emergency health activity

13. Funding

Participants were asked to provide an estimate of their organizations' total income during the last financial year. The results shown in Figure 44 indicate that most national partners receive either up to USD $100,000 or over $1 million. It is also notable that a third of participants preferred not to answer this question.

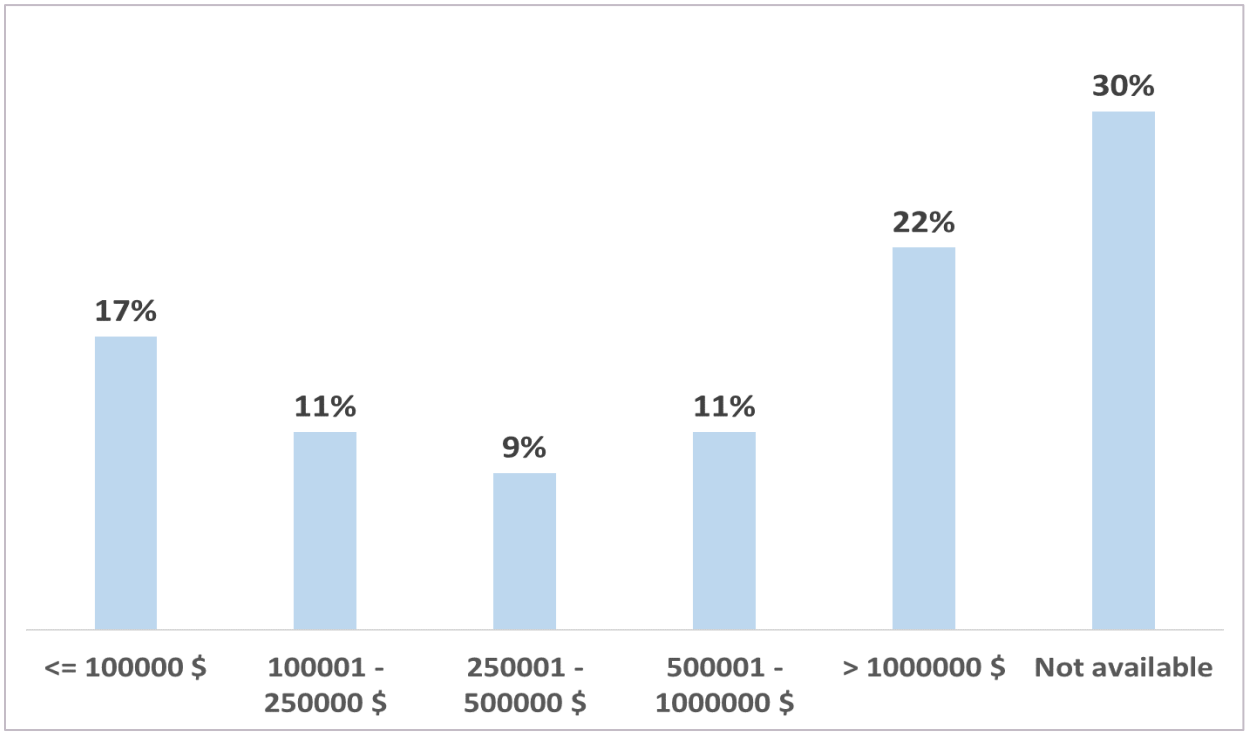


Figure 44. Funding: estimated total income during the last financial year

However, a further breakdown by type of organization shows differing funding patterns between national and local NGOs (Figure 45).

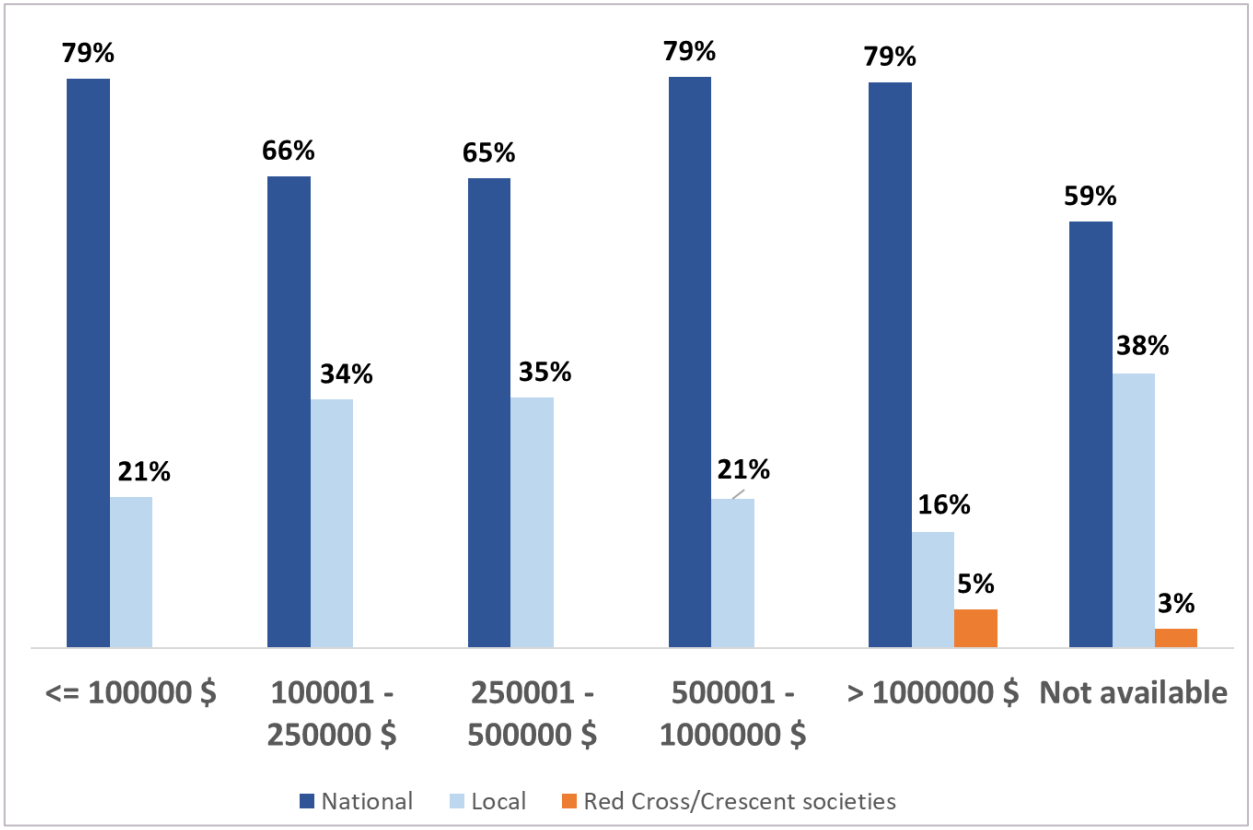


Figure 45. Funding: estimated total income during the last financial year by type of organization

They were then asked to identify the organizations from which they receive a proportion of their funding. The largest proportion of funds is provided by UN Agencies (36%), followed by international NGOs (23%) and private donors (19%). Although to a smaller extent, national NGOs (5%) and governments (4%) also contribute to funding national partners.

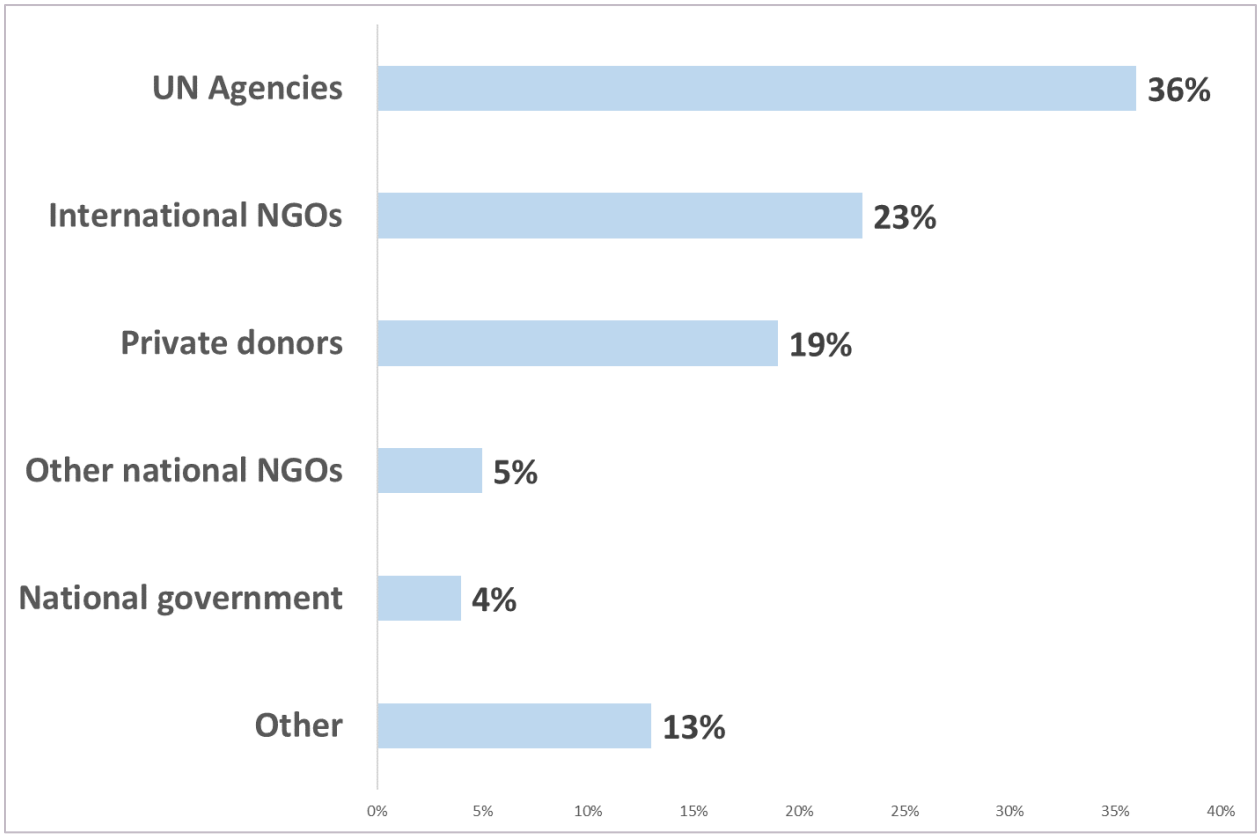


Figure 46. Funding: origin of funds

14. Partnerships with International NGOs

Respondents were asked whether their organization currently has partnerships with international NGOs. Only a third (30%) of participants indicated having such partnerships. Among those who declared having at least one, a large majority of them identified their partnerships as relating to material and equipment provision (90%). As shown in Figure 48, funding provisions characterize 63% of partnerships, while capacity building represents 42%.

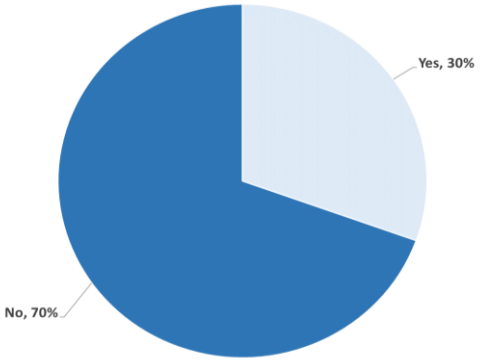


Figure 47. Partnerships with international NGOs

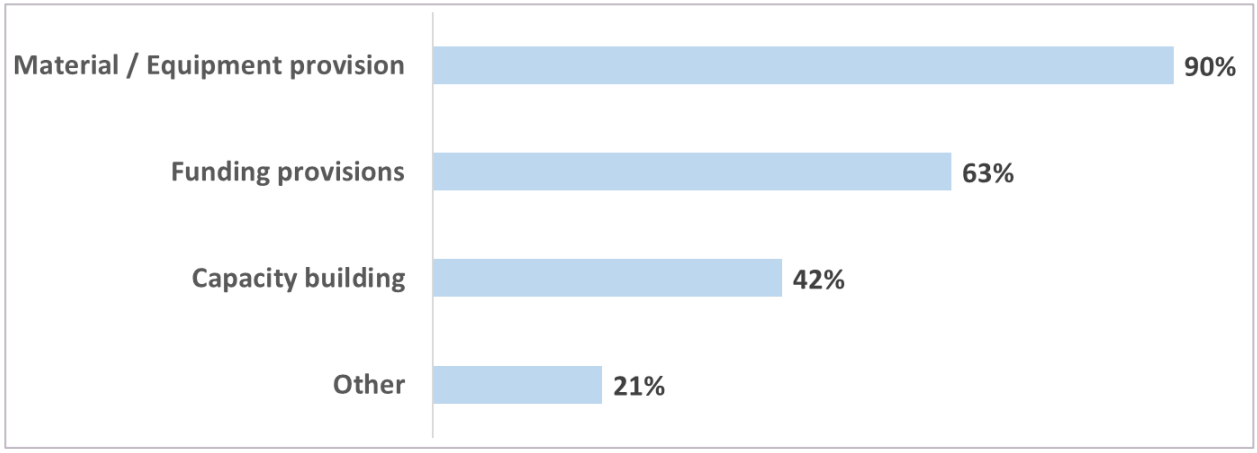


Figure 48. Partnerships with international NGOs by type

15. Humanitarian principles

Respondents were asked to rate their understanding of the four core humanitarian principles: humanity, neutrality, impartiality and independence. These results are encouraging as a large majority (90%) of respondents fully understands the core humanitarian principles. Furthermore, around 65% would be able to train others.

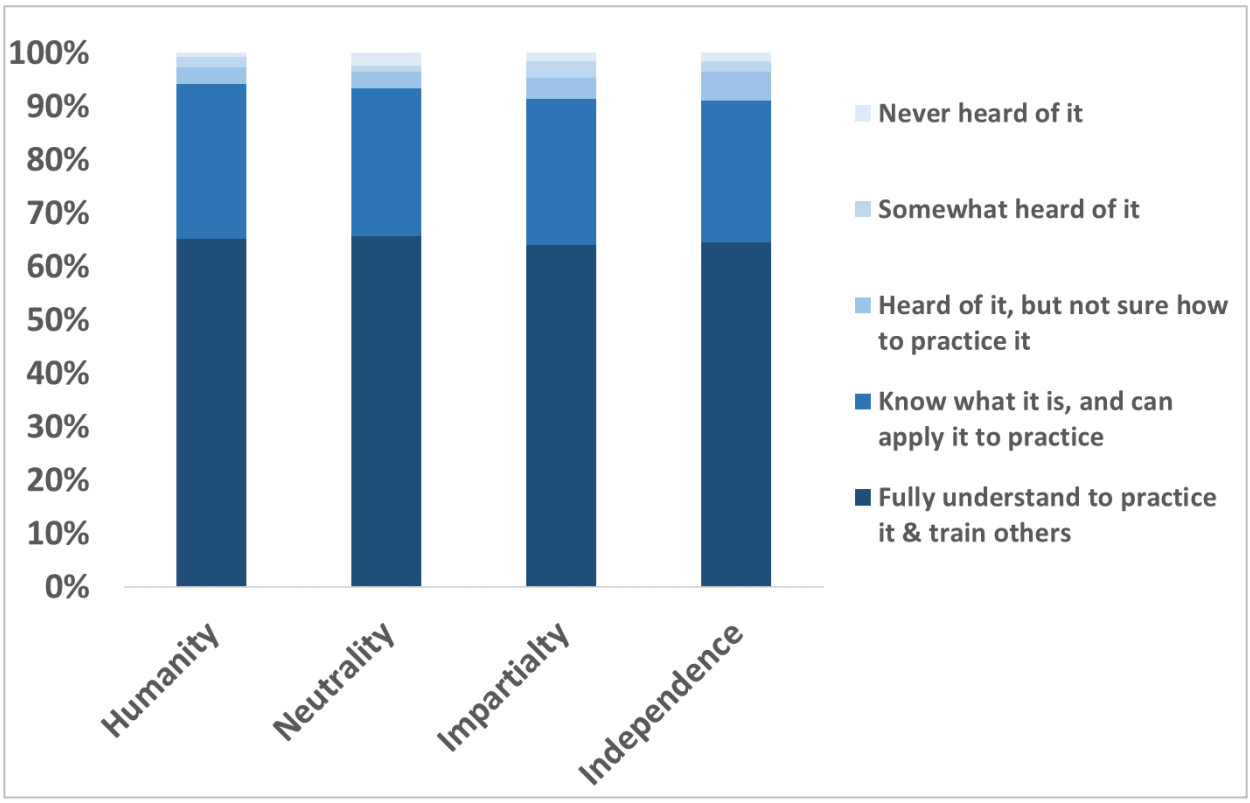


Figure 49. Level of understanding on humanitarian principles

16. Barriers to engagement

Respondents were asked to indicate which barriers have an impact on the speed, scope and scale of their organization's intervention. The top 3 barriers to engagement pertain to concern with low institutional funding pipeline (77%), insufficient organizational seed funding (69%) and inadequate logistics and medical logistics systems (59%).

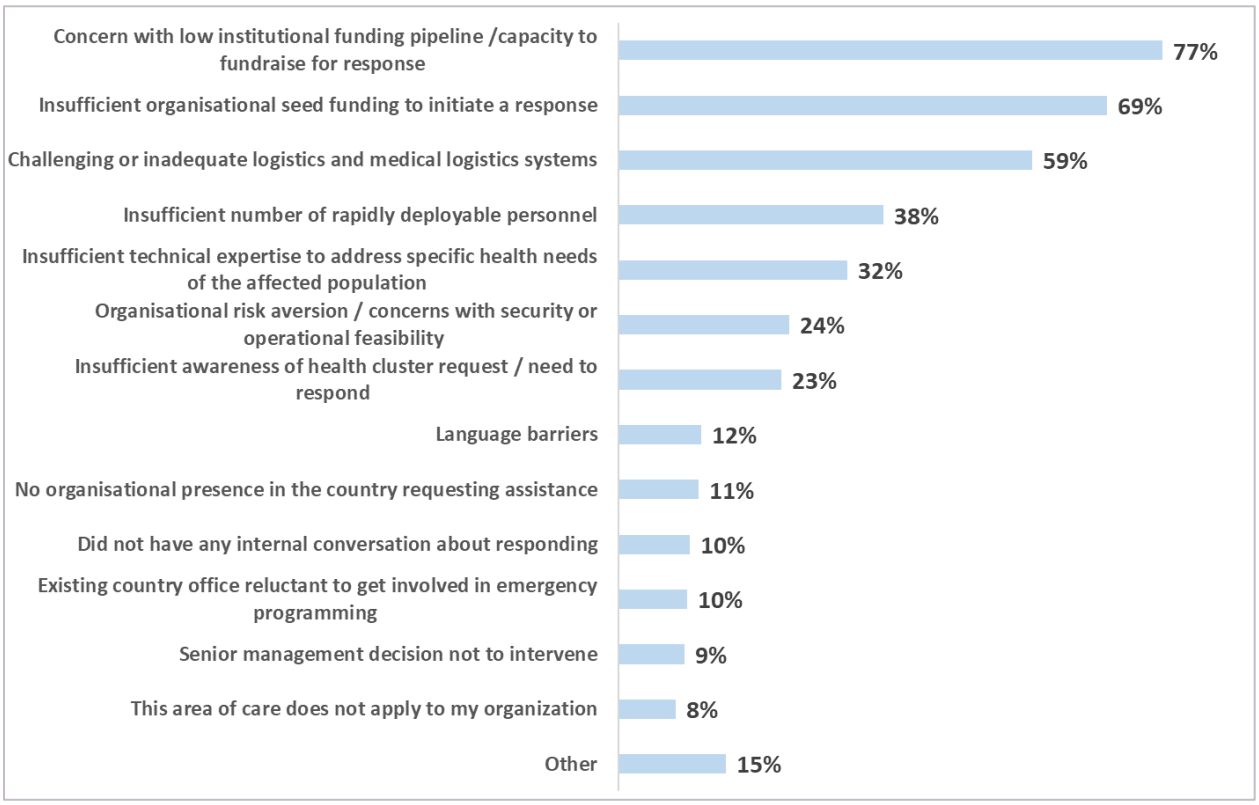


Figure 50. Barriers to engagement: impact on speed, scope and scale of intervention

17. Awareness of the Grand Bargain

The Grand Bargain is an agreement between donors and humanitarian agencies that came out of the 2016 World Humanitarian Summit. It aims to improve the effectiveness and efficiency of humanitarian action and signatories to the Grand Bargain have agreed on a set of commitments to achieve this, including enhancing engagement and support of national organizations in humanitarian response.

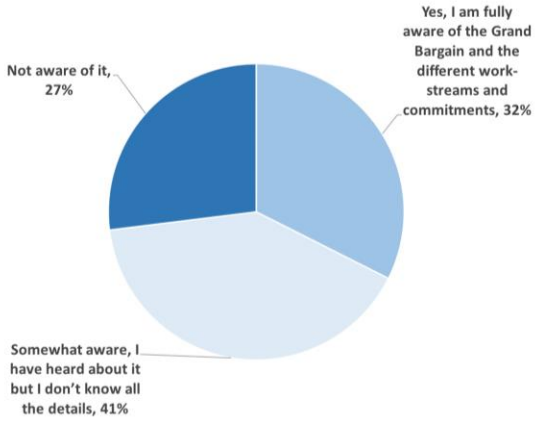


Figure 51. Awareness of the Grand Bargain

Respondents were asked to evaluate their knowledge of the Grand Bargain. The majority of respondents (41%) had heard about the Grand Bargain without knowing the details and a third (32%) indicated being fully aware of its different work-streams and commitments. Almost a third of participants (27%) are not aware of this agreement. A further breakdown by type

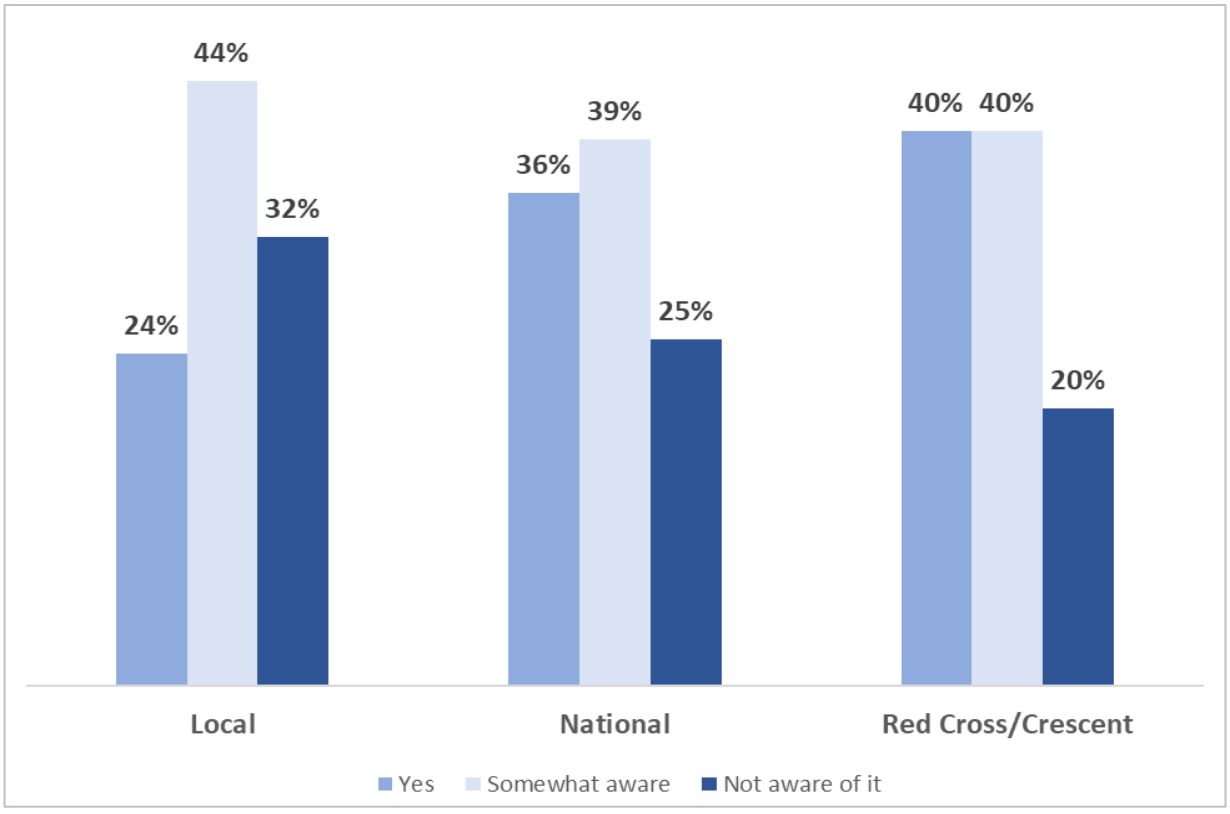


Figure 52. Awareness of the Grand Bargain by type of organization

of organizations indicates a similar pattern across local and national NGOs, with most respondents declaring being somewhat aware of the Grand Bargain (Figure 52).

These results are broadly consistent with the WHO Localisation Analysis 2016-2017 (conducted in 2018). Of the 10 WHO country offices that responded (out of the 30 surveyed), 71% were aware of the Grand Bargain, although only 36% said that they were already engaged in Grand Bargain activities. It is important to note that this distribution may be the result of varying levels of exposure to the Grand Bargain, which has been piloted by some countries and not by others.

This result is supported by the fact that the WHO Localisation Analysis 2016-2017 concluded that 18% of total funding for WHO emergency work in 2016-17 constituted "localization" in some form. This amounted to USD 124.2 million out of a total of USD 696.6 million for 2016-17. A regional breakdown shows EURO as providing the most amount of funding directly to local partners (35%) and AFRO providing the smallest amount (13%).

To gauge the degree to which WHO is practicing the Grand Bargain's "as direct as possible" principle, partners were asked if they were receiving WHO funds via a third intermediary organization (e.g. international NGO). The majority of respondents, 63%, indicated they were not receiving WHO funds via an intermediary; 20% indicated that they were receiving WHO funds via an intermediary; and 14% indicated that they were not sure.

The findings from both the GHC 2019 National Partners' Capacity Survey and the WHO Localisation Analysis report clearly suggest that greater sensitization on the Grand Bargain is needed at country level among all stakeholders to more effectively engage national partners. WHO, as Cluster Lead Agency is both well placed and has a responsibility to further promote and support national partner participation.

IV. CONCLUSIONS

This report aimed to identify critical gaps in health response capacity by capturing information on national partners' technical, operational and coordination capacities, including surge capacity. The following sections lay out five critical gaps in expertise and provision of services as well as key findings pertaining to surge capacity.

Firstly, maternal and newborn health remains a key area of concern. Results have shown that expertise and provision of services in this area remains limited. Less than half of partners provide basic emergency obstetric care (43%), comprehensive emergency obstetric care (31%) or comprehensive abortion care (25%) at the primary and secondary health care level. Overall, this area requires immediate attention as maternal and newborn health care remains insufficient beyond family planning (67%) and antenatal care (64%).

Gaps continue to persist in services pertaining to communicable diseases. The report has highlighted critical gaps in expertise in relation to the use of EWAR (55%) and the diagnosis and treatment of a variety of communicable diseases. Services provided at the primary health care level broadly reflect this pattern. Diagnosis and treatment of malaria remain low at 45% despite affecting nearly all the countries included in this survey.

Results revealed critical gaps in both expertise and provision of services pertaining to STI and HIV/AIDS. In particular, the striking gap between HIV counselling and testing services (46%) and provision of antiretroviral treatment (14%) at the primary health care level requires immediate attention.

Gaps in expertise and provision of services persist for victims of sexual violence. Less than half of national partners provide clinical management of rape survivors (43%), emergency contraception (36%) and post-exposure prophylaxis (30%).

Non-communicable diseases and mental health continue to lag in emergency settings. While for the latter rates of provision for psychosocial support (66%) at the primary health care level are encouraging, critical gaps persist for more specialized services such as acute psychiatric inpatient unit (9%). Similarly, provision of treatment for a variety of NCDs remains limited, with

rates ranging from 52% for the treatment of high blood pressure and cardiovascular disease and 19% for treatment of chronic renal diseases.

In terms of organizational surge capacity, the general trend shows that surge capacity significantly increases after the first 10 days across all specialties. Within shorter response timeframes, the Programme Management, M&E and Data Management and the Community Engagement and Communications specialties have the greatest surge capacities. In line with these results, the estimated population that can be helped over the response timeline remains limited within the first 72h and significantly increases after the first 10 days. Responses in relation to surge capacity in support of Health Cluster coordination functions also highlight that support to Information Management functions continues to lag behind (58%).

Overall, the survey findings indicate a need to strengthen national partners' health response capacity in all the above areas. As such, providing further support to national partners should remain a priority for all interested parties engaged in emergency health action. However, the outstanding question is - 'how can support be most effectively provided and by whom to ensure sustainable response capacity among national partners?'. Suggestions emerging from discussions related to this survey include (i) the implementation of pre-funding mechanisms and the pooling of resources across national NGOs to accelerate capacity building and collective action (ii) more investment in national EMT development and (iii) intensified efforts by international actors; private providers and development actors to provide specialist technical, operational support and capacity development.

As national partners comprise the largest constituency across the Health Clusters and in the face of increasing demand for emergency health action, we hope these findings can inform urgent discussion and action to strength national partner capacity and engagement.

Annex: current services and ability to scale up

For each health service offered by organizations, respondents were asked to evaluate their ability to scale up if required. Therefore, each category of health service has 2 charts. The first – which was included in the main body of this report – contains information about the current provision of the services (see Figure 54). The second chart – presented in this annex - contains information about the provision and the potential scale-up of services (see Figure 53).

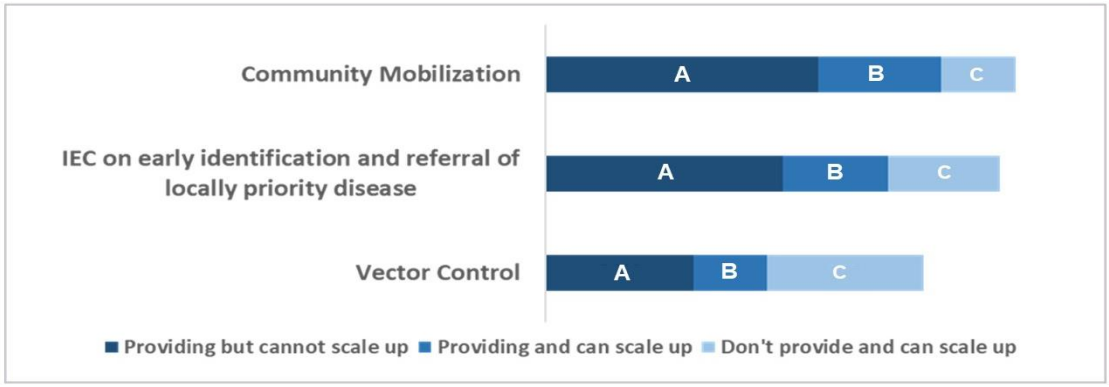


Figure 53. Illustration of scale up charts

This stacked bar chart (Figure 53) allows the visualization of three categories: (A) the percentage of organizations providing a service but unable to scale up, (B) the percentage of organizations providing a service and able to scale up and (C) the percentage of organizations not providing a service but able to scale up. As such, the percentage of organizations currently providing a given service is the sum of category A and B.

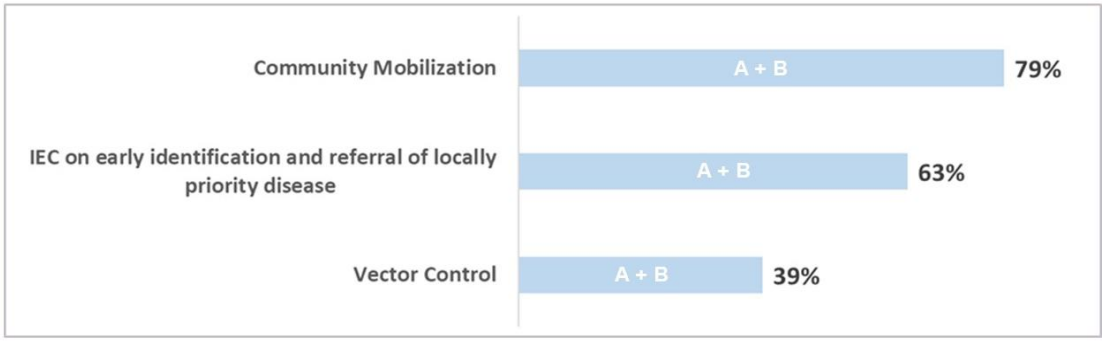


Figure 54. Illustration of provision charts

Note that – as shown in Figure 54 – the resulting percentage matches the chart of current provision of services in the main body of this report. The percentage of organizations that

could scale up if required is obtained by adding category B and C. Finally, the total percentage of organizations that could provide the service if required – with or without scale up – equals the total of the 3 categories.

Services offered: current services and ability to scale up

6.1a Child health (community care)

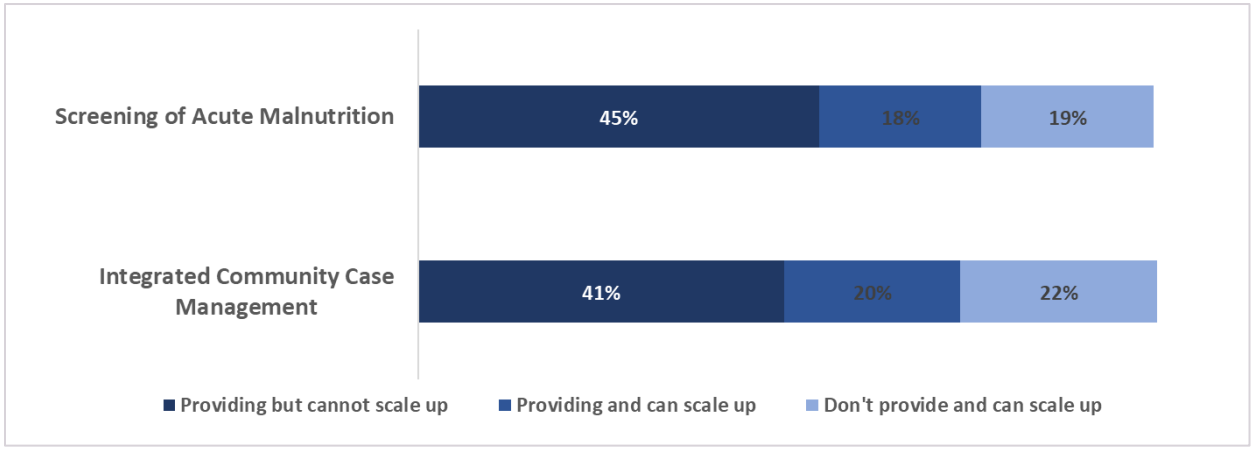


Figure 55. Current services and ability to scale up: child health (community care)

6.1b Communicable diseases (community care)

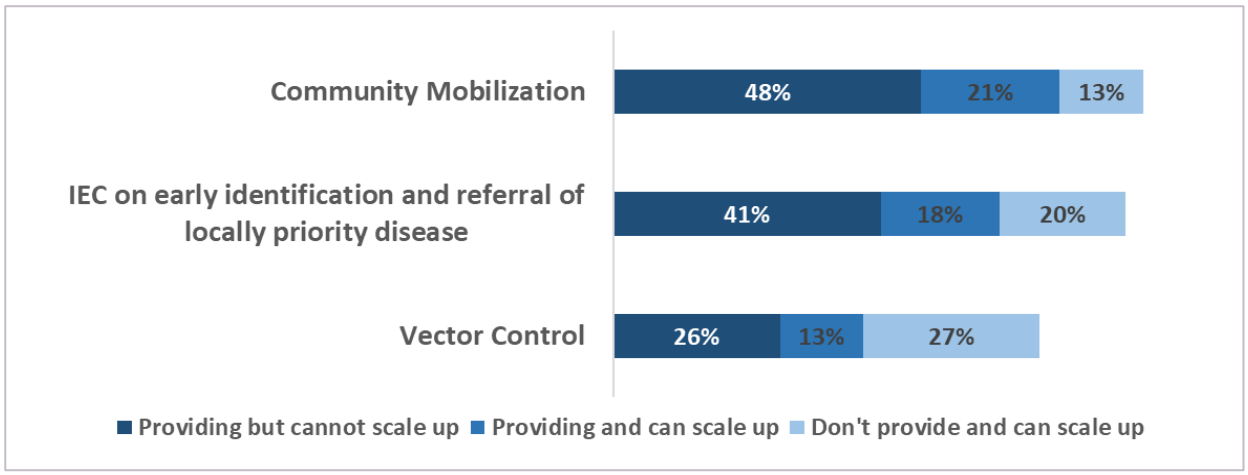


Figure 56. Current services and ability to scale up: communicable disease (community care)

6.2a General clinical services & essential trauma care (primary care)

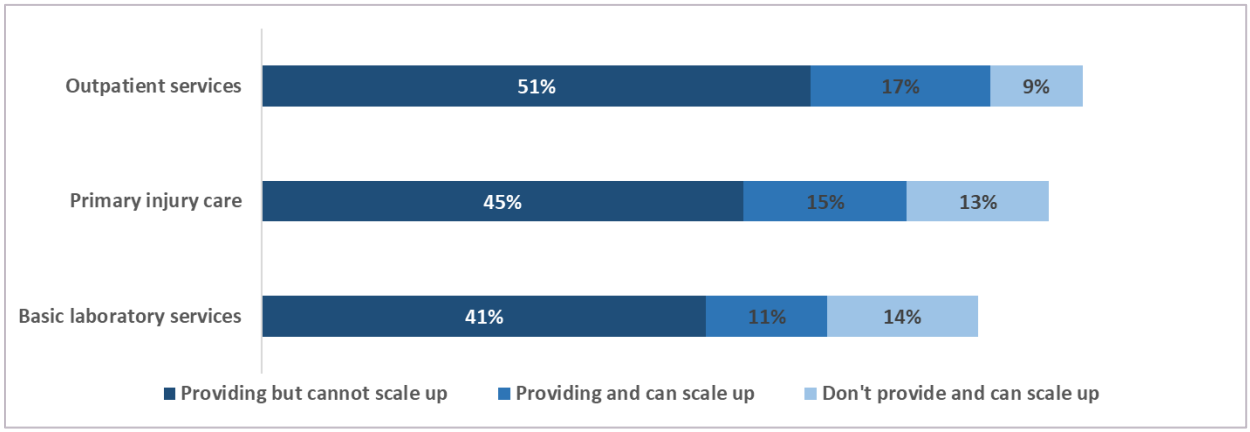


Figure 57. Current services and ability to scale up: general clinical services and essential trauma care (primary care)

6.2b Child health (primary care)

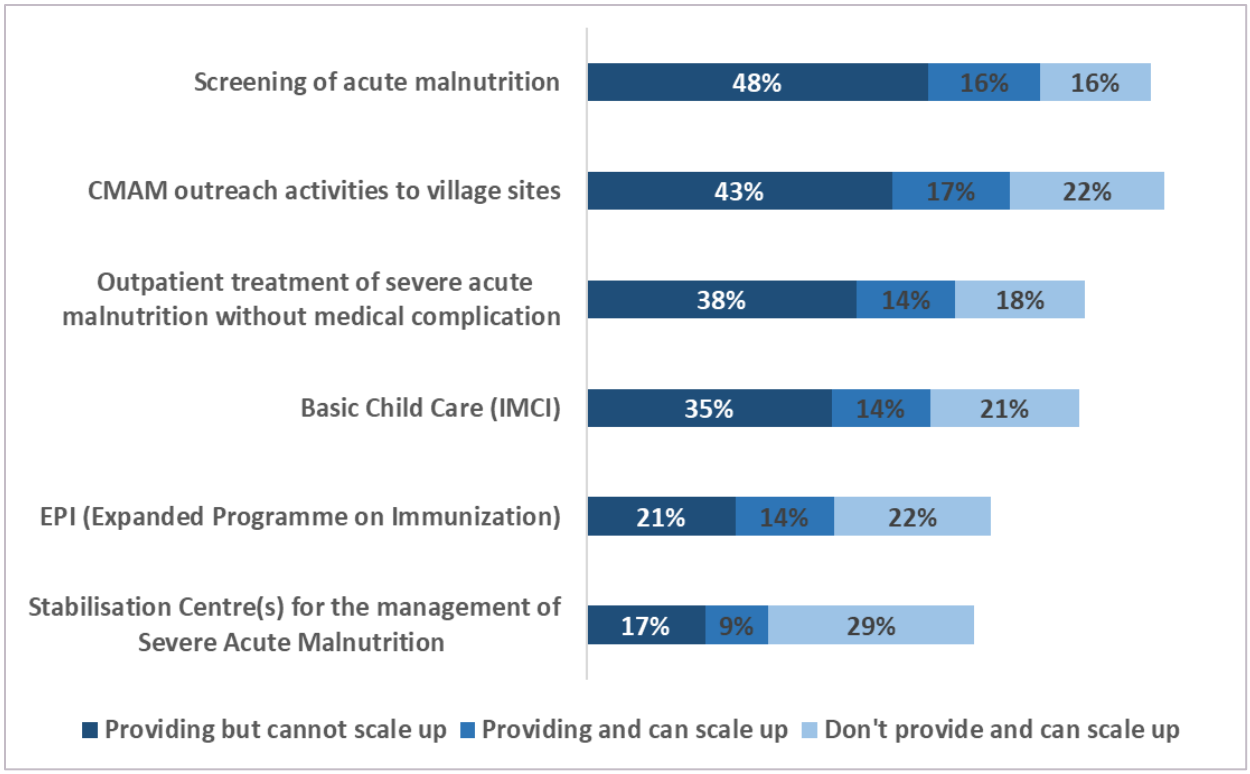


Figure 58. Current services and ability to scale up: child health (primary care)

6.2c Communicable diseases (primary care)

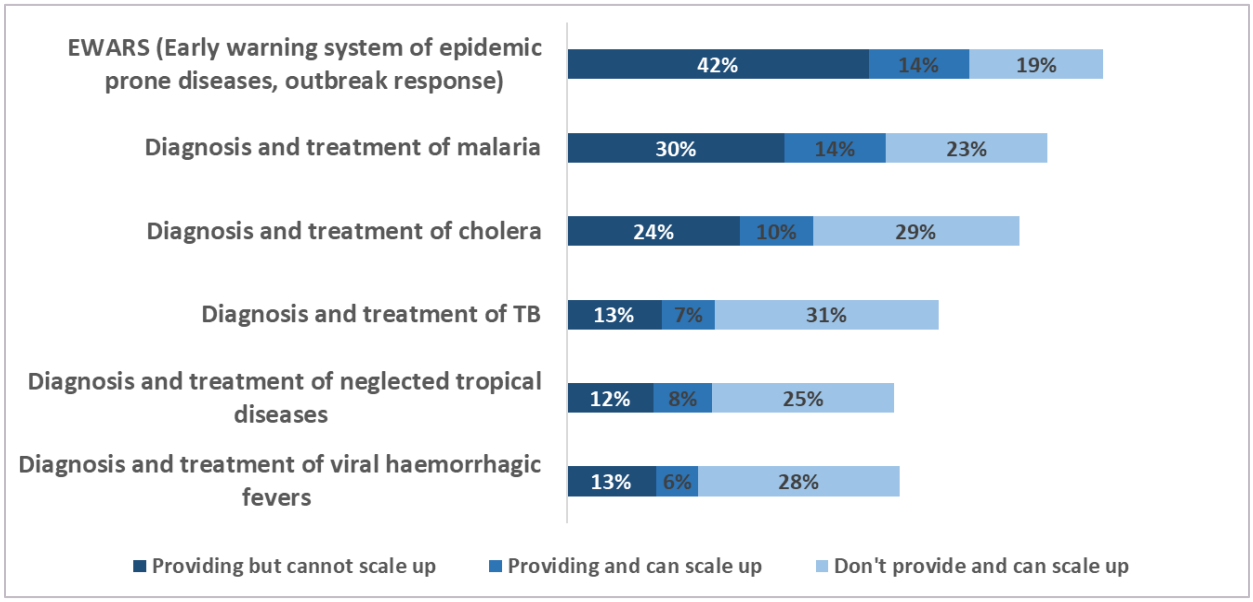


Figure 59. Current services and ability to scale up: communicable disease (primary care)

6.2d STI and HIV/AIDS (primary care)

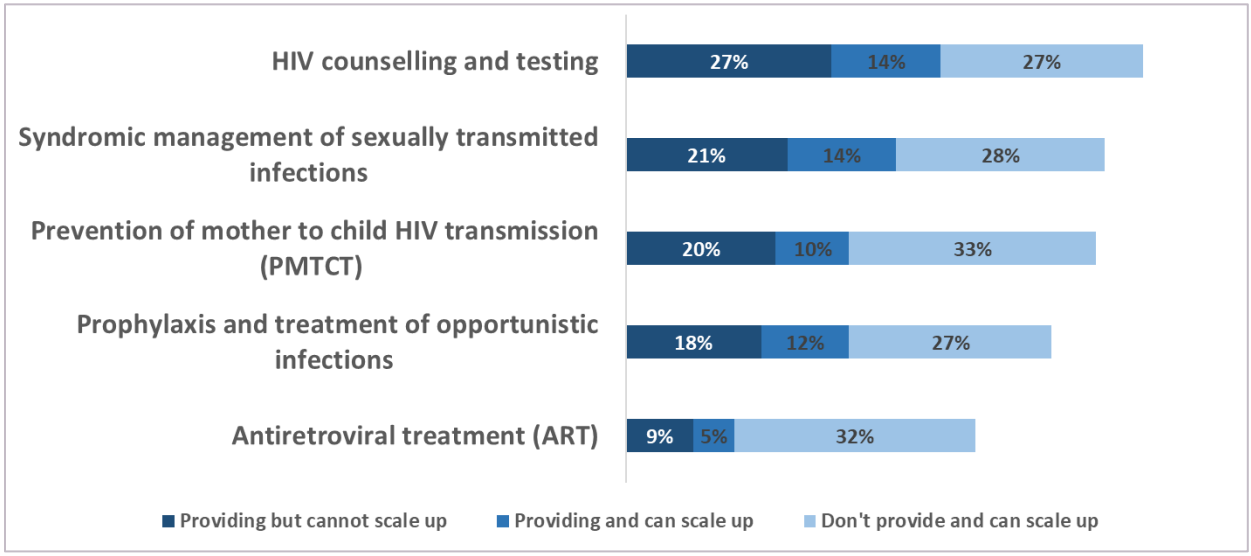


Figure 60. Current services and ability to scale up: STI and HIV/AIDS (primary care)

6.2e Maternal and newborn health (primary care)

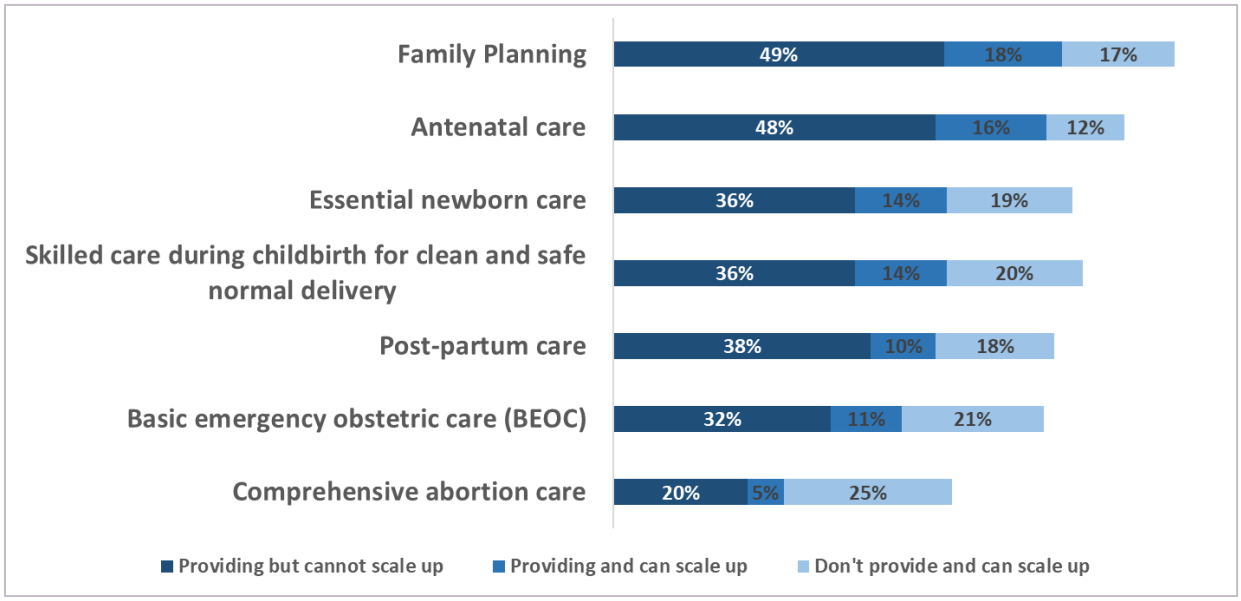


Figure 61. Current services and ability to scale up: maternal and newborn health (primary care)

6.2f Sexual violence (primary care)

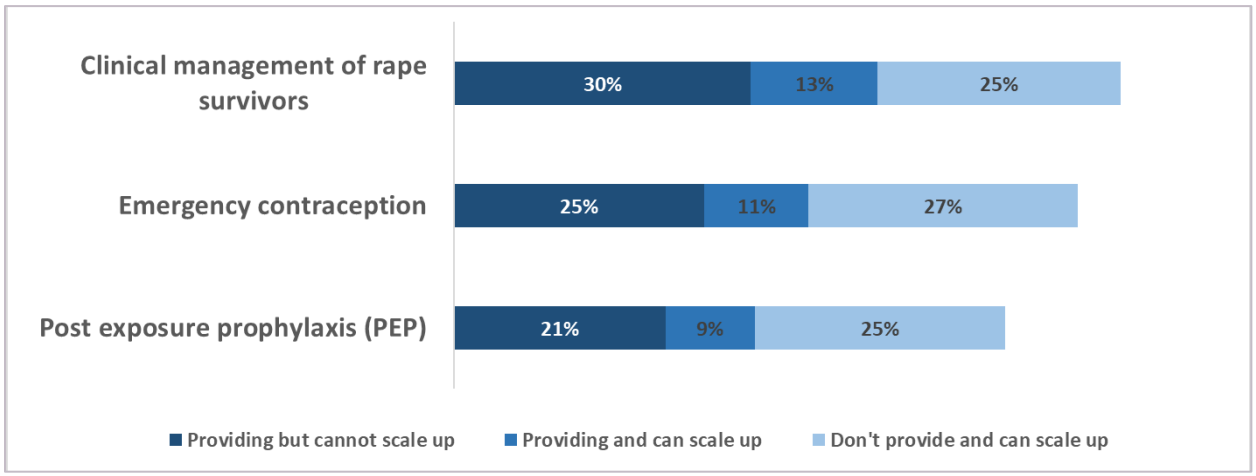


Figure 62. Current services and ability to scale up: sexual violence (primary)

6.2g Non-communicable diseases and mental health (primary care)

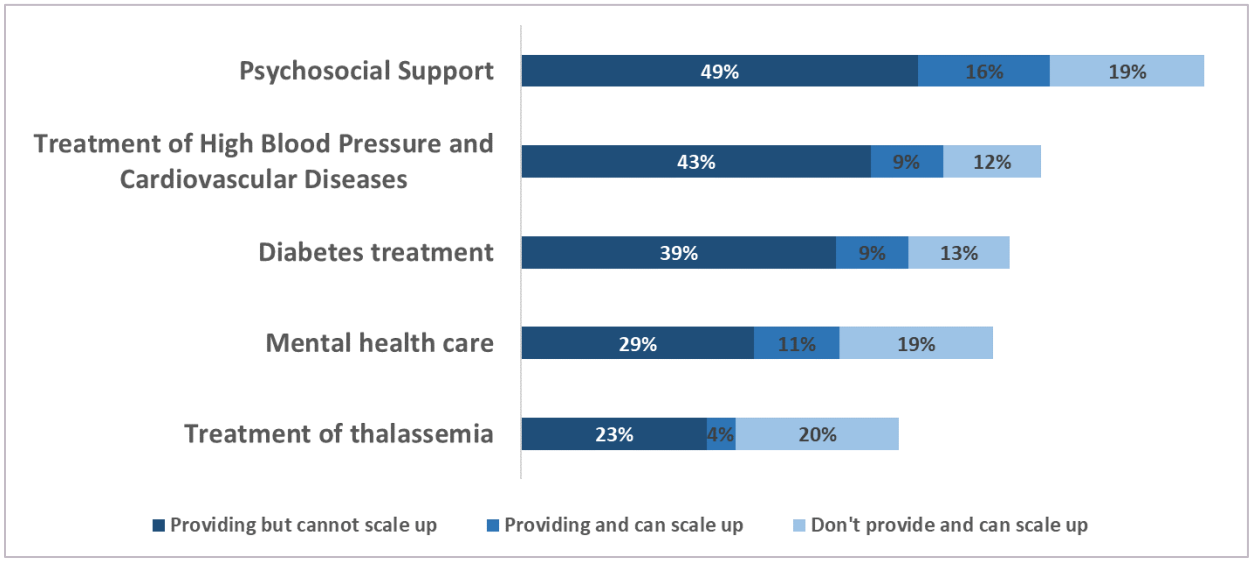


Figure 63. Current services and ability to scale up: non-communicable disease and mental health (primary care)

6.2h Environmental health (primary care)

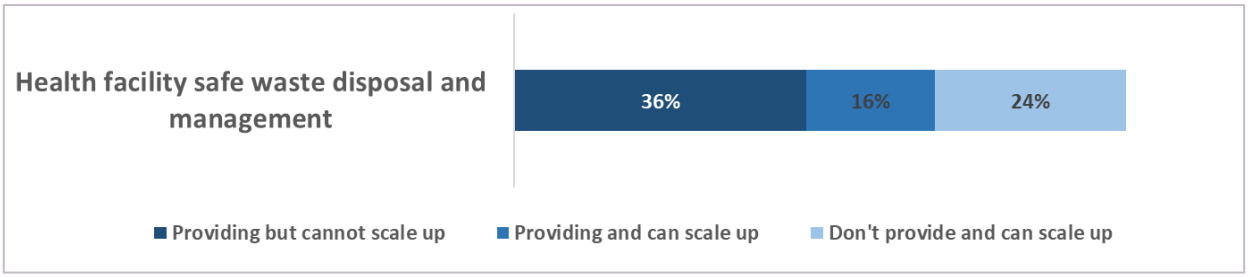


Figure 64. Current services and ability to scale up: environmental health (primary care)

6.2i Older people's health (primary care)

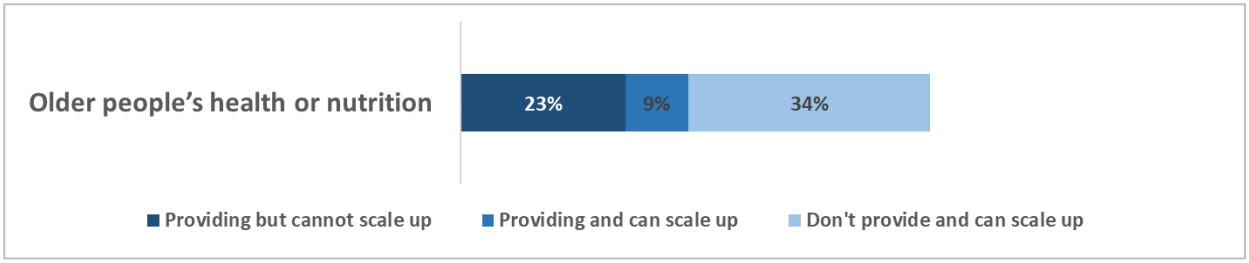


Figure 65. Current services and ability to scale up: older people's health (primary care)

6.3a General clinical services & essential trauma care (secondary care)

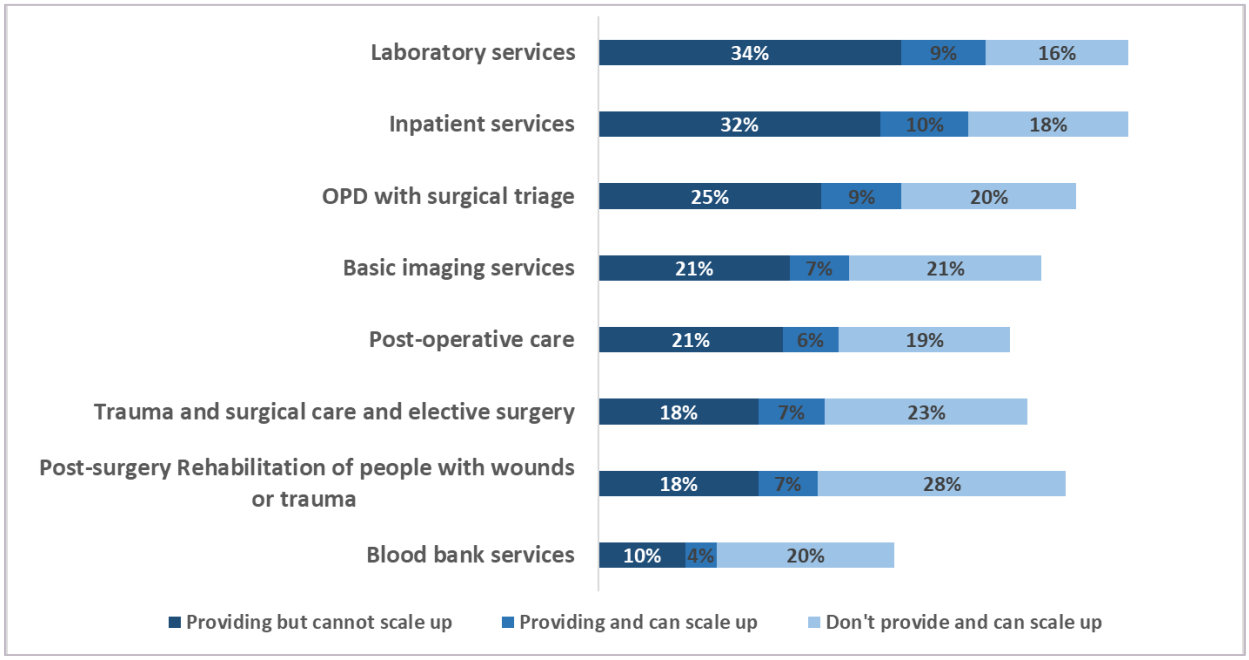


Figure 66. Current services and ability to scale up: general clinical services and essential trauma care (secondary care)

6.3b Child health (secondary care)

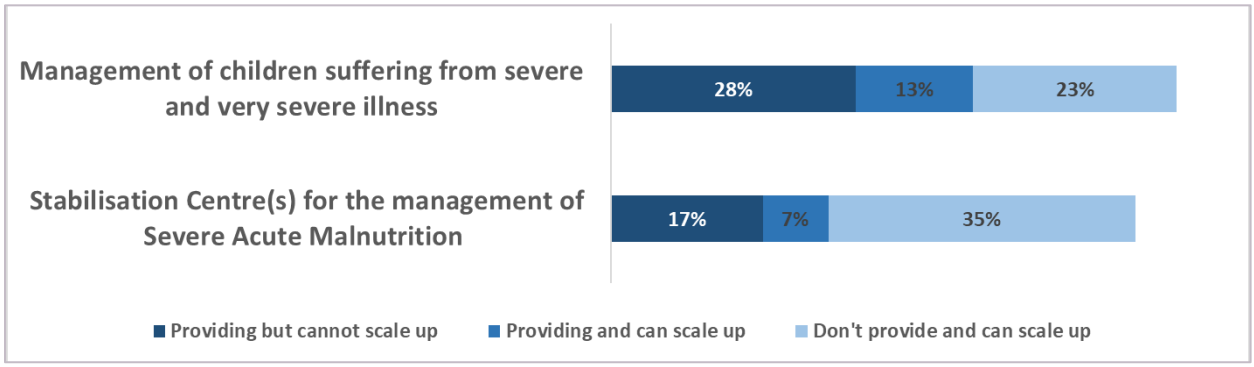


Figure 67. Current services and ability to scale up: child health (secondary care)

6.3c Maternal and newborn health (secondary care)

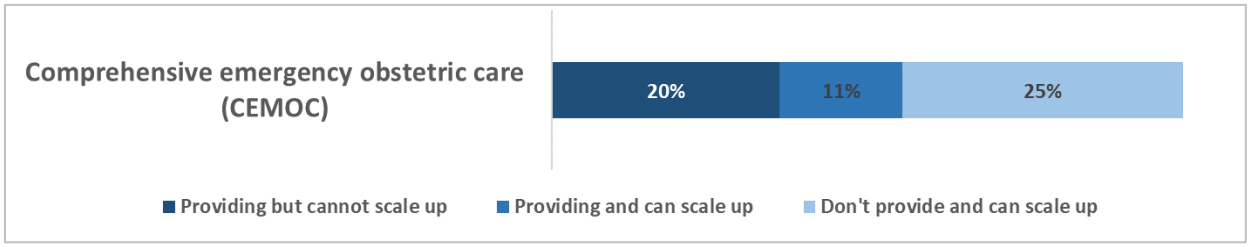


Figure 68. Current services and ability to scale up: maternal and newborn health (secondary care)

6.3d Non-communicable diseases and mental health (secondary care)

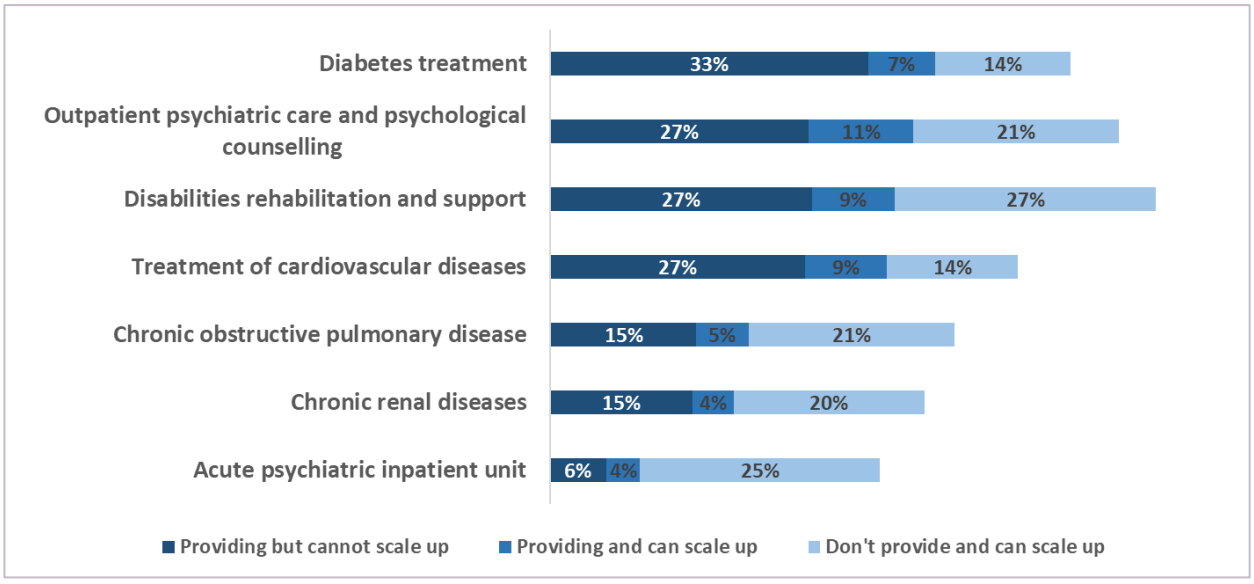


Figure 69. Current services and ability to scale up: non-communicable disease and mental health secondary care)

6.4 General clinical services & essential trauma care (tertiary care)

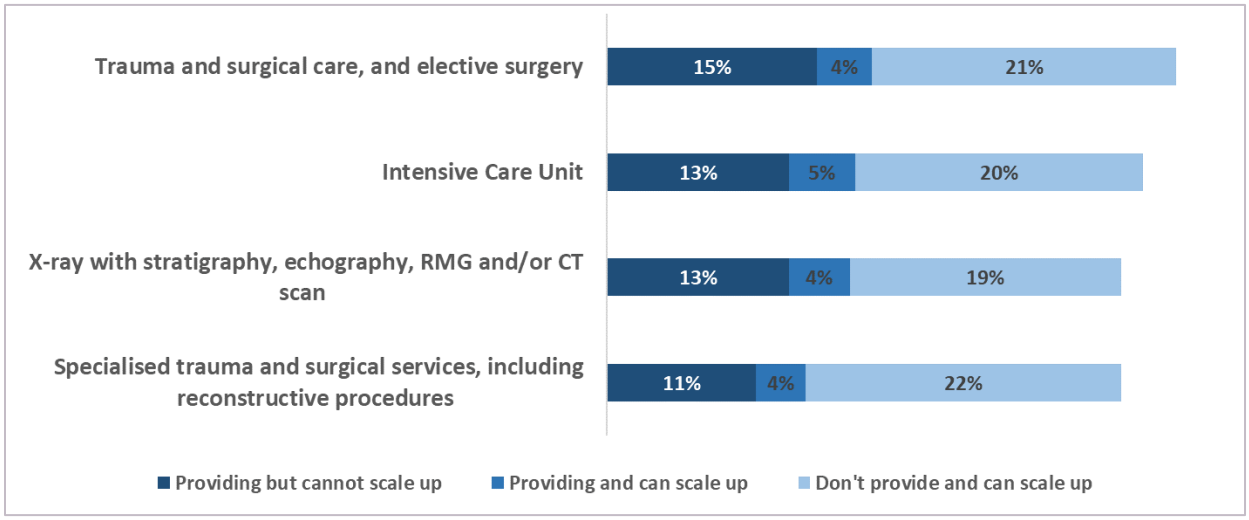


Figure 70. Current services and ability to scale up: general clinical services and essential trauma care (tertiary care)