First Regional Health Cluster Forum on Humanitarian Emergencies

Kobe, Japan
22–24 August 2011
REPORT

FIRST REGIONAL HEALTH CLUSTER FORUM ON HUMANITARIAN EMERGENCIES

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NOTE

The views expressed in this report are those of the attendees of the First Regional Health Cluster Forum on Humanitarian Emergencies and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for the attendees of the First Regional Health Cluster Forum on Humanitarian Emergencies, which was held in Kobe, Japan from 22 to 24 August 2011.
SUMMARY

The First Regional Health Cluster Forum on Humanitarian Emergencies was held in Kobe, Japan from 22 to 24 August 2011.

The objectives of the Forum were:

(1) to share experiences in implementation of the health cluster approach in the Western Pacific Region;

(2) to develop a health cluster operational framework to be used at the national level in the Western Pacific Region; and

(3) to strengthen regional networks and partnerships for implementation of the health cluster approach.

Emergency and disaster management requires a multidimensional approach involving multiple actors. The cluster approach was developed to improve the efficiency and effectiveness of humanitarian response. While various policies, guides and tools related to the Global Health Cluster are in place, the Health Cluster approach and global guidelines have not been fully operationalized in a systematic way in the Western Pacific Region.

While experience with the formal Health Cluster is still limited in the Region, cluster approach principles have been gaining increased support. Member States in the Region have been adopting cluster approach principles in their health sector response, which has improved coordination among stakeholders. During the Forum, several Member States, including Cambodia, China, Fiji, the Philippines and Viet Nam, shared valuable experiences in implementing activities at the national level to improve disaster preparedness and response. The importance of strengthening local capacity was recognized and emphasized by Member States.

The Forum expressed sympathy to those who were affected by the Great East Japan Earthquake that occurred in March 2011 and thanked the presenters from Japan for sharing their experience in the disaster’s health response. Gratitude was also expressed to the Hyogo Emergency Medical Centre for hosting a field visit that was well received by Forum attendees.

Various health security threats exist in the Region, including disease outbreaks, public health emergencies and disasters. Relatively strong government systems are in place to handle such threats. The Region has already established strong health-related programmes, including an emerging disease management programme through the implementation of the Asia Pacific Strategy for Emerging Diseases (APSED). Such existing systems and advantages should be fully utilized to improve emergency and disaster preparedness and response.

The health cluster approach was reconfirmed by the Forum as an important mechanism to improve efficiency and effectiveness through enhanced coordination in humanitarian emergency response in the Western Pacific Region. The Forum attendees expected that the health cluster approach would provide action-oriented information and improve coordination. Some attendees also expressed the need to utilize the health cluster approach as a management tool to improve management of various health responses. Effective implementation of the health cluster approach requires taking into account the regional context.
A simplified, common operational framework can be used as a basis to facilitate implementation of the health cluster at the country level in the Region. The process of collaboratively developing this framework with regional partners and agencies involved in disaster health provides an excellent opportunity to share information and exchange experiences related to the health cluster approach. The Forum supported the proposed approach to develop a simple, flexible, action-oriented common operational framework and to use it as a basis to operationalize the health cluster in the Region. The Forum discussed and welcomed the "Three plus One” functional areas that were developed based on the agreed expected outputs contained in the IASC Health Cluster Guide (2009). The Forum agreed that the proposed functional areas could be used as a basis to facilitate implementation of the health cluster at the country level in the Region.

The Forum recommended that WHO, as the Health Cluster lead agency, should continue to work towards improving operations of the health cluster approach at country level in the Region. As part of such efforts, WHO should organize and facilitate the Regional Health Cluster Forum, held at least annually. WHO should further develop the "Three plus One” regional framework document based on the information and suggestions from the Forum, in order to operationalize the health cluster approach in the Region.

WHO should modify the format of the partners’ profile with updated and complete information provided by health cluster partners, and conduct a study on existing information collection tools and forms that are designed for use immediately following disaster-producing events. Common elements should be identified and informal consultations organized to further develop details on the functional area of “information”. Partners should provide updated information using the modified partners’ profile format.

Finally, WHO and health partners should advocate the health cluster approach, and conclusions and recommendations from this Forum should be shared with the Global Health Cluster.
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Keywords: Emergencies / Disaster planning / Interinstitutional relations / Relief work / Health planning technical assistance
1. INTRODUCTION

In 2005, the Inter-Agency Standing Committee (IASC) adopted the Cluster Approach with the aim to strengthen overall humanitarian response capacity and effectiveness. In the years since then, the adoption of the cluster approach has shown some progress.

To operationalize the health cluster approach in the Western Pacific Region, the World Health Organization (WHO) Regional Office for the Western Pacific, in collaboration with the Centre for Health Development in Kobe, Japan convened the First Regional Health Cluster Forum on Humanitarian Emergencies, from 22 to 24 August 2011.

The Forum was attended by 27 participants from 18 health partner organizations, eight temporary advisers from seven countries and 13 observers from the host country, Japan. The Forum was supported by WHO secretariat members from the WHO Centre for Health Development, the Western Pacific Regional Office, the WHO China country office, Headquarters and the Regional Office for Europe. The Forum's programme of activities and list of meeting attendees are attached in Annexes 1 and 2, respectively.

1.1 Objectives

(1) To share experiences in implementation of the health cluster approach in the Western Pacific Region.

(2) To develop a health cluster operational framework to be used at the national level in the Western Pacific Region.

(3) To strengthen regional networks and partnerships for implementation of the health cluster approach.

1.2 Opening remarks

Dr Shin Young-soo, WHO Regional Director for the Western Pacific, formally opened the First Regional Health Cluster Forum. The Regional Director noted that the health cluster approach, which has been in operation since 2005, presents an opportunity to enhance coordination, effectively mobilize resources and share information among partners. The health cluster approach, however, has not been without challenges. While each organization has different mandates, strengths and paradigms, this diversity can be used as an advantage if used wisely. The Regional Director reiterated the "One" message for united goals to minimize damage and save lives in humanitarian emergencies. He also expressed the Regional Office’s commitment to improving the effectiveness of the health cluster and to developing an operational framework during the Forum.

Mr Toshizo Ido, Governor of Hyogo Prefecture, Japan welcomed Forum attendees to Kobe, Japan. He emphasized WHO's long-standing efforts to protect the health of people in the Western Pacific Region and welcomed their leadership in crisis management. The Governor reflected on the enormity of Japan's recent disaster and the earthquake that affected Kobe in 1995. Support and encouragement were received by multiple partners after these events, which helped Japan reconstruction efforts. Given that the Western Pacific Region experiences many natural disasters, the Forum provided a good opportunity to contribute to an international collaborative system to build capacity in addressing the needs of people when disasters occur.
Dr Masato Mugitani, Assistant Minister for Global Health, Ministry of Health, Labour and Welfare of Japan, welcomed the Forum attendees. The Assistant Minister reiterated the enormity of the tragic events of Japan's 11 March disaster. He expressed gratitude to the countries and agencies who gave assistance during this time. He acknowledged that the nuclear accident was a stressful and worrisome event, for both Japan and the international community, and stressed that long-term care and monitoring had become priorities. Continued long-term support was requested by partners. In turn, partners were encouraged to maximize the opportunity for cooperation presented to them during the First Regional Health Cluster Forum on Humanitarian Emergencies.

1.3 Organization of the Forum

The programme was designed to share experiences and to work with health partners to develop a health cluster operational framework to be used at the national level in the Region.

In a special session, three speakers from Japan presented their experiences during two of Japan's earthquake disasters, the Great Hanshin-Awaji Earthquake in 1995 and the Great East Japan Earthquake in 2011. These presentations served as an informative basis on which to commence Forum discussion. Attendees were also invited to visit Kobe's Hyogo Emergency Medical Centre.

During discussion sessions, each functional area of the proposed operational framework was introduced and supported with presentations of selected Member States' experiences in humanitarian emergency response. Forum attendees were divided into four working groups with nominated chairs, rapporteurs and facilitators to review, critique and suggest content for each section of the framework. This formula for discussion worked well. The proposed framework was reviewed, with the attendees highly engaged in discussion and debate on the merits of each section and its content.

2. PROCEEDINGS

2.1 Overview of the Cluster Approach

2.1.1 History of the Cluster Approach and cluster implementation in the Asia Pacific region

Mr Markus Werne, Deputy Head of the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), presented the history of the Cluster Approach and cluster implementation in the Asia Pacific region. In 2005, an independent review commissioned by the United Nations Emergency Relief Coordinator found significant gaps in humanitarian response. Poor linkages were identified between nongovernmental organizations (NGOs), the Red Cross and countries. Responses to humanitarian emergencies were unpredictable, with erratic coordination and a lack of accountability to beneficiaries, donors, governments and each other. A changing environment was also being experienced since the 1990s, when humanitarian architecture had been designed. In response to a humanitarian response review, it was decided that higher standards of predictability, accountability and partnership in all sectors or areas of activity were required for more strategic responses and better prioritization of available resources. These points formed the aims of the Cluster Approach, one of the three pillars of the humanitarian reform. The humanitarian coordinators system and the humanitarian reserve were the other two pillars of humanitarian reform. Strong partnerships between United Nations and non-United Nations actors formed the foundation.
Since 2005, some protocols have remained the same: the government remains responsible for leading the humanitarian response, and when international assistance is required, the United Nations Regional Coordinator and/or Humanitarian Coordinator coordinates international response in support of government efforts. Changes since 2005 include the establishment of clear, agreed focal points for every area of work (for example, WHO for health) and terms of reference for what that leadership implies. NGOs and Red Cross partners are included in decision-making and planning, emphasizing a “one community” approach. There is now better access to global resources and an identified provider of last resort if nobody can address certain needs.

A Cluster Approach is intended to be used from the start in planning and organizing the international response. In ongoing emergencies, the Cluster Approach is used when: a Humanitarian Coordinator has been appointed; the disaster is beyond scope of any agency; and when the disaster requires a multisectoral response and a wide range of actors. Clusters are also used in contingency planning for disaster-prone countries or for potentially major new emergencies that involve multisectoral responses with the participation of a wide range of international humanitarian actors. It is in this area that the Cluster Approach is most frequently overlooked.

Global cluster leads, such as WHO for the Health Cluster, are responsible for setting standards and consolidating best practices, building response capacity and providing operational support. Cluster leads have a range of responsibilities at field (country) level, which can be found in the IASC Global Health Cluster Guide.

At present, IASC is holding a series of discussions on how humanitarian architecture can be improved. Clusters will continue and IASC would like to review, through a task team, how terms of reference can be simplified; how accountability can be addressed; how cluster approach functions can be communicated; and how to better define the concept of last resort.

2.1.2 Health Cluster and WHO’s roles and responsibilities as the Health Cluster lead agency

Dr Rudi Coninx, Coordinator, Health Action in Crisis, WHO Headquarters, expanded on Mr Markus Werne's presentation by presenting on the Health Cluster and WHO's roles and responsibilities as the Health Cluster lead agency. The role of IASC was reviewed and it was reiterated that this agency involves not only United Nations organizations but also a range of nongovernmental partners including the Red Cross and International Committee of the Red Cross (ICRC).

The Global Health Cluster (GHC) is an IASC forum that comprises key international health entities. It is mandated to build global humanitarian response capacity by developing common guidance and tools, surge systems and global partnerships. The mission of GHC is to provide health leadership in emergency and crisis preparedness, response and recovery; prevent and reduce emergency-related morbidity and mortality; ensure evidence-based actions, gap filling and sound coordination; and enhance accountability, predictability and effectiveness of humanitarian health actions.

GHC has a number of United Nations and non-United Nations partners as well as observers such as ICRC, Interaction, Médecins Sans Frontières and the Sphere Project. WHO is the Health Cluster lead. Ministries of health are not yet formal partners of GHC.

GHC offers standardized orientation training packages and a Global Health Cluster Guide (2010). Policy documents are also being produced (e.g. civil military cooperation in humanitarian emergencies). GHC looks at global issues and lessons learnt, makes
recommendations for improvement and develops a range of tools for data collection. Most recent GHC meeting outcomes have been standard operating procedures for health cluster implementation and encourage implementation of existing tools at country level. They are also involved in policy guidance and are presently working on policy documents for foreign medical teams in humanitarian emergencies.

WHO's operational response is to agree on core commitments across all levels of the Organization and build a predictable response with clear deliverables at all levels (country, regional, global). WHO is also working on building national capacity for preparedness, which has not been a strength of GHC in the past. In the Western Pacific Region, however, preparedness is relatively strong. As such, lessons can be documented for use in other regions.

Finally, the vision is to build dialogue with regions, country offices and partners on how best to support actions in the field to improve predictable approaches and better respond.

2.1.3 Experience of the health cluster approach in the Western Pacific Region

Dr Arturo Pesigan, Technical Officer, Urban Health Emergency Management, WHO Kobe Centre, shared experiences of using the health cluster approach in the Western Pacific Region. He noted that with an overwhelming number of organizations involved in emergencies, coordination needs to be strong. Key elements of the work of clusters are to share information, to reach consensus on needs and standards or assistance, and to share plans and resources.

The limited experience of the Health Cluster in the Western Pacific Region can be divided into three areas:

1. formal activation of the Health Cluster (e.g. in the Philippines, the Lao People’s Democratic Republic and Samoa);
2. health sector coordination (e.g. in Cambodia, China and Viet Nam); and
3. humanitarian networks: involvement in the Asia Pacific Humanitarian network and the Pacific health team in Fiji.

Common tools that are used well included the IASC guidelines on mental health. Other tools such as rapid health assessment tools have not been operationalized. Further discussions and agreements on rapid assessment tools are required. There is also a need to further strengthen engagement with NGOs and work better with government counterparts. Future directions of the Health Cluster in the Western Pacific Region are to strengthen the health cluster network for Asia and the Pacific, improve the coordination and information exchange among humanitarian partners at the regional level and strengthen work in preparedness and recovery.

2.1.4 Summary of comments

Attendees asked questions and made observations on the preceding presentations. Linkages between presentations were noted. While progress has been made in the field of humanitarian emergency management, some questions still need to be addressed. Such questions include the role of the provider of last resort and the role of governments in the Health Cluster. The question of how governments can be better represented was also raised. In addition to linking with government mechanisms, better linking with other partners is required. Collaboration is also needed in providing comments for improvement on policy guidelines.
It was acknowledged that particular emphasis on preparedness is required. The WHO Regional Office for the Western Pacific has experience in looking at past challenges and determining how to address such challenges to set a future direction.

It was noted that the IASC GHC Guide might be better suited for countries without governments or with weak governments. In the Western Pacific Region, however, governments are generally strong, thereby requiring a different strategy to implement the health cluster approach. Questions were raised regarding the relationship between governments and the Health Cluster at the operational level. When each government has its own response system, cooperation is required rather than a paradigm mechanism. In many instances, the cluster is not activated. However, when governments are experiencing an influx of international responders, the GHC Guide can help produce better results. When international support is required, cluster activation is required. Linkage and cooperation with governments is also required. It was recognized that the host government is a primary stakeholder for disaster response. The Health Cluster is a step away from the United Nations-centred approach. There is a role for the cluster system in instances when local systems become overwhelmed in a disaster and fail to recognize that there are unmet needs.

Currently, a gap exists in preparedness for gender and reproductive issues that needs to be addressed. While a minimum services package exists, it is not functioning effectively and requires tweaking for better effectiveness in the field. Gender is however gaining attention in training courses; for example, gender training is a prerequisite for WHO-led Health Cluster trainings.

2.1.5 Sharing of country experiences and lessons

During this plenary session, presentations were given by two attendees from the Philippines and Viet Nam, who outlined their countries’ experiences and lessons learnt in using the health cluster approach during recent public health emergencies.

2.1.5.1 Health Cluster: The Philippine experience

Dr Carmencita Banatin, Director of Health Emergency Management Staff, Department of Health, presented on the health cluster approach in the Philippines. She started with an overview of the evolution of the cluster approach. The Philippines institutionalized the cluster approach in its disaster management system in 2007, following a devastating typhoon in Luzon in 2006. Clusters were used at the regional level during the displacement of the Autonomous Region in Muslim Mindanao (ARMM). The responsibility for health, nutrition, water, sanitation and hygiene (WASH) and psychosocial care was placed under the Department of Health in 2008. In 2009, tropical depression Ondoy occurred as well as the expansion of the health cluster. The health cluster currently sits under the government lead of the Department of Health with WHO as the designated cluster lead.

Developmental challenges were identified during the evolution of the health cluster in the Philippines. It was recognized that there was no venue for international or local NGOs to sit with government. It was initially confusing; the Department of Health did not know how to organize the cluster and there was no database of organizational partners. Multiple meetings were a burden for staff and partners would speak separately with the Department of Health despite coordinated meetings.

Coordination of different groups with different mandates was a challenge; a core group was required. Multiple methods of reporting remained an issue and there was a recognized need to develop a format to suit all partners. It was decided to require a report within 24 hours of a
disaster and a Damage Assessment and Needs Analysis (DANA) within 24–48 hours to understand if the local government could handle the situation.

A number of strategies were taken to address these challenges, including the application of the cluster approach during preparedness planning with regular meetings with a permanent group. Tri-cluster meetings (i.e. health, nutrition and WASH) were held to use time effectively and synergize efforts. The cluster approach is now institutionalized in the Department of Health as a regular programme and experiences good communication and collaboration.

The next steps for the health cluster in the Philippines are to strengthen coordination and create resource mapping and mobilization (to identify areas not covered). Information management (reporting style) needs to be channelled and standardized through the Department of Health. Monitoring and evaluation tools have not yet been developed.

Recommendations from these experiences include development of human resources, training of cluster members to harmonize their understanding of emergency management, setting of benchmarks and standards (for the Philippines setting), packaging of essential health services (minimum essential health services) and development of management tools.

The health cluster approach has been and will continue to be a positive approach to disaster response in the Philippines.

2.1.5.2 Health Cluster: A joint effort to prepare and respond to disasters in Viet Nam

Dr Nguyen Manh Cuong, Deputy General of the International Cooperation Department, Ministry of Health, presented Viet Nam’s experience in the preparation of, and response to, disasters in Viet Nam. From 1996 to 2008, approximately 25 million people were affected by disasters in the country. Both the Government and the Ministry of Health have four levels of organization – from central level to commune level. The Disaster Management Unit is overseen by the Ministry of Health, which in turns supervises Medical Service, Preventive Medicine and Planning and Finance, while collaborating with the Cabinet Office.

Viet Nam applies the cluster approach in seven areas, including health, which involves United Nations agencies, international NGOs, embassies, donors and the International Red Cross and Federation of Red Cross. The health cluster, established in 2009 during typhoon Ketsana, and co-led by WHO, includes the United Nations Population Fund (UNFPA), International Federation of Red Cross and Red Crescent Societies (IFRC), Harvard School of Public Health (HSPH), United Nations Children’s Fund (UNICEF) and Food and Agriculture Organization of the United Nations (FAO). The members are required to share information, update databases, partake in joint activities, and share expertise, experiences and lessons learnt. The objectives of the health cluster are to provide health leadership in emergency and crisis preparedness, response and recovery; to ensure evidence-based actions, gap filling and sound coordination; and to enhance accountability, predictability and effectiveness of humanitarian health actions. Activities performed to date include creating terms of reference for the health cluster, setting up databases and tools, sharing all of these with the Ministry of Health, and performing joint rapid assessments of affected areas. Future activities include building and mapping the capacity of members, updating databases, and developing guidelines, procedures and an action plan for the health cluster. It will also coordinate and support member agencies in conducting rapid health assessments, identifying and analysing gaps, ensuring health needs are addressed, setting standards for relief, ensuring evidence-based planning and internationally accepted policy, advocating for secure humanitarian access and ensuring there are plans and procedures for closing the emergency relief operation.
Numerous lessons were learnt during the preparation of, and response to disasters in Viet Nam. The importance of the Ministry of Health taking a lead and being active in the health cluster approach, guided by a National Action Plan (NAP) to prepare and respond to disasters, was highlighted. Relevant agencies should be assigned by the Ministry of Health to work closely with different health cluster partners under different areas to draft activities. The activities of each member should be in accordance with the NAP, with the health cluster partners being clear on their mandate and response, along with a clear working mechanism between the health cluster and the Ministry of Health.

The recommendations presented for the Ministry of Health included the prompt approval of NAP, which should classify different levels of response according to the magnitude of disaster, a permanent focal point for the Ministry of Health, taking a more active role in coordination with the United Nations. For the United Nations, it is recommended to have only one voice when dealing with disasters, while health cluster partners should allocate annual funds for disaster response.

2.1.5.3 Summary of comments

Attendees asked questions and made observations on the country presentations. It was recognized during the discussion that disaster response should be based on an assessment of needs instead of organizational mandates. It was also noted that governments should take the lead role in disaster response and should have a NAP. Communication between central and local governments during a disaster is vital. During the preparedness stage, local areas should be included in the cluster approach and linkages should be made between central and local levels of government. Preparedness was advocated for during the discussion as it would improve response. It was noted that the Central Emergency Response Fund (CERF) cannot however be used for preparedness.

It was suggested that clearly defined roles for both governments and partners were required as well as a resource mobilization strategy. It was reiterated that running full clusters was labour intensive and required dedicated staff. Clusters were not activated in every emergency. The bulk of emergencies in this Region are considered small or medium. In those situations, flexibility and saving of efforts for larger emergencies is required.

With a deeper understanding of the needs of governments, the health cluster can empower governments to ask for assistance when needed, and say when not needed. Japan, as an example, affirmed what they wanted during their recent disaster (assistance with search and rescue, for example). Value can be added to the activities of governments by supporting partners.

2.2 Special session: Japan Earthquake

2.2.1 Public health activities during the Great Hanshin-Awaji Earthquake - from the view of public health nurses

Ms Noriko Nakano, Deputy Director, Hyogo Prefectural Mental Health and Welfare Centre, presented on the Great Hanshin-Awaji Earthquake that hit Kobe in 1995. In this 7.3-magnitude earthquake, the majority of the 6402 casualties died under crushed houses and buildings. An estimated 40,092 people were injured and more than half a million houses were damaged. Construction of temporary housing, mostly in Kobe City, occurred on a large scale. A total of 173,300 temporary houses, including 42,137 disaster restoration public housing facilities, were provided. Most of these were built to meet the needs of aged persons. Public health activities after the Great Hanshin-Awaji Earthquake, which promoted the 10-year restoration plan, included the following:
• visits to evacuation shelters to investigate damage;
• visits to evacuation shelters to conduct health consultations;
• arrangement of support system of public health nurses in Hyogo Prefecture;
• arrangement of support offers from outside Hyogo Prefecture;
• home visits;
• establishment of systems for home-visit consultations, health consultations, health education; and
• establishment of self-management groups for health promotion, home-visit consultations, health consultations, and health education for survivors in restoration public housing.

Many lessons were learnt from the Great Hanshin-Awaji Earthquake:

• Public health activities during disasters should continue in the long term.
• Public health activities during disasters should promote health: People should be supported to live healthily based on their own values and on individualized care. Local care systems build bonds and community building is important for recovery.
• Health surveys are needed to reinforce health measures (healthy life support): Health surveys should be conducted for four years to understand needs in daily living.
• Mental health care measures should be related to public health activities: Mental health care is very important along with living support. With this understanding, mental health programmes should be operated for five years. Care should continue to be provided with the opening of a centre after nine years.

Enhanced public health activities during normal times (for secure and safe community building) and reinforcement of public health activities during disasters strengthen health response to disasters.

2.2.2 The Great East Japan Earthquake: Report on relief efforts in the Ishinomaki Medical Zone

Dr Tadashi Ishii, Miyagi Prefecture Disaster Medical Coordinator from Ishinomaki Red Cross Hospital, presented his experiences of conducting relief efforts in the Ishinomaki Medical Zone after the 11 March earthquake. In 2006, the Ishinomaki Red Cross Hospital moved to an earthquake-resistant structure outside the tsunami zone. In 2010, the Ishinomaki Regional Disaster Medicine Representative Network Council was established. One month before the earthquake occurred, Dr Ishii was nominated as the disaster coordinator. Prior to the earthquake, Dr Ishii had spent time communicating with field staff and establishing relationships, which greatly assisted his communication and coordination ability during the emergency. The Ishinomaki Red Cross Hospital was the sole disaster relief hospital in the medical zone (with 402 beds, 108 physicians).

Immediately following the earthquake, the Disaster Medical Response Headquarters was established and a level 3 disaster condition was declared. All medical care was suspended in preparation for the disaster response. Within an hour, the triage area was set up at the Ishinomaki Red Cross Hospital. Unlike the 1995 Hanshin-Awaji earthquake in Kobe, the number of injuries caused by "crush syndrome" was low. More than 3000 patients were expected on the first day of the disaster, but the hospital received only 99 patients. The unexpected slow arrival of patients was due to the loss of 12 or 13 local ambulances in the tsunami. By the third day, helicopters were performing rescues, and in the first week, 3198 patients were received.

Since the area surrounding the Ishinomaki Hospital in Miyagi Prefecture was flooded, municipal functions were paralysed. Local fire departments found entire towns destroyed. By 16 March, water had receded. At that time, 300 evacuation centres were functioning;
however, information on the status of available supplies at the evacuation centres was limited. Disaster Medical Assistance Teams (DMATs) started to withdraw services after 48 hours and only the Red Cross team remained on site by Day 6 with no communication available.

Only 16 Red Cross teams were initially available to assist with the response. These teams commenced disaster relief efforts by visiting evacuation centres and conducting surveys with an assessment sheet. Dr Ishii soon developed a system to analyse the situation. Information was available in three days and updated regularly, i.e. every three days. The teams discovered that many evacuation centres had a shortage of food, that people had dispersed leaving many evacuation centres empty, and that approximately 100 evacuation centres were without toilet facilities (no water or sewage systems). Infectious disease experts were assigned to implement a system of "wrap type toilets" that have hygienic sealable bags.

Developing a code of conduct was an important function of the response, as was enhancing coordination with the many medical teams arriving from around Japan. By 26 March, the original 16 teams grew to 59 teams with 100 physicians, thanks to effective coordination efforts. The magnitude of the disaster was on an unprecedented scale. Within Ishinomaki, more than 10,000 people were presumed dead, 70,000 were evacuees, and 43,596 were living in 302 identified evacuation centres. Long-term, large-scale relief efforts managed by the local government were required.

A strong communication system was developed and each team had areas of responsibility. By May, some areas were eliminated while other areas were expanded according to need. A total of 18,381 emergency cases were received in the first 100 days post-disaster. The first-hand experience has shown the importance of response coordination and establishment of incident command structures and systems. Dr Ishii emphasized the value of a flexible management approach and excellent team cooperation in disaster response.

2.2.3 Great East Japan Earthquake 2011: Health impact and recovery of public health systems

Dr Hitoshi Oshitani, Professor, Department of Virology, Tohoku University Graduate School of Medicine, presented on the Great East Japan Earthquake that occurred on 11 March 2011. More than 99% of the 16,424 deaths and 4,787 missing persons (as of 4 August) were from the three prefectures of Iwate, Miyagi and Fukushima.

The Community Health Support Center (CHSC) of Tohoku University Graduate School of Medicine in Sendai was established to provide technical support on health issues in communities affected by the Great East Japan Earthquake. In Miyagi Prefecture, the earthquake greatly affected areas such as Ogatsu and Oshika of Ishinomaki City, where approximately 40% of the population are older than 65 years. In Ogatsu hospital, all hospitalized patients were elderly. While efforts were made to take refuge on the roof of the hospital, all 40 patients and 22 staff died when the tsunami swept over the rooftop.

Ongoing projects in Ogatsu and Oshika areas include:

- health check-ups and follow-up visits of people in affected areas: once every 3 months for at least 2 years;
- technical assistance in recovery of public health systems: a major issue was the limited public health capacity before the disaster; and
- documentation and recording of recovery process of public health.

Initially, public health nurses spent most of their time managing evacuation centres: Ogatsu had 14 centres with 1355 evacuees and Oshika had 40 centres with 2433 evacuees.
(as of 29 March). A cyclic process of assessment, planning and implementation helped guide their efforts. They face major issues and challenges in developing a long-term recovery plan because they are dealing with an ageing population that is likely to be accelerated due to this disaster. There are also many uncertainties, including, for example, not knowing how many people will remain in the community. Only 36% of respondents said they wanted to return to Ogatsu. The public health recovery plan depends on an overall recovery plan, comprising industry, housing and other daily needs (shops, banks, etc.), which has not been finalized. To move forward, leaders must have an understanding that long-term support is necessary; the recovery plan for health should be an integrated part of the overall recovery plan; and the public health recovery plan should be designed as a model for highly ageing societies. The model created can be used for future learning and preparation around the world.

2.2.4 Summary of comments

The Forum organizers thanked the three presenters of the special session. Questions were asked regarding the formation of response teams, which consisted of seven persons: two doctors, two nurses, two pharmacists and one logistician. The team make-up depended on the situation and not on a specific rule. DMATs have five members (two doctors, two nurses, one logistician). There were no public health teams at the time of the Forum.

The criteria for accepting international teams during the recent disaster response were clarified. Knowledge of Japanese language is required for good communication, particularly with the elderly who do not speak English. The Japanese Government allowed teams without Japanese language skills to assist, but local governments did not allow foreign teams.

2.3 Introduction to the regional health cluster operational framework

Dr Li Ailan, Acting Team Leader, Emergency and Humanitarian Action and Medical Officer (IHR), Division of Health Security and Emergencies, WHO Regional Office for the Western Pacific, introduced the proposed health cluster operational framework in the Western Pacific Region to the Forum. The proposed operational framework was developed based on existing policies, guidelines, experiences and lessons learnt from past events. It will be used as an operational framework to guide timely and effective health cluster responses at the country level in the Region. From the various expected outcomes of the Health Cluster, outlined in the IASC GHC Guide, three main functional areas were drawn: information, service delivery, and resources. Monitoring and evaluation (M&E) was added as a cross-cutting functional area. The proposed functional areas are presented in Figure 1.

Figure 1: Proposed “Three plus One” functional areas of the operational framework
2.3.1 Summary of group discussion

To stimulate discussion and feedback regarding the health cluster functions and proposed functional areas of the operational framework, Forum attendees were split into four groups to discuss a number of questions. A summary of the discussion is outlined below.

A range of expectations from the health cluster approach at regional and national levels were identified by the four working groups. At the national level, some attendees of the Forum expressed that, when possible, the health cluster should be integrated into the existing health structure of the ministries/departments of health and play a key role in preparedness and response. Other expectations of the role of the health cluster included the following:

- information collection and mapping related to stakeholders, resources and coverage of services;
- engagement of agencies at the grassroots level including community-based organizations, when possible;
- maintenance of linkages with governments and other clusters that may be relevant to health; and
- capacity-building in preparedness and response.

At the regional level, terms of reference would help guide advocacy, information sharing and coordination to avoid duplications, documenting of lessons learnt, capacity-building and setting of standards for accrediting members. It was suggested for membership to be regularized (based on selection criteria) and for regular communication and meetings to occur. It was expected that partners work as “one”, providing a unified response with each partner working efficiently according to their capacity. Sharing of resources was suggested to maximize current assets (e.g. human resources, expertise, time, finances). A clear understanding of partners’ roles and their capacity is required.

Working groups identified similar regional contextual elements of the Asia Pacific region regarding emergency and disaster response. Some of these included:

- more prone to natural disasters
- strong national and regional leadership
- strong national capacity
- presence of ASEAN promoting public health policies.

The importance of updating partners’ profiles on a regular basis was reviewed. It was noted that the inclusion of profiles of other organizations and national governments is important. It was suggested that the following additional key sections or pieces of information should be included in the partners’ profiles:

- further information on the technical expertise of partners
- availability of equipment (material) resources and warehousing
- links with other agencies and initiatives
- capacities in emergencies.

Working groups welcomed the proposed "Three plus One" functional areas that were developed based on the agreed expected outputs contained in the IASC GHC Guide. They also emphasized the importance of monitoring and evaluation (M&E) as a cross-cutting area. The proposed functional areas were well supported as a basis to facilitate implementation of the health cluster at the country level in the Region.
It was noted that some existing global and regional guidelines could be utilized to support implementation of the operational framework in the Region. Others may need to be modified and/or tailored to meet country needs. Potential areas for more detailed technical guidance (e.g. based on expert consultation) may include:

- risk assessment tools
- practical guide on outbreak response including clinical management
- risk communication (especially emergency communication).

2.3.1.1 Summary of comments

During a collective discussion of group presentations, it was identified that clear definitions were required to delineate what activities should be performed by health clusters and what should be performed by governments. Everyone should, however, be engaged in preparedness. Some attendees expressed the need to utilize the health cluster approach as a management tool to improve management of various health responses. Operational issues and scope of the health cluster, including terms of reference, need clarification.

Mapping of resources (stakeholders, expertise, etc.) is an important area that can be done through the development and maintenance of a database. Also, rapid response teams often experience difficulties obtaining licenses to enter countries rapidly. It was suggested that clusters should accredit the response teams so that they can rapidly enter countries when required.

It was clarified in the discussion that the ASEAN secretariat is different from ASEAN. The mandate of the secretariat is to coordinate activities within the 10 ASEAN States. The ASEAN health ministers meet every two years. There are 10 health-based working groups that operate according to mandates and agreements.

Some attendees expressed reservation about where the authority and power in the health cluster came from, and suggested that cluster systems could be strengthened if authority came from countries.

2.4 Functional Area I: Information

2.4.1 Sharing of country experiences and lessons

2.4.1.1 Health assessment in disasters in Cambodia

During this plenary session, a presentation was given by Dr Khuon Eng Mony, Deputy Director of Preventive Medicine Department, Ministry of Health of Cambodia, who outlined the experiences and lessons of using an information system and health assessment in disasters in Cambodia. A summary of the presentation is detailed below.

The development of the Cambodian health system was guided by the Health Strategic Plan 2008–2015 (HSP2). The vision developed by the HSP2 was “to enhance sustainable development of the health sector for better health and well-being of all Cambodians, especially of the poor, women and children, thereby contributing to poverty alleviation and socio-economic development.”

A health disaster management committee and rapid response team were established and are functioning relatively well at the national, provincial and district levels. National guidelines on health disaster management for provincial hospitals have been endorsed, but an official strategy and policy on disaster response and risk reduction have been only partly implemented.
Ongoing training on disaster management and rapid response is provided yearly by the Cambodian Ministry of Health, based on the annual action plan for disaster risk reduction.

Despite good preparation and response, capacity gaps in the health sector remain. Information is often incomplete, difficult to find, missing or not updated because there is no official common database and because data on health are managed by individual health officers. Rapid assessment reporting on health has not been standardized and the national budget is limited.

Indicators currently used to collect health information during disasters include the type of event; the number of districts, communes and villages affected; the population affected; the number of safe areas and the population affected, damage and losses to health facilities, equipment and material; and mortality, morbidity and other health problems.

Short-term recommendations to the Cambodian Health System consist of restoring priority public health and care services to the pre-disaster level, investigating reported disease outbreaks and providing appropriate treatment. Mid- and long-term recommendations included replacing and/or upgrading health centres and posts in flood-prone areas, developing a data management system for the Health Disaster Management Committee and developing a comprehensive standard reporting format, along with a regulatory framework to streamline Disaster Risk Management into Public Health Management and health infrastructure development.

2.4.1.2 Summary of comments

Attendees asked questions and made observations on the presentation. It was noted that routine data collection forms may miss important information such as sexual and gender-based violence and mental health problems as a result of disaster. Advocacy for data collection on these areas is required.

2.4.2 Presentation of a strategy related to emerging disease surveillance and risk assessment

Dr Takeshi Kasai, Director of Health Security and Emergencies, WHO Regional Office for the Western Pacific, presented on the Asia Pacific Strategy for Emerging Diseases (APSED). The Western Pacific Region is prone to emerging infectious disease outbreaks. Therefore, a regional event-based system is operating every day in the WHO Regional Office. The number of outbreaks is increasing, which may be because of increased surveillance, but risk is being reduced due to improvements in response capacity.

In the 1997 World Health Report, WHO warned the international community of the misconception that infectious diseases had ended. Today, an infectious disease-related event is detected every second day, the media being the fastest information source. In 2000, the Global Outbreak Alert and Response Network (GOARN) was established. Many lessons were learnt from severe acute respiratory syndrome (SARS) in 2003. Based on this experience, the International Health Regulations (IHR) were revised, providing an agreed global framework for the collective international management of epidemics and other public health emergencies while minimizing disruption to travel, trade and economies. In order to meet IHR core capacity requirements in the Region, the WHO Regional Offices for South-East Asia and the Western Pacific developed APSED. This biregional strategy provides a single framework for building capacities required for all three major areas of work: fundamental capacities for managing emerging infectious diseases (EIDs); core capacities required under IHR; and basic capacities required for pandemic preparedness and response.
Functional areas of work were identified and developed by finding a common element and grouping them together into defined categories, namely: surveillance and response, laboratory, zoonosis, infection control and risk communication. These areas were brought down to country level and adapted according to country context. With the implementation of APSED, time from disease onset to official reporting to WHO was reduced and the percentage of countries with surveillance capacity increased. Further, one recently published research paper identified the Western Pacific Region as an improved region in outbreak discovery and response.

In 2009, the world experienced the first influenza pandemic since 1968, providing a major test of the preparedness, resilience and responsiveness of countries, WHO and other organizations/agencies. Strategies proved to be effective. Following this event, Member States were asked how they want to be known by 2015. With those voices, APSED (2010) was developed. In the new APSED (2010), the scope was expanded with three new functional areas added: public health emergency preparedness; regional preparedness; and alert and response and monitoring and evaluation.

While infectious disease is different than humanitarian emergencies, an approach similar to APSED can be used so we are better prepared for health cluster preparation. APSED (2005) served as a common operational framework for developing core capacities for emerging diseases. Its success attributed to the long-term vision, common operational platform and partnerships. The systems developed for the emerging disease programme can be utilized for emergency and disaster preparedness and response.

2.4.2.1 Summary of comments

Attendees asked questions and made observations on the preceding presentation. It was noted that a positive step had been taken to include public health emergencies in APSED (2010) and that ministries of health have been following WHO’s guidance in this area. It was also commented that a biological attack might be not included in APSED (2010). It was noted, however, that this area is in planning for future inclusion (2014/2015). Such a multi-hazard approach could be beneficial.

2.4.3 Introduction of Functional Area I, Information

Dr Takeshi Kasai, Director, Division of Health Security and Emergencies, WHO Regional Office for the Western Pacific, introduced the first functional area of the proposed framework. An “action-oriented” modification on categorizing/groupping and using information was proposed with the following grouping areas for health needs/risks assessments:

- **pre-event basic information**: such as country profiles (district level) prepared in advance;
- **preliminary health needs assessment**: conducted within 24–72 hours for immediate health intervention, jointly with the Ministry of Health, whenever possible; and
- **continuing health needs and risks assessments**: conducted jointly with health cluster partners. Information includes “health service delivery” in addition to the monitoring of health situation and public health risks.

2.4.4 Summary of group discussion

To stimulate discussion and feedback regarding the categorization of the information functional area of the proposed operational framework, a number of questions were introduced and worked through in groups. The main themes presented by each group have been summarized.
Essential information with regard to pre-event, country-focused information could include:

- maps;
- demographic/population characteristics;
- socio-cultural and socio-economic backgrounds;
- health information and vulnerability of the regions (e.g. mortality rates by groups, endemic diseases, epidemics);
- health care system (e.g. description of the health system, number of health personnel, number and location of health facilities, mapping of health cluster focal points system);
- strength of personnel in the regions;
- geographic peculiarities of the area (e.g. isolated, hilly, high altitude); and
- contact details of focal person(s).

This type of information is available at the provincial level. Once collected, this information needs to be stored in a central area.

It was recognized that preliminary assessments should be jointly performed with the Ministry of Health, whenever possible. The preferred time frame for conducting the preliminary health needs assessment was suggested as within 24–48 hours, if possible. Groups emphasized the importance of gathering information that could be collected rapidly in order to define the situation quickly. This information could be used to measure the following:

- magnitude of the emergency and extent of damaged areas;
- number of people affected: rough estimation of injured, pregnant mothers, etc.;
- basic health needs (food, water, etc.);
- functioned status of local government systems and of health facilities;
- status of supplies (How long they will last);
- number of doctors, nurses, etc. working and able to work;
- extent of affected lifelines plus access and communication to the area; and
- risk of secondary disaster.

Continuing health needs and risks assessments, performed jointly with health cluster partners should include “health service delivery” in addition to the monitoring of health situation and public health risks. Information should be collected in a standardized format and may involve health cluster partners by:

- engaging them in the information system (such as data collection and reporting) and in meetings that can be used as an information sharing point;
- gaining input on assessment tools (templates) to be used; and
- having them contribute in terms of resources and expertise (by participating in a joint assessment).

Results of continuing health assessments could be better utilized to prioritize and coordinate the health cluster response in the Region by informing the priority of post-disaster services (given that different agencies within the health cluster will have different priorities and mandates). Based on the data, the priorities could also be jointly agreed to facilitate targeted funding.

Overall, the Forum attendees were supportive of the action-oriented modification on information. Further guidance on operationalizing information collection and assessments is however needed. It was also noted that early decisions are made partially based on knowledge of epidemiology and history of previous disasters.
2.4.4.1 Summary of comments

During a collective discussion of group presentations, it was noted that knowing what sections of the health system will continue to function after an event was important. Filtering of information was identified as an issue and questions were raised on how the information can be effectively filtered for ease of use by coordinators. Experience has shown that it often becomes difficult to assess information and gain a complete picture due to gaps in information data.

An agreed, assessment is needed for the initial 24–48 hour period. With that, an analysis tool and an agreement of what should be collected and analysed are needed. It was questioned whether countries can gain information so quickly; in response, some countries such as the Philippines have a system in place to gather information from the field from local government structures. Media are a quick source of information in a disaster; however, while they can quickly cover the magnitude of a disaster, they are not able to provide specific information about health systems (for example, facilities affected). An established system within the local government network, with defined data collection focal points, could assist in gaining rapid, local data.

2.5 Functional Areas II and III: Service delivery and resources

2.5.1 Sharing of country experiences and lessons

During this plenary session on Functional Areas II and III (service delivery and resources), presentations were given by two attendees from China and Fiji, who outlined the experiences and lessons learnt in their countries during recent public health emergencies. Their presentations have been summarized in the succeeding paragraphs.

2.5.1.1 Practice of major disaster health management in China

Dr Li Zhengmao, Deputy Director, Office of Health Emergency, Ministry of Health of China, presented experiences with disaster health management during two earthquake relief efforts in China. Regular emergency coordination mechanisms in China include Natural Disaster Relief; Earthquake Rescue; Flood, Draught and Typhoon Prevention and Defence; and Public Health Emergency Response. The three core objectives of medical rescue and health management in natural disasters are to treat the injured, to recover basic medical and health services and to implement health and epidemic prevention to prevent disease outbreaks. The State Council earthquake relief headquarters is made of nine subgroups, including the anti-epidemic group. It has been recognized that this group needs to be expanded, strengthening the link with the health and disease prevention group.

After the Wenchuan earthquake, the National Health System was quick to mobilize medical resources, dispatching 1424 medical staff within 24 hours and building a mobile hospital and field blood stations to provide free treatment for the wounded. One-fifth of all injured (10 015 patients) were transferred to 375 hospitals in 58 cities. Coordination with related ministries to give priority to medical supply through railways and air channels was also undertaken. It was identified that a rehabilitation strategy and corresponding network needed to be established to keep coherence between early medical treatment and later. There was also a need for a free treatment policy for the serious wounded and a “Guideline of Emergency Crisis Intervention”, as well as provision of essential medicines and special needs for the vulnerable. To prevent epidemics, it was identified that emergency situation reports must be produced as well as assessments of public health and sanitary needs for the evacuated and provision of hepatitis A and encephalitis B vaccinations. The quality of drinking water and the occurrence of
waterborne diseases must also be monitored and victims, volunteers and rescue responders should be given health education on sanitation.

After the Yushu earthquake, different priorities where identified at different stages, but most important and across all stages was collecting information in a timely manner to adjust work priorities. An integrated command structure, involving the health sector, the military health force and the armed police health force, both centrally and on the frontlines, proved to be beneficial. The equal importance of treating the wounded and preventing epidemics was highlighted, particularly measures to prevent plague and the plateau-related disease.

Service delivery in disasters in China includes the following service areas:

- information collection
- public health risk assessment
- communicable disease control
- water sanitation
- food safety
- environment health
- health education.

External services provision comes from a range of actors (local, central and international) and includes funds, supplies, technical support and rescue teams. The main challenge in this area is timely interagency information transmission and communication, with needs appropriately matched to the capacities of each actor.

2.5.1.2 Disaster preparedness and response in Fiji

Ms Unaisi Bera, Acting Chief Health Inspector and National Advisor for Environmental Health, Ministry of Health, Fiji, presented on the service delivery aspects of disaster preparedness and response in Fiji. The two main seasons in Fiji present different risks: heavy rainfall and flash floods during the hot and wet season, and drought during the cool and dry season.

The disaster response operational framework has different degrees of action and risk, from information dissemination and advocacy to activation of the National Health Emergency Command Centre. Service delivery is divided into the following main areas:

- clinical
- nutrition and food safety
- environmental sanitation
- public health measures.

The priority needs of Fiji can be understood as a four-level pyramid, with water, sanitation and hygiene as the base, followed by basic first aid, health emergency relief and rehabilitation aid, then by emergency food rationing, security and safety, and with technical expertise at the peak.

The National Disaster Preparedness Unit of the Ministry of Health partners with local government departments, local and international NGOs and the private sector. The main coordination challenges are internal and external communications, lack of a notification alert, the overarching responsibilities of National Public Health and Disaster Management Committee and information management.
The future direction to be taken by the Ministry of Health for disaster management will include outreach programmes, development of field hospitals, advocacy and community awareness raising, review of procedural processes of reporting, communication, preparedness and response, review of existing plans and strengthening the communication network, along with community support and community health workers.

2.5.1.3 Summary of comments

At the conclusion of both country presentations, attendees asked questions and made observations. Clarification was sought on whether China and Fiji had established a health cluster in their countries. China has a health cluster with an emergency response stage that works well. UNDP in China is in favour of the disaster approach; the health cluster team is well coordinated. At country level, coordination between national and international partners needs strengthening. Principles of the cluster are actually followed at country level. This is a trend that is specific to this Region which will need to be brought to the attention of GHC.

2.5.2 Introduction of Functional Areas II and III, Service Delivery and Resources

Dr Jostocio Lapitan, Technical Officer, Urban Health Emergency Management, WHO Kobe Centre, introduced the second and third functional areas of the proposed operational framework. Two widely accepted categories of health services from the Sphere Handbook (2011) and the IASC GHC Guide were taken into consideration to propose a regional health cluster operational list of services for discussion among Forum attendees. This list includes:

- clinical services (including injury)
- child health
- communicable diseases
- sexual and reproductive health
- noncommunicable diseases
- mental health and psychosocial support (MHPSS)
- environmental health

2.5.3 Summary of group discussion

Forum attendees engaged in discussion regarding this categorization of services and shared their feedback based on their experience in health response to disasters in the Asia Pacific region. The main themes presented by each group have been summarized.

Health service needs in health response to disasters in the Asia Pacific region depend on the phase of disaster (different phases may have different priority needs) and the type of disaster (e.g. earthquake versus flooding) emphasizing the importance of coordination and leadership on provision of various health services. Cross-cutting issues that may be classified under different clusters include WASH (which may lead to communicable diseases) and nutrition (assessing health impact). A multi-cluster approach could assist in better addressing needs.

Feedback on the modifications to the health services areas categorized under the IASC and Sphere guides was discussed within the groups. It was agreed that having defined service categories is important and useful for needs assessments, communication and coordination, and planning. The Forum members suggested that "nutrition", "STI & HIV/AIDS", "sexual violence" and "maternal and newborn health" remain as indicated in the IASC guide. The proposal to separate "mental health and psychosocial support" from the category of "noncommunicable disease, injury and mental health", and include "injury" under "clinical services" was supported by the Forum, to emphasize the importance of these health services in
the Region. It was also noted that health facilities are often a vital aspect to be addressed for disaster response. Also, the actual response must be based on risk/needs assessments rather than service categorization and category. Finally, definitions should be clear but flexible.

Remembering the importance of engaging the local community in implementing public health measures is one way to facilitate effective (adequate and appropriate) and timely post-disaster public health interventions. Other ways as suggested by Forum attendees include:

- ensuring public health interventions occur at the same time as addressing immediate basic needs (e.g. food, water and psychosocial support) of affected people;
- stockpiling to support appropriate public health interventions; and
- documenting best practices – what worked for a certain country context?

The health cluster could be better utilized to facilitate resource mobilization for health response to emergencies and disasters in the Asia Pacific region. There is a recognized need to increase awareness about existing resource mechanisms, including CERF and the Consolidated Appeal Process (CAP). Other possible mechanisms may include a revolving fund in community, ASEAN foundations and regional banks. Many elements of a response to sudden onset disasters are predictable, allowing for coordination in advance. For interventions that must commence within hours and are not based on needs assessment (trauma, surveillance, etc.), certain funding applications can be prepared ahead of time.

Requesting a realistic amount of funds provides a better chance of success in attaining those funds. Also, having a long-term relationship with donors is beneficial. There was a recognized difficulty in sharing financial resources, but other types of resources could be readily shared (e.g. expertise, supplies and logistics).

2.5.3.1 Summary of comments

During a collective discussion of group presentations, it was noted that narrowing the discussion during group work was initially somewhat difficult. While there was a lot of debate, agreement was possible. There was common understanding that partners need to work as “one” and agree on how to better serve the community.

It was recognized that service delivery is the most important part of the disaster response. If clear service delivery sections are identified, then there can be common understanding. The services should be related to health; whilst most services are the same in every disaster, time of delivery varies. The point was made that the expectation to “solve” normal health problems during a disaster should not be included. Instead, the expectation should be that health problems do not expand during a disaster.

The scope of the health cluster was reviewed in the summary discussion. It was noted that the scope of the services become broader when considering preparedness, response and recovery. GHC has to consider preparedness for response. Their scope is broad; however, they have come along way in terms of bringing partners together and attempting to standardize tools. The challenge now is to get these tools validated.

Initially, GHC was set up to improve disaster response and many partners thought that should be the GHC scope. Preparedness was initially specifically avoided, but it was realized that a good response stands on good preparedness. Unfortunately, it took time for the global level to realize this when the field level was already experiencing it. Experiences and feedback from the field level need to be channelled back to the global level. Practice needs to be translated into policy, and this is evolving.
It was also requested that definitions (for example, the difference between disaster and emergency) be used with consistency, when possible.

2.6 Monitoring and evaluation

2.6.1 Introduction of the "plus one" functional area: Monitoring and evaluation

A number of reference documents are available with suggested M&E methods and indicators, including those commonly used indicators in the IASC GHC Guide and the Sphere Handbook (2011). At present, wide variations in the quality of national data may prevent the development of regional indicators for morbidity and disability arising from emergencies, as well as indicators for the disruption, damage and destruction of health sector services, infrastructure and equipment. A number of possible indicators were proposed for discussion under the categories of:

- indicators for coordination effectiveness
- indicators for public health response
- indicators for impact analysis.

2.6.2 Summary of group discussion

Forum attendees engaged in discussion of M&E and shared their feedback based on their experience in health response to disasters in the Asia Pacific region. The main themes presented by each group have been summarized.

Forum attendees recognized that M&E is as an important cross-cutting function to be addressed separately. The need to clearly define the purpose, scope and process of M&E of the health cluster was identified. Emphasis would need to be made to focus on intervention and process to identify critical points for improvement. Many concerns were raised regarding the M&E component including the following:

- What should be monitored and evaluated?
- What should be the timing of M&E?
- How should the results of M&E be fed back?

2.6.2.1 Summary of comments

Performance evaluation has traditionally been neglected, but it is important. As such, it is time to determine the value added of the health cluster, i.e. what is effective and what is not.

Quality management indicators of each of the operational framework sections are required. The feedback mechanism needs to be defined. Otherwise, it is unclear how to feed back the results of M&E and who should receive/provide the feedback. A participatory method of evaluation with stakeholders would be beneficial but challenging since partners have different understandings and questions for evaluation.

It was also noted that there is a chapter on M&E in the IASC GHC Guide. While it is still focused on response strategy, it provides good guidance. The challenge will be determining how to implement it. Evaluating a cluster will be more difficult than a programme, for example, because of its complex set-up. It was proposed to evaluate cluster partners as well as the cluster itself, but this would be challenging. Another challenge would be deciding on benchmarks and indicators for impact evaluation because other clusters would impact on the work of the health cluster.
The question was raised: If the intention is to improve the cluster process, to whom are partners accountable? In response, the cluster exists to support the national government; therefore, it should be accountable to the national government. In addition, partners are also accountable to the donors. The terms of reference should be the basis of the cluster performance, which raises the importance of having clear terms of reference.

A standard M&E format is required. In this view, an external entity can provide a more objective opinion on the M&E functions. Given that indicators for evaluation would be country specific, M&E led at the regional or global level may not be appropriate.

In a final remark, it was recalled that partners and countries are ultimately accountable to the people they are serving – the beneficiaries.

2.7 Closing session

At the close of the Forum, attendees were asked to give feedback on the meeting, the proposed framework and its functional areas and to share their views on progressing from this point. All responded positively about the experience, the value of the Forum and the consensus on conclusion and recommendation statements to move forward on developing an operational framework for humanitarian emergencies in the Western Pacific Region.

Dr Jacob Kumaresan, Director, WHO Centre for Health Development (WHO Kobe Centre), expressed appreciation for the background work prior to and during the Forum that contributed to the success of the Forum. Dr Kumaresan shared observations that the Forum conclusions and recommendations discuss the cluster approach which extends beyond the sole input of WHO and requested for partners to support the recommendations and continue their participation in future discussions. He extended his gratitude to attendees, on behalf of local partners, for their participation in the Forum, and shared that the WHO Kobe Centre was pleased to be the host. He encouraged attendees to help prepare for a better future and pass it on to the next generation – a lesson gained from the volunteers at the disaster relief centre in Kobe.

Dr Takeshi Kasai formally thanked attendees for their participation in the First Regional Health Cluster Forum on Humanitarian Emergencies and officially closed the Forum.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

3.1.1 The First Regional Health Cluster Forum on Humanitarian Emergencies in the Western Pacific provided various agencies and partners involved in disaster health with an excellent opportunity to share information and exchange experiences related to the Health Cluster approach.

3.1.2 The Forum expressed its sincere sympathy to those who were affected by the Great East Japan Earthquake that occurred in March 2011. The Forum greatly appreciated the presentations made by speakers from Japan who were involved in the disaster's health response.

3.1.3 The speakers from Japan shared the importance of immediately establishing an incident command structure for coordination of health response among stakeholders. Preparation for
incident command, health information management and established expert networks prior to disaster events, as well as the flexible management approach were key factors for success.

3.1.4 While experience of the formal Health Cluster is still limited in the Western Pacific Region, cluster approach principles have been gaining increased support. Member States in the Region have been adopting cluster approach principles in their health sector response which has improved coordination among stakeholders.

3.1.5 The Philippines shared its experience in institutionalizing the cluster approach, emphasizing the importance of having information on partners. Viet Nam developed and implemented its National Action Plan, which emphasizes the importance of identifying clear roles and responsibilities for stakeholders.

3.1.6 China shared its recent experiences in health response to the Wenchuan and Yushu earthquakes, emphasizing the unified and integrated command and control structure, and the provision of medical services, including care of the injured. Fiji has its national disaster preparedness and response plan, which highlights the priority triangle model of service delivery, consisting of water, sanitation and hygiene, first aid, food safety and security, and technical support.

3.1.7 Cambodia shared the experience of its health disaster management committee and the existing surveillance and information system. Some challenges remain in health information collection and assessments, such as developing a standard reporting format.

3.1.8 Member States in the Region have been implementing many ongoing activities at the national level to improve disaster preparedness and response in recent years. The importance of strengthening local capacity has also been recognized and emphasized by Member States.

3.1.9 The Health Cluster approach was reconfirmed by the Forum as an important mechanism to improve efficiency and effectiveness through enhanced coordination in humanitarian emergency response in the Western Pacific Region. The Forum expected that the health cluster approach would provide action-oriented information and improve coordination. Some participants also expressed the need to utilize the health cluster approach as a management tool to improve management of various health responses.

3.1.10 Effective implementation of the health cluster approach requires taking into account the regional context, including leadership and enhanced national capacity of government, as well as existing regional arrangements under ASEAN, such as the existing roles and responsibilities of its sectoral and subsidiary bodies.

3.1.11 The Region has already established strong health-related programmes including an emerging disease management programme through implementation of a common regional framework – the Asia Pacific Strategy for Emerging Diseases (APSED). Such existing systems and advantages should be fully utilized to improve disaster preparedness and response.

3.1.12 The need to better prepare the health cluster for operation in the Region was emphasized and this First Regional Health Cluster Forum itself was recognized as an important part of such preparedness.

3.1.13 Completing the partners' profiles was identified as an important activity for health cluster preparedness. The Forum reviewed the proposed format of the partners' profile and additional information on links with other agencies and initiatives was suggested.
3.1.14 The Forum attendees supported the proposed approach to develop a simple, flexible, action-oriented common operational framework and to use it as a basis to operationalize the health cluster in the Region.

3.1.15 The Forum attendees welcomed the "Three plus One" functional areas that were developed based on the agreed expected outputs contained in the IASC Global Health Cluster Guide. It was also agreed that the proposed functional areas could be used as a basis to facilitate implementation of the health cluster at the country level in the Region.

3.1.16 The action-oriented modification on information was supported by the Forum. However, further guidance on operationalizing information collection and assessments was needed. It was also noted that early decisions are made partially based on knowledge of epidemiology and history of previous disasters.

3.1.17 The Forum attendees reviewed and discussed the proposed categorization of health services and agreed that having a service category is important and useful for needs assessments, communication and coordination, and planning. It was suggested that the categories of "nutrition", "STI & HIV/AIDS", "sexual violence" and "maternal and newborn health" remain as indicated in the IASC GHC Guide. The proposal to separate "mental health and psychosocial support" from the category of "noncommunicable disease, injury and mental health", and include "injury" under "clinical services" was supported by the Forum attendees, to emphasize the importance of these health services in the Region.

3.1.18 There is a need to improve preparedness for resource mobilization, including understanding about existing mechanisms; applications for CERF, Consolidated Appeals Process and Flash Appeal; as well as strengthening donor relations.

3.1.19 Monitoring and evaluation (M&E) is recognized as an important cross-cutting function to be addressed separately. The Forum attendees expressed the need to define clearly the purpose, scope and process of M&E of the health cluster. Emphasis would need to be made to focus on intervention and process to identify critical points for improvement.

3.2 Recommendations

3.2.1 WHO, as the Health Cluster lead agency, should continue to make efforts in preparing for better operations of the Health Cluster approach at the country level in the Region. As part of such efforts, WHO should organize and facilitate the Regional Health Cluster Forum, held at least annually.

3.2.2 WHO and health cluster partners should advocate the health cluster approach. WHO should further develop the "Three plus One" regional framework document based on the information and suggestions from the Forum in order to operationalize the health cluster approach in the Region.

3.2.3 WHO should modify the format of the partners' profile. Health cluster partners should send updated and complete information using the revised template to WHO by September 2011. WHO and health cluster partners should update the partners' profile on a regular basis.

3.2.4 WHO should conduct a study on existing information collection tools and forms that are designed for use immediately following disaster-producing events, identify common elements and organize informal consultations to further develop details on the functional area of "information".
3.2.5 The conclusions and recommendations from this Forum should be shared with the Global Health Cluster.

3.2.6 The Second Regional Health Cluster Forum on Humanitarian Emergencies is tentatively planned to be held in November 2012.
PROGRAMME OF ACTIVITIES

Day 1 – 22 August (Monday)

08:30 – 09:00 Registration

09:00 – 09:30 Opening session

Opening remarks
- Dr Shin Young-soo, Regional Director
  WHO Western Pacific Regional Office
- Mr Toshizo Ido, Governor
  Hyogo Prefecture, Japan
- Dr Masato Mugitani, Assistant Minister for Global Health
  Ministry of Health, Labour and Welfare, Japan

09:30 – 10:10 Group photo and coffee break

10:10 – 10:30 Plenary 1: Overview of the forum

Objectives and agenda

Self-introduction

Nomination of Chairs

Administrative announcements

10:30 – 12:00 Plenary 2: Overview of the cluster approach

History of the cluster approach and cluster implementation
in the Asia Pacific Region
- Mr Markus Werne

Health cluster and WHO's roles and responsibilities
as the health cluster lead agency
- Dr Rudi Coninx

Experience of health cluster approach in the Western Pacific Region
- Dr Arturo Pesigan

12:00 – 13:00 Lunch break
13:00 – 14:30  **Special session: Japan earthquake**

The Great Hanshin-Awaji Earthquake 1995  
- *Ms Noriko Nakano*

The Great East Japan Earthquake 2011 (1)  
- *Dr Hitoshi Oshitani*

The Great East Japan Earthquake 2011 (2)  
- *Dr Tadashi Ishii*

14:30 – 15:00  **Coffee break**

15:00 – 15:40  **Plenary 2: Overview of the cluster approach (continued)**

Country experience of cluster approach

Philippines  
- *Dr Carmencita Banatin*

Viet Nam  
- *Dr Nguyen Manh Cuong*

15:40 – 15:50  **Plenary 3: Introduction to the Framework**

15:50 – 17:30  **Group work I: Why Framework?**

Expectations from the health cluster approach

Regional context

Three plus One functional areas

Partners’ profile

18:00 – 20:00  **Welcome reception**
Day 2 – 23 August (Tuesday)

08:30 – 08:40  Summary of Day 1
08:40 – 09:20  Plenary 4: Group feedback
   Option for grouping
   - WHO
   Country experience of cluster approach
   China
   - Dr Li Zhengmao
   Fiji
   - Ms Unaisi Bera
10:20 – 10:40  Coffee break
10:40 – 12:00  Group work II: Service delivery and resources
12:00 – 13:00  Lunch break
13:00 – 14:00  Plenary 6: Functional Area I – Information
   Country experience of cluster approach
   Cambodia
   - Dr Khuon Eng Mony
   Strategy related to emerging disease surveillance and risk assessment:
   Asia Pacific Strategy for Emerging Diseases (APSED)
   - Dr Takeshi Kasai
   Proposed framework: Action-oriented modification
   - WHO
14:00 – 15:15  Group work III: Information
15:15 – 15:30  Coffee break
15:30 – 17:30  Field visit to Hyogo Emergency Medical Centre
Day 3 – 24 August (Wednesday)

08:30 – 08:40 Summary of Day 2

08:40 – 09:40 Plenary 7: Group feedback

09:40 – 10:30 Group work IV: Monitoring and evaluation

10:30 – 11:00 Coffee break

11:00 – 11:30 Plenary 8: Group feedback

11:30 – 12:45 Plenary 9: Conclusions and recommendations

12:45 – 13:00 Closing session

Closing remarks
- Dr Takeshi Kasai
- Dr Jacob Kumaresan
# LIST OF PARTICIPANTS, TEMPORARY ADVISERS, OBSERVERS AND SECRETARIAT

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<thead>
<tr>
<th>Organization</th>
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Proposed Structure of the Framework

1. Why a Framework?
   This section describes important background information on the cluster approach, including the health cluster, and explains why an effective framework is needed to operationalize the health cluster and to prepare for the health cluster response in the context of the Western Pacific Region.

2. "Three plus One" Functional Areas
   This section describes how the "Three plus One" functional areas have been developed based on the analysis of the IASC Health Cluster Guide (2009). It includes information on service delivery, resources and monitoring and evaluation.

3. Information
   This section focuses on "action oriented" modification, describing the following:
   - pre-event basic information
   - preliminary health needs assessments
   - continuing health needs and risk assessments.

4. Service Delivery
   There are many ways of categorizing various health services. This section proposes a slightly modified service grouping based on the existing guidelines, including the IASC Health Cluster Guide (2009) and the Sphere Handbook (2011).

5. Resources
   This section summarizes existing financial mechanisms such as the United Nations Central Emergency Response Fund (CERF) and the Consolidated Appeal Process (CAP). Other possible resources are also explored.

6. Monitoring and Evaluation
   Monitoring and evaluation (M&E) is an integral part of the health cluster approach, aiming to meet two critical management needs: accountability and learning. This section highlights the need for a simplified M&E system for the health cluster response in the Region, supported by a minimum set of indicators.
Appendices

Appendix 1  United Nations Cluster Approach
Appendix 2  Expected Health Cluster Outputs (IASC Guide)
Appendix 3  Experience of the Health Cluster Approach in the Region
Appendix 4  Partners’ Profiles
1. Why a Framework? (Group Work I)

Introduction

Emergency and disaster management requires a multidimensional approach involving multiple sectors, humanitarian partners, development partners and donor agencies working together to meet various needs at the different phases of emergencies and disasters, including the response and recovery phases. As one of the first responders, the health sector is required to take the key role in the humanitarian response phase.

Emergency management and service delivery agencies usually operate under various auspices, assumptions and values in the delivery of post-disaster services. Despite good intentions, organizational variations in modes of communication, application requirements, scheduling and eligibility standards increase the possibility of inconsistency, conflict and poor coordination in post-disaster service delivery.

Agencies may also fail to address the needs of special populations such as children, the elderly, immigrants and the homeless. For survivors, these types of organizational limitations may add frustration and anger to a chaotic situation, cause potentially life-threatening gaps in immediately and desperately needed assistance, and impede a community's movement towards longer-term recovery. At the end of an emergency operation, people may question the efficiency and effectiveness of the health sector response.

To improve the efficiency and effectiveness of the humanitarian response in a crisis, and to increase predictability and accountability in the main sectors of the international humanitarian response, a cluster approach, including a health cluster, has been developed as a humanitarian reform. Globally, a number of guides and tools, such as the IASC Health Cluster Guide (2009), have been developed to facilitate implementation of the health cluster approach.

To date, the global health cluster approach, including various global policies, guidelines and tools, has not been fully operationalized in a systematic way, taking into consideration the regional context.

In Asia and the Pacific, natural disasters have affected and will continue to affect both developing and developed countries. Nine of the top 10 countries with the highest number of
disaster-related deaths are in Asia. Disaster impacts go beyond infrastructure damage and economic loss. Loss of lives, injuries and disruption of medical care services and public health systems are also consequences of disasters.

In the Western Pacific Region, most countries have strong government systems, including the health emergency and disaster management system. National governments play the key role in organizing the immediate response to disasters, facilitating effective coordination (both internal and external) at the different administrative levels and carrying out the post-disaster recovery programme. It is vitally important for health cluster partners to support government efforts in the context of the “big picture” of a national government’s emergency response and recovery system.

Moreover, countries in the Western Pacific Region have worked diligently to develop and strengthen health-related programmes and systems for emerging disease and public health event surveillance and response. After experiencing significant disease outbreaks in recent years, countries have also improved their public health risk assessment capacity. Existing systems and programmes, including post-disaster surveillance and risk assessments, have supported disaster response and recovery.

The proposed health cluster operational framework was developed with input from existing policies, guidelines, experiences and lessons learnt from past events (Figure 1). It will be used to guide timely and effective health cluster responses in the Western Pacific Region at the country level.

Figure 1. Process of developing a health cluster operational framework
Proposed questions for discussions

1. In your opinion, and based on your experience, what do you expect from the health cluster approach?

2. Based on your experience in emergency and disaster response in the Asia Pacific region, what is our specific regional context?

3. As part of the health cluster preparedness efforts for response, it has been proposed to include partners' profiles that will need to be updated on a regular basis. What do you think are the key sections or types of information that should be included in the profile? What mechanism should be used to keep the profiles up to date?
2. "Three plus One" Functional Area (Group Work I)

Introduction

The health cluster is expected to conduct an appropriate health response to emergencies and disasters in an efficient and effective matter, in coordination and collaboration with affected countries. There are many overlapping and interlinked functional areas that the health partners are expected to support at the different phases of disasters, depending on evolving situations.

The IASC Health Cluster Guide (2009) highlights a number of expected health cluster outputs (Annex 1) and relevant health cluster functions. Many other guidelines also address various functional areas related to health.

Building on the expected health cluster outputs and functions contained in the IASC Health Cluster Guide, the "Three plus One" functional areas were proposed to operationalize the health cluster response in the Western Pacific Region (Figure 1). The “Three plus One” functional areas are Information, Service Delivery, Resources and Monitoring and Evaluation (Figure 2).
Such simplified functional areas aim to facilitate the process of rapid information collection, systematic ongoing needs and risk assessments, and use of information especially assessment results to guide appropriate public health action and service delivery. They also help to improve rapid mobilization and utilization of resources for emergency and disaster response.

**Figure 2. Proposed "Three plus One" functional areas**

**Proposed questions for discussions**

1. What do you think about using the "Three plus One" functional areas to facilitate the operationalization of the health cluster response in the Region?

2. Which guides and tools should be further developed to operationalize the health cluster after a simple operational framework is developed in the Region?
# Expected Health Cluster Outputs (IASC Guide)

## Goal of the Health Sector Response during Humanitarian Crises

To reduce avoidable mortality, morbidity and disability, and restore the delivery of, and equitable access to, preventive and curative health care as quickly as possible and in as sustainable a manner as possible.

## Expected Health Cluster Outputs

<table>
<thead>
<tr>
<th>Output</th>
<th>See chapter</th>
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<tbody>
<tr>
<td>Functioning health sector coordinating mechanisms involving UN agencies, NGOs, CSOs, health authorities, donors, and community members, including between the centre and the field, and with other sectors/clusters</td>
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<tr>
<td>Up-to-date mapping of health actors, available health services, and service delivery activities</td>
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<td>Up-to-date information on the health situation and needs is available to all stakeholders; regular situation reports/health bulletins</td>
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<td>Initial rapid assessment and situation analysis, agreement on priority health problems and risks</td>
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<td>Regular joint situation updates based on monitoring of the situation and of the health services delivered</td>
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<tr>
<td>A joint, regularly updated, health response strategy in the crisis, with clear priorities and objectives for addressing priority health problems, risks and gaps</td>
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<tr>
<td>A joint contingency plan for response to future events that could impact on the populations’ health or partners’ response activities</td>
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<td>Distribution of responsibilities among partners based on capacities to deliver in the field</td>
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<td>Agreed standards, protocols and guidelines for basic health care delivery, standard formats for reporting</td>
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<td>Training materials and opportunities available to all partners for upgrading skills and standards of service provision, as needed</td>
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<td>Agreed health sector elements in joint appeals and CERF applications; agreed priorities for allocation of pooled resources</td>
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<td>A common advocacy strategy and plan</td>
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<td>Joint field visits for monitoring; joint evaluations and lesson-learning</td>
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4. Service Delivery  
(Group Work II)

Introduction

Post-disaster health needs depend on many factors, including type and extent of disaster, stage of emergency or disaster response, and population and geographical locations affected. Both initial rapid assessments and continuing public health risk and need assessments inform appropriate health actions, including types of health services and public health interventions required for emergency or disaster response. During disasters, identification of major causes of morbidity and mortality is important for making decisions on appropriate essential health services, especially in the early phases of response. During the different disaster phases, especially the recovery and reconstruction phase, sustainable health systems and services, especially public health functions in disaster-affected areas, should be ensured.

There are numerous ways of categorizing health services and ensuring service delivery during and after disasters. Different organizations, initiatives and programmes may have unique ways of categorizing and prioritizing health services to meet specific needs. There are also cross-cutting issues or concerns, such as gender equity, that need to be addressed.

The Sphere Handbook (2011) contains four main technical areas of work, namely: (1) water supply, sanitation and hygiene promotion; (2) food security and nutrition; (3) shelter, settlement and non-food items; and (4) health action. The section on health action focuses on essential health services (i.e. preventive and curative health services) that are appropriate to address the health needs of populations affected by disasters. Essential health services include interventions that are most effective in preventing and reducing excess morbidity and mortality from communicable and noncommunicable diseases. They also include services in child health, sexual and reproductive health, injury and mental health.

The IASC Global Health Cluster Guide (2009) divides health services into three levels (community care, primary care, and secondary and tertiary care) and nine sub-sectors, those being: (1) general clinical services; (2) child health; (3) nutrition; (4) communicable diseases; (5) sexually transmitted infections and HIV/AIDS; (6) material and newborn health; (7) sexual violence; (8) noncommunicable diseases, injuries and mental health; and (9) environmental health.

Health services and interventions during emergency and disaster response should be designed and implemented in a way that contributes to strengthening sustainable health systems.
Table 1 highlights two widely accepted categories of health services and proposes a slightly modified service grouping to facilitate the health cluster response in the Western Pacific Region.

Table 1. Categorization of health services during emergency and disaster response

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<tbody>
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<td>1. Control of communicable diseases</td>
<td>1. General clinical services</td>
<td>1. Clinical services (including injury)</td>
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<tr>
<td></td>
<td>7. Sexual violence</td>
<td>7. Environmental health</td>
</tr>
<tr>
<td></td>
<td>8. Noncommunicable diseases, injuries and mental health</td>
<td></td>
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<td></td>
<td>9. Environmental health</td>
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Proposed questions for discussions

1. Based on your experience in disaster response in the Asia Pacific region, what do you think are the most needed health services? Have you experienced any major concerns in the way of organizing health services?

2. Based on the IASC and Sphere guides, and taking into consideration the regional context, seven areas of health services are being proposed to facilitate our regional health cluster operations (see Table 1). What do you think about this modification? Do you have any serious concern(s) about this grouping? If so, what do you suggest to address the concern?

3. How do you think we (as a health cluster) can facilitate effective (adequate and appropriate) and timely post-disaster public health interventions?
5. Resources
(Group Work II)

Introduction

Financial resources are available from the United Nations through the Central Emergency Response Fund (CERF) to meet immediate post-disaster and other emergency needs. Long-term needs are usually met through the Consolidated Appeal Process (CAP). In addition to support from the United Nations, development partners and donor agencies, such as the European Commission’s Humanitarian Aid Department (DIPECHO), Department for International Development (DFID), Swedish International Development Cooperation Agency (Sida), Canadian International Development Agency (CIDA), United States Agency for International Development (USAID), Japan International Cooperation Agency (JICA) and North American Aerospace Defense Command (NORAD), may also provide financial support.

During a disaster, health cluster partners usually receive considerably less money than organizations working on infrastructural recovery, rehabilitation and reconstruction. It may be important to consider how to calculate funds for human loss, disability, personal, social and community distress for varying periods of time until rehabilitation and reconstruction takes place.

Proposed questions for discussions

1. Based on your experience in disaster response in the Asia Pacific region, how can we better utilize the health cluster approach to facilitate resource mobilization?
2. In addition to CERF and CAP, what other possible resources may be available for the health response?
3. Information
(Group Work III)

Introduction

After disasters strike, public health needs change immediately and remain dynamic for a number of months or even years, depending upon several factors, including extent of disaster damage, pre-existing public health needs, capacity and capability of local health facilities and additional public health needs created by the event. It is important for the health sector to undertake timely assessments of health needs or gaps at the different phases of disasters to inform appropriate public health actions. Different types of post-disaster health needs assessments are currently being practised by different health partners at country and international levels.

There are many ways of collecting, organizing and using information related to emergency and disaster management. Taking into consideration the various guides, and in view of the importance of operationalizing health needs and risks assessments in the Region, an "action-orientated" modification on categorizing/grouping and using information is proposed. Information for health needs and risks assessments can be grouped as follows: pre-event basic information; information for preliminary health needs assessments; and information for continuing health needs and risks assessments (Figure 1).

**Pre-event (e.g. pre-disaster) basic information**, such as information on population demographics, disease patterns and health care facilities, is vital for rapid post-disaster assessments. Country profiles with subnational or district-level data, especially in disaster-prone countries, can be a good tool to improve preparedness.

**Preliminary health needs assessments** start immediately following a disaster. To mobilize immediate health interventions, it is vital to consider organizing the preliminary health needs assessments within 24–72 hours, jointly with the Ministry of Health officials. WHO should play a vital role in assessing swiftly the health status of the affected population, and sharing the information and assessment results with health cluster partners, so that an appropriate health response can be initiated to meet the immediate needs, including life-saving activities.
Assessment of health needs and public health risks is an ongoing, dynamic process. Following the preliminary health needs assessment, it is important to conduct **continuing health needs and risks assessments**, including initial rapid health needs assessments, on a regular basis with involvement of health cluster partners. In addition to monitoring the health situation and public health risks (such as communicable disease outbreaks and food safety events), information on health service delivery becomes an essential component of the continuing assessments. Health cluster partners play an important role in providing relevant information and facilitating these joint health assessments. Such assessments should inform the development of priority health actions to meet short- and long-term health needs of the affected population.

**Figure 1. Information for health needs assessments and actions**

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**Proposed questions for discussions**

1. What do you think is the basic or essential information needed with regard to pre-event country profiles?

2. What information is needed for the preliminary health needs assessments (24–72 hours after the disaster) and for guiding the immediate health response? What are the main issues relating to such initial rapid health needs assessments? What time frame and formats should we use?

3. With regard to the continuing assessments, how do you think the health cluster partners should be involved in the process (e.g. using agreed health service categories)? How can results of such regular health assessments be better utilized to prioritize and coordinate the health cluster response in the Region?
Asia Pacific Strategy for Emerging Diseases (APSED)

Introduction

The Asia Pacific region has been an epicentre of emerging diseases and public health emergencies, resulting in significant impacts on health, social and economic development. The Asia Pacific Strategy for Emerging Diseases (APSED) was initially developed in September 2005 as a common strategic framework for strengthening national and regional systems and capacities that are required to manage and respond to all emerging disease threats, including influenza pandemics.

In June 2007, a new global legal framework – the revised International Health Regulations, or IHR (2005) – came into force and became legally binding for all WHO Member States. IHR (2005) calls upon countries and WHO to strengthen their core capacities to detect, assess and respond to any potential and actual public health emergencies of international concern in order to protect global health security. APSED, which was endorsed by Member States in the Asia Pacific region, has served as a road map to guide all the countries in the region in meeting these IHR core capacity requirements.

Since 2005, through the implementation of APSED, considerable progress has been made in strengthening the national and regional systems and programmes related to emerging disease management. All the countries in the region have developed and strengthened their fundamental public health surveillance and response systems for emerging diseases and public health events. The Global Outbreak Alert and Response Network (GOARN) has been further developed in the region to improve regional preparedness for outbreak response.

A number of important factors have contributed to the success of APSED implementation:

- APSED puts forth an agreed long-term vision and appropriate approach for emerging disease management in a collective manner;
- APSED serves effectively as a common regional operational framework to implement the global mandates and policies in the region;
- APSED emphasizes the importance of effective partnerships both at country and regional levels; and
- APSED has a monitoring mechanism in place to facilitate country-level implementation of the regional framework, including an annual meeting of the Asia Pacific Technical Advisory Group (TAG) on emerging infectious diseases, which brings together Member States, WHO and partners to review annual progress and recommend priority actions.
APSED (2010) relevant areas

Building on the achievements of APSED (2005) and the lessons learnt from pandemic influenza preparedness and response, the Strategy was recently updated and its scope was expanded to comprise eight focus areas:

(1) surveillance, risk assessment and response;
(2) laboratories;
(3) zoonoses;
(4) infection prevention and control;
(5) risk communication;
(6) public health emergency preparedness;
(7) regional preparedness, alert and response; and
(8) monitoring and evaluation.

While APSED (2010) continues to focus on emerging diseases, it also seeks to make important contributions in the areas of emergency and humanitarian action as well as food safety. In particular, the following APSED (2010) workplan areas and ongoing activities are relevant to emergency and disaster preparedness and response:

- surveillance and monitoring of disasters and events (including health emergency events);
- risk assessments;
- health response operations using a common operational platform (e.g. Emergency Operations Centre within the health sector);
- database development, including country profiles; and
- public health emergency planning.
Introduction

Monitoring and evaluation is an integral part of the health cluster response to emergencies and disasters. It aims to meet two critical management needs: accountability and learning. Monitoring and evaluation of the health cluster response is often supported by a set of monitoring indicators. Commonly used indicators can be found in the IASC Health Cluster Guide (2009) and the Sphere Handbook (2011). National guidelines should be utilized whenever possible and appropriate.

At present, wide variations in the quality of national data may prevent the development of regional indicators for morbidity and disability arising from emergencies, as well as regional indicators for the disruption, damage and destruction of health sector services, infrastructure and equipment.

Possible indicators:

1. **Indicators for coordination effectiveness**

   - Number of meetings in the different disaster phases (daily/weekly, fortnightly), number of health partners participating in meetings, minutes of coordination meetings including notes on disagreements and proposed follow-up measures, number of periodic public health information sheets/bulletins issued
   
   - Number of temporary, semi-permanent and permanent health facilities established in the affected areas with support from the health cluster partners (mapping).
   
   - Cost-effectiveness of the public health interventions by the health partners – to be decided through consensus (in terms of %, cost per 1000 population affected, number of patients treated, etc).

2. **Indicators for public health response**
• Indicators to measure public health response – by assessing timeliness of public health interventions (regular mapping of the areas affected and functional public health facilities).

• Qualitative and quantitative assessments of public health interventions – in terms of appropriateness and adequacy of public health interventions applied to meet the public health needs of the affected population at the different disaster phases, including geographical coverage in the affected areas (mapping of injured, epidemiological map, geographical mapping of health partners' presence in the affected areas and mapping of functional public health facilities [primary, secondary and tertiary]).

3. **Indicators for impact analysis**

• Events per country per year (frequency – general and hazard specific).
• Events per square kilometre (frequency adjusted to allow comparisons between countries of different geographical sizes, e.g. allows direct comparison of data from different countries).
• Deaths per 100 000 population by age and sex (mortality rate – general and hazard specific).
• Deaths per 1000 population affected by age and sex (fatality rate – general and hazard specific).
• Deaths per hazard event by age and sex (lethality rate – hazard specific).

**Proposed question for discussion**

With regard to monitoring and evaluation of the health sector or health cluster response, do you have any important experiences and lessons from which we can learn? Should we consider "monitoring and evaluation" as an important separate "function" of the health cluster approach? Why?
United Nations Cluster Approach

The cluster approach aims to minimize gaps and maximize the effectiveness of the humanitarian response to an emergency or disaster through different organizations working with each other under a strong leadership.

The cluster approach attempts to do this by:

- ensuring sufficient global capacity is available in all sectors or areas of need;
- ensuring there is predictable leadership in these areas that will improve collaboration;
- promoting the concept of partnership between all actors involved;
- strengthening accountability to both those in need and the global community; and
- improving strategic field-level coordination and prioritization by putting this responsibility in the hands of a competent and credible agency.

CLUSTER COORDINATOR (Country Level): This person has been designated as cluster coordinator by the cluster lead agency at the country level (Table 1). This person is responsible for the day-to-day coordination and facilitation of the work of the cluster.

<table>
<thead>
<tr>
<th>Cluster area of operation</th>
<th>Cluster lead agency</th>
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<tr>
<td>Logistics</td>
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<td>Shelter and non-food items</td>
<td>IFRC</td>
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<td>Water, sanitation and hygiene</td>
<td>UNICEF</td>
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<td>Health</td>
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<td>Camp coordination and camp management</td>
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