

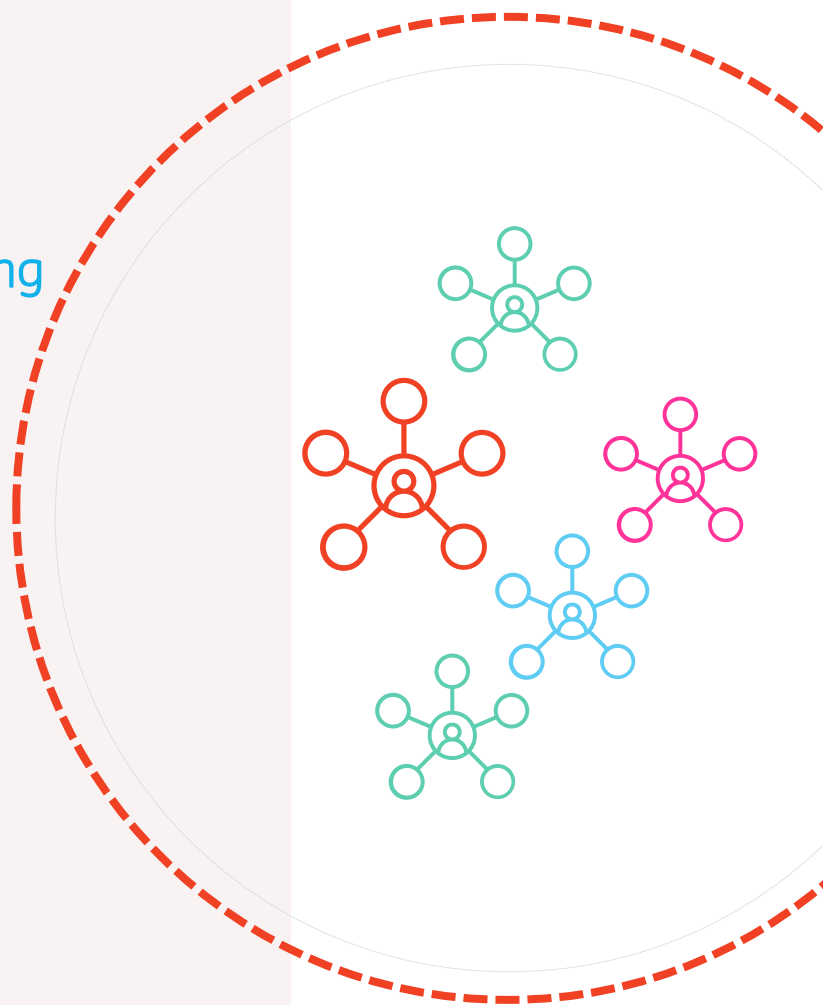
Essential Health Services

A guidance note

How to prioritize and plan
essential health services during
COVID-19 response in
humanitarian settings



**HEALTH
CLUSTER**



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Nureyan Zunong from the READY Initiative¹ for Co-Chairing the Peer Group that helped develop this piece.

Members of the Peer Group:

Nisar Ulhaq (ADRA Yemen); Dora Curry (CARE); Endang Handzel (CDC); Rachel Jane Coghlan (Centre for Humanitarian Leadership); Lauren Brown (Corus International); Michael Obrien (FHI-360); Karl Blanchet (Geneva Centre for Humanitarian Studies); Craig Hampton (Health Cluster Somalia); Dr Fawad Khan, Dr Nasr Mohammed (Health Cluster Yemen); Manuel Carballo (ICMHD); Alice Wimmer (IOM); Stacey Mearns (IRC); Dyness Kasungami-Matoba (JSI/ Global Child Health Task Force); Sonja van Reede (Marie Stopes International); Janet Meyers (Save the Children); Donatella Massai (the READY Initiative); Andre Griekspoor, Alena Stefanie Matzke, Borris Pavlin, Pryanka Relan, Teri Reynolds, Slim Slama, Zandile Zibwowa, (WHO); Ralf Moreno Garcia, Fouzia Shafique (UNICEF); Ali Davis, Naomi Morris, Eba Pasha, Naomi Sorkin (GHC Unit)

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Acronyms

ANC	Antenatal Care
AWD	Acute Watery Diarrhea
BEMOC	Basic Emergency Obstetric Care
CEMOC	Comprehensive Emergency Obstetric Care
COVID-19	Novel coronavirus disease 2019
EHS	Essential Health Services
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunizations
EWAR	Early Warning, Alert and Response
GBV	Gender-Based Violence
GHC	Global Health Cluster
GHRP	Global Humanitarian Response Plan
HC	Health Cluster
HMIS	Health Management Information Systems
HNO	Humanitarian Needs Overview
HPC	Humanitarian Programme Cycle
HR	Human Resources
HRP	Humanitarian Response Plan
HCW	Healthcare Worker
IRC	The International Rescue Committee
PC	Infection Prevention and Control
MHPSS	Mental Health and Psychosocial Support
MISP	Minimum Initial Service Package for Sexual and Reproductive Health
MSP	Minimum Standard Package (for Yemen)
NGOs	Non-governmental organizations
PPE	Personal protective equipment
PHSM	Public Health and Social Measures
RCCE	Risk Communication and Community Engagement
UN	United Nations
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

1. Background

Health clusters and partners are facing considerable technical and operational challenges in humanitarian settings to safely deliver COVID-19 response and maintain essential health services. Increased operational challenges such as movement restrictions, diversion of human resources, supplies and funding as well as increased operational costs contribute to the disruption in availability and utilization of essential health services. Furthermore, fear and mistrust of health care being provided as well as stigma related to COVID-19 has, in many settings, resulted in the decreased utilization of services as affected populations are unwilling to seek care. These disruptions to health services raise concern of the resultant impact COVID-19 may have on excess mortality and morbidity.² Lessons learned from the 2014–2016 West Africa Ebola Outbreak note that disruptions to the provision and utilisation of essential health services resulted in substantial increases in mortality from malaria, HIV/AIDS, and tuberculosis.³

As such the Global Health Cluster and partners have developed this tool to help health clusters and partners utilize a systematic approach to prioritizing, maintaining and adapting essential health services during COVID-19 response should they be unable to continue providing the usual package of services safely.

² See [Health Cluster Survey Findings and Health Cluster Study Findings](#); Global Health Cluster; November 2020.

³ Wilhelm JA, HELLERINGER S. [Utilization of non-Ebola health care services during Ebola outbreaks: a systematic review and meta-analysis](#). *J Glob Health*. 2019;9(1):010406. doi:10.7189/jogh.09.010406

2. Purpose

This tool aims to assist Health Cluster Coordinators and Health Cluster Partners to prioritize and plan essential health services to be maintained or adapted during COVID-19 response when usual capacities to safely deliver services are compromised and increased risks are faced. This includes anticipating non-COVID-19 health needs resulting from the crisis, impacts due to the temporary suspension of essential health services or other factors that may increase the risk of excess mortality and morbidity.

This document incorporates and complements key guidance including from the World Health Organization (WHO), the Global Health Cluster (GHC) and for Humanitarian Program Cycle (HPC), Humanitarian Response Plan (HRP) Guidance for 2021 and should be referred to. *See Annex 2, 3 for further reading.*

This tool should be used when there are barriers to deliver or access the usual services safely during COVID-19 response. However, the principles laid out will be useful in any prioritization process including during HRP development.

Who this document is for?

This guidance should be utilized by health cluster coordinators and health cluster partners in countries involved in a prioritization process of essential health services during a crisis like COVID-19.

3. What are essential health services and why is it important?

In general, **essential health services** are the most critical to deliver in any given context. While there is no commonly agreed definition of essential health services, for the purpose of this document we define essential services as a set of services that are important to saving lives and improving health outcomes.

An **essential package of health services (EPHS)** as defined by the Global Health Cluster Essential Package of Health Services Working Paper⁴ is a set of interventions or services (preventive, promotive, curative, rehabilitative, and palliative) across different levels of care based upon burden of disease, cost-effectiveness analyses, budget impact, fairness, cultural acceptability and/or equity with priority to the worst off. The package should consider current capacities and performance of the health system and is based on a feasibility analysis. It is a set of services endorsed by the government at the national level or agreed to by a substantial group of actors when services are to be provided in areas outside of government control.

Humanitarian actors will have often already prioritized interventions and services that need to be delivered in their context when developing country **Humanitarian Response Plan**, though a formalised EPHS may not have been developed. This is usually distinct from the national basic service package⁵ in terms of design as well as in the mix of delivery platforms (i.e. the way healthcare services are delivered such as temporary use of mobile teams) and will vary by geographic area according to context and need.

Defining the EPHS in humanitarian settings is important as it

- helps to plan, budget and operationalize humanitarian response
- is critical in supporting the IASC commitment to Accountability to Affected Populations (AAP)⁶ and the population's right to know what services they are able to receive⁷

What is prioritization?

HRP guidance states "Prioritization is understood as: (i) focusing the efforts to resolve feasibility constraints on people with the most severe needs so that these people do receive and are targeted for assistance [as part of the HRP] (ii) sequencing responses so that time-critical interventions take place first (iii) articulating responses among

⁴ [Working paper on the Use of Essential Package of Health Services \(EPHS\) in Protracted Emergencies](#), Global Health Cluster and World Health Organization, EPHS Task Team; 2018.

⁵ National basic services packages have been developed or are ongoing such as in Yemen, Afghanistan and Somalia. DCP3 have developed a suggested High Priority Package (HPP) for low income countries to address the most urgent needs, looking at value for money, priority given to the worse off and financial risk protection afforded. See Watkins, D., Jamison, D. T., Mills, A., Atun, R., Danforth, K. et. al. 2017. "[Universal Health Coverage and Essential Packages of Care](#)". In: *Disease Control Priorities* (3rd edition).

⁶ [IASC Revised AAP Commitments on Accountability to Affected People and Protection from Sexual Exploitation and Abuse](#), Interagency Standing Committee; November 2017.

⁷ See also [Protection Mainstreaming Toolkit](#), Geneva: Global Protection Cluster; 2017; [Protection Mainstreaming Training Package Sector-Specific Guidance - Health](#), Global Protection Cluster; 2014.

themselves so that interventions that require others to be implemented first or alongside, are planned in a complementary or overlapping manner.⁸

For the purpose of this document, prioritizing essential health services during COVID-19 involves formally reviewing all health services in a given context. This includes the latest evidence and the priority health needs to select those that are the most appropriate, relevant and feasible to implement (including adaptations possible) within a specified time period given reduced resources and additional constraints being faced.

When should it be done?

As the WHO *Maintaining essential health services: operational guidance for the COVID-19 context interim guidance* states, “When the delivery of essential health services comes under threat protocols for service prioritization and adaptation, can mitigate the risk of outright system failure.”⁹

At the time of writing this tool, many situations have triggered the need for prioritization of essential services. Reasons for not being able to safely deliver the usual package of services have been:

- diversion of resources to establish COVID-19 treatment centers e.g. human resources or health facilities being repurposed
- shortages of PPE compromising safe service delivery e.g. vaccination campaigns¹⁰
- diminished health care work force due staff due to either being infected with COVID-19 or being a contact of someone with COVID-19, thus, requiring isolation
- limited transport capacity, movement restriction impacting medical supply availability

Furthermore, even where services have remained available, utilization has been reported to have decreased due to mistrust or fear of health care provided or potential stigma of having COVID-19.¹¹ This requires health clusters and partners to re-examine which services are appropriate to safely deliver, the service delivery platform and its modality to ensure relevant care.

Therefore, **when the usual services are unable to be safely delivered or accessed** partners should critically review and prioritize which services should be maintained, adapted, or suspended.

⁸ [Humanitarian Response Plan 2021: Guidance on Response Analysis, Formulation of Strategic and Specific Objectives, and Targeting](#), United Nations Office for the Coordination of Humanitarian Affairs; August 2020

⁹ [Maintaining essential health services: operational guidance for the COVID-19 context interim guidance](#), World Health Organization; June 2020

¹⁰ [Pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report](#), World Health Organization; August 2020.

¹¹ [Health Cluster Survey Findings](#), Global Health Cluster; November 2020.

4. Guiding principles for this prioritization process

All modifications to health care service delivery should be made in accordance with guiding principles for humanitarian response such as humanitarian principles¹², IASC Commitments to Protection¹³ and *Quality of Care in Humanitarian Settings Position Paper*.¹⁴ Within these the following should especially be considered:

Safe service delivery

Essential health services must be delivered safely for both patients and health care providers.^{15, 16} The minimum requirements for infection prevention control (IPC) should be enforced at all levels of healthcare to ensure safe service delivery within the COVID-19 context.¹⁷ This should be considered throughout the prioritization and planning process (including inputs and adaptations required).

Community engagement and meaningful participation

Ensure people's voice and own priorities are integrated into the process by meaningful participation of all stakeholders especially the affected population and frontline healthcare workers. This includes understanding needs and preferences of prioritized services to be delivered thereby engendering patient centeredness, fairness, and cultural acceptability. Ensure to communicate decision-making and facilitate transparent processes so that communities are aware of the accountability and feedback mechanisms and how they can challenge decisions.^{18, 19}

Addressing the needs of vulnerable and at risk groups²⁰

Ensure the different health needs of people including those who are vulnerable and at risk of protection²¹ violations are understood and that the prioritization of services does not impact different groups disproportionately.

¹² Humanitarian Principles of humanity, impartiality, neutrality, and independence were codified in [UN General Assembly Resolutions 46/182 of 19 December 1991](#), United Nations; 1991; [UN General Assembly Resolution A/Res/58/114 of 5 February 2004](#), United Nations; 2004

¹³ [IASC Principals' Statement, The Centrality of Protection in Humanitarian Action](#), Inter-Agency Standing Committee; 2013; [IASC Policy on Protection in Humanitarian Action](#), Inter-Agency Standing Committee; 2016; [Protection Mainstreaming Toolkit](#), Geneva: Global Protection Cluster; 2017

¹⁴ [Quality of Care in Humanitarian Settings Position Paper](#), Global Health Cluster; June 2020

¹⁵ ["Keep health workers safe to keep patients safe."](#) World Health Organization News Release; 17 September 2020.

¹⁶ "IASC commitments to protection emphasize that the provision of health care must not increase risk or cause harm. Providing safe health care therefore relates not only to patient safety, such as reducing the risk of medical errors, adverse events or health care-acquired infections but also addressing the safety and security of those accessing or providing care." [Quality of Care in Humanitarian Settings Position Paper](#) Global Health Cluster; 2020, pg. 12

¹⁷ Infection Prevention and Control measures including physical distancing, hand hygiene etc. See [WHO Interim Guidance: Infection prevention and control during health care when coronavirus disease \(COVID-19\) is suspected or confirmed](#), World Health Organization, June 2020.

¹⁸ See also [Coronavirus disease \(COVID-19\): Ethics, resource allocation and priority setting](#), WHO, *Western Pacific News*, 20 April 2020

¹⁹ See also [Ethics: Key questions to ask when facing dilemmas in humanitarian settings](#), Global Health Cluster; 2020.

²⁰ "At risk individual / groups / population: Persons who might be subject to protection violations and abuse. Taking into account the specific vulnerabilities that underlie these risks, including those experienced by men, women, girls and boys, and groups such as internally displaced persons, older persons, persons with disabilities, those with conditions associated with stigma, and persons belonging to sexual and other minorities or marginalized communities." [Draft Joint Operational Framework to Improve Integrated Programming and Coordination Between Health and Protection](#) Global Health Cluster and Global Protection Cluster; 2020.

²¹ "Protection violation: An intentional or unintentional disregard for international human rights law, international humanitarian law and international refugee law, in addition to relevant traditions, customs, spirit of the law and humanitarian principles which usually

Coordination

Prioritization processes during the COVID-19 response must be done in collaboration with all other health cluster partners including Ministry of Health and communities where possible. Having an evidence-based approach that involves all stakeholders will help engender an equitable response. Furthermore, only by understanding what resources are available, the existing capacities and performance of the health system, and who can do what, where and when, can a realistic plan be achieved.

An integrated approach

Where possible an integrated approach should be taken to understand all health threats, health needs and health system capacities i.e., where COVID-19 is a health threat alongside others. Response planning will thereby include adapting modalities and service delivery platforms for both COVID-19 specific services as well as other health services. Having an integrated approach to mitigate 'all causes of mortality' will help determine priorities, where efficiencies and adaptations can be made.²²

An ethical approach

The challenges that arise due to allocation of scarce resources where health needs may remain unmet, is an ethical dilemma health clusters and partners will thereby face. Ethical concepts such as justice (both distributive and procedural), beneficence and utility may be considered to assist decision making, however an ethical approach will also consider that decisions are taken in the right way (sometimes referred to as procedural ethics). The Global Health Cluster guidance *Ethics: key questions to ask when facing dilemmas in humanitarian settings*²³ gives further explanation of these concepts, how to use them and, importantly, processes to help manage dilemmas, most of which have been incorporated into this document.

result in human suffering. This therefore includes inequitable access to and provision of health care services." *Draft Joint Operational Framework to Improve Integrated Programming and Coordination Between Health and Protection* Global Health Cluster and Global Protection Cluster; 2020.

²² In the [Health Cluster Study findings: Key informant interviews from Six countries](#), respondents emphasized that separate facilities established to quickly scale up COVID-19 services to help mitigate transmission, resulted in duplication of inputs e.g. medicines for NCDs, HR etc. Furthermore, COVID-19 specific RCCE efforts were better received by communities when combined with non-COVID-19 health promotion messages that were perceived to be more relevant and urgent.

²³ See [Ethics: key questions to ask during COVID-19 in humanitarian settings](#), for further guidance on ethics concepts and processes useful to manage dilemmas

Ensure coordination

Set up a working group through the Health Cluster (or other relevant platform) with health cluster partners including MoH to collectively prioritize and plan

Ensure participation of affected community
And transparency of decision-making process

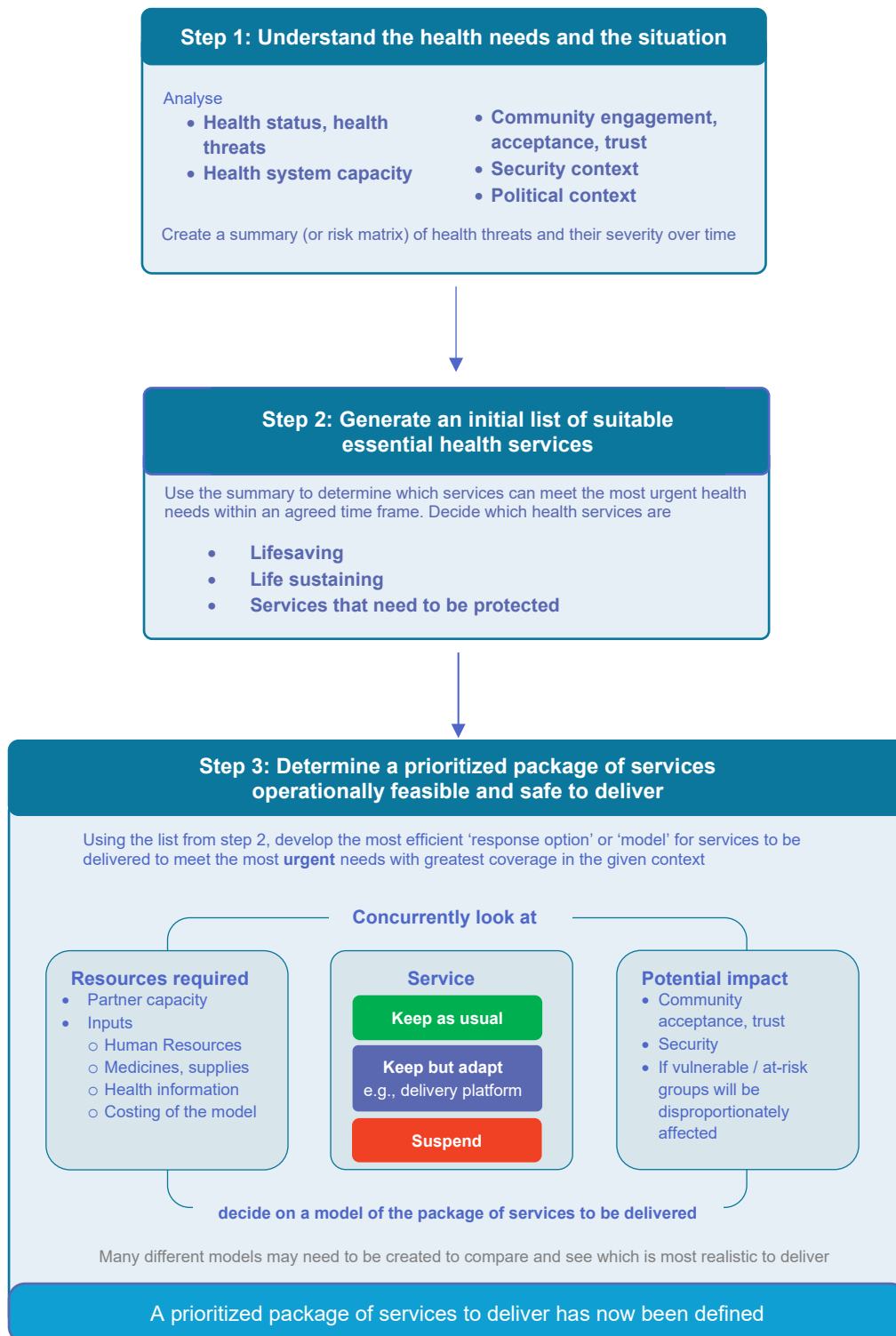


Figure 1. Flowchart showing steps to be taken when prioritizing and planning essential health services to provide during COVID-19 response

5. Steps in prioritization and planning essential health services to provide during COVID-19 response

Create a working group within the Health Cluster (or other relevant existing coordination platform) with health cluster partners including Ministry of Health where possible, to collectively prioritize and plan essential health services to provide.

Step one: Understanding health needs and the situation

To ensure that health services are appropriate and relevant, it is critical to understand the health needs of the population, the operational context including political and security situation, and the specific challenges brought by COVID-19 and its response.

A **risk assessment** tool such as within the GHC Public Health Situation Analysis (PHSA)²⁴ may be useful to assess the greatest risk of **health 'threats'** (such as maternal mortality, malaria), based on its likelihood within the given context and extent of impact should it occur. It should take into account existing **health system capacities**, performance, and any anticipated disruptions (such as ruptures of specific essential medicines, diversion of health care workers) that may affect the risk of health threats. It should include considering the specific risks associated with the four scenarios of COVID-19 transmission²⁵, its waxing or waning impacts (such as lifting of movement restrictions) as well as other existing factors (such as seasonal variation in communicable diseases, anticipated increases in conflict). The risk assessment helps to determine anticipated health needs (i.e. to address the health threats) evolving over time. *See Annex 5 for further explanation of the GHC PHSA risk matrix.*

Health status and health threats

To understand the health needs of the affected population it is important to determine pre-COVID-19 health status, country risk profile - current and anticipated health threats facing affected populations. Therefore, the following areas must be analysed:

Population profile

- e.g., disaggregated by age, gender, urban, rural and displaced populations

Environmental factors

- e.g., overcrowding, drought, floods, conflict, access to water, seasonal variation for vectors for communicable disease such as malaria

Specific challenges brought by COVID-19

Determine current and anticipated health needs due to COVID-19

Anticipated cases of mild, moderate, severe, critical cases
Management of contacts in isolation or quarantine
RCCE activities etc.
Management of co-morbidities of COVID-19 patients e.g. unstable diabetes in severe patients
MHPSS needs
Palliative care etc

²⁴ See [Public Health Information Services: Public Health Situation Analysis](#); Global Health Cluster; 2018.

²⁵ For more details on the four transmission scenarios see [Operational considerations for case management of COVID-19 in health facility and community: Interim Guidance](#), World Health Organization; March 2020.

Major causes of mortality and morbidity

- pre-crisis and current levels including those specifically related to COVID-19 risk factors, e.g., chronic lung disease, all NCD-related risk factors

Health needs of vulnerable and at risk groups

- e.g., due to age, gender, people with disability, other groups or people with conditions associated with stigma, from hard to reach areas etc.

Nutritional status

- prevalence of acute malnutrition, exclusive breastfeeding rate, etc.

Vaccination coverage

- pre-crisis routine immunization rates

Community demand side factors for using for health services including

- health seeking behavior
- Utilization of different health care services and preferences
- barriers to accessing health care

Health system capacity

Understanding existing health capacities, performance²⁶ and anticipated disruptions is important to understand

- how they may affect increased health needs e.g., disrupted supply of medicines affecting ability to provide curative care
- to be able to understand the inputs required to support the provision of health services to meet health needs

Health system capacity

- Reduction in financing, disrupted management, role of non-state actors to provide or maintain services, status of supply chain, basic health information system including EWAR, health care workforce density, distribution, damage to health facilities, attacks against on health care, geographic access to services

Specific challenges brought by COVID-19

Determine current and anticipated health needs due to COVID-19 public health & social measures

such as movement restrictions with possible increase in MHPSS needs
GBV cases
Global acute malnutrition

Decreased utilization or reduction/ suspension of specific health services

such as
Outbreak of vaccine preventable disease due to suspension routine immunization
Possible increase in complicated or severe illnesses, as people delay seeking care

Population perception to safely access essential health services

Movement restrictions due to lock downs or disruption of public transport
Fear of COVID-19 infection at health facilities
Stigma accessing healthcare for potentially having COVID-19
Reduced ability to pay (direct or indirect costs) due to loss of livelihood

Specific challenges brought by COVID-19

Challenges in providing essential health services

Lack of resources and/or resources diverted for COVID-19 response

- Unable to provided services safely (e.g., poor adherence to IPC, insufficient PPE or WASH availability in health care settings) risking safety of staff and patients
- Health facilities or hospital wards repurposed to COVID-19 only services
- HR diverted, or quarantined, or absenteeism at work due to fear or stigma
- Medicines, supplies and other resources are reallocated to COVID-19 management, or not available due to national shortages, or transport problems

²⁶ See [Guidance document to assess a healthcare arena under stress](#) UHC2030 Technical Working Group on UHC in Fragile Settings, June 2019 and [Suite of health service capacity assessments in the context of the COVID-19 pandemic](#) WHO 2020, for further information

Service availability at each level of care and facility

- Number of health facilities and their functionality
- Coverage for BEMOC, CEMOC and newborn care
- Routine EPI coverage
- Quality of facilities and services (or broad understanding of variations)

Community engagement, acceptance, and trust

Community expectations and perceptions

- of types of services and quality of services provided

Community participation in

- deciding what services to prioritize and addressing populations' own priorities

Community acceptance and trust

- in health care, especially in conflict areas or where groups are marginalized

Security and Political Context

It is important to analyse political and security risks and their impact on health needs but also safe service delivery

Security context

- Pre-existing security risks for people accessing essential health services or health care workers delivering health services e.g. conflict, targeted attacks on health care workers
- Potential security concerns due to possible changes in essential health service delivery e.g. attacks on health care workers

Political context

- Current legal and political environment
- Any policy limiting reducing or stopping certain services

Summarizing health threats and its impact

From the above, identify which health threats are most likely to occur over a given period of time with the greatest negative impact, incorporating how health system disruptions, community acceptance, trust and how the security and political context may influence health threats.

Furthermore, determine which health threats, even if affecting low numbers of people, will impact certain vulnerable and at risk groups the most, e.g., survivors of GBV, persons with disabilities, older people, those at the end of life.

Specific challenges brought by COVID-19

Community fear and mistrust of health care services, that they may get COVID-19

Stigma

stigmatization for potentially having COVID-19 even if attending normal health care services

Misinformation, disinformation, trust

Not believing COVID-19 is real, thus, diminishing trust in health services

Community engagement

Movement restrictions impacting face-to-face engagement activities

Specific challenges brought by COVID-19

Violence against health care workers

Increasing mistrust in health care services, or changes to services available resulting in increased violence

Insecurity

due to COVID-19 response measures e.g., food shortages, inflation, loss of livelihoods exacerbating conflict dynamics

Political context

If national COVID-19 response measures are affecting political stability

If political context e.g., stability or turnover are affecting national strategies

Political acceptance

Political acceptance of prioritizing services

Step two: Generate an initial list of suitable essential health services

Using Step one findings, list which services effectively **meet the urgent needs** of the affected population **within an agreed upon time period** (e.g., the next 3 months depending on context).²⁷ Given that resources are scarce, determine which health services are life-saving, life sustaining, or services that need to be protected.²⁸

Lifesaving

Services decrease morbidity and mortality and are time sensitive. Any service disruption will cause immediate loss of life or harm. The UN Central Emergency Response Fund defines life-saving interventions, as those actions that within a short time span remedy, mitigate or avert direct loss of life, and harm to people and protect their dignity.²⁹

Life sustaining

For the purposes of this document, life sustaining services are those which contribute to improving health outcomes, but temporary suspension will not result in immediate loss of life or psychological harm.

Services that need to be protected

These may not significantly decrease mortality or morbidity but are critical to ensuring basic needs and rights are met especially for vulnerable and at risk groups e.g. clinical management of rape for survivors of GBV, accessible care for persons with disability, safe abortion care (to the full extent of the law), palliative care for those at the end of life or suffering.

Step three: Determine a prioritized package of services based upon what is operationally feasible and safe to deliver

To determine a final prioritized package of services, **various 'response options' or models may need to be devised and compared** to see which is operationally feasible and safe to deliver.³⁰

Using the list of services generated in Step 2, optimize and determine the most efficient way to collectively deliver the services within the agreed upon time period that are **operationally feasible and safe to deliver** in the given context. Generally lifesaving services and services that need to be protected, should be prioritized to deliver. However,

²⁷ List of services for national packages have been developed or are ongoing such as in Yemen, Afghanistan, and Somalia. DCP3 have developed a suggested High Priority Package (HPP) for low income countries to address the most urgent needs, looking at value for money, priority given to the worse off and financial risk protection afforded.

²⁸ Noting also that health care comprises of preventive, promotive, curative, rehabilitative care. Contextual findings from Step one will help determine which services are needed e.g., increased health promotion on specific health issues and community engagement activities where there is mistrust or lack of acceptance of health care being provided

²⁹ [United Nations Central Emergency Response Fund: Lifesaving Criteria](#); United Nations; 2020.

³⁰ This step is considered to be conducting a 'response analysis' in the [HPC Step by Step Guidance](#), and the [Humanitarian Response Plan : Guidance on Response Analysis, Formulation of Strategic and Specific Objectives, and Targeting](#).

life sustaining services should also be aimed to be delivered where possible as their suspension will cumulatively result in negative health outcomes over time.

This involves **concurrently** looking at

- all the different services that need to be delivered and which level, including possible adaptations needed (such as use of mobile health clinics, digital and mobile technology) to achieve highest impact (including coverage and effectiveness).
- the resources and inputs required, including the existing capacities and functionality of the health system
- ensuring that the response model does not affect vulnerable or at risk groups disproportionately

Services to maintain, adapt and suspend

When devising the 'response option' or model to deliver services determine how each of these services should be delivered safely, including at what level, by whom and their duration.³¹

Services to maintain

Which services can be provided without any change in mechanism or modality of delivery?

- Until when?

Services to adapt

Which essential health service packages can be adapted or modified? Include

- Service delivery platform or modality (e.g., shifting from health facility based to community-based care, mobile clinics or telemedicine, from public to private providers)
- Health care protocols e.g., follow-up frequency reduced, daily medicines (e.g. ARV) supplied for multiple months to reduce facility visits
- Task shifting, different cadres deliver care (depending on condition and ability to train and supervise, etc.)
- Until when?

Services to suspend temporarily

Generally, life sustaining services can be suspended, however:

- Aim to maintain these services where possible
- These may become urgent to provide over time
- If a service is suspended referral pathways and transition to an alternative care must be explored and defined.
- Until when?

Resources required

Partner capacity

- Ensure there is up-to-date mapping of who is doing what, where, when (4Ws), and determine what partners can provide to support essential health services given resources may be diverted for COVID-19 response
- Examine how coverage of services can be achieved either by
 - individual partners

³¹ See Annex 2 for relevant documents giving considerations for each service (e.g., Maintaining EHS, MISP, MPHSS)

- collaboration with other health partners performing joint activities (e.g. one partner reduces specific services while other partner absorbs, or scales up to cover larger catchment areas)
- with intersectoral partners (e.g., creating integrated 'one stop' centres for women with protection actors, providing health care, CMR as well as GBV case management)

Human Resources³²

- Ensure sufficient trained staff are available to deliver identified essential services safely
- Ensure staff occupational health and safety protocols are in place and implemented
- Determine any alternatives to cover medical staff in primary health facilities when staff are reallocated to COVID-19 treatment center
- Ensure sufficient trained staff are available to provide technical support and supervision to health facilities

Medicine, devices, and supplies

- Define which essential medicines, instrument and equipment are needed to deliver the essential services
- Examine the supply chain requirements (from procurement, transport, storage, distribution to patient of safe medicines and to health facilities for devices) to provide health services safely during COVID-19. This includes vaccines, laboratory reagents, consumables, PPE and other supplies. Examine how feasible it is to ensure availability and quality
- Determine inputs required to mitigate access challenges e.g., due to COVID-19 movement restrictions, curfews, or insecurity, natural hazards (rainy season, flooding, snow etc.)

Health Information

- Early warning, alert and response systems (EWAR), both indicator and event based, are critical to capture public health events, ensure resources are sufficient to support it
- HMIS data will be critical for monitoring essential health service delivery

Costing the response options for a prioritized package of services

The different proposed 'response options' to deliver the package of services need to be costed and compared. Given the time constraints, for the purpose of a prioritization exercise, the most realistic costing method is to cost each of the service delivery platforms based on average catchment areas and current coverage e.g., how much does it cost for a primary care level health facility to deliver the package, disaggregated by staffing, medicines and other consumables, running costs, and basic quality measures such as IPC and WASH.

Health cluster partners should then review each of the different response options to determine

³² For useful suggestions, see [Maintaining essential health services: operational guidance for the COVID-19 context interim guidance](#), Chapter 1.7 Rapidly Optimize Health Workforce Capacity.

- If there is sufficient funding available for the response option to safely provide services?
- Is the health cluster and partners able to fundraise to cover costs?
- Are identified packages cost effective?

Review the impact of each response option

Review each response option to see if the proposed model of services has the potential to impact negatively on

- community trust and acceptance
- safety and security of patients and health care workers
- vulnerable and at risk groups, and that it does not affect different groups disproportionately

**STOP AND
CHECK**



Choose the final model of the package of services

Review each response model and determine which is the most feasible to safely deliver, achieving the most equitable and effective coverage, acknowledging where unmet health needs remain.

A prioritized package of services able to be delivered during COVID-19 has now been developed

6. Next steps

Communication with communities

Ensure that the affected population including vulnerable and at risk groups know their right to health care continues during COVID-19:^{33, 34}

- To increase community acceptance and mitigate exacerbating conflict dynamics, provide clear messages to communities so they know which health care services are being provided including any changes, and being provided by whom
- Work alongside communities and ensure they are aware health care is being provided based on humanitarian principles i.e., impartial, based on need, neutral and independent
- Develop communication strategies using outreach, appropriate communication platforms and languages to provide up-to-date information on continued, adapted and suspended services
- Provide clear messages about when and where to seek care, including access points for people with and without COVID-19 symptoms
- Provide reassurance on safety of health care services to reduce fear and delays in seeking care
- Provide guidance on safe care-seeking behavior, e.g. wearing masks, physical distancing
- Continue to address all other barriers that people may have to seek services
- Ensure communities know how to and are able to give feedback on services available, including how to challenge decisions made on prioritization

Support frontline health care workers

The ethical dilemmas being faced when prioritizing services and allocating scarce resources, where some services may need to be suspended and health needs remain unmet, may cause distress to health care workers and organizational staff. Ensure a supportive organizational and cluster wide environment acknowledging these challenges and the distress that may be felt. Ensure justifications in the prioritization exercise as well as outcomes are well communicated to all staff. Peer group support or basic psychosocial interventions may also be useful to help providers.³⁵

Advocacy³⁶

Given that humanitarian health needs may go unmet, continued advocacy should occur with a variety of stakeholders to garner support to address gaps.

³³ [Protection Mainstreaming Training Package Sector-Specific Guidance - Health](#). Global Protection Cluster: 2014.

³⁴ See [Maintaining essential health services: operational guidance for the COVID-19 context interim guidance](#), Chapter 1.10 Strengthen communication strategies to support the appropriate use of essential services.

³⁵ See guidance on providing MHPSS services to frontline providers confronting ethical dilemmas in [Ethics: Key questions to ask when facing dilemmas in humanitarian settings](#), Global Health Cluster; 2020.

³⁶ For further guidance on advocacy see [Health Cluster Guide](#), Chapter 7: Effective Emergency Health Advocacy, Global Health Cluster; 2020.

- Ensure feedback is given to cluster lead agencies, health cluster partners heads of office, national authorities, donors as well as to Humanitarian Country Teams
- At a minimum in the advocacy brief
 - Use data and information gathered e.g. from a PHSA, monitoring data
 - Describe health threats faced, unmet needs, gaps and challenges.
 - Suggest priority actions that need support

Monitor health needs and situation

Health clusters and partners should continuously monitor prioritized health services being provided, the evolving health needs and operational context as COVID-19 transmission changes, impacting public health and social measures and the barriers to safely provide and access health care services. Attention should be given especially to the impact of suspended services and resultant accumulating health needs of the population. Indicators for monitoring should be agreed upon e.g. coverage and utilization of services.³⁷

Develop criteria to trigger a review of the package of prioritized services

A minimum time period to review the package of prioritized essential health services to deliver during COVID-19 should be agreed upon within country. Information gathered in a PHSA, risk assessment (anticipating the evolution of health threats, and health system disruptions) can help inform this decision. For example, every three months or more frequently especially if services have been suspended. However, using the agreed upon indicators, criteria should be defined to trigger a review of should the situation evolve requiring further adaptations, restoration or suspension of services. Considerations include:

Change in possible health threats

- Change in scenario of COVID-19 transmission impacting public health and social measures
- COVID-19 vaccine availability
- Emerging health threats increasing risk of increased mortality and morbidity e.g., outbreaks of vaccine preventable diseases, utilization of available services dropping below agreed upon threshold (requiring adaptations etc. to services)

Change in context and operational feasibility

- Change in security and political situation
- Change in availability of resources required (e.g., HR, funding, PPE and other supplies)

How to restore services

Consider restoring services when resources are available and/or its operationally feasible to ensure safe service delivery, anticipate any surge demand from backlog of suspended

³⁷ See sample indicators for monitoring essential health services from [Maintaining essential health services: operational guidance for the COVID-19 context interim guidance](#), Annex 1.

services. WHO guidance on maintaining EHS gives specificities on each service and how it may be done.³⁸

Coordination with epidemic response and health development partner coordination mechanisms

Many of the conditions required to maintain safe essential services for the humanitarian target population depend on overall allocation of limited resources in country between the interventions to control the epidemic, the ongoing development programming and the support to the humanitarian services. In case there is no large-scale community transmission leading to significant increased COVID-19 case load with overwhelming of hospitals, the strategic public health objectives and subsequent resource allocation should be guided by all-cause mortality reduction and mitigating socio-economic effects on the most vulnerable.

Maintaining positive adaptations

Certain adaptations triggered by COVID-19 have longer term potential for making services more effective or efficient and will contribute to increased resilience. For example, shifting certain services to the community may have increased their utilization. The accelerated use of telemedicine or using mobile technology to contact patients who need to come to a clinic for a service that was suspended should be sustained as they increase efficiency, reduce overall lost to follow up, and adherence to preventive programs. The investments during the COVID-19 pandemic in IPC, for staff and patient safety, are often addressing pre-existing weaknesses in these essential functions and should thus be maintained when minimum standards for quality and safety have now been achieved.

³⁸ See [Maintaining essential health services: operational guidance for the COVID-19 context interim guidance. Part 2 Life course and disease considerations](#). World Health Organization; 2020.

7. Examples from the field

How health cluster partners have prioritized activities and programmes, an example from IRC

The COVID-19 global crisis presents an unprecedented challenge for NGOs and implementing partners. Country Offices and field teams are being asked to consider which activities and programmes are most critical and able to be safely delivered as well determine how to respond to COVID -19. Three priorities exist

- keeping staff and clients safe
- maintaining existing services where possible
- launching new responses to address the threat of COVID-19.

Program criticality

To navigate these challenges and determine which activities to maintain or begin, the IRC used considerations of '*program criticality*'. This concept balances the risk of providing an activity/ project against the criticality of a program and its outputs. In the COVID-19 crisis, and as countries move towards epidemic peaks (or indeed decrease), decisions are based on four intersecting pressures:

1. Increasing or changing safety and security risks, including transmission of COVID-19
2. Decreasing humanitarian access, including due to national authorities' restrictions on movement to stop the spread of the virus
3. Ethical tensions related to the tension between withdrawal of services and solidarity i.e. reducing services despite the collective effort to address ongoing humanitarian needs
4. Risks to the organization's bandwidth to provide services, and services being overwhelmed.

All four pressures call for a prioritization of effort. Furthermore, as the pandemic shifts and evolves, so will these four dynamics, therefore, requiring prioritization efforts to be revisited over time.

It is important to note program criticality exercises do not attempt to determine the value or importance of programs relative to others. It is an exercise to be used at certain times to assist identifying and temporarily prioritizing activities and objectives which meet the criteria of criticality, and conversely, temporarily deprioritizing activities which do not meet these criteria.

The IRC utilized the general principles contained within the UN Program Criticality Framework³⁹ as a foundation for this process. IRC identified and categorized all its activities and services across sectors as either:

³⁹ [United Nations System Programme Criticality Framework](#), High-Level Committee on Management, United Nations; 2016.

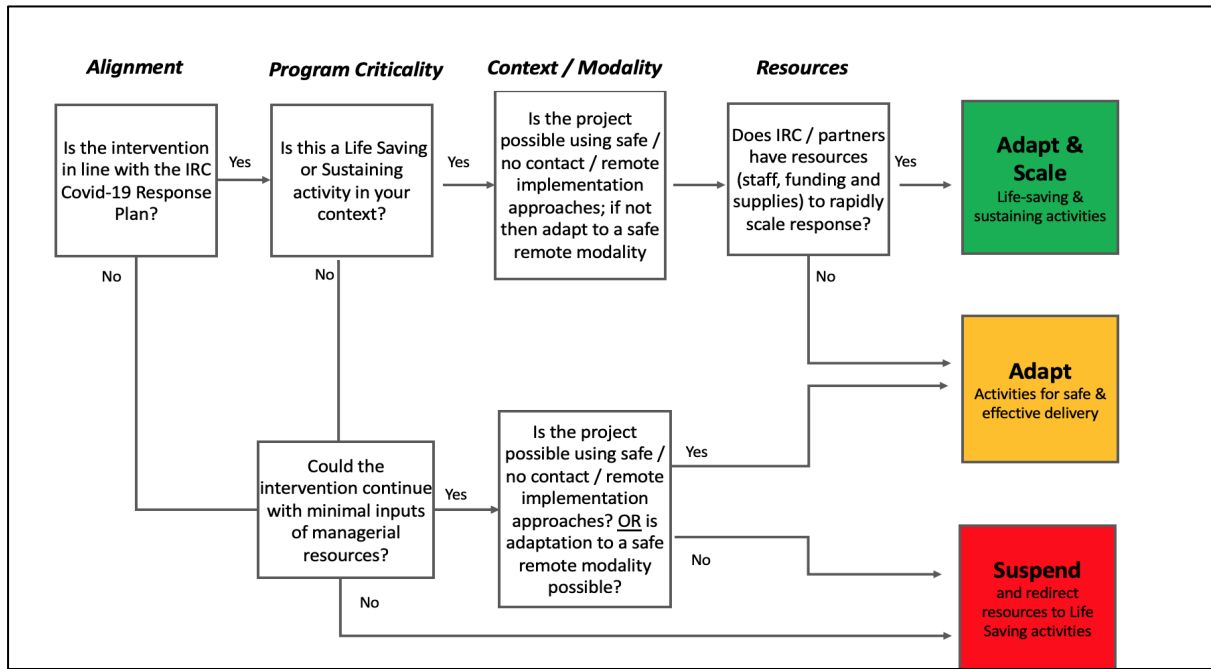
- PC1 = Life-saving activities
- PC2 = Generally can be thought of as life-sustaining activities
- PC3 = Generally can be thought of as life-dignifying
- PC4 = Generally can be thought of as life-enhancing

To ensure it was context specific, all IRC Country Offices completed a program criticality exercise as part of broader country specific COVID-19 contingency and response planning. It is important to note program criticality exercises do not attempt to determine the value or importance of programs relative to others. IRC's overarching aim is to continue programs as much as possible, appropriately adapted to mitigate risk. If country offices have the capacity and resources to safely adapt (risk mitigate) PC1 -4 activities, then all PC1-4 activities should be continued as long as possible through the pandemic. Where capacity and resources become stretched, priority should be given to continue PC1 and PC2 activities, and to temporarily suspend PC3 and PC4 activities. Table 1 provides an overview of this process, and Figure 2 provides a summary decision making framework to facilitate program criticality assessments

Table 1. Overview of IRC's program criticality exercise

Table 1: Overview of program criticality exercise	
1	Establish scope of assessment (e.g. geography/location and timeframe)
2	Review all activities and objectives within the scope
3	Identify activities and projects that contribute to these
4	For each activity/project, review feasibility of implementation (risk mitigation and operations) over COVID-19 planning period
5	<p>Identify PC1 activities/projects and PC2 activities/projects and consider how they can be scaled and implemented in the context:</p> <ul style="list-style-type: none"> • Open negotiations with government authorities and implementing partners to seek authorization to scale up P1 and PC2 activities/projects. Special movement permissions may be required. • Country Offices prioritize PC1 and PC2 programs • where possible repurpose resources (e.g. manpower, experts, managerial capacity) from other programs
6	<p>Identify PC3 and PC4 activities/projects which can be adapted and able to continue with minimal inputs of managerial, manpower, financial and expert resource.</p> <ul style="list-style-type: none"> • aim at sustaining and modifying existing activities; plans to expand activities should be postponed. • PC3 and PC4 activities would be more likely to continue if fully remote modalities are available (thus less risk) • If PC3 and PC3 activities/project cannot be adapted / use remote modalities to minimize risk, they should be suspended.
7	Summarize in a document, consult with relevant technical and functional support colleagues to finalize.
8	Implement and manage the changes

Figure 2. IRC's decision-making framework for program activities



How health clusters have prioritized programmes, an example from Yemen Health Cluster

The need for prioritization

In mid-2020, in anticipation of large reductions in funding compounded by the COVID-19 pandemic the Yemen Health Cluster and partners developed its Extended Humanitarian Response Plan 2020⁴⁰ and prioritized which health services and activities were critical to continue. Although 17.9 million people were identified as being in need of humanitarian health assistance, through a cluster-wide collaborative prioritization process the health cluster identified a core set of services and activities that needed to be maintained, as well as targeted number of people to receive assistance in prioritized geographic areas. 7.3 million people were targeted for health assistance down from 15.8 million the previous year, reducing funding requirements to 203million USD. *See Table 2.*⁴¹

With reductions in funding anticipated to cause disruptions in the provision of essential health services, compounded by COVID-19 response impacting the availability and utilization of health services, clear methodologies were devised aiming to mitigate the risk of excess mortality and morbidity.

Table 2. A comparison of Health Cluster requirements in the Humanitarian Response Plans 2019 - 2020

	HRP 2019 (Jan -Dec)	Extended HRP 2020 (June -Dec)
HRP (all clusters)	Population	30.5 m
	People In Need (PIN)	24.1m
	People targeted	21.4m
	Funding requirement (USD)	4.2bn
	Number of partners	254
Health Cluster	Health Cluster PIN	19.7m
	Health cluster people in acute need	14m
	Health cluster people targeted	15.8m
	Health cluster funding requirement (USD)	627m
	Number of health cluster partners	71
		30.5
		24.3m
		19m
		2.23b + (2.23bn for HRP. 180m for COVID-19 GHRP)
		208
		17.9m
		12.5m
		7.3m to 4.8m (high to low target depending on operational constraints)
		203m ** First line* 147.5m Second line** 46.5m Full cluster response 9m
		45

*First line response: core components of the Yemen Minimum Service Package (MSP)⁴² in high priority districts **Expanded range of health services in the Yemen MSP + excluding 180m for COVID-19 in the GHRP ** excluding 179m USD for 16m people COVID-19 GHRP

Cluster Strategy and Prioritization Process

The health cluster created a two-step approach in the prioritization process with the aim to ensure sufficient coverage of services within priority districts to reach the populations most at risk.

- **Step 1: identifying services as first line or second line** or activities for a full response
- **Step 2: identifying priority districts** to assist using agreed upon indicators to assess vulnerability.

⁴⁰ *Yemen Humanitarian Response Plan Extension, June-December 2020*, OCHA; 2020.

⁴¹ Of note a further prioritization exercise was conducted in September 2020

Step 1: Identifying services as first line or second line

- First line response was defined as life-saving and critical services and core components of the Yemen Minimum Service Package⁴²
- Second line response was defined as other components within the Yemen Minimum Service Package but were not life-saving
- Full response were defined by the health cluster as other activities those which supported fulfilling strategic objectives of the Extended HRP

The Yemen Minimum Service Package⁴²

Developed in 2017 -presents a list of priority health interventions that should be provided by a functional district health system, and composed of interventions already listed in the Yemen Essential (health) Service Package developed by the Ministry of Public Health and Population

The Yemen Health Cluster had previously adopted the Yemen Minimum Service Package, a subset of activities from the Ministry of Public Health and Population (MoPHP) Yemen Essential Health Service Package. This already prioritized list of services was, therefore, reviewed again to determine which interventions were critical to implement within the time period. Services and activities were reviewed to determine which were lifesaving and thereby had the most impact on mortality and morbidity within a short time period. Second-line response was defined as services or activities that were not life-saving, but contributed to the wider package of services in the Yemen Minimum Service Package. See Table 3

Table 3. Prioritized health services and interventions by Yemen Health Cluster

<p>First Line Response: Improve access to critical or essential lifesaving healthcare and psychosocial support to highly vulnerable people at health facilities) primary, secondary, and tertiary including district hospitals) in priority districts or high severity districts</p>
<ul style="list-style-type: none"> • Providing critical healthcare services and trauma care, communicable disease prevention and control and the Minimum Service Package (MSP) for children suffering from severe acute malnutrition with medical complications • Vaccinating vulnerable groups against vaccine preventable diseases (e.g. oral cholera vaccines (OCV), measles, oral polio Vaccine (OPV), diphtheria, measles, MNT etc • Identifying and provide medical care to those affected with preventable (epidemic-prone) diseases. • Providing essential reproductive healthcare for pregnant and lactating women in line with MISp. • Providing clinical assessment and management to already identified mental health cases and refer to specialized facilities • Procuring, pre-positioning and providing essential medicines and supplies to the health facilities delivering MSP • Providing specialized care for cancer, renal failure and Non communicable diseases (NCDs). • Prioritize the continuity of services and supply of 7 health system inputs only to the locations with the highest caseload and highest vulnerability at the district level
<p>Second Line Response: provide a comprehensive package of essential health services in the identified priority districts to vulnerable people</p>
<ul style="list-style-type: none"> • Supporting all additional components of the Minimum Service Package with quality of care • Identifying people requiring mental health and psychosocial support and referring them to specialized services • Establishing and activating referral mechanisms for specialized services • Accelerating routing vaccination and strengthening cold chain systems • Promoting health awareness by engaging community • Re-establish/maintain the drug supply logistics, quality control and health information systems

⁴² [Yemen Minimum Service Package](#), Health Cluster Yemen; 2017.

Step 2: Identifying priority districts to provide services to populations most at risk

In order to identify *priority districts*, the Yemen Health Cluster alongside the Yemen WASH Cluster, worked together with partners, MoPHP and the Ministry of Water and Sanitation in a consultative process, using a Health Cluster Vulnerability Matrix to review severity of needs in each district. This was based on four indicators developed through the Humanitarian Needs Overview (HNO) process and used to rank in all 333 districts from 0-6 risk categories. *See Table 4.*

Vulnerability matrix indicators

1. Impact on exposed population (IDPs %)
2. Access Scoring
3. Health System Capacity
 - a) Functionality of health facilities including density, functionality (fully or partial), distance to health facility, health care workforce density, etc
 - b) Health Services availability including for general and trauma care, IMCI, essential newborn care, family planning services, ANC, BEMOC etc
 - c) Health Human Resources
4. Morbidity and mortality especially for measles, AWD or suspected cholera, diphtheria, neonatal tetanus, malaria and dengue

Table 4 Number of districts ranked high or low by the vulnerability matrix

Ranking	Number of districts	Low or high scoring
0 to 1	22	132 districts in low severity scoring
2	21	
3	89	
4	50	201 districts in high severity scoring
5	82	
6	69	

The districts were ranked 4 to 6. In total 201 in total districts were deemed high severity and prioritized to provided services.

Result

Ultimately 7.3 million people in 201 districts were prioritized to receive services with a tiered approach as to which services were most important to deliver depending on the amount of funds available. The prioritization process that was conducted demonstrates the extreme and difficult steps the health cluster and partners have to take in order to provide lifesaving assistance to people who are most in need whilst facing new health threats and increased operational constraints.⁴³

⁴³ Read more on [Protecting Essential Health Services in Yemen](#), Global Health Cluster Webpage

8. Annexes

Annex 1. Glossary

<p>At risk individual/ groups/ population</p>	<p>Persons who might be subject to protection violations and abuse. Taking into account the specific vulnerabilities that underlie these risks, including those experienced by men, women, girls and boys, and groups such as internally displaced persons, older persons, persons with disabilities, those with conditions associated with stigma, and persons belonging to sexual and other minorities or marginalized communities.</p> <p><i>(Source: Draft Joint Operational Framework between Health and Protection Clusters, Global Health Cluster and Global Protection Cluster; 2020; Protection Mainstreaming Toolkit, Global Protection Cluster; 2020)</i></p>
<p>Essential health services</p>	<p>While there is no commonly agreed definition of essential health services, for the purpose of this document we define essential services as a set of services that are important to saving lives and improving health outcomes.</p>
<p>Essential package of health services (EPHS)</p>	<p>As defined by the Global Health Cluster Essential Package of Health Services Working Paper is a set of interventions or services (preventive, promotive, curative, rehabilitative, and palliative) across different levels of care based upon burden of disease, cost-effectiveness analyses, budget impact, fairness, cultural acceptability and/or equity with priority to the worst off.</p> <p><i>(Source: Working paper on the Use of Essential Package of Health Services (EPHS) in Protracted Emergencies, Global Health Cluster and World Health Organization, EPHS Task Team, 2018)</i></p>
<p>Excess mortality and morbidity</p>	<p>Mortality above what would be expected based on the non-crisis mortality rate in the population of interest. Excess mortality is thus mortality that is attributable to the crisis conditions. It can be expressed as a rate (the difference between observed and non-crisis mortality rates), or as a total number of excess deaths</p> <p><i>(Source WHO definitions emergencies, World Health Organization)</i></p> <p>Excess mortality is a non-specific measure of the severity and impact of a pandemic, which includes indirect deaths. Present modelling estimates predict that secondary indirect deaths will be more numerous in the poorest settings.</p> <p>While data are preliminary and the COVID-19 pandemic is rapidly evolving, evidence and models of indirect mortality and morbidity</p>

	<p>are already emerging in some of the most fragile and conflict affected settings in the world.</p> <p><i>(Source: Preventing and Mitigating Indirect Health Impacts of COVID-19 on Displaced Populations in Humanitarian Settings. Knowledge Brief; Columbia University, DfID, World Bank, November 2020)</i></p>
Lifesaving	<p>Services decrease morbidity and mortality and are time sensitive. Any service disruption will cause immediate loss of life or harm. The UN Central Emergency Response Fund defines life-saving interventions, as those actions that within a short time span remedy, mitigate or avert direct loss of life, and harm to people and protect their dignity.</p> <p><i>(SOURCE: United Nations Central Emergency Response Fund: Lifesaving Criteria; United Nations; 2020.)</i></p>
Life sustaining	<p>For the purposes of this document, life sustaining services are those which contribute to improving health outcomes, but temporary suspension will not result in immediate loss of life or psychological harm.</p>
Prioritization	<p>Prioritization is the final identification of the population (and sub-population) groups and locations that will be targeted by the response based on the response analysis.</p> <p><i>(Source: Humanitarian Program Cycle: 2021 Step by Step Guide. OCHA; 2020)</i></p> <p>Prioritization in this regard is then understood as: (i) focusing the efforts to resolve feasibility constraints on people with the most severe needs so that these people do receive assistance as part of the HRP and are targeted, (ii) sequencing responses so that time-critical interventions take place first, and (iii) articulating responses among themselves so that interventions that require others to be implemented first or alongside, are planned in a complementary or overlapping manner</p> <p><i>(Source: Humanitarian Response Plan 2021: Guidance on Response Analysis, Formulation of Strategic and Specific Objectives, and Targeting. OCHA; August 2020)</i></p>
Prioritized essential health service	<p>For the purpose of this document, prioritizing essential health services during COVID-19 involves formally reviewing all health services in a given context. This includes the latest evidence and the priority health needs to select those that are the most appropriate, relevant and feasible to implement (including adaptations possible) within a specified time period given reduced resources and additional constraints being faced.</p>

Protection violation	<p>An intentional or unintentional disregard for international human rights law, international humanitarian law and international refugee law, in addition to relevant traditions, customs, spirit of the law and humanitarian principles which usually result in human suffering. This therefore includes inequitable access to and provision of health care services.</p> <p><i>(Sources: Draft Joint Operational Framework between Health and Protection Clusters, Global Health Cluster and Global Protection Cluster; 2020; Sphere Association (2018). The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, Fourth edition. Geneva: Sphere Association; 2018.)</i></p>
Response analysis	<p>A process that facilitates the identification of appropriate, relevant and feasible interventions and modalities to respond to the humanitarian needs of population and sub-population groups, as identified in the HNO. It consists of formally reviewing the range of interventions possible to address identified needs and their causes for the various population groups and locations, in order to select those that will meet these needs in the most effective and efficient way.</p> <p><i>(Source: Humanitarian Response Plan 2021: Guidance on Response Analysis, Formulation of Strategic and Specific Objectives, and Targeting. OCHA; August 2020)</i></p>
Service Delivery Platform or Modality	<p>The service delivery platform or “modality of delivery” is the way through which resources and services are delivered. [The definition of modality], therefore, generally consists of describing health facilities but was developed so as to accommodate for modalities that require a more specific approach, such as Field Hospitals, Mobile Clinics or Community Based Workers.</p> <p><i>(Source: HeRAMs: Approach & Roles and Responsibilities of the Cluster, WHO; 2009)</i></p>
Severity of Needs	<p>The severity of needs is defined by the type of humanitarian consequences for people, including the degree of harm to their lives and livelihoods. It is based on the combined analysis of the effects on survival and ability to meet essential needs and expenditures, and of the factors causing these effects (acute and chronic).</p> <p><i>(Source: Humanitarian Program Cycle: 2021 Step by Step Guide. OCHA; 2020)</i></p>

Annex 2: Useful documents to adapt and ensure safe service delivery during COVID-19

1. *Maintaining essential health services: operational guidance for the COVID-19 context. Interim Guidance.* Geneva: World Health Organization, 2020. (<https://www.who.int/publications/i/item/WHO-2019-nCoV-essential-health-services-2020.1>, Accessed on 1 December 2020)
 - a. *Maintaining essential health services: operational guidance for the COVID-19 context. Interim Guidance.* Geneva: World Health Organization, 2020, Chapter 2.2.3 Mental, neurological and substance use disorders
2. *Operational considerations for case management of COVID-19 in health facility and community. Interim Guidance.* Geneva: World Health Organization; 2020. (<https://www.who.int/publications/i/item/10665-331492>, Accessed on 1 December 2020)
3. *Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic. UNICEF/WHO/IFRC; 2020.* (https://www.who.int/publications/i/item/WHO-2019-nCoV-Comm_health_care-2020.1, Accessed on 1 December 2020)
4. *MISP considerations checklist for implementation during Covid-19. Inter-Agency Working Group on Reproductive Health in Crises; 2020.* (<https://iawg.net/resources/misp-considerations-checklist-for-implementation-during-covid-19>, Accessed on 1 December 2020)

Annex 3: Useful documents listing essential health services

1. *HeRAMS checklist.* Global Health Cluster: 2012. (https://www.who.int/hac/network/global_health_cluster/herams_serviceschecklist_2014.pdf?ua=1, Accessed 1 December 2020)
2. Blanchet K, Alwan A, Antoine C, *et al*/Protecting essential health services in low-income and middle-income countries and humanitarian settings while responding to the COVID-19 pandemic *BMJ Global Health* 2020;5:e003675. (<https://gh.bmj.com/content/5/10/e003675>, Accessed 1 December 2020)
3. *Yemen Minimum Service Package*, Health Cluster Yemen; 2017. (<http://yemenhc.org/?wpdmpro=minimum-service-package-guideline>, Accessed 1 December 2020)
4. Watkins, D., Jamison, D. T., Mills, A., Atun, R., Danforth, K. , et. al. . *“Universal Health Coverage and Essential Packages of Care; Annex 3c. Essential Universal Health Coverage: Interventions and Platforms”.* In: *Disease Control Priorities* (third edition): Volume 9, *Disease Control Priorities*, edited by D. T. Jamison, H. Gelband, S. Horton, P. Jha, R. Laxminarayan, C. N. Mock, R. Nugent. Washington, DC: World Bank. (<http://dcp-3.org/chapter/2551/essential-universal-health-coverage> Accessed 1 December 2020)

Annex 4: Further background reading and references

1. Blanchet, Karl et. al. "Priority setting in a context of insecurity, epidemiological transition and low financial risk protection, Afghanistan." *Bulletin of the World Health Organization* 2019;97:374-376 (<https://www.who.int/bulletin/volumes/97/5/18-218941.pdf>, Accessed 1 December 2020)
2. *Central Emergency Response Fund: Lifesaving Criteria*. New York: United Nations; 2010. (https://cerf.un.org/sites/default/files/resources/FINAL_Life-Saving_Criteria_26_Jan_2010_E_0.pdf, Accessed 1 December 2020)
3. *Coronavirus disease (COVID-19): Ethics, resource allocation and priority setting*. Geneva: World Health Organization; 2020. (<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/coronavirus-disease-covid-19-ethics-resource-allocation-and-priority-setting>)
4. *Core Humanitarian Standard on Quality and Accountability* [website]. Geneva: CHS; 2014. (<https://corehumanitarianstandard.org/> Accessed 1 December 2020)
5. *Ethics: key questions to ask during COVID-19 in humanitarian settings*. Geneva: Global Health Cluster; 2020. (<https://www.who.int/health-cluster/en/> , Accessed 1 December 2020)
6. *Global Health Cluster Guidance: A Practical Handbook*. Geneva: Global Health Cluster; 2020. (<https://www.who.int/health-cluster/resources/publications/hc-guide/en/>, Accessed 1 December 2020)
7. *Guidance document to assess a healthcare arena under stress* UHC2030 Technical Working Group on UHC in Fragile Settings, June 2019 (https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/UHC2030_Working_Groups/2017_Fragility_working_groups_docs/UHC2030_Guidance_on_assessing_a_healthcare_arena_under_stress_final_June_2019.pdf , Accessed 8 December 2020)
8. *Health Cluster Guidance: People In Need Calculation Guide*. Geneva: World Health Organization; 2020. (<https://www.who.int/health-cluster/resources/publications/GHC-PiNGuidance-05-08-2020.pdf?ua=1> Accessed 1 December 2020)
9. *Health Cluster Survey Findings*. Geneva: Global Health Cluster; November 2020. (<https://www.who.int/health-cluster/en/> , Accessed 1 December 2020)
10. *Health Cluster Study Findings: Key Informant Interviews for Six Countries*. Geneva: Global Health Cluster; November 2020. (<https://www.who.int/health-cluster/en/> , Accessed 1 December 2020)
11. *Humanitarian Program Cycle: 2021 Step by Step Guide*. Geneva: United Nations Office for the Coordination of Humanitarian Affairs, 2020. (https://assessments.hpc.tools/sites/default/files/km/01.%20HPC_2021-StepByStep_Guide_0.pdf , Accessed 1 December 2020)
12. *Humanitarian Response Plan 2021: Guidance on Response Analysis, Formulation of Strategic and Specific Objectives, and Targeting*. Geneva: United Nations Office for the Coordination of Humanitarian Affairs; August 2020 (<https://reliefweb.int/sites/reliefweb.int/files/resources/Guidance%20HRP%20Prioritisation.pdf> , Accessed 1 December 2020)
13. *IASC Policy on Protection in Humanitarian Action*. Geneva: Inter-Agency Standing Committee; 2016 (<https://interagencystandingcommittee.org/iasc-protection-priority-global-protection-cluster/iasc-policy-protection-humanitarian-action-2016> , Accessed 1 December 2020)
14. *IASC Revised AAP Commitments on Accountability to affected People and Protection from Sexual Exploitation and Abuse*. Geneva: Inter-Agency Standing Committee; 2017 (originally

- developed in 2011)
(https://interagencystandingcommittee.org/system/files/iasc_caap_endorsed_nov_2017.pdf ,
Accessed 1 December 2020)
15. *Infection prevention and control during health care when coronavirus disease. Interim Guidance.* (COVID-19) is suspected or confirmed. Geneva: World Health Organization; June 2020. (<https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC-2020.4> , Accessed 1 December 2020)
 16. *Integrating Palliative Care and Symptom relief into humanitarian emergencies.* Geneva: World Health Organization; 2018.
(<https://apps.who.int/iris/bitstream/handle/10665/274565/9789241514460-eng.pdf?sequence=1&isAllowed=y>, Accessed 1 December 2020)
 17. *International first aid and resuscitation guidance.* Geneva: International Federation of Red Cross and Red Crescent Societies; 2016.
(https://www.ifrc.org/Global/Publications/Health/First-Aid-2016-Guidelines_EN.pdf ,
Accessed 1 December 2020)
 18. [Draft] *Joint Operational Framework to Improve Integrated Programming and Coordination Between Health and Protection.* [to be published] Global Health Cluster and Global Protection Cluster.
 19. "Keep health workers safe to keep patients safe." Geneva: *World Health Organization News Release*; 17 September 2020.
 20. *Noncommunicable Diseases in Emergencies.* Geneva: World Health Organization; 2016.
(<https://www.who.int/ncds/publications/ncds-in-emergencies/en/>, Accessed 1 December 2020)
 21. *Operational Guidance for Continuity of Essential Services Impacted by COVID-19: A practical guide for program implementation and adaptation.* Baltimore: Jhpiego; 2020.
(<https://www.jhpiego.org/wp-content/uploads/2020/06/Jhpiego-Operational-Guidance-for-Continuity-of-Essential-Services-Final.pdf>, Accessed 1 December 2020)
 22. *Preventing and Mitigating Indirect Health Impacts of COVID-19 on Displaced Populations in Humanitarian Settings.* Knowledge Brief on COVID-19 and Displacement. Columbia University Program on Forced Migration, World Bank Group and UNHCR; 2020.)
(https://www.publichealth.columbia.edu/sites/default/files/knowledge_brief_1.pdf, Accessed 1 December 2020)
 23. *Protection Mainstreaming Toolkit* [website]. Geneva: Global Protection Cluster; 2017
(<https://www.globalprotectioncluster.org/themes/protection-mainstreaming/> , Accessed 1 December 2020)
 24. *Protection Cluster Mainstreaming Training Package: Sector Specific Guidance on Health* [website]. Geneva: Global Protection Cluster: 2014.
(<https://www.globalprotectioncluster.org/themes/protection-mainstreaming/>, Accessed 1 December 2020)
 25. *Protecting Essential Health Services in Yemen* [website]. Geneva: Global Health Cluster; 2020. (<https://www.who.int/health-cluster/news-and-events/news/essential-health-yemen/en/> , Accessed 1 December 2020)
 26. *Public Health Information Services: Public Health Situation Analysis SOP.* Geneva: Global Health Cluster; 2018. (<https://www.who.int/health-cluster/resources/publications/Public-Health-Situation-Analysis-SOPs.pdf> Accessed 1 December 2020)
 27. *Pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report.* Geneva: World Health Organization; August 2020.

- (https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1, Accessed 1 December 2020)
28. *Quality of Care in Humanitarian Settings position paper*. Geneva: Global Health Cluster; 2020 (<https://www.who.int/health-cluster/about/work/task-teams/Quality-of-Care-in-Humanitarian-Settings-June-2020.pdf?ua=1> Accessed 1 December 2020)
 29. *Rapid Risk Assessment of Acute Public Health Events*. Geneva: World Health Organization (https://www.who.int/csr/resources/publications/HSE_GAR_ARO_2012_1/en/, Accessed 1 December 2020)
 30. *Response Analysis and Prioritization Guide: Humanitarian Programme Cycle 2021*. Geneva: United Nations Office for the Coordination of Humanitarian Affairs; 2020. (<https://assessments.hpc.tools/km/response-analysis-and-prioritization-guidance-2021> Accessed 1 December 2020)
 31. *Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*. Fourth Edition, Geneva: Sphere Association; 2018 (<https://spherestandards.org/handbook-2018/> Accessed 1 December 2020)
 32. *Suite of health service capacity assessments in the context of the COVID-19 pandemic*. Geneva: World Health Organization; 2020. (<https://www.who.int/publications/i/item/harmonized-health-service-capacity-assessments-in-the-context-of-the-covid-19-pandemic>, Accessed 1 December 2020)
 33. *UHC2030 Health Systems Assessment Technical Working Group* [webpage]; 2020. (<https://www.uhc2030.org/what-we-do/working-better-together/uhc2030-technical-working-groups/health-systems-assessment-technical-working-group/> , Accessed 1 December 2020)
 34. UN General Assembly Resolution A/Res/58/114 of 5 February 2004. New York: United Nations; 2004 (https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/58/114)
 35. *UN General Assembly Resolutions 46/182 of 19 December 1991*. New York: United Nations 1991. (https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/46/182 , Accessed 1 December 2020)
 36. *United Nations System Programme Criticality Framework*. New York: High-Level Committee on Management, United Nations; 2016. (<https://www.unsystem.org/content/programme-criticality-framework-revised>, Accessed 1 December 2020)
 37. *Vaccination in Acute Humanitarian Emergency, A Framework for Decision Making*. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/handle/10665/255575>, Accessed 1 December 2020)
 38. Watkins, David *et al.* "Universal Health Coverage and Essential Package of Care," in *Disease Control Priorities*, 3rd Edition; 2018. (<http://dcp-3.org/chapter/2551/essential-universal-health-coverage>, Accessed 1 December 2020)
 39. Wilhelm JA, HELLINGER S. "[Utilization of non-Ebola health care services during Ebola outbreaks: a systematic review and meta-analysis.](#)" *J Glob Health*. 2019;9(1):010406. doi:10.7189/jogh.09.010406 (<https://pubmed.ncbi.nlm.nih.gov/30701070/> , Accessed 1 December 2020)
 40. *Working paper on the use of Essential Package of Health Services in Protracted Emergencies*. Geneva: Global Health Cluster, EPHS Task Team; 2018 (<https://www.who.int/health-cluster/about/work/task-teams/EPHS-working-paper.pdf?ua=1>, Accessed 1 December 2020)
 41. *Yemen Minimum Service Package*. Health Cluster Yemen; 2017. (<http://yemenhc.org/?wpdmpo=minimum-service-package-guideline> , Accessed 1 December 2020)

Annex 5: Risk assessments and risk matrices

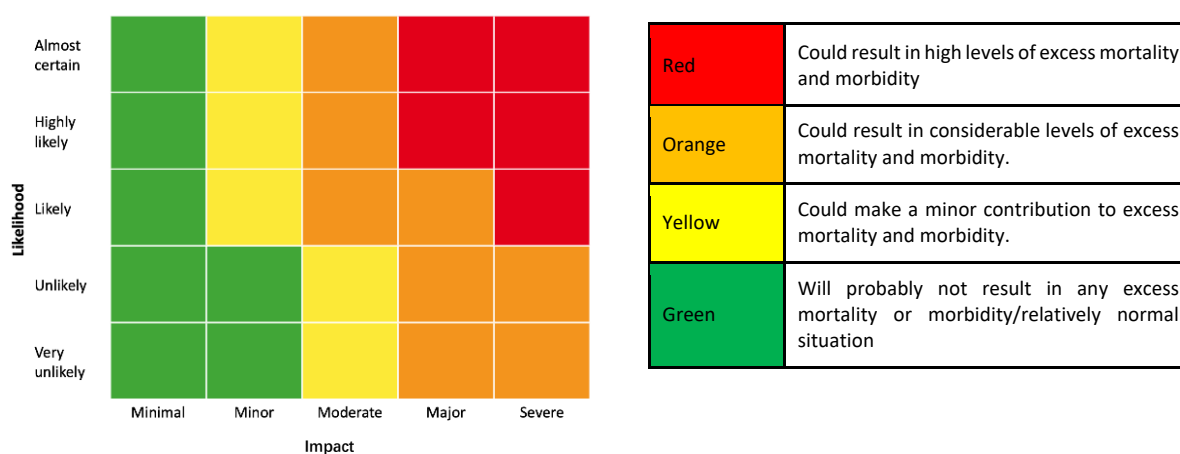
The GHC Public Health Situational Analysis (PHSA) uses risk matrices to help understand the risk of various health threats over time. In general populations are facing multiple health threats at any given time such as maternal mortality and various communicable diseases etc.

Calculating the risk of public health threats

The PHSA states the risk of a health threat is “the extent to which the health problem or group of diseases could result in health impacts, i.e., the magnitude of crisis-attributable excess mortality and/or excess mental health problems.”⁴⁴

The **risk** of any health threat is determined from the **likelihood** of a threat occurring and its public health consequence or **impact**. Using a chart like Figure 3, and plotting likelihood against impact, can help assign an estimate on the level of risk of a health threat.

Figure 3. Definitions for levels of risk, by looking at likelihood against impact



When assessing multiple threats, Table 5 gives an example of listing key health threats and how to present the calculation of its **immediate** risk (an example projecting risks of health threats over time will be provided in Table 6)

⁴⁴ [Public Health Information Services: Public Health Situation Analysis](#), Global Health Cluster; 2018.

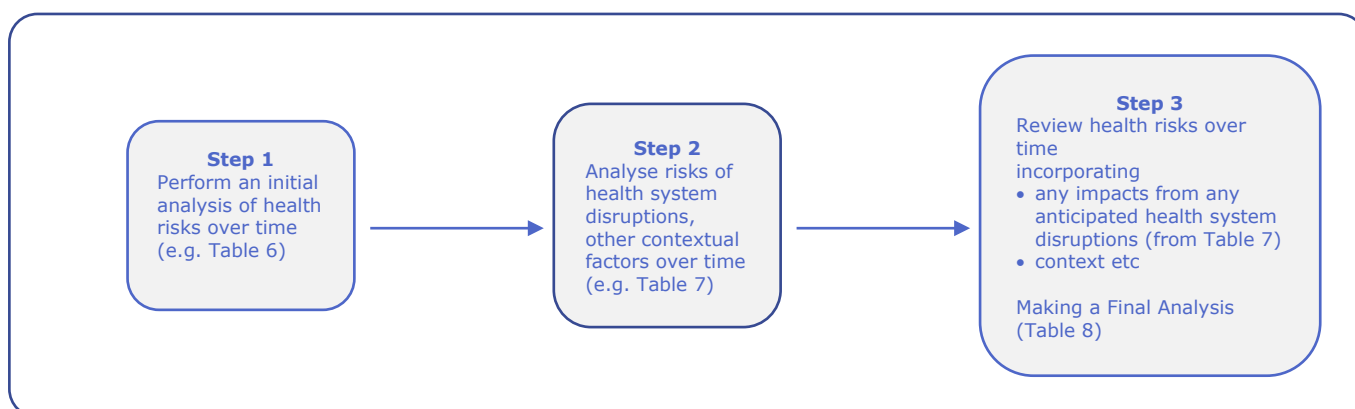
Table 5. Example of key health threats and calculating immediate risks

Table 5. Example of listing key Health Threats and calculating immediate risks				
Public Health Threat	Other details e.g. geographical Scope, population group	Likelihood	Impact (public health consequence) if it happened	Level of immediate Risk
e.g., Decrease in routine vaccinations	e.g., countrywide	e.g., likely	e.g., moderate	
e.g., Malaria	e.g., Eastern states	e.g., likely	e.g., minor	
e.g., Mental Health		e.g., almost certain	e.g., moderate	
e.g., Increase in maternal morbidity and mortality	Pregnant women	e.g., almost certain	e.g., major	
e.g., Increase in GBV	Girls and women	e.g., almost certain	e.g., major	

How to determine risk of health threats over time

An initial analysis of risk of health threats over time should be conducted. However, a risk assessment examining health system disruptions, as well as security and political context should also be completed. This is important for two reasons: 1) understand which disruptions may need to be strategically addressed either by health cluster partners or others to ensure safe service delivery of health services 2) determine if any health system disruptions or contextual factors may impact and increase the risk of health threats.

Figure 4 Steps to be taken to determine risks from health threats over time



Step 1 Analyse health risks over time

- List each health threat in a table, such as table 6
- For each threat assign a risk level using a chart such as above (figure 3). Determine its
 - Likelihood: i.e. probability of a threat e.g. measles occurring.
 - Impact (public health consequence) if it happened i.e., how many people may be affected
 - Add any comments that may be relevant e.g., PHSM measures that may impact other health threats

Table 6. Example of a risk matrix showing resultant impact of potential health threats over time during COVID-19

Table 6 Example of a matrix showing resultant impact of potential health threats over time during COVID-19				
Potential Health Threat	Month(s), starting now			
	1	2	3-6	6-12
COVID-19 cases	Low	Strong PHSM measures including movement restrictions anticipated		
Worse sexual and reproductive health outcomes	No immediate change	Decrease in ANC visits		
Increased NCD burden	Disruption in treatment coupled with COVID-19 related risk factors			
Increased HIV and TB burden	No immediate change	Disruption in treatment, increase in transmission rates		
Trauma	Violent trauma likely to continue			
Increased mental health burden	No immediate increase	Suspension or reduction in MHPSS services, social isolation and broken network increase burden		
Increase in reported GBV cases		Strong PHSM measures including movement restrictions increasing IPV		PHSM measures including movement restrictions reducing

Step 2 Analyse risk of disruptions in health system and contextual factors

- List each health system component and contextual threat in a table, such as table 7
- For each threat assign a risk level using a chart such as above (figure 3). Determine its
 - Likelihood: i.e., probability of the disruption occurring
 - Impact (public health consequence) if it happened

Red	Could result major disruption
Orange	Could result in moderate disruption
Yellow	Risk of minor disruption
Green	Generally, the same as before the crisis
Grey	No plausible assessment can be made at this time.

Table 7. Anticipating disruptions to key health system components and contextual factors during COVID-19

Table 7. Anticipating disruptions to key health system components and contextual factors during COVID-19				
Disruption	Month(s), starting now			
	1	2	3-6	6-12
Inability of providers to maintain all health services	Many services suspended and adapted			PHSM measures including movement restrictions expected to ease
Reduction in financing	Financing redirected to COVID-19 response		Additional funding secured	
Disruption to resources and supply chain (including pharmaceuticals)	Lack of PPE		Anticipated rupture in national supply chain Especially HIV and TB drugs,	
Degraded EWAR system	Lack of health personnel	Surveillance activities diverted to COVID-19	Surveillance activities diverted to COVID-19	
Health workforce diverted or unable to work	Reduction in staff for non-COVID-19 services, fewer NGO staff in country	Infected or quarantined staff		
Attacks against health care workers	Attacks and threats made against HCW		Lack of community acceptance of changes to health services provided	
Conflict			Political instability due to COVID-19 measures, inflation, loss of livelihood	

Step 3 Review risk of health threats

Incorporate findings from Table 7 (disruptions of health systems and other contextual factors) that may affect the risk of health threats over time, resulting a final risk matrix of potential health threats over time (see table 8, next page).

Table 8. Example of a matrix showing resultant impact of potential health threats over time during COVID-19

Table 8: Example of a matrix showing resultant impact of potential health threats over time during COVID-19				
Potential Health Threat	Month(s), starting now			
	1	2	3-6	6-12
COVID-19 cases	Low	Strong PHSM measures including movement restrictions anticipated		
Worse sexual and reproductive health outcomes	No immediate change	Decrease in ANC visits		
Increased NCD burden	Disruption in treatment coupled with COVID-19 related risk factors		National medicine shortage anticipated	
Increased HIV and TB burden	No immediate change	Disruption in treatment, increase in transmission rates	National medicine shortage of HIV and TB medicine	
Trauma	Violent and trauma likely to continue		Risk of Political instability and violence, insecurity in north	
Increased mental health burden	No immediate increase	Social isolation and broken network multiple health disruptions effecting quality COVID-19 care, resulting in high mortality and bereavement		
Increase in reported GBV cases		Strong PHSM measures including movement restrictions increasing IPV		PHSM measures including movement restrictions reducing