FINAL REPORT:

First Annual HUMANITARIAN HEALTH CONFERENCE

Hanover, New Hampshire
September 8 – 10, 2006

Introduction

The provision of health services to populations affected by natural or man-made disasters is a growing field . The response to disasters such as mass movements of refugees, famine, and earthquakes once characterized by an outpouring of charitable giving accompanied by a generous, but relatively unguided, sharing of time and expertise by medical practitioners, has slowly developed a more disciplined and multi-disciplinary approach. Since the late 1970s, a small, but steady, stream of scientific papers, guidelines, and recommendations have appeared in both the professional literature and, to a greater degree, in the publications of donor agencies, United Nations agencies, and the many non-governmental organizations that have arisen to try to ensure a more consistent, more organized, and more technically sound response to those in need.

As a result, the most important, high-priority interventions have been identified and a relatively clear public health approach to emergency relief has been described. Training for those working in disasters is available through short-courses at sites around the world and a growing number of academic institutions offer degree programs that stress well-managed interventions and an evidence-based approach. However, while our knowledge of the problem grows, implementation of the solutions remains, to a large degree, problematic. While most organizations share common problems in this regard, common solutions are rarely worked out.

Part of the problem is, perhaps, the lack of a professional forum within which practitioners of public health in complex emergencies can meet to exchange experiences, and to compare methods and results. In part to address this issue, the Dartmouth Medical School and the Harvard Humanitarian Initiative convened a two-day meeting in Hanover, New Hampshire, at which more than 70 participants from over 40 NGOs, academic institutions, donors and UN agencies gathered. Separate working groups were formed to discuss and explore solutions to four issues that present significant obstacles to a more efficient and effective public health response in emergencies. Each Working Group had its own specific goal, objectives and questions to explore.

This conference is intended to be an annual event at which key technical and operational issues relevant to humanitarian health programs will be discussed. One of this year's principal intended outcomes was the formation of an inter-agency group that could continue to explore solutions to these problems – the conference was to be a starting point, not a one-off event.

Conference Topics and Goals

The four issues explored at the 2006 conference were:

1. Human resources

The goal of the working group was to present a plan for encouraging, identifying, recruiting, educating, training, tracking, retaining and evaluating a cohort of trained professionals competent to deliver relief services during the next decade.

Few health professionals pursue careers in humanitarian assistance. The personal and professional demands of working in poor, remote settings are compounded, especially for US-based health workers, by financial obligations incurred during their training and by the demands of their professional associations. There is no specialization, no professional association, no list of core competencies, and, as a result, no clear career path in emergency relief. The conference sought to address the following questions:

- What skills are required by health professionals in a range of humanitarian settings and how can they can best be acquired?
- Where can agencies find health professionals and people in communities with appropriate potential or skills to staff their programs on a regular basis and what incentives might they be able to offer in order to retain them?
- What might constitute career paths for humanitarian health professionals and how can NGOs develop them in order to retain health professionals?

2. Technical and strategic oversight of humanitarian health programs

The goal was to explore and recommend models of technical and strategic oversight for humanitarian health programs.

The quality of emergency relief has always been an issue. Although several sets of guidelines and standards, such as the Sphere Project, exist, adherence to them is voluntary. Most who provide health services in relatively isolated environments receive only inconsistent supervision. There is no system in place for ensuring regular, constructive peer review, no formal evaluation mechanism, and no enforceable professional standards or accreditation. Some of the larger NGOs maintain teams of technical experts to oversee and ensure the quality of their field programs, but their methods vary considerably and are hampered by the reluctance of donors to fund anything other than field-based service delivery programs. The questions the Working Group on this topic were asked to consider were:

- Should agencies delivering health services in emergencies be required by a donor or other body to ensure access to expert technical support?
- What models of technical support to field programs do these agencies currently employ?

- Can and/or should an independent technical support agency or agencies be established (can technical support be "out-sourced" by implementing agencies)?
- What should be the size and composition of technical support teams?
- How can the development of technical support structures contribute to the development of career paths in humanitarian assistance, as suggested above?

3. Monitoring and evaluation requirements for health programs

The goal of Working Group 3 was to outline the changes in the humanitarian community that need to occur so that monitoring and evaluation occurs in order to improve individual health programs, and guide humanitarian initiatives.

Timely and accurate data is clearly required both to guide health programs and to assess their impact. Current donor-supported efforts seem to focus on health outcomes – nutritional status and mortality rates, for example - and centralized data collection. While these may help judge the effectiveness of resource allocation to a given crisis, they do not help individual agencies design, monitor or evaluate their programs on a regular basis. More needs to be done to improve the quality and consistency of data collection at the level of individual health programs and link these efforts to broader initiatives that aim to track humanitarian health outcomes. Specific questions addressed included:

- What are the ongoing initiatives for promoting data collection and use currently underway and what gaps and lessons exist?
- What previous initiatives or programs have been successful and provide lessons for future efforts.
- What decisions need to be made that are not made now because of lack of data?
- What data needs to be collected in order monitor programs over time at both local and global levels?
- What needs to happen on what levels to make monitoring and evaluation effective at both local and global levels?

4. Coordination

The Working Group's goal was to explore the need for, advantages and disadvantages of a consortium of humanitarian health agencies.

A frequent criticism of humanitarian agencies is that they are more competitive than cooperative, more interested in fundraising than in working together to ensure better outcomes for the populations they claim to be serving. To address this real, but perhaps exaggerated, problem, it has been suggested that a consortium of agencies that focus on health might be able increase the overall efficiency and effectiveness of the health sector by initiating joint projects, conducting training for combined staff, sharing lessons learned, both positive and

negative, from field experiences, and developing and implementing an operational research agenda. Such collaborative arrangements have helped advance NGO participation and outcomes in child survival (the CORE group) and in emergency settings (Reproductive Health Response in Crisis Consortium). Questions for the Working Group included:

- Is there a need for a consortium or inter-agency working group of humanitarian health agencies?
- What would be the mission, key activities and deliverables of such a consortium?
- What models already exist for developing humanitarian consortia and what lessons have been learned?
- What challenges and problems do such consortia face?
- What would be the membership of the consortium?
- What would be the structure and decision-making processes of the consortium?
- How would such a consortium be funded?

Discussion

The conference began in plenary with an overview of the background and objectives of the meeting. Working Group chairs then provided a more detailed outline of the goals and tasks that each group would address. Day 2 was devoted to working group discussions of the problems and questions outlined above. Definitive solutions were not the goal. Instead, experts in each area presented examples from other fields and/or promising experiences from humanitarian agencies to serve as possible models. The ideas presented were distilled and consolidated by the chairs of the working groups and their respective rapporteurs and presented for plenary discussion on the final morning of the conference. Summaries of the presentations are found below:

The Human Resources Working Group envisaged the development of a workforce whose members would identify themselves by declaring "I am a humanitarian". That is, being a "humanitarian" would be recognizable as a profession like any other, with identified core competencies, provision for life-long learning, and cumulative experiences enabling humanitarians to work in increasingly complex situations over longer periods of time. Professionalizing humanitarian workers would imply creating standards and ways of certifying competence and continuous learning opportunities. These might be developed by a consortium of organizations using the evidenced-based approaches of medical certifying bodies such as NBME, ECFMG, AAMC etc. The profession would be taught by a combination of academic courses and practical experiences that would combine to create certificate level curricula delivered by recognized institutions.

This Working Group placed emphasis on the development of national, as opposed to reliance solely on expatriate, staff. In addition to being the largest pool of

available human resources, local staff have an inherent endowment of local knowledge and cultural competency that can take many months, if not years, for expatriates to develop. They represent a sustainable, cost-effective resource with a higher stake in the outcome of their professional performance than international staff, who generally leave the emergency site after a relatively short time. In addition, in a way that could be studied and should be quantified, the development of national staff makes a clear contribution to local capacity to prevent and respond to emergencies – in other words, professionalizing local human resources reduces local vulnerability.

Of the methods by which local staff can be developed, the Working Group placed particular emphasis on mentorship. A number of characteristics of staff development were mentioned, including placing it front and center and planning career-enhancing opportunities for local human resources. "Training with purpose" would include allowing local staff to attend conferences, to climb a career ladder that would include promotion to regional and global positions, that would schedule rotations to field-level work, and that would ensure professional oversight and technical support. Finally, and importantly, graduate-level education opportunities would be tied to service to a humanitarian organization and represent an important, and valued, benefit.

The Working Group mentioned a number of existing programs on which their thinking was based. These included UNICEF's mentoring program, a new US Global Health Corps recommended in the Institute of Medicine (IOM) report, *Healers Abroad* and a number of existing partnerships such as the FAIMER regional institutes, the Public Health in Complex Emergencies training programs of Columbia University and Case Western University, the HELP course of the ICRC, and the International Emergency Medicine programs of the Harvard Humanitarian Initiative and the Johns Hopkins Center for International, Emergency, Disaster and Refugee Studies. Additionally, exciting new initiatives employing local communities such as "Back-Pack medic" programs involving Burmese refugees were highlighted as examples of innovative approaches to community involvement in sustainable solutions post crisis.

International professionals will always be involved, of course. To augment their number, NGO recruiters should explore new, or different, sources of interested personnel. These would include veterans of the armed forces, experts working in the commercial private sector, and the like.

In summary, the Working Group's vision for "Humanitarian 2025" was that of a competitive and widely recognized profession that provided a rewarding career for those who chose it. As a profession, it would have globally accepted standards and a clearly identifiable set of core competencies that could be measured using standard means. The Working Group recommended, as next steps, that discussions be held with accrediting bodies that have experience in developing other health professions and consideration be given to the formation

of a professional association of humanitarian health workers. It was also recommended that pilot programs of innovative strategies to develop humanitarian staff be developed.

The Technical and Strategic Oversight Working Group began its discussions with a recognition of the right of those affected by disasters to receive assistance of the highest quality. It stressed the need for humanitarian organizations to be accountable for the effectiveness of their actions. While priorities have been established and standards have been developed by the Sphere Projects and others, there remains a significant gap between what is written and what is done. Part of this gap can be attributed to a lack of technical support, from central or regional offices of many NGOs, for field operations. As a result, the distinction between "doing the right thing" and "doing things right" is clear. The problem is compounded by the lack of inter-agency cooperation in the field and by relationships between agencies and donors, which are too frequently based on financial, rather than on technical, accountability.

The characteristics of strong technical support would include a close relationship between those working at the most peripheral sites of the system and specialists in the areas in which they are working. Those specialists would have to understand the field context, and would preferably have had experience in hands-on field programs. A system which included constructive supervision and mentoring, a formal forum for the exchange of information and experiences, updating on best practices, and where lessons learned from one emergency could be applied to others would be ideal. In order to avoid confusion, technical standards should be developed and the means of implementing them coordinated.

The Working Group called upon donors to give more support to the assurance of technical excellence in the programs they fund, and upon NGOs to place greater emphasis on building technical capacity within their organizations. It suggested that a web-based repository of best practices, increased scientific exchange among experts, and a 24-hour "hotline" offering technical support to the field be developed. It stressed the need to build local capacity, to further develop academic linkages, and to promote partnerships between research institutions, NGOs, donors, and UN agencies. Finally, the Working Group concluded that timely data collection, analysis, and dissemination, and an assurance that humanitarian assistance programs be evidence-based and of the highest technical quality, were important elements of accountability that have to date been under-emphasized.

The Monitoring and Evaluation Working Group discussed the need both to track health information in emergency settings and to evaluate the performance of humanitarian assistance efforts. Multiple initiatives currently exist (12 were identified, of which 6 are led by UN agencies), but these are characterized, for the most part, by an emphasis on developing indicators that will be used centrally. Concerns were raised about this approach insofar as local programs become

bound to these indicators with the possible consequences that they design programs based on international indicators rather than carefully assessed local needs. The structure of information systems design has too often meant that persons collecting data are not served by this data and that the additional information added further along the chain, such as laboratory confirmation, is not made available to them. In addition, there is a failure to distinguish clearly between monitoring and evaluation resulting in neither activity being done adequately.

The Working Group felt that existing mechanisms to learn from experience and share the lessons learned are inadequate. To paraphrase one member -- instead of having twenty years of experience, we have one year of experience twenty times. To an important degree, the lack of a learning culture arises from pressures to always succeed and not share our "failings" or unexpected results. This culture is due to the prevailing line of accountability, which is between NGOs and donors, rather than between NGOs and beneficiaries. Finally, part of the reason for the skewed line of accountability is that there is insufficient demand from the public and their representatives for more information and for better performance from those responding to crises. In the early 1990's the demand for financial accountability was met by the implementation of systems and resources to assure this information was available. At the very least we must now account and report with the same vigor on the deaths, disease and prevention services among populations in crises.

Information needs are great, but rarely met. Innovation is needed; possibly with cross-sector and private sector collaboration, including the application of new technologies. That said, there is no short cut around the ongoing maintenance and support required for information systems to meet their objectives. The managerial and human resources requirements for successful information systems are essentially lessons that remain unlearned. Through projects like Child Survival (USAID, Johns Hopkins, Basics), Integrated Disease Surveillance and Response (CDC/WHO/AFRO), Routine Health Information Networks (RHINO) MACRO, and Sphere the characteristics of successful program components can be described.

One point of controversy about information system design was the perception that there is now a disproportionate emphasis on surveys. This follows a shift from what was previously almost an exclusive use of surveillance systems. Surveillance systems became less politically influential after mounting frustration with poor coverage and representativeness, the movement of humanitarian activities from camps to rural conflict zones, and a lack of public health information including social or behavioral risk factor information. In addition, the preference by vertical programs for single disease systems resulted in multiple competing systems at the first level of care and public health services. The UNICEF multiple indicator surveys in the 1980's were an important innovation to address the lack of useful information from passive surveillance systems. The

relative ease of implementation, often using teams of external and internal country staff, the flexibility, and lack of ongoing management made surveys in general quite popular. Ultimately, the need for good information requires that we try a phased approach.

a. Undertake the core or high priority activities first, such as mortality and nutrition, and do them well.
b. Use a phased approach for information systems in emergency settings that provides feedback and useful information to local programs and includes at least 2 types of information. For example, clinical and community-based through some types of survey and medical information about types of illness, laboratory, and fatalities based on surveillance. Surveillance methods may be of many types including sentinel sites, or diseases, or a focused integrated system that is either passive or active in design.
c. Invest in the capacity to collect qualitative and contextual data to be able to interpret other survey and surveillance information.

Having described the problem, the Working Group concluded that at least part of it is due to the fact that demands for information at the global level overwhelm the capacity at the local level. It suggested that global indicators be minimized in order to enable local programs to be context-specific rather than to fit a single mold; that the information collection burden on field programs be eased; and that time and money be directed toward improving the training and supervision of those involved in monitoring and evaluation.

It is difficult to evaluate the effect of emergency response programs if these are implementing interventions that have not been proven to be efficient and/or effective. The urgency of the moment frequently results in "something" being done, even if that something is not supported by evidence. Additional research may be necessary to establish the effectiveness of many health activities being routinely implemented in emergencies, and to compare and contrast the strategies by which those interventions are being delivered to intended beneficiaries, to determine whether or not they are being effective. In short, the characteristics of a "good" monitoring and evaluation component are that it 1) is integrated into, and flows from, an initial assessment of needs; 2) includes a chain of evidence linking needs, objectives, activities, outputs, and outcomes; 3) is population-based rather than restricted to often-biased populations drawn from clinic attendees; and 4) is able to take into account a cost-benefit analysis that includes both expected and unexpected, and both positive and negative, outcomes.

The Working Group identified a series of "next steps" that might enhance the monitoring and evaluation of emergency response. These include an updating of the SPHERE Project and similar efforts to include standards for monitoring and evaluation which go beyond selecting indicators and suggest how to collect information via innovative surveillance methods, suited to the contexts in which emergencies unfold, that would adhere to best practices.

In addition, a system of ongoing evaluation of donor-funded health projects should be developed, with an emphasis on comparing the results achieved to the objectives described – are these programs doing what they said they would. Finally, as monitoring and evaluation are key components of project design, graduate programs in public health in complex emergencies should be strongly encouraged to assist in the development of specific competencies for professionals being trained in the area of disaster preparedness and response and in the development of accreditation standards. In keeping with this strategy, collaboration with the Field Epidemiology Training Programs (FETP), the Rockefeller Public Health Schools Without Walls, and other professional programs committed to addressing human resource shortages will be helpful.

The Coordination Working Group acknowledged that all of the problems discussed during the conference are compounded by the relative lack of coordination and cooperation between humanitarian organizations. This has been the prevailing situation, despite widespread recognition that health interventions are of primordial importance in emergency settings, that a relatively limited set of effective health interventions has been identified as life-saving, and that strategies to deliver these services have been, at least to some extent, shown to work. However, the inability of international relief efforts to implement lifesaving strategies on a large scale and in an efficient and equitable manner has been frequently criticized.

The situation is characterized by a lack of coherence regarding the delivery of aid, the lack of a standing forum for discussion among the health professionals engaged in this kinds of work, the lack of professional standards and formal training requirements, and the lack of trust between the international and local groups that constitute the first level of organized response to emergencies. One step that has been suggested to address these problems is to develop a consortium of health-related humanitarian agencies that would develop more or less formal mechanisms to collect and exchange information, to learn from each other in an ongoing fashion, and to undertake self-evaluations on a regular basis.

Models of inter-agency cooperation exist. They include the Inter-agency Network for Education in Emergencies (INEE), the CORE Group of NGOs, the Inter-Agency Standing Committee (IASC) Health Cluster, and the Reproductive Health Response in Crisis Consortium (RHRC). Characteristics that contribute to the success of consortia are a clearly-defined mandate, adequate financial resources, commitment of its members, strong leadership, a membership structure, an appropriate and effective governance structure, a permanent secretariat, and a means of frequently and effectively disseminating information of interest to the entire group. The field of humanitarian assistance could, with creativity and dedication, develop a similar network.

The working group articulated a future vision of a coordinated, high quality humanitarian response in the health sector. The goals needed to achieve that

vision include a credible system of accreditation for humanitarian health workers, improved collaboration and coherence among humanitarian health professionals, and better informed donor and beneficiary communities, to whom humanitarian personnel would be accountable.

The Working Group made a number of specific suggestions:

By consensus, and as later agreed upon in the plenary session, it called for the establishment of a collaborative mechanism for information sharing among humanitarian actors. A venue for discussion and for the design of joint initiatives, such as a mapping of humanitarian actors, existing tools, and current activities, would be created. A steering committee would be designated to oversee these activities. The Working Group made it clear that this formal collaboration would be started as "a premise to be tested" – there are clearly a number of questions that need to be answered: Who will benefit from it? What will be its principal purposes? Would there be meetings, or would activities be conducted only virtually? Finally, what would be the specific content addressed by the collaboration?

The question regarding the desirability of establishing a humanitarian health consortium would be answered, initially, through a broad survey to be undertaken by an interim steering group drawn from the Working Group. The decision as to whether or not to move forward after the survey, and how, would be based on the results. To keep things moving, for the time being, a caucus of those organizations which are currently members of Global Health Council would be formed and would meet at the time of the GHC annual meeting. Results of the survey will be discussed at the cluster meeting and will form the basis on which to move forward. In addition, the idea of a humanitarian health consortium would be presented to the IASC Health Cluster at the time of its meeting, in October, in Geneva, and close links to that group would be established. The working group made it clear that any humanitarian health consortium should be seen as complementary to and not competitive with the IASC Health Cluster.

An important part of the work of the Consortium Steering Group, in the longer term, would be to oversee the recommendations of the other three Working Groups of this Conference. Because there is work involved, and because a voluntary organization might not have the 'legs' of a more formally organized group, an informal straw poll conducted during the plenary session asked whether or not organizations present at the meeting would be willing to contribute $2500 to help finance the Steering Committee and its initial survey. The response was overwhelmingly positive. It was decided, on the recommendation of the Working Group, that the Harvard Humanitarian Initiative/Dartmouth University secretariat, which organized the Conference, would be an appropriate academic group to conduct the survey.

Conclusion

The meeting concluded with a plenary session during which the presentations of each Working Group were presented. The discussion was overwhelmingly positive and the recommendations of the Working Groups, as amended during the course of the session, were adopted. It was generally agreed that this Conference, the first of its kind, may have been a beginning, but was certainly not a self-contained event with a definitive end. Each of the Working Groups recognized the need for further deliberations and, in some cases, for concrete actions to be pursued if the Conference were, in the long run, to be deemed successful. Most critical, perhaps, is the follow-up to Working Group #4, the attempt to develop a consortium of health agencies that would work toward increasing the level of professionalization of the health sector in the field of humanitarian assistance. This is a medium- to long-term undertaking that will require a substantial level of effort, a strong commitment on the part of both individuals and organizations, a home base, such as the Global Health Council, the IASC Health Cluster, or other, and an adequate amount of funding. It was, finally, agreed that the Humanitarian Health Conference be an annual event, to alternate each year between Hanover and Boston. The host for the 2007 meeting will be the Harvard Humanitarian Initiative.

ANNEX: AGENDA

Friday, September 8, 2006
10:00 AM - 2:00 PM **Registration**
2:00 PM **Welcome, Conference Opens.** Introduction of Conference Chair Ronald Waldman, MD - James C. Strickler, MD, Chairman Emeritus, International Rescue Committee
2:15 **Opening Address**: *"Improving Health Outcomes in Humanitarian Settings: Operational and Technical Challenges"*- Richard J. Brennan, MBBS
2:35 **Introduction of Work Group Chairs**
- Ronald Waldman, MD
2:40 **Work Group 1:** *"Human Resources inHumanitarian Action"* - Karen Hein, MD
3:00 **Work Group 2:** *"Meeting Strategic andOversight Requirements and Best Practices in the Field"* - Michael J. VanRooyen, MD, MPH
3:20 **Break**
3:35 **Work Group 3:** *"Tracking Health Information and Humanitarian Performance"* - Les Roberts, PhD
3:55 **Work Group 4:** *"Developing a Collaborative Consortium of Health-Related NGOs"*- Susan Purdin, RN, MPH
4:15 **Closing Remarks** - Ronald Waldman, MD
4:25 **Meeting Our Objectives** - Mary G. Turco, EdD
4:30 **Adjourn**
5:45 **Reception**
6:30 **Dinner**, Welcome to Participants and Special Guests - Susan Dentzer, Dartmouth '77
8:00 Introduction of Jennifer Leaning, MD - Ronald Waldman, MD
Keynote Address: *"The Dilemma of Neutrality"* - Jennifer Leaning, MD
8:50 **Closing Remarks** - Ronald Waldman, MD
9:00 **Adjourn**

Saturday, September 9, 2006
9:00 **Morning Work Group Session**
10:30 **Break**
10:45 **Morning Work Group Session**
12:00 PM **Lunch Provided at Work Group Sites**
1:00 **Afternoon Work Group Session**
2:30 **Break**
2:45 **Afternoon Work Group Session**
4:00 **Work Group Wrap-up**
4:15 **Work Groups Adjourn**
6:00 **Reception**
7:00 **Dinner**, Welcome to Participants and Special Guests
- Mary G. Turco, EdD
8:15 Introduction of Charles MacCormack, PhD; President and CEO of Save the Children/US - Ronald Waldman, MD.
Introduction of the 2006 Boathouse Lecturer, Samantha Power, JD

- Charles F. MacCormack, PhD
8:25 **Boathouse Lecture** - *"THE VOID:Who Will Lead on Human Rights in an Age of Terror?"*- Samantha Power, JD
9:00 **Closing Remarks** - James C. Strickler, MD
9:15 **Adjourn**

Sunday, September 10, 2006
8:30 **Plenary Opens** - Ronald Waldman, MD
8:35 **Work Group Reports** (15 minute presentations and 10 minute discussions)
10:35 **Summary of the Reports and Next Steps to Publish Proceedings**
- Richard J. Brennan, MBBS
- Michael J. VanRooyen, MD
11:00 **Closing Remarks:** *"Where Do We GoFrom Here?"*- Ronald Waldman, MD
11:10 **Farewell, Conference Closes** -James C. Strickler, MD

ANNEX II: ORGANIZATIONS REPRESENTED AT THE CONFERENCE

NGO
Action Against Hunger
Africare
American Red Cross
American Refugee Committee
Americares
CARE
Christian Children's Fund
Child Fund International
CONCERN
C-SAFE
Emergency, USA
Health Volunteers Overseas
International Medical Corps
International Rescue Committee
John Snow International
MERLIN
Mercy Corps
Medecins Sans Frontieres
Oxfam USA
Northwest Medical Teams
Relief International
Save the Children, USA
Samaritan's Purse
World Vision
OTHER AGENCIES / ORGANIZATIONS
American Medical Association - Emergency Preparedness
BPRM
Brown University
Boston University
Case Western University
CDC
Collaborative Direct Action
Columbia University
CORE
Dartmouth Medical School
DFID - UK
Foundation for the Advancement of International Medical Education

George Washington University
Global Health Access Program
Global Health Council
Global Impact
Harvard University
INEE
Johns Hopkins University
New York University
OCHA
OFDA
Tufts University
Tulane University
UNICEF
University of Pennsylvania
World Education