Health cluster guide

A practical handbook

Chapter 8

Integrated programming for better health outcomes: a multisectoral approach

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8.1 Rationale for integrated programming for better health outcomes

There is growing recognition that multisectoral integrated programming is essential for a coherent and effective humanitarian response. The 2016 Agenda for Humanity advocates that the humanitarian agencies move towards an approach of working jointly across sectors and mandates and across the emergency–development divide to deliver on collective outcomes (Agenda for Humanity, core responsibility 4c) *(1)*.

The health status of a population is impacted by multiple factors far beyond the provision of preventive and curative health services. Additional factors directly impacting morbidity and mortality of the population in a humanitarian emergency include availability of water, sanitation and vector control, food security, preventive and curative nutrition services, and protection. Availability of adequate shelter and good camp management will also affect health status. Health interventions may be conducted through or in collaboration with schools, while logistic and telecommunications support will also significantly influence the effectiveness of a health response. Consequently, better health outcomes will require collective action from multiple clusters and sectors.

8.2 What is integrated programming for better health outcomes?

Integrated programming for better health outcomes refers to a way of working whereby there is coordination and strategic collaboration across two or more clusters or sectors with the goal of achieving better health outcomes through collective action. Box 8.1 presents some relevant features of humanitarian clusters.

Box 8.1 Common features of humanitarian clusters

Clusters should have a common understanding of the humanitarian context, implying agreement upon:

- *where* is it happening? geographical dimensions
- *who* are we talking about? vulnerabilities and other cross-cutting issues
- *what* are we talking about? service deliveries
- *when* will it happen? prioritization of interventions
- *how* can humanitarian actors best deliver as a consulted group? joint planning for common outcomes.

Clusters have common mandates:

- adherence to humanitarian principles and principles of partnership
- accountability to affected populations within a people-centred approach
- protection mainstreaming
- combating gender-based violence

- mental health and psychosocial support services
- cross-cutting issues, including age, HIV/AIDS, gender, disability, diversity
- advocacy.

Clusters may have common modalities for response implementation:

- provision of packages for multisectoral service delivery
- joint planning and integrated multisectoral response
- joint resource mobilization for multisectoral service delivery
- linked emergency response with development-oriented and durable solutions.

Integration, as a concept, has a number of different interpretations. It is therefore important to establish a shared understanding between clusters of what integration means. Different processes may promote the integration of activities and contribute to their implementation. A range of integration modalities may be applied depending on the context, the issues being addressed, and existing systems, policies and approaches. Table 8.1 provides examples of approaches to integration, the associated advantages and related activities.

Table 8.1 Integration approaches: advantages and examples of activities

Integration approach	Advantages	Examples
Coherence	Duplication is minimized, ensuring that activities in one sector are not counterproductive for activities in another sector	Ensure the health cluster response plan is coherent with plans of other clusters and sectors Consider existing development programmes when planning the humanitarian response
Convergence	Interventions are aligned to achieve a common goal; each sector prioritizes actions with highest potential to contribute to that goal	Agree on common indicators for joint analysis Prioritize humanitarian needs and consequences Identify shared objectives within the humanitarian response plan
Complementarity	Action in one sector complements action in another sector, enabling increased overall effectiveness	Carry out joint assessments Implement joint targeting (for example, most vulnerable households or population subgroups) Develop joint response plan Develop joint preparedness plan
Combined	Combined effect of intervention exceeds the effect if separately implemented	Carry out joint evaluation Develop a comprehensive package of services covering all basic needs while reinforcing existing systems

To increase the efficiency of integrated programming, an operational framework could be elaborated between different sectors, activities and beneficiaries, focusing on the same common aim.

Effective integrated programming for better health outcomes requires a number of sequential steps:

1. carry out joint or harmonized assessment and joint analysis of the health status and vulnerability of the affected population and underlying contributory causes;
2. jointly prioritize the most vulnerable geographical areas and target populations for a multisectoral integrated response;
3. for each geographical area and target population, jointly define the priority health problems and various interventions required to address the problems and their various contributory causes;
4. define the specific responsibilities of each cluster or sector, and the strategic and operational linkages between the clusters and sectors for collective action;
5. develop and implement an integrated response plan and budget, for increased cost-effectiveness;
6. monitor and evaluate the integrated response plan in terms of progress towards the health outcomes, while addressing the potential for double counting in the monitoring and evaluation framework;
7. ensure that, in most humanitarian contexts, the health cluster works at a minimum as part of an integrated response with the water, sanitation and hygiene (WASH), nutrition, protection, and food security clusters, and with the support of the logistics cluster.

The humanitarian context and the health status and vulnerability of a population, and consequently the goal of the intervention, will affect the level of collective action required with the various clusters. It is the responsibility of health cluster coordinators to reinforce work across clusters and towards collective action and outcomes. An effective multisectoral integrated response requires inter-cluster coordination at national, subnational and operational levels.[1]

Figure 8.1 illustrates how integrated programming can lead to better health outcomes.

[1] See section 2.6 on inter-cluster coordination, Chapter 2.

Figure 8.1 Integrated programming for better health outcomes

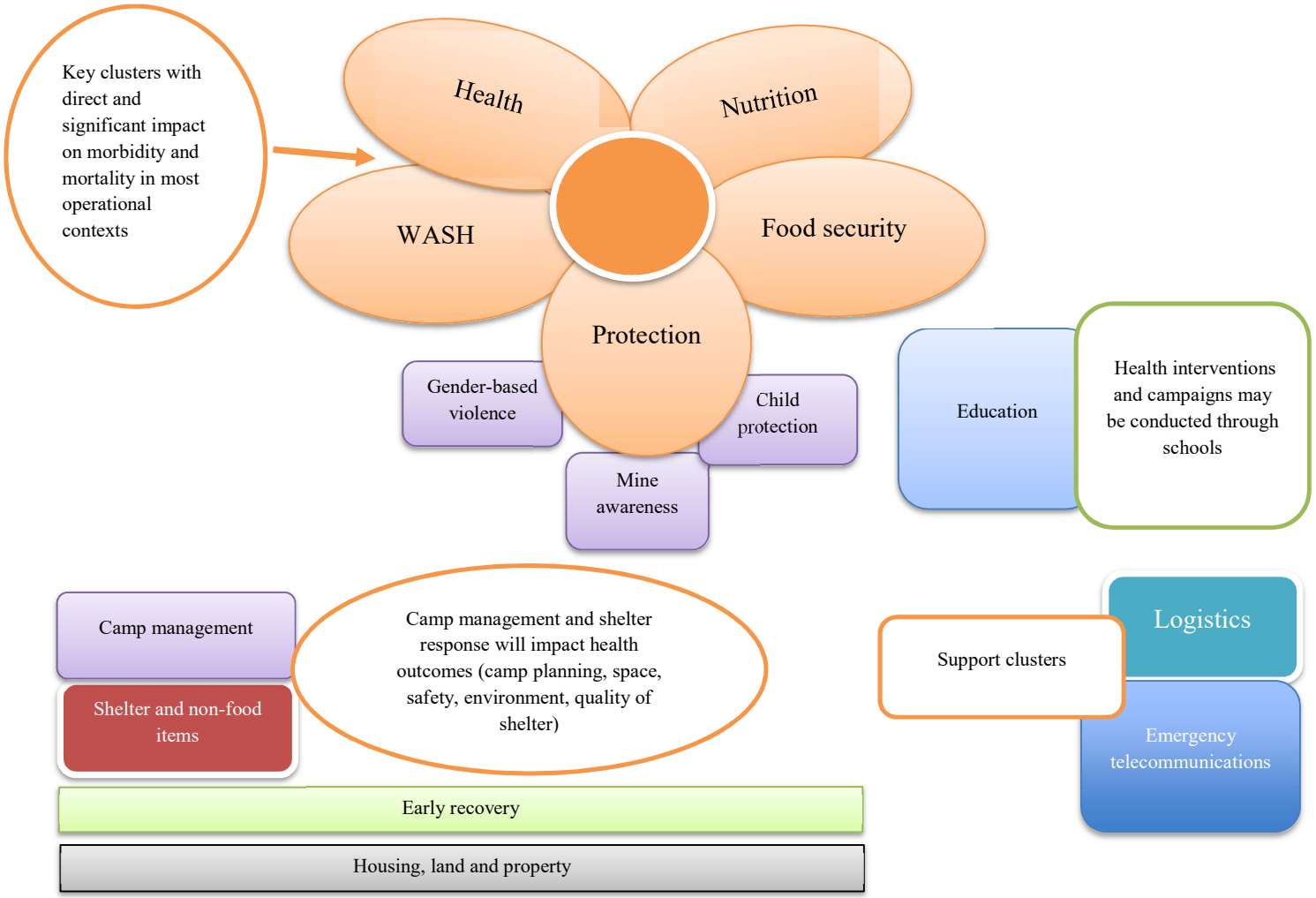


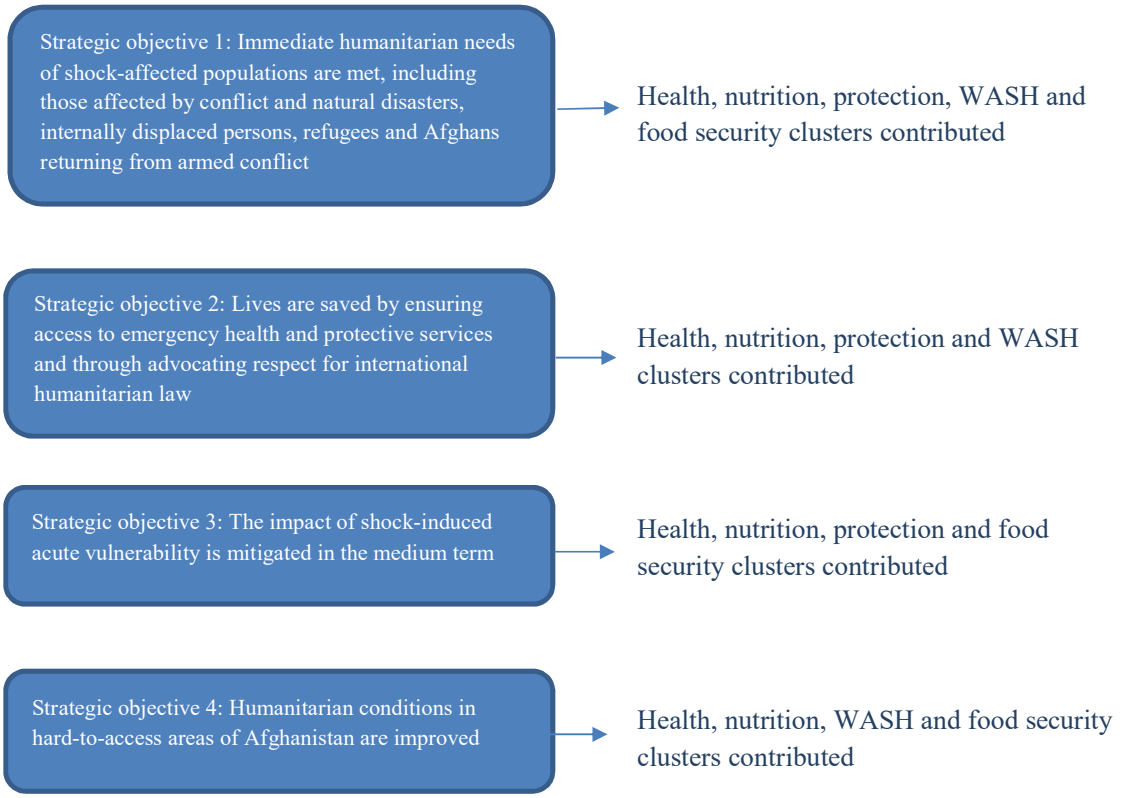
Figure 8.1 illustrates the different ways that the various technical and support clusters may impact health outcomes in an emergency context. Some examples follow.

- The health, nutrition, protection, WASH, and food security clusters are key clusters that are likely to directly and significantly impact morbidity and mortality in operational contexts.
- The protection cluster ensures linkages between the psychosocial services provided through the protection cluster partners and mental health services provided by the health cluster partners.[2] Protection cluster interventions promoting safety have clear links to reducing incidence of violence.
- Increasing access to health services for survivors of gender-based violence and relevant referrals between the protection and health clusters will ensure that the health consequences (both mental and physical) of gender-based violence are addressed. The health consequences of violence are mitigated through multisectoral service provision coordinated across the two clusters.
- The shelter and camp management clusters will impact health outcomes. Overcrowded settlements can contribute to an increase in disease, while poor lighting and lack of safety considerations can contribute to risks of sexual violence, and poor site planning for hygiene and sanitation can lead to disease.
- The education cluster may be used as a platform to conduct health interventions and health education campaigns.
- All clusters have some shared objectives and goals and have shared advocacy mandates, for example the health, education and WASH clusters with regard to monitoring attacks on health facilities and schools.
- Ultimately, all clusters will be working towards achievement of one or more of the overarching strategic objectives outlined in the humanitarian response plan.

Figure 8.2 presents an example from the Afghanistan Humanitarian Response Plan, 2017, showing how each of the key clusters with responsibilities for reducing morbidity and mortality relate to the four strategic objectives outlined in the plan.

[2] See section 2.6 of Chapter 2.

Figure 8.2 Afghanistan Humanitarian Response Plan, 2017: contributions of clusters to strategic objectives



8.3 Applying a multisectoral approach for collective action and better health outcomes

Effective integrated programming requires a multi-cluster, multisectoral approach through all stages of the Humanitarian Programme Cycle, including assessment and analysis, strategic planning, resource mobilization, implementation, and monitoring and preparedness.

8.3.1 Joint assessment and analysis of the situation

Joint assessment

Ideally, key clusters directly impacting morbidity and mortality will carry out a joint needs assessment.[3] However, joint assessments are not always possible, due to such factors as lack of simultaneous availability of key staff from key clusters, or limited opportunities to travel to the assessment area (for example, where air travel is necessary). In such situations, harmonized assessments would be a reasonable second alternative.

[3] See Chapter 10 on needs assessment.

Multi-cluster or multisectoral joint assessments require careful planning and coordination. They take more time and involve more negotiation and compromise than a single sector assessment; nevertheless, the data analysis, triangulation and subsequent decision-making are easier when there is a shared experience. Joint assessments are also a good way to learn about the other participating clusters and sectors and discover areas of shared interest.

Joint analysis

After assessments are carried out, the key clusters directly impacting health outcomes should conduct a joint analysis of the situation.

- Where joint assessments have been conducted, the findings of the assessment should be discussed and agreed upon and used to identify priority geographical areas or vulnerable populations and the priority issues to be addressed.
- Where joint assessments have not been conducted for whatever reason, nevertheless, after assessment the key clusters should get together to conduct a joint analysis, during which the findings from each cluster assessment are presented, along with other relevant information (such as geographical displacement figures, availability of health and social services and access to safe drinking-water). The analysis will enable identification of priority geographical areas and vulnerable populations, and the priority issues to be addressed in the response.

Box 8.2 presents examples from Afghanistan and South Sudan of joint assessment and analysis.

Box 8.2 Afghanistan and South Sudan: joint assessment and analysis

Afghanistan: development of humanitarian needs overview, 2019

Several sector-specific information sources, as well as a multisectoral whole of Afghanistan assessment, provided a comprehensive evidence base for the 2019 Afghanistan humanitarian needs overview. The supporting data sets covered all provinces of Afghanistan and included health information and insights on hard-to-reach districts. As a nationwide, multisectoral assessment, the whole of Afghanistan assessment enabled the humanitarian needs overview not only to compare sectoral needs, but also to give a better understanding of how these needs interacted in different geographical areas. Various sector-specific assessments, including a specific health assessment, were able to build on this multisectoral foundation and expand on technical information that the whole of Afghanistan assessment was not able to provide. The assessment input was combined and triangulated with sector-specific technical studies, including for health.

South Sudan: joint analysis, 2011/2012

While the health, nutrition, food security and WASH clusters did not undertake joint assessments in South Sudan, these clusters regularly conducted joint analysis of the situation, coming together to share the various cluster assessment findings and analysis, which were then cross-tabulated to identify the priority geographical areas and vulnerable populations. This analysis was then fed into the development of the humanitarian response plan, and prioritization criteria for the key cluster response plans.

During joint analysis, the clusters should determine the status of the priority health problems and identify contributory causes. Examples are as follows.

High levels of diarrhoea in children aged under 5 years caused by:

- poor water quality and quantity;
- poor access to water (articulate why – for example, due to long distances to travel to collect water or high prices to pay for water);
- poor sanitation facilities and practices (articulate the situation – for example, open defecation close to houses);
- poor hygiene practices (articulate what these are – for example, generally limited use of soap for handwashing or poor practice in food preparation);
- poor infant and young child feeding practices (articulate what these are and why – for example, early weaning due to cultural norms or mother's older children caring for younger siblings as mothers go to work);
- poor nutritional status (see below).

Increased reproductive health needs due to:

- increased risk of sexual violence during emergencies;
- withholding access to essential goods in exchange for sex;
- poor or no observation of standard precautions, allowing the transmission of sexually transmitted infections, including HIV, to patients or health workers;
- no referral system in place to transfer patients in need of basic or comprehensive emergency obstetric care;
- poor social and sexual behaviours and increased risk-taking behaviours;
- harmful traditional practices;
- stress and malnutrition.

Increased mental health and psychosocial support needs due to:

- pre-existing (pre-emergency) social and psychological problems, such as extreme poverty, belonging to a group that is discriminated against or marginalized, political oppression, severe mental disorder or alcohol abuse;
- emergency-induced social and psychological problems, such as family separation, disruption of social networks, destruction of community structures, resources and trust, increased gender-based violence, grief and non-pathological distress, and depression and anxiety disorders, including post-traumatic stress disorder;

- humanitarian aid-induced social and psychological problems, such as undermining of community structures or traditional support mechanisms, and anxiety due to a lack of information about food distribution *(2)*.

High levels of acute malnutrition in children aged under 5 years due to:

- poor dietary intake (articulate why);
- poor infant and young child feeding practices (outline what these are);
- poor hygiene and care practices (articulate what these are);
- high burden of infectious diseases (articulate the main diseases among children aged under 5 years);
- lack of access to affordable quality child health services (articulate why);
- lack of access to adequate quality and quantity of water (articulate why);
- poor environmental health (specify).

Gender-based violence due to:

- lack of security, presence of conflict, or inadequate shelter, which can pose safety concerns;
- lack of access to resources to meet basic needs, which can drive sexual exploitation, early marriage and intimate partner violence;
- breakdown of social and protective networks;
- risks related to elements of WASH (water collection, latrine design) if gender-based violence standards are not incorporated;
- lack of protection services for survivors;
- underreporting due to sociocultural barriers, stigmatization, shame, fear of reprisal;
- other issues preventing survivors of gender-based violence from receiving health care to mitigate the consequences of violence (and therefore affecting health outcomes), including unsafe access to facilities, untrained staff, insufficient supplies and equipment, underreporting, lack of availability or awareness of services, and lack of referrals between various sectors (for example, in the areas of gender-based violence, health and child protection) *(3)*.

Articulating the various contributory causes of priority problems facilitates the development of an appropriate multisectoral integrated response plan.

Box 8.3 presents an example from Bangladesh of how joint analysis of gender-based violence services contributed to improved planning to counteract the problem.

Box 8.3 Cox's Bazar, Bangladesh: joint analysis of gender-based violence services

In Cox's Bazar, Bangladesh, in 2019, the health sector and the protection sector conducted a joint analysis of the quality of gender-based violence services within primary health care facilities. The health sector working group convened workshops with members from the reproductive health working group, the mental health and psychosocial support working group, the gender-based violence subsector and the child protection subsector to develop an assessment tool, adapted from existing gender-based violence quality assurance tools, that would holistically capture the full range of survivor needs. The joint analysis also assessed selected facilities based on priority standards. By collaborating across clusters, the team members were able to leverage their technical expertise to assess whether the health services met standards for the provision of clinical care, were survivor-centric and child-friendly, and were sufficiently integrated with mental health and psychosocial support services. In taking forward recommendations from this assessment, the health sector was able to ensure that health action plans were fully informed by broader multisectoral concerns.

8.3.2 Planning a multi-cluster response

Based on joint analysis, key clusters should work jointly to:

- prioritize the most vulnerable geographical areas and target populations for a multi-cluster integrated response leading to better health outcomes;
- agree on the priority problems;
- reach consensus on the interventions required by each cluster or sector to address the problems and the various underlying causes;
- formulate a joint operational framework outlining the shared objectives and respective responsibilities of each cluster to fulfil the objectives, and how the key clusters will interact with each other operationally (to be adapted from available global frameworks);
- develop an integrated response plan based on the joint operational framework, including benchmarks, standards, indicators and arrangements to monitor progress towards achieving collective outcomes.

Tools exist to assist with analysis and planning a multisectoral, integrated response for better health outcomes. Box 8.4 presents an example.

Box 8.4 Joint operational framework for effective cholera preparedness and response

The joint operational framework defines the responsibilities and accountabilities of the health and WASH clusters during emergency response in areas of potential overlap.

The objectives are to:

- clarify responsibilities and accountabilities between both clusters, especially as they relate to cholera prevention, preparedness and response actions;
- improve coordination and collaboration among health and WASH field staff during emergency operations.

Source: Global Health and Global WASH Clusters *(4)*.

8.3.3 Incorporating advocacy as required

The health cluster may need to carry out advocacy with one or more of the technical clusters to enlist their engagement in integrated response programming, and with the logistics and emergency telecommunications clusters to ensure necessary logistical and telecommunications support for an effective response.[4]

8.3.4 Resource mobilization

The implementation of collective activities in the health and other clusters may have significant cost implications. Funding the needs assessment and planning components within the humanitarian mechanism is one of the main challenges, especially in protracted crises. Donors are increasingly interested in supporting programmes that bring measurable results for affected populations through joint action and improved service coverage, thereby reducing duplication of effort and increasing the effectiveness of interventions.

Some aspects should be considered for joint resource mobilization.

- Are there any activities to build capacity on technical aspects of the other sectors (for example, WASH providing training to health) included in the funding processes?
- Are there joint funding proposals (including pooled funds)?
- Is there joint advocacy to encourage donors to fund inter-cluster integration initiatives?

8.3.5 Implementation of a multisectoral integrated programme

Each cluster and sector will be responsible for implementing activities and coordinating and collaborating with other clusters in line with the joint operational framework and integrated response plan.

There are many forms of integrated programming. For example, the convergence model focuses on the geographical co-location of the emergency response from several clusters,

[4] See Chapter 7 on advocacy.

with services targeting the jointly identified beneficiaries and providing a standard agreed minimum package. For defining the package, agreement should be reached on the selection criteria for the beneficiaries and the most affected and vulnerable locations, and on the identification of activities at administrative level, while incorporating relevant protection issues. The Yemen Integrated Programming for Famine Risk Reduction *(5)* provides an example:[5] priority districts were identified using specific selection criteria (evidence-based global acute malnutrition rate and food security contributing factors).

Another approach to integrated programming is results-focused programming,[6] which is an approach designed to improve programme delivery and strengthen management effectiveness, efficiency and accountability, based on clearly defined and measurable intended results and impact, rather than on planned activities. It supports moving the focus of programming, managing and decision-making from inputs and processes to the *objectives to be met*: for example, reduced mortality due to a reduction in severe acute malnutrition rates and waterborne and communicable diseases. At the planning stage, results-focused programming ensures that relevant interventions are in place to achieve an expected result. During the implementation stage this approach ensures and monitors that all available financial and human resources continue to support the intended results.

Box 8.5 gives an example from Iraq of integrated programming.

Box 8.5 Iraq: integrated programming to combat gender-based violence

In Iraq, the health cluster promoted increased multisectoral coordination on gender-based violence by establishing a focal point for gender-based violence. This focal point was a member of the health cluster but attended the gender-based violence subcluster meetings and was responsible for sharing information between the two and identifying issues that required joint action. This resulted in greater collaboration around the humanitarian needs overview process and better integration of gender-based violence objectives within the health section of the 2019 Humanitarian Response Plan. In 2019, the health cluster also produced an advocacy paper highlighting key messages for the health sector to take forward to better address gender-based violence.

8.3.6 Monitoring and evaluating a multisectoral response

Regular monitoring information should be collated from each of the clusters, and the performance and outcome of the whole response and individual interventions in terms of achieving collective outcomes should be analysed jointly on a regular basis (monthly or quarterly), and programming interventions adapted as appropriate.

[5] Refer to Annex 8.2 – Minimum IFRR package with cross-sectoral linkages and beneficiary selection criteria.

[6] United Nations Development Assistance Framework Guidance. Key approaches for integrated programming, p 13-16 (https://procurement-notices.undp.org/view_file.cfm?doc_id=120296)

8.4 Principles to enhance a multisectoral integrated response for improved outcomes

A collective outcome is a jointly envisioned result with the aim of addressing needs and reducing risks and vulnerabilities, requiring the combined efforts of humanitarian, development and peacebuilding communities and other actors as appropriate *(6)*.

- Outcomes should be needs based and target those furthest behind – focus will be on those who are most vulnerable.
- Outcomes should be quantifiable, with clear lines of accountability.
- Outcomes should take into consideration age, gender and diversity.
- Involvement must "do no harm" and be consistent with the norms of accountability to affected populations.
- Involvement of civil society, local communities and beneficiaries in planning and implementation for better health outcomes is good practice.
- Implementation should consider comparative advantage, including that of local actors – health cluster partners' mandates, capacities and expertise will be analysed for this purpose.
- Joint operational frameworks for common response scenarios should be used to assist with planning multi-cluster responses. These frameworks aim to identify common entry points for integration. They should be used flexibly and adapted to the specific country context.
- Multi-cluster integrated programming is to be incorporated in the humanitarian health response plan, preparedness and contingency plans, and the humanitarian health response monitoring and evaluation framework.

8.5 Health cluster coordination checklist to ensure a multisectoral, integrated response for collective action and better health outcomes

1. What are the priority interventions (from health and other clusters) for better health outcomes in this specific context?
2. Which clusters are responsible for the various interventions?
3. Have each of these responsible clusters been engaged in:
    - carrying out joint or harmonized assessment and analysis;
    - agreeing on the priority geographical areas and target populations for a multisectoral, integrated response for collective action and better health outcomes;
    - developing an integrated response plan, with budget;
    - agreeing a multi-cluster monitoring and evaluation mechanism (benchmarks, indicators, reporting, monitoring and review process)?

4. What advocacy is required with stakeholders from each of the various clusters to promote multisectoral, integrated programming for collective action and better health outcomes?
5. Is the integrated response plan guiding, and being incorporated into, the emergency health response?
6. Is the multi-cluster monitoring and evaluation plan being used to monitor the emergency health response?
7. Does the health cluster coordinator (or someone representing the health cluster) routinely attend and participate in meetings of each of the clusters that directly impact morbidity and mortality?
8. Do the various coordinators (or their representatives) from each of the clusters directly impacting morbidity and mortality attend and actively participate in the health cluster meetings?
9. Are there other key actions required to enhance multi-cluster and multisectoral integrated programming, and if so, what are they, and are there plans to address these actions?

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