INTER-AGENCY STANDING COMMITTEE
63RD WORKING GROUP MEETING

IASC Cluster Working Group on Health: Progress Report

21-22 November 2005
Hosted by ICVA, International Council of Voluntary Agencies
ECOGIA, Versoix (Geneva)

Circulated 18 November 2005

Executive Summary:

The Humanitarian Health Cluster's strategy will be delivered through a *Joint Initiative to Improve Humanitarian Health Outcomes* consisting of a prioritized action package of 20 inter-related measures to strengthen: early warning; preparedness; capacity building; assessments and strategies; country-based management; review, reporting and lesson learning; and advocacy and resource mobilization.

Capacities for effective and predictable implementation will be strengthened through the *internal readiness improvement plans* of members, and agreements on delivering *core commitments* by them.

The *2006 Workplan* of the *Joint Initiative* has 11 outputs consisting of defined products and services, that can be delivered at a cost of approx US$3 million. In addition, the cost of providing benchmarked healthcare for a moderate-to-serious crisis-affected population of 500,000 is US$8.3 million for the first three months (per capita US$5.5 per beneficiary per month).

Future *working modalities* of the Humanitarian Health Cluster envisage criteria for new members and standing invitees, a steering committee, and a cluster facilitation cell to draw down technical expertise for the specific activities of the 2006 Workplan.

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I Introduction

1. The Outcome Statement of the IASC Principals meeting of 12 September in New York asked[1] the Cluster Leads - with the full support of members - to progress the following priority actions in the period to December 2005:

1. Decide how the cluster will substantially improve the humanitarian response within the sector for new emergencies.
2. Complete assessment of capacities and gaps in the sector.
3. Carry out specific capacity mapping and response planning in consultation with the Humanitarian Coordinators to improve response in a selected number of existing emergencies.
4. Improve non-UN actor involvement in the process, building on regional/national capacities.
5. Ensure integration of cross-cutting issues such as gender, age and diversity; HIV/AIDS; human rights.
6. Undertake coordinated response planning and preparedness measures, build links between clusters and prevent duplication with other structures.
7. Prioritize actionable recommendations for 2006 implementation.
8. Develop recommendations on outstanding cluster specific issues, such as the broader protection framework.
9. Develop a plan for a phased introduction.
10. Prepare cluster-specific resource requirements.

2. These requested actions can be grouped into five key areas, to provide the basis for this progress report to the IASC Working Group for its meeting in Geneva on 21-22 November.

- Strategy for improving humanitarian health response *(including actions 1,8)*
- Capacities for effective implementation *(including actions 2,3)*
- Work-planning *(including actions 5, 6,7,9)*
- Resource implications *(including action 10)*
- Future working modalities *(including action 4)*

3. The Humanitarian Health Cluster has maintained active contact among members since the IASC Principals meeting of 12 September including through two formal meetings[2] at global level. This report also draws from Cluster work experience in relation to the South Asia Earthquake, including meetings held in Geneva, Islamabad,

[1] Para 21 of Outcome Statement

[2] 3rd Meeting (teleconference) of Health Cluster on 30 September and 4th Meeting (face-to-face retreat) on 1 November.

and in the disaster area, and joint coordination, planning and information management work carried out in this acute emergency context.

II Strategy for Improving Humanitarian Health Response

4. The Humanitarian Health Cluster is seized of the importance of demonstrating that the cluster approach will show real results in terms of improving humanitarian health response. Accordingly, we have adopted[3] a ***Joint Initiative to Improve Humanitarian Health Outcomes*** consisting of a prioritized action package of 20 inter-related measures to strengthen: early warning; preparedness; capacity building; assessments and strategies; country-based management; review, reporting and lesson learning; and advocacy and resource mobilization. This strategy is summarized in annex 1 and will be the basis for our workplan in 2006.

III Capacities for Effective Implementation

5. In practice, humanitarian health assistance is delivered by a vast array of entities including national and local authorities and NGOs, international NGOs, the Red Cross/ Red Crescent Movement, UN agencies, private sector, and bilateral donors - in variable configuration depending on the specific crisis circumstances. There are literally thousands of relevant actors and it is not feasible or useful to conduct a conventional mapping of "capacities and gaps" in the health sector. Instead, we think that it is more relevant for the Humanitarian Health Cluster to seek accountable improvements in humanitarian health action in two major ways:

- through the internal preparedness improvement plans of Cluster members;
- through agreements by Cluster members to deliver on core commitments under the framework of the Joint Initiative.

6. **Internal Preparedness Improvement Plans**: All Members of the Humanitarian Health Cluster are committed to strengthening their capacity, predictability, effectiveness, and accountability[4] in relation to preparedness for humanitarian health response. This will be done through reviews that members involved in humanitarian health response work will carry out internally leading to published plans for improvement against which they will report progress. Inter alia, this will include the development and maintenance of agency capacities to deal with 2-3 major emergencies annually (defined as affecting 500,000 people each). To help members, the Humanitarian Health Cluster Steering Committee will issue guidance on the best practice and core format and content of such improvement plans and progress reports.

7. **Core commitments:** Members of the Humanitarian Health Cluster will make explicit the specific products and services that they will deliver, under their accepted

[3] Initially discussed at its 1st (29 July) and 2nd (18 August) meetings, and agreed as part of the Final Report (dated 22 August) of the Health Cluster Working Group.

[4] Requirements as agreed by the IASC Working Group at its New York meeting on 12 July 2005, consequent to the conclusions of the *Humanitarian Response Review*.

policies and mandates, as part of their predictable response to disasters and crises, under specified scenarios. To help members to produce these Core Commitment statements, and to be able to synthesise returns and identify gaps, the Humanitarian Health Cluster Steering Committee will issue a common format.

8. On the issue of focusing on "a selected number of existing emergencies", the Humanitarian Health Cluster prefers a pragmatic approach: we would like to see steady and systematic improvements in delivering humanitarian health outcomes across the spectrum of crises and disasters because that is consistent with the established humanitarian principle of universality, and because we are concerned that a programme in one or two selected countries may be difficult to replicate because of the specificity of country circumstances, personalities, and available funds. However, if the wider IASC process decides that a focus on certain countries or emergencies is necessary, the Humanitarian Health Cluster will play its full role, alongside the other Clusters and in association with the concerned Country Teams. This is in addition to emerging practice (following the South Asia earthquake), that the Cluster approach would be the default model for organising international assistance in future major disasters.

IV Work Plan for 2006

9. The 20 Action Areas of the *Joint Initiative to Improve Humanitarian Health Outcome*s (annex 1) will need to be phased-in depending on available resources and capacities. Annex 2 sets out specific **results that could be achieved in the 2006 Workplan** of the Humanitarian Health Cluster, if adequate resources were made available in a timely manner.

V **Resource Implications** (NOTE: estimates subject to revision as analysis is refined)

10. The resourcing implications of delivering on the *Joint Initiative to Improve Humanitarian Health Outcomes* can be usefully considered under four headings:

- Resourcing humanitarian health action in future emergencies: costs of 3 serious new crises in 2006, each affecting at least 500,000 people;
- Resourcing activities contained in the *2006 Workplan* of the Humanitarian Health Cluster.
- Resourcing the *2006 Internal Preparedness Improvement Plans* of Humanitarian Health Cluster members;
- Resourcing enhancement of humanitarian health action in selected ongoing crises.

11. **Health action in new major emergencies during 2006.** We are learning from the experience of rolling-out the cluster approach in the South Asia earthquake response, and anticipate that the cluster approach will be followed during future major emergencies. Annex 3 sets out an estimate of approx. US$8.3 million for covering the

minimum costs of the first three months of humanitarian health assistance (to agreed benchmarks) for a notional crisis of average intensity and practical challenge, affecting some 500,000 people. For three such crises in 2006, the total would be approx US$25 million. It is emphasised that these are ballpark estimates (average cost per beneficiary per month us$5.5). Actual costs will depend on the specific circumstances and available in-country capacities - and thus the supplementary international assistance that is needed to ensure that health outcomes to agreed benchmarks are obtained.

12. **Humanitarian Health Cluster 2006 Workplan.** The IASC Principals have agreed[5] that the Cluster approach should not require major staff expansion but that if this includes agreed new tasks that were not being undertaken before, then additional human and programming resources would be justified. The 2006 Workplan of the Cluster (annex 2) will undoubtedly require additional human and programming resources and these are estimated at US$3 million for the delivery of clearly identified products and services essential to improve humanitarian health outcomes.

13. **Internal Preparedness Improvement Plans**. Resources for the individual capacity building of members to deliver on their core commitments to the *Joint Initiative to Improve Humanitarian Health Outcomes* will depend on the internal plans that are put forward during 2006, and the agreed modalities for access to the reformed CERF for preparedness.

14. **Enhancing humanitarian health action in selected ongoing crises.** In addition, Humanitarian Health Cluster members will discuss how to enhance delivery in ongoing crises, subject to the outcome of wider discussions in the IASC. The outcome of discussions on humanitarian aid financing predictability, including the CERF, is also awaited before greater specificity is possible. As a notional indicator of the financing implications of "upgrading" humanitarian health action in ongoing crises, the unit cost of approx. US$5.5 per targeted beneficiary per month can be kept in mind. These exclude the costs of recovery and rehabilitation - which are often conducted in parallel to emergency relief, in situations of prolonged or complex crisis.

VI Future Working Modalities of the Humanitarian Health Cluster

15. The Humanitarian Health Cluster plans to organise itself, at the global level, as follows with respect to defining its membership, steering arrangements, meeting, and support arrangements.

6.1 Members and Standing Invitees

16. An open, inclusive, and fully participative approach is sought. The current status of agency involvement in the Humanitarian Health Cluster is at Annex4. Further involvement in the Humanitarian Health Cluster at global level will be approached as follows, with new applicants being put to the Steering Committee for endorsement.

[5] O utcome Statement from the IASC Principals Meeting of 12 September 2005.

- All IASC Members[6] and Standing Invitees[7] are automatically considered to be members and standing invitees, respectively, of the Humanitarian Health Cluster.
- NGOs and academic/research entities who dedicate at least 40% of their resources on aspects relating to humanitarian health assistance in crises and disasters and whose remit is either global or inter-country (ie covering more than one country), are eligible to become members or standing invitees. Members are expected to agree to formulating and reporting on their "self improvement plans" to deliver agreed core commitments.
- Individual experts or institutional entities that, in the view of the Steering Committee, have a contribution to make to the achievement of the objectives of the Humanitarian Health Cluster may be invited as members or standing invitees.

6.2 Steering Committee

17. The Steering Committee will be composed of nominees (usually health directors or emergency directors with substantive health responsibility) from members and standing invitees. The Steering Committee will be convened by WHO in its lead agency capacity, and report to the IASC WG and ERC. The Steering Committee would meet monthly by televideo, and face-to face some four times a year (perhaps at the margins of other gatherings such as the IASC Working Group). Special meetings may be necessitated by sudden crises or unforeseen problems. The Principals on the Steering Committee may designate focal points for day-to day contact and liaison on the work of the Health Cluster. The **terms of reference** of the Steering Committee are as follows:

- Endorsing the priorities and workplan of the Humanitarian Health Cluster, and securing necessary resources;
- Examining health assessments, reviews, and other information and analyses from the field to make informed judgements on policies, and strategies for, and results from, humanitarian health action;
- Agreeing and instituting measures for meeting gaps in, and addressing constraints to, the delivery of effective and efficient humanitarian health action;
- Resolving problems, including difficulties in interagency co-operation;
- Guiding the Health Cluster's response to dilemmas in the practice of principled humanitarian health action;
- Using appropriate professional and policy channels to highlight issues and circumstances that constrain delivery of health assistance to vulnerable populations,

[6] As at November 2005, IASC Members are: OCHA, FAO, UNFPA, UNICEF, UNDP, UNHCR, WFP, WHO

[7] As at November 2005, IASC Standing Invitees are ICRC, ICVA, IFRC, InterAction, IOM, SCHR, RSGIDP, UNHCHR, World Bank

- Providing encouragement and backing for partners facing complex field difficulties in the course of their implementing agreed policies and good practices;
- Advocating action to meet the health needs of neglected populations in crises;
- Ensuring the systematic peer review of the policies and working practices of Health Cluster members, including their declared internal self-improvement plans;
- Ensuring the review and assessment , in a spirit of mutual accountability, of the extent to which partnership agreements (to deliver specific core commitments by member agencies), have been realised;
- Reviewing and formally endorsing recommended benchmarks, standards, and indictors for effective and efficient humanitarian health action;
- Considering and approving, for submission to the ERC and IASC, the annual report of the Health Cluster on the extent to which improved humanitarian health outcomes have been attained.

18. The current membership of the Steering Committee is all the members and standing invitees as at November 2005. NGOs that meet the membership criteria are being actively encouraged to join, with very good success to date. If membership expands considerably, Cluster Members will consider a selection process for a Steering Committee that is capped at an agreed manageable number.

6.3 Cluster Facilitation Cell

19. As lead agency, the WHO Department of Health Action in Crises will house a *Humanitarian Health Cluster Facilitation Cell* drawing on in-house resources and additional human resources recruitment (including by secondment from Cluster members), for specific delivery of the outputs identified in the 2006 Workplan (annex 2). The **terms of reference** of the *Facilitation Cell* will be to:

- Support the implementation of the Workplan of the Joint Initiative to Improve Humanitarian Health Outcomes, including monitoring and reporting on progress;
- Organise and service the meetings and processes of the Steering Committee, including through the preparation of analyses and papers for decision by the Steering Committee;
- Maintain updated knowledge of the health aspects of crises and disasters around the world, facilitate problem solving, and, if necessary, bring issues for resolution to the Steering Committee;
- Maintain contact and liaison with the IASC Secretariat and with other Clusters (especially Nutrition and Watsan-Hygiene) wider arrangements and systems of the international humanitarian system such as UNDAC, CERF, CAPs, etc.

- Ensure that suitable partnership agreements are developed and maintained to call-down the core commitments made by agencies for humanitarian health action;
- Act as operational coordinator and service organiser for agreed common core functions as indicated in the *Workplan* (eg. humanitarian health information management; dissemination of health alerts; maintenance of the emergency health personnel network and training; activation and deployment of joint heath emergency assessment and response teams; and advocacy and resource mobilisation on behalf of member agencies;
- Support joint emergency health coordinators and teams in the field, including through a 24-hour emergency contact system;
- Dispatch elements of the *Facilitation Cell*, when appropriate - for example, within the context of a major disaster or crisis, to support emergency management at an in-country level.
- Ensure that explicit attention is sought from the international community for external constraints such as lack of access (due to insecurity, obstruction, or non-co-operation by responsible parties) or limited resources that do not permit compliance with benchmarks and targets.

6.4 Meeting Modalities

20. The Humanitarian Health Cluster plans to meet by tele/video link every 4 to 6 weeks subject to the requirements of the 2006 Workplan, with additional special meetings when there is a major disaster or crisis. The Facilitation Cell will develop a rolling agenda including a rolling stocktake of the humanitarian health needs and status of major crises and disasters around the world. In addition to the teleconferences, 3-4 face-to-face meetings (perhaps in association with IASCWG meetings if this is convenient to reduce travel) are proposed. Because of the close linkages between health, nutrition, and watsan-hygiene, "triple cluster" meetings are also proposed as part of this programme.

Prepared by Cluster Working Group on Health – November 2005

Annex 1

The Joint Initiative to Improve Humanitarian Health Outcomes

Taking into account the findings and recommendations of the *Humanitarian Response Review*, and other reviews of experience, as well as the resolution by Member States in the 2005 World Health Assembly requesting improvements, a package of inter-related measures within **a Joint Initiative to Improve Humanitarian Health Outcomes** is planned. The extent to which health outcomes improve will depend on available resources and the extent to which outcome focus increases within other elements of the overall international humanitarian system. The proposed actions within the Joint Initiative seek to strengthen the predictability, speed, and effectiveness of international humanitarian health assistance.

The Joint Initiative consists of 20 **prioritized action areas** to be carried out at appropriate levels ie. *globally* (defined here as also including regional and subregional) and at *country level* (defined here as also including provincial and local settings). Regional or sub-regional approaches are essential when emergencies have serious effects beyond the country in crisis, for example when people cross borders.

Early warning

- **Action Area 1** (Global/ Country-based): Background health profiles in a standard format containing essential data for planners and programmers should be prepared, consolidated, and kept updated for all countries in crisis or at high risk of disasters and crises - *so as to* provide the common basis for preparedness and contingency planning;
- **Action Area 2** (Global): A common "Emergency Health Information Service (EHIS)" , including the dissemination of key health guidelines, tools, indicators and benchmarks should be established, *so as to* facilitate assessment, planning, and review tasks;
- **Action Area 3** (Global/ Country-based): A surveillance system should be instituted for all crisis and potential crisis settings - *so as to* pick up early indications of conditions of public health importance;
- **Action Area 4** (Global): Based on this surveillance system, arrangements should be in place to provide assessed and measured alerts of serious health threats in disaster and crisis settings - *so as to* trigger rapid intervention.

Preparedness

- **Action Area 5** (Global/ Country-based): Members of the Humanitarian Health Cluster should develop and publish their internal "self-improvement" plans and report openly on progress *so as to* provide an accountable basis for assessing progress.
- **Action Area 6** (Global): Based on agreed planning assumptions and scenarios of disasters and crises, agencies involved in humanitarian health action should make

clear their core commitments for specific and agreed essential functions and develop robust systems and organisational arrangements for call-down - *so as to* ensure that gaps are identified and filled, and there is optimal agency inter-operability.

- **Action Area 7** (Global): Recognising that human resources are an urgent and serious constraint, a common international "Health Emergency Action Response Network (HEAR - NET)" should be created and sustained *so as to* provide an interagency pool of qualified, experienced, and prepared health personnel for working in crises and disasters;
- **Action Area 8** (Global): A system for training, practicing, and testing the joint working and inter-operability, where appropriate, of humanitarian health service providers should be developed, along with certification or accreditation arrangements *so as to* encourage technical competence, safety, and quality.

Capacity building

- **Action Area 9** (Country-based): For countries in crises or at high risk of disasters and crises, specific strategies and costed plans for investment in health sector risk reduction, preparedness and response, should be prepared and supported, *so as to* reduce vulnerability and to build the capacity of national and local crisis health responders.
- **Action Area 10** (Global): A strategy for human resource development should be developed and promoted with operational agencies, addressing issues such as core competencies, training, accreditation, career paths, continuing education, and peer review *so as to* boost necessary professionalisation of the humanitarian health area.

Assessments and strategies

- **Action Area 11** (Global): A system of skilled and prepared interagency "Health Emergency and Assessment Response Teams (HEART)" should be developed (including rosters, and common training) to be activated and deployed when justified by crises and disasters of appropriate magnitude *so as to* enable the predictable conduct of rapid needs assessments and the efficient organisation of coordination and service delivery on the ground, linking-up with capable in-country or regional agencies and capacities.
- **Action Area 12** (Global): Standardized methods, tools and formats for common use in health needs assessments and monitoring should be developed and agreed among partners *so as to* provide a shared situation overview, and a solid basis for assessing results, unmet needs and gaps, and the rational allocation of resources;
- **Action Area 13** (Country-based): For each crisis situation, the development of a common humanitarian health action plan within an agreed timescale should be a norm, *so as to* provide a reasoned basis for coordination, resource mobilisation, delivery, and the measurement of impact.

Country-based management

- **Action Area 14** (Country-based): A dedicated and competent Emergency Health Coordinator with appropriate technical support should be considered for deployment in support of the UN Resident or/and Humanitarian Coordinator and the in-country UN Country Team/ Disaster Management Team / in-country IASC Team, when justified by the magnitude of specific disasters and crises, *so as to* provide effective capacity and leadership for the health response to crises.
- **Action Area 15 (**Country-based): In specific crisis situations, clear Humanitarian Health Cluster leadership, management and organisational arrangements should be agreed at national and field levels *so as to* allow health assistance partners to discuss and coordinate their respective responsibilities, resolve technical issues in a timely way, address critical gaps in essential healthcare provision, and establish robust mechanisms for reporting & follow-up.

Review, reporting and lessons learning

- **Action Area 16** (Global): An impartially organised "Health Performance and Humanitarian Outcomes Tracking Service" using agreed benchmarks, indicators, and data (disaggregated by age and sex) targets should be set up *so as to* provide a systematic accountable arrangement to assess the timeliness, coverage, and appropriateness of humanitarian health action, as well as the impact of health and wider humanitarian assistance, in relation to targeted populations;
- **Action Area 17 (**Global/ Country-based): Common humanitarian health action reporting formats, standards, and timelines should be agreed, drawing on the best of prevalent models, and utilized in a consistent manner *so as to* reduce transactional costs, and the administrative burdens on hard-pressed operational service providers.
- **Action Area 18** (Global/ Country-based): A systematic joint programme of reviews and evaluations conducted with due transparency and objectivity should be set up so as to foster a culture of lesson learning and accountability (to stakeholders and beneficiaries).

Advocacy and resource mobilization

- **Action Area 19** (Country-based): The emergency health coordination function at country level (see Action Area 14) should include the formulation of the health component of assistance appeals, and the tracking of responses and gaps (including in CAPs, flash appeals, and transitional recovery appeals), *so as to* facilitate the matching of resources and needs;
- **Action Area 20 (**Global): Common strategies and a Cluster-wide service for communicating with public, media, and policy makers, including for the marketing and advocacy of appeals to donors, should be developed, *so as to* facilitate timely financing, especially for "neglected crises", in the spirit of the principles of Good Humanitarian Donorship.

Annex 2

The Joint Initiative to Improve Humanitarian Health Outcomes: Work Plan for 2006

Action Area	Summary Title	Results delivered by end of one year: 2006 (subject to resources)	Resources (US$)
1, 2	Emergency Health Information Service	A. Background standard health profiles produced and disseminated for 16 most significant disaster countries	100,000
		B. Common Cluster policy positions on 4 key policy issues agreed and published.	50,000
5, 6	Predictable and Accountable capacity	C. Self Improvement action plans published by all Health Cluster members	-
		D. Core Commitments to humanitarian health action agreed by all Cluster Members	-
7, 8,10, 11	Health Emergency Action Response Network (HEAR-NET)	E. 100 people trained through 3 courses	900,000
		F. HEART roster and deployment system functional and able to deal with three major crises	100,000
12, 16	Health Performance and Humanitarian Outcomes Tracking Service" (HP-HOT)	G. Standardised methods and formats for needs assessments and monitoring instituted	200,000
		H. Benchmarks, methods, and system for measuring outcomes and performance agreed system-wide	200,000
		I. HP-HOT Service rolled out in all new major emergencies, and 3 ongoing major crises	1,000,000
17, 19, 20	Humanitarian Health Action Plans	J. Common Plans agreed in all major new emergencies in 2006 including their information, advocacy and resource mobilisation aspects	150,000
18	Lesson learning and accountability	K. Common methodology established and used to conduct joint reviews and evaluations in relation to all major new emergencies and 3 selected ongoing crises.	300,000
TOTAL			**3,000,000**

Annex 3

Financing Humanitarian Health Action: New Emergencies During 2006

Estimate of costs of providing humanitarian health assistance for an affected population of 500,000 for the first three months, assuming a sudden or rapid-onset medium-to-serious disaster, an average pre-disaster population profile of a country of low human development index, and at least 65% post disaster disruption of local coping and support capacities - thus necessitating at least 75% dependence on external assistance to meet basic needs, aspiring to achieve benchmark[8] health outcomes.

Service line	**Cost (US$)**
Initial assessments and establishment of emergency presence[9]	50,000
Essential drugs and medical supplies including transport and distribution[10]	750,000
Essential public health protection and promotion[11]	750,000
Human resources for delivering basic primary and hospital care[12]	5,800,000
Health and Mortality Tracking and Assessment of Humanitarian Outcomes, and after-action review/lesson learning[13]	300,000
Cluster Coordination services[14]	650,000
Total for one emergency	**8,300,000**
Total for three emergencies	**24,900,000**
Unit cost per beneficiary per month	*5.5*

[8] Projected benchmarks. Subject to outcome of Consultation and Consensus WHO-hosted Meeting on Assessing and Tracking Humanitarian and Health Outcomes, Geneva, 1-2 December 2005.

[9] Five HEAR-NET people for 2 weeks: subsistence and support 300 USD/day x5x14 + 4,000 USD travel, plus approx 10,000 USD field costs (salary costs of HEARNET are not included here)

[10] Essential medicines and supplies: NEHK for 500,000/3 months: 230,000; Diarrhoea kits (buffer stock for first 500 cases): 20,000; UNFPA kits (1-11) for 500.000: 190,000; Trauma etc kits (buffer stock for 500 cases: 80,000; 30% of airfreight, etc: 160,000; International and local supply management: 70.000.

[11] Including a measles vaccination campaign (9 months-15 years), to target 200,000 at @ 2 USD/ vaccination; setting up disease surveillance system, investigation and follow-up of conditions of public health importance.

[12] Assuming ratio of 1: 300 population, including front line workers (physicians, nurses) as well as technicians (e.g. lab) and administration and logistical staff distributed as follows: approx 95 % would be local staff (1500 @ average 450 USD/month x three months: 1.8 million and 5% (100) are expatriates on short-term contracts at unit cost of USD40, 000 for three months (including salary, DSA, travel): 4 million.

[13] Unit costs of basic mortality and health and humanitarian outcomes tracking service is about 250,000.

[14] Includes information management, situation reporting, appeals and resource mobilisation, programme reporting, etc. Calculations include costs of 10 HEARNET people in two field offices in disaster area and in capital city as well as costs of telecoms, in-country transport, specialist support, and allowance of 50,000 for HQ-based Cluster costs.

Annex 4

Composition of the IASC Humanitarian Health Cluster (as at November 2006)

IASC Members

Office for the Coordination of Humanitarian Affairs, OCHA

Food and Agricultural Organization, FAO

United Nations Children's Fund -UNICEF

United Nations Development Programme - UNDP

United Nations High Commissioner for Refugees - UNHCR

United Nations Population Fund - UNFPA

World Food Programme - WFP

World Health Organization – WHO

IASC Standing Invitees

International Committee of the Red Cross - ICRC

International Council of Voluntary Agencies - ICVA

International Federation of Red Cross and Red Crescent Societies - IFRC

InterAction - American Council for Voluntary International Action

International Organization for Migration - IOM

Steering Committee for Humanitarian Response - SCHR

Representative of the Secretary-General on Internally Displaced Persons - RSGIDP

United Nations High Commissioner for Human Rights - UNHCHR

World Bank

Other Members - Global Level *(joined since August 2005)*

International Centre for Migration and Health

International Medical Corps

International Rescue Committee

Merlin

Terre des Hommes

World Vision