# What is "Inter-Cluster / Sector Collaboration (ICSC)"?

*This document is to be used as a guidance to help cluster/ sector national coordination teams to initiate, implement and monitor Inter-cluster/sector collaboration at country level. The different steps follow the humanitarian program cycle to align intersectoral projects with other projects.*

***Please note, ICSC is replacing the previously used acronym, ISC***

## 1. What is inter-cluster / sector[1] collaboration?

Inter-cluster/sector collaboration (ICSC)[2] refers to the joint actions carried out by relevant clusters/sectors to coordinate joint responses with their partners towards a common objective. Joint responses are delivered at the same time, in the same place, for the same people based on prioritization of needs to achieve a jointly agreed outcome.

Inter-cluster/sector collaboration brings relevant clusters/sectors together to not only share information but to actively plan and work on joint actions. In this way, ICSC takes a step further than simple coordination between clusters/ sectors. ICSC reinforces the work of the Inter-cluster coordination group

[1] Definition of a cluster and a sector: Country-level Cluster terms and definitions | Global Nutrition Cluster

[2]Other acronyms are sometimes used:
ISP = Intersectoral programming: joint programming taken by different humanitarian actors
ISA = Intersectoral action: joint actions taken by different sectors/clusters
ISC = Intersectoral collaboration: previous ICSC acronym used

(ICCG), which is usually led by OCHA and facilitates sharing of information and coordination of humanitarian interventions among different clusters/ sectors at the global and national level.

## 2. What are the advantages of ICSC?

1. ***A people-centered approach***: Recognizing that different sectors are often working with the same households/ persons / communities, ICSC promotes a people- centered approach to the humanitarian response through a holistic lens.
2. ***It pools knowledge and problem-solving capacity***: Through common overarching goals, objectives, and joint actions, ICSC brings together different clusters/sectors/actors, with different knowledge and means, to understand and address multi-faceted and large-scale humanitarian issues.
3. ***Efficienc***y: By proposing joint programming at the same place and same time, the declination of ICSC as joint field implementation can reduce access barriers (cost of transportation, time spent, risk exposure, etc...).
4. ***Reduced costs***: Finally, joint field implementation can reduce costs (by sharing transportation and offices costs, mutualizing staff, etc.), hence more resources become available for the programs.

***Keep in mind that the collaboration between sectors/clusters/actors and the investments made must result in concrete joint actions for the people in need. It is not enough to simply sit in meetings together and consider the collaboration done!***

***Implementation of ICSC requires strong, active, and efficient collaboration at national / subnational level among all partners and governmental bodies***.


On 11 April 2022, a woman walks past shelters at Higlo Internally Displaced Persons (IDP) site in Ethiopia, which hosts thousands of people from drought-affected communities.

## 3. How is ICSC carried out?

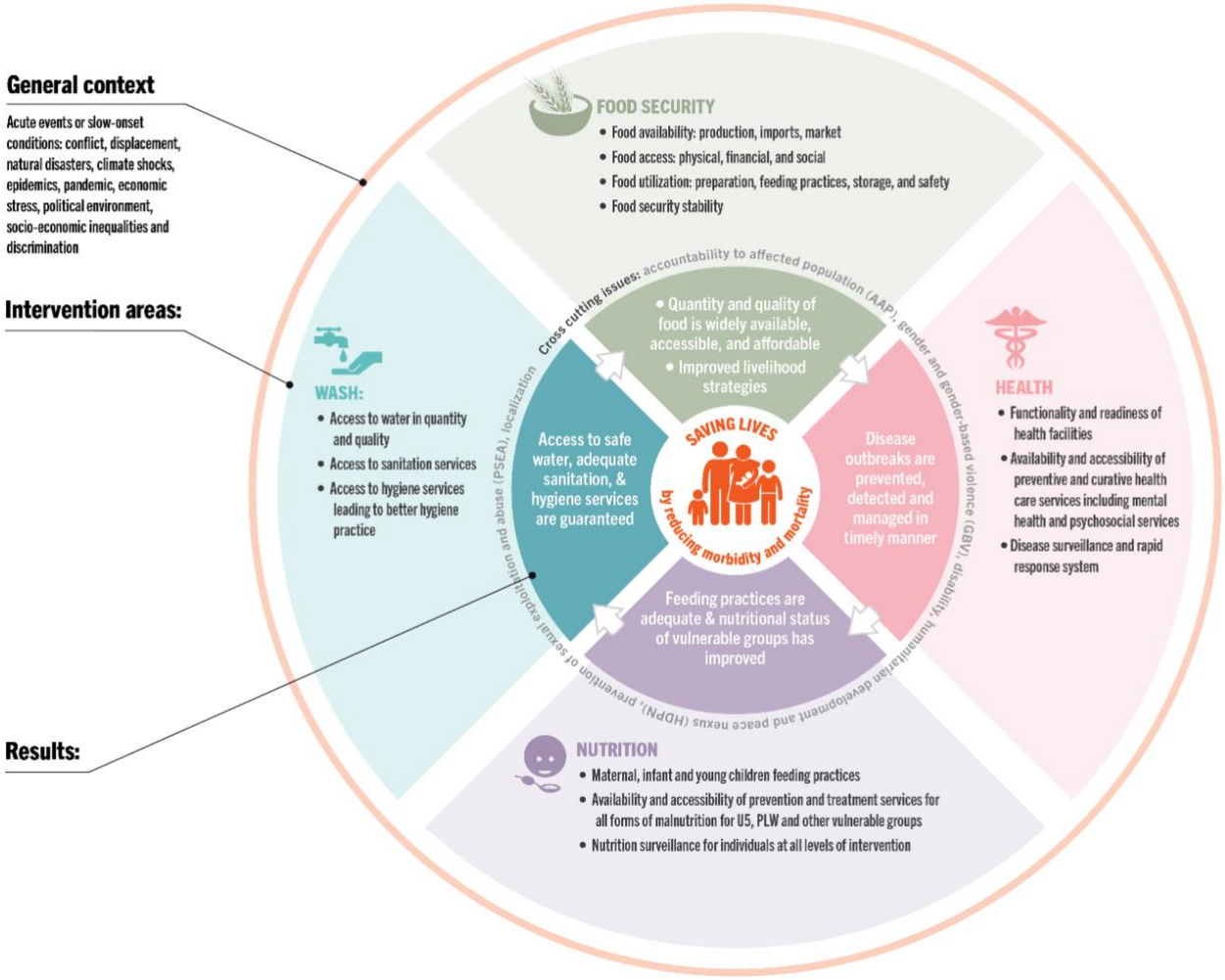
The governance for such collaboration should be kept light and agile, with manageable mechanisms for joint planning, checking in and reviewing progress. To the degree possible, ICSC should use or build on existing coordination structures and style.

In practice, the governance varies from country to country; some have a dedicated ICSC working group, some are using an existing working group, some meet on an ad-hoc basis, and in some countries the government takes the lead and coordinates the ICSC work. Any sector/cluster/actor can call for an ICSC group. The composition of the group (including leadership arrangements) and the TOR should be communicated to OCHA. Monthly meetings should suffice in the long run, but weekly ones might be necessary during the inception phase.

The clusters/ sectors / actors participating in the ICSC work are not fixed. They can vary from one country to another and from one geographical area to another. Most of the time, **WASH, Food Security, Health, and Nutrition clusters/ sectors** are already collaborating to some degree, but this may need strengthening. **Depending on the context and the priority needs** of the population, an ICSC approach could involve less clusters, or other clusters such as Protection, Education, Camp coordination and Camp management (CCCM), Shelter & Non-Food Item or others can also come on board, for more active collaboration. Participation will be driven by the identified common objective that led to the creation of the group. For example, different expertise will be required to respond to a cholera outbreak versus conflict-driven displacement with critical protection concerns.

Below is a conceptual framework aligning the efforts of the four clusters (who developed this guidance note) to deliver holistic packages to the people in need, in the same place and at the same time to reach a common objective: **saving lives by reducing morbidity and mortality.**

# Inter-cluster/sector collaboration: our common objective



## 4. **ICSC along the Humanitarian Program Cycle**:

ICSC can take place at any stage of the **Humanitarian Program Cycle** (HPC), but ideally it follows the entire process. Below is a list of intersectoral actions recommended for each step. At this point, it is also recommended to discuss and involve both ICCG and OCHA in collaborative efforts.


Humanitarian Program Cycle (HPC)

**Step 1**: **Needs assessment and analysis**:

- ***Agree roles and responsibilities and timeframe***. Identify your core team. Agree who will be involved for the joint needs assessment and analysis, roles and responsibilities and timeframe for the analysis. These responsibilities may be adjusted as the plan evolves. Identify a wider group of key actors for consultation and feedback at different stages. Set the scope of the analysis and costing plan.

- ***Joint planning*.** Outline a basic framework for the information needed, agree on key indicators for each sector/cluster and collate and review existing data (secondary data) from respective sectors and identify critical information gaps. Note that the resources need to be aligned with the crisis / problem we want to answer (drought response will differ from a flood response to a cholera outbreak, etc.). Consider if essential information on the cross-cutting themes (Accountability to Affected Population, Gender Based Violence, Disability) and modality of intervention (Cash and Voucher Assistance, in-kind, mixed) is still needed.

- ***Only if required, plan joint data collection.*** Fill the information gaps identified and deepen the understanding of the situation and needs. Collectively select appropriate data collection and analysis methodologies, data collection tools and identify necessary resource. A practical plan should be developed, validated, and implemented to collect complementary information.

- ***Jointly analyze and write up of findings***. Consolidate primary and secondary data and populate the analysis framework. Summarize findings and provide clear, actionable recommendations. Some recommendations may be common to all sectors while some may be sector specific. One specific deliverable may be a joint chapter for the Humanitarian Needs Overview (HNO), or as a minimum, reflect ICSC commitments in the "Sectoral analysis" chapter of the HNO. When no space is provided in the HNO, a separate document can be prepared to highlight the joint analysis of needs and response strategy.

- ***Share joint findings.*** Share the final findings as a whole with all relevant coordination groups– avoid e.g. extracting only the nutrition sections of the report to share with nutrition colleagues. Use different multi-sectoral platforms, groups.

Note this Step will likely be informed by the Joint Intersectoral Analysis Framework (JIAF), which is undergoing review and should be ready for use in the 2024 Humanitarian Programme Cycle (https://www.jiaf.info ).

**Step 2**: **Strategic planning:**

- ***Identify intervention areas for collaboration*.** Agree on roles and responsibilities of each sector for common and complementary activities.

- ***Identify and target the geographical areas of convergence*** by using a ranking system (*Annex 1*). Note: priority areas are usually identified by the ICCG / HCT during the HRP process. However, clusters may need to work jointly at a more granular level, hence the need to refine the targeting exercise.

- ***Plan a joint visit*** to the pre-selected area/region to understand the needs with the community and leaders and agree on a minimum package of support.

- ***Develop an inter-cluster / sector package of interventions*** at household, communities, and facility level (e.g., health center, school). This step will be done jointly, and the defined ideal package can be adapted according to the area, resources available, needs etc. and potentially following a graduation approach (*Annex 2).* When it comes to actual delivery, it is important to note that not necessarily all households / individuals will receive assistance from all clusters, as interventions will remain need based.

- ***Agree on joint targeting*** of the beneficiaries. Targeting should take into account a) an agreed methodology for prioritizing communities, families and individuals, and b) clarification on whether the full minimum package will be delivered to all recipients afresh; whether previously non-present sectors will fill gaps in provision; or, whether a less than all-sectors package is an acceptable minimum standard (for example in some responses it might be better to guarantee

that all people reached have received assistance from a minimum of three of four participating ICSC sectors).

- ***Develop an integrated work plan*** with agreed indicators of success (indicators that clarify the impact of one sector on the outcome of another sector, or jointly agreed outcome) (*Annex 4*).
- ***Encourage local and international partners*** to prepare joint proposals and budgets for inter-sectoral programs.
- ***Prepare a joint HRP chapter*** or as a minimum, reflect the ICSC in the chapter "Cluster/Sector objectives and response". Don't forget to integrate the joint monitoring indicators.

**Step 3**: **Resource mobilization and advocacy**

- ***Define role and responsibilities*** for joint resource mobilization and advocacy efforts.
- ***Estimate costing*** for the identified ICSC package of interventions – this is useful for planning, communication, advocacy, and fund raising.
- Then together, national clusters and their partners can ***develop a concept note*** to donors for funding allocation.
- When monitoring the joint response, if implementation gaps in one or several sectors/clusters due to underfunding are identified, ***joint advocacy*** to donors needs to be strengthened to ensure the implementation of the complementary activities (see *Annex 3* on how to develop an advocacy note).

**Step 4: Implementation and monitoring**

- ***Identify and mobilize partners*** (local and international).
- ***Plan joint training on ICSC*** for partners / government / clusters.
- ***Develop a joint response monitoring plan*** (data collection, joint field visits, joint monitoring visits) based on the agreed objectives, key indicators and measurement methods (Annex 4). Be sure to involve vulnerable communities and minority groups at this stage, applying the principles of Accountability to Affected Populations (AAP).
- ***Agree on a reporting format*** (and visualization tools, if needed – e.g., dashboard) at subnational and national level.
- ***Document and share*** information / outcomes on inter-cluster / sector collaboration during implementation.

## Step 5: Operational peer review and evaluation

- ***Carry out an evaluation of the joint response***. This can be conducted through an After-Action Review (AAR) process which includes the different sectoral aspects.
- ***Document lessons learned*** and share with the implementing partners, as well as the wider ICSC forum, if such exists.
- ***Conduct a lessons learned workshop*** and share findings on what was done well, what was not done so well and methods of improvement.
- ***Develop a workplan*** for the next period/program cycle.


Following the rise in malnutrition cases in the Karamoja Sub Region of Uganda, due to food insecurity and prolonged dry spells, affected children are screened and treated for various health reasons.

**<u>Annex 1</u>: How to define geographic areas of convergence?**

1) **Agree on key sectoral indicators** at national level/ subnational level to assess the severity of the situation in different parts of the country; often one to two indicators per sector are enough. Make sure that each sector/cluster has more a less the same number of indicators to conduct this exercise, to be equally represented in the global analysis. Ideally indicators are chosen from IPC Acute Food Insecurity or IPC Acute Malnutrition analysis if we are anticipating / facing a food / nutritional crisis, but they can also come from other assessments conducted in country. The resources need to be aligned with the crisis / problem we want to answer (drought response will differ from a flood response to a cholera outbreak, etc.). Note to the degree possible, values for these indicators must be available at a subnational level.

2) **Attribute a severity score to each indicator**.

3) Then **sum the total scores** per area / region / district and **get an overall severity score**. The highest number will be the areas with the most severe needs and should be pre-selected for collaboration.

4) Final areas for collaboration will be validated according to the availability of funding, of the partners, etc. This will be collectively decided and validated by the clusters involved.

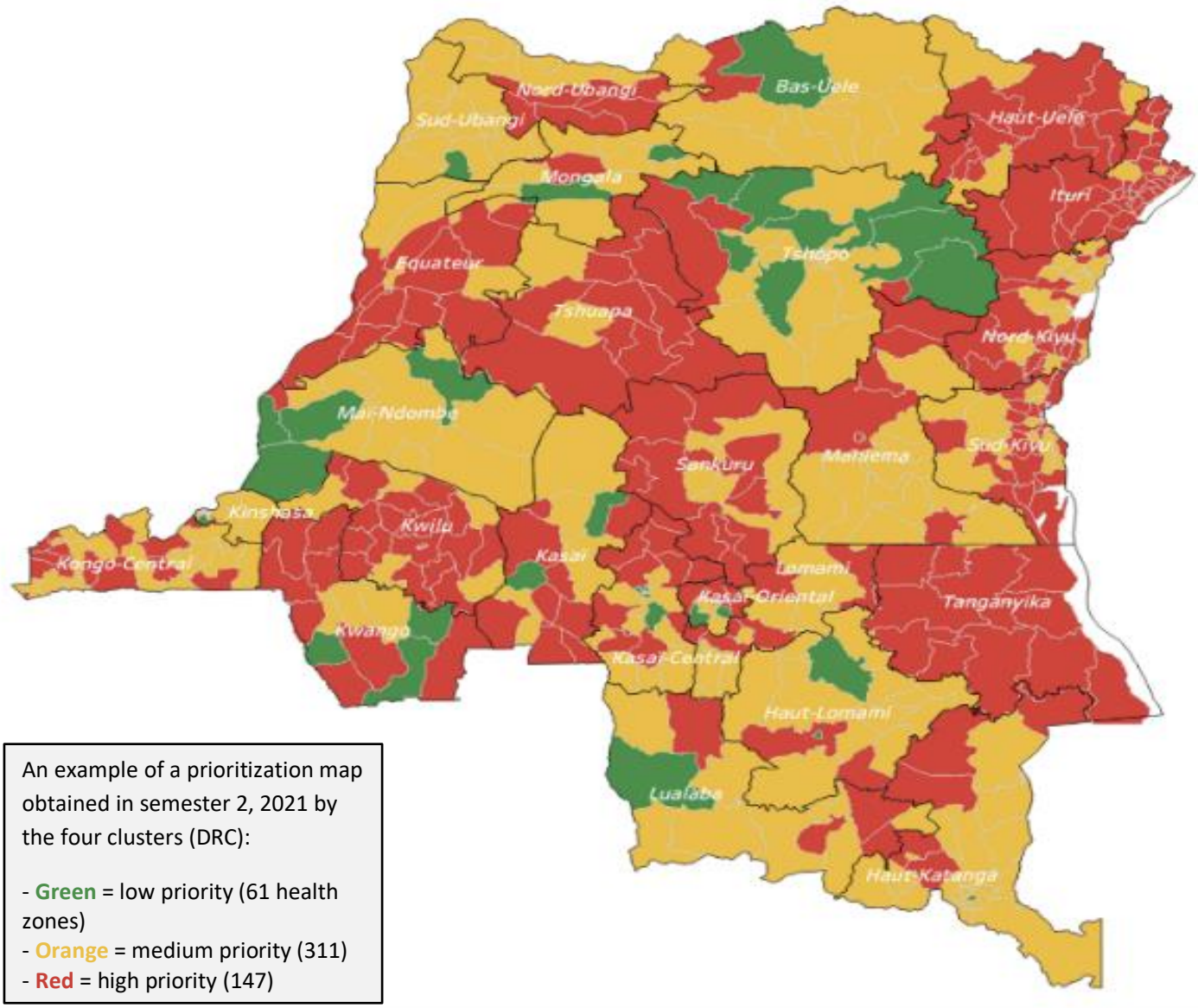
***Example from Democratic Republic of Congo***: The 4 clusters (WASH, Food Security, Health, and Nutrition) agreed on indicators to validate and prioritized the geographical areas to jointly intervene.

| Indicators | Thresholds | Scores |
|---|---|---|
| *Numbers of alerts from the surveillance system during the last 12 months* | 0-1 time | 1 |
| | 2 times | 2 |
| | 3-4 times | 3 |
| *IPC AFI Classification* | Phase 1 & 2 | 1 |
| | Phase 3 | 2 |
| | Phase 4 or more | 3 |
| *GAM prevalence (IPC analysis if available)* | 0 – 9% | 1 |
| | 9,1 – 20% | 2 |
| | More than 20% | 3 |
| *Stunting prevalence* | 0 – 10% | 1 |
| | 10,1 – 20% | 2 |

| | | |
|---|---|---|
| | More than20% | 3 |
| *On-going epidemic:* | | |
| *Measles* | Yes | 2 |
| | | |
| | No | 0 |
| *Cholera* | Yes | 1 |
| | No | 0 |
| *COVID* | Yes | 1 |
| | No | 0 |
| *Ebola* | Yes | 2 |
| | At risk | 1 |
| | No | 0 |
| *Population movement* | Yes | 2 |
| | No | 0 |

By summing the scores obtained, the zones are then prioritized as such:

- Low priority = Scores between 5 and 10
- Medium priority = Scores between 11 and 15
- High priority = Scores between 16 and 20




An example of a prioritization map obtained in semester 2, 2021 by the four clusters (DRC):

- **Green** = low priority (61 health zones)
- **Orange** = medium priority (311)
- **Red** = high priority (147)

**Annex 2: Example of an intersectoral activities package from Yemen, extracted from the Integrated Famine Risk Reduction Package case study, July 2020**

Summary of the initial IFRR minimum package

**Household package**

- Emergency food assistance (GFD, CVA or mixed);
- Emergency agricultural, livestock and fishery inputs support;
- Income generating activities;
- Minimum health service package;
- Consumable hygiene kits, jerry cans, ceramic filters;
- Sustainable access to safe potable drinking water;
- Latrine construction;
- Screening and referral of acutely malnourished children and PLWs.

**Health facility package**

- SAM and MAM management of children and PLW;
- Health education of PLW and caregivers of children 0-24 months (1000 days);
- Targeted food distribution to caregivers of malnourished children;
- Primary and secondary health care;
- Sustainable access to safe water and functional and appropriate sanitation services in Health Facilities and their maintenance;
- Distribution of the consumable hygiene kits and ceramic water filters to caregivers of malnourished children;

**Community package**

- Mother-to-mother support focussing on BCC and IYCF;
- Blanket supplementary feeding;
- Sustainable access to safe drinking water and appropriate sanitation solutions;
- Community-based health interventions;
- Mass livestock vaccinations;
- Basic agro-processing, rehabilitation and resilience building through
- Cash-for-work, Food-for-work, Cash-for-assets, Food-for-assets schemes;
- Demonstration plots.

Intersectoral activity packages can be changed over time; better to start small and expand according to the needs of the population and capacities of clusters and partners involved.

Revised IFRR standard minimum package, 2019

**Household package**

- Food or CVA for 6 consecutive months/rounds to vulnerable households (as per IFRR households vulnerability targeting)
- Counselling on infant and young child feeding to PLW and care takers; Provision of food rations for caretakers at TFCs, provision of referral fees/transportation costs for families with SAM with complication.
- Health education.
- Distribution of safe delivery kits. Case investigation by health RRT, follow up of contacts.
- Water storage and filters to SAM HHs. Latrine construction / rehab / desludging. Provision of consumable hygiene kits to SAM HHs. Coordination with RRTs - cholera
- Provision of school bags and essential learning materials, School feeding .

**Health facility package**

- Conditional and season-specific Cash-for-work and/or Cash-for-Assets to rehabilitate infrastructures (including health facilities)
- Ambulatory treatment of acute malnutrition of under 5 years old and pregnant and lactating Women (PLW)
- Blanket SFP for children 6-23 months and PLW
- IYCF counselling for children 0-23 and PLWs
- Micronutrient supplementation for children 6-59 months
- General services, communicable diseases prevention & control, minimum initial service for RH, inpatient care for SAM and immunization. Training, operational support and incentives for health staff.
- Water quality surveillance. Rehabilitation of water schemes and operational support. Support to sanitation systems (repairs, maintenance, operations).
- Providing access to quality accredited formal education to conflict affected children aged 6-17.

**Community package**

- Conditional and season -specific Cash-for-work and/or Cash-for-Assets to rehabilitate community infrastructure and assets.
- Detection and referal children with severe and moderate malnutrition with complications to treatment centres.
- Capacity building on detection of sever and moderate malnutrition, tracing and IYCF counselling
- Health education,
- Training of community health volunteers (CHV) on health preventive measures,
- Temporary water trucking - (3months).
- Cleaning campaigns in areas with high acute malnutrition rates.
- Training of CHVs on hygiene messages hygiene promotion and community mobilization
- Provision of total lead sanitation, schools rehabilitation, schools furniture, teachers kits, teacher training.

## Annex 3: Process to write an advocacy note to promote ICSC work

***Purpose of an advocacy note:*** *To share the context, the ongoing response, identify challenges / bottlenecks and ways to address them, but the main purpose of an advocacy note is to outline the key asks to your target audience to solve the identified bottlenecks.*

### Step 1. Strategic thinking

Before you start writing an advocacy note for ICSC, think about its purpose and the information needed to present a strong argument and include all relevant clusters from the beginning of the process. You should have a joint conversation to reflect on the following questions:

- **What for?** Define the joint problem you are trying to solve and how it could be best addressed.
- **Which clusters should be part of this reflection to address the highlighted problem?** Your argument will be stronger if it involves all relevant clusters (typically Food Security, Health, WASH, Nutrition and in some contexts also Protection, Education, Shelter).
- **What evidence do all clusters have to illustrate and strengthen your joint argument?**
- **Who are your target audiences?**
- **What are the key questions/doubts of your target audiences?**
- **What do you need to ask them to do differently** (this would be your key asks)**?**

### Step 2. Joint drafting

- All relevant clusters should be included in the conversation from the beginning for joint strategic thinking and writing.

- Any cluster could take the lead on drafting the joint advocacy note, but all relevant clusters are expected to input along the process and jointly validate. It is important to agree on a clear validation process and deadline from the first discussion to avoid unnecessary delays.

### Step 3. Writing process

1. **Title.** Use a short and compelling title that outlines your key joint ask that will be further developed in the document. Consider using a subheading for additional information, if needed.

2. **Opening statement.** Open with a statement that gets your audience's attention right away, perhaps using a prominent fact/data reflecting on the joint problem. This is your lead-in and should be only a sentence or two.

3. **Background information.** In two or three paragraphs, describe the country context, identified needs and its impact on the population. You can include in this section information on the needs identified by each cluster, number of people in need and priority areas. Describe any work with national authorities, where relevant.

4. **Challenges ahead.** Describe the impact caused by the problem if not addressed. You can detail gaps and challenges for an effective response here – for example, limited capacities for ICSC, funding challenges, de-prioritization of specific activities, lack of supplies, or reduced access. Remember, explain why it is important to act and the impact if gaps and challenges are not addressed.

5. **Provide facts and data about the problem.** Data is important to demonstrate that a problem exists and to support your position. Identify facts that are relevant to your audience. To make the document more compelling, present data in a visual format and include photos, graphs, charts, tables, etc (always

ensure an ethical use of data). Some sources of information include: HRP/HNO, Financial Tracking System, IPC reports, cluster dashboards, and joint assessments analysis.

6. **Connect the issue to wider agendas**. Connect the issue to the audience's interest and explain how it contributes to wider agendas, such as SDGs, gender, humanitarian-development nexus, or the realisation of the Grand Bargain commitments on accountability to affected populations or localization of humanitarian assistance.

7. **Your asks.** Clearly state what you want your key target stakeholders to do. The more precise you are on **WHO** has to do **WHAT** and **WHEN**, the clearer your target audience will be in understanding what are you trying to achieve and what it is expected from them. Consider recommendations for different stakeholder groups. For example: governments, donors, OCHA, the wider humanitarian community, development partners, etc.

**Tips to write advocacy notes:**

1. **Be brief**. Keep the document to 1-2 pages with short paragraphs of 1-3 sentences ensuring that in general each paragraph covers just ONE topic.
2. **Be clear**. Use short sentences and **avoid technical language, acronyms, and abbreviations**.
3. Improve your advocacy note with good **inter-cluster/ sector editing and revision**.

**Annex 4:**

# Monitoring and Evaluation of Multi-Cluster / Sector activities in countries Guidance Note

**August 2023**

## Background and rationale

It is becoming increasingly evident that the needs of people affected by humanitarian crises, whether natural or man-made, acute or protracted, are best addressed through a multi-faceted approach, to have more meaningful outcomes. The findings show that this approach is more people-centered, pools knowledge and technical/operational capacity of service/assistance providers and is resource and cost efficient.

Several countries with active humanitarian clusters (specifically, but not exclusively Health, WASH, Food Security and Nutrition) have some form of multi-sectoral collaboration occurring, either formally or otherwise, reinforcing the function of the Inter-Cluster Coordination Group (ICCG).

This being the case, the global Health, WASH, Food Security and Nutrition clusters, who have committed to mutual collaboration, are seeking to identify the level of Inter-Cluster / Sector Collaboration (ICSC) in such countries and the efficiency and effectiveness of this collaboration within their operations.

## Scope of the guidance note

This guidance note is an attempt to provide a list of indicators that can be used to monitor the level of progress (or lack thereof) of multi-sectoral interventions, as well as some clarification on how they can be used.

The list is in no way prescriptive and can be modified, based on the context of each country and the specific needs clusters are trying to address.

The aim of this process is solely to measure the extent to which ICSC is being implemented, its efficiency and effectiveness and not to identify which services are being provided by each sector. Findings from the monitoring could be used by the concerned clusters to take the needful steps to improve the joint response.

For information on different stages of ICSC (e.g., planning and joint geographic prioritization, implementation, advocacy), please refer to "ICSC Key Steps" guidance note available on the gFSC, GHC, GNC and GWC websites.

## Explanation of terms used

**Health care facility:** Health care facilities encompass all formally recognized facilities that provide health care, including primary (health posts and clinics), secondary and tertiary (district or national hospitals);

public and private (including faith-run); and temporary structures designed for emergency contexts (e.g. cholera treatment centres). They may be located in urban or rural areas.[3]

**Institution:** Services/assistance is not necessarily provided at health care facilities. Depending on the context, the need to be addressed and the intended output/outcome, the sites of service/assistance provision can be schools, community centers, old-age homes, etc.

**Service/assistance:** Some clusters provide services, e.g., clinical management of cholera, etc., while others provide assistance e.g., provision of WASH kits, food distribution, child stimulation and Early Childhood Development, etc. Therefore, both words have been used.

**Minimum Response Package:** This is the minimum multi-sectoral service/assistance package that is agreed-upon by the clusters participating in the inter-cluster collaboration in-country. Each facility/institution will have a different service package, appropriate to the setting. This should be identified by the country clusters at the outset of the project.

**Indicator classification:** It is suggested to use output/outcome/impact indicators to measure progress.

- **Process indicators**: these can be used to keep track of accomplishments and to report to donors, if these were included in the project proposals.
- **Joint Response Outcome/Impact indicators:** the list below is not exhaustive by any means. It is up to the country clusters to choose from among this list, or identify different indicators, as per their context. One or more sector-specific indicator from this list can be used by each cluster.

**Effectiveness of ICSC:** Defined as the ability to produce a desired result, indicators measuring the extent to which the planned outcomes have been realized (e.g., reduced number of disease outbreaks, reduction in GAM prevalence, increased Minimum Dietary Diversity in children, increased coverage of WASH services, etc.) can be used. Comparison between targeted and non-targeted areas can help to gauge effectiveness.

**Efficiency of ICSC:** Defined as the ability to produce a desired result with minimal use of time, effort and resources, a combination of indicators measuring the extent to which the planned outcomes have been realized (similar to the example on Effectiveness), along with the duration/budget planned in the proposal can be used.

[3] Framework and toolkit for infection prevention and control in outbreak preparedness, readiness and response at the national level: https://apps.who.int/iris/handle/10665/345251

## List of suggested indicators

| Theme | Indicator | Numerator | Denominator | Notes | Indicator classification (outcome/output/process) | Methodology |
|---|---|---|---|---|---|---|
| Service / assistance Availability | # of functional health facilities/institutions with established capacity to support the delivery of a minimum response package of food security, health, nutrition and WASH services in the past 3 months | # of operational health facilities/institutions (including PHCC, nutrition center, community center, health unit, mobile clinic, old-age home, school, etc. as applicable in relevant country) with availability of Health, Nutrition, WASH and FS services agreed on in-country | Total # of identified/targeted operational facilities/institutions in priority locations | Response packages to be agreed upon at the country level.<br><br>Additional services from other clusters can be included (SNFI, GBV, etc.) as per the country context.<br><br>Depending on the number of clusters providing services, thresholds can be set.<br><br>Frequency to be adjusted according to the agreement in-country. | Output | Personnel at the facility collect the information on a quarterly basis |
| | # of locations with established capacity to support the delivery of a minimum response package of food security, health, nutrition and WASH services in the past 3 months | # of locations with availability of Health, Nutrition, WASH and FS services agreed on in-country | Total # of identified/targeted locations | | Output | HH survey |

| | | | | | | |
|---|---|---|---|---|---|---|
| Service / assistance Accessibility | % of people at the facility/institution who received a minimum response package of food security, health, nutrition, and WASH services in the past XX months | # of age and gender disaggregated individuals (take percentage from the denominator) who received the agreed minimum response package (at facility/institution level)<br><br>Frequency to be determined by project length | Total # of individuals accessing the facility/institution in the specified period | Ideally, can be conducted at mid and end project phases.<br><br>Depending on the number of clusters providing services, thresholds can be set. Alternatively, this can be reported as "% individuals receiving assistance from 2, 3 and 4 sectors respectively."<br><br>Target population per sector may be different, hence different individuals can receive different components based on their needs. % results will need to be interpreted. | Output | Personnel at the facility collect the information on a quarterly basis |
| | % of people from the community who received a minimum response package of food security, health, nutrition, and WASH services in the past XX months | # of age and gender disaggregated individuals (take percentage from the denominator) who received the agreed minimum response package (at community level, i.e., catchment population of the facility/institution)<br><br>Frequency to be determined by project length. | Total # of targeted individuals in the specific community | | Output | Community volunteers conduct an assessment during service/assistance-provision<br><br>OR<br><br>Household survey |

| | | | | | | |
|---|---|---|---|---|---|---|
| | % of people who reported experiencing barriers to accessing a minimum response package of food security, health, nutrition, and WASH services in the past XX months | Total # of age and gender disaggregated individuals from the facility and the community (take percentage from the denominator) who reported not receiving service(s)<br><br>Frequency to be determined by project length | Total # of identified/targeted individuals in priority locations | Ideally, can be conducted at mid and end project phases.<br><br><u>Specify what services were not accessible and why.</u><br><br>If project is implemented at facility and community levels, please conduct separate analysis. | Output | Facility level: Personnel at the facility collect the information<br>Community level: HH survey.<br><br>In resource-constrained environments, KIIs can provide information on barriers (country teams may decide to report on this qualitatively or to keep the % indicator flagging this is an estimation from KIs). |
| Beneficiary Satisfaction | % of women, girls, men, and boys satisfied with the comprehensiveness, quality, and appropriateness of the minimum response package of food security, health, nutrition and WASH services | # of age and gender disaggregated individuals (take percentage from the denominator) who answer a satisfaction survey positively regarding the quality of services they received | Total # of age and gender disaggregated individuals who participated in the satisfaction survey | Ideally, can be conducted at mid and end project phases.<br><br><u>If not satisfied, the sub-standard service should be identified and the reason should be recorded, to take corrective actions.</u><br><br>To ensure complying with AAP commitments | Output | Satisfaction survey (at facility/institution or community level)<br>In resource-constrained environments, KIIs can provide information on satisfaction (country teams may decide to report on this qualitatively or to keep the % indicator flagging this is an estimation from KIs). |

| | | | | | | |
|---|---|---|---|---|---|---|
| Community Engagement | # of male and female community members who actively participated in the planning and implementation of the joint response at XX months | # of age and gender disaggregated individuals (take percentage from the denominator) who report having participated in the planning and implementation of the joint response | Total # of age and gender disaggregated individuals who participated in the survey | Could be included as a section in the same satisfaction survey as above.<br><br>This indicator can be disaggregated at planning and implementation phases.<br><br>Ideally, can be conducted at mid and end project phases. | Process | At least 10 FGDs (100 people) with community members (at facility/institution or community level), if resources allow.<br><br>In resource-constrained environments, KIIs can provide information on level of engagement (country teams may decide to report on this qualitatively or to keep the % indicator flagging this is an estimation from KIs).<br><br>Attendance records of community planning sessions to measure number of individuals participating. |
| | # and % of people who feel adequately involved in the project implementation | # of age and gender disaggregated individuals (take percentage from the denominator) who report having their feedback incorporated into the project cycle of the joint response | Total # of age and gender disaggregated individuals who participated in the survey | | Impact | At least 10 FGDs (100 people) with community members, if resources allow. |

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| | # of key informant interviews and focus group discussions with affected men, women, boys, and girls that have been used to identify selection criteria of target population in the past XX months. | # of Key Informant Interviews/FGDs on selection criteria conducted in the past XX months | Total # of planned Key Informant Interviews/FGDs (if available) | This is not a main indicator but can be used as a sub-indicator of the previous (people who feel adequately involved).<br>If denominator is available, a percentage can be calculated. | Process | M&E officer receives reports from the field and compiles them |
| Joint Response Outcome/ Impact | Incidence for selected diseases | # of new cases of a certain disease | # of people at risk for that disease multiplied by a specific time period | The country Health Cluster can identify priority diseases with linkages to WASH, FSc and Nutrition, to be included in this list.<br><br>One or two outcome/output indicators can be selected to demonstrate the impact of the ICSC intervention, and others can be selected to support that impact, as relevant. | Outcome | Communicable disease surveillance (e.g., EWARS) |
| | Case Fatality Ratio for most common diseases (specify whether at facility or community level) | # of cases of a certain disease in which the patient died | Total # of cases of the disease in a specific time period (fraction of numerator and denominator multiplied by 100) | | Outcome | Communicable disease surveillance (e.g., EWARS) |
| | Vaccination rate of children | # of children 0-59 months fully vaccinated against priority diseases (polio/measles) | Total # of targeted children 0-59 months of age | | Output | Health care provider weekly/monthly reports |
| | GAM prevalence among the U5 | # of Under five children (U5) diagnosed as SAM + MAM in the catchment area | # of U5 screened for malnutrition in the catchment area | Data for both indicators can be obtained prior to, and at the end of, the intervention.<br><br>One or two outcome indicators can be selected to demonstrate the impact of the ICSC intervention, and others can be selected to | Outcome | Nutrition survey like SMART<br><br>SMART and/or any other household assessment including anthropometric measurement based on bilateral pitting oedema + W/H z-score <-2 |

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| | | | | support that impact, as relevant | | |
| | Minimum Dietary Diversity (MDD) for children 6-23 months | # children 6–23 months of age who consumed foods and beverages from at least five out of eight defined food groups during the previous day<br><br>Cut off: At least 5 food groups out of the 8 | # of children 6-23 months assessed | | Outcome | We are looking at the part of HH assessment or SMART survey focusing on prevalence of children consuming a minimum of 5 food groups over 24h.<br><br>Good to separate breastfed from non-breastfed children during the analysis.<br><br>Also split the age groups: 6-11 m; 12-17 m and 18-23 months. |
| | # of people in IPC AFI phase 5 / phase 4 / phase 3 | # of individuals identified as falling under Integrated Food Security Phase Classification Acute Food Insecurity Phase 5 (Catastrophe/Famine) / Phase 4 (Emergency) / Phase 3 (Crisis) | | The indicator can also indicate a % change in the number of people in these IPC phases.<br><br>One or two outcome indicators can be selected to demonstrate the impact of the ICSC intervention, and others can be selected to support that impact, as relevant. | Outcome | IPC AFI analysis |
| | Reduced Coping Strategy Index (rCSI) | % of people whose rCSI improved, in the target area, after the ICSC project. | | This indicator can also indicate the number or % of people adopting crisis / emergency strategies (to be compared to baseline).<br>It can be calculated shortly after intervention and it is a | Outcome | Food security household survey |

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| | | | | useful FS indicator when IPC is not available / recent. | | |
| | Food Consumption Score (FCS) | % of people whose FCS improved, in the target area, after the ICSC project | | This indicator can also indicate the number or % of people with acceptable / borderline FCS (to be compared to baseline).<br>It can be calculated shortly after intervention and it is a useful FS indicator when IPC is not available / recent. | Outcome | Food security household survey |
| | Livelihoods Coping Strategy Index (LCSI) | % of people whose LCSI improved, in the target area, after the ICSC project | | This indicator can also indicate the number or % of people adopting crisis / emergency strategies (to be compared to baseline).<br>It is a useful FS indicator when IPC is not available / recent. | Outcome | Food security household survey |
| | Percent of facilities/institutions with access to a basic drinking water service level | # of facilities / institutions with access to basic drinking water service level | # of facilities/institutions targeted by the joint interventions | One or two outcome indicators can be selected to demonstrate the impact of the ICSC intervention, and others can be selected to support that impact, as relevant.<br><br>Quality of WASH provision | Outcome | Facilities/ institutions monitoring survey |

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| | Percent of facilities/institutions with access to hand washing stations | # of facilities / institutions with access to hand washing stations | # of facilities/institutions targeted by the joint interventions | should conform to SPHERE standards or local standards as agreed by the WASH cluster members. | Outcome | Facilities/ institutions monitoring survey |
| | Percent of households targeted by the WASH activity that are collecting all water for drinking, cooking and hygiene from improved water sources | # of households collecting all water for drinking, cooking and hygiene from improved sources | # of households in the targeted areas with joint interventions | | Outcome | Household survey or based on catchment population for an improved water source |
| | Percent of households practicing key hygiene behaviors (to adapt based on type of kit):<br><br>% of households whose drinking water supplies have a free residual chlorine (FRC)>0.2 mg/L<br><br>Or % of households with soap and water at a handwashing station on premises<br><br>Or other custom related to kit content | # of households surveyed whose drinking water supplies have FRC > 0.2 mg/L<br><br>Or # of households that received a kit where both water and soap are found at the commonly used handwashing station<br><br>Or other custom related kit content | # households that received a WASH kit in the targeted area with joint interventions | Relevant for WASH projects that distribute WASH kits to children enrolled in MAM/SAM treatment, patients discharged from health facilities, or people receiving food security assistance. | Outcome | Post distribution monitoring |

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| Advocacy and Resource Mobilization | # of projects developed and fully funded in the past 12 months within the framework of a joint strategy | # of new multi-sectoral projects developed and funded in the past 12 months, which include Food Security, Health, Nutrition and WASH interventions, and any other sectoral interventions | | | Process | Clusters compile this information |
| | # of national and global joint advocacy events conducted in past 12 months | # of new joint advocacy events conducted in the past 12 months targeting national and/or global audience | | | Process | Clusters compile this information |
| | % of funding received in response to joint funding appeals in the past 12 months. | Amount (as a percentage of the denominator) of funding (in USD) received to implement inter-sectoral projects in the past 12 months | Total funding received by 4 clusters in 12 months | The funding percentage indicator may be used to identify progress year on year. | Process | Cluster Coordinators collect and compile on yearly basis (from FTS, HRP fund tracking, etc.) |
| | % of funding received within the framework of a joint strategy | Amount (as a percentage of the denominator) of funding (in USD) received to implement inter-sectoral projects in the past 12 months | Total amount requested from donors toward implementation of a joint response | Total request could be, for instance, initial request for a CERF or HF allocation.<br><br>This can be used along with or in lieu of the previous indicator, depending on available information | Process | Cluster Coordinators collect and compile on yearly basis (from FTS, HRP fund tracking, etc.) |