

Health Cluster Forum

[4-6 July 2022 \(09.00-18.00 each day\)](#)

Notes for the Record

The Health Cluster Forum, held on 4-6 June 2022 at the Movenpick Hotel in Geneva, Switzerland, was attended by 53 participants (40 in person, 13 online) representing 31 country Health Clusters, WHO at global and regional level and the Global Health Cluster unit (see annex 1). The meeting was preceded by the meeting of the Global Health Cluster Partner Meeting held on the 29-30 June.

The meeting objectives were:

1. Strengthen the understanding of how clusters align with WHO at the global, regional and country level
2. Discuss in depth selected thematic topics that have a direct impact on the work of the clusters
3. Identify practical solutions to identified challenges

All material related to the meeting is [available here](#).

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DAY 1: 4 July 2022

Welcome and meeting objectives (L. Doull, GHC)

L. Doull, GHC Coordinator, warmly welcomed participants after a 2-year hiatus of the forum due to the COVID-19 pandemic and outlined the meeting objectives and the proposed agenda. She screened a [prerecorded video from Mike Ryan](#), Executive Director, WHO Emergencies Program, and welcomed Altaf Musani, Director, Health Emergency Interventions; and Scott Pendergast, Director, Strategy, Programmes and Partnerships, Health Emergencies.

1.1 Strengthening the understanding of how clusters align with WHE at the global, regional and country level

A. Musani opened the session by commenting that the availability of funds for emergencies do not meet current needs. He then addressed the importance of linking emergencies to long-term development strategies that enable peacebuilding and how this still presents a challenge for implementation and funding. Finally, he addressed humanitarian space and current challenges for humanitarian health workers, including attacks on health care, and the fact that upholding international humanitarian law and ensuring last mile service delivery continues to challenge the humanitarian response.

L. Doull introduced the WHA dialogue regarding coordination of health emergencies which included the Director General's White Paper "[10 proposals to build a safer world together](#)" discussed by Member States.

S. Pendergast continued the discussion by presenting [the Global Architecture for HEPR](#), initiated earlier this year at the request of Member States in preparation for the World Health Assembly (WHA) in May 2022. It considers the societal changes in health, economy, climate, etc. triggered by COVID-19. This intervention aims to address not only pandemics but also a broader range of health emergencies. Based on several recommendations from the past two years to strengthen the HEPR ecosystem, three key system gaps are discussed: Governance, Systems, and Financing, focusing on three guiding elements: Equity, Inclusion, and Coherence. It is recognized that while health emergencies are the focus, the implications extend far beyond health, particularly in the areas of social protection, security, climate, economics, and finance, as well as in the intersection of primary health care, health promotion and health security.

In addition, he pointed out that refocusing the architecture back to communities is critical, as ultimately all health emergencies begin and end in communities. then focus on strengthening national systems, supported by global and regional capacity. He then emphasized the need for increased funding, primarily either through increased domestic funding or through better use of existing international and multilateral funding. He also spoke about the need to increase our rapidly scalable financing and the establishment of a new financial intermediary fund through the World Bank and

WHO, aimed at pandemic response and preparedness and prevention. Over the next six months, there will be a consultation on how to accelerate the implementation of these strategies.

Key discussion points	Key actions/recommendations
• How does this affect the approach in which response is implemented, specifically HRP, SPRP? • The proposed model continues to be focused on epidemic/pandemic/emerging crises. How this will respond to protracted crises? • Participants inquired how this initiative will address integration and collaboration from member states in future emergency situations. • Participants agreed that the issue is about really capturing learning and positive experience on dealing with these crises to better inform the way forward.	• GHC/HCCs encouraged to actively contribute to the dialogue on how this architecture should evolve.

1.2. Update from the Global Health Cluster

L. Doull presented the [most recent Health Cluster trends](#) in terms of activated clusters, funding and coordination capacity, followed by an update on the GHC Strategic Priorities 2020-2023. Discussion was held on the ongoing global initiatives to strengthen coordination and multisector collaboration, including the [Evaluation of the UNICEF role as cluster lead/co-lead agency](#), the WFP-UNHCR internal cluster review and finally the UN Secretary-General's Action Agenda on Internal Displacement. She concluded by presenting the GHC team and the current efforts to fill vacant positions.

E. Fitzpatrick presented [the Health Cluster capacity and development strategy](#) and the mid-term review. She highlighted the 4 thematic priorities: (i) implementing the Health Cluster Coordination Learning Programme, (ii) increasing the engagement and participation of Health Cluster partners in learning and training activities and as part of the Health Cluster Coordination Training Teams, (iii) ensuring the quality of all learning and capacity development activities, and (iv) strengthening and improving coordination with other capacity development stakeholders. She elaborated on the upcoming SIMEX training and related funding. She highlighted the importance of measuring the impact of trainings and how this directly affects health cluster performance. She highlighted the need for localization strategies and how the GHC can support this. The mid-term review can be found [here](#).

A. Griekspoor, Senior Policy Advisor, gave a short summary on the Cash-Based Interventions Task Team and how partners have taken up this approach to provide access to health services. He mentioned there are some gaps in understanding how the Task Team guidance has impacted partners decision making towards the use of cash modalities and the outcomes in providing better access to health. He introduced the [Barrier Analysis Guide and Role of Cash & Voucher Assistance for health outcomes](#), and further explained the rationale for its development – namely this analysis focuses on

the types of barriers that can be changed through different financing modalities. He concluded by highlighted key Task Team accomplishments such as the [CaLP partnership](#), the Community of Practice for Health, as well as influencing Cash and Voucher Assistance policy for health at the global level.

L. Aguilar, GHC Senior Information Management Officer, spoke [about the Joint Intersectoral Analysis Framework \(JIAF\)](#), an evolving approach to analyze the multiple needs of populations in crisis used in the Humanitarian Needs Overview. Currently, the JIAF 1.1 provides an assessment of the scale, severity, and vulnerability of a crisis, as well as geographic information and an explanation of the causes and impact of the crisis. He explained the steps of the updated JIAF 2.0, which are: analytical framework, people in need estimation methodology, severity estimation approach, and cross-sector analysis. Finally, he mentioned that a simulation exercise testing JIAF 2.0 will be undertaken by the end of August 2022 and that the Health Cluster will be invited to participate.

Key discussion points	Key actions/recommendations	
- Participants discussed how to make better use of tools such as the HRP to advocate for filling the clusters needs such as staffing, funding and other resources - There is a report currently being drafted on how to do activity-based costing or unit-based costing (from A.Griekspoor) - New guidance to do barrier analysis for access and utilization, will help identify options to reduce out of pocket expenditures, including the specific role for CVA for health - Doing barrier analysis is already part of PiN, the new guidance will help clusters to do this better, in the upcoming HNO 2023 - The Joint Intersectoral Analysis Framework (JIAF) is a relatively new methodological approach to analysing the multiple needs of populations in crisis. It is one of the 10 key commitments of Grand Bargain: Agenda for Humanity in 2016 - JIAF 2.0 is under development. The project is inter-cluster and interagency, and GHC is part of the development team. - JIAF 2.0 teams include the analysis framework, People in Need Estimation methodology, Severity Estimation Approach, and Intersectoral Analysis - When JIAF 2.0 methodology is ready, webinars will take place with all Health Clusters.	- Proposition to begin Localization efforts, including mapping and creating a baseline - HCCS: HCCs please reach out to the CDCG if you would like tailored induction packages - Ensure all Health Cluster Team members have completed the eLearning - HHCs CDCG will be mapping and reporting on progress to achieve this goal	
	<th data-bbox="1318 1084 1953 1122">Key gaps/challenges</th>	Key gaps/challenges
	- Achieving full funding of HRP activities is becoming increasingly challenging, including the challenge on diversifying funding. - There is still hesitancy from partners to adopt more CVA solutions.	

1.3. Gender Based Violence session

S. Zariv, Technical Officer, GBV in Emergencies, WHO introduced [the Gender-Based Violence in Emergencies \(GBViE\) initiative](#), which aims to enhance accountability within WHO for addressing gender-based violence in health emergencies, strengthen the capacity of Health Cluster partners and health providers to coordinate and deliver GBV services, and promote learning within the health sector about effective responses to gender-based violence. She provided an overview of key achievements, including improved coverage and quality of services for survivors in 14 countries and that 10 out of 12 of the humanitarian appeals and/or response plans include health services related to gender-based violence. She emphasized the importance of institutionalizing GBViE and that supporting partners/countries with tools through training and localization can support the inclusion and mainstreaming of GBV initiatives. She then elaborated on the linkage of the WHO PRSEAH strategy to GBViE. Here you can find online access for [Guideline](#) and [eLearning](#)

F. Tabu, Health Cluster Coordinator, Cox's Bazar, talked about the coordination of Health Sector Response to GBV in Cox Bazar, Bangladesh. He began with a snapshot of the situation in Cox's Bazar. There are currently 33 camps with a population of 900,000 refugees, 52% of whom are women. Some of the implementation challenges include knowledge gaps, local politics, low reporting, staff turnover, socio-cultural factors, human trafficking and perpetrator accountability systems. With the implementation of GBViE strategies like the UNCHR Blueprint which is complementary to health sector quality assurance tool and a collaboration with Ready Initiative on child protection case referral which include GBV and sexual abuse, case handling has improved, including better awareness, increased staff capacity and better monitoring. Next steps include integration with other tools such as HeRAMS, and advocacy for continued funding and uninterrupted availability of resources and staff.

Key discussion points	Key actions/recommendations
- Participants discussed promising practices on coordination of health sector response to GBV in their contexts such as creation of women safe spaces, working with subhubs, training of midwives and other first contact personnel - Health cluster adaptation to ensure health care services for GBV survivors include care for intimate partner violence survivors shared experiences and how victim and support services rely on the service availability - Intersection between GBViE and PRSEAH,	Ensure that norms and standards are being upheld and that all health partners understand how all this work is contributing to GBViE
	Key gaps/challenges Continued advocacy is still needed to mainstream services at all levels of care.

1.5 Preventing and Responding to Sexual Exploitation, Abuse and Harassment

Dr. G Gamhewage, Director, Prevention and Response to Sexual Exploitation, Abuse and Harassment PRSEAH (WHO), [introduced the PRSEAH strategies](#) and actions taken by WHO, focusing on how it is being integrated into the Health Cluster and the accountability process for all partners engaging with WHO and the Health Cluster, presented the WHO Unified framework for addressing sexual misconduct including the [Dashboard on investigations into sexual misconduct](#). The focus is on operationalizing these strategies and embedding them as a dedicated pillar in the emergency response as well as strengthening prevention by working on community participation and reporting mechanisms; and from an operational standpoint, improving capacity at all levels, starting at the country level with a strategy to implement PRSEAH in all phases of the humanitarian response.

Key discussion points	Key actions/recommendations
- HCCs and participants shared some of their experiences in the field and examples of how to respond. - Investigations should not be performed by HCCs or supervisors, they must be reported. - Interest expressed in more trainings adapted to the humanitarian contexts.	- Encouragement for HCCs to take an active leadership role within their teams and clusters. - HCCs to reach out to HQ if support is needed. - HQ will organize modules/webinars on: - PSEA Partner Protocol. - Risk assessment before the end of the year

1.6. Health Cluster Coordinators Session

In advance of the meeting, an anonymous survey was sent out to HCCs on various topics. The results of the survey can be found [here](#).

A. Musani opened the meeting by pointing out the importance of exercises like this to strengthen communication between management and field teams. Not all topics could be addressed, but the most important ones were highlighted in the following order: First, contracts, followed by mobility issues. He pointed out the HCC problem with temporary contracts and that this problem led to constant gaps. He then spoke about the "country business model" to make HC coordination costs more efficient and emphasized that he understands that HCCs are asking for fixed-term contracts.

He continued talking about mobility issues and how HR is now being restructured, at least in terms of centralizing data on where staff members are located. It has been extremely difficult to get current data on this, but efforts are currently underway to simplify the process and understand the location of the workforce. After this crucial step is achieved, it will be

easier to implement mobility according to performance metrics so that team members can continue to grow and develop their career paths.

Other topics health cluster coordinators raised included capacity development, technical assistance for HNO/HRP, HQ /RO/WCO interaction, communication and collaboration with the Global Health Cluster, donor fatigue, cross-country emergency response and current environment constraints including attacks on agencies by authorities and negative media campaigns.

Key discussion points	Key actions/recommendations
• New country business model expected by the end of the year will affect current recruitment and movement of HCC. • This will be switching to a centrally owned regionally managed approach.	• HCCs are encouraged to reach out to GHC to voice their concerns • GHC to continue discussions with WHO/HEI Management toward solving these issues
	<th data-bbox="1318 597 1940 633">Key gaps/challenges</th>
	• The session was based mostly on HR and career growth issues for HCCs

2.2 Inter-cluster / multi-sector collaboration

Dr. H. Hassan, Inter-cluster Focal Point, GHC. Introduced the intersectoral help-desk started stating that effective inter-sectoral coordination is an essential part of any emergency response that is accountable to the affected populations and Global Food Security, Health, Nutrition and WASH clusters committed to work together through an inter-sectoral collaboration platform at global level. The inter-sectoral collaboration platform of the 4 clusters is a space to discuss and exchange ideas on joint technical response to scenarios such as the current food security crisis in the Horn of Africa. The forum does not replace ICCG, nor does it create a parallel coordination structure. He also explained the goal of the GHC inter-sectoral Helpdesk which is to provide country clusters with regular guidance for joint programming, advocacy, implementation and monitoring

Dr. A. Ngoy, Health Cluster Coordinator, Burkina Faso, presented [Intersectoral Collaboration Model, Burkina Faso](#). He began by explaining that intersectoral collaboration is still in its early stages and is being driven by several initiatives, notably a joint advocacy paper that focuses mainly on food security but opens up the space for collaboration with other clusters, and a case study on cross-sector collaboration with input from the food security, health, nutrition, and WASH clusters. To implement these strategies, the following actions are needed: it is desirable for a sector/cluster to take the lead on the intersectoral collaboration initiative. He stated that an understanding/agreement on cross-sector collaboration and the multi-sectoral approach, including the creation of operational guidelines, is needed at the cluster lead agency level. He then addressed some of the problems faced, such as the lack of input from partners in the field and the fact that project monitoring is still sectoral, which prevents the multisectoral approach from making further progress. Finally, the different geographic coverage with different project lifecycles makes complementarity between multisectoral projects difficult. He concluded by stating the next steps are to advocate with donors to support project funding while maintaining visibility of each sector for transparency and proposal monitoring, and to advocate with cluster members to support this collaborative approach.

Dr. Fawad Khan, Health Cluster Coordinator, Yemen, shared lessons learned from country experience and spoke about the 2022-2023 strategy for inter-cluster collaboration in Yemen, which includes the following strategies: Integrated Hunger Risk Reduction, Collaboration among MHPSS Clusters, and People with Disabilities in Reporting and Mapping of Health Interventions. He explained the components of the inter-cluster collaboration response strategy. These include needs assessment, focused/targeted interventions, scaling up cash-based interventions, and ensuring access to services for vulnerable populations and marginalized groups, and finally close monitoring of interventions to identify gaps and take countermeasures. He concurred with the previous presentation from Burkina Faso on the difficulties in successfully implementing these strategies.

L. Doull explained that the GHC inter-sectoral helpdesk is ready to provide the necessary support to advance inter-cluster collaboration and multi-sectoral approach at country level.

The discussion was prompted by the following guiding questions

- What specific support do country clusters and their partners need to roll-out a multisectoral approach?
- How can country clusters maximize the commitment and advocacy of GHC, GNC, GWC and GFC to advance inter-sectoral collaboration in their countries of operation?
- What opportunities do the current food insecurity response and upcoming HPC cycle provide us to advance the multisectoral approach?
- How can we strengthen coordination at sub-national level?

Key discussion points	Key actions/recommendations
• Minimum package can be flexible and adaptable to the context. • Phased implementation encouraged starting with full presence areas gradually expanding to other areas. • Intersectoral coordination is not duplicating existing mechanisms; it is an informal platform to facilitate technical discussion between clusters.	• GHC intersectoral helpdesk support is available and reachable at country level. • Country clusters can request support for guidance, tools, advocacy, and training for the members of their country clusters.
	Key gaps/challenges • Alignment between sectors is still in developing phase, this might compromise leadership and decision making between clusters.

2.2 Public Health Situation Analysis

This session was formed by two parts; brief introduction to PSHA and an interactive training exercise; delivered by Luis Aguilar, GHC Information Management team lead Jonny Polonsky, Epidemiologist, WRE. The session objectives were to improve the capacity and quality of health analysis by:

1. Assessing how health information is structured, organized, related, and categorized in an emergency.
2. Distinguish what PHIS tools (including HeRAMS, EWARS, HC Bulletins) are relevant for collecting health data by information domain.
3. Dissect the information needs of a PSHA and choose relevant PHIS data sources.

Part 1 – Introduction

C.Habib, Training and Capacity-strengthening Information Management Officer, [presented a shortened version of a training introducing the PHSA](#)

Part 2 – Working groups

The participants were divided in various groups to further work in this topic, the results of this exercise can be found [here](#)

Key discussion points	Key gaps/challenges
• Having a template and guideline on PHSA is useful and important for the response, • Important to update them to be more adaptative to Health Cluster needs. • Keep in mind who the PHSA users (audience) are and write accordingly. • <i>HC responsible for PHSA, otherwise, long time to get final clearances. This ownership includes the decision on when to update, and what information includes.</i> • The template helps to avoid missing components. Important to keep the short format short. Include a table of contents. A brief executive summary. Visuals and charts, and links to the information sources. • The detailed input from the groups is available here https://bit.ly/PHSA2022	• Need to address the local context

2.3 Health Cluster Quality Toolkit

M. O'Brien, Associate Technical Director, FHI 360 & GHC Focal Point for the Quality Improvement Task Team, outlined the session goals, which was to introduce the quality improvement task team and the quality tool kit and its implementation. He spoke about the definition of quality of care and then reviewed the work of the quality improvement task team, [including the quality assurance and quality improvement for healthcare in humanitarian settings guide](#).

He spoke about GHC's leadership role in quality improvement and collaborative efforts with other partners and UN agencies. He then highlighted the quality of care domains followed by the launch of the [Quality Improvement Toolkit](#) and the review process of other efforts and documents to create a comprehensive resource for implementers. He updated on next steps, which include in-country piloting, translation into French and Arabic and technical assistance.

Key discussion points	Key actions/recommendations
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The session then had a [brief exercise](#) with follow up questions to discuss among tables. During the discussion, HCCs concluded / requested the following:

- Guidance on how to adapt tools including standards/analyses of results, on how to implement assessments and quality improvement mechanisms e.g., estimation of personnel and funding.
- Development of qualitative and quantitative indicators.
- Knowledge sharing between countries, including regional workshops.
- Further training for HCCs and partners on quality standards, toolkit and implementation.
- How can alignment between WHO and HC work on quality be ensured.

- Toolkit is in an early launch phase, call for Clusters to participate in rollout.
- HCC feedback will be included in the technical support provided to countries once piloting phase is completed

2.4 Mental Health and Psychosocial Support

Dr Fahmy. Hanna, Technical Officer, Department of Mental Health and Substance Abuse, WHO presented the latest updates for MHPSS, including advocacy at the management level, and increased country support. He mentioned that WHO is now involved in IASC MHPSS working groups as co-chair. He discussed the country-level updates, mentioning the intersectoral coordination groups and cross-sectoral work on MHPSS, as well as some of the support provided under this initiative, such as remote online coordination, surge capacity through standby partnerships, in-country support missions and annual retreats for the MHPSS TWG co-leads. He spoke about the [online course on implementing MHPSS in emergencies](#), reported on the current response in Ukraine, and concluded by presenting a recently published [collection of MHPSS success stories from different countries](#).

A. Ladyk-Bryzghalovaa, Technical Officer, MHPSS Program, WHO Ukraine, shared her experiences with the response in Ukraine, challenges and areas for improvement; she mentioned the success of working groups and the expansion of MHPSS to local contexts when possible.

I. Weissbecker, Technical Officer, Department of Mental Health and Substance Abuse, WHO introduced the Mental Health and Psychosocial Support minimum service package (MSP), the structure including funding, leadership, and technical areas that include health, child protection, education, shelter, and GBV. She explained that the MSP is aimed at program planners, coordinators, donors, implementing partners, and technical advisors. She gave a brief introduction to the MSP key activities and introduced the MSP Gap Analysis Tool, which provides information on MSP activity coverage and gaps and how they have evolved over time. She presented the Cost Calculation Tool, which is designed to help implementers and users optimize the calculation of costs for MHPSS MSP activities. She concluded the session with information on how to [access the package](#).

Key discussion points	Key actions/recommendations
- Importance of ensuring MHPSS is intersectoral but with strong health engagement. - Overview of tools available to help adapt, plan and coordinate MHPSS to suit individual context. - Standardization of the minimum service package was appreciated as it will give predictability on costing for donors and together with the addition of the surge of human capacity will help to fill the key MHPSS gaps in the field. - Help and support is always available at HQ/ RO and potential deployment of SBP to support interagency MHPSS. - Thanks to the advocacy of WHO and many partners, mental health has been prioritized as an essential need. - HCCs shared that MHPSS capacity building and training programs that began before the outbreak of COVID-19 were able to successfully continue after movement restrictions were put in place.	- Minimum service package webinar will be held soon to explore the tool in detail - GHC and Country Health Clusters to continue advocating for MHPSS integration in primary and general healthcare.

2.5 Conflict sensitivity analysis and programming

M. Boddaert, Technical Officer, Interagency Policy for Emergencies, Health Emergency Interventions WHO spoke about conflict sensitivity and supporting peace in health interventions. She presented the session objectives which were to introduce the Global Health for Peace Initiative (GHPI) and explain conflict sensitivity and peacebuilding capacity, and to identify key entry points and opportunities for conflict sensitivity and peace responsiveness with HCCs. She provided an overview of WHO: Vision Global Health for Peace Initiative (GHPI), concepts that aim to position WHO and the health sector as an influencer of peace by designing health interventions that are conflict sensitive and contribute to peace outcomes. She briefly explained the links between health and peace and how health can provide an entry point for dialogue that can strengthen community relations and trust. She spoke about conflict sensitivity and avoiding negative impacts that can cause or contribute to conflict and thus damage the drivers of peace. The session concluded with a case study.

Key discussion points	Key actions/recommendations
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Possible way forward for HCCs: • Training on the approach • Engage with peacebuilding actors • Amplify local voices of actors who are aware of issues that affect conflict dynamics. • Proposals: incorporate conflict sensitivity • Indicators: measure conflict sensitivity in assessments and monitoring. • The GHPI's webpage: https://www.who.int/initiatives/who-health-and-peace-initiative	• Training modules under development and the Health for Peace Initiative Handbook to be launched this year
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DAY 3: 6 June 2022

3.1 Package on High Priority Health Services in Humanitarian settings (HHH)

A. Griekspoor, Senior Policy Advisor, WHO [presented the H3 package for health services](#). He explained how this initiative started and that it is a package that can realistically be implemented by humanitarian partners in the field. To develop this package, a set of priority health interventions for humanitarian operations was first identified to ensure that services could realistically be delivered to populations affected by protracted emergencies in low-resource settings. He then explained that this package is consistent with the [WHO UHC compendium](#).

J. Fogarty, Technical Officer, Integrated Health Services, Clinical Services and Systems, WHO, explained the process of developing the H3 package, starting with compiling and analyzing existing country and global packages using the case studies of Northwest Syria, Afghanistan and Somalia. Then, diseases with a high Burden of Disease (BoD) in humanitarian settings were identified, including common conditions not covered by BoD. The existing packages were then cross-referenced with the UHC Compendium of Health Interventions and services were mapped to delivery platforms and finally expert review to select relevant services and validate entire package. He addressed the topic of contextualization and mentioned a tool currently being developed that will allow the user (country or partner) to view all the services in the H3 package and then comment on them and adapt them to their needs.

A. Griekspoor then explained how this H3 package can be implemented. He gave a timeframe of 8 to 10 weeks for completion of the package, focusing primarily on establishing a solid baseline prior to implementation to ensure consistency among partners in supporting service delivery. Once developed and costed, partners and HCCs can use H3 to; define resource requirements (HWF, medicine, equipment), improve quality of care, including treatment protocols, training needs, improve consistency between partners in supporting service delivery, as a reference for activity/unit-based costing for the HRP, donor proposal and required budgets, monitoring functionality and performance of service delivery health facilities.

Key discussion points

Key actions/recommendations

HCCs discussed how the package is intended to mitigate major discrepancies in interpretation of service priorities but requires that cluster coordination are established as standards, to be proactively driven by GHC and must ensure practical links with quality assurance and costing.

- Partners and coordinators need to look at constraints for implementation and deliver package,
- Activity based costing (e.g., HRP) requires simplified approach that can be used by Health Clusters,
- Costing and budgeting of interventions more complicated technically than designing a services package, inputs not often useful at country level. Suggest costing of service platform (e.g., staffing, drugs, etc.)

- Approach needs to be field tested and have more information on practical implementation.

- Consultation with frontline workers suggested.

3.2 COVID-19 response

E. Pasha, GHC COVID-19 Task Team focal point, [Presented the most recent C-19 developments](#) to provide a wider scope of lessons learned and implementation; she then followed with the ongoing work of the COVID-19 Task team explaining that the global perspective has shifted towards vaccination and presenting the [position paper on equitable vaccination access](#) produced by the Task Team. Continued with other areas of work such as the COVAX delivery partnership and other work developed, she concluded by explaining that the response is shifting from an emergency phase to a preparedness phase and presented some points for the future of the COVID-19 response. highlighting the [2022 SPRP](#) and actions moving forward, focusing primarily on ending the emergency phase of the response and presenting the investments done in health system strengthening that can be capitalized to continue the strengthening of response of countries.

M. Shafiq, Cross-border Turkey Health Cluster Coordinator, presented the lessons learned and Integration Plan with the Turkey Cross-border Cluster focusing on surveillance, infection prevention and control and vaccinations concluded presenting how this integration was also included in hospitals specifically in ICUs with strategies such as telemedicine and infrastructure investments and enhancements (surveillance and capacity or trainings in lab support, oxygen supply).

The session concluded with a “sticky note exercise” with the aim to find gaps and lessons learned and share from Clusters’ experiences. The results can be found [here](#)

Key discussion points

HCCs amply discussed and shared their experiences in various key areas.

- Surveillance Labs and Public Health Intelligence,

Key actions/recommendations

- HCCs proposed the creation of a research working group to advance

• Vaccination Engagement, • Coordination, • Preparedness and response, • Clinical Care/EHS/ Resilient health systems, • Research and development,	the current field experiences in collaboration with local institutions.
	Key gaps/challenges
	• Vaccine hesitancy is having a negative impact on delivery of other vaccines • COVID-19 fatigue, • Personnel Shortage. ◦ Health workforce has not increased with COVID19 pandemic, task shifting only, • Vaccine uptake low, pressure for 70% coverage overshadowing other lifesaving needs.

3.3 Humanitarian Development and Peace Nexus

A. Griekspoor, Senior Policy Adviser, began the conversation by noting that there are many ways to put the HDPN into practice, and that it is not so much what we can do, but how to prioritize. He briefly recapped basic concepts, emphasizing that the HDPN is designed to work together with development actors in a complementary way, focusing on fostering connections through coordination. This is not about sharing information separately, but about finding common areas of concern and working together to advance common causes. He then explained how to identify common concerns, operational challenges, bottlenecks in the health system, and entry points where collaboration leads to better outcomes for affected communities. The success of the HDPN is seen when the situation changes and interventions reach more people, especially those most in need with more and better services without sacrificing financially. He concluded by saying that this should be seen as an opportunity to bring in resources and expertise from development to achieve better humanitarian programming and hold development actors accountable for its part.

Key discussion points	Key actions/recommendations
• HCCs expressed the need for clarity and guidance on a definition of HDN and humanitarian development peace nexus (HDPN) and how these concepts should be implemented from a practical point of view. • Donors are driving uptake of the HDN concept, however there is a risk of no funding for the actual implementation. • There are small practical steps to be made to go beyond the theory, for example looking at what can be done to build resilience	• WHO / Health Cluster needs to provide leadership and bring development and humanitarian partners/donors to the table to define, discuss and implement HDPN and the role of Health within the nexus.

- Rich information /experience within clusters (Afghanistan, South Sudan, Sudan Yemen, Iraq) which needs to be more effectively documented. Country profiles drafted by EMRO a useful baseline but need more systematic capture of current practice; this is needed from across all regions. - HDPN is not the end of humanitarianism, it is not about handing over to development and stopping humanitarian work.	
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3.4 Next steps and priorities for 2022

A. Musani opened the session and praised the work of the HCCs as well as the cluster teams and subnational coordinators. He acknowledged there are often many uncertainties that are difficult to manage and thanked all their efforts to push through the COVID -19 pandemic, and other crises related to conflicts, food shortages, climate change etc. He highlighted the importance of data management and sharing and spoke about WHO data infrastructure projects that will support the work of health clusters and broader emergency operations and encouraged coordinators to keep pushing data.

He also highlighted health resources and the fact that they are not being adequately addressed in funding. He mentioned the increasing burden of food insecurity and malnutrition on health systems and emphasized the need to collaborate with other clusters to respond to this threat. He acknowledged the increasing number of FCV situations that will lead to an increase in outbreaks and epidemics. He highlighted there are big challenges ahead, leading to further complexity for humanitarian actors because there is an expectation to do more with less.

Key discussion points	Key actions/recommendations
- The Health Cluster Coordinator role requires them to be 'masters of managing complexity & navigators of uncertainty' - Noted that post pandemic, clusters & FCV more widely are data rich but must use this data more effectively to demonstrate impact & better position health when developing or pursuing advocacy efforts. - Key metrics to be considered are those related to humanitarian /health access; health system capacity & functionality; funding & their overall impact on risks & population vulnerability - especially when used for advocacy.	A. Musani, HEI Director, would like to keep more regular contact with HCCs

- Resources for Health - analysis of health within HRP notes that health is one of the most underfunded sectors. New WHO HEPR Strategy could be a useful tool to help position health more robustly within funding efforts.

3.5 Closing Remarks and Q&A with Dr. Mike Ryan

Dr. M. Ryan, Executive Director WHE Programme joined remotely to address some of the concerns that HCCs had expressed at the beginning of the forum. He began by addressing the complex role of the Health Cluster Coordinator and how important it is in humanitarian response, followed by recognition that better career development is needed for HCCs, and acknowledged that more support is needed from country offices and HQ. He went on to say that coordination with partners and, when possible, with governments is critical and how this improves the response and enables sustainability. He asked for feedback from HCCs on strengthening the role of clusters and how WHE can support this.

Key discussion points

- The HCC expressed their concerns and requested for support in the following areas:
 - How the role of the Health Cluster be mainstreamed or integrated within the organization
 - Ethiopia: how can WHE support the coordination capacity with WHO and other actors, need to urgently improve telecommunications,
 - Population displacement and protection
 - Food insecurity and the Horn of Africa crisis
 - Collaboration with other UN Agencies and clusters

Key actions/recommendations

- Dr M. Ryan suggested to have a WHE Town Hall staff panel dedicated to the HCCs. GHC to follow-up on planning.

Annex 1: List of participants

Country	Name	Last Name	TITLE
Afghanistan	Dayib Ahmed	Mahamed	Dr
Bangladesh	Francis	Tabu	Dr
Burkina Faso	Alain	Ngoy	Dr
Cameroon	Emmanuel	Douba Epee	Dr
Chad	Amadou Mouctar	Diallo	Dr
Colombia	Mauricio	Cerpa Caldeiron	Mr
Cross-border NE Syria	Naseer	Nizamani	Dr
DRC	Alou Badara	Traore	Dr
Ethiopia	Beatrice	Muraguri	Ms
Honduras	Luis	Macias	Dr
Iraq	Kamal Sunil	Olleri	Dr
Lebanon	Christina	Bethke	Ms
Lebanon	Myriam	Sassine	Ms
Mali	Poda	Gnimbar	Dr
Mozambique	Theodore	Yamdji	Dr
Myanmar	Gabriel	Novelo	Dr
Niger	Didier	Tambwe	Dr
Niger	Calixte	Ndabumviyubusa	Dr
Nigeria	Mie	Okamura	Dr
oPT	Chipo	Takawira	Ms
Somalia	Erna	van Goor	Ms
South Sudan	Mukeshkumar	Prajapati	Dr
Syria Damascus	Azret	Kalmykov	Mr
Turkey-Gaziantep	Shafiq	Muhammad	Mr
Whole of Syria	Nasr	Mohamed	Dr
Ukraine	Emanuele	Bruni	Dr
Venezuela	Maria Mercedes	Munoz	Dr
Yemen	Khan	Muhammad Fawad	Dr

Zimbabwe	Nkosilathi	Mpala	Mr
EMRO	Ayadil	Saparbekov	Dr
EURO	Oleg	Storozhenko	Dr
HQ	Altaf	Musani	Mr
HQ	Gaya	Gamhewage	Dr
HQ	Andrea	Vergara Velarezo	Ms
GHC	Linda	Doull	Ms
GHC	Emma	Fitzpatrick	Ms
GHC	Betina	Petry Nectoux	Ms
GHC	Saba	Zariv	Ms
GHC	Paola	Vargas	Dr
GHC	Eba	Pasha	Dr