HEALTH CLUSTER COORDINATION TRAINING

6-13 November 2016, Jordan

Training Report
(Final Draft)

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Annexes

1. Summary

This first joint Health Cluster Coordination Training for current and potential Health Cluster Coordinators and Information Management Officers took place at the Dead Sea, Jordan from the 6 to 13 November 2016. The Health Cluster Capacity Development Strategy 2016 - 2019, the Health Cluster Coordination Competency Framework and the Standards for Public Health Information Services in Activated Health Clusters are all at an advanced stage and this training enabled the joint piloting and implementation of these initiatives.

The training was designed by the Global Health Cluster Capacity Building Task Team and the Public Health Information Services Task Team and other members of WHO staff by means of a Joint Training Working Group which was set up specifically for this purpose. The training built on the recommendations in the Health Cluster Professional Development Initial Findings and Recommendations November 2014, and the lessons learned from the relaunch of Health Cluster Coordinator Training in Divonne-Les-Bains France, from the 14 to 20 September 2015.

The eight day training programme contained a blend of didactic and practical sessions, including desk top exercises and a two day simulation exercise, and closely followed the Humanitarian Programme Cycle.

The training was attended by 42 Participants with a wide range of experience, and who represented EMRO (28), AFRO (10), EURO (3) and SEARO (1) WHO regions. There were 25 current or potential Health Cluster Coordinators and 17 Information Management Officers. 29 were working for WHO and 13 were working for INGOs, 10 of the latter were working for the six members of the NGO Consortium Health Cluster Support Programme led by Save the Children UK, i.e. GOAL, Malteser International, MEDAIR, Premier Urgence International, Save the Children UK and World Vision International. The other three INGO Participants were from IRC (2) and NRC (1). There were 32 male and 10 female Participants. Please see **Section 7** for more information about the Participants.

The feedback from the Participants and the Training Team was very positive. Participants average rating of the training overall was 4.6 out of a maximum rating of 5, and they provided constructive feedback throughout the training. The training was rigorously evaluated and provides a firm foundation for developing and strengthening future training for Health Cluster Coordination Teams. Please see **Section 10** for more information about the feedback from the Participants and Training Team.

We would like to gratefully acknowledge funding and in-kind support from the World Health Organisation, European Commission Humanitarian Office (DG ECHO), the United States Agency for International Development's Office of Foreign Disaster Assistance (USAID/OFDA), Save the Children UK, Malteser International and the Government of Macau.

2. Introduction and Background

2.1. Overview of the humanitarian challenges

The humanitarian system is facing major challenges; the level of humanitarian need and the subsequent demands on the humanitarian community is at the highest ever recorded. There are more people in need of humanitarian assistance than ever before; an

unprecedented 65.3 million people around the world have been forced from home. Among them are nearly 21.3 million refugees. As of October 2016, UN-coordinated appeals and refugee response plans within the Global Humanitarian Overview (GHO) require US$22.1 billion to meet the needs of 96.6 million people in 40 countries. In October 2015, 82 million people were targeted to receive aid. Together the appeals are funded at $10.2 billion leaving a shortfall of $11.9 billion. This questions the humanitarian community's ability to continue to meet the needs of affected people, especially in protracted crises, where 80 per cent of humanitarian assistance now takes place, and where humanitarians are asked to stay longer and to do more with less. The first World Humanitarian Summit was held in Istanbul, Turkey on 23 and 24 May 2016. It convened 9,000 Participants from 173 Member States, including 55 Heads of State and Government, hundreds of private sector representatives and thousands of civil society and non-governmental organization representatives. The Summit confirmed financing as a key enabler and catalyst for meeting and reducing humanitarian needs. Building upon the conclusions of the Secretary-General's High-Level Panel on Humanitarian Financing and the Secretary-General's Agenda for Humanity, commitments were made to ensure increased access to life-saving humanitarian assistance and protection for over 130 million people in need worldwide. Several commitments were aimed at making existing funds go further. It was recognized that financing should play a lead role in the new way of working. Specifically, Participants agreed on the need for more direct, timely and predictable humanitarian financing. Commitments were made to increase resources and widen the donor base by expanding financing streams and mechanisms, escalating risk insurance, garnering greater support through pooled financing mechanisms and mobilizing Islamic social finance. Member States broadly supported the proposed increase of the Central Emergency Response Fund (CERF), a 'fund for all, by all', to $1 billion. One country showed its intent by increasing its donation through the CERF by 25 per cent. There was a pledge to provide $147 million over five years, as well as an initiative to use fund-backed risk financing to help pay the premium for establishment of an innovative risk insurance financing mechanism.

Strengthening the Health Cluster

As the number and complexity of emergencies has grown, the human and technical capacity to effectively coordinate the health response of diverse actors has not evolved proportionally. An assessment of current Health Cluster Professional Development initiatives shows that there is an overall shortage of Health Cluster Coordination personnel with the right mix of technical skills and competencies combined with the necessary leadership, coordination, and communication competencies, who are supported by competent support teams, are able to mobilize additional technical expertise and financial resources, and who are available to be deployed at short notice and to remain in position for extended periods.

There are currently 24 countries with active health clusters, most with one or more sub-national hubs. As of October 2016 only 50% of national health clusters had a full time Health Cluster Coordinator; 50% of clusters had a dedicated Information Management Officer; 25% of clusters had a part-time Information Management Officer; 25 % of Clusters had no Information management capacity. Staffing gaps are often solved by adding Health Cluster responsibilities onto existing staff (so-called "double-hatting"), who may not have the necessary skills, knowledge or support to fulfil these roles adequately. Despite best efforts, this short- term approach can result in poor strategic planning for

emergencies, weak coordination and poor information management, which in turn may result in a less than optimum response to the needs of affected people.

The Global Health Cluster (GHC) seeks to address the limited pool of competent Health Cluster personnel by developing Health Cluster Coordination Training as part of a wider Health Cluster Capacity Development Strategy.

There have also been significant changes in the humanitarian system and extensive and continued changes in the WHO /Health Cluster Lead Agency have taken place. The WHO is reforming to be better equipped to address the increasingly complex challenges of health emergencies in the 21st century. From persisting problems to new and emerging public health threats, WHO needs the capability and flexibility to respond to this evolving environment. The Reform has three aims: programmatic reform to improve people's health; governance reform to increase coherence in global health and managerial reform in pursuit of organizational excellence.

This new and revised Health Cluster Coordination Training reflects these changes in order to ensure that Participants have the requisite skills and knowledge to effectively fulfil their roles and responsibilities. The training curriculum has been designed around the phases of the Humanitarian Program Cycle as endorsed by the IASC Principles, and builds on the directives of the Reference Module for Cluster Coordination at Country Level (2015), both documents are among the eight protocols supporting the implementation of the Transformative Agenda.

3. Aims and Objectives

3.1. The aims of this training were to:

1. Build and strengthen the capacity of Health Cluster Coordinators to lead and coordinate the planning, implementation and monitoring of more effective, efficient, timely and predictable evidence based humanitarian health interventions in acute and protracted emergencies.

2. Build and strengthen the capacity of Information Management Officers to lead and coordinate the generation of evidence based planning, implementation and monitoring of humanitarian health interventions in acute and protracted emergencies.

3. Ensure that Participants can effectively and collaboratively carry out the tasks and duties associated with the Terms of Reference for Health Cluster Coordinators and Information Management Officers.

3.2. Specific Objectives:

On completion of this training ALL Participants will be able to:

1. Understand and apply the key elements of the Transformative Agenda and Humanitarian Reform in WHO and the implications for the Health Cluster.

2. Describe the role of the Global Health Cluster in facilitating access to information, guidance and tools.

3. Describe, understand and implement the 6 Core Cluster Functions at national and sub national level.

4. Describe and understand the key roles and responsibilities of the Health Cluster Coordinator and Information Management Officers and how these link to other Health Cluster roles at country level.

5. Gain knowledge and understanding about collaborative leadership styles.

6. Identify and reflect on their own preferred styles of leadership and the areas they need to further develop and strengthen

In addition Information Management Officers will also be able to:

7. Implement and manage core field based information management tools

8. Describe, understand and implement the Public Health Information Services core quality standards

The specific learning objectives and key messages for each session and training components, including the Simulation Exercise, were based on the Health Cluster Coordination Competency Framework and the structure of the training followed the Humanitarian Programme Cycle:

- Needs Assessment and Analysis
- Strategic Response Planning
- Resource Mobilization
- Implementation and Monitoring
- Review and Evaluation

And the six core functions of a Cluster at the country-level:

- Supporting Service Delivery
- Informing Strategic Decision making of the HCT
- Planning and Strategy Development
- Advocacy
- Monitoring and Reporting
- Contingency Planning, Preparedness and Capacity Building

4. Strengthening Competencies

The Global Health Cluster Capacity Development Task Team, in collaboration with the Global Health Cluster Public Health Information Services Task Team, has developed a Health Cluster Coordination Competency Framework (HCC CF) which is in the final stages of receiving endorsement from the Global Health Cluster Strategic Advisory Group for a scheduled launch before the end of 2016. The HCC CF aims to be inclusive of the priorities, approaches and structures of the different members and organizations that carry out Health Cluster activities in emergency situations. It identifies eleven functional competencies with specific examples of behaviours, each of which have been grouped into domains that are reflective of the stages of the Humanitarian Programme Cycle stages and the Cluster Functions at Country Level. The Competency Framework also

contains ten competencies that are personal, rather than role-specific, in nature. **Please see Annex 1 for the HCC CF.**

During and after this training Participants had the opportunity to work on, strengthen and receive feedback on three of the personal competencies which they identified as a high priority for their own professional development. Eight Team Facilitators observed these competencies in up to 6 Participants during the training and SIMEX activities and produced a short report with positive and constructive feedback on each of these competencies. This report was sent to the Participants shortly after the training, with an optional opportunity to discuss this feedback with the Team Facilitator by means of a 30 minute phone or skype call. **Please see Annex 6: Personal Competencies Observation and Feedback Form.**

5. Training Design and Methodology

The training was designed by the Global Health Cluster Capacity Building Task Team and the Public Health Information Services Task Team, and other members of WHO staff by means of a Joint Training Working Group (JTWG), The JTWG is a time limited group set up specifically for the purpose of designing, coordinating and delivery a training event. The JTWG had three face to face meetings between May and September 2016 and bi weekly teleconferences. The Health Cluster Coordination Training also built on the recommendations in the Health Cluster Professional Development Initial Findings and Recommendations November 2014, the experience of relaunching Health Cluster Coordinator Training in Divonne-Les-Bains France in September 2015 and the planning which had already been carried out for the postponed Health Cluster Coordinator Training scheduled for July 2016.

This eight day training programme contained a blend of didactic and practical sessions, including desk top exercises and a two day simulation exercise, and closely followed the Humanitarian Programme Cycle.

The agenda, content and methodology was designed in order to ensure that there was a good balance between technical knowledge and theoretical input from Trainers and Facilitators, and practical sessions in order to share experience, to apply learning, enable reflection and to receive feedback on performance and outputs.

In order to ensure high levels of attention, concentration, reflection, retention and application most of the more didactic/theoretical sessions took place in the morning and most of these sessions also had short practical group work exercises. This balanced and blended approach to learning ensured that the training was building on good learning practice and the training methodologies responded to a wide range of learning styles.

Compulsory Pre Reading

The Participants were asked to ensure that they had completed the following pre-readings before starting the training. Pre-reading was kept to a minimum in recognition of response priorities and high workloads.

- Reference Module for Cluster Coordination at the Country Level (June 2015)
- Humanitarian Programme Cycle Reference Module Version 1.0 (June 2015)
- Multi-Sector Initial Rapid Assessment Guidance - Revision (July 2015)

- Accountability to Affected Populations Operational Framework

6. The Training Agenda

The training agenda consisted of a combination of joint sessions for Health Cluster Coordinators and Information Management Officers, separate sessions for each Cadre and team sessions for small mixed groups to apply learning and to prepare for and take part in the Simulation Exercise.

There were two versions of the agenda: one for Participants, and a more detailed agenda for the Training Team.

6.1. The Participants Training Agenda

	Time	Sat 5	Day 1 Sun 6	Day 2 Mon 7	Day 3 Tues 8	Day 4 Wed 9	Day 5 Thurs 10	Day 6 Fri 11	Day 7 Sat 12	Day 8 Sun 13
		Activity	Session	Session	Session	Session	Session	Session	Session	Session
Morning Session	8.30 - 10.15	. Arrival of Participants . Hotel Check-in	1.1. Updates from the Global Level	2.1. The Public Health Information Services Standards	3.1.Humanitarian Response Planning	4.1. Resource Mobilisation: Donor relations and humanitarian health funding	5.1.. Humanitarian Health Response Monitoring - field based information systems	6.1. Contingency Planning, Preparedness, readiness and capacity building (PPE)	7.1. SIMEX	8.1. SIMEX
			Break	Break	Break	Break	Break	Break	Break	Break
	10.45 - 12.30	. Arrival of Participants . Hotel Check-in	1.2. Health Cluster Coordination Overview Critical Health Cluster issues	2.2.Needs assessment and analysis	3.2. Humanitarian Response Planning con't	4.2. Resource Mobilisation: Project development and monitoring	5.2. Humanitarian Health Response Monitoring - field based information systems con't	6.2. Advocacy with Key Stakeholders	7.2. SIMEX	8.2. SIMEX finished at 1100
			Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
Afternoon Session	13.30 - 15.15	. Arrival of Participants . Hotel Check-in	1.3. The Principles of Coordination and Partnerships	2.3. Needs asssessment and analysis (cont'd)	3.3. Information Management Officers - PRIME 3.3. Health Cluster Coordinators - Inter Cluster Coordination	4.3. Infomration Management Officers - 3W & HeRAMS 4.3. Health Cluster Coordinators - Cross Cutting Issues (Diversity, AAP)	5.3. Inforamtion Management Officers - EWARS (Surveillance) 5.3. Health Cluster Coordinators- Transition and Clusters Deactivation	Friday Break	7.3. SIMEX	8.3.Simex and Team debriefs Final Evaluations
			Break	Break	Break	Break	Break	Break	Break	Break
	15.45 - 18.00	. Arrival of Participants . Hotel Check-in	1.4. Collaborative Leadership	2.4. Joint Desk top exercsie on needs assessment (based on Simex)	3.4. Joint desk top exercise on HRP (based on Simex)	4.4. IMOs HeRAMS on PRIME 4.4. HCCs CERF exercise	5.4. IMOs - EWARS (Alert) 5.4. HCCs - Peer Exchange on coordination dilemnas	6.4. Start of SIMULATION EXERCISE and SIMEX schedule	7.4.SIMEX	8.4. Final Evalutations, Plenary session, certificates and closing of training
			Break	Break	Break	Break	Break			Training closed at 1700
Evening	1900 - 2000	1800- 1930 Welcome Reception - Registration - Introductions - Expectations - Training Overview	1.5. Team Building (Practical activity)	Free Evening	Optional Clinics 1. PRIME 2. Cluster vs Sector Coordination with Training Team	Free Evening	Optional Clinics 3. 3W Analyser 4. AAP 5. Further Journeys in Leadership	6.5. SIMEX	7.5. SIMEX	Participants depart

6.2. The Training Teams Training Agenda

	Time	Sat 5	Day 1 Sun 6		Day 2 Mon 7		Day 3 Tues 8		Day 4 Wed 9		Day 5 Thurs 10		Day 6 Fri 11		Day 7 Sat 12		Day 8 Sun 13	
		Activity	Session	Trainers	Session	Trainers	Session	Trainers	Session	Trainers	Session	Trainers	Session	Trainers	Session	Facilitators	Session	Facilitators
Morning Session	0830 - 0845		Facilitator Perry Seymour		Facilitator Gillian O'Connell		Facilitator Perry Seymour		Facilitator Gillian O'Connell		Facilitator Perry Seymour		Facilitator Gillian		Simex Manager Heini Utunen		Simex Manager Heini Utunen	
	8.45 - 10.15	Training Team meeing	1.1. Updates from the Global Level - Emergency Reform Humanitarian Architecture (TA) WHS - 5 committiments	Linda Doull, Ahmed Zouiten & Brian Tisdall	2.1. PHIS Standards	Olivier le Polain	3.1.Humanitarian Response Planning - Role of HCC .Cluster response plans/Strategic Objectives . Promoting standards . Activity based Costing - refer to but not in detail	Ahmed Zouiten	4.1. Resource Mobilisation: Donor relations and humanitarian health funding (ERX) . Introduction to humanitarian funding . Donor relations . Donor communication top tips	Faisal Yousaf	5.1. Humanitarian Health Response Monitoring	Francesco Checchi	6.1. Contingency Planning, Preparedness, readiness and capacity building (PPE)	Ahmed Zouiten	7.1. Simex	Simex Team	8.1. Simex	Simex Team
			Break		Break		Break		Break		Break		Break					
	10.45 - 12.30	Final Prep	1.2. Health Cluster Coordination Overview Critical Health Cluster issues Cluster activation/deactivation . Roles, responsibilities and functions of the Health Cluster . Structure of the ideal cluster team . Deliverables of the Health Cluster at country level . Performance Standards (PHIS) - signposting . Humanitarian Program Cycle	Ahmed Zouiten and Linda Doull	2.2. Needs assessment and analysis	Francesco Checchi	3.2.. Humanitarian Response Planning con't . Choosing indicators . Compiling and presenting an indicator registry . Weekly and monthly monitoring	Ahmed Zouiten	4.2. Resource Mobilisation: Project development and monitoring . Project development . Monitoring and reporting . Prioritization . Vetting proposals . Quality programming	George Petropolous (OCHA)	5.2. Humanitarian Health Response Monitoring (45 mins) CCPM (60 mins)	Francesco Checchi (HHRM) Ahmed Zouiten (CCPM)	6.2. Advocacy with key Stakeholders, e.g. - Attacks on Health Workers - SGBV - Adpative programming	Brian Tisdall and particpants	7.2. Simex	Simex Team	8.2. Simex finished at 1100	Simex Team
			Lunch		Lunch		Lunch		Lunch		Lunch		Lunch		Lunch		Lunch	
Afternoon Session	13.30 - 15.15	. Arrival of participants . Hotel Check-in . Registration	1.3. The Principles of Coordination and Partnerships	Linda Doull	2.3.Needs assessment and analysis	Francesco Checchi	3.3. PRIME 3.3. HCCs - Inter Cluster Coordination	Samuel Petragallo Linda Doull	4.3. 3W/HeRAMS 4.3. HCCs - Cross Cutting Issues	Samuel Petragallo Ahmed Zouiten	5.3. EWARS - Surveillance 5.3. HCCs - Tranistion/deactivation of Clusters	Chris Haskew & Niluka Wijekoon Kannangarage Linda Doull	Friday Break		7.3. Simex	Simex Team	8.3.Simex Technical Feedback to whole group - 45 mins - Simex Team de briefs x 2 and final evaluation 30 mins	Gillian O'Connell and Training Team
			Break		Break		Break		Break		Break		Break		Break		Break	
	15.45 - 1730	. Arrival of participants . Hotel Check-in . Registration	1.4. Collaborative Leadership Reflection Group - How is my leadership style? (45 mins)	Perry Seymour	2.4. Joint Desk top exercsie on public health situation analysis (based on Simex)	Olivier le Polain and Francesco Checchi	3.4. Joint desk top exercise on HRP (based on Simex)	Ahmed Zouiten	4.4. HeRAMS on PRIME 4.4. HCCs - CERF	Samuel Petragallo Ahmed Zouiten	5.4. EWARS - Alert 5.4. HCCS -Peer Exchange on coordination dilemnas	Chris Haskew and Niluka Wijekoon Kannangarage Ahmed Zouiten	6.4. Start of SIMEX and Simex schedule	Simex Team	7.4.Simex	Simex Team	8.4. Simex Team debrief x 2, Final on line evaluation - 30 mins Followed by whole group plenary Q&A - 45 mins Certificates and closing of training - 15 mins	Gillian O'Connell Training Team
	17.30 - 18.00		End of day review -daily evaluations - Navigation group feedback Parking lot reminder	Perry Seymour	End of day review	Gillian O'Connell	End of day review	Perry Seymour	End of day review	Gillian O'Connell	End of day review	Perry Seymour					Training closed at 1700	
	18.00 - 18.30		Break		Break		Break		Break		Break		Break		Break			
	1830 - 1900		TT Meeting		TT Meeting		TT Meeting		TT Meeting		TT Meeting		TT Meeting		TT Meeting			
Evening	1900 - 2000	1800 - 1930 Welcome Reception Opening of training, welcome and introductions, overview of training, expectations,	1.5. Team Building	Gillian O'Connell and Gerbrand Alkema	Free Evening		Clinics 1. Prime 2. Cluster vs Sector Coordination	Samuel Petragallo Ahmed Zouiten	Free Evening		Clinics 1. 3W Analyser 2. AAP 3. Further Journeys in Leadership	Emma Fitzpatrieck Perry Seymour	6.5. Simex	Simex Team	7.5. Simex	Simex Team	1730 - 2030 Training Team debrief	

Legend	Training Team Meeting	Welcome Reception	Whole group	Split grroup	Team DTE/SIMEX Rooms	Clinics

Clinics

The training agenda contained two one hour evening slots for Clinics on topics mainly identified by the Participants. These optional sessions were an opportunity to go deeper into areas covered in the main agenda. With the exception of a session on PRIME the topics were based on suggestions identified by the Participants and which the Training Team were able to provide or support. One clinic was provided by a Participant. The Clinics were well attended and positively received by the Participants, and were as follows

Clinic	Led by	Number attending
PRIME	Samuel Petragallo	20
Cluster Vs Sector Coordination	Ahmed Zouiten	10
3W Analyser	Syed Haider Ali - ***Participant IMO from Yemen***	19
Accountability to Affected Populations – A People Centred Approach	Emma Fitzpatrick	8
Further Journeys in Leadership	Perry Seymour	5

Faisal Yousaf also provided a Clinic over lunch on Day 5 on Budgeting which was attended by two Participants. This topic had been requested by the Participants.

7. The Participants

The training was attended by 42 Participants with a wide range of experience, and who represented EMRO (28), AFRO (10), EURO (3) and SEARO (1) WHO regions. There were 25 current or potential Health Cluster Coordinators and 17 Information Management Officers. 29 were working for WHO and 13 were working for INGOs, 10 of the latter were working for the six members of the NGO Consortium Health Cluster Support Programme led by Save the Children UK, i.e. GOAL, Malteser International, MEDAIR, Premier Urgence International, Save the Children UK and World Vision International. The other three INGO Participants were from IRC (2) and NRC (1. There were 32 male and 10 female Participants.

	Health Cluster Coordinators	Organisation	Current Position	WHO Region
1	AL SHAMI, Reem	IRC		EMRO
2	AL NAGGAR, Mohammed	WHO	Sub National Health Cluster Coordinator	EMRO
3	AL SOOFI, Ahmed	WHO	Sub National Health Cluster Coordinator	EMRO
4	ARMAH, Magda	WHO	Health Cluster Coordinator	AFRO
5	AWADH, Eman	WHO	Sub National Health Cluster Coordinator	EMRO
6	BWALE, Pierre	Medair		AFRO
7	CALDERON ORTIZ, Mauricio	WHO	Coordinator	EMRO
8	CRAGIN, Will	WHO	Health Sector Co-Lead	EMRO
9	GOCOTANO, Allison	WHO	Sub National Health Cluster Coordinator	SEARO
10	GUYO, Argata Guracha	WHO	Sub National Health Cluster Coordinator	AFRO
11	HRYCKOW, Natascha	WHO	Surge Capacity - Consultant	EMRO
12	KHAN, Sardar	WHO	Health Cluster Coordinator	EMRO
13	LAI, David	World Vision International		AFRO
14	LARKIN, Mary	Première Urgence International		AFRO
15	RAHEEM, Abdulrahman	WHO		EMRO
16	LUKWIYA, Michael	WHO	National Professional Officer	AFRO
17	MAYOUFI, Mouna	IRC		EMRO
18	MENGISTU, Abebayehu	WHO	Deputy Emergency Coordinator	AFRO
19	NAIDU, Uday Raj	GOAL		AFRO
20	OKHOWAT, Ali	WHO	Technical Officer	EMRO
21	OLLERI, Kamal	WHO	Health Cluster Coordinator, a.i.	EMRO
22	AHMED, Abdihamid	Save the Chidren International	SCI Cluster Co-Lead	EMRO
23	SHIHAJI, Wilbert	Malteser International		AFRO
24	STEPHEN, Mary	WHO	National Professional Officer	AFRO
25	VALDERRAMA, Camilo	WHO	Health Cluster Coordinator	EURO
	Information Management Officers	**Organisation**	**Current Position**	**WHO Region**
1	ALI, Syed Haider	WHO	Information Management Officer	EMRO
2	ALGHRAIRI, Mohamedsabri	WHO		EMRO
3	ANNUH, Seth	Malteser International		AFRO
4	ASSI, Moubadda	WHO		EMRO
5	BOSHARA, Mohamed Abdalla	WHO	Information Management Officer	EURO
6	GAI, Malick	WHO	Information Management Officer	AFRO
7	HALIMAH, Sara	WHO	Technical Officer	EMRO
8	KARRAR, Eiman	WHO	National Professional Officer	EMRO
9	KIPTERER, John	World Vision International		EMRO
10	LUKWIYA, Bernard	Goal		EMRO
11	MASSIDI, Christian	WHO	Data Manager	AFRO
12	MVERECHENA, Stancelous	NRC		EMRO
13	NORE, Amar	WHO	IM Specialist	EMRO
14	ODUOR, Bernard	Goal		AFRO
15	RADYSH, Ganna	WHO	National Professional Officer	EURO
16	SAFI, Dawran	WHO		EMRO
17	TOURE, Ousmane Boubacar	WHO	Data Manager	AFRO

Teams

The Participants were allocated to four desk top exercise and SIMEX teams based on their role, region and gender.

Participants Expectations

Before the training started the Participants were asked to identify their top three expectations of the training. Thirty seven Participants sent in their expectations in via Moodle. These were reviewed by the Training Team on the 5 November and responded to during the Welcome Reception. There were only two expectations not covered by the training, i.e. that there would be an immediate follow up to this training and that the link between a humanitarian response and longer term development programming would be addressed,

7.1. The Participants Pack

Information for Participants before, during and after training was shared on Moodle. Moodle is a learning platform designed to provide educators, administrators and learners with a single robust, secure and integrated system to create personalised and training specific learning environments. This information included Participant and Training Team profiles, visa and venue information/logistics, personal competencies selection, expectations, essential pre-reading, learning and training materials and evaluation tools.

A copy of a Participant Pack with all of this information in one downloadable document was also available on Moodle and is in **Annex 4.**

8. The Trainers and Facilitators

The training and facilitation was coordinated and conducted by the Joint Training Working Group, in close collaboration with the Global Health Cluster Unit, the Capacity Development Task Team, the Public Health Information Services Task Team and other WHO/ERM units. A Guest Speaker from OCHA, George Petropoulos, also supported the training.

The technical content of the training was under the direction of Global Health Cluster Coordinator Linda Doull, Global Health Cluster Medical Officer Ahmed Zouiten, Public Health Information Services Task Team Chair Olivier le Polain and former Public Health Information Services Task Team Chair Francesco Checchi.

The overall facilitation of the training, including guidance on the learning and development aspects, was provided by Global Health Cluster Learning and Development Consultant and Capacity Development Task Team Co Chair Gillian O'Connell and NGO Consortium Health Cluster Support Programme Learning and Development Consultant Perry Seymour.

The SIMEX Manager was Heini Utumen, with support from Louise Atkins and Ursula Zhao. NGO Consortium Health Cluster Support Programme Manager Sian Watters and GOARN Staff Development Officer Renée Ann Christensen also supported the SIMEX.

Additional technical input and curriculum development advice was provided by members of the Joint Training Working Group, this included Christopher Haskew and Niluka Wijekoon Kannangarage from WHOs Health Operations Monitoring and Data Collection, Health Information Management Team, Emma Fitzpatrick Consultant with the Global Health Cluster who were present for the full duration of the training.

The Secretariat was coordinated and provided by Carolyn Patten- Reymond, Administrative Assistant - Global Health Cluster.

The Training Team		
Name	**Organisation**	**Position**
Ahmed Zouiten	WHO/GHCU	Medical Officer, Global Health Cluster
Banan Kharabsheh,	WHO/Jordan	Communications
Brian Tisdall	WHO	EMRO - Regional Adviser
Carolyn Patten-Reymond	WHO	Administrative Assistant - Global Healt Cluster
Christopher Haskew	WHO	Health Operations Monitoring and Dat Collection, Health Informatic Management
Emma Fitzpatrick	WHO/GHCU	Consultant Global Health Cluster
Faisal Yousaf	WHO	External Relations Office Resource Mobilization and Extern Relations
Francesco Checchi	Independent Consultant	Public health specialist with expertise epidemiology and disease control armed conflict and natural disaster setting
Gerbrand Alkema	Save the Children UK	Health Cluster Support Expert
George Petropoulos	OCHA	Head of Programs and Operations f OCHA Country Based Pooled Fund (CBPFs)
Gillian O'Connell	WHO Consultant	Learning and Development consultant f GHC. Co-lead of the Capaci Development Task Team
Heini Utunen	WHO	Technical Officer, Knowledge Transfer f Outbreaks. Department of Pandemic an Epidemic Diseases. Outbreaks and Healt Emergencies Cluster
Linda Doull	WHO/GHCU	Global Health Cluster Coordinator
Louise Atkins	WHO	Technical Officer (Surge) Surge and Cris Support Unit
Niluka Wijekoon Kannangarage	WHO	Health Operations Monitoring and Dat Collection, Health Informatic Management.
Olivier Le Polain	Public Health England	Public health specialist registrar
Perry Seymour	Save the Children UK - Consultant	Humanitarian Learning & Developmer Consultant
Renee Christensen	WHO	Global Outbreak and Response Network
Samuel Petragallo	WHO	Data Manager - Decision Support Systems
Sian Watters	Save the Children UK	NGO Consortium Health Cluster Suppo Programme Manager
Ursula Zhao	WHO	Technical Officer Pandemic and Epidemic Diseases

Two sessions were co-facilitated by Participants:

- Ali Okhowat Health Cluster Coordinator from Egypt/Cairo – Session 6.1. Contingency Planning, Preparedness and Capacity Building,

- Camillo Valderrama Health Cluster Coordinator from Turkey/Gaziantep and Mohamed Abdalla Boshara Information Management Officer: - Session 6.2. Advocacy with Key Stakeholders/Attacks on Health Workers

Both sessions very highly rated by the Participants and the JTWG would like to increase Participant involvement in session facilitation in future trainings.

Please see Annex 3: The Training Team Matrix for a more detailed breakdown of the Trainers and Facilitators for each session.

9. The Simulation Exercise (SIMEX)

The two day SIMEX scenario was based on a real protracted crisis with small changes to accommodate the training context. The same scenario was also the basis for practical sessions and desk top exercises in the preceding training, and the SIMEX itself started with an escalation of this crisis.

The aims of the SIMEX were to:

- Build and strengthen the capacity of Health Cluster Coordination Teams to lead and coordinate the planning, implementation and monitoring of more effective, efficient, timely and predictable evidence based humanitarian health interventions in the field over 15 days following the onset of a large scale emergency.

- Practice and reintegrate what has been learned in the training.
- Experience Health Cluster functions in different stages and deliverables related to an emergency situation.

The specific objectives of the SIMEX were to:

- Demonstrate knowledge of the Emergency Response Planning and Humanitarian Program Cycle.
- Apply field skills, including team work, self and stress management, working under pressure, and an understanding of the code of conduct and ethics.
- Build on and exercise professional and interpersonal skills of increasing importance: learning how to handle diverging views, positions, interests and values, networking techniques, negotiating skills.

During the previous practical sessions and desktop exercises the Participants developed the following documents:

- A yearly Humanitarian Needs Overview
- Strategic objectives and detailed activities
- A strategic response plan including a monitoring framework.
- A CERF proposal

The following drills also took place with a set of deliverables which built on the earlier learning activities:

- Organizing a Needs Assessment exercise
- Participating in a Needs Assessment Mission
- Strategic Response Plan
- Presenting the Cluster Response Plan to the Ministry of Health
- Resource Mobilisation – Donor Conference
- Implementation, Monitoring and Evaluation

Members of the Training Team took on the roles and provided feedback on the deliverables throughout the SIMEX.

10. The Evaluation of the training

10.1. Feedback from Participants

Feedback was collected from the Participants throughout the training by means of:

- Daily feedback from participant representatives in short navigation meetings with the Training Facilitators at the end of days 1 to 6. This feedback was immediately fed back to the Training Team in the daily Training Team meetings and acted upon where possible and appropriate.
- A "Parking Lot" for questions and queries which were unanswered or nor addressed in the sessions, the questions were mostly responded to the following day in plenary by the appropriate member of the training team.
- On line evaluation forms for days 1 – 6.
- On line feedback on the whole training and SIMEX on the last day
- A SIMEX debrief with all Participants in plenary and in their teams

Feedback from the Participants

The feedback from the Participants was very positive and showed high levels of Participant satisfaction with the quality of the training. Participants rated the training overall at **4.6 out of a maximum rating of 5**, and provided constructive feedback throughout the training. The training was rigorously evaluated and provides many examples of how the Participants intend to use and apply their learning, and provides a firm foundation for developing and strengthening future training for Health Cluster Coordination Teams. Feedback was collected from the Participants on a wide range of areas and the full results can be found on Moodle in the section for the Training Team. The full feedback will be referred to by the JTWG when planning and designing future trainings. The content of the evaluation tools and the feedback collected is in **Annex 5**.

The rating scale for charts 1, 2 and 3 was:

5 = Excellent 4 = Good 3 = Average 2 = Poor 1 = Unacceptable

Chart 1: Final Overall rating by Cadre

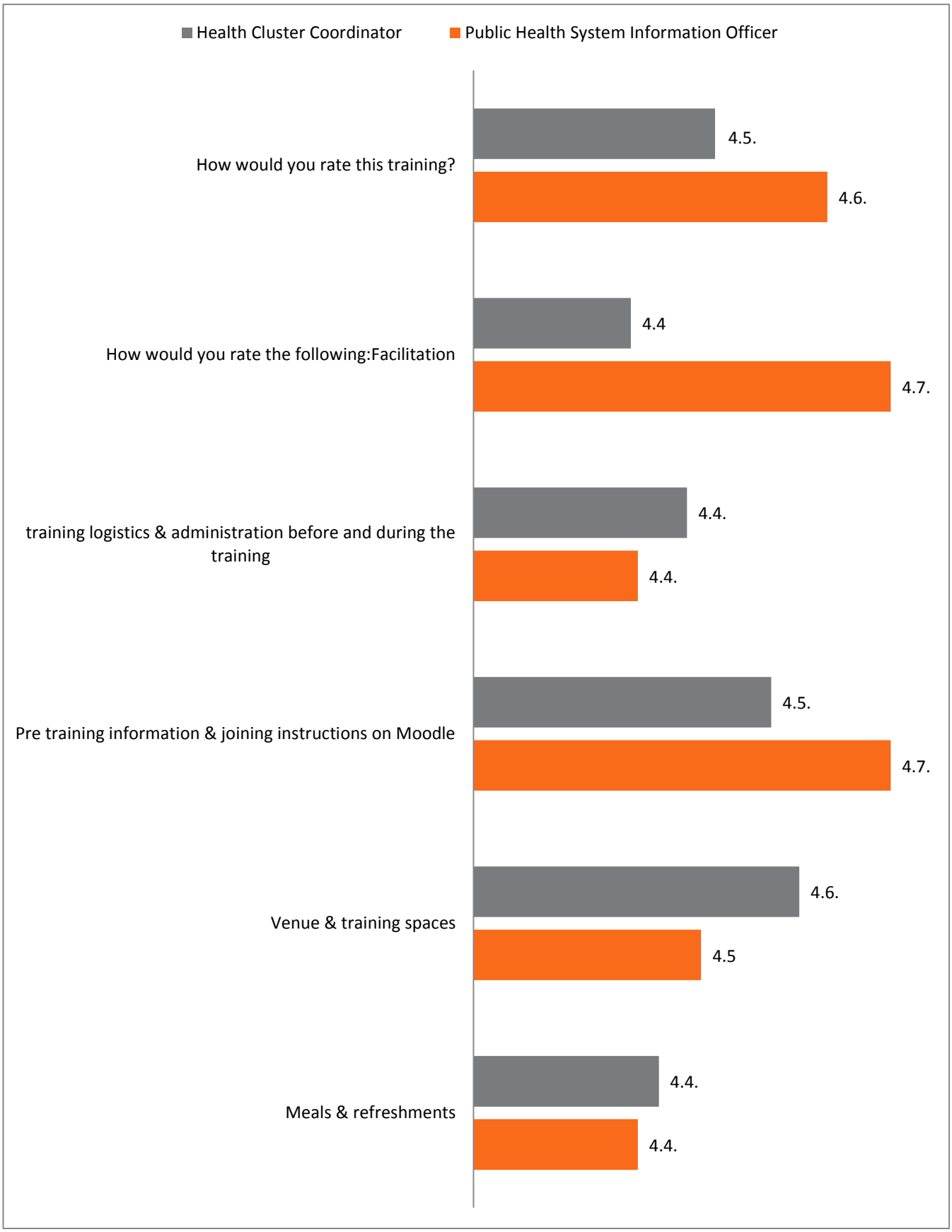


Chart 2: Final Overall Rating by Team

Teams: The Participants were allocated to four desk top exercise and SIMEX teams based on role, region and gender. The results show that some teams rated elements of the training more highly than others but the feedback tools did not enable a full analysis as to why.

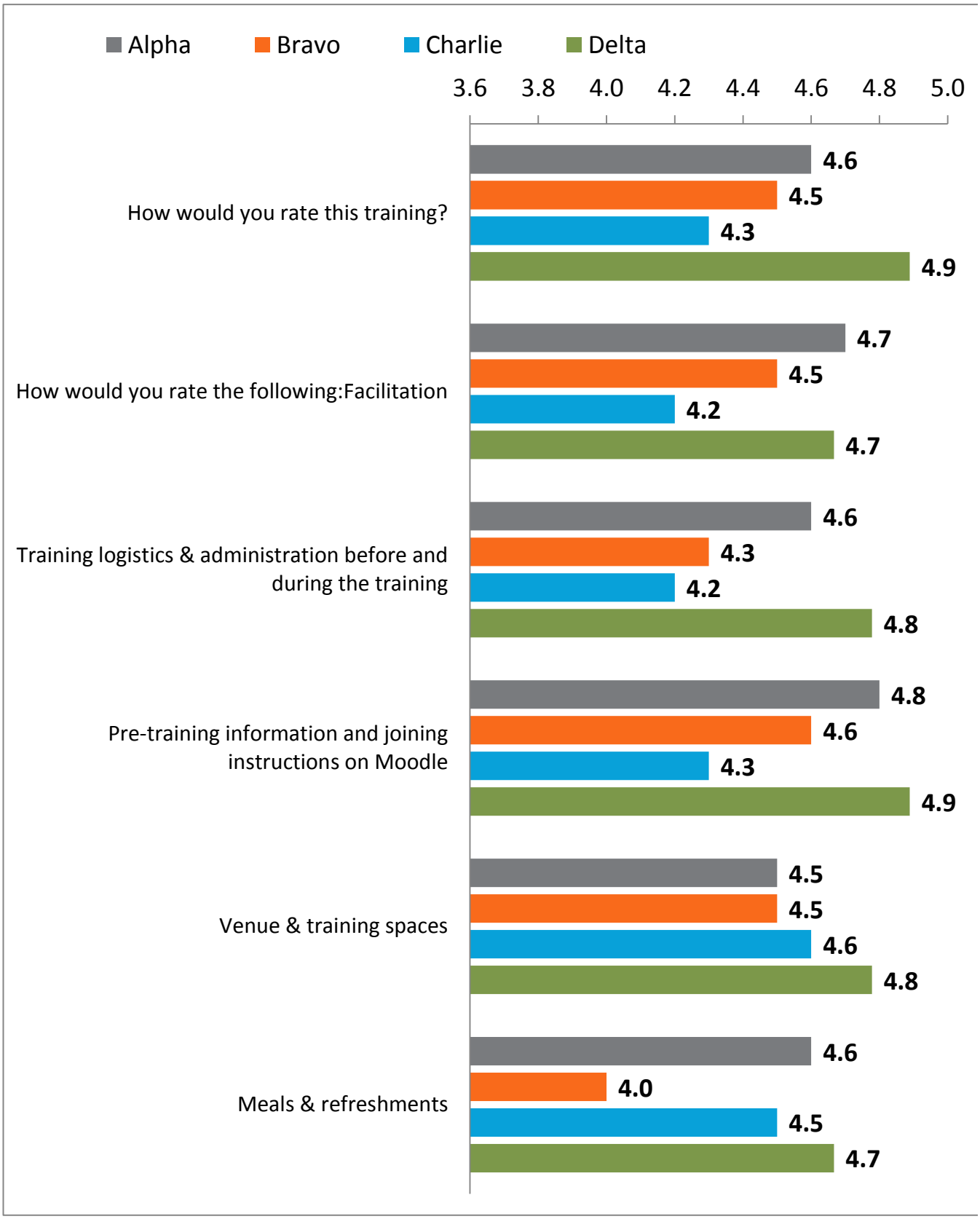


Chart 3: **Relative ratings of each session in Days 1 – 6**. Please note some of the Clinics were not included in the daily evaluation forms.

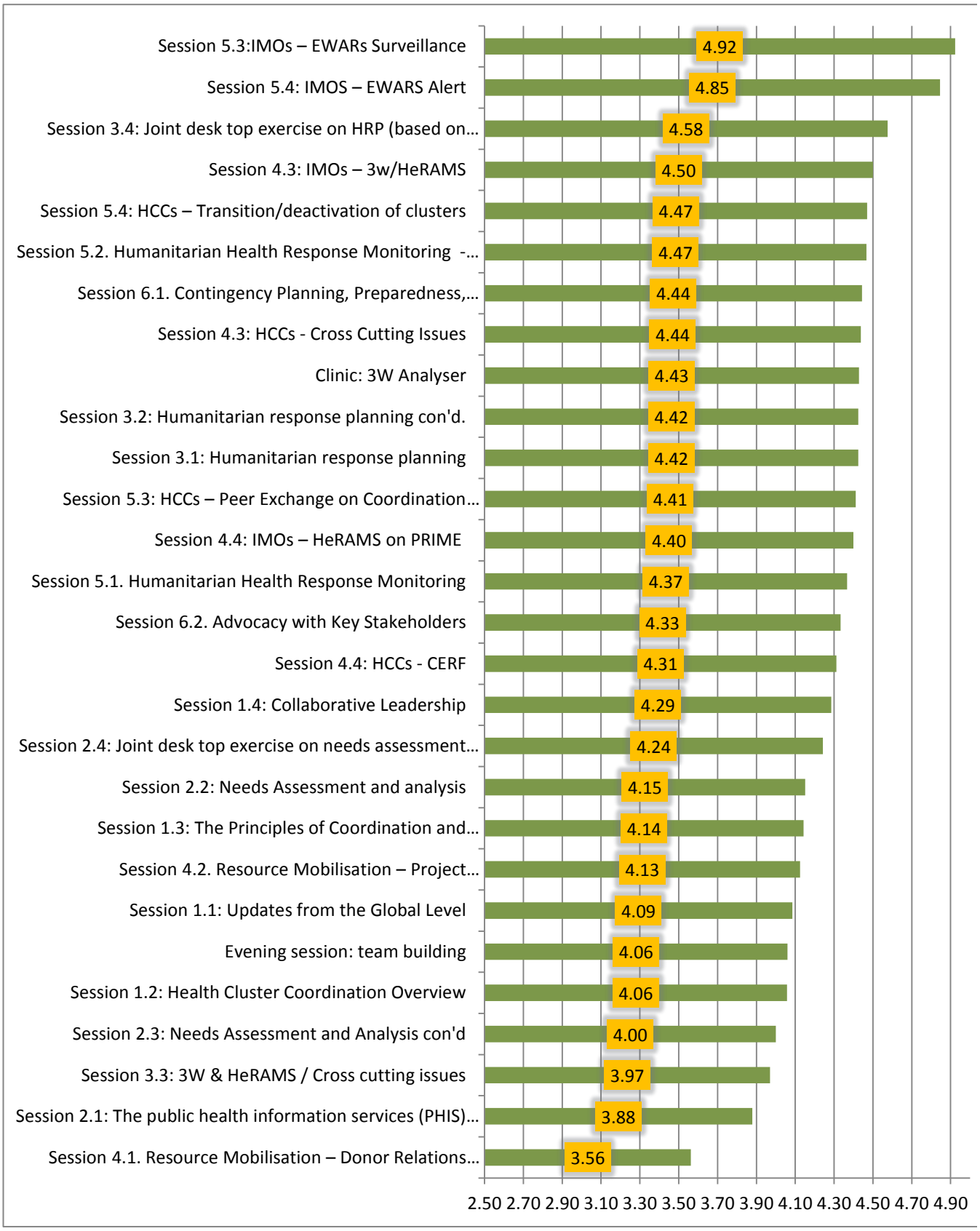
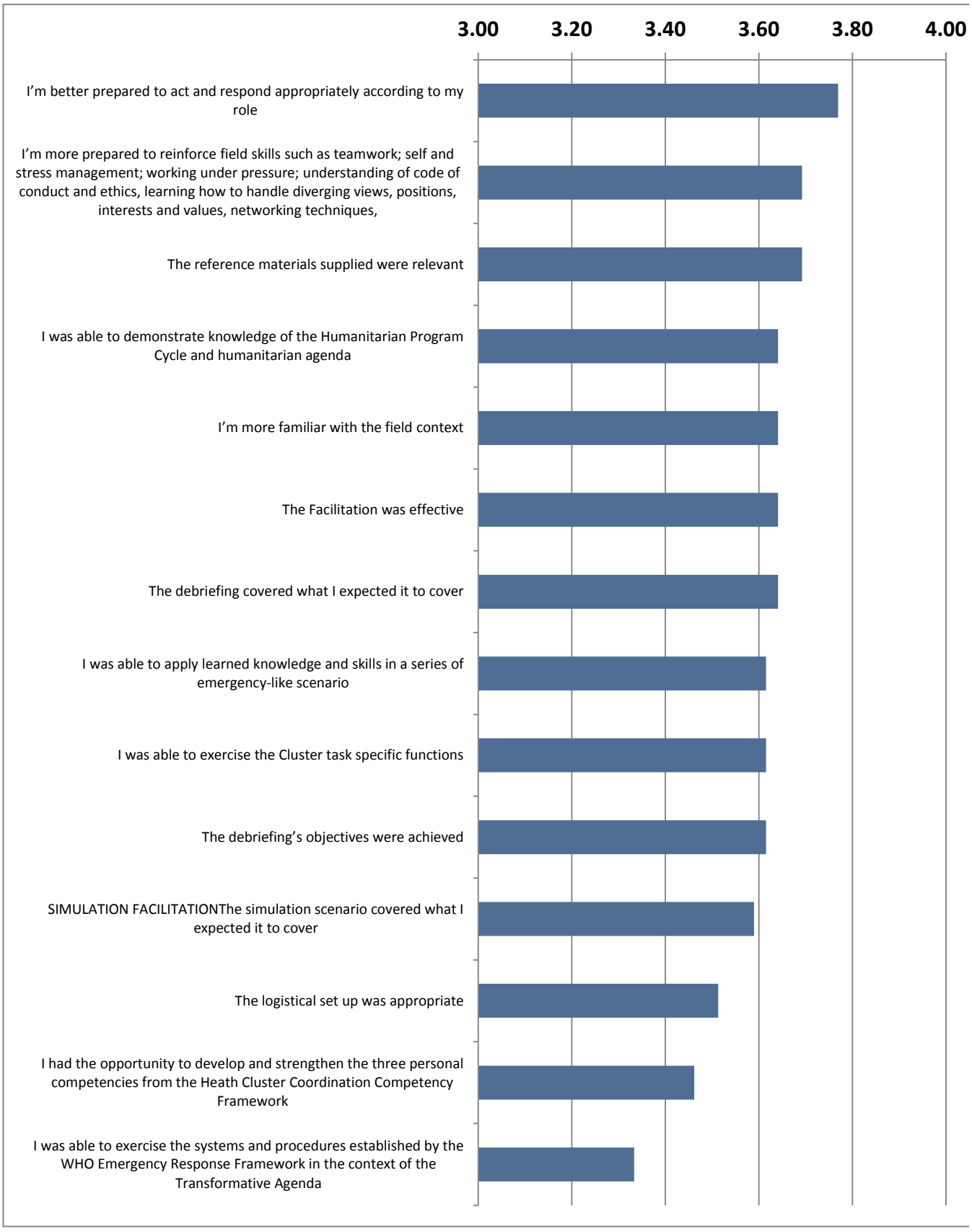


Chart 4: Feedback from the Participants on the SIMEX

The SIMEX used a different rating scale and was based on: 1 – Strongly Disagree, 2 Disagree, 3 Agree, 4 Strongly Agree. The chart below shows agreement with all of the statements.



In the final evaluation the Participants were also asked:

Q. Were any critical themes missing or inadequately addressed? If yes, which ones?

There was a very little consistently in the responses to this, the feedback which received more than one mention was:

Feedback	Number of times mentioned
More on Advocacy	3
Negotiation Skills	3
Role and Responsibility of the Lead Agency and Co - Leads	3
More Case Studies and good practice examples	3

Q. How could we improve future trainings?

Most of the comments were very positive and showed very high levels of Participant satisfaction with the training. Constructive feedback was received on the following:

Feedback	Number of times mentioned
Shorten the training	2
Increase the duration of the training	1
Have more time for feedback on the SIMEX outputs	1
Provide follow up training and guidance on use of tools	1
Repeat the training in AFRO	1
Provide good practice examples	1
Review the mandatory readings and ensure sessions do not repeat the content unnecessarily	1
Have more on gender mainstreaming	1
Reduce team size for desk top exercises and SIMEX	1
Have EWARS super users	1
Room was too cold! Have a social event at the end of the training.	1
More time to see surrounding areas	1

10.2. Pre and Post Training Questionnaire

The Participants were asked by email to complete a 45 minute pre training questionnaire on arrival at the venue. The questionnaire consisted of 34 questions which were designed to test the knowledge base expected of all Participants. It had been planned to repeat this questionnaire with the same questions on the last afternoon of the training with all Participants at the same time in order to measure the immediate impact of the training on this knowledge base. However, due to technical problems it was not possible for the Participants to access the questionnaire and the link was sent to the Participants the day after the training.

The Results

Forty-one of the 42 Participants completed the pre-training questionnaire, with a median score of 21.57. The maximum possible score was 34.

However only 16 Participants completed the post- training questionnaire (one of which was the person that did not complete the pre-questionnaire) with a median score of 22.86

Of the 15 comparative results the pre-questionnaire the median score was 22.06 and the post- questionnaire score was 23.6.

So the results are not able to give a reliable measure of the impact on the training on the knowledge base of Participants.

10.3. Feedback from the Training Team

The Training Team met at the venue after the training finished at 1730 on 13 November 2016.

The meeting was attended by: Ahmed Zouiten, Banan Kharabsheh, Carolyn Patten-Reymond, Christopher Haskew, Emma Fitzpatrick, Francesco Checchi, Gerbrand Alkema, Gillian O'Connell, Heini Utunen, Linda Doull, Louise Atkins, Niluka Wijekoon Kannangarage, Olivier le Polain, Perry Seymour, Renee Christensen, Sian Watters, Ursula Zhao

The Agenda

1. A facilitated review of what went well and what needs to changed regarding the:

    - Joint training model
    - The Health Cluster Coordinator sessions
    - The Information Management Officer sessions
    - The SIMEX

2. A review of feedback from the Participants final evaluation

3. Recommendations to the Capacity Development Task Team and Public Health Information Services Task Team **(please see Section 12)**

1. **The feedback from the review by the Training Team was as follows:**

The Joint Training Model	
What went well	**What needs to be improved**
The pilot is done!	IMOS/HCC/SIMEX – needs better "alignment"
Great to share experience	Needs more curriculum development to avoid silos
Structure of the training overall - OK	More shared learning
Brought us staff together	Consider public health profile for joint model - EPI
Products were tested	Fine tuning tasks/contents for SIMEX
Logistically smooth	More on leadership and communication
Learnt from each other and the two roles and relationships	Donor engagement, community relations, ICC and pitching health
Group size seemed to be managed well	Be clear on roles
Builds Health Cluster community	Clear intro at beginning about what course can/can't deliver (competencies) and where it sits in broader L&D agenda
Enhanced profile of IMOs	
Improve the balance of HCC/IMO in the curriculum	

The Health Cluster Coordinator components	
What went well	**What needs to be improved**
Good sharing of experiences	Provide Community of practice – work streams CO-RO- HQ
It was realistic to their role	Work on real pending HRP
Good mix of WHO and partners	IMOs and HCCs - have some knowledge of Participants – cater to that, CVs
Some sub national Participants	Case studies
Great structure around the HPC	More clear lessons learned and best practice
Gained insight,knowledge and respect for IMOs	RM session should be more focussed and action orientated
	More needed on post resource mobilisation – "day to day" action
	Include AAP as a session – some kind of community focussed session PEOPLE
	More Public Health analysis
	Addressing/accommodating different levels of HCCs

The Information Management Officer components	
What worked well	**What needs to be improved**
EWARs – (enough to start)	PRIME /HERAMs/3W
Standards are starting to bring IMOs and HCCs together around common expectations	More practical
Encouraging the sharing of experiences	More practice (more hands on)
Worked well in this setting including SIMEX in a predictable manner	More depth/access and more indepth materials
Networking	Tools, templates, resources!
	Improve wider breadth of competencies, more coverage
	Don't overwhelm them, pre learning to bring them all to a level playing field on the residential
	Deliver trainings or adapt learning content/methods for different levels
	Less academic/more operational

The SIMEX	
What went well	**What needs to be improved**
Participants seemed engaged and it went well	Injects – need to be more detailed
The debriefs went well	Scripts, with highlighted learning objectives and competencies
Flexible and adaptable	Have more props/costumes
Well thought and realistic scenarios	Good to be flexible but structure is also good
Right workload	As a facilitator – deadlines/tasks weren't all done
Email responses to ad hoc requests	Rethink group size - 11/12 is too big
Timely and tailored feedback	Have model answers and less ad hoc feedback
It was well coordinated	Have more focussed link to competencies – testing what they were supposed to know
	Have IMO/HCC technical backstopping permanently on EXCON
	Add more blended methods
	IDP camp – have representative of the affected population

Other feedback from the Training Team
Needs to be a better IMO balance in the curriculum
Concern that the IMOs had been "silent" in some sessions e.g Desk Top Exercise on Humanitarian Response Planning
Refer to the PHIS standards more throughout the training
Make the IMO sessions more operational
Give more applications for PRIME
Make the 3Ws more realistic
Have more visuals and infographics
Avoid holding training in October and November - HRP season
Reinstate an introduction to the training at the start of the Day 1 – doing this all at the Welcome Reception meant that the training overview was not effectively covered
Need to set direct training event within the broader capacity development/learning and development agenda – and explain this to the Participants
High level negotiation skills should be in the agenda
Improve assessment of Participants beforehand
Have shorter days
Advocacy is very WHO centric – need to address this
The Clinics worked well and should be retained
Don't try to "trap"the Participants!
Use case studies and bring in best/good practice - some sessions were very theory orientated
Improve balance of Participants - have more partners – should be 50/50% WHO and Partners
Review Resource Mobilisation session – more action orientated
Have session on AAP
Add Co Leadership to the content of the training
Have more Public Health Analysis
Give "straighter" and more direct feedback to Participants
How do we address disagreement on content/key messages in the Training Team if it arises during a session
The SIMEX
Maybe we gave too many directions/instructions – should step back and see if Participants can generate their own work load – make own decisions
Outputs were good and some effective leadership was observed
Not always clear what was expected of the Participants and Training Team – have more clarity on learning outcomes
Recognise that learning is in the preparation and what the Participants learn from each other
Give feedback after each deliverable – link feedback to learning objectives and competencies – what did they learn and how did they learn it
Develop the role of the observers – they could do more! Have technical observers
ExCon Team should be dedicated to running the SIMEX – i.e. not playing roles
Have IMO Technical backstopping in ExCon
Have a tighter structure

11. Financial Report

The direct costs of this training for 42 Participants were are follows:

ITEM	COVERED BY	CURRENCY	AMOUNT	EXCHANGE RATE	AMOUNT US$
Venue	Save the Children UK	JOD	56698	0.708	80082
WHO Travel - including per diem (WHO staff/Consultant)	WHO	USD			119603
Save travel	SAVE	GBP	2200	0.8	1760
Consortium-covered travel	Consortium	GBP	4800	0.8	3840
Non Consortium NGO participation (estimated)	Consortium	GBP	1280	0.8	1024
Stationery	WHO	JOD	264	0.708	373
NGO Facilitator participation	Consortium	GBP	2200	0.8	1760
Consortium facilitators pre-training costs	Consortium	GBP	8000	0.8	6400
Consultant contract	WHO	USD			8400
					223242

This represents **a unit cost** per participant **of USD$ 5315.28**. Benchmarking this unit cost against similar length and level training provided by other providers suggests that this unit cost is a little high. However this has to take into account the quality of the resources committed to this training, particularly the high number and standard of trainers and facilitators.

It is also a significant reduction in the unit cost of USD$ 8254.65 for the 20 participants on the Health Cluster Coordination Training 14 – 20 September 2015, in Divonne-Les-Bains, France.

12. Recommendations from the Training Team Meeting on the 13 November 2016

1. To produce a Health Cluster Coordination training package, including an outline of the SIMEX, based on the session plans, content, learning and training materials and compulsory and recommended readings from this joint training pilot. This training package will be the foundation, with regular updates and refinements by the JTWG, for the design and content of future direct training events and the development of on line learning modules.

2. The Capacity Development Task Team to meet in December 2016 with representatives of the PHISTT in order to agree a joint training and learning plan for 2017, this plan will include direct training target groups, proposed dates and locations, and the introduction of on line learning and a mentoring programme for Health Cluster Coordinators and Information Management Officers.

3. To proceed with the development and implementation of Professional Development Pathways and Professional Development Plans for Health Cluster Coordinators and Information Management Officers in 2017.

Also:

4. To continue to use Moodle to support training coordination and administration, and Participant on boarding.