HEALTH CLUSTER

Credit: Iraq Health Cluster

Health Cluster Forum

Meeting Report

3-5 April 2017, Montreux, Switzerland

EXECUTIVE SUMMARY

The third annual Health Cluster Forum was held on 3-5 April 2017 in Montreux, Switzerland. Seventeen Health Cluster Coordinators (HCCs) and two Health Cluster Co-coordinators participated from five World Health Organization (WHO) regions, with staff from WHO regional offices and headquarters, Strategic Advisory Group (SAG) members and the Global Health Cluster unit (GHCU).

The overall purpose of the Forum was to improve the Health Cluster capacity building efforts in cluster coordination and leadership, address challenges and areas of concern as selected by participating HCCs, and to document good practices.

The three-day forum provided the Health Cluster Coordinators and team members with the opportunity to present their cluster experience and perspectives through informal presentations, group work and plenary discussions.

Overall outcomes of the Forum included:

- Strengthened relations and networks among Health Cluster Coordinators.
- Lessons learnt documented.
- Recommendations formulated to strengthen coordination and improve the health sector humanitarian response.

Common themes emerging from the meetings covered: the lack of adequate staffing; the continuing challenge of double-hatting in some countries; the need for technical guidance and clarity on roles and accountability; administrative system constraints; the need for increased training and mentoring; advocacy for access, security against attacks on health care and protection of the health community.

Key concerns raised during the Forum included the need to: adapt the cluster approach in response to protracted crises; transition from cluster to sector coordination ensuring a stronger role of government at national and subnational levels; tighten links between response to infectious diseases, humanitarian crises and development partners.

Participants agreed on the following key recommendations needed to address these concerns. Detailed recommendations and allocated responsibilities are listed in Annex 3.

Key recommendations

1. Clarify roles and responsibilities for emergency health response (to all hazards) within WHO at all levels.

- Develop standard operating procedures to manage L3 outbreak response, that clearly stipulate the role of clusters, OCHA and other programmes.

2. Clarify roles, responsibilities and expectations of the Health Cluster within the WHE Incident Management System (IMS).

3. Develop guidance for HCCs and cluster partners to strengthen capacity building for partners and communities.

4. Ensure appropriate briefing and support regarding roles and responsibilities of Heads of WHO Offices vis-a-vis the cluster and humanitarian response.

5. Clarify the oversight mechanism for the coordination of Emergency Medical Teams (EMTs) within humanitarian response.

6. Develop guidance and best practice toolkits that include a systematic knowledge bank that is accessible to HCCs.
   In particular: develop a core indicators list for collective response monitoring; and develop guidance to strengthen inter-cluster coordination.

7. Develop a comprehensive advocacy strategy, to include a specific chapter on attacks on health care.

The Global Health Cluster (GHC) is committed to support the implementation of these recommendations in collaboration with its partners, in order to strengthen cluster capacity and the quality of cluster response. The GHC unit would like to thank all the participants for their valued contribution to the discussion.

DAY 1 – 3 April 2017

INTRODUCTION

Today, 128.6 million people are in need of help, 92.8 people are expected to receive aid and the total requirements to meet the need exceed $22 billion[1]. In 2016 WHO responded to 47 emergencies. Of which, five— Iraq, Nigeria, South Sudan, Syrian Arab Republic, and Yemen—were designated grade 3 acute emergencies, denoting the highest level of organizational response. There were also responses to twenty-six other acute grade 1 and grade 2 emergencies, as well as 16 countries in protracted crises[2].

In April 2017, there were 23 activated Health Clusters, of which 2 regional responses (see Annex 4).

The 2017 Health Cluster Forum provided an opportunity for all Health Cluster Coordinators (HCCs) to meet and share their technical and operational challenges good practices and needs. Seventeen HCCs and two Health Cluster Co-coordinators participated from five WHO regions, with staff from WHO regional offices and headquarters, Strategic Advisory Group members and the Global Health Cluster unit (see Annex 2).

Opening and Session 1.1 Purpose of the Health Cluster Forum

Linda Doull welcomed participants and facilitators, presented the changing humanitarian context and purpose of the Forum: to improve Global Health Cluster (GHC) capacity in cluster coordination and leadership; to address challenges and areas of concern to HCCs; to document good practices.

Participants agreed the agenda, objectives and expected outcomes:

- Strengthening relations and networks among HCCs.
- Documenting lessons learned.
- Drafting recommendations to strengthen coordination and improve the health sector humanitarian response.

Small groups identified key issues for consideration throughout the Forum:

- Networking, e.g. support visits between field offices.
- Sharing lessons learned and challenges.
- Developing a thematic toolbox/toolkit to be readily accessible and continually updated.
- Understanding roles and accountability lines of the IMS in the context of WHE reform.
- Building better health outcomes and technical capacities.

[1] Global Humanitarian Overview 2017

[2] WHO. UPDATE | WHO Health Emergencies Programme: progress and priorities, 2016

Recommendation Session 1.1

Development of a toolbox/toolkit - beyond general guidelines - to include proven methodologies and tools for dealing with protracted crises.

Session 1.2 Global trends: the role of the Health Cluster

Focal point: Linda Doull, Global Health Cluster Coordinator

Linda Doull provided a brief overview on key internal and external events which influence the current and future role of the Health Cluster. During the World Health Assembly in May 2016, the WHO Member States mandated the creation of the new Health Emergencies Programme (WHE). Since then the Emergency Operations Department (EMO)has started to establish appropriate emergency management structures for the new programme and is in the process of developing Standard Operating Procedures (SOPs), together with the Department of Management and Administration (MGA). In addition, EMO has introduced the incident Management System (IMS) to lead and manage emergencies in-country, with strengthened technical and operational support provided by teams at regional and headquarters levels.

In May 2016, the World Humanitarian Summit (WHS) also highlighted the unprecedented scale of humanitarian needs and made the call for a New Way of Working to more effectively address them. She also informed participants of the Grand Bargain commitments which will also influence the work of the Health Cluster.

The concept of the "Grand Bargain" outlines how aid agencies need to monitor and respond systematically to multi-dimensional nature of health needs and be more aware of the critical inter-sectoral action required with Nutrition, WASH , Food Security and Protection for improved health outcomes. The spirit of the Grand Bargain is reflected in the Global Health Cluster Statement delivered during the WHS Special Session on Global Health[3], that includes the following pledges:

- To accelerate collective action – grounded in humanitarian norms – to increase the life-saving impact of humanitarian assistance.
- To strengthen capacity to deliver essential health service packages and to prevent, detect and response to all major health threats.
- To enhance multi-sectoral programmes to meet complex needs.
- To increase community engagement to understand risks and vulnerabilities and inform programming.
- To robustly monitor programme effectiveness using technically sound indicators.

[3] http://www.who.int/hac/global_health_cluster/GHC_WHS_statement_final.pdf?ua=1

- And to protect access to health care by monitoring attacks, advocating for change, and applying strategies to deliver health services in difficult to access environments.

Discussion

Integrated communication is necessary. Participants expressed concern that there are too many approval levels to clear within the WHO system before information can be shared and disseminated, which impedes timely decision making and advocacy.

The cluster needs to have a clear role and more effectively demonstrate its added value. To strengthen Cluster leadership, WHO has, to date, recruited 15 dedicated HCCs on fixed-term contract and recruitment is ongoing to fill the remaining 9 HCC positions. Whilst WHO investment in HCC positions is very welcome, it was noted that other critical cluster positions such as Information Management Officers and some sub-national positions remain at the mercy of often un predictable event based funding. As Cluster Lead Agency, WHO needs to more systematically fundraise for these other cluster coordination team roles.

Concern was expressed about the potential investment consequences of the WHO's new country business model priority system where Syria is ranked as a priority one while Turkey is a category two – when both serve the L3 Syria crisis.

The Health Cluster system needs to build national capacities both in governmental and nongovernmental (local NGOs) sectors, ensuring there is full service coverage of the populations in need when the cluster exits. In Yemen there has been a struggle to find national NGOs with both technical and operational capacity needed to respond to this deepening L3 crisis. GHC partners must work more closely with national partners to build technical and institutional capacities.

Humanitarian coordination during infectious disease outbreak needs further clarification and improvement, including more deliberate action to bring technical experts into the Cluster. The new IASC protocol for L3 Activation for Infectious Hazard Response will engender greater collaboration between the Cluster and disease networks such as GOARN. Inter-cluster engagement for such L3 activation needs to be clarified.

A Global Cluster Description Mapping exercise conducted in 2015 by OCHA and the Global Cluster Coordination Group identified 276 cluster entities (national and subnational) across all clusters, highlighted how over burdensome coordination structure has become and how poorly resources were distributed.

In Syria, for example, having 150 cluster coordination positions had not necessarily lead to good results. Clusters need less structure to be more effective. Building networking capacity and advocacy with partners is essential.

Clusters are under pressure to perform more with less funding. It was noted that in South Sudan, the humanitarian and development sectors and donors must work closely together and donors should ensure resources are not fragmented.

Recommendations from Session 1.2:

Country Health Clusters:

- HCCs should plan the cluster exit strategy from the beginning of the crisis. This includes working on transition from cluster to sector coordination with a stronger role of government, involving authorities at national and sub-national levels.

Headquarters - WHO and GHC:

- Provide a cluster support toolbox/toolkit easily accessible and regularly updated.
- Streamline WHO clearance and approval levels to enable more timely information sharing.
- Develop guidance on how to improve inter-cluster collaboration towards collective outcomes.

Session 1.3 GHC Multi-Year Strategy 2017-2019: new strategic priorities and enabling actions

Focal point: Sonia Walia, OFDA, GHC/SAG

Sonia Walia presented the new GHC Multi-Year Strategy 2017-2019. Strategic priorities include:

- SP1: Strengthen the capacity of national/regional and global level actors to prevent, prepare for, respond and recover from public health and humanitarian emergencies.
- SP2: Strengthen inter-cluster and multi-sector collaboration to achieve better health outcomes.
- SP3: Strengthen collective and respective health information management.
- SP4: Address strategic and technical gaps.
- SP5: Strengthen health cluster advocacy at country and global level.

The GHC will develop annual work-plans with detailed activities, timelines and responsible entities in support of the Multi-Year Strategy. The work-plan will be approved and adapted as appropriate by the GHC Strategic Advisory Group following consultation during GHC Partner Meetings.

The GHC Strategic Advisory Group will oversee the implementation of the annual work-plan and the Multi-Year Strategy and report back to partners on a an annual basis. A monitoring framework will be developed to ensure regular and harmonized tracking of implementation of the strategy. The framework will serve as a basis for regular review and analysis of the global situation, and grounds for revision of strategy and priority objectives and activities.

Discussion

Plenary questions and issues raised included how to monitor outcomes and achievements and how to ensure that indicators are measurable and reflect outcomes.

Since 2006, gaps have been highlighted between national authorities and the cluster in terms of planning exit strategies. Innovative ways of working at local level and building national capacity is important but this work needs to be coordinated from outside the country.

Some participants felt the strategy was too open to interpretation and should be more precise. There was concern about the need to clarify roles and responsibilities at different levels including the roles and responsibilities of cluster partners.

Guidance for creating a work-plan at country level and further training for cluster coordinators was requested.

Participants were asked to identify what was missing, needed to be improved, and what was good with the strategy.

What is missing from the strategy?

For SP1:

- Prioritize accountability at regional and country level to beneficiaries and communities.
- Strengthen and expand the principles of the Grand Bargain.
- Develop strategies for capacity building for the HCC teams and local partners.
- Include more actions with partners.
- Develop guidance for performance monitoring of emergency health response.

For SP2:

- Clarify what is meant by "empowered leadership" and what this means for the Health Cluster and WHO and country, regional and global levels.

For SP3:

- More standard products are expected but the purpose of each new product should be clarified.

- Information should be used for action, not for process in order to avoid "paralysis by analysis."
- Better communication is needed between GHC partners and their field staff around global commitments to the Health Cluster.

For SP4:
- Specify responsibilities and accountability at each level.
- Develop practical guidance from GHC.
- Tools and guidance are needed to monitor outcomes and achievements of the cluster.

For SP5:
- Increase advocacy for well-conceived action by authorities and international actors.
- Define integration of cross-cutting issues such as gender.
- Strengthen humanitarian/development cooperation.

What areas need to be improved/strengthened in the strategy:

For SP1:
- The relevance of various elements in the overall mission needs to be spelled out.

For SP2:
- Resources for the cluster need to be improved.

For SP3:
- Objectives should be reorganized.
- Strategic gaps and technical issues should be differentiated.
- Training should be boosted at country and local level.
- Better communication of data is needed.

For SP5:
- The strategy should be more specific regarding advocacy.

What are the strengths of the strategy?

For all strategic objectives:
- The strategy takes into account the current WHO's reform on emergencies.
- The participatory process used in the development of the strategy is valuable.
- The strategy incorporates and reflects inputs from previous cluster meetings.

Session 1.4 Differentiated coordination solutions: working in partnership

Focal points: Trina Helderman, Medair, GHC/SAG;
Pat Drury, Manager, Global Outbreak Alert and Response Network;
Fawad Khan, HCC, Iraq;
Jorge Martinez, Health Sector Coordinator, North East Nigeria; and
Flavio Salio, Emergency Medical Teams, WHO

The purpose of the session was to discuss the role of the cluster in government-led sector coordination, working within the Emergency Operations Centre (EOC) (case study on North East Nigeria presented by Jorge Martinez); the interface with Emergency Medical Teams (EMTs) and the cluster approach, filling the trauma service gap and how to remain impartial (case study on Iraq presented by Fawad Khan); and the interface with other partner coordination mechanisms: Global Outbreak Alert and Response Network (GOARN) (presented by Pat Drury).

Pat Drury, presented information on the recently launched 'GOARN 2' strategy and commented that the 'rebranding of **GOARN'** would be a test of how well the WHO handles "the next Ebola crisis." GOARN rapid response capacities aim to strengthen rapid response (to infectious disease outbreaks) teams (RRTs) through supporting coordination, trainings, standards, quality assurance and tools. Coordinated support to countries for outbreak response will be faster with more capacity available. GOARN RRT should assure a higher level of quality, operability and safety with dependable, more targeted and reliable capacity, increased acceptance and country trust, including engagement of member states and NGOs. Donor confidence should also be higher.

Jorge Martinez compared WHO's response in **NE Nigeria** as having been a 'pilot project' with the wider emergency reform process, it being the first IASC L3 activation since WHE was established. The presentation revealed that whilst the Incident Management System (IMS) provides a standard approach to the response, it also raises questions on how the Health Cluster coordination approach links with lead partners on the ground – WHO and Ministry of Health.

Discussion

Plenary discussion highlighted challenges about WHO leadership and concerns about the interface with the Health Cluster. WHO Emergency Coordinators and Incident Managers need to be enabled to be immediately effective when deployed and the Health Cluster needs to be empowered within the IMS structure.

The presentation of the **Iraq humanitarian crisis** focused on how to effectively respond to trauma needs, and WHO's role as Provider of Last Resort (POLR). The EMT model was used in a conflict zone for the first time and expanded its remit to plan and support the entire trauma services pathway, including the engagement of new service providers including the private sector. WHO took

the lead in securing funds for the trauma response. EMT deployment and WHO role as POLR has raised some important issues to consider when similar needs arise in other contexts, namely:

Strengths
- Sets a precedent for EMTs working in conflict zones.

Challenges
- Finding providers with capacity to work in security compromised locations and willingness to work in presence of military actors.
- Way forward – stronger links for efficient and effective referral pathway, data collection, coordination and planning.
- Assuring impartiality of service delivery.

Exit strategy
- Building capacity of national health workforce.

The EMT response for trauma setup and interfacing of different actors is a challenge but is necessary to address a critical gap in humanitarian health response.

Recommendations from session 1.4

For WHO and the GHC
- Identify how the Health Cluster can more effectively engage a more diverse range of partners whilst maintaining the impartial delivery of assistance.
- Empower the Health Cluster within the IMS structure.

Session 1.5 Remote programming and monitoring – a practical approach

Focal points: Trina Helderman, Medair, GHC/SAG;
Kim Yves-Créac'h, The Operational Partnerships

The purpose of the session was to introduce the remote management project which has been initiated in response to expressed needs by HCCs and GHC partners for more concrete operational guidance.

Trina Helderman updated participants on the findings of the baseline Literature Review which described four forms of remote programming (remote contact, remote management, remote support and remote partnership). The central differentiating factor being, who has overall authority and accountability.

Discussion

In plenary, the HCC for Fiji remarked that it was almost impossible in his experience to do any sort of remote management with a sovereign government

in place after the initial emergency phase. Other participants questioned remote partnership management without technology and also asked about the source of funding to support new technologies. There was consensus on the exacerbated risk in remote management, especially related to possible loss of quality, particularly where partners who can access hard to reach populations may have limited previous experience or capacities. However, in the case of managing polio campaigns in Syria, remote management proved very effective with 95 percent coverage and eradication of polio following the October 2014 outbreak.

Recommendations from Session 1.5

Country Health Clusters

- Examine how remote partnerships could function where technology is absent.
- Consider how to assure quality control via remote management in situations where Country Health Clusters work with a diverse range of partners.

Headquarters - WHO and GHC

- Actively engage HCCs in the next phase of the remote management project – country case studies and peer reviews.
- Examine funding possibilities for remote management.

DAY 2 – 4 April 2017

Session 2.1 Inter/multi-cluster coordination: How do we ensure more effective joint operational programming for better health outcomes?

Focal points: Magdalene Armah, HCC, South Sudan
Linda Doull, Global Health Cluster Coordinator

The session's purpose was to present the GHC, OFDA funded inter-cluster coordination (ICC) project which will assist clusters in realizing pledges made during the World Humanitarian Summit. A case study from the South Sudan's ICC group was also shared to highlight existing good practice and areas for improvement.

Linda Doull updated participants on the agreed actions from the GHC Partner Meeting in December 2015, which included improving joint assessment and analysis at country level and to form a global inter-cluster task team of health, WASH, nutrition, food security and protection clusters to explore and develop joint operational frameworks for common response scenarios to more effectively enable rapid and coherent multi-sector response. Proposed response scenarios include nutrition crisis, cholera/AWD; other vaccine preventable diseases; gender-based violence and mitigating the impact of attacks on health care. The approach includes developing a conceptual framework for inter-cluster coordination, based on bottle-neck analysis; country support missions to trial and develop best practice guidance. These activities are to happen over three years with two frameworks developed per year.

The South Sudan case study was presented by Magdalene Armah, HCC. With a population of 12 million people and over 50 years of conflict, the six-year old independent country now has many displaced people with acute health needs. NGOs provide 80 per cent of health services and acute malnutrition is the main issue. South Sudan is home to all communicable diseases.

An effective response therefore requires strong coordination in these areas: joint situational analysis and cross sectoral prioritization for response, as well as gap identification. The strength of the response to date has been harnessing technical partnerships for improved health outcomes and providing a stronger voice for advocacy. The Clusters have been proactive rather than reactive. The challenge is balancing the operational risks versus harnessing the full capacity and complement of the cluster partners.

Discussion

Working groups considered the following questions:

- What is the ICC programming inception point?
- Must we always do inter-cluster programming?

- How do we mitigate programme and agency territorial debates and improve the response through a collective win-win situation?
- What actions can the GHC take to aid collaborative inter-cluster working in the field?

Discussion revealed that the GHC should clarify and formalize its role in guiding and supporting more effective country level inter-cluster collaboration.

The core list of common indicators needed revision. To address follow-up of quality of care in particular, a standard tool or checklist should be implemented to allow for systematic standard monitoring. A clear communications mechanism was missing to share tools between GHC, ICC Group and other cluster coordinators. A strategy was needed to enable challenges to be communicated in the face of government restrictions.

Participants suggested that focal points for Health and WASH should be appointed in each country cluster to perform routine supervisory visits which would include corrective action, capacity building, monitoring and coordinating supply management. All partners should agree on the lead focal point.

Recommendations from Session 2.1:

Country Health Clusters
- Strengthen monitoring, supervision and corrective action roles.

Headquarters - WHO and GHC
- Set indicators and benchmarks to ensure quality of care standards, including medical care and WASH, are being met.
- Clarify, formalize ICC guidance for implementation at country level.
- Define roles, responsibilities and expectations of country-level inter-cluster mechanisms.
- HCCs to be invited to attend Global WASH and Nutrition Cluster meetings, when required to share good practice.

Country Health Clusters and Headquarters - WHO and GHC:
- Agree scorecard standards and set up monitoring.

Session 2.2 Localization: strengthening national capacity

Focal points: Linda Doull, Global Health Cluster Coordinator
Mohammad Daoud Altaf, Health Cluster Coordinator, Afghanistan

The purpose of this session was to discuss the meaning of national capacity building; and to what degree the Health Cluster is responsible for national partners meeting international standards and key areas to consider when working with government and partners for transition.

In Afghanistan, the Health Cluster has been established for seven years. Six million people are in need of basic health services. Thirty million people are affected by damaged health services including direct damage, disruption of supply chain and delivery of services. Risk factors are associated with frequent disease outbreaks. Risk analysis has been carried out in 32 out of 34 provinces.

In 2015, the Health Cluster began a transition plan with the Ministry of Health (MOH). However, the plan has not been implemented due to escalation of the conflict and humanitarian needs, and funding constraints which hinders capacity development needs to effectively transfer authority back to government.

The National Emergency Response Plan for Health (NERPH) is in place with a limited surge capacity plan to mobilize resources. Basic and essential packages of health services are provided by the government in collaboration with humanitarian partners. Eighty percent of the population has no access to government-provided services. Capacity building is a long process especially at the local level. The Health Cluster is supporting provincial and district-level hospitals.

Discussion

Discussions revealed that only Afghanistan, Ukraine and the Central African Republic have cluster transition plans in place. Questions were raised as to how to transition from cluster to government ministry as well as working with development agencies.

Discussions focused on the role of the Health Cluster in strengthening national capacity building; how to complement the role of the MOH and tools and/or support needed to strengthen the Health Cluster in building national capacity.

The standardized package of services transferred to the MoH depends on the level of disruption of health services and the MoH technical and funding capacity to support services.

Funding partners also need to be part of the transition planning conversation, especially in fragile states. For capacity building, the country context and

relative strength of the government should be considered, linking humanitarian and development areas.

The transition plan must address every area of public health using a health system governance model offered by WHO at national and sub-national levels.

Country clusters should agree on transition plans with MOHs in order to build leadership, institutions and technical expertise. This can be done by identifying gaps in MOH plans and analyzing regulatory mechanisms.

Recommendations from session 2.2

Country Health Clusters:

- Share best practices on transition through field exchange visits facilitated by the Global Cluster.
- Define areas where national capacity building is needed, such as in response preparedness, recovery or health system strengthening.
- Support establishing thematic working groups with local health authorities.

Headquarters - WHO and GHC:

- Explore support for training in global health to support transition.
- Ensure predictable and sustainable funding is in place.

Session 2.3 Increasing partner engagement

Focal point: Emma Fitzpatrick, Global Health Cluster unit

The session explored challenges and opportunities to increase participation in the Health Cluster from key partners, including MOH; national NGOs, international NGOs and UN agencies and donors.

Group discussions resulted in a list of recommendations related to donors, national NGOs, international NGOs (INGOs) and UN agencies.

Recommendations from session 2.3

Related to resource mobilization / donors

- Provide one template for proposal development.
- Provide a one-pager on effective communication with donors.
- Provide guidance on 'acceptable donors' in case they are parties to a conflict.
- Provide guidance on how to engage with donors on multi-sectoral funding.
- Sharing of regular information from donors on the projects they are funding.

- Provide orientation for new HCCs on CERF-pooled funds.
- CCs should reach out to development/stabilization donors to ensure there are complementary links with humanitarian donors/programming, ensuring all funding sources are complementary.

Related to national NGOs

- Screen NGOs according to predefined criteria. For example, consider the Emergency Medical Teams (EMT) paper on basis for accreditation of partners.
- Integrate national NGOs in the humanitarian programme cycle.
- Include national NGOs in CERF project cycle and funding.
- Provide help on how to build technical capacities for national NGOs (e.g. how to write and submit a donor report).
- Encourage national NGOs to be active in the cluster, e.g. to participate in sub-cluster and attending meetings on rotational basis.

Related to international NGOs

- The Health Cluster could work as interface between MOH and INGOs if there is disagreement.
- GHC to urge more commitment from the NGO HQs to participate in Country Health Clusters.
- Send the Health Cluster information management officer (IMO) in person to collect data from INGOs.
- Ask INGOs what data is most useful and helpful for them.

UN agencies

- Engage UN agencies in the Strategic Advisory Group and technical working groups.
- Engage heads of agencies with health cluster actions.
- Fully involve agencies in resource mobilizations including joint projects and innovative funding mechanisms.
- HQs of each agency should liaise with each other to create formal working arrangements.

DAY 3 – 5 April 2017

Session 3.1 Strengthening leadership

Focal point: Rick Brennan, Director, Emergency Operations, WHO Health Emergencies Programme

The purpose was to provide an overview of WHE strategic direction and the commitment of WHO as Cluster Lead Agency at national, regional and global levels and to introduce the new Incident Management System (IMS).

Rick Brennan described developments at WHO headquarters regarding global and country-level clusters. He talked about changes within IASC and the broader humanitarian system that will make additional demands on the cluster to be more efficient, effective and flexible, but also provide more opportunities in respect of the new protocol for L3 Activation for Infectious Hazards.

Finally, he discussed how the IMS is being implemented. He clarified that instead of the cluster being subsumed by the IMS, the IMS should support the cluster to fulfil its core functions. There is a real opportunity now to get clusters operating at an optimal level. Of the six IMS critical functions, the Health Cluster needs to drive health services by assessing the needs, identifying gaps and ensuring good quality services.

Within the highest level of WHO, leadership has become more conscious of the critical role of partnership at the sub-national level. Coordination models are being more closely examined and in recent years, there has been more buildup of national capacity in some regions, particularly in the Americas and ASEAN.

As governments evolve their own emergency response systems around the world, the Health Cluster must adapt. Governments are becoming more assertive about their oversight of humanitarian activities. Fewer clusters are being activated. Speed, scale and effectiveness are key expectations by governments now. In conflict-affected situations we must uphold humanitarian principles as we work with a wider, range of new partners.

Currently, in about 70 countries, governments are establishing their own emergency operations, using Emergency Operations Centers (EOCs) for the management and coordination of responses. The interface between the EOC and Health Cluster needs to be clarified to ensure effective coordination whilst also maintaining its independent voice.

Rick Brennan asked participants to discuss how development and humanitarian organizations can work better together with local actors using resources more effectively to serve people in context of the Grand Bargain commitments to localization.

Discussion

Participants' discussion revolved around concerns with clarification of roles and reporting lines between cluster, sector and the IMS and a desire to avoid parallel duties, such as three different actors calling on a partner such as MSF to come to meetings involving EMTs. There were calls for guidance on how the IMS fits in at country level for the cluster.

The IMS is meant to be a flexible approach. The Incident Manager (IM) reports to the Head of WHO Country Office and must be adapted in a protracted context such as in South Sudan and Yemen. The Head of WHO Country Office can also become the Incident Manager.

In Ukraine for example there are no funds for a full-blown IM so there is double-hatting with the Head of WHO Country Office and the HCC. There is a need to think outside the box in this case with different SOPs.

In South Sudan, partners have been lost due to increased insecurity and there are unfilled functions such as in communications. Risk analysis could be sourced from the IMS. The Information Manager is placed within the structure but there is concern over the IM's availability to provide information and technical expertise quickly enough.

Recommendations from session 3.1

Headquarters - WHO and GHC:

- Consider how to more effectively integrate EMT deployment and cluster approach within the IMS, especially in light of possible competing interests.
- Devise ways to better manage outbreak response, also involving OCHA and other WHO technical programmes.
- Provide clear guidance on cluster roles within the IMS.
- Sensitize Heads of WHO Country Offices coordination approaches and make sure those with emergency experience are in priority and vulnerable countries.

Session 3.2 Update on Mainstreaming Accountability to Affected Populations (AAP) and Protection in Health Coordination: Where are we now? What are the next steps?

Focal point: Patricia Colbert, Senior Adviser, GENCAP

The purpose of the session was to understand the inter-relationship of gender, protection, Gender Based Violence (GBA) and Sexual Exploitation and Abuse (SEA) as they pertain to Accountability to Affected Populations (AAP).

Linda Doull introduced Patricia Colbert, adding that health was somewhat behind in systematically adopting the IASC Framework for AAP.

The main challenge is how to more effectively translate the Grand Bargain commitments on strengthened accountability to affected populations, gender based mainstreaming and combating gender based violence. More linkage is needed across cross cutting issues with health.

Patricia Colbert challenged participants to think about how to better humanize services delivered, how to demonstrate humanitarianism. The health needs of a 15 year-old girl, 80 year-old woman, 10 year-old boy and 50 year-old man are all very different. Protection, gender and 'do no harm' lenses must be applied to everything a cluster does.

The AAP tool recently developed by the GHC is to be shared with HCCs for feedback and to collect examples of best practices in mid-April. This will be followed with country specific piloting to further refine before widespread dissemination to all clusters. The tool will be constantly updated by examples and inputs received.

The tool is a way of improving the quality of cluster interventions. HCCs are not required to become experts on gender but to ensure that the questions and issues are being addressed. Patricia reiterated that working on gender isn't about just working with women.

Discussion

Plenary discussion focused on the reality that the HCCs alone should not attempt to provide everything for the community, but to find partners who can provide the services and to build capacity. The tool should be seen as an opportunity to provide better services to those in need, rather than as a policing exercise for the clusters to evaluate uptake.

Recommendations from session 3.2

Clusters should develop a more "people-centred" mindset as humanitarians, knowing that health needs vary depending on, at the most basic level, on age and gender.

Session 3.3 Information Management—update on Public Health Information Standards (PHIS) and rollout

Focal point: Olivier Le Polain, Public Health England, Chair of the GHC Public Health Information Services (PHIS) Standards Task Team

The session's purpose was to share information about the latest development of Public Health Information Services (PHIS) work and planned actions to move forward. The background of the PHIS was described and current task members listed.

Now that PHIS standards have been established, they will be rolled out over the next few months, ensuring they are incorporated into the information management work-plan in all active Health Clusters by December 2017. This will be done using a pashed approach based on priority needs and country capacities. Support will take the form of strengthening PHIS standards in countries as well as remote support, mentoring/coaching, training and increasing PHIS capacity in countries.

Discussion

Comments from group discussion included that the tools cannot be rolled out in a country without having an Information Management Officer in post. Yet it is vital to have this system to capture information, and demonstrates the cluster's work and added value through regular reporting so that funds can be secured for the response.

WHO must invest in longer term Information Management capacity in all emergency countries. The Health Cluster needs dedicated information management, accessible at all times. These dedicated focal points will need to bridge the gap between cluster and WHO team. HCCs shod be assertive in requesting for information management capacity from their respective WRs and the GHCU.

Recommendations from session 3.3

Country Health Clusters

- At the country level, HCCs must ask for dedicated information management capacity.
- Analysis support is needed as well as specific indicators for reporting on a monthly basis on progress and outcomes.

WHO

- WHO must provide longer term dedicated information management capacity in countries.

Session 3.4 Advocacy and attacks on health care

Focal points: Erin Kenney, Project Manager, Attacks Project
Mary Pack, IMC, GHC/SAG member

The purpose of the session was two-fold, firstly to present the Attacks on Health Care methodology and to discuss a timeline for country roll-out; and secondly to present key results from the 2015 survey on Health Cluster advocacy needs and consider whether they are still valid.

In her presentation of the Surveillance System for Attacks on Health Care (SSA), Erin Kenney said health care is increasingly under attack, yet there is no systematic collection of data, no consolidated data or trend analysis. The extent and nature of the issue and the impact on public health are also not known. There is a need for data that can inform advocacy and WHO has the mandate to collect this data.

There were 896 attacks in 25 countries over the past three years. Attacks are broadly defined, from mattresses stolen from a medical store to patients shot in their beds.

The SSA initiative began with a strong partner perspective but has recently become more influenced by WHO perspectives. The revised methodology was still in development and needed to find a balance between the two perspectives in its final expression.

Lessons learned from pilot testing in Gaza and two other locations included the need to make the tool more sensitive, open, useful, verifiable and timely. The data will be public.

The SSA will be rolled out as follows: 15 May 2017 to start a five-country rollout to Iraq, Yemen, Afghanistan, South Sudan and Nigeria; 1 September 2017 for DRC, Ethiopia, Mali, Somalia and Syria; and 1 October 2017 to produce the first WHO quarterly dashboard. In the context of the SSA, the HCCs' role is to promote and explain its use, facilitate preparations and discussions with contributing partners and serve as liaison between partners.

It is proposed that health resources and availability mapping (HeRAMs) will overlay the knowledge using the new point system, in order to determine the true impact of an attack. As soon as the attack is reported at the country level, it can go on WHO database. Information such as GPS locations can be hidden in the public-facing data.

A checklist compendium will be designed to help HCCs identify possible solutions to mitigate the impact of attacks, e.g. having bulletproof windows in a triage center, or a buddy system for doctors at risk of abduction. The expectation is that both partners and WHO could change their policy on proposals, such as fortifying hospitals.

In respect of advocacy needs, mobilization of resources, humanitarian access and attacks on health care and health care workers, were the priorities identified in the 2015 survey. Participant discussion focused on whether the priorities had changed and how the GHC could help to address them.

Discussion

Discussions revealed the same issues (mobilization of resources, humanitarian access, attacks on health care and health care workers) were still advocacy priorities. Participants stated that to identify and prioritize advocacy areas, HCCs needed training. They also said they needed funds and human resources for capacity building in this area.

In general, cluster advocacy should be undertaken at local and national government levels. Resource mobilization advocacy at the global level should support efforts to secure funding for minimum cluster capacity to reduce human resource gaps. Health staff and hospitals should be protected through advocacy with governments. More money and human resources were needed across all clusters.

Plenary group work revealed many questions and potential flaws with the new SSA's criteria and point system for confirming an attack. For example, several participants felt more than one source was needed for confirmation. Also, cluster partners as well as WHO workers should be considered as eyewitnesses.

The human element and stories must emerge behind the numbers in the context of health care attacks. This is the most challenging part of using the methodology – how to link the numeric evidence to the impact on health.

Asked what the challenges would be to apply the SSA in their country clusters, HCCs listed communication with the field for timely reporting as a top concern, as well as safety for the information reporter. They also said there were risks of damaging relationships with government which necessitated verification of attacks to take place outside the cluster.

Asked what preparatory work needed to be done in their countries or with global or regional partners before the SSA could be applied, discussion focused on the need to sensitize the MOH and identify focal points.

Asked what support they needed, HCCs cited help in the form of innovation and technology (for example, drones) as a top priority. They added that data gathering from other agencies and better access to Google mapping would be helpful. They also suggested working through civil military channels (advocating for military to follow rules of war and not target health providers), fortifying health care facilities and withdrawing support if attacked.

Recommendations from session 3.4

Country Health Clusters:

- Actively promote the use of the revised IASC age and gender marker.
- Provide opportunities for gender mainstreaming and address marginalized populations like LGBTi (Lesbian, Gay, Bisexual, Transgender/Transsexual and Intersexed) communities.

Headquarters - WHO and GHC:

- Continue to focus on the same issues around advocacy and attacks on health care identified in the 2015 survey.
- Provide training to HCCs so that they can better identify advocacy areas and prioritize issues.
- Mobilize resources for advocacy at the global level to provide minimum funding to close staffing gaps.
- Mobilize advocacy at local and national government levels including protecting health staff and hospitals.

All:

- Be more direct and targeted as a sector in specific advocacy efforts.
- Address administrative blockages at borders and in governments to allow medicines into countries and work visas for health workers.
- Ensure more consistent reporting of attacks on healthcare.

Meeting Summary — next steps

Focal point: Linda Doull, Global Cluster Coordinator

Linda Doull closed the three-day Health Cluster Forum and defined next steps, required actions and timeframes. Many of the key actions had been captured in the recommendations.

HCC expectations of GHC include more regular and better access to guidance and best practice examples, support missions and coordination reviews.

The GHC Multi-Year Strategy feedback had been very helpful and would be taken into the upcoming meetings with the Strategic Advisory Group and GHC partners.

The Health Cluster Forum will be held on an annual basis for at least the next 2 years thanks to OFDA funding.

The GHC unit, GHC partners and WHO as Cluster Lead Agency are fully committed to supporting Country Health Cluster teams and partners and appreciate the work and recommendations gathered though-out this Forum.

Annex 1: Agenda

Health Cluster Forum
Montreux (Hotel Eden Palace du Lac), Switzerland
3-5 April 2017
Agenda

The purpose of the forum is to improve the Global Health Cluster capacity building efforts in cluster coordination and leadership, address challenges and areas of concern as selected by the participating Cluster Coordinators, and to document good practices.

Outcomes of the Forum include:

- Strengthen relations and networks among health cluster coordinators
- Documented lessons learnt.
- Recommendations to guide the work to continue to strengthen coordination and improve the health sector humanitarian response.

DAY 1
Monday 3 April 2017

08.30-08.45	**Welcome, opening remarks**
Presenter: Linda Doull, Global Health Cluster Coordinator	
Session 1.1	
08.45 - 10.00	**Participant introductions** **Agenda and purpose of the forum**
Focal points:	Global Health Cluster Unit GHC Strategy Advisory Group

The purpose of this session is to:

- Introduce all participants and meeting facilitators
- Agree on the meeting agenda, objectives and expected outcomes and rules of engagement

Method: Presentation & plenary discussion

Background documents

- Meeting Agenda

Further reading (available on SharePoint)

- Results from Pre- Health Cluster Forum Questionnaire

10.00-10.30	**Coffee**
Session 1.2	

10.30-12.00	Global trends: the role Health Cluster
Focal point:	Linda Doull, Global Health Cluster Coordinator

The purpose of this session is to:

- Review of the major internal and external factors (current crises, post-WHS, Grand Bargain) that are or may influence the work of the health cluster.

Method: Plenary presentation and Q & A

Background documents

- Global Health Cluster Partner Statement – World Humanitarian Summit, May 2016
- IASC System-wide Level 3 Activation for Infectious Disease Events

Further reading (available on SharePoint)

- Grand Bargain final May 2016
- Agenda for humanity**:** Annex to the Report of the Secretary-General for the World Humanitarian Summit

Session 1.3	
12.00-13.00	GHC Multi-Year Strategy 2017-2019: new strategic priorities and enabling actions
Focal point:	Sonia Walia, OFDA, GHC/SAG

The objectives of the session is:

To present the new GHC Multi-Year Strategy 2017-2019

The expected of the session is to:

- Have a better understanding of the GHC Multi-Year Strategy and its implications in the day to day work of Clusters at Country and sub-national level

Method: Plenary presentation and Q & A

Background documents

- Draft Health Cluster Multi-year strategy – 2017-2019

13.00-14.00	Lunch
Session 1.4	
14.00-16.00	Differentiated coordination solutions: working in partnership
Focal points:	Trina Helderman, Medair, GHC/SAG Pat Drury, Manager, Global Outbreak Alert and Response Network Muhammad Fawad Khan, Health Cluster Coordinator, Iraq

Jorge Martinez, Health Sector Coordinator, North East Nigeria
Flavio Salio, Emergency Medical Teams, WHO

The purpose of this session is to discuss:

- The role of Cluster in government led Sector coordination
  - Working within the EOC [Case study – North East Nigeria]
- Interface with EMTs and the Cluster Approach
  - Filling the a service gap
  - How to remain impartial? [Case study - Iraq]
- Interface with other partner coordination mechanisms: Global Outbreak Alert and Response Network (GOARN).

The expected outcome of the session is to identify:

- The different coordination needs and related actions that contribute to the various models, in relation to preparedness, response, recovery.
- What specific support is needed to achieve the identified actions at country and global levels.

Method: Plenary presentation & group work

Further reading (available on SharePoint)

- Emergency Medical Teams: https://extranet.who.int/emt/sites/default/files/EMT%20Booklet.pdf
- Global Outbreak and Response Network: http://www.who.int/ihr/alert_and_response/outbreak-network/en/

16.00-16.30	**Coffee break**
Session 1.5	
16.30-17.30	**Remote programming and monitoring – a practical approach**
Focal points:	Trina Helderman, Medair, GHC/SAG Kim Créac'h, The Operational Partnerships

The purpose of this session is to:

- Present background of the project
- Introduce the remote management project

The expected outcome of the session is:

- Capture opportunities, challenges, recommendations and lessons learned in regards to Remote Programming within Clusters.
- To provide direct feedback to the consultants on the development of the guidance and tools to facilitate the work of humanitarian actors working by remote programming.

Method: Plenary presentation and discussion

Background documents

- Definitions of Remote Programming

Further reading (available on SharePoint)

- Humanitarian Programming and Monitoring in Inaccessible Conflict Settings: A Literature Review

17.30-18.00	**End of the day 1 wrap-up**
18.00-18.45	**Welcome reception**

DAY 2
Tuesday 4 April 2017

08.30-08.45	**Outline and objectives of day 2**

Objective

- To agree the day's agenda.

Session 2.1	
08.45-12.15	**Inter/multi – cluster coordination: How do we ensure more effective joint operational programming for better health outcomes?**

Focal points: Magda Armah, Health Cluster Coordinator, South Sudan
Linda Doull, Global Health Cluster Coordinator

The purpose of this session is:

- To present the GHC ICC project outline in the context of Grand Bargain commitments and WHS pledges
- Country level focus: Case study of South Sudan inter-cluster coordination group

The expected outcome of the session is:

- To Define next steps/actions needed to achieve better outcomes in terms of:
  - Joint planning, analysis and response
  - Improved inter-cluster coordination group engagement
  - Roles and responsibilities of the Health Cluster in inter/multi – cluster coordination
  - How can the Global Health Cluster support country clusters in strengthening inter-cluster coordination?

Method: Presentation and group work

Background documents:

- Briefing - OFDA funded Inter Cluster Collaborative Initiatives 2017
- Health and WASH Clusters: Concept note on strategies to improve a coordinated and integrated response to cholera and other AWDs
- Draft Humanitarian Country Team Terms of Reference

Further reading (available on SharePoint)

- HPC Reference Module 2015
- OCHA: Global Overview Coordination Arrangements 2016
- Emergency Response Preparedness Guidance 2015
  - Annex_7-Contingency_plan_template

10.00-10.30	**Coffee Break**
12.15-13.30	**Lunch**
Session 2.2	
13.30-15.30	**Localisation: strengthening national capacity**
Focal points:	Linda Doull, Global Health Cluster Coordinator Mohammad Dauod Altaf, Health Cluster Coordinator, Afghanistan

The purpose of this session is to discuss:

- What do we mean by national capacity building?
- To what degree is the health cluster responsible for National partners meeting international standards?
- Key areas to consider when working with government and partners for transition. (Case study Afghanistan).

The expected outcome of the session is to define:

- The role of the Health Cluster in strengthening national capacity building.
- How to compliment the role of the MOH.
- Tools and/or support needed to strengthen the health cluster in building national capacity.

Method: Presentation and group work.

Background documents:

- Global Health Cluster Partner Statement – World Humanitarian Summit, May 2016
- National and Local Responders (Localisation) Actual commitments agreed by Grand Bargain Sherpas

Further reading (available on SharePoint)

- Agenda for Humanity: Annex to the Report of the Secretary-General for the World Humanitarian Summit
- Grand Bargain May 2016

- ICVA Grand Bargain Explained

15.30-16.00	**Coffee break**
Session 2.3	
16.00-17.30	**Increasing partner engagement**

Focal point: Emma Fitzpatrick, Global Health Cluster Unit

The purpose of this session is to explore:

- Challenges and opportunities to increase participation in the health cluster from key partners:
  - MOH
  - National NGOs
  - International NGOs, UN Agencies
  - Donors

The expected outcomes of the session are to:

- Identify best practices to improve partner engagement at country level
- Identify areas where international GHC partners can provide support.

Method: Presentation and group work

Background documents:

- Draft Humanitarian Country Team Terms of Reference
- Global Health Cluster Partner Statement – World Humanitarian Summit, May 2016

17.30-18.00	**End of the day 2 wrap-up**

DAY 3
Wednesday 5 April 2017

08.30-08.45	**Outline and objectives of the meeting**
Objective • To agree the day's agenda	
Session 3.1	
08.45 - 10.30	**Strengthening leadership**
Focal points:	Rick Brennan, Director, Emergency Operations, WHO Health Emergencies Rob Holden, Senior Emergency Adviser, WHO Emergency Operations
The purpose of this session is to: • Provide an overview of WHE strategic direction and the commitment of WHO as CLA at national regional and global levels. • Introduce the new Incident Management System. **The expected outcome of the session is to identify:** • Understanding of the new WHE structure at country, regional and global levels • Define how HCCs and the health cluster can work strengthen leadership at country level. **Method:** Plenary presentations and Q&A **Background documents:** • Incident Management System: revised chapter of the Emergency Response Framework	
10.30-11.00	**Coffee break**
Session 3.2	
11.00-12.00	**Update on Mainstreaming AAP and Protection in Health Coordination: Where are we now? What are the next steps?**
Focal point:	Patricia Colbert, Senior Adviser, GENCAP
The purpose of this session is to: Understand the complementarity of gender, protection, Gender Based Violence (GBV) and Sexual Exploitation and Abuse (SEA) as they pertain to AAP. **The expected outcome of the session is:** To be able to articulate how all of these cross-cutting issues together make	

major contributions to improving the quality of assistance provided and the impact it has on the lives of those being assisted.

Method: Plenary presentation and Q & A

Background documents:

- Health Cluster Operational guidance on Accountability to Affected Populations

12.00-13.00	**Lunch**

Session 3.3

13.00-14.00	**Information management – update on Public Health Information Standards (PHIS) and rollout**
Focal point:	Olivier Le Polain, Public Health England, Chair of the GHC/PHIS Task Team

The purpose of this session is to discuss:
Information about latest development of PHIS work moving forward.

The expected outcome of the session is:
An understanding of the work plan forward of the GHC PHIS Task Team and feedback and engagement from participants.

Method: Plenary presentation and Q & A

Further reading (available on SharePoint)

- Standards for Public Health Information Services in Health Clusters and Other Crisis Sectoral Coordination Mechanisms

Session 3.4

14.00-15.30	**Advocacy and attacks on health care**
Focal points:	Erin Kenney, Project Manager, Attacks Project Mary Pack, IMC, GHC/SAG member

The purpose of this session is to discuss:

- New timeline for the roll-out of the attacks on health care tool
- Key results from the 2016 survey on Health Cluster Advocacy needs: are they still valid?

The expected outcome of the session is:

- Identify areas that the GHC can support country health clusters.

Method: Plenary presentation and Q & A

Background documents:

- WHO's Plan for the collection and verification of data on attacks on health care in 17 priority countries facing emergencies

- Attacks dashboard_2016_ANNUAL

Further reading (available on SharePoint)

- Attacks Project Document Budget March 2017
- Attacks Communications Procedures 21 March 2016
- WHO talking points on attacks against healthcare March 2016

15.30-16.00	**Coffee**
16.00-17.00	**Meeting summary – next steps**
Focal point:	Linda Doull, Global Cluster Coordinator

The objectives of the session are to:

- Agree on commitments by the HCCs/GHC on performance standards.
- Define next steps/actions needed and the timeframe

Method: Guided discussion

17.00-17.30	**Closing remarks**
17.30-18.00	**End of the forum evaluation**

Annex 2: List of participants

Organization	Title	Name	Last Name	Position
Health Clusters				
Country				
Afghanistan	Dr	David	Lai	Health Cluster Coordinator
Afghanistan	Dr	Daoud	Altaf	Health Cluster Coordinator
Chad	Dr	Amadou	Diallo	Health Cluster Coordinator
Colombia	Dr	Cecile	Barbou de Courieres	Health Cluster Coordinator
Democratic Republic of the Congo	Dr	Ernest	Dabire	Health Cluster Coordinator
Fiji	Dr	Rok Ho	Kim	Health Cluster Coordinator
Iraq	Dr	Fawad	Khan	Health Cluster Coordinator
Mali	Dr	Theodore	Yao	Health Cluster Coordinator
Niger	Dr	Rosine	Sama	Health Cluster Coordinator
North East Nigeria	Dr	Jorge	Martinez	Health Cluster Coordinator
Pakistan	Dr	Michael	Lukwiya	Health Cluster Coordinator
OPT	Ms	Sara	Halimah	Health Cluster Coordinator
South Sudan	Ms	Magdalene	Armah	Health Cluster Coordinator
Sudan	Dr	Eiman	Karrar	Health Cluster Coordinator
Turkey-Gaziantep	Dr	Jamshed	Tanoli	Health Cluster Coordinator
Turkey-Gaziantep	Dr	Abd Arrahman	Alomar	Health Cluster Co-Lead, SAMS
Whole of Syria	Dr	Mauricio	Calderon	Health Cluster Coordinator
Whole of Syria	Dr	Mouna	Mayoufi	Health Cluster Co-Lead, IRC
Ukraine	Mr	Craig	Hampton	Health Cluster Coordinator
Yemen	Dr	Alaa	Abou Zeid	Health Cluster Coordinator

	Mr	Will	Cragin	Coordinator
GHC Strategic Advisory Group				
International Medical Corps	Ms	Mary	Pack	Vice President for Domestic and International Affairs
Medair	Dr	Trina	Helderman	Emergency Response Officer – Health and Nutrition Specialist
Office of Foreign Disaster Assistance - United States of America	Ms	Sonia	Walia	Public Health and Nutrition Advisor
UNFPA	Dr	Wilma	Doedens	Technical Advisor Sexual and Reproductive Health in Crises
WHO EMO Policy	Dr	Andre	Griekspoor	SAG co-chair, Senior Technical Officer
WHE/EMO				
Director's Office	Dr	Rick	Brennan	Director
GOARN	Mr	Pat	Drury	Manager
EMT	Mr	Flavio	Salio	Technical Officer
Other interested parties/speakers				
Operations Partnership	Mr	Yves-Kim	Créac'h	Consultant
GenCap	Ms	Patricia	Colbert	Global Senior GenCap Advisor
Public Health England	Dr	Olivier	le Polain	Chair Public Health Information Services Task Team
Office of Foreign Disaster Assistance - United States of America	Dr	Jolene	Nakao	Public Health and Medical Technical Advisor
WHO Regional Offices				
World Health Organization (AFRO)	Dr	Michel	Yao	Programme Area Manager, AFRO
World Health Organization (EMRO)	Mr	Brian	Tisdall	Focal Point, EMRO

World Health Organization (EURO)	Dr	Dorit	Nitzan	Focal Point, EURO
World Health Organization (SEARO)	Dr	Arturo	Pesigan	Focal Point, SEARO
World Health Organization (AFRO)	Dr	Thierno	Balde	Partnership Focal Point, AFRO
Global Health Cluster unit				
Global Health Cluster unit	Ms	Linda	Doull	Global Health Cluster Coordinator
Global Health Cluster unit	Ms	Emma	Fitzpatrick	Technical Officer
Global Health Cluster unit	Ms	Elisabetta	Minelli	Secretariat (Technical Officer)

Annex 3: Health Cluster Forum 2017 recommendations

Recommendation Session 1.1 Purpose of the Health Cluster Forum

Development of a toolbox/toolkit - beyond general guidelines - to include proven methodologies and tools for dealing with protracted crises.

Recommendations from Session 1.2 Global trends: the role of the Health Cluster

Country Health Clusters:

- HCCs should plan the cluster exit strategy from the beginning of the crisis. This includes working on transition from cluster to sector coordination with a stronger role of government, involving authorities at national and sub-national levels.

Headquarters - WHO and GHC:

- Provide a cluster support toolbox/toolkit easily accessible and regularly updated.
- Streamline WHO clearance & approval levels to enable more timely information sharing.
- Develop guidance on how to improve inter-cluster collaboration towards collective outcomes.

Recommendations from session 1.4 Differentiated coordination solutions: working in partnership

For WHO and the GHC

- Identify how the Health Cluster can more effectively engage a more diverse range of partners whilst maintaining the impartial delivery of assistance.
- Empower the Health Cluster within the IMS structure.

Recommendations from Session 1.5 Remote programming and monitoring – a practical approach

Country Health Clusters

- Examine how remote partnerships could function where technology is absent.
- Consider how to assure quality control via remote management in situations where Country Health Clusters work with a diverse range of partners.

Headquarters - WHO and GHC

- Actively engage HCCs in the next phase of the remote management project – country case studies and peer reviews.
- Examine funding possibilities for remote management.

Recommendations from Session 2.1 Inter/multi-cluster coordination: How do we ensure more effective joint operational programming for better health outcomes?

Country Health Clusters
- Strengthen monitoring, supervision and corrective action roles.

Headquarters - WHO and GHC
- Set indicators and benchmarks to ensure quality of care standards, including medical care and WASH, are being met.
- Clarify, formalize ICC guidance for implementation at country level.
- Define roles, responsibilities and expectations of country-level inter-cluster mechanisms.
- HCCs to be invited to attend Global WASH and Nutrition Cluster meetings, when required to share good practice.

Country Health Clusters and Headquarters - WHO and GHC:
- Agree scorecard standards and set up monitoring.

Recommendations from session 2.2 Localisation: strengthening national capacity

Country Health Clusters:
- Share best practices on transition through field exchange visits facilitated by the Global Cluster.
- Define areas where national capacity building is needed, such as in response preparedness, recovery or health system strengthening.
- Support establishing thematic working groups with local health authorities.

Headquarters - WHO and GHC:
- Explore support for training in global health to support transition.
- Ensure predictable and sustainable funding is in place.

Recommendations from session 2.3 Increasing partner engagement

Related to resource mobilization / donors
- Provide one template for proposal development.
- Provide a one-pager on effective communication with donors.
- Provide guidance on 'acceptable donors' in case they are parties to a conflict.
- Provide guidance on how to engage with donors on multi-sectoral funding.
- Sharing of regular information from donors on the projects they are funding.
- Provide orientation for new HCCs on CERF-pooled funds.
- CCs should reach out to development/stabilization donors to ensure there are complementary links with humanitarian donors/programming, ensuring all funding sources are complementary.

Related to national NGOs

- Screen NGOs according to predefined criteria. For example, consider the Emergency Medical Teams (EMT) paper on basis for accreditation of partners.
- Integrate national NGOs in the humanitarian programme cycle.
- Include national NGOs in CERF project cycle and funding.
- Provide help on how to build technical capacities for national NGOs (e.g. how to write and submit a donor report).
- Encourage national NGOs to be active in the cluster, e.g. to participate in sub-cluster and attending meetings on rotational basis.

Related to international NGOs

- The Health Cluster could work as interface between MOH and INGOs if there is disagreement.
- GHC to urge more commitment from the NGO HQs to participate in Country Health Clusters.
- Send the Health Cluster information management officer (IMO) in person to collect data from INGOs.
- Ask INGOs what data is most useful and helpful for them.

UN agencies

- Engage UN agencies in the Strategic Advisory Group and technical working groups.
- Engage heads of agencies with health cluster actions.
- Fully involve agencies in resource mobilizations including joint projects and innovative funding mechanisms.
- HQs of each agency should liaise with each other to create formal working arrangements.

Recommendations from session 3.1 Strengthening leadership

Headquarters - WHO and GHC:

- Consider better integration of EMT initiation and cluster approach within the IMS, especially in light of possible competing interests.
- Devise ways to better manage outbreak response, also involving OCHA and other programmes.
- Provide clear guidance on cluster roles within the IMS.
- Sensitize Heads of WHO Country Offices and make sure those with emergency experience are in priority and vulnerable countries.

Recommendations from session 3.2 Update on Mainstreaming Accountability to Affected Populations (AAP) and Protection in Health Coordination: Where are we now? What are the next steps?

Clusters should develop a more "people-centred" mindset as humanitarians, knowing that health needs vary depending on, at the most basic level, on age and gender.

Recommendations from session 3.3 Information Management—update on Public Health Information Standards (PHIS) and rollout

Country Health Clusters

- At the country level, HCCs must ask for dedicated information management capacity.
- Analysis support is needed as well as specific indicators for reporting on a monthly basis on progress and outcomes.

WHO

- WHO must provide longer term dedicated information management capacity in countries.

Recommendations from session 3.4 Advocacy and attacks on health care

Country Health Clusters:

- Actively promote the use of the revised IASC age and gender marker.
- Provide opportunities for gender mainstreaming and address marginalized populations like LGBTi (Lesbian, Gay, Bisexual, Transgender/Transsexual and Intersexed) communities.

Headquarters - WHO and GHC:

- Continue to focus on the same issues around advocacy and attacks on health care identified in the 2015 survey.
- Provide training to HCCs so that they can better identify advocacy areas and prioritize issues.
- Mobilize resources for advocacy at the global level to provide minimum funding to close staffing gaps.
- Mobilize advocacy at local and national government levels including protecting health staff and hospitals.

All:

- Be more direct and targeted as a sector in specific advocacy efforts.
- Address administrative blockages at borders and in governments to allow medicines into countries and work visas for health workers.
- Ensure more consistent reporting of attacks on healthcare.

Annex 4: Country Health Clusters