

HEALTH CLUSTER FORUM

26 – 28 June 2018, Geneva, Switzerland

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EXECUTIVE SUMMARY

The fourth annual Health Cluster Forum was held on 26-28 June 2018 in Geneva, Switzerland. The Forum convenes Health Cluster Coordinators (HCCs) and Co-Coordinators annually to engage in cluster capacity building efforts, share leadership best practices, address challenges and areas of concern, and to document action points.

At the three-day forum, coordinators shared their cluster experience and perspectives with their colleagues 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 Forum covered: continuing challenges ensuring adequate resources mobilization for the health cluster team and for partner response; the need for guidance on how WHO reorganization will impact the work of the health cluster teams and partner engagement; appropriate flexibility for HCCs to tailor WHO mechanisms and processes to reflect their respective contexts, including stronger involvement of NGO HCCs; the need for further clarity on management and where the HCC, Co-HCC and HC team roles fits within the broader organizational architecture; the importance of ensuring an integrated response across sectors and thematic areas.

Key concerns raised during the Forum included the need to: help other functions understand the role and limitation of the coordinator; improve information management balancing the need to rapidly access information with developing a more sustainable information management system; consider the four aspects of quality in cluster work: patient safety, effectiveness of treatment, people centeredness, equity; create longer terms solutions without neglecting the need to invest in short-term responses; ensure that health is included in any discussion of cash programming.

Twenty-three Health Cluster Coordinators (HCCs), seven Health Cluster Co-coordinators and Information Management Officers (IMOs) from partner organizations (iMMAP, International Medical Corps, Save the Children, International Rescue Committee), one Incident Manager and one Technical Officer participated from five World Health Organization (WHO) regions, with

Health Emergencies Programme (WHE) staff from WHO regional offices and headquarters, GHC Strategic Advisory Group (SAG) members and the Global Health Cluster unit (GHC unit). Representatives from the Health System Strengthening and Mental Health Departments also participated in relevant sessions. See list of participants (Annex 1).

The GHC unit thanks all participants of the 2018 Forum for their candid insight and fruitful debates on the complex issues challenges facing clusters. The GHC unit looks forward to future collaboration with participants as work continues to implement these recommendations to strengthen clusters' capacity to respond to the emergencies impacting the people they serve.

MAIN RECCOMENDATIONS

SESSION 1.2 Strengthening the understanding of how clusters align with WHO at the global, regional and country level

Health Cluster:

- Demonstrate and advocate for the added value of coordination and its underlying principles.
- Promote Principles of Partnership to strengthen and diversify partner engagement in coordination in changing environments.

WHO headquarters (HQ):

- Clarify Health Cluster engagement and role within an outbreak response structure and the Incident Management System (IMS) structure.

SESSION 1.3 Humanitarian Development Nexus: global policy and country implementation

Health Cluster:

- Deepen cluster understanding of the humanitarian and development interface and tools to enable this; promote and support closer engagement between respective actors, including Government where appropriate.
- Proactively encourage development partners to engage in the cluster and vice versa.

All levels:

- To achieve Universal Health Coverage in Fragile and Vulnerable Countries (FVC) countries, WHE and WHO Health System Strengthening (HSS) staff must collaborate at all three levels of the organization to jointly undertake health system assessments and develop preparedness plans.

- Recognise that Humanitarian-Development Nexus (HDN) plans and strategies will vary when dealing with legitimate government and non-legitimate authorities and structures.

GHC unit:

- Explore more systematic engagement & support on HDN discussion and implementation within WHE and HSS at the global and regional level.

SESSION 1.4 Cash-based interventions for health programmes in humanitarian contexts

Health Cluster:

- Ensure HCCs demonstrate they have considered the use of cash in programming (even if the outcome is negative).
- HCCs should facilitate the technical discussion on cash with partners and represent the outcome of the discussion in the ICCG.
- Health must be a part of any cash discussion, so that health is included in the Basic Needs basket.

WHO HQ:

- WHE Humanitarian Policy and Guidance / CashCap to provide support on cash transfer programming to identified Health Clusters.

SESSION 2.1 Exploring alternative coordination mechanisms – ensuring principles of partner coordination

WHO HQ:

- Consider more neutral language around coordination architecture to promote closer collaboration and improve the interface between existing and newly activated coordination mechanisms (national or international) and partner network engagement.
- Strong leadership from WHE needed with HCC and WHO roles clarified within the IMS structure.

Health Cluster:

- Ensure appropriate use of different HR surge mechanisms for different contexts with the flexibility to adapt for acute and transition to protracted.
- Avoid disempowering the HCC vis-a vis through overly rigid application of IMS.
- When Emergency Operation Centres (EOCs) are activated, ensure the Health Cluster is involved in coordination architecture discussions from the immediate planning stage to help clarify roles and responsibilities.

- Further enhance Health Cluster and Emergency Medical Teams (EMTs) collaboration to avoid parallel coordination mechanisms.

All levels:

- All WHO staff must take the online IMS training, available on the OpenWHO platform at <https://openwho.org/courses/incident-management-system>.

SESSION 2.2 Ensuring an integrated response

All levels:

- Recognize the importance of ensuring an integrated response across sectors and thematic areas and thematic areas.

Global Health Cluster:

- Promote subject matter experts available to support Health Clusters (Mental Health and Psychosocial Support, Sexual and Reproductive Health, Gender-based violence, WASH and Protection).
- Sexual and Reproductive Health (SRH) project teams to ensure sustainable plans for a comprehensive SRH package are developed, beyond implementation of the pilot project.
- Within the Acute Watery Diarrhoea (AWD)/cholera framework, GHC to clarify the roles of HCC, WHO, Ministry of Health/Ministry for Water, Sanitation and Hygiene and UNICEF in terms of responsibilities and accountabilities.

Health Cluster:

- HCCs to refer to the Sphere Standards and Inter-Agency Standing Committee (IASC) Monitoring and Evaluation Framework on Mental Health and Psychosocial Support in Humanitarian Emergencies (MHPSS) when developing Humanitarian Response Plans.
- HC partners to engage with communities and local authorities on SRH.
- HCs to address Gender-based Violence (GBV) as a health issue and not just what body takes on the coordination (GBV sub-group under health or protection).
- HC partners to find a system to share GBV information appropriately, as it is a challenge how to respect patients' data confidentiality while addressing response needs.

SESSION 3.1 Information Management

WHO HQ:

- GHC and Health Emergency Information and Risk Assessment (HIM) teams need to find sustainable solutions for long-term dedicated Information Management support for Health Clusters.
- GHC and HIM team to conduct further PHIS piloting and thorough evaluation of integrated information management teams and their effectiveness.

Health Clusters:

- HCC and IMO terms of reference to include producing Public Health Information Services Standards outputs and setting up information management working groups across clusters/sectors.
- HCCs to continue Health Resources Availability Mapping System (HeRAMS) roll-out to monitor health service availability over time rather than just serving as a one-off baseline.

SESSION 3.2 Ensuring essential quality of care – the role of cluster teams and cluster members

Health Cluster:

- HCCs to understand that quality assurance and improvement is one of the health cluster's roles and promote use of appropriate quality assurance tools and processes.

Global Health Cluster:

- Establish a GHC Task Team on Quality with broad representation from different groups, including HCCs and GHC partners, as well as EMTs, Global Outbreak Alert and Response Network (GOARN), Health System Strengthening (HSS) quality team.
- Learn from EMTs and Iraq cluster experiences in development of clinical and operational standards, tools and processes.

DAY 1 – 26 JUNE 2018

OPENING and SESSION 1.1 Introduction to participants and facilitators

On behalf of the Global Health Cluster unit (GHC unit), Emma Fitzpatrick and Elisabetta Minelli welcomed all participants to the 2018 GHC Forum. They presented the Forum objectives and agenda including:

- Strengthening and understanding how clusters align with WHO at the global, regional, and country level.
- Global policy and country implementation of the Humanitarian-Development Nexus (HDN).
- Cash-based interventions for health programme's in humanitarian contexts.
- Exploring alternative coordination mechanisms and ensuring the principles of partner coordination.
- Ensuring an integrated response.
- Strengthening the understanding of how clusters align with WHO at the global, regional and country level.
- Information management.
- The role of cluster teams and mechanisms in ensuring essential quality of care.

Following the adoption of the agenda, participants introduced themselves.

SESSION 1.2 Strengthening the understanding of how clusters align with WHO at the global, regional and country level

Focal Point: Linda Doull, Global Health Cluster Coordinator

Linda Doull presented perspectives on [how the Cluster aligns with WHO at the global, regional and country level](#). She informed participants about the Global Programme of Work 13 (GPW 13), which will re-organize WHO around three primary goals: promoting health, keeping the world safe and serving the vulnerable. Health emergencies and global health security are therefore strategic organisational priorities for WHO, with the stated goal of better protecting 1 billion more people from health emergencies. Furthermore, Universal Health Coverage (UHC) cannot be achieved without addressing health emergencies and strengthening health systems in the FVC. The WHO Thirteen General Programme of Work (GPW 13) presents an opportunity for the Health Emergencies Programme (WHE), the cluster and other partner networks to augment the impact of their work, with greater focus on results at country level.

She also explained that the Director-General's new vision is to ensure WHO works more cohesively throughout the organization and across the health system itself. To this end, implementing the GPW 13 will be a country-driven process and will lead to a shift of resources, responsibilities and accountabilities towards the country and regional levels. How this shift occurs is being determined through the WHO Transformation exercise currently taking place.

Referencing the current GHC Strategy 2017-2019, she reiterated that partner engagement and clusters will continue to play a major role in achieving the targets of GPW 13. However, to do so, HCCs must strive to make coordination 'fit-for-purpose', more flexible and appropriate to context, a more engaged process, including investing in inter-sectoral humanitarian responses and better understanding of the cluster's role and responsibilities within the WHO Incident Management System (IMS). Furthermore, clusters must better advocate for the significance and impact of their work.

DISCUSSION

While participants commended the Director-General's transformative agenda, they raised concerns about how the organization will ensure it achieves the ambitious targets outlined in GPW 13. In particular, HCCs asked for clarification on how the one billion targets were set, how the targets will be tracked to ensure achievement, and whether the organization has the financial resources needed for such a transformative agenda. They additionally highlighted the need for the programme of work's applicability at a country level to be more clearly defined. HCCs also requested further clarification on the cluster positioning within the Incident Management System and the Country Business Model.

HCCs emphasized the need to better demonstrate the cluster's added value given the upcoming reforms. Clusters must advocate for their work in order to maintain the relevance and value of coordination and partnership to the GPW 13 targets. There is an opportunity for HCCs to share their operational knowledge, including making more active contributions to implementation and good practice. The Mali Cluster Coordinator noted that most clusters already are working with many of the GPW 13 targets and, therefore, the programme of work presents an opportunity for clusters to better communicate their leadership and engagement.

Speaking about the IASC Principles decision to undertake a light review of coordination architecture including the "responsible disengagement" of the cluster, the HCCs highlighted the need to more strategically discuss the future of the cluster approach and how it may transform in country-specific coordination arrangements. HCCs also identified defining and planning solutions for Internally Displaced Persons (IDPs) in emergency responses as an area clusters could

make a greater impact. For example, health clusters should coordinate with different sectors to develop solutions before IDP situations become protracted.

RECOMMENDATIONS FROM SESSION 1.2:

Health Cluster:

- Demonstrate and advocate for value added of coordination and its principles.
- Focus on the Principles of Partnership to strengthen and diversify partner engagement in coordination in changing environments.

WHO HQ:

- Clarify the Health Clusters engagement and role within an outbreak response structure and the IMS structure.

SESSION 1.3 Humanitarian Development Nexus: global policy and country implementation

Session Chair: Alaa Abou Zeid, Operational Partnerships, WHE/EMRO

Focal Points:

Andre Griekspoor, Senior Policy Advisor, WHE Emergency Operations

Arun Mallik, Sudan Health Cluster Coordinator

Adanadji Yaoklou Mawuemiye, Northeast Nigeria Health Cluster Coordinator

Shafiq Muhammad, Northeast Nigeria, Borno State Health Cluster Coordinator

Andre Griekspoor presented a general overview of the [Humanitarian-Development nexus \(HDN\)](#), after which the HCCs from Sudan and Nigeria shared case studies illustrating its implementation on the ground. Historically, humanitarian and development approaches were seen as oil and water, unable to link. The two disciplines had their own independent funding systems and planning and reporting mechanisms. Programming was believed to transition from a purely humanitarian response into recovery and development programming. However, in practice this often left gaps in programming and funding. The humanitarian and development communities have increasingly realised that joint and connected programming can provide for a bigger impact. According to the *new way of working*¹, humanitarian organizations

¹ Former UN Secretary-General Ban Ki-moon and the heads of UNICEF, UNHCR, WHO, OCHA, WFP, FAO, UNFPA and UNDP, with the endorsement of the World Bank and the International Organization for Migration, signed at the World Humanitarian Summit a "Commitment to Action" document, in which they agreed on a New Way of Working in crises. Its aim is not only to meet

need to connect with long-term health systems strengthening at the same time that development partners invest operationally in conflict affected areas. Development donors are increasingly interested in funding humanitarian programs, leading to decreasing actual gaps in funding and programming opportunities for humanitarian partners.

However, humanitarian and development programming need to do a better job of communicating with each other. Clusters have the opportunity to lead coordination between humanitarian and development actors. When development actors have a seat at the table, clusters can be a platform for discussing common challenges and solutions, while still maintaining their distinct coordinating mechanism.

In [Sudan](#), a recovery and reconstruction strategy has been paired with a multiyear humanitarian strategy built off an essential package of health services. The health cluster has played a vital role in the strategy by encouraging development partners to engage with health cluster partners at coordination meetings. Furthermore, the cluster strives to sensitize health cluster partners on prevention and preparedness, rather than solely focusing on humanitarian responses. Health cluster partners are currently exploring new ways to integrate UHC into the cluster's work. The Sudan Health Cluster will continue to work with Health Emergency Humanitarian Action Coordination Committee of Sudan's Health Sector Partners Forum (HSPF) which was established in November 2016.

[Northeast Nigeria](#) is a second example of a cluster coordinating development and humanitarian programming. The region is not homogenous: in some parts of the region service delivery is completely disrupted and the population relies entirely on humanitarian aid delivered by mobile teams, whereas more stable parts of the region are already being introduced to a World Bank Performance-based Finance System. As such, there is strong interest from the National Ministry of Health (NMOH), donors, and development agencies in coordinated development and humanitarian programming. The Nigeria Country Office recently led a health system assessment to identify priorities for a roadmap to HDN.

Dirk Horemans participated on behalf of the WHO Health Systems Strengthening Department and gave a brief introduction from the floor about [health system development aspects to be considered for HDN](#). It is key that the humanitarian community understands the various development stakeholders, partners, actors and tools, in order to initiate and sustain collaboration and vice versa.

humanitarian needs, but also to reduce needs, risks and vulnerability over time. Read more <https://www.agendaforhumanity.org/initiatives/5358>.

DISCUSSION

Through group work, HCCs brainstormed ways the six health system building blocks could be integrated into humanitarian responses: service delivery, health workforce, information, medical products, financing, and leadership/governance, and thought on how to systematize actions that clusters are already taking to address each of them. Some emerging ideas included:

- Pursuing multi-year funding with flexibility over how funding modalities are addressed.
- Linking the essential package of services provided in humanitarian responses with the health system package of services.
- Working to build the capacity of national health authorities and strengthen district health capacities.
- Link humanitarian responses with national essential medicine lists.
- Train the local workforce to respond quickly and effectively to disease outbreaks.
- Conducting in-depth health system assessments to serve as a baseline before health emergencies or disease outbreaks.

HCCs additionally brainstormed ways for development and humanitarian actors to collaborate on joint health system analyses.

Participants raised concerns about the lack of applicability of HDN to some cluster countries. Coordinators from Syria, Turkey and Somalia, for example, highlighted the challenge of investing in development and health system strengthening in fragmented countries that lack unified leadership under the Ministry of Health. Coordinators questioned the feasibility of incorporating non-government controlled areas into HDN work, despite the need to uphold humanitarian principles.

HCCs discussed the need to create long-term solutions without neglecting the need to invest in short-term responses. For example, mobile teams are appreciated as they are seen as important elements of a short term response, but they can also contribute to overall national capacity building and therefore strengthen resilience.

RECOMMENDATIONS from Session 1.3:

Health Cluster:

- Considering there is no one single solution on the interface between humanitarian and development, clusters need to better understand the development and humanitarian actors and tools available to promote and support closer engagement.

- Ensure the voice of cluster partners is reflected in development forums and vice versa.
- Ensure, where possible, that the Government is engaged in both humanitarian and development forums.
- Proactively encourage development partners to engage in the cluster.
- Consider adding development partners to the cluster 4/5Ws.

All levels:

- UHC can only be achieved through investment in FVC. To this end, WHE and Health System Strengthening (HSS) staff must collaborate at all three levels of the organization to jointly undertake health system assessments and develop preparedness plans.
- Use the six health system building blocks to identify HDN solutions.
- Need to create longer term solutions without neglecting the need to invest in short-term responses.
- Recognise that HDN plans and strategies will vary when dealing with legitimate government and non (legitimate) authorities and structures.

GHC unit:

- Explore more systematic support on HDN discussion and implementation within WHE and HSS at the global and regional level.

SESSION 1.4 Cash-based interventions for health programmes in humanitarian contexts

Focal Points:

Andre Griekspoor, Senior Policy Advisor, WHE Emergency Operations
Elodie Ho, Consultant, CashCAP

Andre Griekspoor and Elodie Ho, led the discussion on [the use of cash based interventions for health in humanitarian settings](#). Over the past several years, multi-purpose cash transfers have been progressively replacing in-kind assistance. Donors like European Civil Protection and Humanitarian Aid Operations (ECHO) and the United Kingdom Department for International Development (DFID) have been pushing partners to use cash as their preferred and default modality. Health is consistently one of the top three highest uses for multi-purpose cash transfers. Aid recipients generally use a substantive amount of the cash they receive for health, mostly for indirect costs such as transport to medical appointments. As such, it is imperative that HCCs and health cluster partners become familiar with cash transfers and how they can be used to the cluster's advantage. Andre referred to the recently published [Health Cluster and WHO Working Paper on Cash](#) and reflected that addressing health needs is different, and therefore requires a careful discussion on the potential added

value and limitations of cash-transferred programme to achieve health outcomes and/or health sector specific objectives. Elodie introduced participants to the different types of cash modalities and what situations they are best suited for. For example, conditional restricted cash could be used to encourage recipients to access health services, by requiring them to pick up the cash from a clinic and to spend it on a consultation.

DISCUSSION

Despite the growing prevalence of cash transfer programming in humanitarian settings, discussions at the Forum highlighted the challenges of applying cash to the health sector. Preventative health services do not have the same demand as food, shelter, or other basic needs. As such, cluster coordinators were sceptical that cash transfers would actually be used by recipients to access health services.

Furthermore, cluster coordinators expressed concern that cash transfers or vouchers could reinforce a system where patients are charged out-of-pocket for health services. The Syria cluster coordinator for example, argued against the use of cash programming because it diverts funds from the public health system to a private health market. He additionally expressed concern about corruption and the possible use of cash vouchers to create a war economy. Other participants countered that, while the primary goal should be universal coverage under national health insurance schemes, cash vouchers could be used to supplement insufficient health insurance funds. Additionally, in cases where the public health system has extremely limited capacity, paying out-of-pocket for the private sector could be the only avenue for accessing health services. Dirk Horemans from the HSS Department, for example, stressed that informal payments can be a major barrier to accessing health services in humanitarian settings and there is an opportunity for cash programming to address this.

The ultimate conclusion was that, while there are legitimate concerns about the applicability of cash programming to the health sector, all clusters must at least demonstrate that they have considered using cash, to meet the Grand Bargain commitments.

RECOMMENDATIONS from Session 1.4:

Health Cluster:

- As per the Grand Bargain commitments, HCCs have to demonstrate they have considered the use of cash in programming (even if the outcome is negative).
- HCCs need to help facilitate the technical discussion on cash with partners and represent the outcome of the discussion in the Inter-Cluster

Coordination Group (ICCG). Coordinators should start by reading the working paper on cash.

- Health must be a part of any cash discussion, so that health is included in the basic needs basket.

WHO HQ:

- GHC Cash-based Interventions Task Team to implement the proposed work-plan.
- Andre and Elodie to provide support on cash transfer programming to identified health clusters.

DAY 2 – 27 JUNE 2018

SESSION 2.1 Exploring alternative coordination mechanisms – ensuring principles of partner coordination

Session Chair: Michel Yao, Programme Area Manager, WHE/AFRO

Focal Points:

Tony Stewart, Technical Officer, Global Outbreak Alert and Response Network

Rosie Jeffries, Bangladesh Health Sector Information Management Officer

Sara Halimah, occupied Palestinian territory (oPt) Health Cluster

Coordinator

Paul Cox, Team Leader, WHE Emergency Operations Centre

Participants discussed ways that clusters can strengthen collaboration through alternative coordination mechanisms and evolving coordination networks and processes. Focal points presented three response mechanisms that clusters should engage with to improve health responses: Emergency Operation Centres (EOCs), EMTs and GOARN.

Paul Cox presented on [cluster collaboration with health EOCs](#). In 2012, WHO identified that each region and country was responding to health emergencies differently, without any coherent standards or coordination. Health EOCs were developed to fill this gap. Operations centres are more than a building - the main purpose is coordination of operational information and resources for strategic and/or tactical management of public health events and emergencies. EOCs bring all sectors together in one room for collaboration, ensuring everyone is working off the same information and making evidence-based decisions during emergencies. Timely, accurate information sharing and exchange is integral to emergency responses. One of the best ways to share information is simply by getting colleagues together in the same room as often as possible.

Michel Yao presented on the [Central African Republic and Democratic Republic of the Congo cases](#). He highlighted that there is room for health clusters and other clusters to be proactively incorporated into Health EOCs during outbreak events. Having a cluster liaison sitting at the table with communicable disease staff during decision making would help prevent both duplications of work and gaps in the emergency response. Health EOCs must better understand the role of clusters and ways their resources can be drawn upon to help during outbreak responses. As such, it would be helpful for the GHC and HCCs develop recommendations on how clusters and Health EOCs can work together. For example, clusters could contribute to gather operational information (such as 4Ws), develop joint analyses, provide primary health care

services, collaborate with other sectors. More in general, Health EOCs should analyse the situation, define strategy and the gaps for each of the response areas, and call in assets and capacities needed from different partners' networks.

Sarah Halimah presented a [case study on the occupied Palestinian territory \(oPt\)](#) to illustrate ways clusters can interface with EMTs on trauma response. Since March 30, 137 people have been killed and 14,821 injured in Gaza during mass protests. The injuries strained an already limited health system and hospitals simply did not have the capacity to absorb such severe trauma cases. As no additional international EMTs responded to the request for EMTs (beside the Russian Federation), the health cluster tapped into the existing visiting EMTs through partners to fill this gap. Because Member States cannot bilaterally coordinate EMT entrance with the Palestinian authorities, it was the health cluster that stepped in to coordinate the access support needed for EMTs. Furthermore, rather than bringing in new field hospitals, the health cluster coordinated for EMT specialised cells to be embedded in empty local hospitals. This had two major gains for the health system: the cluster ensured underutilized hospitals were being used and EMTs working in consultation with local doctors and nurses gave them training and exposure they would not have had otherwise. The cluster led the trauma working group, and was also able to coordinate with health cluster partners to ensure that 70,000 non-trauma emergency cases had access to health services. It was suggested that WHO should explore regional advisory groups on trauma response to strengthen its capacity in this area.

In Bangladesh, Rosie Jeffries presented how [the cluster coordinated with GOARN and EMTs on the management of infectious disease](#). A diphtheria outbreak was declared in December 2017. The sector quickly established that actors on the ground did not have the capacity to manage the outbreak. EMTs and GOARN were utilized to provide technical and clinical support. While these surge mechanisms ultimately were successful in containing the outbreak and decreasing cases, the case study also highlights coordination challenges and lack of an exit strategy. In this situation and given the context and capacities on the ground, an emphasis was quickly placed on getting EMTs to the ground, yet it proved challenging to maintain the coordination mechanism put in place by surge staff when the initial wave of staff left. When setting up coordination mechanisms, their continuity and/or potential handover arrangements need to be considered from the start. Furthermore, although GOARN is an invaluable mechanism for containing an acute event within a chronic emergency, WHO should not overly rely on GOARN as a substitute for long-term human resources strategies. GOARN is a technical surge support mechanism for short-term technical needs encompassing various technical expertise (case management, epidemiology, etc.). Short deployments place a heavy on-boarding workload

on local staff and can undermine WHO credibility with the MOH and other partners. In addition, it was mentioned that local partners would appreciate recognition of participation in EMTs trainings.

DISCUSSION

Group work provided participants the opportunity to elaborate on the role that HCCs play in managing interactions with other coordination mechanisms and response actors. Participants considered how the cluster can profit from integrating with EOC, GOARN, and EMTs.

Ideas brainstormed by the HCCs included:

- The HCC maintaining constant communication and collaboration with the EOC team lead. The cluster can help identify outbreak hot spots and utilize cluster partners' capacity on the ground to address gaps, produce operational information such as 4Ws, gap analysis.
- The cluster could provide the Health EOC a roster of cluster partners' staff with specific expertise and field experience that could be utilized during an acute response.
- HCCs and EMT coordination cell need to communicate closely and communicate with partners about what they can expect. It's the role of the cluster to negotiate and facilitate collaboration so there is no duplication or disruption of services.

RECCOMENDATIONS from Session 2.1:

WHO HQ:

- Consider more neutral language around coordination architecture to promote closer collaboration and improve the interface between existing and any newly activated coordination mechanisms (national or international) and partner network engagement.
- Coordination requirements and their evolution should be considered in all phases from preparedness through to recovery and evaluation. Principles of Partnership, Humanitarian Principles and Emergency Management should underpin all humanitarian coordination mechanisms.
- Strong leadership from WHE needed with HCC and WHO roles clarified within the IMS structure.
- WHO should explore regional advisory groups on trauma response.
- EMTs to consider providing certificates to local partners for training completed.
- GHC and EMTs to organize a webinar on EMTs for HCCs and GHC partners.

Health Cluster:

- Ensure appropriate use of different human resource surge mechanisms for different contexts with the flexibility to adapt for acute and transition to protracted.
- To avoid that having to report to WHO Incident Manager the HCC role is disempowered vis a vis the partners:
 - HCCs should report to the person mandated to represent WHO as Cluster Lead Agency on the Humanitarian Coordination Team. WHO has the dual responsibility to represent both WHO as an Agency, and as Cluster Lead Agency, represent the interests of the cluster partners.
 - HCCs should always collaborate across all IMS functions.
 - Other functions should understand the role and limitation of a HCC (role to coordinate with no direct authority over partners – the power of influencing).
- Recognising that establishment of a national EOC (usually by the National Disaster Management Agency) or a specific Health EOC is usually the decision of the Government, the health cluster should try and be involved from the planning stage in the discussion on wider coordination architecture from the to help clarify roles and responsibilities.
- Ongoing dialogue between HCC and the EOC coordinator is essential.
- Health Cluster can facilitate access of EMTs in instances where EMTs cannot work bilaterally with the government.
- EMTs need to collaborate with health clusters to avoid parallel coordination mechanisms.
- Clusters need to recognize GOARN for what it is – a technical surge support mechanism for short-term technical needs, not a long-term capacity building solution. The WHO Country Office should secure more stable, longer term human resource capacity at the earliest opportunity.

All levels:

- All WHO staff must take the online IMS training, available on the OpenWHO platform at <https://openwho.org/courses/incident-management-system>.

SESSION 2.2 Ensuring an integrated response

Session Chair: Wilma Doedens, UNFPA

Focal Points:

Linda Doull, GHC Coordinator

Fahmy Hanna, Technical Officer, Mental Health, WHO

Elisabeth Roesch, GBV Technical Officer, GHC unit

Veronique Urbaniak, SRH Project Manager, GHC unit

Jean McCluskey, Consultant, GHC unit

The purpose of this session was to discuss areas to improve inter-cluster coordination and achieve a more integrated response during crises. Focal points demonstrated the added value of collaborating more closely with other sectors and developing joint operational frameworks for common response scenarios, in particular related to cholera/acute watery diarrhoea, protection, nutrition and logistics. Linda Doull provided [an update on the status of the joint operational frameworks](#) and introduced other areas in emergency settings where inter-cluster coordination is key: mental health and psychosocial support (MHPSS), sexual and reproductive health rights (SRHR) and gender-based violence (GBV).

Fahmy Hanna presented a [model for coordinating mental health and psychosocial support based on the Inter-Agency Standing Committee MHPSS guidelines](#). Mental health and psychosocial support is a cross-cutting issue across different clusters including health, protection, and education. Clusters need a mechanism to come together to exchange knowledge on tools and best practices for addressing mental health in humanitarian settings through having one MHPSS working group. An inter-agency monitoring framework for MHPSS exist and Means of Verification are currently being developed. Fahmy also introduced the Sphere Handbook mental health standards and the key actions proposed, including ensuring that there is at least one staff member at every health facility who manages diverse, mental health problems in adults and children.

Veronique Urbaniak presented the two-year project funded by The Netherlands on [delivering integrated SRHR services in emergencies through the Health Cluster](#). It is often difficult for women to access family planning and safe abortion services at the primary care level during conflict. The goal of the project is not to compete with existing SRHR providers but rather to collaborate and communicate on how to adjust strategies to better serve populations. WHO seeks to use its technical expertise to strengthen the capacity of cluster partners and local health providers, harmonize data management information systems, and improve the delivery of quality services. The project is targeting Bangladesh, Yemen and the Democratic Republic of Congo (DRC), where teams have started mapping the services, procuring commodities and setting up research protocols. Training activities are being planned for coordinators, service providers and the community.

Elisabeth Roesch presented the [project on gender-based violence in emergencies](#) funded by the U.S. Department of State/Bureau of Population, Refugees, and Migration. Through WHO's role as the health cluster lead, the project aims at systematically integrating the response to GBV into emergency

responses. Globally, about one out of three will have experienced sexual and/or intimate partner violence (IPV). In humanitarian settings, research suggests prevalence is much higher (with a recent study in South Sudan showing up to 2/3 of women experiencing violence). While health can be the main entry point to address GBV, it is not always the case, as health actors may not be trained in how to provide support to survivors, there may be security or social barriers to women accessing services, and coordination between the multiple actors working with survivors, in particular those within the health and protection sectors, may be weak. Consequently, there is a significant need for collaboration between the health and protection clusters on the response to GBV. WHO is currently leading scoping missions in Bangladesh, DRC, Yemen, Nigeria, Iraq, Afghanistan and Syria to map the cross-cutting partners and conduct stakeholder assessments. Country-level trainings and workshops will begin next year.

Coordination between the health and WASH clusters is a key component of integrated and comprehensive responses to cholera outbreaks in humanitarian crises. Jean McCluskey is working with GHC and the Global WASH Cluster to define the [enablers to a coordinated and integrated Acute Watery Diarrhoea \(AWD\)/cholera response](#) including recognition of cholera as a multi-sectoral issue, leadership and accountability, relationships and communication, effective surveillance and joint analysis and one joint, tested plan. She highlighted that the heart of an effective cholera response is integration. The health and WASH cluster coordinators and the Ministries of Health and Water must have strong working relationships. Joint, tested plans must be developed around collective objectives to avoid having separate WASH and health responses. Information gathering, technical support, quality monitoring and the surveillance of at risk populations should also have a multi-sectoral approach.

DISCUSSION

HCCs engaged in group work to brainstorm ways cluster coordinators can prioritize addressing GBV within the health sector and challenges they may face in providing services to survivors of intimate partner violence and rape. Actions prioritized included:

- Mapping and evaluating the capacity of health partners and ensuring they have GBV protocols in place.
- Identifying and sharing a GBV referral pathway with partners and health facilities.
- Ensuring that health workers are trained for GBV and that there are quality health services available with a clear referral pathway.
- Raising awareness on IPV with health providers and partners.
- Improving clinical settings in relation to privacy issues.

Participants identified institutional barriers, a general lack of capacity, insufficient legal reinforcements and legal loopholes in many countries, cultural barriers, and stigma as challenges impeding the health cluster's capacity to address GBV and IPV. They also referred to long lasting discussion on whether GBV work should be coordinated under the health or protection cluster and agreed on the need to collaborate.

In addition to discussing the health cluster's capacity to address GBV, participants elaborated upon the critical areas health clusters need to address in the joint operational framework to cholera and AWD outbreaks within humanitarian crises. Coordinators emphasized that cholera is a multi-sectoral issue and, therefore, it is key to engage with development actors in responses. WASH and health partners need to coordinate surveillance, joint analysis, information sharing, and community engagement activities.

RECCOMENDATIONS from Session 2.2:

All levels:

- Recognize the importance of ensuring an integrated response across sectors and thematic areas and thematic areas.

Global Health Cluster:

- Subject matter experts are available to support health clusters (MHPSS, SRH, GBV, WASH, Protection).
- SRH project teams to ensure sustainable plans for a comprehensive SRH package are developed, beyond implementation of the pilot project.
- GHC to build the operational framework on AWD/cholera on the five proposed enablers.
- GHC to consider that the development of an operational framework for AWD/Cholera can serve as a basis for a framework to respond to other water borne diseases.
- Within the AWD/cholera framework, GHC to clarify the roles of HCC, WHO, MOH/MOW and UNICEF in terms of responsibilities and accountabilities.

Health Cluster:

- HCCs to refer to the Sphere Standards and IASC Monitoring and Evaluation Framework on MHPSS when developing Humanitarian Response Plans.
- HC partners to engage with communities and local authorities on SRH.
- HCs to address GBV as a health issue and not just what body takes on the coordination (GBV sub-group under health or protection).
- HC partners to find a system to share GBV information appropriately, as it is a challenge how to respect patients' data confidentiality while addressing response needs.

DAY 3 – 27 JUNE 2018

SESSION 3.1 Information Management

Focal Points:

Samuel Petragallo, Information Manager, WHE Health Information Management and Risk Assessment (HIM)
Boris Pavlin, Epidemiologist, WHE/HIM
Stephanie Daviot, International Organization for Migration

Boris Pavlin elaborated on the adoption and roll-out of the [Public Health Information Services \(PHIS\): successes, challenges and the way forward](#). He illustrated the PHIS standards and the [tools](#) that are available to an emergency activated cluster to support their achievement, and the integration of information management assets and restructuring of information management teams. Historically, information management assets working in WHO Country Offices have not coordinated data well leading to overlaps and gaps in information available. As such, there is an organisational push for the creation of fully integrated information management teams within WHO Country Offices, including health cluster IMOs. It is important to note, however, that the health cluster IMO cannot be diverted to performing Country Office work. Over the past year, the PHIS roll-out and IM team restructuring has been piloted to varying degrees in Northeast Nigeria, South Sudan, Somalia and Ethiopia. In South Sudan, for example, a single health information team lead has been given supervisory authority over all information management assets. In general, the HIM team is confident based on the pilots that the model is functioning. However, some challenges have been identified, including the health cluster's need to be serviced with information rapidly, insufficient funding for information management assets and tensions over the HCC no longer directly supervising the health cluster IMO. A concept note on the integrated information management unit has been developed and will be disseminated. The HIM team additionally pushed cluster coordinators to be more accountable for information management, including regularly producing health cluster bulletins. It was also suggested that IM working groups be created across clusters/sectors.

Samuel Petragallo presented the HeRAMS, an approach for monitoring health facilities, services, and resources availability during emergencies. Without health partners contributing data and sharing data across the sector, it would be impossible to accurately monitor service availability in conflict settings. Every partner delivering services bears a responsibility for reporting information back to the community. As such, the health cluster is integral to gathering the essential information for HeRAMS. It is additionally important that the cluster helps share the collected results more widely so that it can help drive emergency response and tailor actions taken.

Stéphanie Daviot from the International Organization for Migration (IOM) updated participants on the Displacement Tracking Matrix (DTM), which IOM uses to monitor movement and displacement. The tool registers and surveys internally displaced person (IDP) households to gather specific information. IOM seeks to collaborate with HCCs to further integrate health data into the tool, with the goal of making the tool more useful to health partners. In Afghanistan, for example, DTM has been tailored to track tuberculosis (TB) and vaccination data.

DISCUSSION

Participants raised numerous concerns with the rollout of the integrated information management teams. While they appreciated the HIM team's assessment that the current model is working, some HCCs pushed their need to be further engaged on the HIM assessment of how the model is working in practice before drawing conclusions. To date, South Sudan is the only country where full integration has been implemented, therefore the model cannot be determined to be a success based on only one country. There is a perceived risk that the integrated information management team lead may act as a gate keeper and add an additional unnecessary level of reporting for the HC IMO. HCCs additionally expressed concerns with adequately protecting integrated data. They noted that cluster data is not WHO data. It is difficult to gather information in conflict settings and, as such, it requires the cluster coordinator to build trust with partners. Some coordinators worry they will lose partners' trust if the information is pooled together and the cluster loses control over it. Finally, participants acknowledged that health cluster information needs are not predictable and can rapidly change and HCCs are concerned they will not be able to access the information in a timely manner when they need it.

Cluster coordinators spoke highly of the HeRAMS tool, indicating that it gives WHO greater credibility with health partners and the MOH. They additionally asked for greater clarifications on the difference between HeRAMS vis-a-vis other information tools, including Service Availability and Readiness Assessment (SARA). They hypothesized that the HeRAMS platform could be used as a monitoring tool for SARA. Cluster coordinators from Yemen, Libya and Turkey additionally shared they find DTM information to be helpful and would appreciate integrating more health components to the tool.

Linda Doull presented a review of the information products produced by the clusters and highlighted that many health clusters do not produce bulletins with the frequency requested according to the PHIS standards and also do not undertake the annual Cluster Coordination Performance Monitoring (CCPM) exercise as prescribed by the IASC. HCCs reported some of the reasons for this

lack of progress: lack of information management capacity and partners not reporting on a regular basis.

Linda also introduced the GHC advocacy strategy 2017-2019 as it includes an objective related to capacity building. HCCs expressed a preference for regional workshops and remote support from global level. They also encouraged the development of toolkits available that would become available through the website.

RECCOMENDATIONS from Session 3.1:

WHO HQ:

- Dedicated IM support is currently not sustainable for all clusters long-term. The GHC and HIM teams need to find solutions.
- GHC and HIM team to conduct further piloting and thorough evaluation of integrated information management teams and their effectiveness.

Health Clusters:

- HCC and IMO TORs to include producing bulletins and setting up IM working groups across clusters/sectors.
- HCCs to continue rolling out HeRAMS to help collectively build a comprehensive picture of the situation in terms of health resources and services availability. The tool will help HCCs monitor the situation over time rather than serving just as a baseline.
- HCCs to consider complementarity of HeRAMS with SARA.
- HCCs to provide feedback on how to tailor DTM to meet the needs of the cluster.

SESSION 3.2 Ensuring essential quality of care – the role of cluster teams and cluster members

Session Chair: Patricia Kormoss, Operational Partnerships Officer, WHE/EURO

Focal Points:

Fawad Khan, Iraq Health Cluster Coordinator

Sean Casey, Pacific Health Cluster Coordinator

Focal points discussed with participants the role of cluster coordinators and cluster partners in ensuring essential quality of care. The goal of the session was to avoid discussing quality generally and instead start identifying tools which could be used by clusters to promote/assess quality standards and support quality improvement actions. Andre Griekspoor summarised the need for monitoring quality, safety and performance in emergency settings. The four essential aspects of quality are: patient safety, effectiveness of treatment,

people centeredness, and equity. However, quality of care looks different in each emergency setting. To this end, there has been momentum to create a Task Team on Quality under the Global Health Cluster. This group would be responsible for identifying key dimensions of quality standards and developing tools and processes that could be implemented in humanitarian contexts. The tension between quality and operational responsiveness would be addressed and the roles of the cluster, partners, health authorities and WHO in monitoring quality defined.

Sean Casey presented an [overview of the Emergency Management Team \(EMT\) quality control standards](#). EMTs have a responsibility to meet certain preparedness standards that are agreed upon in advance of deployment. The MOH then issues licenses for EMTs to operate during emergencies. While these standards help EMTs mobilize quickly and not create burden on local health systems, they do require a huge upfront investment of resources, staff, and technical guidance. EMT preparedness standards could serve as a model to develop standards for partners operating in protracted emergencies. However, it is unlikely partners would have the same capacity for upfront investment.

Fawad Khan shared with participants [a case study of the Iraq Cluster Quality of Care \(QoC\) tool](#), an approach which was developed subsequent to the rapid scale up of service delivery during the Battle of Mosul, with the aim of ensuring all services provided should have a minimum standard of quality. Using the UN Refugee Agency (UNHCR) score card as a basis, a QoC survey tool was developed and provided to one health cluster partner to conduct the survey in the 55 IDP camps. The survey will act as the baseline for future measures of health services offered in primary health care clinics including key points such as medical care offered to patients, their safety and the competence of the health staff. The information was collected real-time using tablets that immediately sent the information to a central site to ensure accuracy.

Patient observations and interviews were conducted in the health centres. The data was subsequently analysed by the cluster to provide feedback to partners on how they could improve the quality of their services. The cluster made clear to partners that the goal was not to monitor their work but rather to enhance basic standards. Partners were asked to conduct independent self-monitoring on a monthly basis and revert to the cluster. The cluster will conduct a repetition of the assessment (phase 2) toward the end of 2018.

DISCUSSION

Participants engaged in group work to debate the role of cluster coordinators and cluster partners in ensuring quality of services. The coordinators discussed:

1. What can clusters do to prevent harm?

HCCs proposed that clusters should orient partners on 'do no harm', sensitize the MOH, avail standard protocols, and commit to formal quality standards through formal Memoranda of Understanding (MOU) between partners and the MOH.

2. What can clusters do to improve quality of care?

HCCs proposed that clusters should help develop and/or promote existing national standards and encourage partners to follow these standards.

3. What is the role of the cluster in external validation of implementing partners?

The HCCs proposed that the cluster plays a role in standard and strategy development, project review and implementation, data analysis and feedback, and advocating for transparency.

4. What still needs to be developed to support clusters vis-a- vis Essential Quality of Care?

Clusters need to be more aware of existing tools. These tools should be simplified as much as possible so they can be shared with partners and additionally need consider different settings and communities. A readily-accessible platform of all standards should be created.

RECCOMENDATIONS from Session 3.2:

Health Cluster:

- HCCs to understand that quality assurance and improvement is one of the health cluster's roles
 - Prevent harm, improve quality of care, external validation of implementing partners, identify gaps and tools needed
 - Learn from Iraq Cluster (Quality of Care) case study in development of tools and processes
- Where feasible:
 - conduct the QoC assessment twice a year by the cluster in order to:
 - Increase accountability and responsibility of partners toward quality service-provision.
 - Enhance Accountability to Affected Population through the patient satisfaction component.
 - conduct the QoC self-assessment on a monthly basis by the humanitarian partner in order to:
 - Feel involved in ensuring adequate services provision.
 - Improve self-capacity.

Global Health Cluster:

- Establish a GHC Task Team on Quality with broad representation from different groups, including HCCs and GHC partners, as well as EMTs, GOARN, HSS quality team.
 - Map tools, define framework.

- Consider the 4 aspects of quality: patient safety; effectiveness of treatment; people centeredness; equity.
- Define the role of the cluster, MOH, partners and donors in quality assurance and improvement.
- Learn from EMTs experience in development of clinical and operational Standards.
- Learn from Iraq example on development of tools and processes.
- Practical implications need to be considered (i.e. legal agreements, MOUs, budget) for establishing and sustaining quality processes.

SESSION 3.3 Strengthening the understanding of how clusters align with WHO at the global, regional, and country level

Focal Points:

Rick Brennan, Director, WHE/EMO

Michel Yao, Programme Area Manager, WHE/AFRO

Alaa Abou Zeid, Operational Partnerships Officer, WHE/EMRO

Patricia Kormoss, Operational Partnerships Officer, WHE/EURO

To conclude the 2018 Forum, Rick Brennan provided updates on the WHE and further elaborated on the Director-General transformation exercise and GPW 13, including potential implications to the work of the cluster. He shared that across the leadership team there is a general acknowledgement that Emergency Operations is the area of the organization that has progressed the most over the last year. In spite of the pressures for WHO to reform and respond to an increasing spectrum of emergencies, WHE is getting significant recognition for its progress. However, there will be upcoming changes as the WHO restructures itself around the GPW 13 strategic priorities. The organization will need to achieve a better balance between the normative guidelines expected of WHO and its operational work.

During the WHE Directors retreat, held on 26-27 June 2018, it was discussed how to promote strengthened and integrated operational partnership networks as components of the DG's Global Health Emergencies Corps. Each network has a comparative advantage and existing synergies need to be recognized. A regional expansion of partnership networks, including GOARN and EMTs, is being planned to ensure greater convergence.

It was stressed that WHO is not adequately resourcing information management in cluster countries. WHE must work to improving its collective operational response, including providing more logistical and technical support to cluster coordinators, including IMO.

Within the broader United Nations and humanitarian system, most recent priorities include improve humanitarian financing, accountability to affected populations – ensuring the voices of beneficiaries are heard-, collective advocacy, the humanitarian development peace nexus. Given the contraction of the humanitarian space and limited resources available, the Director-General is working on a more coherent and robust advocacy strategy to position WHO stronger politically.

DISCUSSION

Following Rick Brennan's presentation, HCCs were given the opportunity to engage in dialogue and give feedback to the WHE/EMO Director. It was discussed that WHO's lack of investment in monitoring and evaluation (M&E) is impacting the quality of emergency programming. M&E training is a priority for the department and project management training is available for cluster coordinators.

Coordinators additionally highlighted challenges with resource mobilization and management. Dr Brennan shared that one of the Director-General's priorities is the movement of resources and funding to country level.

Finally, HCCs reiterated their concerns about the centralizing of information and maintaining cluster coordinator's autonomy from WHO. Decisions made by HCCs need to continue to be driven by the needs of the people they serve and partners, independent of WHO. In the same direction, it was discussed that when a IMS structure is activated, the HCC shall report to the WHO person that is in the Humanitarian Country Team. On the other side, there was debate on what function shall be representing WHO in the cluster – the partner coordination function or health operations function person.

Linda Doull concluded the forum thanking all the participants, presenters and facilitation team. She committed to provide the participants with the report of the forum, including a list of concrete action items.

Annex 1: List of participants

Organization	Name	Last Name	Position
Afghanistan	Wael	Eskander	Information Management Officer
Afghanistan	David	Lai	Health Cluster Coordinator
Bangladesh	Rosie	Jeffries	Health Cluster Coordinator
Bangladesh	Khalid	Tahir	Incident Manager
Cameroon	Emmanuel	Douba Epee	Coordinator
CAR	Richard	Fotsing	Health Cluster Coordinator
Chad	Jeannot	Kabelambe Wabulakombe	Co-Health Cluster Coordinator
DRC	Ernest	Dabire	Health Cluster Coordinator
DRC	Sandy	Wenzi	Co-Health Cluster Coordinator
Iraq	Fawad	Khan	Health Cluster Coordinator
Jordan	Christina	Bethke	Health Sector Coordinator for South Syria Hub
Libya	Ishtiaq	Bashir	Technical Officer
Mali	Bachir	Mbodj	Health Cluster Coordinator
Myanmar	Allison	Gocotano	Health Cluster Coordinator
Nigeria - North East	Adandji	Yaoklou Mawuémiyo	Health Cluster Coordinator
Nigeria - North East	Muhamma d	Shafiq	Health Cluster Co-Lead
oPT	Sarah	Halimah	Health Cluster Coordinator
oPT	Abdelnaser	Soboh	Sub-cluster Coordinator
Pacific Islands	Sean	Casey	Health Cluster Coordinator
Pakistan	Michael	Lukwiya	Health Cluster Coordinator
Somalia	Dayib	Ahmed	Health Cluster Co-Lead, SC
South Sudan	Magda	Armah	Health Cluster Coordinator
Sudan	Arun	Mallik	Health Cluster Coordinator
Syria	Azret	Kalmykov	Health Cluster Coordinator
Turkey- Gaziantep	Jorge	Martinez	Health Cluster Coordinator
Whole of Syria	Kais	Al Dairi	Health Cluster Co-Lead, IRC
Whole of Syria	Annemarie	ter Veen	Health Cluster Coordinator (WoS)
Yemen	Bridget	Mung'atia	Health Cluster Co-Lead, NGO

WHO Regional Offices			
AFRO /WHO	Michel	Yao	Programme Area Manager
EMRO/WHO	Alaa	AbouZeid	Partnerships Officer
EURO/WHO	Patricia	Kormoss	Partnerships Officer
Partners			
UNFPA	Wilma	Doedens	GHC SAG / Technical Advisor Sexual and Reproductive Health in Crises
IOM	Daunia	Pavone	DTM
WHO / HQ			
WHE/EMO	Rick	Brennan	Director
WHE/EMO/ AME/EOC	Paul	Cox	Team Lead
WHE/EMO	Andre	Griekspoor	SAG co-chair, Senior Policy Adviser
WHE/EMO/ GOARN	Tony	Stewart	Global Outbreak Alert and Response Network
WHE/EMO/ AME/EMT	Christophe	Schmachtel	Emergency Medical Teams
WHE/EMO/ OPM	Adelaide	Davis	Emergency Management & Support
WHE/HIM	Boris	Pavlin	Health Operations Monitoring & Data Collection
WHE/HIM	Madeleine	Crowe	Health Operations Monitoring & Data Collection
WHO/HIS	Dirk	Horemans	Service Delivery and Safety
WHO/NMH	Fahmy	Hanna	Evidence, Research, Action on Mental & Brain Disorders
GHC unit			
GHC	Linda	Doull	Global Health Cluster Coordinator
GHC	Emma	Fitzpatrick	Technical Officer
GHC	Elisabetta	Minelli	Technical Officer
GHC	Gabriel	Novelo Sierra	Technical Officer
GHC	Carolyn	Patten	Administration
GHC	Elisabeth	Roesch	Technical Officer
GHC	Veronique	Urbaniak	Technical Officer
GHC	Jean	McCluskey	Consultant