Health Cluster Forum
26-28 June 2019, Geneva, Switzerland

Note for the Record

The Global Health Cluster Forum, held on 26-28 June 2019 in Geneva, Switzerland, was attended by 49 participants, representing 17 Health Cluster Coordinators (HCCs) and 6 Health Cluster Co-Coordinators from Save the Children, World Vision and Medecins d'Afrique, from 20 different clusters. Participants also included staff from the WHO Health Emergencies Programme at global, regional and country level and the Global Health Cluster unit (see annex 1 – list of participants).

The meeting objectives were to:

- Strengthen the understanding of how clusters align with the WHO Health Emergencies Programme (WHE) at the global, regional and country level.
- Ensure an understanding of the recent Inter-Agency Standing Committee (IASC) Reform.
- Ensure a complete understanding of the revised Humanitarian Programme Cycle tools and understand the new focus and expectation on the clusters and cluster coordinators.
- Strengthen inter-cluster/sector planning and response.
- Increase understanding and operational application of the Humanitarian Development Nexus.
- Contribute to the revision of the Extended Health Cluster Strategy 2017-2019 to 2020-2021.

All material related to the meeting is available at https://www.who.int/health-cluster/capacity-building/health-cluster-forum-2019/en/.

DAY 1: 26 June 2019

Session 1: Welcome and Introduction

Linda Doull, GHC Coordinator, opened the meeting and welcomed participants. She outlined the Forum aims as i) sharing best practices, ii) addressing challenges and areas of concern, iii) promoting IASC and other relevant policies, iv) engaging in cluster capacity building efforts to improve the health sector humanitarian response.

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

In response to the HCCs request for greater involvement in preparedness action and to learn more about the WHO Transformation, Dr Jaouad Mahjour, Assistant Director-General (ADG), Emergency Preparedness, Health Emergencies Programme (WHE), provided an overview of the current WHO Transformation process, presenting the new WHO organigramme, with three major pillars reporting directly to the Director-General: enabling functions, programmes and the emergency programme. He then presented the WHE programme functional structure and highlighted that by creating Divisions for Emergency Preparedness and Emergency Response, the Director-General was sending a strong political message that preparedness is a key priority. Dr Mahjour also stated that Regional Directors have in principle, agreed the high-level superstructure, and each region will determine to what extent they will align related functions within their existing organizational architecture or through new structures.

J. Mahjour provided an overview on WHO's work on preparedness and readiness. He presented that 60% of countries are "not prepared" highlighting the need for action. WHO has the right preparedness tools, but the work to be done now is a scale up to use the tools for true country level impact. He highlighted that Health Clusters (HCs) have a key role to play in preparedness and readiness, and that when countries are not prepared, some of the work gets transferred to the HCs during the response. He ended the presentation by stating that this discussion is the start of a broader discussion on how Health Clusters and HCCs can strengthen their role in preparedness.

Key discussion points	Key actions/recommendations
• Situating the GHC within the Health Emergency Intervention (HEI) department and being separated from SHOC, should not diminish the Health Cluster role; it will work across the entire WHE programme.	On transformation, new structure • WHE leadership to clarify cluster position within the new structure.

• Conceptually, response and preparedness are a continuum – no matter the structure, there will be strong collaboration. • HCCs expressed that WHO must revise its culture (not just structure) and that to date, they do not see any change of culture on the ground. • The ordering of functions in the current functional organigramme does not dictate level of priority. • In terms of funding for preparedness, the money is mainly at the country level, while the global level will support. • Country preparedness plan is the responsibility of the Ministry of Health, not the HCC. • Many preparedness tools are available; but contact with regions needed to access /collate these documents (even in draft form). WHO Heads of Country Offices will need to be involved when discussing the tools that are circulating. • HCCs recognise that DG intends WHO to be more operational but would appreciate more clarity on what this means for WHO and HC.	• WHE leadership to clarify role of headquarters (HQ) vs Regional Office (RO) for country cluster support. • Change needs willingness by all to work collectively and collaboratively – a new structure does not resolve the issues at stake. On Health Cluster role in preparedness • Preparedness is a priority, as evidenced by the new WHE functional structure. • Health Cluster role in preparedness can be strengthened. • GHC to actively engage with the new Division on Preparedness to enhance harmonisation of multi-hazard preparedness and readiness. Similar interaction required at RO and country office level. • Multiple tools exist but need to clarify their status, relevance and make more accessible to clusters. • Clarify WHO stance on engaging HCs in outbreak preparedness.

Session 1.2: IASC Reform: Structure, Priority Areas of Work

Yasin Samatar, IASC Secretariat, introduced the IASC Reform, beginning with a brief overview of the IASC, its history and introducing the four broad workstreams of the IASC: strategic decisions on operational issues, policy development, advocacy and dialogue. In terms of Reform, he stated that the Committee remains the same (with the 19 Principals) and that the three structures supporting them are: i) Deputies forum, ii) Emergency Directors Group (EDG), iii) Operations,

Policy and Advocacy Group (OPAG). The OPAG then has five results groups: i) Operational response, ii) Accountability and inclusion, iii) Collective advocacy, iv) Humanitarian-development nexus, v) Humanitarian financing. The new structure is in its first year and will be evaluated for usefulness in March 2020.

Marina Skuric-Prodanovic, Chief, System-Wide Approaches and Practices Section, presented the Global Cluster Coordinators Group (GCCG), which was created in 2014 and brings together, on a monthly basis, the 11 Cluster Coordinators and the four Areas of Responsibilities of the Protection Cluster. The main purposes and objectives of the GCCG are: field support, information-sharing, guidance and tools, advocacy and data collection. She highlighted that despite being 11 clusters, everyone is functioning within one system, and should therefore aim for a certain level of standardization with monitoring and analysis of trends. She ended by presenting that they have done a mapping of engagement of the GCCG, EDG and the joint steering committee and that missions are being planned to this end, but that information on country context needs is also appreciated.

Key discussion points	Key actions/recommendations
• IASC is one of the only bodies where UN and non-UN entities sit together. • HCCs expressed interest in the work of the IASC and the five result groups and in the process for the selection of Humanitarian Coordinators. They requested information is shared on a regular basis. • Owing to high turnover, it is important to look at the mapping of every GCCG mission held to assure institutional memory. • In terms of GCCG missions, HCCs expressed interest in receiving the terms of reference in advance to be able to plan and benefit from them; they were also encouraged to request GCCG missions, as needed. • HCCs expressed that the ICCG meetings are becoming more about operations and less about inter-cluster coordination.	• HCCs to familiarise themselves with the new IASC structure. • IASC to share more broadly the call for Humanitarian Coordinator nominations. • GHC unit to ensure more systematic communications on IASC and GCCG work to regional and country level, including planning of missions and their terms of reference. • HCCs (in their role as ICCG members) to be more aware of /request GCCG missions to support the ICCG in its work. • Where needed, HCCs to request the GCCG (and other IASC bodies) to escalate issues impacting on optimal coordination.

Session 1.3: Humanitarian Development Nexus in practice

R. Van de Weerdt, Chief, Fragile, Conflict and Vulnerable settings (FCV), introduced the work on FCV and the purpose of the session that was to define tangible steps and potential resources to help ensure that the health cluster adheres to and implements the Humanitarian Development Nexus linked to the work of FCV and Health System Strengthening.

A. Griekspoor, Senior Policy Adviser, described collective Humanitarian Development Nexus (HDN) outcomes in FCV settings, and discussed the progress on the FCV Framework for collective programming in fragile, conflict and vulnerable settings, which has the following points: i) bringing together joint analysis, ii) costed essential packages, adapted to different operational and security contexts, iii) health systems strengthening and inputs from health service programs for package implementation and financing, iv) specific solutions for connection of humanitarian and development coordination platforms, v) early Warning Systems, vi) innovative models for logistics support and supply chain, vii) development of standard plans. He highlighted that the UHC 2030 working group on fragile settings includes WHO, development partners and humanitarian partners, focusing on advocacy, health system analysis and a study on strengthening humanitarian and development stakeholder coordination in fragile settings.

D. Lai, HCC Afghanistan, presented the work Afghanistan has done to promote linkages between humanitarian and development. He presented the One UN document created at the request of the government, which supports the UN development system, but includes the HDPN, with six thematic areas, one of which is health. He presented how the team aligned the Sustainable Development Goals, with the Humanitarian Response Plan sectors and the One UN thematic areas, allowing them to look at collective outcomes and produce tangible linkages between the work. He highlighted that the goal is not to move away from humanitarian and start funding development activities, but rather looking at how the humanitarian activities are done in a more resilient way.

Key discussion points	Key actions/recommendations
• HCCs expressed the need for clarity and guidance on how to determine which countries fall under FCV and what settings or regions in a country are to be considered FCV settings. • Clarity was also requested on a definition of HDN and humanitarian development peace nexus (HDPN) and how these concepts should be implemented from a practical point of view. • Donors are driving uptake of the HDN concept, however there is a risk of no funding for the actual implementation.	• FCV team to share FCV strategy, defining priority countries and activitiesFCV/GHC to share guidance on FCV definition to determine which settings/regions of a country are fragile. • WHO / Health Cluster needs to provide leadership and bring development and humanitarian

• HDN is not the end of humanitarianism – fragile settings will likely remain fragile. It is not about handing over to development and stop the humanitarian work. • There are small practical steps to be made to go beyond the theory, as for example looking at what can be done to build resilience in the next 6 months. • HDN discussion is related to whether clusters have transitions strategies and plans to bridge and move towards the development arena.	partners/donors to the table to define, discuss and implement HDN. • HCCs to request HQ/RO for guidance, support missions, good practices on HDN. • GHC unit to map which clusters have a transition strategy/plan.
Session 1.4: PHIS benchmarking and performance tracking	
B. Pavlin, Epidemiologist, Health Information Management (HIM) department and N. Morris, Information Management Officer, GHC, presented the findings of the PHIS tracking 2019 and discussed with HCCs how to strengthen the implementation of the PHIS at country level.	
Key discussion points	**Key actions/recommendations**
• Participants provided detailed feedback on the following specific topics: Public Health Situation Analysis (PHSA), Rapid Health Assessment (RHA), HeRAMS, integrated Information Management Unit, Health Cluster Bulletin, information management officer staffing (see annex 2). • It is key to make public and share the PHIS products to ensure the information is disseminated to all relevant stakeholders. • Some services (e.g. RHA, PHSA, mortality estimation) are more challenging to be produced than others. • IMO capacity is recognized as an ongoing challenge requiring advocacy by all. • HeRAMS external evaluation was completed in 6 countries. Recommendations from the workshop held on 24-25 June 2019 - to be disseminated - led to development of strategic objectives.	• HIM to share concept note for Integrated Information Management Unit for further comments by HCCs. • HCCs to provide corrections to their country performance to GHC unit. • HCCs to discuss results of PHIS country performance in country teams. • HIM and GHC unit to provide bilateral support on specific challenging services. • HIM and GHC unit to provide information on GHC Information Management Task Team development and gather inputs from HCCs on specific services (e.g. RHA and HeRAMs). • Directors WHE Health Information Management and Emergency

	Operations to articulate WHE strategy for IMO long-term investment across the organization.

DAY 2: 27 June 2019

Session 2.1: Humanitarian Programme Cycle new process and tools

The purpose of this session was to introduce the revised humanitarian programme cycle (HPC) process and tools and understand the new focus and expectation on the clusters and cluster coordinators.

Ignacio Leon-Garcia, Chief, Assessment, Planning and Monitoring Branch, OCHA introduced the enhanced HPC approach, explained the rationale for the change and highlighted what is new from the previous approach. He stressed this has been a collective change supported by consultations with a variety of stakeholders throughout the revision process. One of the differences is that humanitarian action will be driven and explained to governments based on evidence rather than solely based on the mandate of humanitarian actors.

Herbert Tatham, Assessment, Planning and Monitoring Branch, OCHA, presented the enhancing of the needs analysis and the Humanitarian Needs Overview (HNO). He mentioned the following improvements: 1) emphasis on jointly agreeing on scope of analysis and conducting inter-sectoral analysis; 2) identifying current humanitarian consequences of a crisis and their evolution; 3) centered on selected priority population groups (including sub-groups) and geographic areas identified as most vulnerable; 4) projection of current humanitarian consequences and needs based on risk, vulnerabilities and capacities; 5) continuous monitoring of situations, needs and response. He also described the step-by-step approach that should be followed.

Martin Buettner, Assessment, Planning and Monitoring Branch, OCHA, presented the changes in the Response Analysis and Planning. Intended improvements related to: 1) improving needs-based prioritization of Humanitarian Response Plans (HRPs) and providing explicit rationale for who/what/which locations are prioritized for inclusion in HRP, as based on HNO; 2) shifting to outcome-oriented (inter-sector) SMART response objectives and coordinated/multi-sector response required to meet them; 3) promoting coherent response planning: sector plans framed by inter-sector objectives and underpinning response approach/targets; and 4) project activities/targets systematically linked to Cluster log-frame/activities/targets (HPC tools).

Nick Imboden, Assessment, Planning and Monitoring Branch, OCHA, presented the key changes for monitoring the HPC. He highlighted the importance of continuous and integrated demand-driven monitoring. He described how to establish a realistic, outcome-oriented monitoring framework and plan, and finally provided key planning and monitoring tools and indicated why, when and how to use them.

Key discussion points	Key actions/recommendations

• The HPC process is OCHA led but all actors including WHO should be vocal and express their priorities based on evidence.
• There is a recognized need to move from a sectorial response to a more integrated response.
• Health Cluster Core Indicators are available online and linked with the HNO.
• The People in Need should be anchored in as many of these indicators as possible, but mainly based on HCC expert judgement.
• Injecting health analysis into HRP prioritization discussions at ICCG / inter-sector level is key and focusing on where health related factors drive humanitarian consequences or cause/exacerbate other needs to ensure these factors are prioritized.
• Health Cluster Coordinators should be firmly plugged into these ICCG/inter-sector discussions, to
  o articulate scope/nature of required health programming within a multi-sectorial response approach;
  o in parallel, keep cluster members updated internally, discuss feasibility/nature of required health programming cluster internally, and inject back into inter-sector discussions.
• Clarity was requested on how to conduct activity-based costing and result based costing.
• Monitoring should benefit as much as possible from existing data and monitoring mechanisms, including cluster monitoring system like 3Ws or donor reporting.
• Humanitarian Insight (https://hum-insight.info/) is a new online platform displaying information from all Humanitarian Response Plans, including funding requirements and funding level.
	• GHC unit to disseminate information on new HPC process and tools to all HCCs and EMO colleagues at HQ and regional offices, including calendar of available trainings at country level.
	• HCCs to familiarise themselves with new process and tools.
	• HCCs to request support from the GHC/ROs as appropriate.
	• HIM and GHC unit to disseminate information on how to calculate the 'people in need' and 'people reached'.
	• GHC to re-circulate guidance on activity- based costing and result based costing.
	• HCCs to engage in updating of the Humanitarian Insight platform.

Session 2.2: Quality Improvement	
E. Pasha, Technical Officer, Global Health Cluster unit, presented on the concept of improvement of quality of care and provided an overview of the work of the GHC Task Team on Quality Improvement (QITT) and its focus on quality of care and medicines quality assurance.	

F. Khan, HCC Iraq, presented the project on quality of care in Iraq; J. Martinez, HCC Turkey, presented a series of quality improvement actions implemented in Syria; J. Tanoli, HCC Yemen, presented on the Quality of Care Task Team in Yemen and how guidance and benchmarks were created.

A. Griekspoor, Senior Policy Advisor, FCV, provided an update on the development of the Health Facility Assessment Tool (HFAT). He stressed that the tool should be adapted depending on the context. Before implementing the tool, HCCs should plan, negotiate and explain to partners to gain technical knowledge on the application of the tools to be able to monitor and assess the implementation.

Key discussion points	Key actions/recommendations
During the discussion, HCCs requested the following: • Defining minimum standards / red lines for quality, including development of tools that can be adaptable for each context/country e.g. modular. • Development of guidance on how to adapt tools including standards/analyses of results, on how to implement assessments and quality improvement mechanisms e.g. estimation of personnel and funding. • Development of qualitative and quantitative indicators. • Knowledge sharing between countries, regional workshops. • Country specific support to adapt the tools. • Training for HCCs and partners on quality standards and implementation. • Development of quality improvement approach i.e. how to take or support corrective actions.	• HCCs to join the QITT, if interested. Workshop is being planned for September 2019. • QITT to take into consideration the discussed HCC's requests when defining its work-plan and next actions. • HCCs to consider using the HFAT once finalised. Use needs to be adapted to the context, also considering complementarity and synergies with HeRAMS and SARA.

Session 2.3: Inter-Cluster Initiatives

Anna Ziolkovska, Deputy Coordinator, Global Nutrition Cluster, presented on integration for health and nutrition outcomes. She reported that a structure to support integration is in place: Inter-Cluster Working Group for Nutrition (Global Nutrition Cluster and global Food Security Cluster partners) formed in 2012, with Global WASH and Health Cluster participation since 2018. A new Integration Helpdesk position has been established with the GNC to support 4 cluster country-level integration for which experienced consultants are being selected. She also mentioned that tools are developed to kick start integration, including a training package and a collection of good practices.

Annarita Marcantonio, System-Wide Approaches and Practices Section, OCHA, presented on the Inter-Cluster Coordination Groups. Firstly, she shared the terms of reference highlighting the roles and responsibilities. Secondly, she

described the ICCG performance monitoring that should be undertaken at least once a year in protracted crises and within three to six months after the group set up. The process is composed of a survey, analysis of the results and report, and a final workshop.

Breanne Kaiser, Consultant, Global Health Cluster unit, introduced briefly the work that has just started on health and protection to define gaps and operational activities. She mentioned there will be a key informant interview and a literature review as a basis to start defining an operational framework.

Elisabeth Roesch, Gender-Based Violence in emergencies advisor, gave a quick update on the GBV project in emergencies; the finalization of technical guidelines on the clinical management of rape, including new components on intimate partner violence and mental health and psychosocial support; a research conducted with the Johns Hopkins University on quality assurance for GBV in Iraq and Nigeria; a new project on how to adapt MH PSS services to GBV survivors. She also mentioned GBV support is available for country clusters in new emergencies, as needed.

Linda Doull, Global Health Cluster Coordinator, presented on recent developments in the field of new-born care in humanitarian settings as well as child and adolescent health in emergencies. She particularly focused on key actions for newborn health in fragile and humanitarian settings based on the new Global Roadmap for Newborn Health in Fragile and Humanitarian Settings.

Key discussion points	Key actions/recommendations
• Integration is encouraged by donors and it is backed up by technical rationale (multiple studies on effectiveness of integration). • South Sudan mentioned a nutrition-health workshop held in 2018. However, integration needs to move beyond this and the focus should be on developing shared indicators needed to monitor this collaboration. This may require separate information management officers to support integration. • In Iraq nutrition is a sub cluster of the health cluster. It was mentioned that the leadership could rotate among the various cluster lead agencies, to remove silos and territorialities. • In Yemen, the funds from Humanitarian Pooled Funds is secured for integrated high impact activities among the 4 life-saving clusters. The program is monitored through 9 output indicators. • HCCs expressed interest that studies, good practices on the cost benefit analysis of integration should be collated.	• GHC to formalise engagement with the new GNC hosted integration helpdesk and inform HCCs how best to engaged and request assistance /country support missions as needed. • Countries identified for the documentation of the case studies, integration training, and support of the integration helpdesk were Yemen, Chad, DRC, CAR, WoS, Nigeria, Ethiopia, South Sudan. • Yemen HCC to share with the GHC and GNC a list of the nine indicators for monitoring integration.

	• HCCs to engage with the ICCG performance monitoring tool. • HCCs to request GHC unit for support on GBV in emergencies as needed. • HCCs to include newborn health strategy actions in Health Cluster work-plans. • All to collect good practices on integration among the 4 lifesaving clusters, and protection.

DAY 3: 28 June 2019

Session 3.1: Health Cluster National Partners' Capacity Mapping

Elisabetta Minelli, Technical Officer, Global Health Cluster unit, presented the preliminary results of the Health Cluster National Partners' Capacity Survey. The aim of this session was to gather HCC's feedback to be included in the final report of the survey. She presented the scope and objectives of this survey, the target and the response rate, as well as the collaborative process that has seen the participation of the HCCs throughout.

Participants were divided in 5 groups and were asked to answer the following questions on results and next actions:

RESULTS

- Overall, do these preliminary results resonate with you?
- What are the most worrying gaps that you would flag for immediate action?

ACTION

- What is the health cluster currently doing to support national partners?
- What more could/should the health cluster do to support national partners?

Full reporting from the 5 groups is available in annex 3.

Key discussion points	Key actions/recommendations
• Generally international partners are perceived to be stronger than national, but this is not necessarily always the case. • Health Clusters need to include partnering with national NGOs as part of the preparedness work and capacity building of local/national actors. • Health Cluster needs to look at local partners directly as part of localization strategy and as a bridge to HDN. • Explore option of a global dashboard to display partners' capacity for each cluster and enable regular updates. • Identified challenges with this survey included: lengths (especially surge capacity question), possible bias with self-reporting by NGOs (officer reporting in the organization, false perception of survey results being related to funding and positioning in the cluster), harmonisation of very different contexts when aggregating the results (e.g. Ethiopia and Libya have a very small number of NGOs). • Suggested actions to be taken to address gaps included: advocacy to focus on meaningful involvement of national NGOs in partnership	• HCCs to provide further feedback on preliminary results via online form, as appropriate. • GHC unit to provide HCCs with a country level analysis of the data collected per country. • GHC unit to work on comparison between results from the international partners' survey and the national partners' survey. • GHC unit and SAG to provide opportunities for further discussion on working with and greater inclusion of national authorities and partners. • GHC to have more defined position on localisation.

(partnership between national and international NGO); capacity building to address gaps technically and operationally, and on the whole cycle of resource mobilization; fundraising for national NGOs (prefunding mechanisms to initiate the response; country based pooled funds could be an option, in certain countries); mapping engagement of partners across sectors in order not to overload national NGOs; looking for opportunities to pool resources across NGOs to do capacity building; create a mechanism for bi-directional accountability. • Consider how the Health Cluster can more effectively support national NGOS and national and local authorities to fulfil their mandate. It is very context dependent whether capacity should be created with governments and/or national NGOs. Even if government services are available, national NGOs also play a beneficial advocacy role for the human rights and protection of marginalized groups. • It was noted that national NGOs and Ministries of Health are currently not members of the GHC Strategic Advisory Group.	

Session 3.2: Extended Health Cluster Strategy 2017-2019 to 2020-2021

In their capacity as members of the GHC Strategic Advisory Group (SAG), Jorge Martinez, HCC Turkey, and David Lai, HCC Afghanistan, informed participants that the SAG has agreed the Global Health Cluster Strategy should be extended from 2017-2019 to 2020-2021. They discussed the consultations undertaken to date to determine whether any revisions were required, and if yes, what these revisions are. They introduced the survey undertaken by partners, which asked partners whether they believe progress was made on the Strategy Priorities outlined in the 2017-2019 Strategy, and whether these priorities remain relevant. The HCCs were then asked to get into groups and provide feedback on the survey results for each of the strategic priorities. Each group circulated across each station which corresponded to one strategic priority, and answering the questions of: i) do you agree with the survey results? ii) has progress being made? and iii) is this priority still relevant?

Key discussion points	Key actions/recommendations
Complete feedback will be summarized and collated as part of the consultation process for the extension of the strategy. Some of the main points discussed were the following: Strategic Priority 1	• GHC unit to collate and analyse qualitative feedback from March 2019 survey, Partner Meeting and Health Cluster Forum.

• Very relevant, with very little progress, especially subnational positions and IMOs. • Need to understand importance of GHC within WHO transformation. • Need to shift to have a better and more realistic alignment with the HDN. Strategic Priority 2 • High priority issue, with some progress in 2.1, but not so much in 2.2. • Clusters need more guidance on operational collaboration with other clusters, stressing the difference between integrated and multi-sector interventions. • This is being done at the country level, but not so much at the global level. • Suggestion to add a third activity, 2.3: Definition of key areas of collaboration at global level (ex: leadership of shared areas of work). • Different clusters will not collaborate if their funding streams are different. Strategic Priority 3 • Relevance should be higher, and progress should show less advancement. • Recognized need to recruit, deploy, build capacity of information management offices, ensure stable contracts to contribute to progress. Strategic Priority 4 • Progress on 4.4 and 4.3, but slower on 4.1. • Cluster coordination in outbreaks is an issue ex: Ebola in DRC. • Need further guidance on HDN, and the new HNO and HRP. • Need to strengthen dissemination of lessons learned and best practices from the HC. • Lack of knowledge among the HCCs on the existence of the online repository. • Highlighted importance of AAP, but that there are many existing concept notes and papers, but operationalization is missing. Strategic Priority 5 • SSA remains extremely relevant but it has shown limited effectiveness and carries a lot of political sensitivity.	• GHC unit to share feedback with GHC Strategic Advisory Group for decision on next steps of the extension process. • GHC unit to share link to the GHC Knowledge Bank and the WHO and UNHCR Memorandum of Understanding.

• There are data gaps, as well as access constraints in reaching beneficiaries and beneficiaries reach goods and services – request to get data disaggregation. In addition, it was noted that (a) not all Ministries of Health from countries where health cluster/sector exists were consulted about the GHC Strategy extension and that (b) the GHC strategy and GHC work-plan should have more balanced representation of cluster priorities/actions/needs in acute and protracted emergencies.	
Session 3.3: Feedback from the survey on supporting country health clusters, next steps and priorities for 2019	
Emma Fitzpatrick, Technical Officer, Global Health Cluster unit, and Sean Casey, HCC, Pacific, facilitated a session in which the HCCs were divided into five groups, corresponding to key thematic areas covered over the past two days and in the Survey on Supporting Country Health Clusters. These were: preparedness, HDN, Information Management, Quality Improvement and Capacity. Each group had to raise quick wins and big asks that they would like to ask of the GHC related to these five themes. The results of this was then presented in plenary, with each group presenting a list of quick wins and big asks (see annex 4).	
Key discussion points	**Key actions/recommendations**
• All quick wins were accepted. • The big asks that received the most votes during prioritisation (i.e. identified as being of greatest priority) were: o Dedicated full-time cluster IMOs o Technical capacity supporting and training with dedicated support missions o Human rights and advocacy training o Training HCCs on IMO competencies	• GHC unit to summarise the exercise and follow up on the identified priorities. • GHC unit to share information on accessing standby partners.
Session 3.4: Conclusions	
Linda Doull summarised the past three days, thanking all participants and closed the meeting.	
Key discussion points	**Key actions/recommendations**

• More clarity requested on HDN, as well as more country application guidance. • Current funding for the GHC work-plan ends February 2020; securing future funding will be a SAG priority. • To date, two out of five GHC Global Goods submitted have been retained as part of the transformation process: improved inter-cluster coordination and implementing PHIS. Partner capacity mapping has been submitted to re-consideration. The implications for funding are still unclear.	• Be clear on what HCCs and HCs in country need from the GHC unit. • Embrace technical and operational integration.

Annex 1: List of participants

Country	Region	Name	Last Name	Position
Afghanistan	EMRO	David	Lai	Health Cluster Coordinator
Afghanistan	EMRO	Sayib	Ayubi	Technical Officer
Cameroon	AFRO	Emmanuel	Douba Epee	Coordinator
CAR	AFRO	Richard	Fotsing	Health Cluster Coordinator
CAR	AFRO	Arsène Elimu	Biringanine	Health Cluster Co-Lead - Médecins d'Afrique
Chad	AFRO	Amadou Mouctar	Diallo	Health Cluster Coordinator
DRC - Kinshasa	AFRO	Sandy	Wenzi	Health Cluster Co-Lead – Médecins d'Afrique
DRC - Goma	AFRO	Denon	Tshienda Muana	Health Cluster Co-Lead – Save the Children
Ethiopia	AFRO	Wilbert	Shihaji	Health Cluster Coordinator
Iraq	EMRO	Fawad	Khan	Health Cluster Coordinator
Libya	EMRO	Hussein	Hassen	Health Cluster Coordinator
Mali	AFRO	(Mohamad ou) Bachir	Mbodj	Health Cluster Coordinator
Mali	AFRO	Alou Badara	Traoré	Health Cluster Co-Lead – Save the Children
Mozambique	AFRO	Van Goor	Erna	Health Cluster Coordinator
Myanmar	SEARO	Allison	Gocotano	Health Cluster Coordinator
Niger	AFRO	Roland	Pognon	Health Cluster Co-Lead - WVI
Nigeria - North East	AFRO	Muhamma d	Shafiq	Health Cluster Coordinator
Pacific Islands	WPRO	Sean	Casey	Health Cluster Coordinator
Pakistan	EMRO	Michael	Lukwiya	Health Cluster Coordinator
Somalia	EMRO	Craig	Hampton	Health Cluster Coordinator
South Sudan	AFRO	Magda	Armah	Health Cluster Coordinator
South Sudan	AFRO	Dayib	Ahmed	Health Cluster Co-Lead - Save the Children
Turkey-Gaziantep	EURO	Jorge	Martinez	Health Cluster Coordinator
Whole of Syria	EMRO	Christina	Bethke	Health Cluster Coordinator
Yemen	EMRO	Jamshed	Tanoli	Health Cluster Coordinator
Regional Offices				
EMRO/WHO	EMRO	Alaa	Abouzeid	Team Lead, Operational Partnerships

WHO /HQ				
WHE		Jaouad	Mahjour	Assistant Director-General, Preparedness
WHE/FCV		Renne	Van de Weerdt	Chief, Fragile, Crises & Vulnerable Settings
WHE/FCV		Andre	Griekspoor	Fragile, Crises & Vulnerable Settings
WHE/HIM		Boris	Pavlin	Health Operations Monitoring & Data Collection
WHO/HIM		Emanuele	Bruni	Health Operations Monitoring & Data Collection
WHO/HIS		Dirk	Horemans	Service Delivery and Safety
OCHA				
IASC		Yasin	Samatar	IASC Secretariat
OCHA		Marina	Skuric-Prodanovic	OCHA, Chief, System-Wide Approaches and Practices Section
OCHA		Annarita	Marcantonio	OCHA System-Wide Approaches and Practices Section
OCHA		Ignacio	Leon	OCHA, Chief, Assessment, Planning and Monitoring Branch
OCHA		Herbert	Tatham	OCHA, Assessments, Planning and Monitoring Branch
OCHA		Nick	Imboden	OCHA, Assessments, Planning and Monitoring Branch
OCHA		Martin	Buettner	OCHA, Assessments, Planning and Monitoring Branch
Global Health Cluster				
GHC		Linda	Doull	Global Health Cluster Coordinator
GHC		Emma	Fitzpatrick	Technical Officer
GHC		Elisabetta	Minelli	Technical Officer
GHC		Naomi	Morris	Consultant
GHC		Eba	Pasha	Technical Officer
GHC		Elisabeth	Roesch	Technical Officer
GHC		Carolyn	Patten	Administration
GHC		Breanne	Kaiser	Consultant
GHC		Irena	Djordjevic	Intern
GHC		Kate	Maynard	Intern

Annex 2: PHIS break out groups - minutes

IMO Capacity

Key Points
ERF has IMO as a standard part of every country structure, IMOs have been advocated for by all members of teams and leverage provided through various surveys yet IMO capacity is currently 40%.
Iraq is a good example of capacity now depleted, originally 6 but now 1 National which has received training and handover but not sufficient capacity.

Recommendations
Advocacy and training/awareness required at all levels of leadership including topics such as:
- IMO competencies
- PHIS, espcially areas were responsibility lies – see Table 8 of PHIS Guidance

Recruitment/Retention:
- Incentives including trainings
- Capacity build non IMOs including simple PHIS tasks
- Effective and realistic work plans
- Proactive recruitment (university courses, rosters, public health background)

Integrated Unit
- All HCCs to review concept note

Public Health Situation Analysis (PHSA)

Key Points
- PHSA, even though uses secondary (usually publicly available) data, may reveal negative attributes that may anger MOH
    - Even if language of e.g. HRP was agreed with govt, sometimes MOH may not have seen this
    - Sharing PHSA within Cluster is crucial. If shared with Cluster, it's basically shared with Govt even if MOH isn't member of Cluster
    - Right now, the PHSA has so much depth that our direct counterparts in MOH may need to consult widely within MOH to get feedback on all aspects of PHSA
    - The most contentious part is the political context
- There is an internal WHO fear of sharing, lest we share wrong info or we offend someone
- Confusion about timing of first PHSA when WHO engages in protracted crisis (answer: go straight to long-form PHSA as soon as possible; we're still catching up on some of our protracted crises)

Recommendations

- Consider outsourcing PHSA process to a 3rd party to mitigate relationship risk with govt (currently, this is partly happens with the PHSA consultant that works offsite…)
- HQ should conduct study of timing of PHSAs to identify pain points (e.g. time after written before approved for sharing
- MOH should be given heads-up before PHSA is even started, explain what it is and that it's based on secondary data
- PHSA should NOT require clearance by MOH (same as like HC Bulletin or EIS posts)
- PHSA should NOT require clearance higher than HCC
- Remove or minimize political context in PHSAs as it can be found elsewhere, and it is the main point of contention

Rapid Health Assessment (RHA) / Health in Assessments

Key Points

- WHO may not need to do health assessments if other partners' assessments are satisfactory
- What do we mean by "rapid"?
- Disagreement on whether to promote health-specific assessments (pro: get more depth, health questions require technical expert; con: time and assessment fatigue) or contribute health questions to multi-sectoral assessments (pro: they're happening anyway, simple health questions can be done by whoever is on the multi-sectoral team, promotes inter-sectoral communication; cons: good health questions may be too technical for non-experts, may not get enough info for our needs)

Recommendations

- Should provide guidance on options and phases (different intensities of assessment for different stage of emergency – e.g. week 1 versus week 4)
- Whether health-specific assessments or questions are contributed to intersectoral assessments, the questions should come from us (not non-experts)
- Start by asking what you want the assessment to accomplish (what actions will be taken), then work back to the questions
- Do thorough secondary data review before doing primary data collection, to avoid duplication
- Bring minimum package of health commodities/services when conducting assessments so as not to go empty-handed
- Leverage partners for health assessment

Health Cluster Bulletin (HBC)

Key Points

- Need IMO to provide data for Bulletins – can help write bulletin if they have public health skills (not just IT background)
- Important to engage with partners (this should be core HCC business anyway)

Recommendations

- HCB is not rocket science – in absence of IMO, HCC should still be able to create HCBs

Health Resources and Services Availability Monitoring System (HeRAMS)

Key Points

- Challenges around implementation often related to misperception around the articulation of HeRAMS other related assessment/monitoring approaches
- Challenges also related to the misperception of the monitoring nature of approach (and its use as an assessment "tool")
- Challenges around the use of tools vs "phases"
- Challenges around governance (WHO/MoH/HC)
- Challenges around capacity: need for increased support capacity

Recommendations

- Clarify the articulation of HeRAMS and other related assessment/monitoring approaches (under way with the development of the technical guidance)
- Clarify the fundamentals of the approach (under way with the development of the technical guidance particularly on Core Principles)
- HeRAMS has initially been developed in emergency contexts but responds in practice to needs that are often encountered outside of usual emergency / response settings. Its use should be guided by need
- Governance at country level: there is no one-fits-all model on governance. Principles are that
    - WHO is the prime responsible for the implementation of the HeRAMS approach to ensure technical consistency and potential to deploy in any context/country regardless of other classifications/mechanisms
    - MoH buy-in and empowerment on the process is fundamental
    - HeRAMS is a collaborative approach that requires collaboration from all health sector actors, and particularly service providers and will seek to blend into existing intra and inter sectoral coordination mechanisms, including Health Cluster, where relevant
- Governance at global level: will be reinforced with the creation of a steering committee (or expansion of the ToR of the current Reference Group) still to be decided
- Capacity still is a challenge to date despite an increasing network of "HeRAMS practitioners". This is due to the increasing number of support requests. Support

capacity has also been reinforced globally to help absorb this scale and further reinforce capacities at all levels (mostly through on the job training).

Annex 3: National partners' capacity survey break out groups - minutes

Group 1

- Results represent the current situation however, there are some areas and contexts where it doesn't apply – ex: in Libya don't have national NGOs working in health and therefore response was 0
- Clinical service on HIV, STI and sexual violence need to be improved and capacity building in this
    - Capacity gaps in funds, technical experience
    - Action to be taken to address gaps: advocacy to focus on meaningful involvement of national NGOs in partnership (partnership between national and international NGO), capacity building to address gaps technically and operationally, fundraising (country based pooled funds could be an option, in certain countries)
- National NGOs have said they have low capacity – this is something we MUST address
    - Many of the issues we see in current responses is having only international staff
    - Doing a survey that deals with the anthropological issues would be very beneficial
    - Must see how to work better with national stuff
- Essential element of the survey is to come up with key indicator conclusions to really guide our future work

Group 2

- Would be helpful to receive a country level analysis, not just raw data – the trends seen in a country and compared with regional and global level
- Important distinction between a national NGO that has a certain size and capacity and others that have a one-off facility with a certain service they provide – this is important to note and take into account – would like to have the ability to partition by size and duration of response
- Difficult to determine reported capacity and actual capacity – this is where seeing the more country level analysis would help
- Saw how much presence partners have in other sectors – a lot of NGOs will say yes to any grant offered to build their space – challenge around generalist and having a decent minimal level of health capacity
- Next steps:
    - Global dashboard to be able to see country results and enable regular updates
    - Need to look at local partners directly as part of localization strategy and as a bridge to HDN – plan that looks at long term partnership which helps to build the capacities of the local partners, which is usually a process that is longer than a single project
    - Country pooled funds are an opportunity to enable RM

    - Mapping engagement of partners across sectors – in order to not overload national NGOs
    - Looking for opportunities to pool resources across NGOs to do capacity building
    - Create a mechanism for bi-directional accountability
    - Make sure utilizing the real capacities of the NGOs
    - Mechanism to transition local partners from emergency to more development and help them to navigate a space that might be tenuous after health cluster departure
- Pacific islands (Sean HCC) does not work with any national NGOs – but in a disaster, have to see whether our objective is to include MORE NGOs or include less NGOs and the government should take care of a lot of it (not for protracted emergencies, but rather disaster)
    - Do we want to create fragmentation with many NGOs or do we want to do localization whereby the government does what they should be doing?
    - The assumption that national NGOs are good works in some areas but maybe shouldn't be the ultimate goal.
    - Even when you have services from the government, you might still benefit from national NGOs for human rights and protection because you will always have marginalized groups
    - Question of whether capacity should be built at government level or with national NGOs – depends on the context
    - This is very context dependant

Group 3

- Issues that made the survey not reflect the reality
    - Response rate
    - Self evaluation, therefore a certain bias
    - Question of who is doing the responding – is it an individual who can reflect the entire response of the organization?
    - Whether the responses are linked to position in cluster and funding
- Should encourage more integration between health and nutrition clusters but in some clusters we should encourage less integration so as to not become generalists
- Capacity building in tertiary care and referral services/specialized services need to be addressed
- Next steps:
    - S. Sudan actively seeking out national NGOs to engage and provide capacity building
    - A lot of national NGOs do not have the financial buffer to initiate the response – can have a prefunding mechanism to ensure that national NGOs are able to implement projects quickly
- A lot of national NGOs do not have resources to do assessments, as a cluster we can link them with assessments and provide the information

- There was no question in the survey on their perceived gap – in terms of what they need from the cluster to improve their abilities
- Capacity building process cannot be transient, it should be throughout

Group 4

- HVI, GBV low capacity
- Weakened hospital waste management is a gap
- Anthropology is needed, but probably not in all contexts
- Community care vector control is a gap
- Child care is reported as high, but does not reflect what is being seen in country – maybe a question of understanding of the question
- Should separate mental health from NCDs
- Low does not necessarily mean a gap – ex: we do not want everyone having stabilization centers, maybe we should be asking if they know where to refer
- Next step: Capacity building with local NGOs
- Redesign of questionnaire to last 15 minutes

Group 5

- Capacity building around external relations to be able to do RM and understand and find ways to agree with requirements imposed by donors
    - Whole management cycle of RM ex: resource mobilization
- Some countries have no national NGOs or they are not allowed to work – how can we engage with them?
- Some contexts have national NGOs but they are all development that do not wish to enter the humanitarian area
- Utilize existing relationships with national NGOs and WHO partnerships to be able to respond quickly when there is a sudden onset emergency
- In some contexts we can strengthen government advocacy capacities, but in others we cannot.
- Government of Ethiopia very restrictive with creation of national NGOs – do not have the money to satisfy the government requirements – legal framework discouraging the creation of national NGOs
- Should be some connection with locally available funding mechanisms

Annex 3: Results from next steps and priorities for 2019 consultation - minutes

Group 1: Preparedness

- Quick wins:
    - Countries in AFRO regions have preparedness plans, adapt prepositioning of stocks and supplies according to the readiness checklist
    - Use the existing EOC – do not create by thematic area
    - Mapping of development partners in order to best link with them – linking preparedness with HDN
- Big asks
    - Trainings which the EMTs are doing – but the cluster coordinators do not know what they are doing – more linkages between cluster coordinator and EMT
    - Training on different topics/thematic: IHR
    - Capacity building for simulation exercises for preparedness
    - Resource mobilization for preparedness – donors are reluctant to give money

Group 2: HDN

- Quick wins:
    - Mapping to show what is going on and what level all the countries are on this concept and do case studies on countries that are ahead of others
    - Map out what is being done in the way presented by OCHA – SDG mapped to what is in the HRP and mapped to other frameworks
    - Identify focal persons – HDN supposed to enhance/strengthen emergency team talking with development teams – find someone that we can speak with/engage with to move this forward
    - Go beyond WHO through the WR – speak with UNDP, UNDAF etc.
- Big asks:
    - Unpack HDN – still a bit hazy, sounds a bit theoretical – need to make it more practical ex: an integrated action plan bringing together humanitarian response and development programs
    - Having definitions for the words used – shouldn't assume that we all understand what reconstruction, rehabilitation, rebuilding, durable solutions etc. means – maybe put on a spectrum
    - Funding – everything seems to be donor driven – can the major actors speak the same language (ECHO, DFID, USAID) – when they say HDN do they mean the same thing?
        - Put money where their mouths are – humanitarian donors don't want to give money for development and development donors don't want to give money for response – but these need to be bridged for HDN
    - Protect the humanitarian space, in terms of principles
        - Likelihood of development overwhelming and taking over everyone because they have money, frameworks, are government-led etc.

        - May end up getting lost in this process – need the experts to let us know how to do this

Group 3: Information manager

- Quick wins
    - Upload all information of these workshops and have access to them
    - Work with OCHA to provide country level briefing on the new HPC – HNO and HRP
    - Update PHSA
- Big asks
    - Incident management officer with a background in public health – understand PH and be able to do epi analysis and be able to understand trends
    - Train partners on information management
    - Health cluster coordinators should have some competency on information management – training
    - Capacity building for national staff – promote national information officer capacity at national level – job done by international staff can be done by national staff
    - IMO roster for health – there is a WHE HIM roster, but hardly anybody on it or nobody is released by supervisor
        - Send requests for standby partners

Group 4: Quality Improvement

- Quick wins
    - Quality of care should be mainstreamed at the different levels
    - Tool to monitor the perception of the community on the quality of services they receive
    - HeRAMs – some countries don't have it – wealth of information
- Big asks
    - Get training from the health systems strengthening colleagues to build capacity
    - Support missions to countries – working on quality of care to get extended support (more so than from the quality of care working group)

Group 5: Capacity (focused on mechanism, rather than topic)

- Quick wins
    - Having monthly webinars on specific topics
    - Knowledge bank – use if it exists, create if it doesn't exist – it exists, ask to recirculate awareness of it
        - Needs to be updated

        - If you have stuff from regions, send to others - ex: EMRO asked for specific guidance to be included
    - WhatsApp group between cluster coordinators
    - SSA trainings for partners – informing cluster coordinators that this program exists and that they can request access
    - Online trainings for health cluster coordinator training
        - Being developed, will be done by end of July in English and available for those inside and outside WHO

Big asks

- IHR trainings – engage health clusters in the existing WHE trainings
- Human rights and advocacy – topic for capacity building – can be a quick win with a half day at the next forum or a big ask by having a longer course

Ideas without homes

- Quick wins
    - Hard copies of SPHERE to countries (100 or more)
    - Vests with cluster logo
    - Health cluster orientation via OpenWHO platform
- Big ask
    - HRP costing overview – cost per head with government spending
        - Some countries do activity-based costing and others do project-based costing
        - To help with costing
        - Have to say what you want to cost and what methodology is used to bring it to the experts

Looming concerns

- Capacity building for surveillance officers – build the capacity and be able to provide information to partners where WHO does not have surveillance capacity
- Increasing technocratic style
    - Need to increase quality of data, but worry that we swing too far to the other side because the more time spent on the computer takes you away from the response
- How can we easily access standby partners?
- Donor pressure to work with consortia outside of the cluster
- Becoming more and more difficult to identify subnational cluster coordinators in countries with clusters activated at multiple levels – what can we do
    - Four-week training in Ethiopia and then had a one-week training with identified individuals and have a plan to follow up with them, maybe through missions

    - Not always possible to have dedicated subnational cluster coordinators – but alternative solutions can be found.

- Big asks with highest priority after prioritisation by HCCs:
    - Dedicated cluster IMO (full time) – 12 votes
    - Technical capacity supporting and training with visits to country offices (support missions) – 9 votes
    - Human rights and advocacy training – 9 votes
    - Training HCCs on IMO competencies – 9 votes
    - More IMOs – 8 votes
    - Cluster coordination and IMO training and mentoring – 7 votes
    - Resource mobilization for stock prepositioning – 5 votes
    - Vests/t-shirts with GHC logo – 4 votes
    - HRP costing – 4 votes