

Virtual Global Health Cluster Partner Meeting 17-18 June 2020 (11.00-13.30 each day)

Note for the Record

The 26th Global Health Cluster Partner Meeting, held on 17-18 June 2020, was attended by 81 participants representing 33 partners, 3 interested parties, 2 country Health Clusters, WHO at global and regional level and the Global Health Cluster unit (see annex 1). The meeting was preceded by the meeting of the Global Health Cluster Strategic Advisory Group on 16 June 2020.

The meeting objectives were:

- To share good practices and lessons learned from the COVID-19 response:
 - On maintenance of essential health services;
 - On case management of COVID-19 in low resource settings.
- To update partners on the recent global developments on mental health and psychosocial support in humanitarian settings and discuss country-level implementation.
- To present the new Global Health Cluster (GHC) position paper on quality of care in humanitarian settings and discuss dissemination for use at country level.

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

DAY 1: 17 June 2020

Session 1: Welcome and meeting objectives (L. Doull, GHC)

L. Doull, GHC Coordinator, welcomed participants and outlined the meeting objectives. She welcomed Dr Soce Fall, Assistant-Director General, Response Division, WHO Health Emergencies Programme, to his first GHC Partners' meeting and invited him to give the opening remarks.

Session 2: Opening remarks (Dr Soce Fall, WHO)

Dr S. Fall opened the meeting by thanking the many GHC partners involved in the Ebola and larger humanitarian response in the Democratic Republic of Congo last year. He noted that COVID-19 presents an unprecedented challenge, particularly highlighting the increasing transmission trends in many countries affected by humanitarian crises and the socio-economic impact to come. Importance was placed on balancing the pandemic public health response with protecting the most vulnerable populations by maintaining essential health services including HIV, pediatric, sexual and reproductive health. He recognized that operational adaptation is not always easy, and that more can be done to learn from each other on how to adapt existing WHO guidelines. He mentioned that WHO, as co-lead of the UN Crisis Management Team, is making every effort to overcome the hurdles associated with COVID-19, including the Supply Chain Coordination Cell, Medivac and new humanitarian hubs. While there are many challenges ahead related to supplies, funding, movement restrictions and other operational challenges, he expressed confidence that Health Cluster partners will demonstrate their ability to meet the evolving health needs.

Discussion points:

- Moving to a more decentralized approach will be critical to reaching communities while preserving safety. A successful, localized COVID-19 response requires contributions from partners.
- In line with the Grand Bargain commitments, WHO is prioritizing countries for funding allocations and attempting to protect the country level from the gaps felt at the global level.
- The lifting of containment measures to address the negative socio-economic impact presents a delicate and potentially dangerous balance if public health measures are not in place.

Session 3: Maintenance of essential health services during COVID-19 response (Chair: Michelle Gayer, IRC)

M. Gayer, Director, Emergency Health, International Rescue Committee (IRC), introduced the session by highlighting the need to learn from past outbreaks. Particularly the fact that the initial outbreak response can sometimes supersede essential health services leading to a situation where the mortality and morbidity from preventable illnesses becomes worse than the outbreak itself.

J. Ali, Senior Medical Advisor, International Medical Corps (IMC), shared the immediate priorities addressed by [IMC in Iraq](#): preparing health facilities, integrating Risk Communication and Community Engagement (RCCE) activities into community

health models, needs analysis for Personal Protective Equipment (PPE) and Infection Prevention and Control (IPC) materials, mitigation measures in Internally Displaced Persons (IDP) camps and operational adaptations. The Health Cluster in Iraq created adapted guidance on isolation in IDP camps and shielding the most vulnerable. Ongoing challenges remain the recruitment of staff, access to certain locations, and maintaining a stockpile of PPE and other medical supplies.

R. Cummings, Senior Humanitarian Health Advisor at Save the Children UK, acknowledged the understandable focus on case management or establishing isolation facilities but also recognized that COVID-19 will have an impact on non-COVID-19 health outcomes if health services are not protected. Drawing on field experience in Cox's Bazar, she noted that there is a decrease in demand for essential health services due to fear of exposure but also due to conflicting Water Sanitation and Hygiene (WASH) and Health messaging at the start of the outbreak if one should stay at home or enter a healthcare facility when sick. A major outstanding challenge is deciding when it becomes necessary to scale down health services, how to do so in a coordinated way with other partners, and how to increase surveillance and data reliability/reporting from partners to course correct and adapt service provision.

L. Logre, Head of Technical Department, Premiere Urgence Internationale (PUI), shared experience from Nigeria and the Central African Republic of supporting the Ministry of Health (MoH) in continuing lifesaving and life-sustaining services during the COVID-19 pandemic. While some services were scaled-down or managed remotely, essential health services were prioritized to guarantee the minimum package of services.

Key discussion points	Key actions/recommendations
<ul style="list-style-type: none"> Partners agreed that robust coordination (centralized and decentralized), information sharing and localization of the response are critical in responding to pandemics and outbreaks. The Health Cluster has a role in adapting guidance at the country and global levels to ensure service access for all vulnerable groups (e.g. through remote service provision, telemedicine, etc.). The Health Cluster can provide critical support to the MoH to strengthen their strategic response plans, conduct gap analysis, or provide other supports. Partners shared examples of their own frameworks for adapting global guidance and mentioned existing frameworks (e.g. UN Program Criticality Framework, CERF lifesaving criteria, etc.) as a priority to promote and share. 	<ul style="list-style-type: none"> GHC to accelerate investment in building coordination capacity, especially at national and local levels. Partners to participate and share information to identify gaps in service provision and Country Clusters to systematically gather information. GHC to facilitate collation and sharing of frameworks for adaptation. GHC to support partners with contingency planning (risk assessments, availability of contingency stocks, etc.), including protection of their staff, in

<ul style="list-style-type: none">Partners noted the importance of localization, particularly in task shifting and capacitation of community health workers to support COVID-19 sensitization. Partners agreed that there is a need to increase remote programming and to strengthen work with national authorities and local partners in a decentralized manner.Partners noted the critical role of risk communication and community engagement in the response to overcome misinformation.Partners gave country level examples of disruptions in supply chain and decreased utilization of essential health services by the community, indicating that COVID-19 will have an impact on broader health outcomes.It was suggested that the COVID-19 response may be an opportunity to adopt new or different delivery models for an evidence-based shift in care delivery.There is a need to further analyse whether remote programming adopted during the movement restrictions was successful.	<p>order to mitigate the impact of staff being unable to provide services.</p>		
	<table><tr><th>Key gaps/challenges</th></tr><tr><td><ul style="list-style-type: none">Partners reported ongoing lack of access to PPE and essential supplies.Healthcare waste management remains a challenge in both community and healthcare facility settings, particularly when there are large volumes of PPE.Partners would like to see more tools to accompany guidance (flow charts, decision trees, monitoring charts, etc.).</td></tr></table>	Key gaps/challenges	<ul style="list-style-type: none">Partners reported ongoing lack of access to PPE and essential supplies.Healthcare waste management remains a challenge in both community and healthcare facility settings, particularly when there are large volumes of PPE.Partners would like to see more tools to accompany guidance (flow charts, decision trees, monitoring charts, etc.).
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Session 4: Case management of COVID-19 in low resource settings (Chair: Mike O'Brien, FHI360)

M. O'Brien, Health Advisor, Crisis Response Team, FHI360 opened the session and encouraged partners to share their field experience in adapting and operationalizing guidance regarding case management of COVID-19 in low capacity and humanitarian settings. He acknowledged the challenges in these settings given the more limited capacity to test.

S. Mearns, Senior Technical Advisor for Emergency Health, International Rescue Committee, [shared her experience](#) in developing and adopting local MoH and global WHO guidance (such as isolation unit design and PPE conservation guidance), consolidating guidance (such as contact tracing, case management and surveillance guidance for community health workers) and developing tools (such as oxygen management charts) that field teams can operationalize to create detailed standard operation procedures (SOPs).

M. Hallissey, Global Health Advisor, GOAL, shared field experience from operations in sub-Saharan Africa on applying learning from the Ebola outbreak to inform the RCCE activities in respond to COVID-19. She acknowledged the challenges of delivering services due to movement restrictions.

M. Kempster, Global Health Advisor, Relief International, shared that case management of COVID-19 has been a constant learning process without a one-size-fits all solution. She highlighted the importance of community acceptance of case management approaches and gave examples of community health workers supporting contact tracing and risk communication measures.

Key discussion points	Key actions/recommendations
<ul style="list-style-type: none"> Partners recognized that global guidance is useful but may be vertical and siloed, while operational needs are horizontal and integrated. Partners discussed the need to operationalize global guidance both at the country level and in different settings, mentioning the need to “take the what and add the how”. Guidance must be timely and based on the operational realities. Partners acknowledged that most WHO guidance will require country-level adaptation and the GHC shared that the WHO Health Ops help desk coming online soon can support in operational work. Partners questioned if the Health Cluster should take the lead to consolidate and operationalize WHO guidance at the country level on behalf of all partners. Partners noted the value of OpenWHO trainings and shared that agencies will still need to complement. Discussion continued on the importance of localization and how to strengthen it. While streamlined access to funding for partners is one aspect, the concept of partnership needs to be extended beyond grant-recipient dynamics. Case management of COVID-19 was described as a constant learning process without a one-size-fits-all approach. As technical updates are released, partners must first understand the new guidance before sharing with country-based teams for implementation. Partners shared examples of pivoting development programs to address and maintain essential humanitarian services and moving to increased remote services provision. 	Key actions/recommendations
	Key gaps/challenges
	<ul style="list-style-type: none"> GHC to capture current learnings on case management for future outbreaks. GHC to consider how it can support guidance adaptation, contextualization and consolidation in a more coordinated manner. GHC to consider who (GHC Unit, COVID-19 Task Team and/or partners) could have a role in developing more structured packaging of both available guidance and trainings targeted to humanitarian settings. <ul style="list-style-type: none"> More direction from WHO is needed when making pragmatic or tough decisions in the field (what to do if a standard cannot be met, what are the ethical implications, who is accountable?). Forecasting surge capacity and needs particularly of medical staff has been a challenge.

DAY 2: 18 June 2020

Session 1: Mental health and psychosocial support in humanitarian settings (Chair: Claire Beck, WVI)

F. Hanna, Technical Officer, WHO, Co-Chair of IASC Mental Health and Psychosocial Support (MHPSS) in Humanitarian Contexts Reference Group, [reported](#) that according to a recent Lancet [publication](#), in conflict settings one in five people require some form of MHPSS support. He gave an overview on wide range of [MHPSS global goods](#) published to support COVID-19 response. He noted that the forthcoming minimum service package in addition to the [surge of human capacity](#) will help fill the key gap in MHPSS in the field. He highlighted the momentum for MHPSS at the global level, such as the UN Secretary General's [policy brief](#) on COVID-19 and the need for action on mental health, identifying mental health as a basic need and calling on all agencies and governments to integrate MHPSS into all sectors to mitigate the mental health impact of COVID-19.

M. Gayer, Director, Emergency Health, International Rescue Committee, shared field experience from Yemen, Libya and Uganda regarding integration of mental health into primary healthcare. She emphasized the utility of global goods and tools such as the mhGAP Humanitarian Intervention Guide and noted the challenges COVID-19 has presented in continuing community-based MHPSS health programs.

O. Rebolledo, MHPSS Program Manager, International Organization for Migration, described the operational strategy to deploy mobile teams to deliver MHPSS services in hard-to-reach areas of northern Nigeria. She highlighted the importance of integrating mental health with livelihood and protection for a multisectoral approach.

P. Koyiet, Senior Technical Advisor Mental Health and Psychosocial Support (MHPSS), World Vision International, shared the public health approach taken to address MHPSS service provision in DRC, through sectoral integration and strengthening community-based support systems, such as faith leaders, lay helpers for long-term trust and self-sustaining community programmes. The challenge remains how to ensure effective trainings and supervision during COVID-19 in the shadow of conflict, as community health workers and faith-based teams take initiative to continue programming in their communities despite movement restrictions.

S. Zariv, GBV in emergency settings advisor, WHO, indicated two new chapters in the updated Clinical Management of Rape Guidelines on MHPSS and intimate partner violence. Details were shared about the development of an advanced training for mental health providers that goes beyond the provision of basic psychosocial support to address how to deliver specialized mental health support in a way that is adapted to GBV survivor needs. It is anticipated for release in 2021.

R. Van De Weerd, Director a.i. and Global Health Cluster SAG co-chair, Health Emergency Interventions, WHO, emphasized that in Yemen, the investments in mental health prior to COVID-19 are clear. She noted that the Humanitarian Country Team efforts, Health Cluster coordination work, and the inter-cluster coordination mechanisms have paid off and will have a lasting impact.

Key discussion points	Key actions/recommendations
<ul style="list-style-type: none"> Partners underlined the importance of integrating severe cases into primary health care models and ensuring capacity to manage them holistically. <ul style="list-style-type: none"> Partners noted an overemphasis of pharmacological interventions, rather than integration with community and family level care, psychotherapy, sufficient follow-ups and clinical supervision. Thanks to the advocacy of WHO and many partners, mental health is prioritized in the revised GHRP as an essential need, and a specific MHPSS indicators have been included, and should be included in all HRPs going forward. <ul style="list-style-type: none"> As per SPHERE standard indicator, at least 1 person trained and system in place to manage MHPSS services in every health facility was recommended as indicator. Standardization of the minimum service package was appreciated as it will give predictability on costing for donors and together with the addition of the surge of human capacity will help to fill the key MHPSS gaps in the field. Partners shared that MHPSS capacity building and training programs that began before the outbreak of COVID-19 were able to successfully continue after movement restrictions were put in place. Partners noted the update shared on the new training package in development on GBV that intends to go beyond basic PSS support. 	Key actions/recommendations
	<ul style="list-style-type: none"> GHC and Country Health Clusters to continue advocating for MHPSS integration in primary and general healthcare. GHC and partners to continue advocating for an MHPSS focal point at the HQ, regional and country levels. GHC agreed that there is a need for MHPSS surge capacity.
	Key gaps/challenges
	<ul style="list-style-type: none"> Partner capacity to provide MHPSS is limited, as demonstrated by partner capacity surveys. <ul style="list-style-type: none"> Gaps in MHPSS in primary healthcare, article shared available here. Partners face the challenge that investments in MHPSS staffing are at the field level but not at the regional or HQ level for coordination and interagency work.

Session 2: Quality of care in humanitarian settings (Chair: Haley West, IOM)

E. Pasha, former Quality Improvement Task Team focal point, presented on the [GHC position paper on quality of care in humanitarian settings](#) that is being launched. The presentation provided background on the Quality Improvement Task Team and the methodology used to develop the position paper. The position paper itself describes minimum issues that need to be addressed to ensure quality of care in humanitarian settings. Partners were encouraged to disseminate the paper and adopt it in the implementation of their programmes at country level.

A. Challier, Health and Nutrition Technical Advisor, Action Contre la Faim, (ACF) shared field experience from Yemen, on an assessment tool and supervision framework developed to assess the quality of care in healthcare facilities. The pilot of the questionnaire and overall supervision framework has not been implemented in Yemen yet. ACF will re-engage with the Quality Improvement Working Group in Yemen in order to confirm their plan and achievement. The questionnaire is focusing mainly on two components of quality of care: people-centered (patient satisfaction mainly) and safety (including safe infrastructure and design; patient safety; IPC; availability of medicines and material). She noted the limitation of the approach was a lack of information from community members without access to healthcare facilities. This questionnaire is available to other partners for piloting.

Key discussion points	Key actions/recommendations
<ul style="list-style-type: none"> Partners noted the utility of the GHC position paper on quality of care in humanitarian settings. Partners shared that they are developing their own frameworks and adapting or implementing existing frameworks. <ul style="list-style-type: none"> IRC established a quality improvement task team and are creating their own quality of care framework through this team and will review to ensure it covers what is articulated in the GHC position paper. Concern found an existing 5-S framework to be useful. It is a management approach for improvement of hospital services. 5S signifies "Sort", "Set", "Shine", "Standardize" and "Sustain" to improve working environment and nurture positive mindset of the staff. 	<ul style="list-style-type: none"> Partners agreed that it is important to develop a framework with accompanying tools and resources, including appropriate checklists and indicators. Resources are needed for the continuation of the Quality Improvement Task Team workplan <ul style="list-style-type: none"> GHC Unit to prepare funding proposal to sustain the work of the Task Team. GHC Unit to reach out to partners to express interest to co-lead the Task Team. Partners agreed that financial and human resources are needed to

<ul style="list-style-type: none"> • There was agreement that increased use of frameworks and toolkits aid in documenting good practices, gaps and lessons learned to determine where to invest more resources. • GHC unit shared example of SOPs in development for Sexual and Reproductive Health (SRH) but then faced scaling down in services due to COVID-19 further diverting limited resources. • Partners discussed the role that Country Health Clusters can have in supporting to harmonize and contextualize tools for partners to support MoH facilities, using the position paper as a platform. • Partners noted that the GHC QITT have a work plan and have identified priority activities that need to be conducted in 2020. • WHO reminder that the Health Facility Quality Assessment Tool is available to partners for piloting if properly resourced. Tool was previously developed by GHC Essential Package of Essential Services Task Team and further work on this is under the GHC QITT. • Partners noted that the IM Task Team in collaboration with the QITT will be creating indicators on quality of care and welcome partner contributions. 	<p>ensure quality improvement of their work:</p> <ul style="list-style-type: none"> ◦ Donors to commit to support technical assistance and supervision. <p>Key gaps/challenges</p> <ul style="list-style-type: none"> • Health Clusters noted challenges at the country level regarding time required for partners' adaptation of frameworks.
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Session 3: COVID-19 Task Team update and Q&A (Chair: Haley West, IOM)

E. Pasha, GHC COVID-19 Task Team focal point, shared the purpose and primary outputs of the COVID-19 Task Team, available [here](#). She also described the two core groups that have been established: (1) Emerging needs and themes group to determine gaps in guidance, challenges and good practices; (2) Learning group to review identified gaps and respond to support countries. The first activity of the Task Team was to conduct a rapid gap analysis and the results indicated that the largest gaps are in guidance around case management and surveillance, particularly where there are limited supplies, low testing capacities and limited PPE.

K. Blanchet, Director, Geneva Centre for Education and Research in Humanitarian Action (CERAH), shared the new [platform](#) created by CERAH, Johns Hopkins University and the London School of Hygiene and Tropical Medicine. This platform will help identify gaps in guidance and will soon begin to share the guidance collected in collaboration with the task team.

Key discussion points	Key actions/recommendations
<ul style="list-style-type: none"> Partners noted the updates on the COVID-19 Task Team. 	<ul style="list-style-type: none"> No key actions/recommendations reported.
Session 6: Conclusions and next steps (Claire Beck, SAG Co-Chair; Linda Doull, GHC Coordinator)	
<p>C. Beck, WVI, SAG Co-Chair summarized the key points and related recommendations and highlighted the following priorities:</p> <ul style="list-style-type: none"> Role of the Health Cluster in coordination, information sharing and adaption of guidance. The role of partners and Country Health Clusters in building the capacity of the MoH to increase resilience to continue during crises. The importance of localization and task shifting in times of crisis, enabling community healthcare workers and local staff to take the lead. Country adaptation of guidance requires more support on how to operationalize in resource scarce situations and greater pragmatism around making difficult decisions. MHPSS should be central to all GHC partners' programming, not just in the health space, but across all sectors. It is a priority for the UN and the WHO and IASC, and the donors to ensure that communities have their MHPSS needs met. Quality of care position paper is useful and will need a framework to operationalize it and ensure that quality is actually demonstrated. Partners should continue to engage in the Task Team and express interest to co-lead the Task Team. SAG survey will be administered soon to understand what partners think about the role of the GHC SAG, expectations and what they would like the SAG to do in the future. <p>L. Doull thanked everyone for their collective engagement in a time when partners are more stretched than ever but also most needed than ever. She reported that the items discussed with the SAG are included in the GHC work-plan and that the GHC unit will reach out to all partners to ask for commitments towards the implementation of the work-plan.</p>	

Annex 1: List of participants

Organization	Name	Last Name	Position
GHC Partners			
Members			
Action contre la faim	Caroline	Antoine	Health Advisor
Action contre la faim	Adelaide	Chailier	Health and Nutrition Technical Advisor
Action contre la faim	Sarah	Brousse	Technical Advisor
Action contre la faim	Alexandre	Letzelter	MHPSS Technical Advisor
Center for Disease Control - United States of America	Kevin	Clarke	Medical Epidemiologist
Center for Disease Control - United States of America	Richard	Garfield	Team Lead
Center for Disease Control - United States of America	Barbara	Lopes Cardozo	Psychiatric Epidemiologist
Center for Disease Control - United States of America	Leisel	Talley	Team Lead
Columbia University	Rachel	Moresky	Director, International Emergency Medicine Fellowship & sidHARTE Program
Concern Worldwide	Christine	Bousquet	Health Advisor
Concern Worldwide	Breda	Gahan	Senior Health and HIV Advisor
Department for International Development - United Kingdom	Pip	Millard	Humanitarian Advisor
European Commission Directorate for Humanitarian Aid	Chiara	Giusto	Policy Assistant Health and Nutrition
FHI360	Michael	O'Brien	Health Advisor, Crisis Response Team
GOAL	Marie	Hallissey	Global Health Advisor
GOAL	Geraldine	McCossan	Global Health and Policy Advisor
Harvard Humanitarian Initiative	Sean	Kivlehan	Affiliate Faculty
Harvard Humanitarian Initiative	Michelle	Niescierenko	Director, Global Health Program
Hope Worldwide	Charles	Ham	Global Disaster Response Coordinator
iMAPP	Jon	Carver	Representative in Geneva

International Medical Corps	Javed	Ali	Senior Medical Advisor
International Medical Corps	Suzanne	Gosling	Director for the Technical Unit
International Medical Corps	Jill	John-Kall	Senior Health Advisor
International Organization for Migration	Olga	Rebolledo	Programme Manager
International Organization for Migration	Haley	West	Migration Health Emergency Operations Officer
International Rescue Committee	Michelle	Gayer	Director, Emergency Health
International Rescue Committee	Stacey	Mearns	Senior Health Coordinator
International Rescue Committee	Nathaly	Spilotros	Reproductive Health Specialist
INTERSOS	Miguel	Castillo	Health Program Advisor
Johns Hopkins University	Donatella	Massai	Senior Researcher
JSI	Nadia	Olson	Senior Technical Advisor
Malaysian Medical Relief Society	Masniza	Mustaffa	Health Coordinator, Health Unit
Medair	Namseon	Beck	Senior Health and Nutrition Advisor
Medair	Heidi	Giesbrecht	Senior Health and Nutrition Advisor (DRC and GERT)
Medical Teams International	Franky	Tyler	Global Humanitarian Health Advisor
Medical Teams International	Trina	Helderman	Consultant
USAID/Bureau for Humanitarian Assistance	Jolene	Nakao	Public Health and Medical Technical Advisor
USAID/Bureau for Humanitarian Assistance	Sonia	Walia	Public Health and Nutrition Advisor
Premiere Urgence Internationale	Louise	Logre	Head of Technical Department
Relief International	Melanie	Kempster	Global Health Advisor
Relief International	Ann	Koontz	
Samaritan's Purse International Relief	Megan	Vitek	Medical Technical Advisor
Save the Children	Rachael	Cummings	Senior Humanitarian Health Advisor

U.S. Department of State/Bureau of Population, Refugees, and Migration	Courtney	Blake	Senior Humanitarian Advisor
UNFPA	Nadine	Cornier	Head of the Response and Technical Support Unit
UNFPA	Henia	Dakkak	Programme Advisor - Humanitarian and Fragile Context
UNHCR	Allen	Maina	Senior Public Health Advisor
UNICEF	Sarah	Karmin	Programme Specialist
UNICEF	Carlos	Navarro Colorado	Principal Advisor, Public Health Emergencies
UNICEF	Willis	Ouma Agutu	Health and Nutrition Project Officer
World Vision International	Claire	Beck	Director, Global Technical Team (Humanitarian Operations)
World Vision International	Phiona	Koyiet	National Coordinator, Gender and Disability
Associates			
IPAS	Bill	Powell	Senior Medical Scientist
Global Clusters			
global Food Security Cluster	Bruno	Minjauw	Global Coordinator
Interested Parties			
Geneva Centre of Humanitarian Studies	Karl	Blanchet	Director of Geneva Centre of Humanitarian Studies
Global Affairs, Canada	Claudia	Therault	Senior Policy Analyst
Ministry of Foreign Affairs of the Netherlands	Janneke	Rijnart	Senior Policy Officer
Ministry of Foreign Affairs of the Netherlands	Jennie	Vande Weerd	Health Systems Management Advisor
OCHA	Annarita	Marcantonio	
WHE			
Director a.i.	Renee	Van De Weerd	Director A.I.
EMT	Flavio	Salio	Manager

Fragile and Vulnerable Countries Team, Emergency Operations	Andre	Griekspoor	Senior Policy Advisor
Fragile and Vulnerable Countries Team, Emergency Operations	Teresa	Zakaria	Health Emergency Officer
GOARN	Pat	Drury	Manager
PAHO	Fernando	Hernandez	
PAHO	Irma	Morales	
SEARO	Sugi	Perera	Partnerships Officer
EMRO	Alaa	Abou Zeid	Team Lead
WHO	Janet Victoria	Diaz	Network Leader
WHO	Soce	Fall	Assistant Director-General
WHO	Teri	Reynolds	Scientist
WHO	Saba	Zariv	Technical Officer, GBV in emergencies
WHO - Other departments			
Mental Health	Fahmy	Hanna	Technical Officer
Mental Health	Inka	Weissbecker	Technical Officer
Mental Health	Mark	Van Ommeren	Coordinator
Health Clusters			
Afghanistan	David	Lai	Health Cluster Coordinator
Turkey - Gaziantep	Jorge	Martinez	Health Cluster Coordinator
Global Health Cluster			
Global Health Cluster	Mohira	Babaeva	Project Manager
Global Health Cluster	Linda	Doull	Global Health Cluster Coordinator
Global Health Cluster	Emma	Fitzpatrick	Technical Officer
Global Health Cluster	Elisabetta	Minelli	Technical Officer, Secretariat
Global Health Cluster	Naomi	Morris	Consultant, Information Management
Global Health Cluster	Eba	Pasha	Consultant, COVID-19 Task Team
Global Health Cluster	Carolyn	Patten-Reymond	Assistant
Global Health Cluster	Kathleen	Sullivan	Consultant, Communications and Knowledge Management

Global Health Cluster	Cleophas	Tavaya	Consultant, Information Management
SAG members			