Health Cluster Annual Cluster Coordination Performance Monitoring Report

2019

Email - healthcluster@who.int

Website - www.who.int/health-cluster/

TABLE OF CONTENTS

ACRONYMS

AAP Accountability to Affected Populations
AIDS Acquired Immunodeficiency Syndrome
CCPM Cluster Coordination Performance Monitoring
GBV Gender Based Violence
GHC Global Health Cluster
HCT Humanitarian Country Team
HIV Human immunodeficiency virus
HPC Humanitarian Programme Cycle
HRP Humanitarian Response Plan
IASC Inter-Agency Standing Committee
INGO International Non-Governmental Organization
NGO Non-Governmental Organization
WHO World Health Organization
IMO Information Management Officer

ACKNOWLEDGEMENTS

The Global Health Cluster gratefully acknowledges inputs to the Cluster Coordination Performance Monitoring.

We express our sincere thanks to the Health Cluster international and national partners and their focal points for having taken the time to fill in the survey, to the Health Cluster Coordinators and Co-Coordinators that have facilitated the process within their own country health clusters, as well as to the colleagues from Emergency Operations within the WHE Programme in the regions that have been supportive of the activities involved in completing the CCPM.

1 INTRODUCTION

1.1. The Health Cluster

The Health Cluster is a vital operational partnership network that galvanizes the collective capacities of over 900 partners at country level, of which 56 engage strategically at the global level, to achieve better health outcomes in humanitarian and public health emergencies. In 2019, there were 29 Health Clusters/Sectors, of which 2 were regional coordination mechanisms working to meet the health needs of approximately 65 million people worldwide. WHO is the IASC designated Cluster Lead Agency and provides coordination and secretariat support.

The Health Cluster aims to accelerate collective action, as locally as possible and as internationally as necessary, to ensure crisis affected communities receive immediate life-saving support and continued access to essential health services.

Health Cluster partners engaged at the global level to deliver the GHC Strategic Priorities for 2017-2019:

1. Strengthen the coordination, technical and operational capacity of national-, regional- and global-level actors to prevent, prepare for, respond and recover from public health and humanitarian emergencies;
2. Strengthen inter-cluster and multi-sector collaboration to achieve better health outcomes;
3. Strengthen our collective and respective health information management;
4. Address strategic and technical gaps; and
5. Strengthen health cluster advocacy at country and global level.

At the country level, the Health Cluster serves as a mechanism for partners to harmonize efforts and use available resources efficiently within the framework of agreed objectives, priorities and strategies, for the benefit of the affected population(s). This includes addressing gaps, avoiding duplication, and resisting the establishment of parallel structures, wherever possible. The cluster should provide a framework for effective partnerships among international and national humanitarian health actors, civil society and other stakeholders, and ensure that

international health responses are appropriately aligned with national structures. In a sector of increasing needs and diminishing resources it is paramount that intensified efforts are made to address critical gaps in the Health Cluster response by strengthening partner capacities, collaborating with new actors and diversifying services.

1.2. The Health Cluster Coordination Performance Monitoring

Cluster Coordination Performance Monitoring (CCPM) is an IASC mandated self-assessment of cluster performance against the 6 core cluster functions plus Accountability to Affected populations. It is a country led process, supported by Global Clusters and OCHA. The CCPM can be applied by both clusters and sectors. CCPM assists in taking stock of what functional areas work well and what areas need improvement. CCPM assists with raising awareness of support needed from the HC/HCT, cluster lead agencies, global clusters or cluster partners and gives an opportunity for self-reflection. CCPM is also important for strengthening transparency and partnership within the cluster. CCPM is IASC mandated to be completed annually and within 3-6 months of an activated Cluster and is relevant to all parts of the GHC Strategy 2017-2019.

The Four Steps of CCPM

Step I: Planning

Agreement on implementation and timeframe

Step II: The Survey

Country and Sub National level survey to coordinator and partners

Step III: Cluster analysis and action planning

Final CCPM report and Action Plan

Actions for improvement, timeframe and responsible for follow-up

Step IV: Follow-up & Monitoring

Take stock of progress at monthly cluster meetings and quarterly progress reporting to the HCT

Health Cluster Annual CCPM Report, 2019

This report presents an overview of all CCPMs completed for 2019 with specific emphasis on the analysis provided from step II, the surveys. The result of this exercise will help to more effectively identify areas to improve coordination performance including future partner engagement, strategic planning, mechanisms on accountability to affected populations and work on advocacy for the Health Cluster at Global and Regional level.

2. METHODOLOGY

2.1. Process and timeline

The process was led and supported by the GHC unit and entailed the following steps

- Design an analysis plan for the CCPMs completed in 2019 utilising existing data stored in Limesurvey (WHO hosted platform for survey.)
- Gather feedback on process from Health Cluster Coordinators
- Validate the data internally
- Analyse the data at National, Regional and Global level.
- Prepare the final report

This work was completed between December 2018 and February 2019, the CCPMs were completed at Country level from January 2019 to January 2020.

2.2. Technical Methodology

Two online surveys were distributed, one targeting cluster coordinators and the other, cluster partners. The surveys were primarily comprised of likert-type questions. These questions use scaled responses, usually from very negative to very positive. For example, if partners were asked "How frequently they attended cluster meetings", their response options would be: Always, Often, Sometimes, Rarely, Never. These options can then be coded from 1 (Never) to 5 (Always). To calculate an overall score, the average score is calculated. Using the same example, all partner's responses would be added together and then divided by the number of partners responding. In the country level reports a different methodology was used that looked only at absolute figures (in this instance, anyone who reported attending cluster meetings was counted in the positive, and only 'Never' counted as negative). Doing this provides an overall figure, but it does not show the variety in the same way a calculated figure can. For this reason, a different approach was taken for analysing CCPM at the global level. To keep the results in a similar format, the calculated likert scores were re-coded into a percentage (e.g. if the average response to "How frequently do you attend cluster meetings?" was 4.3, and the total possible score was 5, the percent score would be 86%.)

Once the findings were processed, results were compared with available secondary data on cluster performance. The cluster currently conducts systematic reviews of the Public Health

Information Services. The results of the last survey (collected in January, 2020) were used to help interpret the findings from the CCPM. In addition, the cluster conducted a survey on information management capacity in March 2019. The results of this survey were also used to help triangulate the findings collected during this assessment.

2.2.1 Limitations

There are some limitations with this approach as the survey questions did not all use the same scales. In some cases, there may have been more negative options than in others. To address this issue, the meanings of the various levels were carefully considered during analysis.

For the design of the analysis plan, validation of data and analysis required for the final report most questions were asked using a likert methodology (with answers on a scale from very positive to very negative). To analyze the responses, all likert-type questions were re-coded into numeric form (1 = the most negative answer, and a higher subsequent number provided to each more positive answer option). The number of response options provided in the survey varied, usually between 4 and 6. The results were then averaged into an overall score (using the scale set for each individual question). These scores were then calculated into a percentage using the maximum possible score and the calculated average.

This is a different methodology than is being used at the country level were all potentially positive responses are classified in the same group as the most positive responses. This new methodology should be considered more accurate.

It is important to note that the CCPM methodology is perception based and does not necessarily provide a concrete means of comparison across health clusters. Even with clear instructions in the survey, it is quite likely that a high score in one location is not equal to the same score in another as the individuals who respond to the survey do so from their own perspective in a given context. It is for this reason that additional sources of data were used to help understand cluster performance.

2.3. Assumptions and Limitations

The following assumptions should be taken into consideration in the analysis and interpretation of data:

- Possible bias with self-reporting by Coordinators and Partners.
- Additional statistical analysis completed did not take the non-response rate into consideration and data were not weighted so findings should only be considered 'suggestive of possible trends'.
- Data takes into account the activity of the Cluster throughout the 2019 HPC.

3. SURVEY RESULTS

3.1. Completion and Response rate

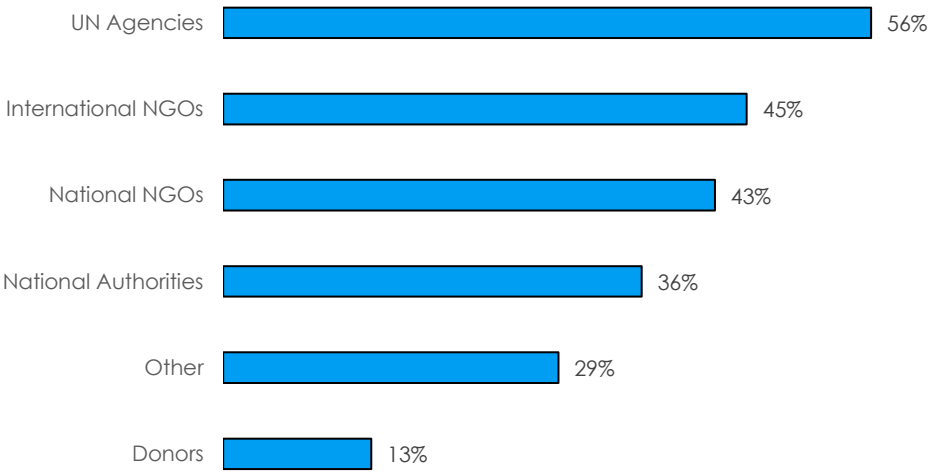
3.1.1. Overall Completion Rate

In 2019 out of the 27 National Health Clusters, 16 completed CCPMS (60%). The 2 Regions did not complete the process. The Region of the Pacific did not complete CCPM in 2019 due to the globally supported platform Prime and process not being appropriate for context, this will be further explored and for 2020. The Whole of Syria did not complete due to the complexity of the response in all 3 offices (Damascus, NE Syria and Gaziantep). Of the 16 Clusters that completed, 5 (Democratic Republic of the Congo - 3 locations, Nigeria – 1 location, Niger – 1 location, Somalia – 9 locations, and Myanmar – 2 locations) also facilitated the process at the Sub National level. Iraq completed but did not use the globally supported system, therefore are reflected in the total completion number only (16). Throughout the rest of the report all analysis is for the remaining 15 Clusters. The GHC annual target of 75% was not met, however, this is still an improvement of the previous year where only 33% were completed. In addition, Mozambique and WOS who did not complete in 2019 have started the process early in 2020.

	National Level CCPM	Sub National CCPM	Coordinators and Co Coordinators Responses	Partners Responses
AFRO	7	5	12	240
EMRO	6	9	15	209
EURO	1	0	1	7
SEARO	2	2	4	106

Table 3.1: Summary of CCPMs completed at Regional, National and Sub National level with total number of respondents on the partners survey (including International, National, Donor and Ministry of Health).

3.1.1 Response Rate of Partners by Type of Organization and Region

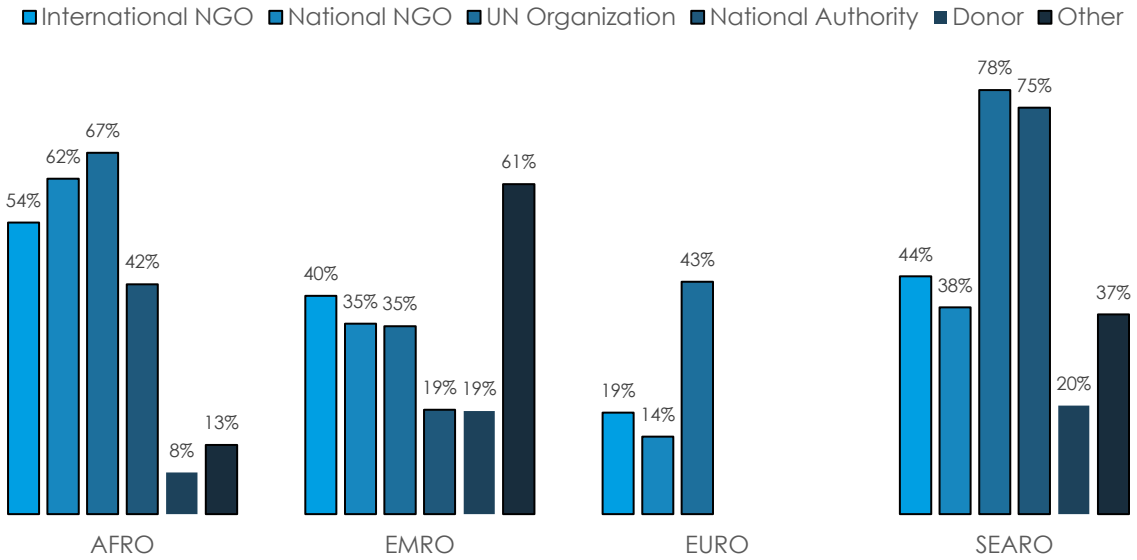


Graph 3.1: Global response rate by organisation type

Coordinators responses on known numbers of each partner and organisation category were utilized to calculate the response rate. Organizations were asked to indicate their organizational type (graph 3.1).

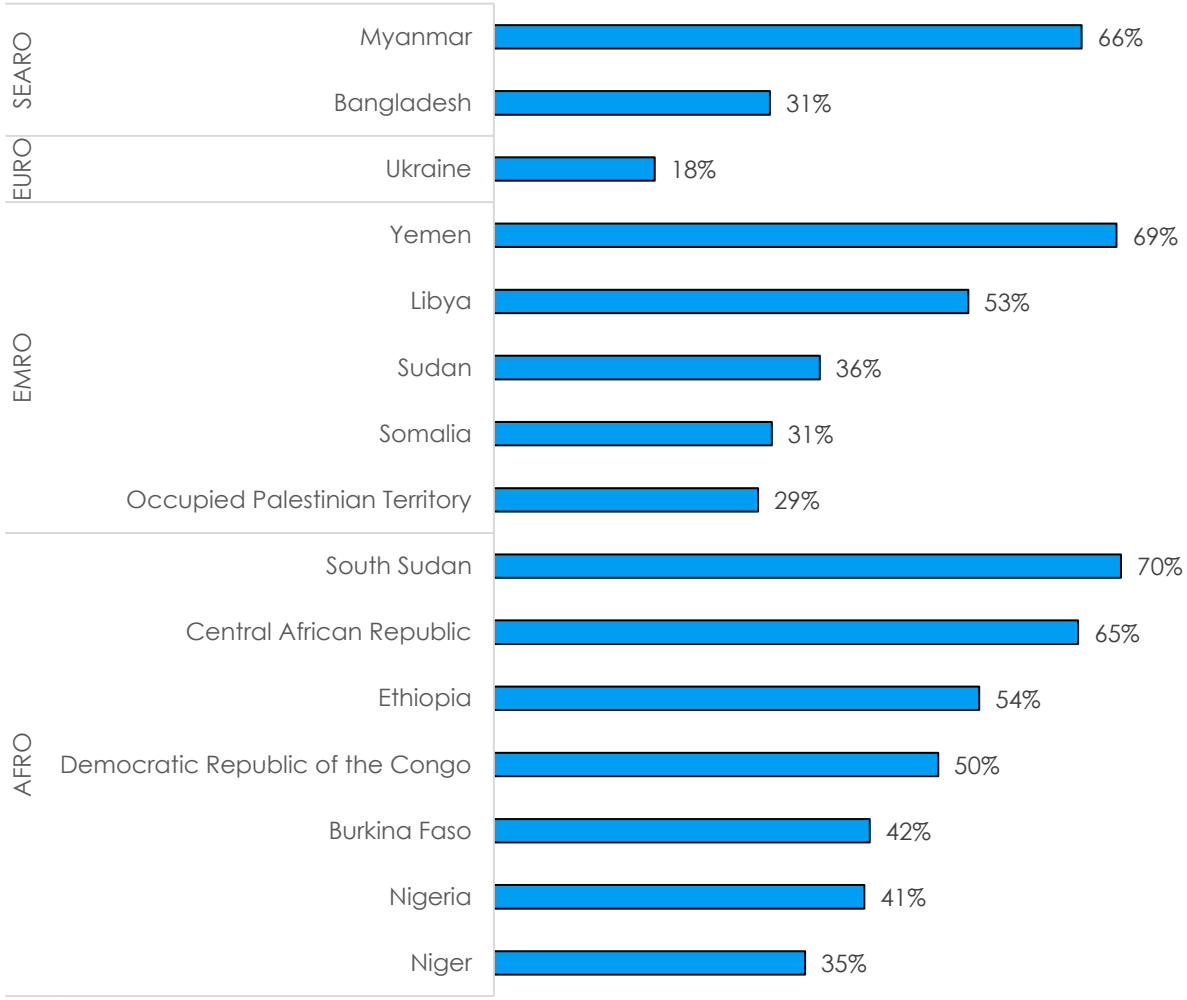
Partners by Region

When disaggregated by Region it can be evidenced NGOs across all had a relatively good response rate, with national authorities having slightly lower response rates and donor response rates generally low. This is due to less familiarity of the process; many do not manage to attend all partner meetings where it is introduced; access partly due to language barriers.



Graph 3.2: Response rate of partners by organization type by region

Response Rate by Country



Graph 3.3: Response rate by country. Nb. OPT was re-opened, final RR not reflected throughout this report was 78%.

It is noted that the response rate differs across clusters within Regions. SEARO (Myanmar), EMRO (Yemen), AFRO (South Sudan and CAR) all had over 60% response rate, whereas other Clusters across all Regions had an overall response rate of 42%. It was agreed, due to context in some Clusters and data available, that a response rate of 20% was significant and a report was therefore produced for use in step 3 of the CCPM process. Iraq utilized a separate system from the GHC supported Prime platform to complete their CCPM and it was not within the resources of this project to include the results in further analysis for this report due to the format of available data.

For Somalia, 14 CCPMs were initially started, 1 National and 13 at Sub National. An unprecedented 9 Sub Cluster CCPMs were completed. 2 sub clusters did not manage to complete any of the process, and 2 had insufficient responses to generate final reports,

however, these individual responses were extracted for use at Country and Sub Cluster level and are included in the data analysis for this report for both partners and coordinators.

3.2. Summary Results – Overall Performance

The following overview takes a primarily regional perspective, comparing the various regions and looking at areas where they are strong, as well as weak. Data is also broken down to the cluster level (and global level results are calculated using cluster averages). Where results were unclear, data was further broken down showing detailed results by region. The only regions included in this analysis are AFRO, EMRO and SEARO, removing EURO since there was only one cluster that responded and the results of only one location are insufficient to provide a regional level overview.

In some cases, further analysis was conducted using statistical tests. Though any response rate for an online survey over 40% is considered good, any response rate lower than 100% needs to take bias into consideration (e.g. partners most likely to respond are those most actively engaged with the cluster – this can be useful for some questions, but not for all). Furthermore, any statistical analysis was conducted on the entire partner dataset with no consideration for weighting (as some clusters had many more responses than others, their results will be over reflected in the statistical analysis), for this reason the more detailed analysis should be considered suggestive of a trend and not a concrete finding.

All the tables are colour coded where blue indicates positive results (75%+), the darker the blue, the higher the score. For scores below 75%, the colour shifts to grey becoming darker as the score gets lower.

- Supporting service delivery
- Informing strategic decision-making of the HC / Humanitarian Country Team
- Planning and strategy development
- Advocacy
- Monitoring and reporting on implementation of cluster strategy and results
- Preparedness for recurrent disasters
- Accountability to affected populations

3.2.1. Supporting service delivery

- Provide a platform to ensure that service delivery is driven by the agreed strategic priorities
- Developing mechanisms that eliminate duplication of service delivery

	Partner satisfaction with meeting frequency	Organizations ability to participate fully in cluster meetings (access, language).	Cluster meeting ability to identify and discuss needs, gaps and response priorities	Clusters ability to take strategic decisions about the direction of the humanitarian response	Frequency of partner contribution to 3W mapping	Partner contribution to analysis of gaps and overlaps in 3W data	Use of cluster analysis of gaps and overlaps in partner decision making
AFRO	92%	88%	87%	82%	87%	83%	80%
EMRO	89%	86%	82%	74%	83%	76%	82%
SEARO	89%	83%	78%	73%	85%	78%	78%

Table 3.2: Information on Health Clusters ability to support service delivery by Region.

Generally, the health cluster is considered strong in support to service delivery. The one area that appeared slightly weaker was the ability for the cluster to take strategic decisions about the direction of the humanitarian response. The cluster level breakdown, shown below, shows the locations contributing to the lower scores for EMRO and SEARO are Libya, Somalia, Sudan and Myanmar – all locations experiencing complex protracted crises with heavy political considerations which are likely to impact the direction of the humanitarian response.

		Partner satisfaction with meeting frequency	Partners ability to participate fully in cluster meetings (access, language).	Cluster meeting ability to identify and discuss needs, gaps and response priorities	Clusters ability to take strategic decisions about the direction of the humanitarian response	Frequency of partner contribution to 3W mapping	Partner contribution to analysis of gaps and overlaps in 3W data	Use of cluster analysis of gaps and overlaps in partner decision making
AFRO	Burkina Faso	97%	85%	85%	82%	92%	72%	68%
	CAR	88%	80%	87%	81%	85%	76%	72%
	DRC	89%	83%	89%	79%	78%	81%	74%
	Ethiopia	92%	88%	92%	75%	82%	86%	85%
	Niger	84%	83%	82%	73%	88%	78%	76%
	Nigeria	95%	93%	83%	84%	89%	85%	83%
	South Sudan	98%	96%	91%	91%	96%	93%	89%
EMRO	Libya	79%	68%	68%	68%	72%	53%	77%
	OPT	88%	98%	79%	77%	80%	88%	80%
	Somalia	91%	86%	86%	73%	82%	77%	82%
	Sudan	93%	95%	87%	74%	84%	75%	88%
	Yemen	89%	85%	80%	78%	88%	76%	83%
EURO	Ukraine	90%	75%	54%	71%	64%	67%	70%
SEARO	Bangladesh	88%	82%	85%	77%	85%	79%	82%
	Myanmar	89%	85%	73%	71%	85%	78%	75%
Global		90%	85%	81%	77%	83%	78%	79%

Table 3.3: Information on Health Clusters ability to support service delivery by Cluster. Clusters highlighted reflect data aggregated from all sub cluster CCPMs.

3.2.2. Informing strategic decision-making of the HC / Humanitarian Country Team

		Organizations that used sectoral needs assessment tools and guidance agreed by cluster partners	Organization involved in coordinated sectoral needs assessment and surveys	Organizations participation in joint situation analyses	Organizations that shared reports of its surveys and assessments with the cluster
AFRO	Burkina Faso	74%	51%	82%	69%
	CAR	75%	56%	81%	82%
	DRC	77%	64%	81%	67%
	Ethiopia	64%	71%	67%	76%
	Niger	82%	70%	76%	70%
	Nigeria	79%	75%	66%	73%
	South Sudan	87%	79%	84%	90%
EMRO	Libya	56%	56%	7%	60%
	OPT	70%	79%	55%	74%
	Somalia	73%	74%	57%	73%
	Sudan	79%	64%	44%	71%
	Yemen	75%	66%	49%	71%
EURO	Ukraine	60%	53%	33%	70%
SEARO	Bangladesh	82%	71%	56%	73%
	Myanmar	65%	71%	56%	65%
Overall		73%	67%	60%	72%

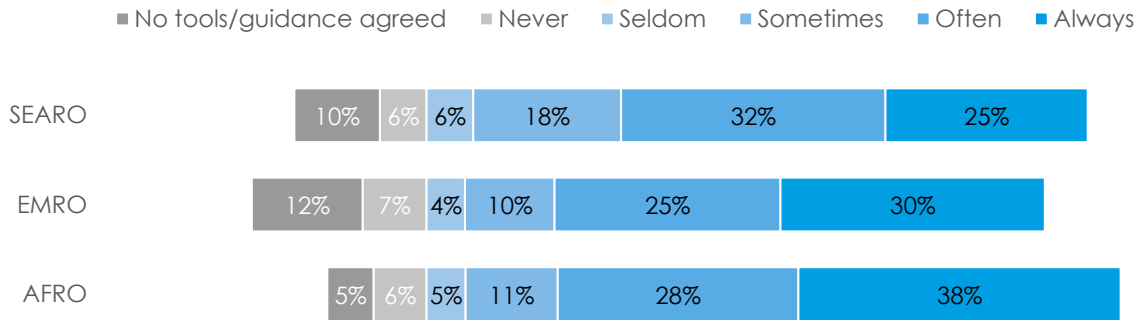
Table 3.4: Information on Informing strategic decision-making of the HC/Humanitarian Country Team. Needs assessment and gap analysis, and analysis to identify and address (emerging) gaps, obstacles, duplication, and cross-cutting issues by Health Cluster. Clusters highlighted reflect data aggregated from all sub cluster CCPMs.

	Organizations that used sectoral needs assessment tools and guidance agreed by cluster partners	Organization involved in coordinated sectoral needs assessment and surveys	Organizations participation in joint situation analyses	Organizations that shared reports of its surveys and assessments with the cluster
AFRO	79%	70%	78%	76%
EMRO	72%	71%	50%	72%
SEARO	72%	71%	56%	69%

Table 3.5: Information on Informing strategic decision-making of the HC/Humanitarian Country Team. Needs assessment and gap analysis, and analysis to identify and address (emerging) gaps, obstacles, duplication, and cross-cutting issues by Region.

The table above indicates that partners are often not involved in joint analysis, considering that the organizations most likely to respond to survey requests are those most actively engaged, it is likely that the real figure is lower than the table above indicates. For this reason, engagement in joint analysis may need greater focus in 2020. AFRO had four clusters that appear to have worked on joint situation analyses over 2019 (South Sudan, Burkina Faso, CAR and DRC). These four locations have raised the regions overall score, however, 3 out of 4 of those same clusters had far lower scores for coordinated assessments (Burkina Faso, CAR and DRC).

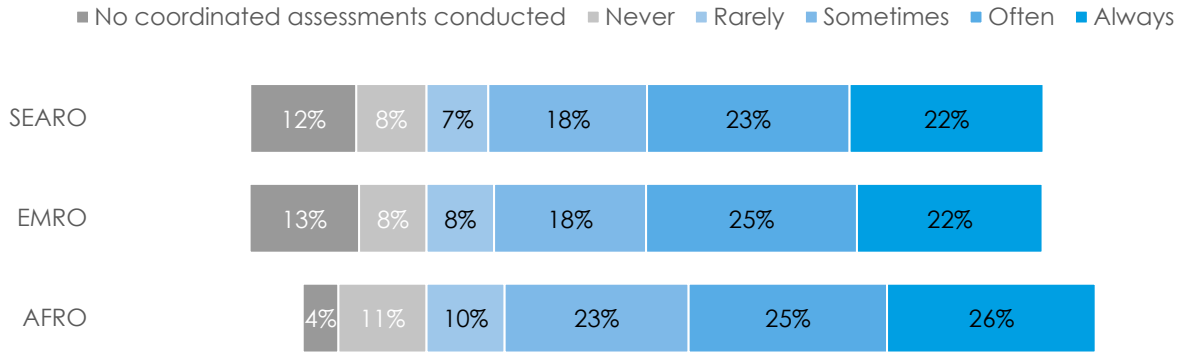
When asked if they used sectoral needs assessment tools and guidance agreed by cluster partners, responses were not overly positive. Further examination of these results (shown in the graph below), indicates that in some locations (notably EMRO and SEARO), tools and guidance may not always be available. Some more exploratory analysis showed that there was a positive correlation between national NGOs and responding that they had never used agreed tools/guidance, while UN organizations had a negative correlation for the same answer option[1]. This suggests that national NGOs are more likely than any other organization to report that they do not use agreed guidance and tools. Further information to understand why this correlation exists would be useful. It is possible that language barriers or lack of resources could play a role. It is also possible that the focus of tools and guidance are better suited to the UN programming (explaining why UN organizations were the least likely to report never using agreed tools and guidance). At this stage, further information is required to determine why guidance and tools are not being used when they are available.



[1] Pearson correlation, p = 0.030 and p = 0.005 respectively

Graph 3.4: Regional breakdown of responses to "Organizations that used sectoral needs assessment tools and guidance agreed by cluster partners".

In terms of the lower scores on involvement in coordinated assessments, it is important to note that not all cluster locations implemented coordinated assessments in 2020.



Graph 3.5: Regional breakdown of responses to "Organizations involved in coordinated sectoral needs assessment surveys".

Examining the above graph shows that over ten percent of partners in both SEARO and EMRO indicated that no coordinated assessments were conducted, explaining why the results for AFRO appear more positive. Though only a small number of partners indicated they always engaged in coordinated assessments, it is important to note that 'participation' is an objective term, and many organizations do not have the resources available to dedicate to large scale assessments. Further investigation into the options available for engagement in these assessments and seeing if partners with limited resources may also be involved in analysis or validation processes is recommended.

Regarding sharing reports and data from assessments, some further analysis showed a positive correlation between UN organizations and responding that all data had been shared while INGOs were not[2]. It is unclear why this may be, but it might be different understandings of what constitutes sharing 'all data'.

The following tables breakdown the views of partners who were involved in joint situation analyses with the cluster, and how relevant they felt the process was relating to the various areas outlined in the tables.

[2] Pearson correlation, $p < 0.001$ for both

	Have these analyses identified risks, needs, gaps, capacity to respond, and constraints?				
	Risks	Needs	Gaps in response	Capacity to Respond	Constraints to Respond
AFRO	80%	85%	78%	81%	80%
EMRO	78%	87%	82%	78%	77%
SEARO	72%	80%	78%	80%	75%

Table 3.6: Health Cluster ability to complete needs assessment and gap analysis, and analysis to identify and address (emerging) gaps, obstacles, duplication, by Region.

Though the results were not overly strong, all are above average. They suggest that some additional focus might be useful in gaps analysis, risk identification, capacity to respond and constraints, while identification of needs is quite good.

The below table helps identify which cluster locations were strongest in identification of priority concerns:

		Have these analyses identified risks, needs, gaps, capacity to respond, and constraints?				
		Risks	Needs	Gaps in response	Capacity to Respond	Constraints to Respond
AFRO	Burkina Faso	48%	52%	48%	50%	48%
	CAR	76%	82%	68%	77%	77%
	DRC	76%	80%	75%	76%	77%
	Ethiopia	78%	81%	81%	78%	78%
	Niger	69%	81%	74%	75%	69%
	Nigeria	92%	95%	87%	88%	93%
	South Sudan	89%	93%	88%	91%	86%
EMRO	Libya	100%	100%	75%	75%	75%
	OPT	75%	86%	77%	75%	73%
	Somalia	76%	86%	80%	75%	74%
	Sudan	78%	81%	81%	88%	81%
	Yemen	85%	92%	89%	85%	85%
EURO	Ukraine	75%	88%	75%	50%	75%
SEARO	Bangladesh	76%	81%	75%	79%	69%
	Myanmar	70%	79%	79%	80%	79%
Total		78%	84%	77%	76%	76%

Table 3.7: Health Cluster ability factor cross-cutting issues into needs assessment and gap analysis. Clusters highlighted reflect data aggregated from all sub cluster CCPMs.

As can be seen, the strongest clusters stood out as Nigeria, South Sudan, and Yemen (all with scores above 85%)[3]. The clusters most in need of strengthening are Burkina Faso, Ukraine and Niger.

Cross-cutting issues were examined separately.

	Have these analyses considered cross cutting issues?							
	Age	Gender	Diversity	Human Rights	Protection	Environment	HIV/AIDS	Disability
AFRO	87%	87%	80%	78%	85%	75%	77%	75%
EMRO	85%	88%	80%	85%	85%	75%	67%	78%
SEARO	81%	87%	76%	84%	87%	74%	74%	79%

Table 3.8: Health Cluster ability factor cross-cutting issues into needs assessment and gap analysis.

Age, Gender and Protection were all well considered in joint analysis. However, other cross-cutting issues, that may not have received the same advocacy, did not score as strongly. Disability is a concern considering its relationship to health. Environment and HIV/AIDS stood out, quite strongly, as the areas requiring the most strengthening. The variations in analysis capacities can also be seen at the cluster level shown below. Within AFRO, Burkina Faso[4] stood out as needing significant strengthening in analysis of cross-cutting issues, while Ukraine in EURO would also benefit from further analysis strengthening. Consideration of Human rights also appears weaker in many of the AFRO located clusters (Burkina Faso, DRC and Niger).

		Have these analyses considered cross cutting issues?							
		Age	Gender	Diversity	Human Rights	Protection	Enviro.	HIV/AIDS	Disability
AFRO	Burkina Faso	54%	54%	44%	50%	52%	46%	44%	42%
	CAR	88%	90%	84%	78%	86%	72%	68%	65%
	DRC	77%	77%	73%	69%	81%	67%	76%	65%
	Ethiopia	81%	84%	69%	78%	81%	66%	72%	79%
	Niger	85%	84%	74%	74%	80%	70%	75%	74%
	Nigeria	95%	95%	92%	87%	88%	89%	88%	86%
	South Sudan	98%	98%	87%	89%	93%	85%	82%	88%
EMRO	Libya	100%	100%	100%	100%	100%	100%	100%	100%

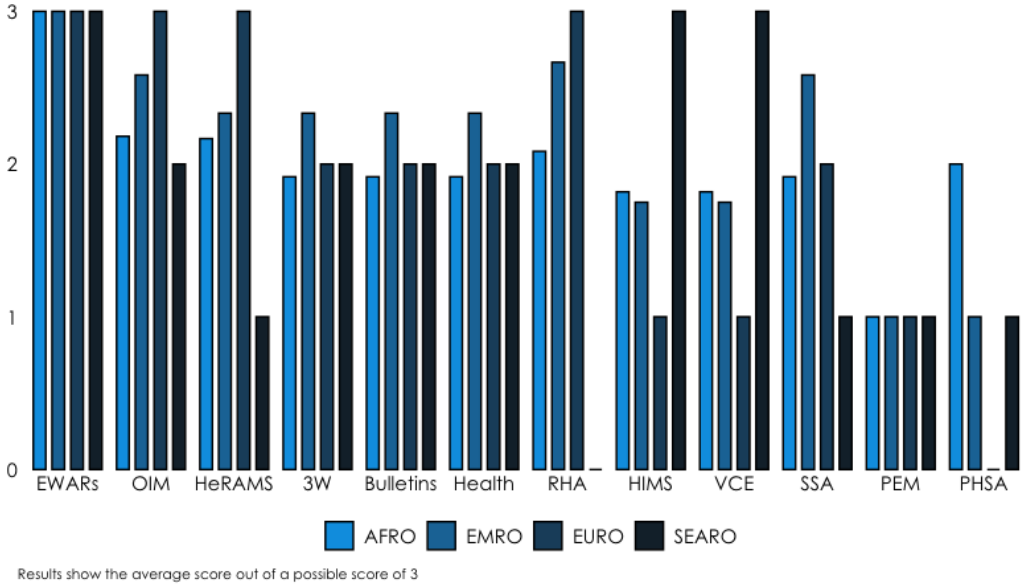
[3] Please note that Libya also scored quite well, but only one partner responded to the questions in this section which provides insufficient data to draw conclusions

[4] The cluster in Burkina Faso was only officially activated in December 2019 so weak results are expected and the cluster should progressively strengthen as it becomes more established

	OPT	91%	93%	91%	89%	91%	61%	43%	89%
	Somalia	80%	85%	77%	84%	85%	76%	73%	78%
	Sudan	91%	88%	84%	81%	94%	84%	78%	75%
	Yemen	94%	93%	81%	83%	79%	75%	56%	72%
EURO	Ukraine	88%	75%	50%	50%	50%	50%	88%	75%
SEARO	Bangladesh	82%	87%	71%	84%	88%	75%	74%	82%
	Myanmar	81%	88%	79%	83%	86%	74%	75%	78%
Total		86%	86%	77%	79%	82%	73%	73%	76%

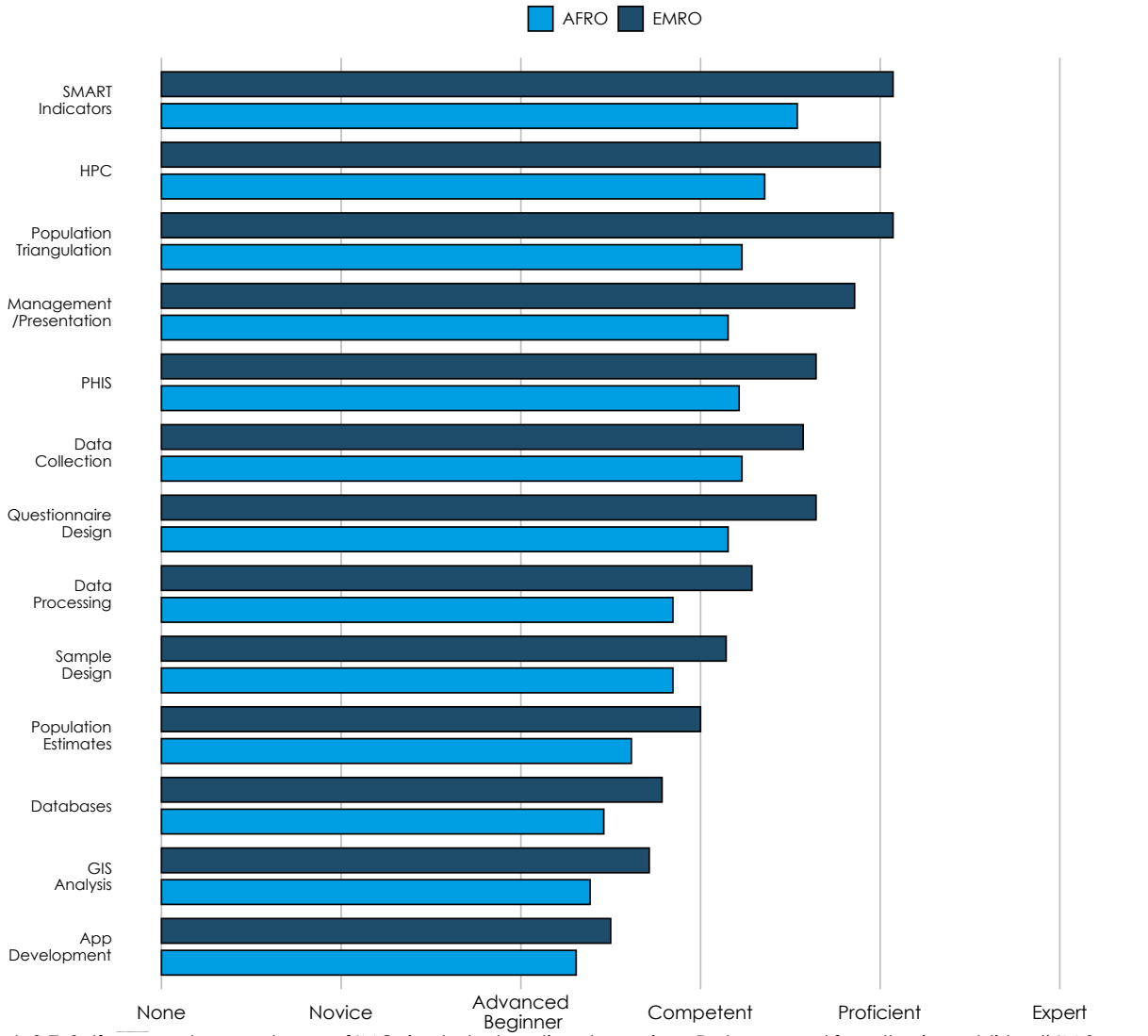
Table 3.9: Health Cluster ability factor cross-cutting issues into needs assessment and gap analysis. Clusters highlighted reflect data aggregated from all sub cluster CCPMs. (note the Libya data is based on responses from only one partner)

Examining these results, it is important to consider the limitations of a perception-based survey. One concern with surveys such as the CCPM one is the potential for reporting bias. It is likely that results here are not as comparable as they may seem, with partners reporting on the status of the cluster as compared to other clusters in the same location (and not to other *health* clusters). If that is the case, it is possible for the cluster to falsely appear weak (or strong) if the other clusters are also weak (or strong). To address this bias, it can be helpful to consider the results of other surveys. The Global Health Cluster also tracks the status of Public Health Information Services (PHIS). As these services comprise most of the outputs on public health information for the cluster, they can be considered a tangible measure of the productive capacity of each cluster. The results in the table above show that the AFRO and EMRO regions are stronger than both EURO and SEARO. They also suggest that AFRO is the strongest overall. However, when examining the results of the January 2020 PHIS survey, AFRO often scores lower than other regions.



Graph 3.6: Results from the PHIS survey from January 2020 showing the average score for each PHIS service by region.

Further examining data from a survey on information management conducted in early 2019, shows similar results. The graph below only looks at the results for EMRO and AFRO (as responses for EURO and SEARO were limited). The data looks at self-assessed capacity in relevant IM competencies for cluster locations in both regions. Much like the results of the PHIS survey, AFRO consistently scores lower.

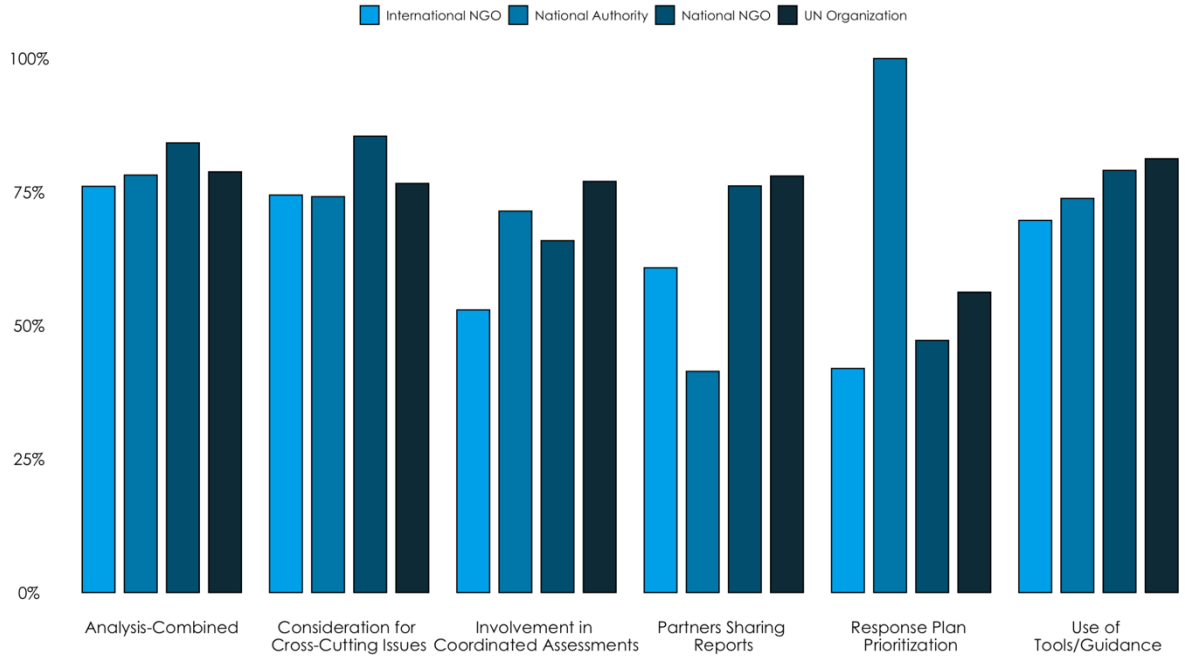


Graph 3.7: Self-assessed competency of IMOs in cluster locations by region. Data sourced from the (unpublished) IM Survey 2019. As results were limited for SEARO and EURO, the graph only shows the results from EMRO and AFRO.

Though the assessed competencies in the graph above do not explicitly cover 'analysis', there are some competencies listed that could be considered 'proxies'. The five competencies that best proxy analysis are: 'Data processing' (as that is a first step towards data analysis), sample design (as designing samples requires an understanding of statistics), population estimates (these often require advanced analytical and research

skills – including statistical knowledge), GIS Analysis (which is a form of analysis), and – to a lesser extent – app development (as it requires coding capacity that is often used in more advanced software for visualization e.g. R and Python). All of these 'proxy' analysis competencies fall below the "Competent" line in the AFRO Region suggesting clusters there could benefit from strengthening analytical capacity, contrary to the results of the CCPM survey that indicate the AFRO region is strongest in analysis.

As the graphs from the PHIS and IM Surveys highlight, reporting bias likely plays a role in the CCPM survey results. Understanding this bias in detail would require further study. One possibility is that the cluster is ranked comparatively to what other organizations in the area are doing –e.g. the health cluster in a given location may not be producing very much compared to other health clusters around the globe, but it may still be advanced compared to other organizations in that specific context. To check this theory, type of organization was factored into the analysis. Looking at AFRO alone, the below graph looks at the average responses to the questions in the Informing Strategic Decision-Making of the HC / Humanitarian Country Team section. The results were calculated by giving equal weight to each national cluster to ensure a surplus of responses from one area wouldn't skew the results.



Graph 3.8: Overall Score for AFRO Region on question related to Informing Strategic Decision-Making of the HC / Humanitarian Country Team. Results are disaggregated by type of organization reporting. The 'Other' and 'Donor' categories have been removed due to low response rates.

The results indicate that National NGOs and UN Organizations usually rate the cluster higher, with International NGOs almost always ranking the lowest.

Though it may not be possible to understand the exact source of the bias, there is enough contradictory findings to conclude that any recommendations should factor it in. Moving forward, any analysis of CCPM data, should include triangulation with available secondary information to ensure the interpretation of findings factors in likely bias.

3.2.3. Planning and strategy development

	Organizations have helped to develop cluster strategic plans	Cluster strategic plan guided the response of the organization in the last 6 months	Cluster partners agreed technical standards and guidance and have applied them	Cluster partners participated in prioritizing proposals under the strategic plan within a transparent process.	Proposals were prioritized against the strategic plan in a manner that was fair to all partners	The cluster coordinator reported on the cluster funding status against needs in appropriate time frames
AFRO	79%	80%	82%	85%	81%	83%
EMRO	72%	78%	71%	71%	74%	79%
SEARO	70%	72%	76%	83%	82%	82%

Table 3.10: Health Cluster ability to develop sectoral plans, objectives and indicators that directly support HC/HCT strategic priorities, adherence to and application of standards and guidelines, clarifying funding needs.

The table above indicates that all regions could use support on the development of strategic plans. The data also suggests EMRO might benefit from a bit more support in engaging partners to help prioritize proposals and to develop agreed technical standards and guidance.

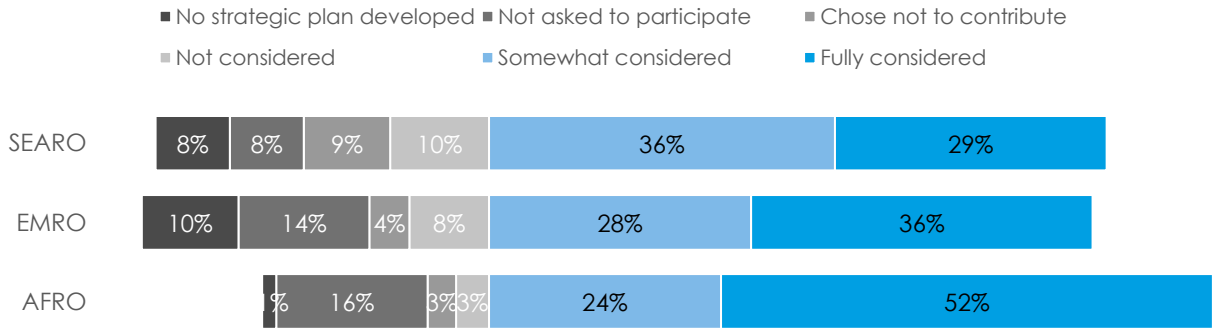
		Organizations have helped to develop cluster strategic plans	Cluster strategic plan guided the response of the organization in the last 6 months	Cluster partners agreed technical standards and guidance and have applied them	Cluster partners participate in prioritizing proposals under the strategic plan within a transparent process.	Proposals were prioritized against the strategic plan in a manner that was fair to all partners	The cluster coordinator reported on the cluster funding status against needs in appropriate time frames
AFRO	Burkina Faso	67%	69%	58%	49%	45%	69%
	CAR	74%	77%	76%	79%	70%	76%

	DRC	74%	77%	79%	83%	77%	83%
	Ethiopia	76%	80%	62%	76%	85%	84%
	Niger	74%	71%	84%	83%	83%	72%
	Nigeria	83%	80%	85%	85%	84%	84%
	South Sudan	89%	93%	92%	91%	90%	93%
EMRO	Libya	58%	72%	52%	51%	60%	76%
	OPT	72%	79%	65%	87%	81%	81%
	Somalia	71%	76%	71%	66%	69%	75%
	Sudan	73%	80%	81%	80%	81%	91%
	Yemen	78%	84%	78%	78%	86%	83%
EURO	Ukraine	64%	100%	73%	80%	90%	69%
SEARO	Bangladesh	66%	72%	80%	85%	86%	83%
	Myanmar	73%	72%	72%	82%	79%	81%
Total		73%	79%	74%	77%	78%	80%

Table 3.11: Health Cluster ability to develop sectoral plans, objectives and indicators that directly support HC/HCT strategic priorities, adherence to and application of standards and guidelines, clarifying funding needs. Clusters highlighted reflect data aggregated from all sub cluster CCPMs.

The cluster level breakdown suggests that Burkina Faso, Libya and Somalia would benefit from support in planning and strategy development while South Sudan, Nigeria, Sudan and Yemen all appear relatively strong in this core function.

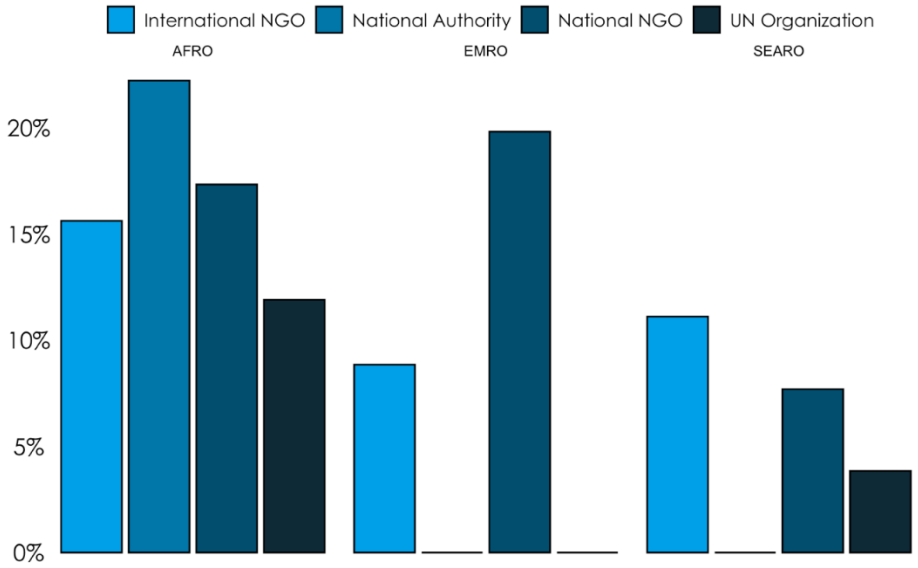
One of the topics that stood out as particularly weak was partner involvement in developing cluster strategic plans. Breaking these results down further, the reasons appear varied.



Graph 3.9: Regional breakdown of responses to "Organizations have helped to develop cluster strategic plans"

The table above indicates that there were some issues with partners feeling they were not asked to participate; this was particularly evident in the EMRO and AFRO regions. To

better understand this, some further analysis was conducted that showed a positive correlation[5] between national NGOs and responding that the cluster did develop a strategic plan, but their organization was not asked to participate.



Graph 3.10: Percent of respondents (by type and region) who reported that they felt they were *not* invited to participate in the development of strategic plans

As shown in the graph above, it was national organizations that were most likely to report they were "not invited to participate" in cluster strategic plan development. More information is required to determine if this is merely a perception common amongst local NGOs (and they are, in fact, being included) or if there are any reasons they might not be invited for inclusion (for example, communication issues, access issues or language barriers may pose a problem). That same question showed that UN Organizations were the most likely to feel their contributions had been taken fully into consideration[6], while international NGOs had a negative correlation[7] with the same answer option (suggesting they were the least likely to feel that their contributions had been fully taken into consideration). This data suggests that further effort is needed to ensure international NGOs feel their contributions are taken into account while further research would be useful to determine why national NGOs feel they might not be invited to participate.

[5] Pearson correlation $p = 0.002$
[6] Pearson correlation $p < 0.001$
[7] Pearson correlation $p < 0.001$

3.2.4. Advocacy

	Issues requiring advocacy been identified and discussed together	Organizations have participated in cluster advocacy activities
AFRO	87%	78%
EMRO	77%	74%
SEARO	78%	81%

Table 3.12: Identifying advocacy concerns that contribute to HC and HCT messaging and action. Undertaking advocacy activities on behalf of cluster participants and affected people

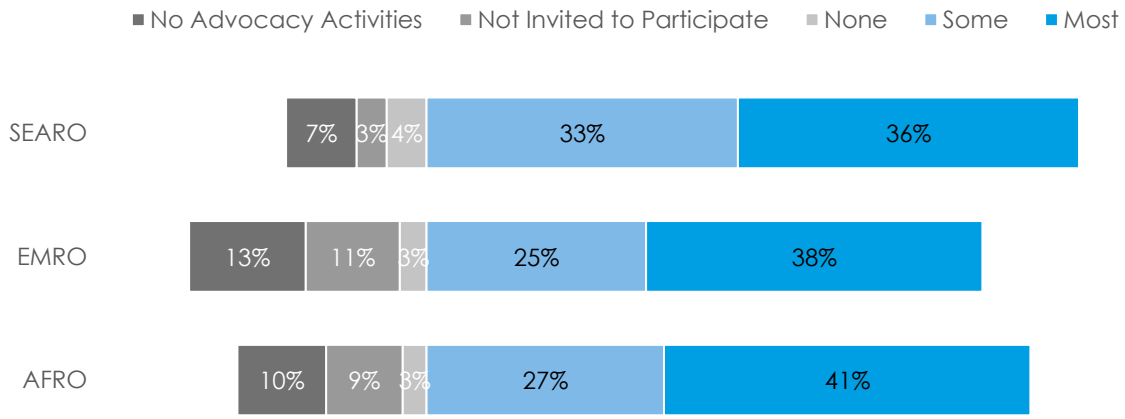
Though the results at the regional level do not appear concerning, when broken down by cluster it becomes clear that some more work would be useful in strengthening health cluster advocacy.

		Issues requiring advocacy been identified and discussed together	Organizations have participated in cluster advocacy activities
AFRO	Burkina Faso	72%	58%
	CAR	83%	72%
	DRC	84%	73%
	Ethiopia	82%	71%
	Niger	80%	78%
	Nigeria	90%	85%
	South Sudan	93%	87%
EMRO	Libya	65%	62%
	OPT	68%	64%
	Somalia	80%	79%
	Sudan	73%	66%
	Yemen	81%	73%
EURO	Ukraine	47%	35%
SEARO	Bangladesh	76%	79%
	Myanmar	80%	82%
Total		77%	71%

Table 3.13: Identifying advocacy concerns that contribute to HC and HCT messaging and action. Undertaking advocacy activities on behalf of cluster participants and affected people. Clusters highlighted reflect data aggregated from all sub cluster CCPMs.

When all clusters are given equal weights, the overall picture at the global level suggests further work is needed in engaging partners in advocacy activities.

Delving into this further, the graph below shows that "no advocacy activities" w noted across all regions, and in both AFRO and EMRO some partners indicated that advocacy activities took place but that they were not invited to participate.



Graph 3.11: Regional breakdown of responses to "Organizations have participated in cluster advocacy activities"

Unlike the previously mentioned cases there was no correlation between organization type and perception of not being invited to participate. The results do, however, indicate that further information on advocacy activities may be useful and that there should be a greater focus on engaging partners in advocacy activities moving forward in 2020.

3.2.5. Monitoring and reporting on implementation of cluster strategy and results

	Cluster bulletins or updates highlight risks, gaps and changing needs.	Program monitoring and reporting formats are agreed by the cluster	Has the cluster taken into account the distinct needs, contributions and capacities of women, girls, men and boys in its response and monitoring
AFRO	80%	76%	83%
EMRO	83%	74%	80%
SEARO	79%	71%	80%

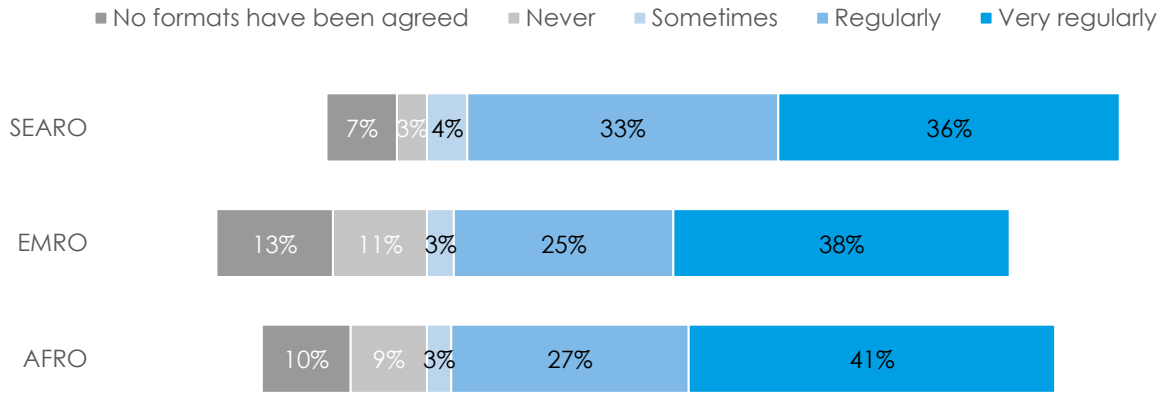
Table 3.14: Monitoring and reporting on implementation of cluster strategy and results.

Though the cluster is generally considered to be doing well on monitoring and reporting on the implementation of the cluster strategy and results, agreed formats do not seem to be as available or used as they might be.

		Cluster bulletins or updates highlight risks, gaps and changing needs.	Program monitoring and reporting formats are agreed by the cluster	Has the cluster taken into account the distinct needs, contributions and capacities of women, girls, men and boys in its response and monitoring
AFRO	Burkina Faso	63%	52%	72%
	CAR	74%	69%	74%
	DRC	75%	68%	77%
	Ethiopia	78%	62%	78%
	Niger	77%	64%	80%
	Nigeria	83%	84%	87%
	South Sudan	90%	91%	92%
EMRO	Libya	74%	48%	71%
	OPT	81%	66%	88%
	Somalia	83%	78%	79%
	Sudan	85%	71%	80%
	Yemen	85%	75%	84%
EURO	Ukraine	63%	60%	90%
SEARO	Bangladesh	81%	79%	84%
	Myanmar	78%	64%	77%
Total		78%	69%	81%

Table 3.15: Monitoring and reporting on implementation of cluster strategy and results. Clusters highlighted reflect data aggregated from all sub cluster CCPMs.

When broken down to the cluster level, as shown in the table above, it is clear that issues with agreed formats exist in most clusters (only making AFRO appear stronger because two clusters – Nigeria and South Sudan – had strong positive responses).



Graph 3.12: Regional breakdown of responses to "Program monitoring and reporting formats are agreed by the cluster"

The above table indicates that in EMRO and AFRO, part of the problem is a lack of agreed formats. Moving ahead it may be worth looking at the formats that have already been developed and identify some 'best practice' cases that can be shared both throughout and across regions. This process could lead to the identification of some more standard (global) formats that can be widely shared and adapted for a given country context.

3.2.6. Preparedness for recurrent disasters

	Organizations helped to develop or update preparedness plans (including multisectoral ones) that address hazards and risks	Organizations committed staff or resources that can be mobilized when preparedness plans are¬†activated
AFRO	87%	83%
EMRO	80%	85%
SEARO	86%	82%

Table 3.16: Preparedness for recurrent disasters.

In general, the cluster was strong on preparedness for recurrent disasters.

		Organizations helped to develop or update preparedness plans (including multisectoral ones) that address hazards and risks	Organizations committed staff or resources that can be mobilized when preparedness plans are activated
AFRO	Burkina Faso	65%	54%
	CAR	74%	78%
	DRC	87%	80%
	Ethiopia	82%	76%
	Niger	86%	83%
	Nigeria	91%	86%
	South Sudan	93%	91%
EMRO	Libya	77%	75%
	OPT	70%	88%
	Somalia	83%	88%
	Sudan	86%	88%
	Yemen	77%	79%
EURO	Ukraine	76%	73%
SEARO	Bangladesh	90%	86%
	Myanmar	84%	79%
Total		81%	80%

Table: Preparedness for recurrent disasters. Clusters highlighted reflect data aggregated from all sub cluster CCPMs.

At the cluster level, the results still show generally strong work on disaster preparedness. A few specific clusters stood out as needing further support, notably Burkina Faso and Ukraine.

3.2.7. Accountability to affected populations

	Cluster partners agreed and applied mechanisms (procedures, tools or methodologies) for consulting and involving affected people in decision-making.	Cluster partners agreed and applied mechanisms (procedures, tools or methodologies) to receive, investigate and act on complaints by affected people.
AFRO	79%	77%
EMRO	69%	68%
SEARO	72%	69%

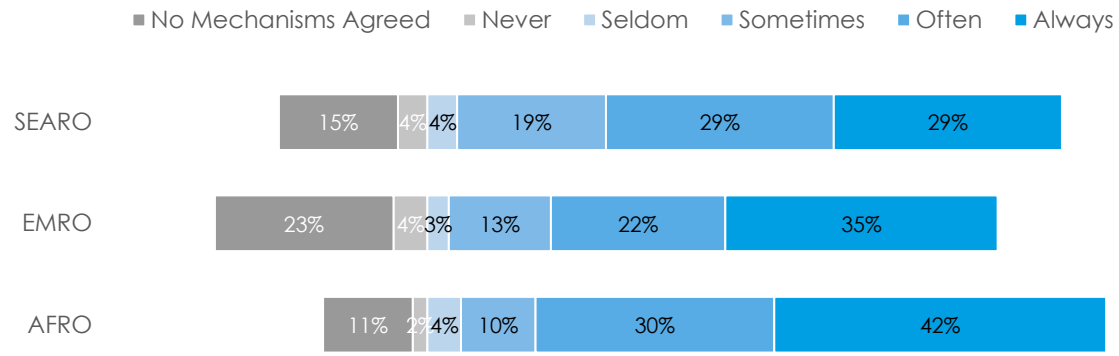
Table 3.17: Accountability to affected populations.

Accountability to affected populations is an area that perhaps needs the greatest focus moving forward in 2020.

		Cluster partners agreed and applied mechanisms (procedures, tools or methodologies) for consulting and involving affected people in decision-making.	Cluster partners agreed and applied mechanisms (procedures, tools or methodologies) to receive, investigate and act on complaints by affected people.
AFRO	Burkina Faso	56%	45%
	CAR	77%	67%
	DRC	80%	78%
	Ethiopia	63%	52%
	Niger	81%	81%
	Nigeria	82%	87%
	South Sudan	83%	83%
EMRO	Libya	38%	38%
	OPT	62%	58%
	Somalia	73%	72%
	Sudan	68%	69%
	Yemen	72%	70%
EURO	Ukraine	78%	47%
SEARO	Bangladesh	78%	76%
	Myanmar	67%	64%
Total		**71%**	**66%**

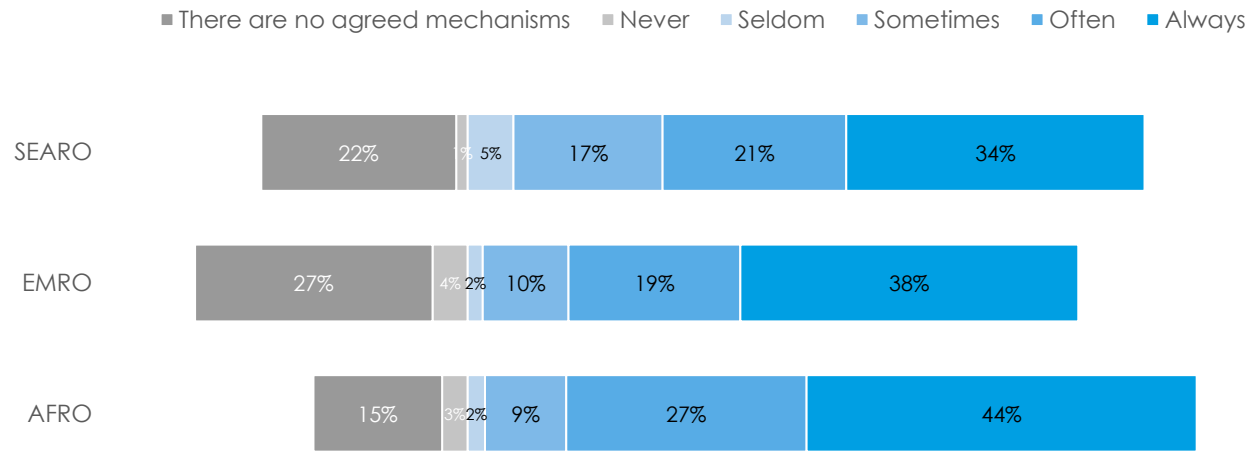
Table 3.18: Accountability to affected populations. Clusters highlighted reflect data aggregated from all sub cluster CCPMs.

Further examination of the results at the cluster level highlights the trend further with most clusters scoring below 75% when asked about agreement and application of procedures to investigate and act on complaints. Consultation with affected populations scored marginally better but could still benefit from further work.



Graph 3.13: Regional breakdown of responses to "Cluster partners agreed and applied mechanisms (procedures, tools or methodologies) for consulting and involving affected people in decision-making."

The above graph indicates that lack of agreed mechanisms for consultation are an issue in several locations, particularly in the EMRO and SEARO regions. Where mechanisms are in place, many do appear to use them 'Often' or 'Always' so it is likely that putting mechanisms in place will result in a marked increase in this indicator moving forward.



Graph 3.14: Regional breakdown of responses to "Cluster partners agreed and applied mechanisms (procedures, tools or methodologies) to receive, investigate and act on complaints by affected people.

The graph above suggests a similar consideration for AAP investigation and reporting mechanisms. Both SEARO and EMRO would benefit from identifying agreed mechanisms to implement but considering most organizations do implement mechanisms once they have been agreed, the agreement itself may provide a large step forward.

4. CONCLUSIONS

The CCPM seeks to understand cluster partner's perceptions of country cluster performance against the 6 + 1 core coordination functions over the year as perceived by partners engaged with the cluster. Though perception-based measurements are incredibly valuable, it is important to note that they are not always able to provide a clear comparison of multiple clusters across the globe. Partners report on performance based on their own experiences within the specific country context they are operating in. Lack of trust can also play a role if partners believe the survey is not wholly anonymous and may impact (among other possibilities) possible future funding opportunities. In this sense, the results of the CCPM survey should not be considered as the sole definitive measure of cluster performance. Additional monitoring, looking at tangible measures (such as production and implementation of the various PHIS services) can help to provide a more holistic overview.

The results of this survey suggest that partners are generally content with the performance of the health cluster. The analysis of the results indicates that the health cluster is strong in supporting service delivery and emergency preparedness. Common areas identified for improvement include the development and sharing of agreed standard formats for monitoring and reporting, as well as for AAP mechanisms, and greater partner engagement and inclusion in joint analysis and strategic planning.

The results suggest the following priority areas for the coming year:

4.1. Focus for 2020

- Development and systematic use of AAP mechanisms
- Encourage more joint analysis with health partners and other clusters/sectors
- Examining participation of local NGOs (particularly in the EMRO region) in strategic planning)
- Strengthening advocacy work