STUDY TO EXAMINE MULTISECTORAL COLLABORATION FOR COVID-19 RESPONSE IN HUMANITARIAN SETTINGS

FINAL REPORT

Global Health Cluster
May 2023
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<th>ACRONYM</th>
<th>FULL TEXT</th>
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<tbody>
<tr>
<td>CCCM</td>
<td>camp coordination and camp management</td>
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<tr>
<td>COVID-19</td>
<td>coronavirus disease</td>
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<td>GHC</td>
<td>Global Health Cluster</td>
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<td>GHRP</td>
<td>Global Humanitarian Response Plan for COVID-19</td>
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<td>HCT</td>
<td>Humanitarian Country Team</td>
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<td>HRP</td>
<td>Humanitarian Response Plan</td>
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<tr>
<td>ICCG</td>
<td>Inter-Cluster Coordination Group</td>
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<td>IDP</td>
<td>internally displaced people</td>
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<td>IPC</td>
<td>infection prevention and control</td>
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<tr>
<td>KII</td>
<td>key informant interview</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>OCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<tr>
<td>PHEIC</td>
<td>public health emergency of international concern</td>
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<td>Q&amp;I</td>
<td>quarantine and isolation</td>
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<tr>
<td>RCCE</td>
<td>risk communication and community engagement</td>
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<tr>
<td>SOP</td>
<td>standard operating procedure</td>
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<tr>
<td>SPRP</td>
<td>COVID-19 Strategic Preparedness and Response Plan</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNCT</td>
<td>United Nations Country Team</td>
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<td>UNEP</td>
<td>United Nations Environment Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNOPS</td>
<td>United Nations Office for Project Services</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WASH</td>
<td>water, sanitation and hygiene</td>
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<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WOAH</td>
<td>World Organisation for Animal Health</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Acknowledgements
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The authors’ views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
Executive Summary

Background and rationale for the study

The first case of coronavirus disease (COVID-19) was identified in the People’s Republic of China at the end of December 2019 and confirmed on the 7 January 2020. On 30 January 2020, the Director-General of WHO declared the novel coronavirus (2019-nCoV) outbreak a public health emergency of international concern (PHEIC), the highest level of alarm under the International Health Regulations (2005). This prompted the launch of the COVID-19 Strategic Preparedness and Response Plan (SPRP) by WHO on 4 February 2020.

Over the course of February and March 2020, it became increasingly clear that COVID-19 would have both direct impacts on human health and indirect impacts on livelihoods and socioeconomic development, and that a whole-of-society response was required. On 25 March 2020, the United Nations launched a US$2 billion coordinated Global Humanitarian Response Plan (GHRP) to protect millions of people by tackling COVID-19 in some of the world’s most vulnerable countries and contexts. The GHRP outlined the indirect socioeconomic impacts of the COVID-19 pandemic and the most affected and at-risk population groups. The strategic priorities emphasize the importance of working across a range of sectors in addition to health.

Prior to the COVID-19 pandemic, outbreaks of diseases such as Ebola and cholera had highlighted the importance of multisectoral collaboration as a part of any response in low-capacity and humanitarian settings. The SPRP and GHRP together framed the COVID-19 response for humanitarian actors and highlighted the need for multisectoral collaboration at multiple levels in the response to COVID-19 in humanitarian settings. A range of guidance and support on multisectoral collaboration for humanitarian actors was developed by bodies such as the Global Health Cluster and Global Cluster Coordination Group. Studies conducted by the Global Health Cluster COVID-19 Task Team in 2020 highlighted that significant technical gaps and challenges were hampering multisectoral coordination and programming for the COVID-19 response. Nevertheless, strong multisectoral coordination mechanisms that were in place prior to COVID-19 generally resulted in joint guidance, frameworks and programming.

Study design

In 2022, the Global Health Cluster initiated this study to examine multisectoral collaboration for COVID-19 in humanitarian settings to further understand how multisectoral collaboration had been occurring in the response to COVID-19. The focus of the study is on multisectoral collaboration related to health outcomes, usually involving the health cluster, health cluster partners and other sectoral clusters responding to COVID-19. Multisectoral collaboration is defined as “where actors representing two or more technical sectors, usually aligned to the humanitarian clusters or line ministries, work together to achieve a shared goal”.

The research for the study was based a global survey, six country case studies and secondary document review. The global online survey was distributed to 31 settings where the health cluster is currently active. It was distributed by health cluster coordinators to those who could inform the study and 222 responses were received. The country case studies examined multisectoral collaboration in the COVID-19 response via secondary data review and key informant interviews with 59 people in total. Six country case studies were conducted between October 2022 and January 2023 in Burkina Faso, Central African Republic, the Republic of Iraq, the Republic of Mozambique, the Republic of the Union of Myanmar and the Republic of
the Sudan. The majority of survey respondents were health cluster staff and partners, although staff from other clusters and coordination bodies did respond. Those interviewed in case study countries were more diverse and included those from other clusters, humanitarian coordination bodies, government officials and donors.

**Findings**

**Analytical question 1: How did multisectoral collaboration and action of the health clusters and health cluster partners evolve during the COVID-19 response to reach people affected by humanitarian crises?**

**Pre-existing multisectoral collaboration**

1. Pre-existing humanitarian structures including clusters and ICCG facilitated multisectoral collaboration during COVID-19.


3. Pre-existing relationships between humanitarian and government actors supported the COVID-19 response, particularly at sub-national level.

**Adaptation in multisectoral collaboration for COVID-19 responses – coordination**

4. The SPRP pillars were frequently used to guide coordination processes, including multisectoral components.

5. The clusters all played an important role in leading and enabling multisectoral collaboration in the COVID-19 responses with health, water, sanitation and hygiene (WASH), camp coordination and camp management (CCCM) and protection being the most prominent. The health cluster was very active in initiating multisectoral collaboration within the cluster system.

6. Ministry of health and national government leadership facilitated multisectoral collaboration for health outcomes.

**Adaptation in multisectoral collaboration for COVID-19 responses – technical collaboration**

7. Multisectoral collaboration utilized community-based approaches to strengthen engagement with communities and deliver appropriate COVID-19 prevention messages.

8. Technical guidance developed and shared by the health cluster and others supported the protection of communities, staff and volunteers from the spread of COVID-19.

**Adaptation in multisectoral collaboration for COVID-19 responses – operational collaboration**

9. All case study countries reported operational multisectoral collaboration, particularly at a sub-national level.

Although not specific to multisectoral collaboration for health outcomes (being also relevant to other types of outcomes), the study also found that: (1) increased and more diverse multisectoral collaboration during COVID-19, reported in three out of six countries; and (2) a key enabling factor for multisectoral collaboration was the availability of COVID-19-specific funding across all sectors.

The study also found several examples of the guidance material on multisectoral collaboration in the Health
Recommendations

A series of recommendations are provided in section 7, building on recent reports by the WHO Director-General, which set out a range of proposals to strengthen the global architecture for health emergency preparedness, response and resilience. These recommendations are organized according to main actors and multisectoral collaboration goals:

- Global Health Cluster and its partners
  - Multisectoral collaboration for health outcomes
  - Multisectoral collaboration generally
- World Health Organization
  - Multisectoral collaboration for health outcomes
  - Multisectoral collaboration generally
- Global Cluster Coordination Group
- National governments, including national ministries of health
  - Multisectoral collaboration for health outcomes
  - Multisectoral collaboration generally
  - Other recommendations
- Donors

Since some recommendations should be taken forward by multiple actors there is a degree of repetition. Each recommendation is followed with specific details and justification taken from the study findings.
1. Background to the study

Prior to the coronavirus disease (COVID-19) pandemic, outbreaks of diseases such as Ebola and cholera highlighted the importance of multisectoral collaboration as a part of any response in low-capacity and humanitarian settings. Recent outbreaks of Ebola virus disease in West Africa (2014–2016) and the Democratic Republic of the Congo (DRC) (2019–2020)\(^2\) have been particularly rich in learning for the humanitarian community in areas such as the importance of community engagement, a broad-based humanitarian approach to outbreak response and the need to build on existing leadership and coordination structures where possible.\(^3\)

Following the onset of the novel COVID-19 pandemic it was quickly recognized that a whole-of-society, multisectoral response was necessary, including the adoption of key public health and social measures needed to reduce COVID-19 spread and the impact of the disease, especially in low-capacity and humanitarian settings.

Studies conducted by the Global Health Cluster (GHC) COVID-19 Task Team in 2020\(^4\),\(^5\) highlighted that significant technical gaps and challenges hampered multisectoral coordination and programming for the COVID-19 response. Nevertheless, strong multisectoral coordination mechanisms that were in place prior to COVID-19 generally resulted in joint guidance, frameworks and programming.

In 2022, the GHC initiated the current study to further understand how multisectoral collaboration had been occurring in humanitarian settings in the response to COVID-19. The focus of the study is on multisectoral collaboration related to health outcomes, usually involving the health cluster coordination team, health cluster partners and other sectoral clusters responding to COVID-19.

The terms “multisectoral” and “intersectoral” are used in various ways in the humanitarian and development sphere. The following definition was adopted for this study:


\textit{Multisectoral collaboration} is where actors representing two or more technical sectors, usually aligned to the humanitarian clusters or line ministries, work together to achieve a shared goal.


The analytical questions underpinning the study were:

1. How did multisectoral collaboration and action of the health clusters and health cluster partners evolve during the COVID-19 response to reach people affected by humanitarian crises?

2. What factors enabled or limited health cluster and health cluster partner engagement in

\(^2\) The outbreaks of Ebola virus disease in West Africa (2014–2016) and DRC (2019–2020) were both declared as a Public Health Emergency of International Concern (PHEIC) by the WHO.

\(^3\) \url{https://odi.org/en/insights/covid-19-five-lessons-from-ebola/}


\(^5\) \url{https://healthcluster.who.int/publications/m/item/health-cluster-country-based-key-informant-interviews-report}, accessed 18 February 2023.
multisectoral collaboration and action for the COVID-19 response?

Given that learning on multisectoral collaboration from previous outbreaks was relevant to the COVID-19 response, it is hoped that this study can in turn document practices that will be relevant to responses to future disease outbreaks and pandemics, especially those in low-capacity and humanitarian settings.

The study was financed by the United States Agency for International Development (USAID) Bureau for Humanitarian Assistance.

2. Study methodology

2.1 Inception process

The Operations Partnership was selected to implement the study. A steering group was put in place by GHC to support and oversee the study, comprising GHC partners. The inception process for the study involved a secondary data review and a series of virtual consultation meetings and interviews with steering group members. This led to the development of a detailed inception report with timeline and project plan. The inception report was finalized in August 2022. The inception phase included the development of an analytical framework for the study, which identified specific criteria, indicators, indicator measurement details and key questions. The analytical framework outlined the design of the study and the specific requirements of to be included in five key informant interview (KII) guides for specific key informant groups and an online survey. An overview of the study scope, objectives and analytical framework are annexed (see annexes 1 and 2, respectively).

The analytical framework introduced categories of multisectoral collaboration that were developed following the initial secondary data review. These categories proved helpful in analysing the data and are referenced in this report.

2.2 Online survey

An online survey was conducted over a period of five weeks in late 2022. The online survey was designed to explore multisectoral collaboration practices impacting health outcomes among humanitarian actors as part of COVID-19 responses. The survey was available in Arabic, English, French and Spanish languages. It was distributed by the GHC on 13th October 2022 and remained open for responses until 17th November 2022. In total 222 people responded to the survey. The number of responses per country was uneven across the 31 settings where the health cluster is currently active (see Fig. 1).

Survey response data was analysed using Alchemer (online survey platform) and Tableau (data analysis and visualization software). Qualitative data was analysed in native languages. The data was disaggregated by World Health Organization (WHO) region. Variations in response from different groups of actors was examined, specifically: organization type, whether respondents work at national or sub-national levels, and whether each respondent’s role is primarily focused on health or multisectoral work. A detailed report on the survey data and findings is available separately.
Figure 1. Online survey responses by country (number indicates responses received from that country)
2.3 Country case studies
Six country case studies were conducted between October 2022 and January 2023 in Burkina Faso, Central African Republic, the Republic of Iraq, the Republic of Mozambique, the Republic of the Union of Myanmar and the Republic of the Sudan. Case study countries were identified by the GHC with respective cluster coordinators volunteering to participate in the study. The goal of the case studies was to develop an in-depth understanding of how multisectoral collaboration has been occurring in humanitarian settings, adaptations made and factors that enabled or limited engagement in multisectoral collaboration. Efforts were made to conduct case studies in a range of contexts and regions. The only WHO region where the health cluster is active that was not represented in the study was the Region of the Americas.

Secondary research was conducted to understand the broad impacts of COVID-19 in each country as well as specific strategies or approaches that were employed by the health cluster or other humanitarian coordination bodies. The target for each country case study was to conduct 15 KIIIs with representation from key stakeholder groups, including: health cluster officials, health cluster partner staff, general coordination staff, government officials and donor representatives. Interviewees were given the option of being interviewed in Arabic (Iraq/Sudan only), French (Burkina Faso and Central African Republic only), Portuguese (Mozambique only) or English. All interviews we conducted virtually (using the Zoom platform). In total 59 interviews were conducted, which was 66% of what was originally planned (for breakdown, see Table 1).

<table>
<thead>
<tr>
<th>Type of organization</th>
<th>Number of key informant interviews</th>
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<tbody>
<tr>
<td></td>
<td>Burkina Faso</td>
</tr>
<tr>
<td>Health cluster coordination team</td>
<td>4</td>
</tr>
<tr>
<td>Health cluster partners</td>
<td>1</td>
</tr>
<tr>
<td>General coordination staff</td>
<td>2</td>
</tr>
<tr>
<td>Government officials</td>
<td>1</td>
</tr>
<tr>
<td>Donors</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>9</td>
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</table>

Table 1. Profile of key informant interviewees, by country and type of organization

Interview recordings were transcribed and coded according to the indicators identified in the analytical framework. Arabic and Portuguese language interview data were translated into English prior to analysis. Information was assembled in a data matrix. The scope, nature and sufficiency of the data was assessed considering relevance, recency, granularity, representativity and reliability of the source. This assessment enabled identification of the amount and type of evidence available for each indicator. A description of evidence under each indicator was then conducted, with key findings being identified where evidence was

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6 The key informant interview category “general coordination staff” includes representatives from the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA), other clusters and WHO officials not directly involved in the health cluster.
corroborated from multiple sources. Finally, an interpretative analysis was performed to build an integrated and cohesive picture of findings, and to focus attention on the original analytical framework questions. Case study reports were compiled in English (Iraq, Mozambique, Myanmar, Sudan) and French (Burkina Faso and Central African Republic) and drafts were shared with the relevant cluster coordinators to ensure accuracy before reports were finalized.

2.4 Secondary data review
A global secondary, background data review was conducted as part of the inception phase. Some sources were identified by the steering group. An online search was also conducted for relevant documents focusing on those produced by humanitarian actors during the COVID-19 response and those relating to previous outbreaks in humanitarian settings. The inception report included an analysis of 30 key documents that made reference to multisectoral collaboration in the response to COVID-19. Some additional documents that were considered relevant were published during the study period. These have been considered in this final report. Finally, each of the six case studies included analysis of relevant secondary data from that context. This included COVID-19 epidemiology, humanitarian/government response plans and situation reports. In total 228 documents were analysed. Fifty-five global-level documents and 173 documents related to the case study countries.

2.5 Data analysis process
The six case study reports, survey data, and related secondary data were analysed and summarized in this report. The Operations Partnership employed its established analytical standards throughout the process, including:
1. The use of an analytical framework to guide and structure data collection and analysis.
2. Objectivity and independence from political considerations.
3. The systematic review of all available information.
5. Transparency regarding limitations, uncertainties and/or confidence in main analytic judgments.
7. Incorporating alternative hypotheses when and where appropriate.
8. Demonstrating relevance and timeliness on answering specific research questions that directly support the decision-making processes and decisions it aims to inform.
9. The use of clear and logical argumentation tied to evidence, reasoning and related claims.
10. The use of structured techniques to mitigate the influence of potential cognitive interpretation biases.

2.6 Limitations and constraints
The online survey received the targeted number of responses. However, responses were unevenly spread across country settings, with no responses from the Republic of Burundi, Republic of Madagascar, the Federal Republic of Somalia, Syria Damascus, Whole of Syria and Ukraine. 222 responses were received in total, of which 121 surveys were fully complete. The remaining responses were partially complete. A

Sources consulted included WHO, UN OCHA and other humanitarian agencies, including nongovernmental organizations (NGOs).

The plan agreed during the inception phase was to send the survey to 50 people in each of the 30 health cluster settings. It was hoped that 10–20% would respond. The response was within this range with 14% of the targeted population submitting a survey response.
technical error in the survey design meant that three of the 14 key questions that the survey set out to explore were not triggered. Each of these omitted questions was addressed in all case study countries so this is not considered as a major information gap. Lastly, because the survey was predominantly multiple choice, the data gathered did have some limitations in terms of depth of understanding in some areas. This was anticipated in the inception phase. To increase the response/completion rate, it was agreed to balance the time taken to complete the survey with the depth of information gathered and type of questions asked.

The case study country selection took longer than anticipated to finalize. Some case studies proceeded in October 2022 and went according to plan, whereas for other countries the process of securing interviews with potential informants was delayed until December 2022/January 2023. The delays faced in conducting country case studies narrowed the timeline for analysis of data. The level of documentation shared by interviewees explaining key examples of multisectoral collaboration was relatively low and it appears that details of multisectoral collaboration during COVID-19 were often not documented, although fortunately there were exceptions that have been drawn on where possible in this report.

For two countries, the number of key informants interviewed was well below the target (Central African Republic and Sudan). More than the required number of key informants were approached for these countries, but many were not able to prioritize time to contribute to the study or had moved on to other roles. This means that the case studies are not as detailed as envisaged, especially for the early part of the COVID-19 response, and that the information gathered, while useful, has not been validated or corroborated to the degree originally planned.

Finally, it is important to highlight that multisectoral collaboration is a complex and multi-faceted topic. During the inception phase it was agreed that a focus on multisectoral collaboration leading to health outcomes should be adopted. This decision helped to focus the selection of key informants and data analysis. However, it is important to highlight that this study was not a programmatic evaluation and did not have the scope to confirm whether concrete and measurable health outcomes were achieved as a result of the collaboration described.

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9 A risk assessment for each proposed country was required by the donor that supported the study. The final clearance for case study countries was then received in late August 2023.
3. Background to multisectoral collaboration in the response to COVID-19

The first case of COVID-19 was identified in the People’s Republic of China at the end of December 2019 and confirmed on 7 January 2020. On 30 January 2020, the WHO Director-General declared the novel coronavirus (2019-nCoV) outbreak a public health emergency of international concern (PHEIC), the highest level of alarm under the International Health Regulations (IHR) (2005). This prompted the launch of the first COVID-19 Strategic Preparedness and Response Plan (SPRP) on 4 February 2020. The SPRP was quickly followed on 12 February by operational planning guidelines to support UN Country Teams to develop country preparedness and response plans. These guidelines introduced eight “major areas of the public health preparedness and response”, which became known as the SPRP pillars. An update to these guidelines in May 2020 introduced a ninth pillar (see Fig. 2).

<table>
<thead>
<tr>
<th>Pillars</th>
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<tr>
<td>1. Country-level coordination, planning and monitoring</td>
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<td>2. Risk communication and community engagement</td>
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<td>3. Surveillance, rapid response teams and case investigation</td>
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<td>4. Points of entry, international travel and transport</td>
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<td>5. National laboratories</td>
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<td>6. Infection prevention and control</td>
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<tr>
<td>7. Case management</td>
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<tr>
<td>8. Operational support and logistics</td>
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<tr>
<td>9. Maintaining essential health services and systems</td>
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</tbody>
</table>

Figure 2. The nine pillars from the SPRP operational planning guidelines (draft updated 22 May 2020)

Over the course of February and March 2020, it became increasingly clear that COVID-19 would have both direct impacts on human health and indirect impacts on livelihoods and socioeconomic development, and that a whole-of-society response was required. On 25 March 2020, the United Nations (UN) launched a US$2 billion coordinated Global Humanitarian Response Plan (GHRP) to protect millions of

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14 A tenth pillar, “Vaccination”, was added in subsequent editions of the SPRP.
people by tackling COVID-19 in some of the world’s most vulnerable countries and contexts. The GHRP outlined the indirect socioeconomic impacts of the COVID-19 pandemic, highlighting the main macroeconomic impacts, along with the “collateral effects on people” including: livelihoods and food security; protection and rights; education and society; and reduced supply chains and logistics. The GHRP identified the most affected and at-risk population groups, including those facing chronic disease and undernutrition, displaced people, people with disabilities, children, women and girls, those with frequent social contacts and people losing their income. Three strategic priorities were outlined, two of which emphasize the importance of working across a range of sectors in addition to health (see Fig. 3). The GHRP also listed eight overarching guiding principles for the response, one of which was “Building on existing coordination mechanisms”. This brings important implications for multisectoral collaboration because it stresses the use of existing humanitarian architecture at country level, such as the Humanitarian Country Team, clusters and Inter-Cluster Coordination Group (ICCG).

Figure 3. The three strategic priorities outlined in the GHRP for COVID-19

The SPRP and GHRP together framed the COVID-19 response for humanitarian actors and highlighted the need for multisectoral collaboration at multiple levels in the response to COVID-19 in humanitarian settings.

At a global level, coordination bodies such as the Inter-Agency Standing Committee (IASC), the GHC, and Global Cluster Coordination Group (GCCG) all played key roles in providing guidance on key issues related to multisectoral responses to COVID-19 in humanitarian settings. For example, the updated SPRP Operational planning guidelines16 introduced a set of special considerations for low-capacity and humanitarian settings, some of which were focused on multisectoral collaboration. This was organized around the nine SPRP pillars and steps/actions.17

Another key initiative was the Basic information package for COVID-19 response18 which was developed by


17 It is noted that while several of the pillars such as risk communication and community engagement, and infection prevention and control imply a need for multisectoral collaboration, specific guidance on the topic is not given in this document.

the GCCG and launched in June 2020. The “Key messages on coordination for COVID-19 response” included a clear statement on collaboration across sectors:

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**Key Message 6: Ensure collaboration and coordination with other agencies and sectors – Foster collaboration across the different sectors and organizations to ensure coherent and complementary interventions. Strengthen collaboration on information sharing, joint analysis, joined-up planning and programming.**

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The basic information package included an “Inter-Cluster/Sector Matrix on COVID-19 response” that aimed to promote multisectoral collaboration and highlighted specific actions that combinations of two or more sectors could take jointly in the COVID-19 response.

In another example, the office of the United Nations High Commissioner for Refugees (UNHCR) produced key protection messages in March 2020 to support asylum seekers, refugees and internally displaced people who are especially vulnerable to health risks and other protection concerns.

At a country level, national preparedness and response plans were developed in many countries. In low-capacity and humanitarian settings these were usually produced by national governments with significant support from UN country teams. These frequently featured multisectoral collaboration plans.

The milestones relevant in guiding multisectoral collaboration over the first six months of the global COVID-19 response are summarized in Annex 3.

In December 2020, the Global Humanitarian Overview (GHO) (2021) summarized the evolving approach to the response stating that: “Humanitarian programming is adjusting to treat COVID-19 in a more integrated manner, as the pandemic’s health and non-health effects merged with the impacts of other shocks and stresses. As a result, for 2021, COVID-19 analyses and responses have been integrated into ‘regular’ [i.e. annual] HNOs and HRPs as well as into inter-agency response plans.”

Towards the end of 2020, the GHC COVID-19 Task Team conducted two studies: an online survey for all country health clusters and key informant interviews in six country health clusters. The two studies were designed to identify good practices and to better understand the technical and operational challenges faced by health clusters and partners during COVID-19 response and as part of efforts to maintain

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essential health services in humanitarian settings. Among other topics, these studies examined multisectoral collaboration in COVID-19 responses. Key observations are described below:

- **Operational challenges.** These often emerged due to limitations related to lockdowns, restrictions on movement and gatherings, restrictions preventing or limiting the deployment of international staff, and insufficient funding.
- **Technical challenges.** Multisectoral efforts needed to consider home-based care, screening and quarantine at points of entry, and community-owned risk communication to help break chains of transmission and mitigate the impacts of the pandemic. Other common challenges included lack of guidance for managing overcrowded shelters and dwellings.
- **Pre-COVID-19 practices.** Where strong multisectoral coordination existed prior to COVID-19, good practice was demonstrated resulting in joint guidance, frameworks and programming.

The current study set out to explore these and related topics in further detail.

Since the study commenced, additional COVID-19 related studies have highlighted some additional relevant information:

- The Inter-Agency Humanitarian Evaluation (IAHE) of the COVID-19 humanitarian response24 highlighted risk communication and community engagement (RCCE) as a “particularly strong aspect of the collective response to COVID-19, generating significant learning that can be applied to other responses.” The evaluation commented on the efforts to improve multisectoral collaboration between clusters in the response stating: “It is noteworthy that there were very deliberate attempts made at the global level, both collectively between all clusters, but also bilaterally between specific clusters, to identify and explain some of the more important linkages. These guidance documents were made available on cluster websites and were frequently disseminated at country level through the clusters and ICCGs. Notwithstanding the fact that the sectoral nature of the clusters meant they continued to work independently of each other, this evaluation acknowledges the efforts that were made to identify and promote synergies between them.” Less positively, the evaluation noted: “Despite recognition of the need for a holistic response to COVID-19, the evidence shows that COVID-19 did not significantly change existing levels of collaboration and coordination between humanitarian, development and peace actors, and there were no new nexus approaches in case study countries25 as a result of COVID-19. One potential reason for this is that the barriers to progress on the nexus are structural and the response to COVID-19 was unable to achieve a breakthrough in addressing these.” This is similar to the conclusion of another 2020 study26 examining how the ‘nexus approach’ had been put into action in the COVID-19 response.
- A 2022 report by WHO27 examines the African regional response to the COVID-19 pandemic by

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25 The case study countries that were part of the IAHE were Bangladesh, Colombia, DRC, Philippines, Sierra Leone, Somalia, Syria and Turkey.
assessing the preparedness and response of the countries in the WHO African Region against the Strategic Preparedness and Response Plan (SPRP). Among other lessons learned, the report highlights: “African countries have sufficient capacity and have responded swiftly and appropriately to the COVID-19 pandemic, even with limited resources. The activation of a multisectoral-agency response enabled coordination of all available resources towards the COVID-19 response, with the health sector coordinating alongside other ministries/agencies.”

- An evaluation of the protection of the rights of refugees during the COVID-19 pandemic highlighted a wide range of collaboration types between health and protection actors and noted examples of efforts to increase access to health care for refugees in camps during the pandemic. The evaluation found: “a wealth of evidence on the extent of global-level coordination and its influence on the coherence of approaches at the country level.”

- An extensive literature review exploring how health systems in fragile and conflict-affected countries respond to acute shocks found that after the initial phase of acute shock, leadership is central to translating existing knowledge and resources into action, improving collaboration among actors and promoting community engagement. The review found: “Health systems in fragile and conflict-affected settings faced uncertainties in prioritizing action, allocating resources and managing acute shocks. Uncertainties required leadership in using knowledge to foster dynamic interaction and networking among decision-makers, frontline workers and community members so that actions reflect the needs of the community in real-time to absorb shocks and initiate rapid response.” The review also found that involvement of multiple sectors (both health and non-health) influenced the health system’s adaptive capacity to respond to shock, and lack of collaborative stakeholder effort diminished adaptive capacity. Finally, the review found: “Settings that have the ability to engage governmental or non-governmental agencies other than in the health sector exhibited the transformative capacity to make a change in the system,” and further: “Empowering and including communities in responses improved community acceptance of transformative changes and response.”

Finally, it is important to note that 2022 saw the publication of a new One Health Joint Plan of Action that sets out to improve prevention, monitoring, detection, control and containment of zoonotic disease outbreaks and is jointly published by the Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), WHO and World Organisation for Animal Health (WOAH). The plan notes: “The complexity and interconnectedness of the health challenges threatening humans, animals, plants and the environment, where they coexist, require holistic, integrated solutions”. “Multisectoral action and partners” is one of the guiding principles of this plan.

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30 In this literature review, the term “leadership” refers to either institutional leadership (i.e. the capacity of multiple organizational actors to engage in information sharing and collaboration for emergency preparedness and response), or to political leadership (i.e. the capacity of political and bureaucratic leaders to make administrative decisions essential for crisis management).

4. Findings: Multisectoral collaboration during the COVID-19 response

Overarching question 1: How did multisectoral collaboration and action of the health clusters and health cluster partners evolve during the COVID-19 response to reach people affected by humanitarian crises?

This overarching question was broken down into four specific criteria, each with indicators and key questions that were included in KII s and survey design. The findings related to each criterion are outlined below.

4.1 Pre-existing multisectoral collaboration

Specific criterion: What pre-existing multisectoral collaboration was in place before COVID-19, and how did it enable or hinder COVID-19 responses in reaching people affected by humanitarian crises?

4.1.1 Key findings from case study countries and survey

Pre-existing multisectoral collaboration was discussed in case study KII s and explored in the online survey. Each case study identified pre-existing collaboration highlighted by multiple key informants (three or more). Topics highlighted by multiple informants were then synthesized and categorized along with relevant survey data to identify the key findings listed below.

Key Finding 1. Pre-existing humanitarian structures including clusters and ICCG facilitated multisectoral collaboration during COVID-19

Multisectoral coordination mechanisms and structures were the most common form of collaboration prior to COVID-19 reported by survey respondents (selected by 31% of respondents) closely followed by strategic-level collaboration mechanisms (such as multisectoral needs assessments strategic plans and strategies, selected by 30% of respondents).

In the survey, respondents were asked: “Who took the lead in multisectoral collaboration prior to COVID-19?” The most frequently selected options were “MoH [ministry of health]/Government” (selected by 27% of respondents) and Health cluster (selected by 26%). “ICCG32” and “Health cluster partners” were also selected (20% and 28% respectively). It is important to note that respondents whose work was focused on sectors other than health or multisectoral selected Inter-Cluster Coordination Group (ICCG) more frequently in comparison to health actors. “Other clusters” was only selected by 1% of survey respondents. The ICCG was more frequently selected by those whose work focused on specific sectors other than health, and among those working across multiple sectors.

These survey data were confirmed in the case study interviews. Key informants outlined how MoH, health

32 The Inter-Cluster Coordination Group (ICCG) is also known as the Inter-Sector Working Group (ISWG) in some country settings. The term ICCG is used throughout this report in reference to both ICCG and ISWG.
cluster and ICCG all provided coordination support prior to COVID-19 in the majority of the countries and confirmed that this was useful in responding to COVID-19. Participants in four of the six country case studies specifically highlighted the health cluster as a significant leader in multisectoral collaboration prior to COVID-19.

93% of survey respondents reported that pre-existing humanitarian response-related multisectoral collaboration was useful in supporting the COVID-19 response (74% selected “yes, useful”; 19% selected “partially useful”). This was corroborated in the case studies in Burkina Faso, Iraq, Mozambique and Myanmar. In Burkina Faso, pre-existing humanitarian coordination structures contributed to the transition to a multisectoral approach in response to COVID-19. This was facilitated by multisectoral collaboration related initiatives already being implemented (for example between the water, sanitation and hygiene (WASH), health and nutrition clusters). In Iraq, the pre-existing humanitarian architecture – specifically the health cluster, other clusters, ICCG and camp-level coordination mechanisms\(^{33}\) – proved an important platform for multisectoral collaboration in the COVID-19 response. In Myanmar, respondents specifically highlighted that having the health cluster in place prior to COVID-19 was important during the initial period of COVID-19 (March–June 2020) due to its role in disseminating key information from the MoH, WHO, the UN Country Team (UNCT) and Humanitarian Country Team (HCT) to health cluster partners.

The ICCG was reported as being functional prior to COVID-19 in several countries and was generally seen as a useful platform for multisectoral collaboration during the COVID-19 response. In Myanmar, there was also an example of a sub-national ICCG being in place prior to COVID-19 in Rakhine State.\(^{34}\) This mechanism was reported to be particularly helpful for multisectoral collaboration and its impact was strengthened due to it having a clear Terms of Reference and full-time staff. However, some variations were also reported. For example, in Sudan, one respondent reported that pre-COVID-19 the ICCG would provide recommendations on activities to the HCT, and that this interaction was valuable. However, during COVID-19 it was felt that roles and responsibilities were unclear, and the premise that each sector in the ICCG had an equal say, led to a lack of leadership. There was no clear or formal structure for multisectoral collaboration, and any multisectoral coordination tended to be ad hoc, driven by a specific response and mostly operational in nature.

Other pre-existing coordination structures involving humanitarian actors that proved helpful for multisectoral collaboration in the COVID-19 response were the HCTs and UNCTs. For example, in Iraq, the HCT initiated a multisectoral collaboration initiative focused on COVID-19 quarantine and isolation areas in camps for internally displaced people (IDP). In Myanmar the UNCT played a key role in defining the responsibilities of international actors to complement the government-led response to COVID-19.\(^{35}\)

The survey data show what specific types of multisectoral collaboration was in place prior to COVID-19. The four most frequently selected options were multisectoral needs assessments, multisectoral coordination platforms, joint strategic plans and multisectoral coordination mechanisms. The least selected options were implementation of multisectoral programming through consortiums, shared use of facilities, or common distribution mechanisms (see Fig. 4). This suggests that pre-existing multisectoral collaboration tended to be focused more at the strategic and coordination levels (often in areas associated with the humanitarian programme cycle) than at the technical and operational levels.

\(^{33}\) At the onset of COVID-19 in February 2020 there were 43 formal IDP camps in Iraq, hosting 55,503 IDP households.

\(^{34}\) Referred to as the “Sittwe-Based Inter-Cluster Coordination Group”, focused on Central Rakhine.

\(^{35}\) During the period prior to the military takeover in February 2021.
Key Finding 2. Pre-existing government structures facilitated multisectoral collaboration during COVID-19

As stated, when survey respondents were asked “Who took the lead in multisectoral collaboration prior to COVID-19?” “MoH/Government” was the most frequently selected option.

In case study interviews, pre-existing government structures for multisectoral collaboration were referenced in all countries. In Mozambique, the MoH defined an internal taskforce comprising mostly departmental directors, national directors and their deputies, and chaired by the National Director for Public Health of the Ministry of Health. A key task of the national taskforce was to ensure multisectoral collaboration. This was not a new undertaking for the MoH as there are frequent emergencies that require a multisectoral response, such as cholera outbreaks and cyclones. In Burkina Faso, at the government level, forms of collaboration between the different ministries were in place to respond to epidemics (particularly dengue epidemics) through a national epidemic management committee (a standing committee that meets quarterly). However, this mechanism was only used in the COVID-19 response at the sub-national level (led by administrators at the provincial level). In the Central African Republic, it was reported that there were parallel multisectoral coordination streams: there was ministerial engagement, which is positive, although this was sometimes perceived as being politicized. The level of government stream provided opportunities for building relationships that would otherwise not have been
possible but also led to duplication of effort as the same issues were often discussed in both UN- and government-led fora.

There were also examples of pre-existing government led multisectoral collaboration that were not specifically developed for emergencies or outbreaks. For example, in Myanmar the administration departments at state/region and township levels were reported to be important pre-existing mechanisms for that proved important during the COVID-19 response. The administration departments have the responsibility for coordination across the local government system, the mandate for community safety and security, and the authority to give instructions to communities. They worked in close coordination with the relevant health departments in the COVID-19 response.

**Key Finding 3. Pre-existing relationships between humanitarian and government actors supported the COVID-19 response, particularly at sub-national level.**

Case study interviews highlighted that pre-existing working relationships between humanitarian and government actors were important in the COVID-19 response.

For example, in Iraq, pre-existing national and sub-national relationships between health cluster partners, governorate-level directorates of health and other clusters (such as camp coordination and camp management (CCCM), WASH and shelter/non-food items (NFI)) were widely reported as critical components in enabling the initial response to COVID-19, especially during the period when lockdowns inhibited the movement of a number of key personnel. Strong relationships had been built up between these stakeholders prior to COVID-19 because of ongoing collaboration efforts focused on provision of health, WASH and other sectoral services in IDP camps.

In Myanmar, the close pre-existing working relationships between sub-national clusters\(^\text{36}\) and the State Health Department in Rakhine were highlighted as an important enabler in the COVID-19 response. As with Iraq, these relationships had been built up during ongoing multisectoral collaboration for service delivery in IDP camp settings.

In Burkina Faso, several interviewees emphasized the importance of pre-existing working relationships between clusters and government health actors at national and sub-national levels. In this case these relationships had been developed in responses to previous epidemics (e.g. Ebola, dengue). Such relationships were reported to be a favourable factor in the response to COVID-19.

**4.1.2 Concluding comments**

The key findings listed above highlight the importance of pre-existing coordination structures for multisectoral collaboration in COVID-19 responses. The case studies show that humanitarian actors and governments both played important roles in these structures with precise roles and responsibilities varying by country and context. The health cluster and ICCG were the most frequently referenced humanitarian coordination structures prior to COVID-19.

The findings reveal the importance of pre-existing relationships between humanitarian and government

\(^{36}\) Including health, shelter-NFI-CCCM, WASH, nutrition, and protection, most of which were activated following a spike in crises related to violence and displacement in 2013.
actors for multisectoral collaboration and align with previous research on this topic.\textsuperscript{37}

Alongside the MoH and health cluster-led pre-existing coordination mechanisms, the ICCG played a prominent role and was generally cited as an important platform for enabling multisectoral collaboration in most case study countries where strong leadership was in place.

Clusters that had been established prior to the COVID-19 pandemic were frequently highlighted as important enablers for multisectoral collaboration during COVID-19 responses. The health cluster was frequently singled out by respondents as the cluster that took a lead on multisectoral collaboration most frequently, although it should be noted that the majority of those respondents were health cluster partners.

Pre-existing multisectoral relationships at national and sub-national levels helped to enable collaboration across the different sectors. Finally, governments were actively engaged in multisectoral coordination prior to COVID-19, although this could result in some duplication.

Given the above conclusions, it is critical to recognize the importance of establishing multisectoral collaboration prior to disease outbreaks and other crises. The GHRP adopted “Building on existing coordination mechanisms” as one of the guiding principles for the response.\textsuperscript{38} The study found numerous examples of where existing coordination mechanisms served as an important platform for multisectoral collaboration for health outcomes in the COVID-19 response.

Multisectoral collaboration platforms should have clear division of roles and responsibilities and leadership. Modalities may vary dependent on the type of response. It is also important that coordination structures maintain close coordination with government, both MoH as well as general administration or coordination departments at sub-national levels.


4.2 Key adaptations in multisectoral collaboration for COVID-19 responses

Specific criterion: What were the key adaptations that occurred in multisectoral collaboration to ensure COVID-19 responses reached people affected by humanitarian crises? How effective was each of these, and why?

Adaptations in multisectoral collaboration was discussed in interviews for each country case study. Each case study identified key adaptations that were highlighted by multiple key informants (usually three or more). Detailed examples can be found in each case study report. The topics highlighted across the six case studies were then synthesized and categorized along with relevant survey data.

The four categories used were those defined at the start of the study:
- Strategic approaches to collaboration (e.g. needs assessments, frameworks and plans developed).
- Coordination platforms or mechanisms.
- Operational approaches to collaboration (e.g. between partners).
- Technical approaches to collaboration (e.g. guidance, standard operating procedures (SOPs) or protocols.

Following synthesis of this information the key findings from the study are described below. The findings are divided into those focused on multisectoral collaboration for health outcomes, the designated focus of this study and findings related to other types of outcomes.

4.2.1 Findings focused on multisectoral collaboration for health outcomes

Coordination findings

Key Finding 4. The SPRP pillars were frequently used to guide coordination processes, including multisectoral components.

The WHO COVID-19 Strategic Preparedness and Response Plan (SPRP) provided a framework that set out the priority public health measures to be put in place and the strategic activities to be undertaken to enable countries to prepare and respond to COVID-19. These were drawn from the available evidence on COVID-19. The activities were structured around the eight operational and technical pillars, later expanded to ten (see Fig. 2).

Several countries implemented the proposed pillar approach in some form (identified in Burkina Faso, Iraq, Mozambique, Myanmar and Sudan) with the pillars informing how both government and UN coordination processes were organized.

Multisectoral collaboration for health outcomes was most frequently triggered by coordination processes focused on Risk communication and community engagement (RCCE) (Pillar 2) and Infection prevention and control (Pillar 6). However, examples of multisectoral collaboration for health outcomes were identified in coordination informed by other pillars, for example:

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39 This was not possible for Central African Republic or Sudan case studies due to the limited number of KIIs.
• **Country-level coordination, planning and monitoring** (Pillar 1) – For example, discussions at HCT level in Iraq triggered efforts to implement quarantine and isolation areas in IDP camps.

• **Surveillance, rapid-response teams, and case investigation** (Pillar 3) – For example in Myanmar, WASH and nutrition staff and volunteers formed part of COVID-19 surveillance in IDP camps (examples from both Rakhine and Kachin States).

• **Points of entry, international travel and transport** (Pillar 4) – For example in Myanmar, local nongovernmental organizations (NGOs) provided a wide range of health and non-health support to help operationalize isolation facilities in support of immigration authorities for migrant workers returning from Thailand to Myanmar during 2020. Another example from Mozambique is given below.

• **Case management** (Pillar 7) – For example in Myanmar after the military takeover, a wide range of modalities was employed to support home-based care during the delta variant wave of COVID-19 in mid-2021. This often involved community-based organizations and volunteers with no formal training or background in health being the first line of support to COVID-19 patients.

Interviewees in Burkina Faso, Mozambique and Sudan clearly used the pillar terminology and explained how the pillar approach informed the formation of technical working groups for COVID-19 responses. The pillars were seen as an enabler by one interviewee in Sudan, as they helped to resolve some of the issues that had arisen due to competing interests. In Myanmar, the pillars informed the structure of the UN country preparedness and response plan and were also used within the government response as a way to organize state-level COVID-19 taskforces.41

It is important to note that the pillars do not appear to have been used prescriptively and there are variations in how they were applied in different country settings. For example, in Myanmar, the pillars partially informed the establishment of four technical groups for the COVID-19 response by WHO: coordination, laboratory, RCCE, and EPI/Vaccination,42 which align with the relevant SPRP pillars.

There were challenges reported with the use of the SPRP pillars. One interviewee in Sudan reported that the pillar approach lacked clarity, with the pillars and agencies identified but not the sectors that needed to participate. While there was a multisectoral structure and coordination with other clusters, the response did not really take a multisectoral approach, rather adopting more of a multi- or inter-agency approach. The response in Sudan was predominantly a health response, with the pillars heavily focused on health activities. There were mixed views on this focus on health. The lack of clarity on roles and responsibilities, especially regarding leadership, was seen as putting the burden for the response on the health sector, and it was not until the impact of COVID-19 and its wider implications became more obvious, (on food security, economy and access), that other sectors began to engage. At a sub-national level, the focus on health resulted in other sectors giving less attention to COVID-19.

Although respondents from the Central African Republic did not specifically mention the pillar approach, in April 2020 a COVID-19 taskforce was created, co-chaired by the health and WASH clusters, and involving most other clusters. The focus was very practical (e.g. the design of isolation centres in case they were needed). This example demonstrated good joint working with the shelter clusters.

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41 During the period before the military takeover in February 2021.
42 EPI is the Expanded Programme on Immunization which was very well established in Myanmar prior to the COVID-19 response.
In Mozambique, ten pillars were identified for the response, and each had a technical working group with specific remits for each: (1) Surveillance; (2) Points of entry (POE); (3) Laboratories; (4) Case management; (5) infection prevention and control (IPC); (6) WASH; (7) Risk communication and community engagement; (7) Procurement and logistics; (8) Human resources; (9) COVAX (vaccination); (10) Continuity of essential health services.43 These were overseen by a coordination group, whose role included convening and coordinating periodic meetings of this multisectoral group for the management of the health emergency, coordinating the development and approval of strategies and SOPs that govern the functioning of public health emergency operations centres (EOC), liaising with the technical work groups (TWGs), and with partners in general especially on risk communication. The only TWG group whose terms of reference specifically mention multisectoral collaboration was the points of entry group, which included a specific remit to strengthen multisectoral coordination at entry points (i.e. migration, customs, agriculture, transport operators, travel agencies, among others), to support prevention and control activities.

The COVID-19 response of each technical working group had to follow the rules/guidelines developed by WHO and the US Centers for Disease Control (CDC), which were adapted to the local context.44 The working groups included relevant line ministries and sectors and were replicated at the sub-national (provincial) level. At national level the COVID-19 response had greater engagement from more senior leadership across the different line ministries, including the Ministries of Defence, Interior and Justice, than previous responses. TWGs involving Health Directorates discussed policy and strategy and developed work plans. The aim was to support the Ministry of Health (MoH) to consider the latest evidence and best practices, adapt them to Mozambique, discuss policy and strategy, and develop workplans and guidance. The TWGs provided technical recommendations to inform COVID-19 public health messaging, preventative measures to be undertaken, and coordinated preparedness and response activities. The TWGs were led by the MoH and co-chaired by partners, and this was replicated at the provincial level. This approach enabled partners to move forward with multisectoral plans for COVID-19, which sought to protect people and support social cohesion. Existing working groups adjusted their plans considering the COVID-19 response. At the sub-national level, for example in Cabo Delgado, the humanitarian community worked with the provincial and district health authorities who led the coordination. Some adaptations were made for COVID-19 responses. For example, WASH actors in the infrastructure working group supported those delivering HIV services to ensure that the necessary water supply for handwashing was available.

In Sudan, the pillar approach was introduced at a national level in May 2020 through Sudan’s COVID-19 Country Preparedness and Response Plan (CPRP) this identified eight pillars focused on the major areas of the public health preparedness and response: (1) country-level coordination; (2) points of entry; (3) surveillance, rapid-response teams, and case investigation; (4) national laboratories; (5) case management; (6) risk communication and community engagement; (7) infection prevention and control IPC; and (8) operational support and logistics. Interventions were focused on:45

- National coordination: promoting whole-of-society coordination mechanisms (including hospital and community preparedness plans support to preparedness and response – including the health, transport, travel, trade, finance, security and other sectors).
- Risk communication and community engagement.
- Surveillance, and risk and severity assessments.

43 COVID-19 Coordination and TWG organization in Mozambique.
44 Grupo Técnicos de Trabalho, (Prevenção e Reposta ao COVID-19), Ministry of Health, Mozambique.
• National laboratories.
• Infection prevention and control.
• Case management and health services.
• Operational support and logistics.

In May 2020, the COVID-19 Addendum to the HRP for Sudan\(^{46}\) was launched, focused on the non-health aspects of the response. This was complemented by the HCT-UNCT COVID-19 Country Preparedness and Response Plan (CPRP)\(^{47}\) launched in July 2020, which was aligned to the Global Humanitarian Response plan (GHRP) and WHO COVID-19 Strategic Preparedness and Response Plan (SPRP) in support of the Government of Sudan’s efforts in preparing and responding to the pandemic. The CPRP was focused on the health-related response to the pandemic and covered nine pillars: (1) country-level coordination; (2) points of entry; (3) surveillance, rapid-response teams and case investigation; (4) national laboratories; (5) case management; (6) risk communication and community engagement; (7) infection prevention and control; (8) operational support and logistics; and (9) maintaining essential health services and systems.

The SPRP pillar coordination approach was strengthened during the COVID-19 response and engaged cluster partners and line ministries. There was a wide range of partners engaged in the coordination of the response, from UN agencies, international and national NGOs, donors and academia. They met weekly to share updated information, studies and achievements, and to identify roles and contributions. There has been increased multisectoral collaboration between humanitarian actors in Sudan from 2021 onwards. As part of the response to recent conflict, there has been increased operational collaboration between health, nutrition, food security and livelihoods, and WASH, with the health cluster taking the lead.

In Burkina Faso, coordination committees were established based on the pillar approach, led by the government and with the support of the health cluster partners. Ten thematic groups were put in place by the CORUS\(^{48}\) (Response Operations Centre for Health Emergencies) level: (1) surveillance; (2) infection prevention and control; (3) case management; (4) logistics; (5) laboratory capacity building; (6) planning; (7) risk communication and community involvement; (8) security; (9) administration; and (10) finance, analysis, reflection and research. The CORUS was the interface between the health cluster and the coordination structures of the Prime Minister’s Office. The roles of each party were clear, particularly at the operational level. The health cluster was the lead, in tandem with the Ministry of Health (represented by CORUS and designated "incident manager"). The CORUS was used for the first time as a structure for coordinating the response. There were also additional thematic groups in place including: cash transfers (coordinated by FAO and WFP); mental health and psychosocial support (coordinated by the International Organization for Migration); information management (IMWG) (coordinated by OCHA); community engagement and accountability (CEA); as well as a rapid response mechanism (coordinated by OCHA and Action contre la Faim)\(^{49}\). However, these groups were seldom mentioned by key informants and the rapid response mechanism was not reported to have been effective.


\(^{48}\) CORUS is the “Centre des Opérations de Réponse aux Urgences Sanitaires” which is part of the National Institute of Public Health (INSP) and was put in place in 2018. http://www.corus.gov.bf/corus , Accessed 14 March 2023

Key Finding 5. The clusters all played an important role in leading and enabling multisectoral collaboration in the COVID-19 responses with health, WASH, CCCM and protection being the most prominent. The health cluster was very active in initiating multisectoral collaboration within the cluster system.

In the online survey, respondents were asked which factors enabled collaboration. Responses to this question were diverse. “Collaboration triggered by cluster coordination approach (multisectoral needs assessments, strategic plans and multisectoral strategies)” was the highest-ranking factor, with 31% of respondents selecting this option. “Collaboration triggered by technical capacity (such as multisectoral guidance, standard operating procedures and protocols)” was the second highest ranking factor, with 23% of respondents selecting this option (see Fig. 5 for a summary of responses).

Respondents were asked which cluster(s) enabled the collaboration factors selected. The clusters most frequently reported to have enabled collaboration for the selected factors were the health cluster (29%), and the WASH (14%), nutrition (12%) and CCCM clusters (9%).

Respondents whose role was focused on a specific sector (either health or another sector) selected the health cluster as an enabler of collaboration more frequently than those working across multiple sectors or clusters. Respondents whose focus is working on the health sector selected other sectors as collaboration enablers less often. This suggests that respective efforts between the health cluster and those working across multiple sectors could be better understood or better appreciated.

The relationship between the factor selected and the enabling cluster was also analysed. It is striking that the health cluster was considered the enabling cluster for collaboration triggered by the cluster

Figure 5. Survey responses: “Select the three main factors that, in your opinion, enabled multisectoral collaboration.”
coordination approach in 100% of cases,\textsuperscript{50} followed by the WASH cluster in 40% of cases.\textsuperscript{51} The health cluster was also selected as an enabler in 70% of the cases where “collaboration triggered by the host government” was selected and in 66% of the cases where “collaboration triggered by operational capacity” was selected. The WASH cluster, in addition to being identified as an enabling cluster where collaboration triggered by the cluster coordination approach was selected (40%), also stands out for its involvement as an enabler where “collaboration triggered by operational capacity”\textsuperscript{52} was selected (50% of cases). Apart from the health and WASH clusters, there are no significant trends in the linkages between enabling factors and enabling clusters selected.\textsuperscript{53}

Another survey question asked: “Which clusters other than health had played a leading or prominent role in multisectoral collaboration in the COVID-19 response?” The health cluster was not given as an option.\textsuperscript{54} The clusters most frequently selected were WASH (29%), protection (23%), CCCM and nutrition (both 17%). Fig. 6 illustrates the related survey data and suggests that all clusters played an important leadership role in multisectoral collaboration in the COVID-19 response in at least one or more contexts.

\begin{flushleft}
\textsuperscript{50} It is important to stress that 93% of the survey respondents represent an organization that is a health cluster member.
\textsuperscript{51} Multiple clusters could be selected in the response to this question.
\textsuperscript{52} Referring to collaboration involving consortium projects, shared use of facilities, volunteers and distribution mechanisms.
\textsuperscript{53} Two additional points of note are: (1) the protection cluster was selected as an enabler in 33% of cases where “collaboration triggered by existing humanitarian partnerships” was selected; and (2) the food security cluster was selected as an enabler in 30% of cases where “collaboration triggered by host government” was selected.
\textsuperscript{54} The health cluster was not given as an option since it was assumed to have played a prominent role in multisectoral collaboration from the point of view of survey respondents. This question was designed to look beyond the health cluster.
\end{flushleft}
The Health Cluster Guide recommends the following step for multisectoral programming: “Ensure that, in most humanitarian contexts, the health cluster works at a minimum as part of an integrated response with the water, sanitation and hygiene (WASH), nutrition, protection, and food security clusters, and with the support of the logistics cluster”. Based on the survey it seems that these clusters did indeed play a key role in multisectoral collaboration in the COVID-19 response. However, it is important to note the prominence of the CCCM cluster in the survey results as both an enabler and a lead of multisectoral collaboration in many contexts.
The case studies largely confirmed the survey findings in terms of the roles that other clusters played. A summary is presented in Table 2.

<table>
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<th>Nutrition57</th>
<th>Food security</th>
<th>Other clusters</th>
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<td></td>
<td>Education</td>
</tr>
<tr>
<td>Sudan</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>Education, Shelter/NFI</td>
</tr>
</tbody>
</table>

Table 2. Summary where examples of clusters leading or enabling multisectoral collaboration were highlighted in case study countries.

**Key Finding 6. Ministry of health and national government leadership facilitated multisectoral collaboration for health outcomes.**

The case studies highlight several examples where ministries of health (MoHs) initiated multisectoral coordination processes and initiatives within the government system. For some countries this continued throughout the COVID-19 response at both national and sub-national levels, for others it was only apparent during the initial phase of the response or changed due to the political dynamics changing. There were also multiple examples of MoHs interacting with humanitarian actors on multisectoral collaboration issues, usually in close collaboration with the health cluster. The pillars were often used as a start point for the organization of the response.

In Myanmar, in the first year of the pandemic, the national response to COVID-19 was led by the Government specifically the Ministry of Health and Sports (MoHS), supported by the United Nations (UN) system. Humanitarian actors had a clear focus on specific populations affected by conflict and displacement. There was multisectoral collaboration across the entire response. The MoHS produced a Health Sector Contingency Plan, released on 15th April 2020, which served as the main plan for government alongside the COVID-19 Economic Recovery Plan (CERP), released on 27 April 2020. The CERP emphasized a whole-of-nation approach and underlined the principle of “leaving no one behind”. From a multisectoral collaboration perspective, both plans were important. The Health Sector Contingency Plan laid out the specific COVID-19 response coordination mechanisms for all key stakeholders at central, state/region and township levels with a goal of joint implementation of the identified public health measures for preventing and managing COVID-19 outbreaks at the community level. This plan was informed by existing national plans for pandemics that were developed previously, such as the National Strategic Plan for Zoonotic Influenza and Human Influenza Pandemic Preparedness and Response (2017) and the National Action Plan for Health Security (2018). Following the military takeover in February 2021, the situation changed radically. Many previous channels of multisectoral collaboration simply stopped, especially those working

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56 Working as Shelter/NFI/CCCM cluster in Myanmar.
57 Nutrition cluster is not activated in Iraq.
Government engagement and leadership was at both national and sub-national levels. At the national level in Burkina Faso, forms of collaboration between the different ministries have been put in place to respond to epidemics (particularly dengue epidemics) through a national epidemic management committee (a standing committee that meets quarterly). However, this was only used at the sub-national level through the governors.

In Central African Republic, a dedicated COVID-19 Director was appointed by the Minister of Health a few months after the beginning of COVID-19 however, it was unclear whether this was politically or practically motivated. The general view of respondents was that this role did not strengthen collective response.

In Mozambique, Ministry of Health leadership was reported to be effective, with multisectoral plans in place from the national to community levels, particularly during the roll out of COVID-19 vaccinations. In Sudan the high-level representation from the Federal Ministry of Health, and decision-makers from the ministries assisted in the process of developing the two protocols: 1) back to school protocol; 2) campaign for post lockdown, post quarantine. The first involved the education sector.

In Iraq, the involvement of Governorate-level Directorates of Health in health cluster meetings added value to multisectoral collaboration, because of the extent of relevant initiatives being taken within the government system.

Technical collaboration findings

**Key Finding 7. Multisectoral collaboration utilized community-based approaches to strengthen engagement with communities and deliver appropriate COVID-19 prevention messages.**

Multisectoral collaboration had a strong community focus during the COVID-19 response, this ranged from ensuring appropriate health prevention measures, to reducing stigma on health prevention and social messages, as well as to identify gaps and needs to ensure that communities health and wider needs were met. Examples included the following:

- **Ensuring community-friendly technical resources.** In Myanmar, efforts were made to ensure the translation of technical documents into forms that could be trusted, understood and acted upon by communities (considering literacy levels, language, culture and communication/engagement preferences). This was carried out nationally via a risk communication and community engagement (RCCE) technical group led by WHO, which pulled in specialists in accountability to affected people from other organizations and aligned messages with key partners such as the United Nations Children’s Fund (UNICEF) and United Nations Office for Project Services (UNOPS). There was also a sub-national example where the communicating with communities working group in Rakhine, led by the office of the United Nations High Commissioner for Refugees (UNHCR) took a lead on developing localized technical materials. In Sudan, the health sector worked closely with the protection sector around issues of health-related stigma and social messages during the lockdown, as well as the WASH sector on the integration of key messages on IPC, for host communities and in camps.

- **Community approaches using social media.** In Iraq, established social networks were used to gather information about gaps and community needs, and was important in ensuring that health and wider needs were met. There was a great deal of support from communities and from the Iraq private
sector was reported to be coordinated organically via social networks (usually making use of social media). This was an important forum for people to gather information about gaps and needs in their community and played an important role in ensuring that health and wider needs were met. Respondents gave examples of donation of funds and gifts-in-kind to cover needs for health (e.g. oxygen, personal protective equipment (PPE)) and non-health needs (food supplies). These approaches were complemented by the Iraq Information Centre58, used by the clusters as a vehicle to send awareness messages to IDPs and other crisis-affected populations.

- **Use of community health workers and volunteers in camps.** In Iraq, engagement with community health workers was reported to be focused on infection prevention and control measures in the first 2–3 months of COVID-19. However, health cluster partners began to receive information and concerns about people losing jobs, facing economic difficulties or facing mental health problems. This triggered a process of developing referral pathways to humanitarian actors and other service providers who could deliver support in mental health, psychosocial support, protection, food security and livelihoods.

- **National messaging on COVID-19 for RCCE.** In the Central African Republic, a taskforce was instrumental in the development of national messages on COVID-19. This was the product of close collaboration among the health and WASH clusters and the accountability to affected populations sub-group. Together this collective effort produced messages that were signed off by Government at national level. A similar approval process for the approval of health messages was in place in Sudan, where as part of a national RCCE strategy to strengthen messaging, all materials needed to go through one channel of approval to avoid duplication. In addition to support the roll out of health messaging under the leadership of the Federal Ministry of Health, there was the engagement and active involvement of the Media Ministry.

**Key Finding 8. Technical guidance developed and shared by the health cluster and others supported the protection of communities, staff and volunteers from the spread of COVID-19**

There was a strong concern that humanitarian activities and workers could contribute to the transmission of COVID-19, especially in camp settings. This problem was often tackled by the health cluster, ICCG and other clusters, in keeping with the ‘do no harm’ guiding principle. In Mozambique, the Ministry of Health prepared a guide for assessing readiness of the COVID-19 response plan and existing capacities, this identified gaps at the health facility level including those requiring WASH input (e.g. handwashing facilities, waste management). There was a variety of indicators covering aspects such as health infrastructure, personnel and supplies. In Myanmar, a wide range of technical SOPs focused on risk communication and disease surveillance were developed in local languages for community volunteers supporting WASH, health, nutrition and food security activities in camp settings. In Iraq, the shelter/NFI cluster took the lead in developing guidance for construction workers to prevent transmission of COVID-19 in camp settings.

**Operational collaboration findings**

**Key Finding 9. All case study countries reported operational multisectoral collaboration, particularly at a sub-national level.**

Operational multisectoral collaboration was diverse and related to specific population group and risk

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58 The Iraq Information Centre was a humanitarian call centre hosted by UNOPS.
Factors. Examples included:

- **Adaptations were made to existing projects and health facility infrastructure to reduce the spread of COVID-19.** Existing humanitarian projects were adapted to the realities of COVID-19, especially from an IPC perspective. In Myanmar this included WASH, as well as health and nutrition interventions. In Mozambique and Sudan, support was provided to make adaptations to health facilities infrastructure, such as increasing handwashing facilities or altering patient flow through the facility to protect more vulnerable patients from contracting COVID-19, such as those with chronic illnesses.

- **Multisectoral collaboration supported the establishment and management of COVID-19 treatment, isolation/quarantine centres.** In Sudan, different sectors supported the establishment of isolation centres to reduce the transmission of COVID-19. The WASH sector provided WASH facilities, and the food security sector supported food for the isolation centre, while the health cluster ensured that minimum standards were maintained and that vulnerable groups could access the centres. In Iraq, the health and shelter clusters, with input from CCCM, protection, food security and WASH clusters, developed detailed guidance for “Establishment and management of quarantine and isolation areas.”59 And in Myanmar, similar guidance was produced by the ICCG, the interim operational guidance for quarantine and isolation in IDP camp settings60 as IDPs were quickly recognized by humanitarian actors as subject to specific needs and risks due to COVID. This document was published by the ICCG in May 2020 and lays out risks and recommendations for the humanitarian community to consider in their operations. It was built on the guidance issued by the Ministry of Health and Sports and WHO.

- **Multisectoral collaboration supported the establishment of camps for new internally displaced people.** For example, following escalation of fighting in Cabo Delgado in Mozambique, ensuring that they had measures in place to reduce the transmission of COVID-19 and support IDPs access to health care, including treatment for COVID-19 illness. In Myanmar the camp management authorities and agencies often triggered operational multisectoral collaboration initiatives. These included the establishment of quarantine facilities requiring support from health, WASH, shelter and food security and provision of food in hospitals caring for COVID-19 cases requiring support from health, WASH and food security/World Food Programme (WFP). There were examples of referral pathways being put in place at the camp level, for example health workers (mobile clinic staff working for local NGO undertook nutrition surveillance in camp populations and referred severe and moderate malnutrition cases to an international NGO (INGO) providing nutrition services.

- **Multisectoral collaboration supported health logistics.** In Mozambique, a specific logistics cluster was formed at one sub-national level to manage logistics issues across the active agencies, led by the provincial health authority to ensure the continued supply of key commodities to health facilities. In Burkina Faso there was a pooling of transportation resources to circumvent the restrictions imposed by containment measures and continue the implementation of humanitarian activities.

### 4.2.2 Findings focused on multisectoral collaboration for other outcomes

These additional findings are not specific to multisectoral collaboration for health outcomes. However, since they emerged as key themes in country case studies they are outlined here.

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There was increased and more diverse multi-sectoral collaboration during COVID-19.
Half of the case study countries (i.e. Iraq, Mozambique and Myanmar) reported greater and more diverse collaboration across multiple sectors during the COVID-19 response. There was a wider participation of actors recognizing that the broad impact of COVID-19 demanded a whole-of-society approach. This included a wide range of government ministries, the development and private sectors, and civil society. In Myanmar, civil society organizations (CSOs) and community-based organizations (CBOs) played a critical role in complementing the government-led response across multiple sectors, especially during lockdowns and periods where movement restrictions were in place. In Mozambique, it was reported that there was more participation from a wider range of actors, including those regarded as less traditional actors, such as different ministries (e.g. Defence, Interior and Justice), law enforcement, the private sector and civil society.

There was a more diverse range of multisectoral initiatives undertaken that were led by various sectors/clusters during the COVID-19 response. In Iraq there was a more diverse range of multisectoral initiatives and actors during the COVID-19 response. Some of these were initiated by the health cluster or partners. For example, WHO/health cluster put in place a range of SOPs and trained security personnel manning city checkpoints on how to identify and refer potential cases of gender-based violence (GBV) using a referral pathway developed in collaboration with the GBV sub-cluster. In Mozambique, the health cluster and partners worked with the protection cluster to ensure safe access to sexual and gender-based violence (SGBV) services.

A key enabling factor for multisectoral collaboration was the availability of COVID-19-specific funding.
Most countries reported the enabling value of specific COVID-19 funding. In the Central African Republic this was used to fund a planned multisectoral strategic vision when in 2020 and 2021 US$14m from OCHA core humanitarian funds was allocated in support of these plans. These funds were distributed across all sectors, and it was regarded as one of the most important factors motivating multisectoral collaboration. In Myanmar, 29% of the Myanmar Humanitarian Fund US$16.3M was allocated to COVID-19-related projects across sectors including WASH, health, food security, cash assistance, education and protection (GBV prevention and response). Pre-existing coordination mechanisms (e.g. ICCG, coordination of humanitarian donors), and operational collaboration with the WASH and nutrition clusters, made it possible to rapidly mobilize funds (jointly in particular), to coordinate quickly and that the capacities and roles of each are quickly identified to be operational promptly and to reach the affected populations in Burkina Faso.

In Iraq, where a very diverse range of multisectoral collaboration initiatives were reported by different actors, those organizations with flexible funding and multisectoral capacities were able to make significant contributions to multisectoral priorities, for example, and many respondents reported the Iraq Humanitarian Fund to be an important support mechanism (especially from around September 2020) after the plan to establish quarantine and isolation areas in IDP camps was put in place. In Mozambique, there was a coordinated multisectoral response and mobilization of resources to create an IDP camp in Cabo Delgado.

However, there was not always flexible and timely funding to support operations. In Mozambique, one interviewee stated that resources facilitated through COVAX alleviated some of that pressure. They added that prior to COVAX, even when vaccines were procured, there was a lack of funding to cover the operational costs of implementing the planned vaccination campaign despite roll-out plans being in place.
There were also shortages in funding to non-health sectors. In Central African Republic this affected their role in the response and their participation in coordination mechanisms such as through the COVID-19 taskforces. In Sudan, there was a lack of funding to support for education or WASH programming, as well as programming in remote areas.

Another problem faced with regards to funding was inflexibility in mobilizing and reallocating funds. In Iraq, one interviewee stated that delays in funding and provision of supplies to the country limited COVID-19 programming. Another stated that funding shortages prevented them from covering some of the gaps and needs identified in the national health system, especially at the sub-national level. In Mozambique, this had a significant impact on WASH, specifically the provision of purified water to local communities, as was cited as a challenge by a variety of interviewees.

There were challenges in funding to local organizations that undermined their potential contribution to multisectoral initiatives. Additionally, resources were reportedly concentrated in secure, easy-to-reach areas. The response in remote areas with access issues lacked human and material resources, especially as the lack of access limited the presence of NGOs in these areas, which undermined multisectoral collaboration (Central African Republic and Sudan). For example, in Sudan, it was hard to deliver a multisectoral response in remote areas, due to a lack of funding or presence of, for example, a WASH actor to support WASH facilities in health facilities and schools, especially in those areas where there were only government facilities. While there was good collaboration in other areas, with additional funding this could have been increased and it was a challenge to mobilize resources right away. In Iraq, existing humanitarian actors generally did not have the capacity to oversee multisectoral response operations focused on establishment of quarantine and isolation areas at camp level. Most humanitarian actors had capacity in one area only and not across all required sectors (such as health, shelter and WASH). The HCT agreed that the Iraq Humanitarian Fund (IHF)61 would support several consortium-based multisectoral interventions, each bringing together sectoral components led by different agencies. While this worked in some instances, there were implementation delays at several sites due to agency-level delays in procurement and delivery of key supplies. This frequently undermined the effectiveness of the intervention.

Other observations

There were also several apparent outliers in the data (points that were highlighted in only one or two countries) that are nevertheless relevant to report:

- **Strategic/coordination/operational:** The establishment of national strategic collaboration structures in the Central African Republic was broadly perceived as being positive. A COVID-19 taskforce was established in April 2020, created and co-chaired by the health and WASH clusters and involving most other clusters. The focus of the task force was very practical and focused initially on how to maintain existing humanitarian operations in a COVID-19-safe manner, as this was felt to be most appropriate to the national context (e.g. the design of isolation centres in case they were needed). This example demonstrated good joint working with the shelter clusters. However, it proved difficult to sustain COVID-specific coordination structures as other humanitarian concerns took precedence over COVID-19.

- **Strategic:** In Burkina Faso, the Government established an “Action Humanitaire” (Humanitarian Action) committee, which was an important venue for multisectoral collaboration discussions. Representatives from WHO and HCT (UN Resident Coordinator) were invited to this committee. Approaches discussed at this level were translated at operational level where possible.

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61 The Iraq Humanitarian Fund (IHF) is a pooled fund led by the Humanitarian Coordinator (HC) and managed by OCHA.
– for example joint funding allocations were made to multisectoral programming approaches as a result.

• Coordination: In Iraq and Mozambique, multisectoral collaboration benefited from lessons learned from prior emergencies and learning from other countries. For example, in Mozambique, there were clear structured collaboration mechanisms that built upon existing structures and working groups, adapted to the COVID-19 response and incorporating lessons learned from previous emergencies (e.g. cholera outbreaks and cyclones), these mechanisms were replicated at sub-national levels.
4.2.3 Cross reference with multisectoral collaboration materials in Health cluster guide

Lastly, in each case study country data was examined in line with the two ways of looking at multisectoral collaboration presented in the Health Cluster Guide. The guide outlines four approaches to integration: coherence; convergence; complementarity; and combined. In the country case studies there was a wide range of practice in the first three categories but less in the “combined” approach. Some technical guidance documents set out to encourage combined approaches (e.g. in roll out of quarantine and isolation areas in IDP camps), but evidence of frameworks for implementation were not commonly referenced. Where consortium approaches were employed, they had mixed results. For example, the consortia built in Iraq for IHF proposals to fund setup of quarantine and isolation areas was broadly in keeping with a combined approach but had mixed levels of success due to contextual and agency level challenges.

The guide also outlines sequential steps for integrated programming. Table 3 summarizes the extent of evidence for each step found in case study countries.

<table>
<thead>
<tr>
<th>Sequential steps required for effective integrated programming for better health outcomes</th>
<th>Case study countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Carry out joint or harmonized assessment and analysis of the health status and vulnerability of the affected population(s) and underlying contributory causes.</td>
<td>Substantial evidence in some countries and online survey</td>
</tr>
<tr>
<td>• Jointly prioritize the most vulnerable geographical areas and target populations for a multisectoral integrated response.</td>
<td>Substantial evidence in some countries and online survey</td>
</tr>
<tr>
<td>• For each geographical area and target population, jointly define the priority health problems and various interventions required to address the problems and their various contributory causes.</td>
<td>Substantial evidence in some countries</td>
</tr>
<tr>
<td>• Define the specific responsibilities of each cluster or sector, and the strategic and operational linkages between the clusters and sectors for collective action.</td>
<td>Substantial evidence in some countries</td>
</tr>
<tr>
<td>• Develop and implement an integrated response plan and budget, for increased cost-effectiveness.</td>
<td>Limited evidence (example identified in Iraq)</td>
</tr>
<tr>
<td>• Monitor and evaluate the integrated response plan in terms of progress towards the health outcomes, while addressing the potential for double counting in the monitoring and evaluation framework.</td>
<td>Limited evidence (example identified in Iraq)</td>
</tr>
<tr>
<td>• Ensure that, in most humanitarian contexts, the health cluster works at a minimum as part of an integrated response with the water, sanitation and hygiene (WASH), nutrition, protection, and food security clusters, and with the support of the logistics cluster.</td>
<td>Substantial evidence in some countries and online survey (CCCM &amp; shelter/NFI clusters played a key role in multiple countries)</td>
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Table 3. Extent of evidence identified in case study countries for each integration step in the health cluster guide

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4.2.4 Concluding comments
The findings most relevant to multisectoral collaboration for health outcomes are flagged above and span all categories, including strategic, coordination, technical and operational. It is noteworthy that the highest number of collaboration adaptations focused on health outcomes were identified at the operational level.

The following are concluded to be the multisectoral collaboration adaptations that were most likely to contribute to health outcomes in the COVID-19 response so far.

- Leadership of multisectoral collaboration by ministries of health.
- Use of SPRP pillars under government leadership.
- Multisectoral collaboration driven by community feedback and engagement in needs assessment, surveillance and in the design of public health measures.
- Health sector leadership of technical guidance for health and other sectors. Examples included SOPs, guidelines and protocols, focused on assessing preparedness/readiness, case management, quarantine and isolation, and IPC measures.
- Adaptation of existing projects and health infrastructure to reduce transmission of COVID-19 and protect the delivery of essential health services.
- Multisectoral collaboration focused on the establishment and management of treatment and isolation centres to reduce the transmission of COVID-19.
- Problem solving by multisectoral groups on logistics challenges.

While global guidance and tools such as the SPRP, GHRP and the basic information package produced by the Global Cluster Coordination Group (GCCG) were mentioned by several key informants, they were generally not prominent as key findings. This does not mean they did not play an important role but could instead be a reflection of the key informant profile. The main exception is the pillar approach introduced in the SPRP, which was evident in several coordination structures in case study countries.

It is also important to highlight that while there was evidence of many of the integration steps in the Health Cluster Guide being taken, there was limited evidence from the study of clusters developing integrated response plans and budgets or supporting the monitoring and evaluation of integrated response plans.
4.3 Challenges faced and how they were tackled

Specific criterion: What were the challenges faced in multisectoral collaboration in the COVID-19 response in humanitarian settings and how were they overcome?

4.3.1 Synthesis of challenges faced

Challenges were discussed in KII for each country case study. Where multiple key informants (usually three or more) highlighted a challenge, these were recorded. The challenges faced in each case study country are grouped and synthesized in Table 4. Some additional challenges not specific to multisectoral collaboration have also been included in Table 5.

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes in multisectoral collaboration challenges reported by key informants</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic</td>
<td><strong>Initial assumptions about the impact of COVID-19 were not accurate for Central African Republic because of its demographic profile.</strong> Planning premises were difficult given that models for the transmission of COVID-19 were developed for very different populations profiles. For example, the Central African Republic has a comparatively small number of people over 60 and a comparatively high number of people under 25. This meant that the humanitarian community did not have a clear idea of the scale of the problem they needed to address. In addition, models did not consider issues of poverty, conflict and access of the scale they are experienced in the Central African Republic.</td>
<td>Central African Republic</td>
</tr>
<tr>
<td>7 reported</td>
<td><strong>Relevance and relative importance of COVID-19 to population faced by acute humanitarian needs.</strong> For example, in Burkina Faso there were difficulties implementing the COVID-19 response at provincial level due to the fact the disease was perceived as low risk and as a “wealthy disease”. The lack of knowledge and poor communication about the disease at the beginning of the COVID-19 response led to a sense of mistrust among the population and low adherence to measures to protect against the disease. Thus, when the vaccination campaign was launched, preceded by a significant “infodemic” (with a mixture of true and false information), the population had very little adherence to the vaccination process as it was perceived as not useful and sometimes even dangerous. In the Central African Republic, the reduced relevance of COVID-19 in a country with deep underlying problems meant that maintaining focus on COVID-19-related issues was difficult. This was successfully overcome in the early months of the pandemic but the decline of the COVID-19 response coordination system in late 2020/early 2021 was partially attributed to a sense that COVID-19 was not an issue of primary relevance to the population. In Myanmar, this was a change that emerged following the military takeover, as the population faced conflict and displacement and the focus</td>
<td>Burkina Faso, Central African Republic, Myanmar</td>
</tr>
</tbody>
</table>

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63 This was not possible in CAR or Sudan due to the number of KII.
changed to acute emergency needs such as provision of food/cash assistance, and while COVID-19 was deprioritized. Additionally, the scale of humanitarian needs increased significantly and there were shortfalls in the humanitarian funding required.

**Limited role of NGOs and local civil society organizations (CSOs), community-based organizations (CBOs) and other community organizations in the national COVID-19 response plan.** In the period prior to the military takeover in Myanmar, some health cluster partners reported that the role of NGOs, CSOs, CBOs and other community organizations was not clearly identified in government plans to respond to COVID-19. Local organizations were very active throughout the response, playing a role in dissemination of health information, providing volunteer services at community quarantine centres, providing food and other support, providing psychosocial support and other activities. They were often the only actors with access to communities during lockowns. A Dec 2020 report by a local NGO involved in coordination of CSOs recommended that a multisectoral approach to COVID-19 is needed to enhance localization and recommended improved collaboration between local organizations, local authorities and government going forward.

**New engagement principles for UN with government following military takeover in Myanmar.** While the new engagement principles for UN with the Government allows collaboration for the COVID-19 response, during the period immediately following the military takeover in February 2021 there was confusion/reluctance to continue engagement with the Ministry of Health. Additionally, the civil disobedience movement, which included civil servants and health care workers, led to significant disruption in health care services. The effect of both the reduced engagement by the health cluster and WHO, and the disruption of the health care services at multiple levels (national, regional and local), had the effect of creating huge information and collaboration gaps.

**Coordination**

9 reported

**Parallel coordination processes** (UN- and government-led). For example, in the Central African Republic, the parallel processes run by the UN-led cluster system and the government meant that, at best, cluster lead agencies and other international representatives needed to duplicate their efforts on coordination. The importance of ensuring that the government coordination and leadership signed off all plans, guidelines and messages also meant that the ICGG and the COVID-19 task force had less flexibility than they felt they needed. Some cluster partners were reluctant to be involved or influenced by the government process as they believed it was too politicized.

**Limited engagement of other sectors during the initial phase of the COVID-19 response and burden of response fell on the health sector and cluster** (especially in first 4–6 months). Despite a multisectoral structure and coordination with other clusters, the response did not really take a multisectoral approach. Instead, it felt more multi-agency/inter-agency. Initially there was stronger engagement, however the pillar approach lacked clarity, with pillars and agencies identified but not sectors. This ambiguity meant that when the restrictions of movement and lockdowns were put in place, two to three
months after the response began, there was less engagement – leading to it being described as a health response with some elements from other sectors. Over time, this changed as the impact of COVID-19 and its wider implications became more apparent, and it started to affect food security, women, access, and the economy, then other sectors began to engage more, such as through provision of cash distributions, for those who lost their jobs (e.g. taxi drivers, those working in restaurants).

**Government coordination of multisectoral initiatives. Unclear process and decision-making structures** (both between ministries and between the national and sub-national levels). In Burkina Faso, on the government side, there were too many entities involved in coordination led by the government at the beginning, which required outside help to streamline the coordination structure. In Mozambique, an ongoing decentralization process led to confusion at the sub-national level, where the process of decentralization of the government had doubled all institutions, resulting in a lack of clarity on which departments could authorize projects, with some overlap and competition over resources. In Myanmar (prior to the military takeover), when a multisectoral collaboration by health cluster partners required involvement or approval of ministries other than health, nutrition or WASH (which were all the responsibility of MoHS and/or State Health Dept) there were delays or impediments in getting approval from the relevant ministries (e.g. Ministry of Education and Ministry of Social Welfare, Relief and Resettlement).

**Difficulties in implementing the ‘One Health’ platform.** were found in Burkina Faso. This was felt to be due the concepts not being sufficiently thought through, and that adjustments were needed, entailing additional work including determining at which level should the platform be, for example at the level of the Prime Minister or the President. There were also difficulties due to delays in institutional and legal processes.

**Technical 5 reported**

**Working with uncertainties about COVID-19 and provision of accurate technical guidance** (in first 6–8 months of pandemic in particular). For example, in Iraq, and given that COVID-19 was a new disease, there was a degree of trial and error in the first six months of the response. Not all technical questions could be clearly answered. One respondent stated that the approach by the clusters was a bit slow and reliant on trying to base plans on perfect analyses, which was not realistic.

**Limited multisectoral capacities/agencies.** Establishment of quarantine and isolation areas in IDP camps progressed faster where there were agencies present with capacity across multiple sectors. In other IDP camps, health cluster partners had to coordinate with other organizations with WASH, shelter, construction and food assistance capacities to establish quarantine and isolation areas. The required interagency coordination took extra time and slowed down implementation in a number of IDP camps.

**Lack of available technical expertise (staffing) for key areas such as IPC.** There were significant challenges in human resources. COVID-19 was new and the expertise for the response in key areas (such as IPC) and coordination between the different sectors was challenging because those with required expertise were not available or delayed in deploying.
Additionally, everyone was learning how best to deal with COVID-19. Coordination improved as experience was gained.

**Operational Challenges**

**Implementation process for quarantine and isolation (Q&I) areas in IDP camps was very inconsistent.** This was the main multisectoral collaboration challenge outlined by interviewees in Iraq. Some Q&I areas were established relatively quickly (within 1–2 months), primarily as for example, a health cluster partner had capacity to deliver all the health, shelter and WASH components needed for a Q&I area. However, this was exceptional as most health cluster partners lacked capacity across multiple sectors. The implementation of Q&I areas in most camps was generally a challenging experience, with some areas taking over six months to be activated and some being abandoned in 2021 as no longer needed. Challenges included: difficulty forming a consortium that could cover all the sector components required; supply chain and site planning issues, and challenges with the food security component of the Q&I area, for example food differed in Q&I areas than in the rest of the camp (dried food ration opposed to cooked/hot food).

**Challenges with limited supply chain and lack of preparedness** (e.g. tents, shelter materials, medical consumables, personal protective equipment (PPE), water).

There was limited relevant preparedness in Iraq for the type of response identified (i.e. Q&I areas in camp settings). One interviewee highlighted that preparedness measures for a cholera outbreak (e.g. large tents, construction materials, WASH equipment, medical consumables, PPE) would have been highly adaptable to the needs in the COVID-19 response. The latest cholera outbreak in Iraq was three years ago and subsequently key stocks were not maintained.

In Mozambique, there were inadequate supplies such as PPE, for staff. Some supplies were hard to obtain or delayed, for example, WASH actors struggled to obtain enough water.

**Lack of flexible and timely funding to support operations,** with a lack of funding for the implementation of activities, for example, vaccines were supplied but there was a lack of funding to conduct the campaign. In addition, agencies that wished to adapt existing programmes towards the COVID-19 response needed approval (from their head offices and donors) which was often hard to achieve.

**Access to key populations and availability of staff during lockdown.** In Mozambique, there were inadequate staff due to movement restrictions, issues with access etc. Agencies’ biggest challenges were the movement restrictions, and the resulting inability to move staff. They faced problems getting people back from leave, and absences due to sickness and quarantine restrictions, this affected both COVID-19 and non-COVID-19 programming. In Sudan, it was hard to identify a WASH actor to support WASH facilities in health facilities and schools. In Myanmar, humanitarian needs emerged in a wider range of locations in the country following the military takeover, due to conflict and displacements. Humanitarian actors’ access to populations in need has been hampered by insecurity, disruption to the banking system, road blockages, visas for foreign staff and other access restrictions.
Difficulty obtaining secondary information on the (non-health) impact of COVID-19. The study notes that the recognition of the multisectoral impacts of COVID-19 (i.e. outside the health sector) took some time. The first assessments and studies were not published until May 2020.

Responding in remote areas difficult due to lack of presence of key capacities. For example, it was hard to deliver a multisectoral response in remote areas, due to the lack of presence of a particular sector such as a WASH actor to support WASH facilities in health facilities and schools, especially in those areas where there were only government facilities.

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Other challenges reported</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination</td>
<td><strong>Major shift of context bringing changed cluster membership.</strong> Following the military takeover in February 2021, engagement with the Ministry of Health was significantly reduced. Additionally, there was an increase in the number of local organisations (CSOs, CBOs etc) interested to be part of the health cluster. Cluster membership grew significantly throughout 2021 and 2022, with a large number of people joining virtually from remote locations (due to access and security issues in country, and due to visa challenges for expatriate staff).</td>
<td>Myanmar</td>
</tr>
<tr>
<td></td>
<td><strong>Reliance on virtual meetings reduced interactions and limited participation.</strong> For example, people faced internet connection issues or a lack of computers, phones or internet access to enable participation. There were reports of lower engagement during meetings.</td>
<td>Mozambique</td>
</tr>
<tr>
<td>Technical</td>
<td><strong>Developing standards for a large volunteer health worker role in the response.</strong> The reliance on volunteers to sustain health service delivery following the military takeover led to a range of issues around technical standards and incentives being offered to volunteers. This is an ongoing discussion topic with work currently underway to harmonize approaches with the objective of harmonization of approaches across clusters.</td>
<td>Myanmar</td>
</tr>
<tr>
<td>Operational</td>
<td><strong>Weak disease surveillance systems.</strong> Public health information was evolving quickly and there was a constant demand for data and information that could not be fulfilled given the weak systems for information gathering. This was a continuing challenge compounded by a lack of testing facilities and was never overcome satisfactorily. Surveillance tools such as the Integrated Disease and Response System/Early Warning System were not adapted to the evolving trend of the epidemic. The case definition remained the same in 2022 as at the beginning of the epidemic, the influenza surveillance sites kept the same configuration.</td>
<td>Central African Republic</td>
</tr>
</tbody>
</table>
Building trust with communities about COVID-19 and compliance with public health measures was challenging. Several key informants in Burkina Faso mentioned the need to improve risk communication. The challenge of maintaining the population’s trust and the tendency to switch to unreliable sources of information was highlighted, particularly regarding the risks that this management of information during the COVID-19 pandemic poses for future vaccination campaigns (e.g., measles), with a mistrust of vaccines that has been reinforced in a context where vaccination has been subject to many rumours and has generated very little adherence.

In Iraq, there were challenges for health cluster partners when they were asked to work in a camp in which they did not have prior experience. It was difficult to build understanding and trust with a new community, especially during the period of lockdown/movement restrictions. One health cluster partner tackled this challenge by working very closely with the relevant Department of Health in the area. Additionally, community and agency interest in COVID-19 declined quickly during 2021 after lockdowns were ended.

In Mozambique, it was reported that there was a lot of stress and rumours, which meant responding agencies could spend a lot of time resolving misinformation rather than responding. There was a great challenge due to a lack of compliance with preventative measures, namely, social distancing, hand washing. It was felt that people stopped complying with the measures, in part due to misinformation as it cascaded down from the international level to the national level. This was despite, efforts to adapt IEC materials to the local context and provide messages in all languages.

<table>
<thead>
<tr>
<th>Lack of WHO/Health cluster surge capacity.</th>
<th>Myanmar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some respondents suggested that WHO and the health cluster would have benefitted from additional surge coordination capacity at the national level to manage COVID-19. A related challenge was continuity gaps between key personnel departing Myanmar and their replacement arriving.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resource limitations.</th>
<th>Central African Republic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing available financial resources was a challenge. This resulted in overstretched public services. For example, the need to ensure testing for travellers coming into the country at points of entry, meant that the government’s donor imposed free PCR serological tests for travellers in the only governmental laboratory, while the same tests were chargeable at the Pasteur Institute laboratory in Bangui. This led to increased frustration among national laboratory staff who felt their workload increased without any compensation.</td>
<td></td>
</tr>
</tbody>
</table>

Table 5. Additional challenges highlighted in case studies (not specific to multi-sector collaboration)

Some of the case studies also flagged outliers that were not highlighted by multiple stakeholders but were assessed to be important to highlight. The outliers are summarized in Table 6 and are divided into those faced in multisectoral collaboration as well as more general challenges.
There is a lack of a legal framework and guidance to ensure the structures, for example public health emergency operating centres (PHEOC) can effectively coordinate a response (government/MoH). PHEOCs exists on paper but have not yet been fully implemented. Similarly, the taskforces are not institutionalized, but are typically ad hoc for each emergency.

Cluster meeting schedules clashed, limiting multisectoral collaboration opportunities. Generally meeting clashes were resolved quickly but when key sectors such as WASH and health could not attend each other’s meetings this had a negative impact (reported for a sub-national cluster).

Multisectoral collaboration by clusters/humanitarian actors was geared to coordination and planning, not operations and implementation. The platforms were mostly for coordination where tasks were discussed in the multisectoral platform, but implementation was conducted by individual agencies.

Access in insecure areas. Accessing some districts in north of Cabo Delgado was a challenge due to violence, so there was no direct access to communities in high-risk areas. Although this is not specific to COVID-19.

Provision of technical training on COVID-19 by WHO to health cluster partners and local organizations could not be delivered at scale. WHO offered a wide range of training to health cluster partners. This included multisectoral topics such as home-based care for COVID-19 patients. However, some of this was provided face-to-face and limitations were placed on the number of participants. Multiple health cluster partners suggested that technical training could reach more relevant people if conducted online without number of agency participants being capped. There were also requests to provide training on an ongoing basis to support new hires, rather than training being done on a one-off basis.

Availability of testing facilities for COVID-19 leads to patchy information on transmission/trends. Although not strictly a multisectoral collaboration issue, limited availability of testing in Myanmar made management of the pandemic challenging throughout as early warning and action was hampered by patchy information about disease transmission.

Table 6. Less commonly reported challenges to multisectoral collaboration, by case study country

### 4.3.2 Concluding comments

A very wide range of challenges was reported. Much of this diversity can be attributed to varying country contexts, operating environments and the local public health measures adopted for COVID-19.

**Operational challenges.** More operational challenges were reported as key findings in country case studies than for the other three categories (13 sets of challenges were categorized as operational). Specific
types of operational challenges were diverse, but two types of operational challenges were reported across three country case studies:

- **Building trust with communities** about COVID-19 and compliance with public health measures was challenging (reported in Burkina Faso, Iraq, Mozambique) and generally tackled via RCCE, translation of materials, working with CSOs and community feedback mechanisms.
- **Access to key populations and availability of staff during lockdowns** (reported in Mozambique, Myanmar and Sudan) and generally tackled via virtual meetings/coordination, digital data collection, and close cooperation with community organizations.

**Strategic and coordination challenges.** There were nine instances where strategic challenges were highlighted by multiple interviewees, and seven instances of coordination challenges. One strategic challenge and one coordination challenge was reported in three or more countries:

- **Strategic:** Relevance and relative importance of COVID-19 to population faced by acute humanitarian needs (reported in Central African Republic, Myanmar (following the military takeover) and Burkina Faso). This was a difficult challenge to tackle as funding was short and had to be prioritized for the most acute humanitarian needs in each country, which did not always include COVID-19. In addition, there was many other issues to be managed for the communities.
- **Coordination:** Government coordination of multisectoral initiatives. The decision-making process and structures were unclear between ministries, and between national and sub-national levels (reported in Burkina Faso, Mozambique and Myanmar). This was generally tackled by trying to offer support and advice, and bringing stakeholders from multiple sectors, ministries and levels into health cluster meetings. However, it was often a difficult issue for the health cluster and partners to influence.

**Technical challenges.** Technical challenges were reported by respondents less frequently than the other types of challenges. Of the countries that reported challenges, these centred on the lack of information on how COVID-19 (as a novel-virus and disease) would affect people and the wider multisectoral implications it may have:

- Public health information was evolving quickly and there was a constant demand for data and information, which could not be fulfilled given the weak systems for information gathering that were available (e.g. in the Central African Republic). In the early days of the outbreak there was a tendency for each cluster to develop its own protocols for some issues, such as social distancing. This was overcome by the establishment and leadership of the COVID-19 task force.
- Challenges related to provision of accurate technical guidance were reported in Iraq. Given that COVID-19 was a new disease, there was a degree of trial and error in the first six months of the response. Not all technical questions could be clearly answered. This challenge was tackled by ensuring a steady flow of information and clearly indicating where there was uncertainty. One UN agency representative interviewed stated that the approach by the clusters was a bit slow and was reliant on trying to base plans on perfect analyses, which was not possible in this situation. In the event of a new/novel disease outbreak in the future there should be a more flexible approach that encourages action, iteration and constant adjustment.
- Difficulty in obtaining information on the secondary impact of the pandemic. It was reported in Burkina Faso and Sudan that the recognition of the multisectoral impact took some months.

One of the reasons that technical challenges were not highlighted to the same extent as the other categories could be the fact that in some countries it was challenging to access key informants with first-hand knowledge of the first six months of COVID-19 responses, when technical challenges were probably the most pronounced.
In synthesizing the challenges, it was not always straightforward to categorize each challenge due to the diversity of ways they were described by interviewees. It is also noted that there is some overlap with the exploration of limiting factors (section 5.2). Lastly, it should be stressed that the exploration of challenges was a qualitative exercise so the categorization and counting of instances above should be treated with caution.
4.4 Good practices

Specific criterion: What were the good practices, and can they be applied in the future?

4.3.1 Synthesis of good practices highlighted

Good practices were discussed in key informant interviews for each country case study. Interviewees usually highlighted either a product (such as a guidance document) or a practice that they recommended for future application in response to disease outbreaks. Good practices have been grouped and synthesized below.

Strategic good practices

Relatively few strategic-level good practices were highlighted in case study countries, as compared to other areas. In Central African Republic, the WHO global guidance materials on COVID-19 were seen as a good practice because they helped inform and guide the MoH plans at the beginning of the pandemic, while also encouraging an alignment of UN and government plans. In Sudan, one of the recommended good practices for the future focused on preparedness across sectors/clusters for future disease outbreaks. It was suggested that every sector should be aware of the scientific background on existing/emerging viruses and should maintain an overview on disease transmission/epidemiology.

Coordination good practices

A wide range of coordination good practices were proposed in country cases studies. The main themes and examples are described below.

Overall UN–government coordination practices:

- **Sudan**: The coordination structure using the pillars approach was effective. At the beginning, there was a lot of issues with competing interests and the pillar approach helped at both national and sub-national levels.
- **Sudan**: Constant communication between sectors helped in catching and managing the ripple effects of COVID-19 while also responding to the wider socioeconomic impacts faced as a result of COVID-19.
- **Mozambique**: The high-level engagement from the Ministry of Health and the President helped the COVAX technical working group⁶⁴ to ensure good collaboration between government and partners. This collaboration, ensured that agencies were part of the process, collaborating with ideas, so they were able to respond to the government's expectations in terms of response. This in turn led to timely access to resources and greater complementarity and helped reduce duplication, which was essential given the limited resources.

Multisectoral coordination practices:

- **Myanmar**: Bringing non-health actors such as OCHA and UNHCR into meetings with state-level health directorates gave OCHA and UNHCR deeper insight into the health situation, while also encouraging the health directorate to consider the wider opportunities for multisectoral collaboration for health outcomes.
- **Central African Republic**: Close collaboration between health and WASH clusters at all levels led to stronger planning and response, for example through the provision of more effective hygiene services in IDP camps.

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⁶⁴ The vaccination technical working group (called COVAX and Pillar 9 in Mozambique) was led by the National Directorate of Public Health (DNSP) and co-led by WHO and UNICEF.
- **Burkina Faso**: Use of a matrix to suggest where collaboration between sectors/cluster could take place was helpful for triggering discussions between groups or two or more clusters.65
- **Sudan**: The leadership approach of WHO is to encourage multisectoral responses from the outset of outbreaks. The example of Ebola was also given where multisectoral collaboration involving the health cluster, the environment agency, and immigration authorities was a component of the response. When clear epidemiological information exists, it becomes easier to mobilize fast when other sectors expect they will be affected by the health situation.

**Technical good practices**

A range of technical documents and guidance were highlighted by key informants in country case studies.

- **Iraq**: Guidance on quarantine and isolation in IDP Camps.66 Several key informants found this to be a very helpful document that was developed quickly using the best available scientific information on COVID-19 combined with experience from responding to cholera. Informants stated that this document should be used as a start-point in the event of future disease outbreaks involving new or novel flu-like viruses in camp settings, which are highly transmissible. It is a useful resource where there may be a risk of local health facilities becoming overwhelmed in a disease outbreak.
- **Iraq**: Shelter cluster construction protocol for COVID-19. The shelter/non-food items (NFI) cluster led on establishment of guidelines67 to support site safety on construction projects following lifting of lockdowns.
- **Iraq**: Shelter cluster guidance materials on tent replacement. The shelter/NFI and health clusters collaborated to develop guidance on replacement of tents in camps to reduce risk of COVID-19 transmission.68
- **Myanmar**: Harmonizing support and guidance for community-level volunteers leading to the development of Curriculum on COVID-19 response for Myanmar Community Health Volunteers.69 This was a collaborative effort by health cluster partners, WHO, United Nations Population Fund (UNFPA), Myanmar Red Cross Society and various NGO/local organization networks. This was developed in the period after the military takeover at a time when local NGO/local organizations networks were playing a critical role in helping develop and disseminate this guidance, which was especially important for the response to the third wave of COVID-19. Alongside health-focused topics the curriculum covers topics such as volunteer safeguarding, community engagement, psychosocial support and protection (GBV, discrimination and stigmatization).

Alongside technical documents, broader technical practices were also highlighted:

- **Myanmar**: Investment in translation of key guidance materials was frequently highlighted as a good

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65 It is assumed that this matrix was the one launched by GCCG in 2020 as part of the Basic Information Package for COVID-19 (outlined in Section 3 of this report). However, it has not been possible to confirm this with key informants (they were possibly not aware of where the original document came from.


practice. Myanmar is very diverse in terms of ethnicity, culture and language. Health, WASH and nutrition clusters often worked together with the communicating with communities working group (coordinated by UNHCR) to translate emerging technical and scientific guidance into forms that could be understood and accepted by communities (using visual and other media where necessary). Such capacity was critical for effective RCCE in response to COVID-19.

- **Mozambique**: There was a strong emphasis by the Government in their leadership role, particularly towards ensuring that the overall multisectoral response was evidence based, with more rational, more cautious decisions. This was achieved through a combination of observing other countries' experiences, conducting field level evaluations and utilizing epidemiology and routine data. With points of entry, a balance was maintained, for example, there were some COVID-19 waves during which countries closed their doors to South Africa. In Mozambique, the Government felt that the risks were more likely to come from uncontrolled entry, so the borders were kept open, and it was easier to control who entered the country.

- **Sudan**: Request expertise and support early. The Federal Ministry of Health allowed partners and other experts to be part of the decision-making process. They knew they had a gap, and so sought support and additional expertise including health volunteers.

**Operational good practices**

Most of the operational-level good practices proposed by key informants were not truly multisectoral, being managed by health sector/cluster actors only. These are not included in this report. Examples of multisectoral good practices are listed below.

- **Myanmar**: RCCE Strong community engagement on COVID-19 at multiple levels proved critical for support to multisectoral RCCE work, which involved the health cluster, along with CCCM, communicating with communities working groups and the ICCG. Management of rumours was critical. Good practice examples included the approaches employed in Rakhine State by the communicating with communities working group and the collaboration with State Health Departments to monitor and respond to rumours on Facebook. There was a suggestion that the extent of community engagement in Rakhine during the first and second waves of COVID-19 decreased the impact of the third wave (in comparison to other parts of Myanmar).

- **Central African Republic**: At sub-national level, local partners worked together well across several sectors, as they had done before COVID. For example, in the delivery of effective handwashing stations in IDP sites.

- **Mozambique**: Collaboration to ensure the appropriate infrastructure was in place to:
  - Ensure the availability of key resources as needed, according to mapping (assessments of readiness), and provide details to share with other sectors (e.g. WASH to collaborate to ensure the availability water and a disinfectant were available at the entrance of each health facility, with an identified individual to monitor hand washing).
  - Put in place infrastructure and measures to enable patient flow, which allowed existing health facilities to safely accommodate both patients with chronic and noncommunicable diseases, as well as those with mild illness and unconfirmed COVID-19 infection. This involved the health sector working closely with the WASH sector.

Some operational good practices highlighted are multifaceted and hard to categorize, for example, in Central African Republic the development of national messages on COVID-19 by the health and WASH clusters and the integration of accountability to affected populations (AAP) approaches delivered strong and effective messaging. Another example was the integration of COVID-19 vaccination into routine EPI services. This had benefits in terms of community acceptance as well as financial efficiencies and helped the COVID-19 vaccination programme to reach more people. These examples have both operational and technical collaboration elements.
5. Findings: Enabling and limiting factors for multisectoral collaboration

Overarching question 2: What factors enabled or limited health cluster and health cluster partner engagement in multisectoral collaboration for COVID-19 preparedness and response?

To compare data from the case studies and the online survey, enabling and limiting factors highlighted in country case study KIIIs were categorized using the same list of nine options used in the online survey.

5.1 Enabling factors

The online survey highlighted a wide range of enabling factors. The most frequently selected was “collaboration triggered by the cluster coordination approach” (selected by 31% of respondents). Collaboration triggered by technical capacity, strategic plans, existing humanitarian partnerships and resources/funding were also selected relatively often but in general the distribution shows significant variation. The analysis of case study data revealed a similar pattern with “collaboration triggered by the cluster coordination approach” being the most referenced enabling factor and a wide range of other factors being selected with no discernible pattern across countries.

The case studies gave an opportunity to better understand the reality under each category. For example, the types of enabling factors triggered by the cluster coordination approach in case studies countries included the following.

- Clear and timely guidelines, plans and information updates by WHO/health cluster.
- Clear division of roles and responsibilities among partners/clusters.
- UN/WHO/health cluster leadership and coordination within humanitarian structures.
- UN/WHO/health cluster coordination with government.
- Online coordination meetings.
- Active engagement of international organizations.

Pre-existing multisectoral coordination structures, such as the Inter-Cluster Coordination Group (ICCG) and health cluster, were seen to have enabled collaboration, especially at the local level, and with the involvement of sub-national government authorities in Myanmar. This was similar in the Central African Republic, where multisectoral coordination occurred under the umbrella of Inter-Cluster Coordination Groups (ICCG) at the national and sub-national levels, including weekly coordination meetings that included all humanitarian clusters. In Burkina Faso, the consensus among informants interviewed was that collaboration was enabled by the existence of pre-pandemic coordination structures, including around the Ebola and dengue epidemics and operational collaboration with the WASH and nutrition clusters.

To navigate the heightened tensions following the military takeover in February 2021, the health cluster in Myanmar established an alternative coordination platform with humanitarian partners in March 2021 (the Health Operational Group). This reported to the humanitarian governance structure and was therefore a means for collaboration and coordination with other clusters such as WASH and nutrition, while maintaining minimal communication with the de facto military government. This had a positive impact on coordination, especially considering the environment of fear and caution that limited coordination and communication after the military takeover.
The majority of enabling factors reported in KIIs were areas where the health cluster had control or influence.

Figure 7 shows the enabling factors selected by survey respondents, whereas Table 7 summarizes the examples given in country case studies using the same headings. Table 7 is ranked but this ranking should be treated with a degree of caution because it is drawn from qualitative data.

Figure 7. Enabling factors ranking from online survey

\footnote{The survey question asked respondents to “Select the three main factors that enabled multisectoral collaboration”.}
<table>
<thead>
<tr>
<th>Enabling factors ( Ranked )</th>
<th># of references in KIIs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Collaboration triggered by cluster coordination approach</strong> (e.g. multisectoral needs assessments, strategic plans, multisectoral strategies). For example, in Sudan, clarity of global multisectoral guidance during the initial stages of the response enabled UN agencies to prepare country-specific CPRPs and strategies, establish coordination frameworks, and devise clear roles for each humanitarian sector and partners within them to address the response pillars. In Burkina Faso, the existence of framework documents such as the national response strategic plan, the humanitarian response plan, tools for standardizing activities, have enabled partners to respond quickly and prioritize activities concerning the COVID-19 pandemic while planning for both maintaining existing humanitarian interventions.</td>
<td>17</td>
</tr>
<tr>
<td><strong>Collaboration triggered by host government.</strong> For example, in Mozambique and Burkina Faso, enabling factors reported were often related to strong coordination among response actors and with the government. Committed government leadership, clear messaging, adequate assessments of needs and strengths, as well as the readiness to share resources among response partners made a considerable contribution to the response.</td>
<td>13</td>
</tr>
<tr>
<td><strong>Collaboration triggered by resources/funding.</strong> For example, in Iraq, pre-existing stocks and flexibility of pooled funds through the IHF allowed quick adjustments as new target areas and needs were identified.</td>
<td>13</td>
</tr>
<tr>
<td><strong>Collaboration triggered by operational capacity</strong> (e.g. consortium projects, shared use of facilities, volunteers and distribution mechanisms). For example, in Iraq, camp-level coordination structures were important for decentralized decision-making, operational decisions, access to remote areas. In Myanmar, one health cluster partner representative stated that multisectoral coordination mechanisms, like the ICCG helped facilitate logistical matters such as the procurement of medicines, PPE, etc.</td>
<td>11</td>
</tr>
<tr>
<td><strong>Collaboration triggered by technical capacity</strong> (e.g. multisectoral guidance, SOPs, protocols). For example, in Sudan, regular technical support and guidelines, such as IPC measures, provided by WHO enabled partners from multiple sectors to implement COVID-19 programming. In Mozambique it was reported that strong, flexible communication mechanisms enabled coordination, facilitated the identification of needs and existing capacities, and allowed for the timely sharing of appropriate measures and guidelines to multisectoral partners and local communities, making it a major contribution to the COVID-19 response.</td>
<td>11</td>
</tr>
<tr>
<td><strong>Collaboration triggered by existing humanitarian partnerships</strong> (e.g. cluster-to-cluster collaboration). For example, in the Central African Republic, multisectoral coordination occurred under the umbrella of Inter-Cluster Coordination Groups (ICCG) at the national and sub-national levels, including weekly coordination meetings which included all humanitarian clusters.</td>
<td>7</td>
</tr>
<tr>
<td><strong>Collaboration triggered by feedback from communities.</strong> In the Central African Republic, the multisectoral COVID-19 response was enabled by the engagement at the local and community level in the preparation the response. In Myanmar, one UN agency representative also cited the importance of working with local Ethnic Health Organizations because of their good reputation in their communities, facilitating risk communication and community engagement. Another iterated that health staff in hospitals across Rakhine state saw an important added value working with cohesive community structures. They facilitated the verification of rumours and misinformation through an CWC group operating under UNHCR, and communication of updates with the local communities in their local languages.</td>
<td>6</td>
</tr>
<tr>
<td><strong>Collaboration triggered by strategic plans</strong> (e.g. Global Humanitarian Response Plan/Humanitarian Response Plan). For example, in Myanmar, after the military takeover, the UN developed an Emergency Response Plan (between July–December 2021). Notably, throughout these plans, the pandemic itself was a strong motivator for enhanced multisectoral collaboration to address increasing needs.</td>
<td>6</td>
</tr>
<tr>
<td><strong>Collaboration triggered by donors/foreign governments.</strong> For example, in Burkina Faso, donors identified a favourable context where they could be involved in multisectoral collaboration initiatives. The World Bank was notably identified for having enabled the strengthening of strategic coordination and encouraged partners to commit.</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 7. Enabling Factors ranking from case study KIIs

54
5.2 Limiting factors

The online survey also highlighted a wide range of limiting factors. The most frequently selected factor was “collaboration triggered by resources/funding” (selected by 34% of respondents). This was followed by a wide range of other factors. The analysis of case study data revealed a similar pattern with “collaboration triggered by resources/funding” also being the most referenced limiting factor. This was followed by a wide range of other factors with no discernible pattern across countries.

As with the enabling factors, the case study data gave an opportunity to better understand the reality under each category. The types of limiting factor “triggered by resources/funding” included the following.

- Limitations arising from programming overlap, resource wastage, inefficient use of resources and funds.
- General shortages in funding and resources.
- Limited funding to non-health sectors.
- Shortages in vaccine supplies into the country.
- Limited funding and resources at the sub-national level.
- Limitations and inflexibility in mobilizing and reallocating funds and resources created competition over resources.
- Resources and funding shortages to local partners undermined their contribution to multisectoral collaboration.

The limiting factors reported during key informant interviews were a diverse blend of factors under the control of the health cluster and partners, under their influence, and external factors (which featured less in the list of enabling factors). Approximately twice as many limiting factors were reported in KIIs as compared to enabling factors.71

Figure 8 shows the limiting factors selected by survey respondents whereas Table 8 summarises the examples given in country case studies using the same headings. Table 8 is ranked but as before this ranking should be treated with a degree of caution because it is drawn from qualitative data.

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71 A total of 88 specific enabling factors were identified from KIIs, compared to 172 limiting factors.
The question asked respondents to “Select the three main factors that hindered/created challenges to achieving multisectoral collaboration”.

Figure 8. Limiting factors ranking from online survey\textsuperscript{72}
<table>
<thead>
<tr>
<th><strong>Limiting factors (ranked)</strong></th>
<th><strong># of references in KIIs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Collaboration triggered by resources/funding.</strong> For example, in Burkina Faso, key informants describe limited resources for setting up the response, with difficulty in sometimes reallocating existing funds despite existing clauses (multi-annual funding). These limitations on resources are described as having caused competition over the funds available with a “jostling” or “war” on funding between the various partners, which would persist after the pandemic. In the Central African Republic, resources were reportedly concentrated in secure, easy-to-reach areas. The response in remote areas (with access issues) lacked human and material resources, especially as the lack of access limited the presence of NGOs in these areas, which undermined multisectoral collaboration. In Iraq, limited funding and resources were further squeezed against the scale of emerging COVID-19 needs, which undermined the response in distant and underserved populations, including IDP camps. At the sub-national level, limited resources and qualified health staff limited multisectoral and health interventions. In Myanmar, repurposing and mobilizing funds and resources since 2020 was an obstacle considering restrictions arising from conflict and COVID-19 measures, the chronic underfunding of humanitarian plans in the country even prior to COVID-19, as well as obstacles arising from the country’s collapsed financial system and later restrictions on imports. Local NGOs working at the community level faced considerable resource and funding shortages, which undermined the sustainability of their projects.</td>
<td>37</td>
</tr>
<tr>
<td><strong>Collaboration triggered by cluster coordination approach</strong> (e.g. multisectoral needs assessments, strategic plans, multisectoral strategies). For example, in the Central African Republic, it was reported that the COVID-19 taskforce originally involved participation of partners from most clusters. But by 2021, the COVID-19 taskforces included mainly health and WASH cluster partners only. In Myanmar, several key informants described the COVID-19 response in Myanmar as very much health-focused, with multisectoral mechanisms being relatively limited in comparison, especially at the national level. In Sudan, multisectoral collaboration reportedly lacked leadership and division of roles across the various sectors and partners. Coordination mechanisms were reportedly unable to assign roles to partners according to their proven expertise and capacity. One respondent operating at the sub-national level stated that the COVID-19 response was too focused on health at the expense of other negative impact the pandemic had in other sectors, such as food security and livelihoods. In Iraq, at the sub-national level, lack of leadership on multisectoral collaboration was reported to be limited due to capacity constraints amongst the clusters and ICCG.</td>
<td>32</td>
</tr>
<tr>
<td><strong>Collaboration triggered by operational capacity</strong> (e.g. consortium projects, shared use of facilities, volunteers, distribution mechanisms). As urban areas in Sudan were the most affected by the virus, the response was focused there, and most specifically in Khartoum state, however most humanitarian agencies had no or limited presence here. This also may have distracted the response from other affected areas. In Burkina Faso, limited internet access, the distribution of staff on the COVID-19 response and humanitarian interventions, internal policies and the limited technical capacities of some partners in these contexts, have limited the ability to mobilize different actors in multisectoral collaboration and limited the ability of some actors to participate in the coordination mechanisms. The ability to mobilize human resources at the operational level with these constraints was also mentioned.</td>
<td>26</td>
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<tr>
<td><strong>Collaboration triggered by host government.</strong> In Mozambique for example, a decentralization process, underway since 2020, across all levels of governance in the country might have created confusion and added constraints and delays to the COVID-19 response. One interviewee stated that it was not always clear what the exact roles of each of the government entities were and whom they should be getting approval from for implementation. In addition, the MoH reportedly did not have official public health emergency operating centres, and the COVID-19 taskforces established under its umbrella were largely ad hoc, and lacked leadership, operational guidelines, and a clear legal framework and structure, which made it challenging to operative efficiently and led to approval delays. In Myanmar, on 28 October 2022, the Myanmar State Administrative Council (SAC) issued a new Organisation Registration Law (ORL) (State Administration Council Law No 46/2022). The new law made it illegal for NGOs to operate without registration, introducing severe criminal penalties for non-compliance. Many INGOs with expired registrations had applied for renewal since February 2021 but were informed that the registration process was suspended until the new law came into effect.</td>
<td>26</td>
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</table>
Collaboration triggered by technical capacity (e.g. multisectoral guidance, SOPs, protocols). For example, in Sudan, COVID-19 was a challenge to everybody, and technical expertise had to be developed along the way. This was also reflected in coordinating a multisectoral response to a virus that no-one had experience dealing with.

Collaboration triggered by feedback from communities. In the Central African Republic for example, RCCE reportedly lacked proper oversight especially regarding ensuring that information shared by partners with local communities are based on scientific evidence.

Collaboration triggered by strategic plans (e.g. Global Humanitarian Response Plan/Humanitarian Response Plan). For example, in Burkina Faso, the Global Humanitarian Response Plan was perceived by some informants as rigid and “heavy”. Some informants stated that they did not feel sufficient support from the GHC for the country to feel “accountable”. The coordination mechanisms were “top down” between the global, regional and country but there was limited ability to feed local insights into the planning process. In Myanmar, one local NGO representative stated that strategic response plans developed by UN agencies often lacked understanding of local contexts, often rendering them of less use by local actors. They added that the heavy red-tape and bureaucratic nature of UN operations was an obstacle against timely and flexible implementation of COVID-19 programming and addressing needs caused by escalated conflict.

Collaboration triggered by donors/foreign governments. A shift in US Government funding approach (i.e. under the Trump administration) impacted WHO adversely, significantly undermining the ability to rapidly mobilize funding and surge capacity in initial phase of COVID-19 in Iraq.

Collaboration triggered by existing humanitarian partnerships (e.g. cluster-to-cluster collaboration). For example, in Iraq, funding and coordinating some multisectoral interventions proved costly, laborious and eventually ineffective, as was the case with several quarantine and isolation areas. By the time they could be built, focus had shifted to vaccination, and fear of social stigma and shrinking livelihoods had begun undermining communities’ cooperation with restrictive health measures.

Table 8. Limiting factors ranking from case study KII s
6. Conclusions

The overall objective of this study is to better understand how multisectoral collaboration for COVID-19 responses has been occurring in humanitarian settings. This was explored by examining multisectoral collaboration in the response to COVID-19 in six countries where the health cluster is active, and through a global survey that was sent to all health clusters/sectors supported by the Global Health Cluster. The following definition was applied: Multisectoral collaboration is where actors representing two or more technical sectors, usually aligned to the humanitarian clusters or line ministries, work together to achieve a shared goal.

Overarching study question 1

How did multisectoral collaboration and action of the health clusters and health cluster partners evolve during the COVID-19 response to reach people affected by humanitarian crises?

The findings of this study underline the importance of getting coordination right before an outbreak or crisis occurs. Pre-existing coordination platforms such as the cluster, ICCG and government-led structures were critical for multisectoral collaboration during the COVID-19 response. The ICCG was cited as an important platform for enabling multisectoral collaboration in most case study countries. Humanitarian clusters that were established prior to COVID-19 were frequently highlighted as important enablers for multisectoral collaboration during the COVID-19 response. Health clusters were frequently singled out by respondents. Aside from coordination structures, pre-existing multisectoral relationships at national and sub-national levels helped to enable collaboration across the different sectors in the COVID-19 response. Outbreak and epidemic preparedness measures were often helpful where they existed and where they identified multisectoral collaboration.

When the COVID-19 pandemic hit, there was an initial period of adaptation at the strategic level when overall plans and national coordination structures were defined. This was frequently informed by global plans and guidance provided by the UN and the various national clusters, with the SPRP and its ‘pillars’ approach being commonly referenced as a useful guide to design of coordination structures. This study highlights the importance of complementary and joined-up leadership by government-led and UN-led humanitarian coordination mechanisms to help adapt multisectoral collaboration to meet the specific health and non-health needs of communities during COVID-19 responses. This resonates strongly with recently published research on how health systems respond to acute shocks and the type of leadership required to foster dynamic interaction between decision-makers, frontline workers and community members.73

The role of respective ministries of health and health clusters was prominent in multisectoral collaboration for health outcomes, but equally there is evidence of collaboration being initiated by other actors. Actors initiating or supporting multisectoral collaboration included non-health government departments and ministries, international organizations and other humanitarian clusters – with WASH, protection, CCCM and nutrition being the most frequently referenced. The WASH cluster was frequently cited as a key player in initiating and supporting multisectoral collaboration around IPC measures.

The Global Humanitarian Response Plan for COVID-19 directed humanitarian actors to work through

existing coordination structures where possible. Examples from this study show how the existing humanitarian clusters and government structures formed the backbone upon which multisectoral collaboration for health outcomes was based. This broadly correlates with the finding from the recent Inter-Agency Humanitarian Evaluation of the COVID-19 response that “in the context of a rapidly evolving situation, the humanitarian response was best served by working through existing coordination structures rather than seeking to adapt them”.74 However, there were also several examples of where adaptations such as taskforces and working groups brought different sectors together to collaborate to tackle key problems or issues. The SPRP pillars formed a useful reference point for these adaptations but were not used prescriptively. Taken together these conclusions are consistent with one of the documented lessons from Ebola epidemics: “No single coordination model has emerged as most effective but ensuring clarity of roles and responsibilities is important across contexts”.75

One of the most challenging areas for the health cluster and its partners has been operationalization of multisectoral collaboration. Nevertheless, the study highlights examples of how multisectoral collaboration has been operationalized, usually at the sub-national level, and with a high potential to support health outcomes. Equally, the good practices were diverse and difficult to codify, with each approach having been highly tailored to the local context and operating environment, which is perhaps the key message. Given the existing capacities of the health cluster it will not always be possible to closely support operational arrangements for multisectoral collaboration at the sub-national level. Nevertheless, examples from case study countries show that sub-national health clusters and a sub-national ICCG can have a huge added value where they do exist. Additionally, CCCM was often a key partner in roll out of COVID-19 preparedness and response and related multisectoral collaboration in camp settings at sub-national level.

The other related point to highlight is the importance of strong community engagement in the response to COVID-19. This has been a significant factor in supporting and sometimes initiating multisectoral collaboration. Case study countries highlight the relevance of community feedback mechanisms, rumour management/monitoring and careful translation of public health information. There are cases where community interface mechanisms such as communicating with communities and accountability to affected people working groups have played a key role in contributing to risk communication and community engagement. There was a need and opportunity to engage civil society in the response in all case study countries. However, in countries such as Myanmar, working with local NGOs and volunteer networks was also critical to reach populations where there was limited access for international humanitarian actors.

In terms of challenges, the COVID-19 pandemic clearly presented a very wide range of challenges in all countries. Many of the frequently reported challenges in this study were operational in nature. These were diverse across the case studies countries. However, the challenge of building trust with communities about COVID-19 and related public health measures, and the challenge of accessing key locations during lockdowns, were the most often cited. Several strategic and coordination challenges were reported and the two most frequently highlighted in country case studies were the relevance and relative importance of COVID-19 to populations facing acute humanitarian needs (reported in three countries) and government coordination of multisectoral initiatives, with decision-making structures lacking clarity (also in three case study countries).

Overarching study question 2

What factors enabled or limited health cluster and health cluster partner engagement in multisectoral collaboration for COVID-19 preparedness and response?

Data gathered in the case studies and global survey together give a picture of the main enabling and limiting factors experienced. The most frequently referenced enabling factor in both the survey and case studies was collaboration triggered by the cluster coordination approach. This included provision of guidance, plans and information by WHO/health cluster, clear division of roles among humanitarian actors and coordination between humanitarian actors and government. However, it is important to note that a wide range of other factors were also perceived as enabling for multisectoral collaboration, these include committed government leadership in the response; appropriate levels of funding; regular technical support and guidelines, such as IPC measures, to facilitate the implementation of multisectoral programming; strong, flexible communication mechanisms; and strong community engagement.

The most referenced limiting factor in both the survey and case studies was collaboration triggered by resources/funding. Key informants highlighted shortages of funding and resources, limited funding to non-health sectors, shortage of flexible funding at the sub-national level and competition over limited resources, as important limiting factors for multisectoral collaboration. However, a wide range of other limiting factor categories were also referenced, these included the lack of experience and knowledge of COVID-19 as a novel virus and related disease. Coordination challenges included: the reduction of the participation of other clusters in coordination mechanisms over time; weak multisectoral coordination mechanisms; that the COVID-19 response was too focused health at the expense of the negative impact the virus had on other sectors, such as food security and livelihoods. Operational constraints such as limited internet access, the distribution of staff on the COVID-19 response and humanitarian interventions, internal policies and the limited technical capacities of some partners in these contexts, reduced the ability to mobilize different actors in multisectoral collaboration and restricted participation in the coordination mechanisms. There were also challenges related to working with host governments – for example changes in laws and regulations for NGOs following the military takeover in Myanmar –that limited the scope of multisectoral collaboration and incomplete decentralization processes created confusion in Mozambique.

Other conclusions
This study has highlighted a very wide range of experiences, practices and perceptions on how multisectoral collaboration occurred in the response to COVID-19 in humanitarian settings. While there are common threads, there are probably more differences between groups of countries examined. For example, in Iraq and Myanmar, as compared to Sudan and Central African Republic.

The country case studies provide important information about what happened and what was learned about multisectoral collaboration in the response to COVID-19 and in each specific context. Given emerging understanding about the strong benefits of multisectoral collaboration in outbreak and pandemic responses, these case studies and the good practices highlighted in this report should prove useful in preparations for future outbreaks and pandemics, especially those involving contagious respiratory diseases.
7. RECOMMENDATIONS

The recommendations listed below build on recent reports by the WHO Director-General that set out a range of proposals to strengthen the global architecture for health emergency preparedness, response and resilience.\(^6\)\(^7\) These proposals strongly promote interagency and multisectoral collaboration and closely align to the International Negotiating Body\(^7\) process and associated pandemic treaty.

Recommendations are organized per actor group. Since some recommendations should be taken forward by multiple groups there is a degree of repetition. Each recommendation is followed with specific details and justification taken from the study findings.

7.1 Global Health Cluster and its partners

Multisectoral collaboration for health outcomes

- **Multisectoral guidance for health outcomes should be produced as part of the response to future pandemics.** Along with key scientific/technical information during COVID-19, this was important to help drive multisectoral collaboration initiatives.

- **The health cluster should plan to play a role in adapting technical guidance to specific humanitarian settings in future outbreaks and pandemics.** The country case studies show that country health clusters played a key role in adapting guidance for multisectoral collaboration in distinct types of humanitarian settings (e.g. conflict settings, displacement settings, settings with functioning government system). Building on this study, country level adaptations should be captured and shared for mutual learning.

- **Pillars of the type used in the SPRP can form a useful start point for county-level coordination in future outbreaks and pandemics.** The study shows that the SPRP pillars were useful as a guide to coordination and were applied flexibly at country level. In the future, guidance related to each pillar could specifically indicate what type of multisectoral collaboration is recommended, building on the findings of this study. It is recommended that health cluster coordination teams and partners are supported to develop their roles building on the experience of the pillar approach, and also informed by the recent proposals on health emergency preparedness and response,\(^7\) to enhance and foster multisectoral collaboration.

- **The Health Cluster Guide should be augmented with additional guidance and tools for multisectoral collaboration.** The Health Cluster Guide offers appropriate models for multisectoral collaboration driven by the health cluster. The information could be developed in two ways: (1) build specific user-friendly guidance on the role of the health cluster in multisectoral collaboration in outbreaks and pandemics, which could include checklists and tools which could be

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\(^7\) https://inb.who.int

used by the cluster teams in country; (2) add suggestions on how the health cluster could encourage other parts of the humanitarian system (ICCG, HCT) and government to lead multisector collaboration. Cluster coordinator training could also be developed to include multisectoral collaboration for pandemics/outbreaks.

- **National health clusters should have a contingency plan for pandemics.** It is recommended that each health cluster has an updated contingency plan to support scale up for future pandemics, especially given the experience of the wide range of new cluster partners that emerged during COVID-19. This should be aligned to government contingency plans, should include plans to rollout remote coordination processes to be used in event of lockdowns and movement restrictions and plans to support/include a greater number of cluster partners, including local organizations.

- **Where sub-national health clusters are established, they should be resourced and supported to fulfil their functions.** The study highlights strong benefits of well-resourced sub-national health clusters for multisector collaboration. Designated staffing, clear terms of reference and strong working relationships with other sub-national clusters and ICCGs were all important factors for initiating multisectoral collaboration for health outcomes. The study also highlights the difficulties that can be faced when a sub-national cluster is not properly supported.

- **The GHC should share lessons learned on multisectoral collaboration with other clusters as part of preparedness.** The study highlights the importance of the partnership between the health cluster and other clusters (e.g. CCCM for multisector collaboration in camp settings often along with WASH, shelter/NFI, protection, nutrition and food security). There are also lessons on site planning and preparedness for pandemics in camp settings. The health cluster and CCCM cluster should convene to compare lessons learned from COVID-19 and any preparedness investments that could be made for future outbreaks/pandemics, as well as incorporating key learning into guidance and training.

- **Risk communication and community engagement experiences should be documented and shared.** The study highlights the success of several community engagement practices that were linked to multisectoral collaboration and action. For example, working with broadcasters/media, monitoring social media, engaging with rumours on social media, using social media influencers and having a clear sign-off process for messaging. Documentation of successful RCCE practices is recommended for future use and to inform strategies for new outbreaks and pandemics.

**Multisectoral collaboration generally**

- **The GHC should work with the Global Cluster Coordination Group to produce multisectoral guidance for future pandemics.** The study found that the basic information package and sector coordination matrix provided helpful guidance for a range of multisectoral collaboration initiatives. This would be applicable to future outbreaks and pandemics. The wider experience of using these tools should be reviewed and evaluated to inform plans and guidance for multisectoral collaboration in future pandemics, with general overarching guidance available for multisectoral collaboration applicable for all forms of outbreaks/pandemics, complemented by guidance for specific diseases.

- **The GHC should work with the Global Cluster Coordination Group and OCHA to identify how learning from this study can be built into preparedness.** The study highlights the importance of a well-resourced ICCG structure with clear terms of reference and leadership prior to a pandemic. Where such structures exist, it is possible for them to adopt a pandemic preparedness plan in close collaboration with the health cluster and HCT. The study also highlights the importance of clear roles and responsibilities and particularly clear decision-making processes/leadership between clusters, ICCG, HCT and the UN country team for pandemics, and highlights the risks involved in the UN setting up a coordination system siloed from government. This learning should be incorporated in preparedness for future pandemics and outbreaks.
• The GHC should explore opportunities for dissemination of key learnings from this study at country level. Most of the above recommendations have potential implications for country-level clusters, and it may be helpful to foster dialogue on these topics with countries that were not covered as a case study to understand any additional experiences or good practices that could be built into preparedness.

7.2 World Health Organization

Multisectoral collaboration for health outcomes

• WHO should conduct a wider review of multisectoral collaboration for health outcomes in the COVID-19 response. This study focuses on the work of the health cluster in humanitarian settings. The learning from this study should be complemented by examination of multisectoral collaboration initiatives undertaken by WHO and by governments in both humanitarian and non-humanitarian settings. This fits with the direction that WHO has recently set for health emergency preparedness and response (HEPR), which strongly emphasizes multisectoral approaches, including promotion of operational readiness of five interconnected HEPR systems: collaborative surveillance; community protection; safe and scalable care; access to countermeasures; and emergency coordination.80

• A broader review of the SPRP and the effectiveness of the pillars approach for multisectoral collaboration should be undertaken. This study gives some insight into how the SPRP and its related pillars were used to inform multisectoral coordination processes by humanitarian actors. Work under pillars such as RCCE and IPC were particularly rich in multisectoral collaboration. A wider review of how the SPRP and its pillars helped and hindered multisectoral collaboration in the response to COVID-19 is recommended as part of efforts to strengthen the global architecture for health emergency preparedness and response.

• Encourage implementation of digital data collection and surveillance. The lockdowns during COVID-19 further highlighted the relevance and effectiveness of digital data collection and surveillance tools to maintain data collection and sharing and inform on trends, and areas of focus, and enable all actors to effectively plan their response, so is key to multisectoral collaboration. Efforts to support ministries of health to improve the collection of epidemiological, morbidity, mortality and contextual data for the COVID-19 should not be lost and should be mainstreamed into current tools and methodologies.

Multisectoral collaboration generally

• Future pandemic responses should recognise the differential impacts of disease across different countries/geographies and support country leadership to contextualize approaches. The study found that COVID-19 was not a high priority for some countries at specific times due to the local epidemiology and the prominence of other humanitarian priorities. Each country response needs to consider flexibility and contextualization, especially for humanitarian settings. Country teams that decide not to prioritize response to pandemics would still need to maintain a minimum level of surveillance and readiness in case the situation deteriorates.

7.3 The Global Cluster Coordination Group

- The GCCG should review the wider experience of multisectoral collaboration in the COVID-19 response and use of related guidance. This study has focused on multisectoral collaboration for health outcomes, drawing from insights from a range of humanitarian actors. However, a significant number of survey respondents and key informants represented health actors. It is therefore important to consider how multisectoral collaboration has supported other outcomes (such as nutrition, protection, etc.) and understand in more detail the experience of multisectoral coordination bodies such as OCHA/ICCG in fostering collaboration in the COVID-19 response. This study also highlights the important roles that CWC and AAP working groups can play in outbreak/pandemic response.

- The GCCG should consider how multisectoral collaboration could be better monitored in country level response. This study has found the incidence of multisectoral collaboration increased during the response to the COVID-19 pandemic. However, aside from coordination supported by ICCG, there is no process to track and document multisectoral collaboration. While it is important to encourage organic teamwork and collaboration between sectors, if multisectoral collaboration is agreed to be a critical component of response at a country level then it would be helpful to develop frameworks for leadership, accountability and quality control.

- The GCCG/clusters should gather experiences of how operational multisectoral collaboration can best be achieved, for outbreak/pandemic responses, and more widely. This study shows how diverse approaches to operational-level multisectoral collaboration occurred in the responses to COVID-19 while noting that this was one of the more challenging areas for the response in many countries. The experience of other clusters in this area should be examined in the response to COVID-19, but also considering work on related topics such as area-based coordination and localization.

- UN OCHA should continue to strengthen Inter-Cluster Coordination Groups. The study highlights the importance of a well-resourced ICCG structure with a clear Terms of Reference and leadership in place prior to a pandemic. Where such structures exist, it is possible for them to adopt a pandemic preparedness plan in close collaboration with the health cluster and HCT. The study highlights the importance of clear roles and responsibilities and particularly clear decision-making processes/leadership between clusters, ICCG, HCT and the UN country team for pandemics, and the risks involved in the UN setting up a coordination system siloed from or in parallel to the government. This learning should be incorporated in preparedness for future pandemics and outbreaks.

7.4 National governments, including national ministries of health

Multisectoral collaboration for health outcomes

- Governments should examine the effectiveness of the pillar approach for multisectoral collaboration in the COVID-19 response. The study shows that the SPRP pillars were useful and were applied flexibly at country level based on the feedback received from key informants. It would be useful to conduct lessons learned at country level across government departments, and in collaboration with WHO, to enable further learning relevant to that context on multisectoral collaboration for health and other outcomes. This learning should be applied to future preparedness for outbreaks and pandemics.

- Governments should explore opportunities for digital data collection and health surveillance. The lock downs during COVID-19 further highlighted the relevance and effectiveness

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81 Notably the Basic information package for COVID-19 and its associated sector coordination matrix.
of digital data collection and surveillance tools to inform trends, and areas of focus, and enable all actors to effectively plan their response so is key to multisectoral collaboration. Efforts made to improve the collection of epidemiological, morbidity, mortality and contextual data for the COVID-19 should not be lost and should be mainstreamed into current tools.

- **Identify successful risk communication and community engagement practices.** The study highlights the success of several community engagement practices that were linked to multisectoral collaboration and action. For example, working with broadcasters/media, monitoring social media, engaging with rumours on social media, using social media influencers and having a clear sign-off process for messaging. Successful and feasible risk communication and community engagement practices should be identified and documented for inclusion in future strategic plans.

**Multisectoral collaboration generally**

- **Governments should promote high-level engagement and leadership for multisectoral collaboration in outbreak response.** The study shows the positive impact that high-level engagement can have in encouraging collaboration between government departments and between government and nongovernmental actors (such as NGOs and local organizations and private sector). There are examples of this level of coordination being led by the prime minister or president’s offices, as well as by ministers of health.

- **Governments should examine their legal framework for cross-government coordinating bodies as part of pandemic preparedness.** A clear legal framework and terms of reference are required to enable a coordinating or cross-government department to facilitate multisectoral collaboration (e.g. PHEOCs). Such a body should have clear authority within the government system that is activated during an outbreak or pandemic. In some countries the disaster management authority has the required mandate. Such a framework must identify how the government system can coordinate with non-government actors contributing to response (e.g. NGOs, private sector).

**Other recommendations**

Other recommendations from the study relating to the health component of the COVID-19 response (not multisectoral collaboration)

- **Governments should expand health facility preparedness for outbreaks and pandemics.** The study found examples of health facility preparedness exercises for outbreaks and pandemics that involved WASH and other sectors. Such preparedness activities were seen as a good investment, for example health facility readiness assessment in Mozambique.

- **Governments should implement the One Health platform.** The study demonstrated the potential value in having existing platforms for multisectoral coordination, such as the One Health platform. However, the study also found that such platforms will only be effective they are functional, clearly articulated in term of roles and mandate, and include the relevant actors both national and internationals. Governments should, therefore, pursue and implement the development of the one Health approach in line with IHR 2005.

- **Adaptive approach to global pandemics.** This study highlights the importance of country-to-country learning and adaptation through a pandemic (i.e. decision-making based on best possible epidemiological data, knowledge of what is working in neighbouring countries, building up their own contextually relevant evidence base for decision-making).

- **The value of utilising existing systems and processes.** The study identified the effectiveness of delivering a COVID-19 vaccination programme on top of systems and structures already in place for EPI, which can be considered in future pandemics.
7.6 Donors

- **Humanitarian donors should consider making increased use of country-based, flexible pooled funds to support multisectoral projects.** There is evidence from the study that adaptive country-based pooled funds can provide funding for multisectoral initiatives.

- **Humanitarian donors should take a balanced approach to funding health and non-health interventions in an outbreak or pandemic.** The study highlights an issue where pandemic-related funding focuses on health. There have been instances where insufficient funding to other sectors as part of a multisectoral interventions has hampered the operational convergence needed to address the indirect impacts of COVID-19 within the response.

- **Localization strategies should be adopted by donors in a pandemic.** Many local organizations have close ties with communities, which is a significant advantage for public health support (particularly for RCCE). Their proximity, deep local knowledge and cultural/political awareness can give them unique advantages over international organizations during lockdowns. Additionally, the study shows that there were often shortages of funding for sub-national multisectoral collaboration projects.
Annex 1: Objectives and scope of the study

**Overall objective**
To better understand how multisectoral collaboration for COVID-19 response has been occurring in humanitarian settings.

**Scope of Study**
The study will review multisectoral collaboration throughout the COVID-19 response, including initial adaptations, and any subsequent evolutions during and after completion of GHRP 2020. The different types of multisectoral collaboration undertaken for the COVID-19 response will be explored, specifically those that supported or contributed to better health outcomes.

The study will focus on multisectoral collaboration between the health cluster and/or health cluster partners and other humanitarian and health actors responding to COVID-19.

Given the vast range of multisectoral collaboration in the COVID-19 response, the study will specifically focus on multisectoral collaboration initiated, led or supported by the health cluster or by health partners. For example:

- Collaboration with the nutrition cluster to ensure aligned messaging, sensitization and promotion of improved hygiene practices.
- Ensure the safe planning and alternative shelter with the shelter cluster and support the management of isolation and quarantine centres with the CCCM cluster.
- Ensure effective collaboration with the WASH cluster for health facility assessments and on IPC measures.
- Work with other clusters including CCCM and education to support risk communications and community engagement.
- Work with the protection cluster to ensure safe access to SGBV services.
- Partner to partner collaboration to deliver services (e.g. partners delivering food distribution coupling with health service deliver; protection partners providing services in health facilities).

Further examples of collaboration are outlined in the inter-cluster/inter-sector matrix for COVID-19.82

**Overarching study questions**

1. How did multisectoral collaboration and action of the health clusters and health cluster partners evolve during the COVID-19 response to reach people affected by humanitarian crises?

This includes:

- Strategic approaches to collaboration (e.g. needs assessments, frameworks and plans developed).
- Coordination platforms or mechanisms.
- Operational approaches to collaboration (e.g. between partners).

• Technical approaches to collaboration (e.g. guidance, SOPs or protocols).
• Good practices developed and challenges faced.

2. What factors enabled or limited health cluster and health cluster partner engagement in multisectoral collaboration for COVID-19 preparedness and response?

How will learning from the study be used?

1. Further improvement of the ongoing COVID-19 response by:
   • contributing to a better understanding of good practices and challenges faced in multisectoral response throughout COVID-19; and
   • sharing learning to assist and inform countries as they continue to respond to COVID-19 pandemic and related humanitarian needs.

2. Used by the GHC and country health clusters in ongoing preparedness and response for COVID-19, and other future outbreaks, or pandemics (such as pandemic preparedness plans).

3. Improvement of multisectoral collaboration in humanitarian settings more generally, such as shared learning for health clusters and others at country level.

Above text taken from Study Inception Report, 8th August 2022.
### Annex 2: Analytical framework (excerpt)

<table>
<thead>
<tr>
<th>Overarching question</th>
<th>Specific Criteria</th>
<th>Indicators</th>
<th>Details of how indicator is measured</th>
<th>#</th>
<th>Key Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How did multisectoral collaboration and action of the health clusters and health cluster partners evolve during the COVID-19 response to reach people affected by humanitarian crises?</td>
<td>What pre-existing multisectoral collaboration was in place before COVID-19 and how did it enable or hinder COVID-19 response to reach people affected by humanitarian crises?</td>
<td>Type of pre-existing multisectoral collaborations, by strategic, coordination, operational, technical</td>
<td>description purpose lead/participation did it help/hinder response</td>
<td>1.1</td>
<td>What multisectoral collaboration was in place prior to COVID-19? Who took the lead? Who was involved? -strategically e.g. needs assessments, frameworks and plans developed -coordination platforms or mechanisms -operationally e.g. between partners -technically e.g. guidance, SOPs or protocols developed.</td>
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<td>1.2</td>
<td>Did this pre-existing multisectoral collaboration support the COVID-19 response? If so, how?</td>
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<td>1.3</td>
<td>Did this pre-existing multisectoral collaboration hinder the COVID-19 response? If so, how?</td>
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<td>1.4</td>
<td>Was there a functional multisectoral, multi-partner coordination mechanism in place for COVID-19 preparedness and response to reach people affected by humanitarian crises? If so, how did it impact multisectoral collaboration? Did it focus on the strategic, coordination, operational or technical level? Who led this? Who was involved?</td>
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<td>1.5</td>
<td>What steps were taken to adapt multisectoral collaboration amongst the health cluster, health cluster partners and other actors for COVID-19? Why? Were these steps effective? Who took a lead? Who was involved?</td>
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<td>1.6</td>
<td>Were new policies, strategies, approaches, tools developed to support multisectoral collaboration? Who led these? Who was involved? Were these effective? When were they brought in?</td>
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- Strategic approaches to collaboration e.g., needs assessments, frameworks and plans developed
- Coordination platforms or mechanisms
- Operational approaches to collaboration e.g., between partners
- Technical approaches to collaboration, e.g., guidance, SOPs or protocols
- Good practices developed and challenges faced
<table>
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<tr>
<th>Section</th>
<th>Question</th>
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<tbody>
<tr>
<td>1.7</td>
<td>Which actors, cluster(s) or sector(s) played the lead role in multisectoral collaboration?</td>
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<tr>
<td>1.8</td>
<td>Were there particular contexts or activities in which a particular cluster or sector took the lead? If so, what was the health cluster or health cluster partner(s)' role?</td>
</tr>
<tr>
<td>1.9</td>
<td>Which type(s) of multisectoral collaboration attempted by the health cluster or health partners were most effective?</td>
</tr>
<tr>
<td>1.10</td>
<td>Were there any good practices that could be replicated in the future? Would this good practice be applicable for COVID-19, other outbreaks or pandemics, or humanitarian response more generally?</td>
</tr>
<tr>
<td>2.1</td>
<td>Which factors enabled multisectoral collaboration involving health cluster partners and health cluster coordinators at national level? Did different factors apply to national and international partners?</td>
</tr>
<tr>
<td>2.2</td>
<td>Were there any pre-existing humanitarian partnerships which helped enable collaboration across sectors/clusters? Who was involved and how did it work?</td>
</tr>
<tr>
<td>2.3</td>
<td>Did any of the following coordination approaches help to enable multisectoral collaboration? (range of options given in survey)</td>
</tr>
<tr>
<td>2.4</td>
<td>Did the planning processes for GHRP and HRP enable collaboration between sectors/clusters? If so, how? Between who?</td>
</tr>
<tr>
<td>2.5</td>
<td>To what extent did relevant technical capacity enable collaboration with other actors?</td>
</tr>
</tbody>
</table>

### What were the good practices and can they be applied in the future?

**Good practices identified, by strategic, coordination, operational, technical**

**Description of good practices that were identified, by global, regional, national and sub-national. Who led these? Why were they successful?**

**What challenges were faced by you and other health partners in developing multisectoral collaboration to support in the COVID-19 Response reaching people affected by humanitarian crises? At what level?**

- Levels (implicit as this is answered in Section 0): (Global (GCCG/IASC), Regional, country (Health cluster) other clusters, UN mechanisms (ICCG, HCT), national government, donors, NGO fora, international NGOs, national NGOs)

**What were the key challenges faced by GHC and its partners in developing multi-sectoral collaboration in COVID-19 response, by strategic, coordination, operational, technical**

**Key challenges described and analysed by global, regional, national and sub-national levels**

**What were the challenges faced in multisectoral collaboration in the COVID-19 response in humanitarian settings and how were they overcome?**

**Types of key challenges faced by GHC and its partners in developing multi-sectoral collaboration in COVID-19 response, by strategic, coordination, operational, technical**

**2. What factors enabled or limited health cluster and health cluster partner engagement in multisectoral collaboration for COVID-19 preparedness and response?**

**# and type of enabling factors, by strategic, coordination, operational, technical**

<table>
<thead>
<tr>
<th>Location (glob, reg, nat, sub-nat)</th>
<th>Type of respondent (UN, INGO, NNGO, Govt, Sector, Coord/Implementation)</th>
<th>Context (crisis type and funding and capacity (operational and technical levels))</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.12</td>
<td>Was any action taken to mitigate this/these challenges? What? Who by? Was it successful?</td>
<td></td>
</tr>
</tbody>
</table>

**2.1**

**2.2**

**2.3**

**2.4**

**2.5**
<table>
<thead>
<tr>
<th>2.6</th>
<th>To what extent did relevant operational capacity enable collaboration with other actors?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.7</td>
<td>To what extent did the ability to mobilize resources enable collaboration with other clusters/sectors? For whom?</td>
</tr>
<tr>
<td>2.8</td>
<td>To what extent did political support (by local government, donors or foreign governments) enable multisectoral collaboration? If so what happened and who was involved? e.g., government, HCT, donor governments?</td>
</tr>
<tr>
<td>2.90</td>
<td>To what extent was multisectoral collaboration successful? (rank: a lot, somewhat, it was not successful, unsure?) Why?</td>
</tr>
<tr>
<td>2.10</td>
<td>What other factors enabled multi-sector collaboration? What were these?</td>
</tr>
<tr>
<td>2.11</td>
<td>Which factors limited multisectoral collaboration involving health cluster partners and health cluster coordinators at national level? Did different factors apply to national and international partners?</td>
</tr>
<tr>
<td>2.12</td>
<td>Which factors limited multisectoral collaboration involving other actors at sub-national level? Did different factors apply to national and international partners?</td>
</tr>
<tr>
<td>2.13</td>
<td>Were there any pre-existing humanitarian multisectoral partnerships which limited collaboration across sectors/clusters?</td>
</tr>
<tr>
<td>2.14</td>
<td>Did the planning processes for GHRP and HRP limit collaboration between actors? What could be done to improve collaboration?</td>
</tr>
<tr>
<td>2.15</td>
<td>To what extent did technical capacity limit collaboration with other actors?</td>
</tr>
<tr>
<td>2.16</td>
<td>To what extent did operational capacity limit collaboration with other actors?</td>
</tr>
<tr>
<td>2.17</td>
<td>To what extent did the ability to mobile resources limit collaboration with other actors?</td>
</tr>
<tr>
<td>2.18</td>
<td>To what extent did political support (support from local government, donors or foreign governments) limit multisectoral collaboration? How?</td>
</tr>
<tr>
<td>2.19</td>
<td>Were there any other factors that limited multisectoral collaboration?</td>
</tr>
</tbody>
</table>
Annex 3: Milestones in the global response to COVID-19

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Relevance to multisectoral collaboration</th>
</tr>
</thead>
</table>
• One of six strategic objectives was to “Minimize social and economic impact through multisectoral partnerships.”  
• Highlighted that “A PHEIC will test the resilience of nations, businesses, and communities, depending on their capacity to respond. [...] A comprehensive approach to risk management is therefore required and must take a whole-of-society and whole-of-government approach.”  
• Also highlighted as part of Pillar 1 (Coordination, planning, financing and monitoring): “At country level, a multisectoral, whole of government coordination mechanism and knowledge hub that brings together critical people and information is required to inform, monitor and review (including through intra-action reviews) national responses.”  
• Following the SPRP the health cluster worked to scale up its support in humanitarian settings. |
| 11 Mar 2020| WHO classifies COVID-19 as a pandemic                                      | Importance of a whole-of-government, whole-of-society approach is restated |
| 17 Mar 2020| Interim Guidance on Scaling-up COVID-19 Outbreak Readiness and Response Operations in Camps and Camp-like Settings⁴⁴ | • Developed for the IASC by IFRC, IOM, UNHCR and WHO.  
• Recognised the specific challenges and vulnerabilities faced by populations in camps.  
• Emphasised the importance of multisectoral partnership as key to scale up outbreak readiness and response operations. |
• Emphasises “Multisectoral gender-based violence prevention and response services” as a response requiring acceleration/scale up.  
• A specific multisectoral indicator was put in place: “Proportion of countries with a functional multisectoral, multi-partner coordination mechanism for COVID-19 preparedness and response.”  
• Specific multisectoral response initiatives were highlighted in three countries (Chad, Somalia and Iran). |

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 April 2020</td>
<td>COVID-19 Strategy Update&lt;sup&gt;86&lt;/sup&gt;</td>
<td>Updated version of SPRP which further highlights secondary impacts of COVID-19: “Societal and economic disruption: shocks to health and social care systems and measures taken to control transmission have had broad and deep socio-economic consequences.”</td>
</tr>
</tbody>
</table>
| 6 May 2020  | Interim Guidance on Public Health and Social Measures for COVID-19 Preparedness and Response Operations in Low Capacity and Humanitarian Settings launched<sup>87</sup> | • Launched by the IASC.  
• Recognition that COVID-19 is one of many risks faced by vulnerable communities in humanitarian settings.  
• Emphasised importance of supporting referral pathways for multisectoral response.  
• Articulation of special consideration to be given to outbreak response in Urban Informal Settlements and Slums. Multisectoral response proposed as a key principle in such settings: “Adopt an area-based integrated multisectoral response, that recognizes the spatial characteristics as well as social and cultural norms and power dynamics.” |
| May 2020   | GHC COVID-19 Task Team established<sup>88</sup>                     | Objectives are: i) collate country-level technical, operational and coordination challenges; ii) promote and support adaptation and use of COVID-19 guidance for low capacity and humanitarian settings; iii) support multisectoral action iv) capture and share lessons learned, good practices; and v) advocacy to address unmet needs/operational barriers. |
| June 2020  | Basic Information Package for COVID-19 response launched<sup>89</sup> | • Developed by Global Cluster Coordination Group.  
• Intends to provide essential resources and best practice on coordinating a response to COVID-19.  
• Intends to support sector and inter-sector coordination focal points in countries without a formal humanitarian response system, including Resident Coordinators Offices.  
• Contains materials originally written for countries with established humanitarian coordination systems but may be adapted for all settings.  
• Included links to a specific “Inter-Cluster/Sector Matrix on COVID-19 response”<sup>90</sup> highlighting specific areas of collaboration between different sectors to enhance response to COVID-19. |

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<sup>86</sup> https://www.who.int/publications/i/item/covid-19-strategy-update---14-april-2020  
<sup>88</sup> https://healthcluster.who.int/our-work/task-teams/covid-19-task-team  
<sup>89</sup> https://healthcluster.who.int/publications/m/item/basic-information-package-for-covid-19-response-(june-2020)  
<sup>90</sup> https://healthcluster.who.int/docs/librariesprovider16/meeting-reports/inter-cluster-sector-engagement-matrix-covid-19.xlsx?sfvrsn=a62fbf6f_3