STUDY TO EXAMINE THE COORDINATION OF COVID-19 RESPONSE IN HUMANITARIAN SETTINGS

FINAL REPORT

Global Health Cluster
June 2023

ACKNOWLEDGMENTS

CONTENTS

ACRONYMS

ACRONYM	FULL TEXT
AFRO	Regional Office for Africa
EMRO	Regional Office for the Eastern Mediterranean
EOC	Emergency Operating Centre
EPI	Expanded Programme on Immunization
GBV	Gender-Based Violence
GHC	Global Health Cluster
GHRP	Global Humanitarian Response Plan
HCT	Humanitarian Country Team
HeRAMS	Health Resources and Services Availability Monitoring System
HRP	Humanitarian Response Plan
IASC	Inter-Agency Standing Committee
ICCG	Inter-Cluster Coordination Group
ICRC	International Committee of the Red Cross
ICU	Intensive Care Unit
IDP	Internally Displaced Person
IMS	Incident Management Support
IMST	Incident Management Support Team
IPC	Infection Prevention and Control
ISWG	Inter-Sector Working Group
IT	Information Technology
KII	Key Informant Interview
LGU	Local Government Unit
LWG	Logistics Working Group
MHNT	Mobile Health and Nutrition Team
MoH	Ministry of Health
MoH	Ministry of Public Health
MSF	Médecins Sans Frontières
NDVP	National Deployment and Vaccination Plan

NES	North-East Syria
NGO	Non-Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
PAHO	Pan American Health Organization
PHEOC	Public Health Emergency Operating Centre
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
SDR	Secondary Data Review
SEARO	South-East Asia Regional Office
SPRP	Strategic Preparedness and Response Plan
WASH	Water, Sanitation and Hygiene
WHE	WHO Health Emergencies
WHO	World Health Organization

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EXECUTIVE SUMMARY

The purpose of this study was to better understand and review how the coordination of coronavirus disease (COVID)-19 responses has been occurring in humanitarian settings, including maintenance of essential health services in such contexts. The study aimed to identify good practices, successful strategies, and challenges faced within and between the various coordination structures established to support COVID-19 responses, during and after completion of the COVID-19 Global Humanitarian Response Plan (GHRP) 2020. Within it, is also mapped the coordination structures in place across humanitarian settings and how they were adapted.

Main study questions

1. What good practices and challenges have emerged within and between different coordination structures for COVID-19 responses and humanitarian health responses?
2. What good practices do health cluster partners use and what challenges to they face to engage with coordination of COVID-19 responses at national and sub-national levels? Findings should also explore the different experiences of national partners/nongovernmental organisations (NGOs) and international partners/NGOs.
3. How did the different coordination mechanisms (both separately and in concert) enable or limit COVID-19 responses, including maintaining essential health services in humanitarian settings?

Project background

In response to the unprecedented threat to global public health and socioeconomic stability, particularly in countries affected by humanitarian crises, the Global Health Cluster (GHC) scaled up its country coordination support to provide context-appropriate technical and operational guidance to effectively implement the COVID-19 Strategic Preparedness and Response Plan (SPRP) 2020[a] and GHRP 2020,[b] then subsequently the SPRPs 2021 and 2022,[c,d] as an integral component of subsequent humanitarian response plans. These serve both to mitigate the direct impact of COVID-19, and to maintain the provision of existing humanitarian health action, including essential health services.

Study methods and limitations

Overall approach

The Operations Partnership (OP) was selected to conduct the study for the GHC. The study was designed with input and direction from a Steering Group under the Global Health Cluster COVID-19 Task Team. The study was designed to ensure a comprehensive approach with the intention of providing analysis to inform change and development

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[a] 2019 Novel Coronavirus (2019-nCoV): Strategic preparedness and response. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/strategic-preparedness-and-response-plan-for-the-new-coronavirus, accessed 1 February 2023).
[b] COVID-19 Global Humanitarian Response Plan. Geneva: United Nations Office for the Coordination of Humanitarian Affairs; 2020 (https://www.humanitarianresponse.info/en/programme-cycle/space/document/covid-19-global-humanitarian-response-plan, accessed 1 February 2023).
[c] COVID-19 Strategic Preparedness and Response Plan. Geneva: World Health Organization; 2021 (, https://www.who.int/publications/i/item/WHO-WHE-2021.02, accessed 1 February 2023).
[d] COVID-19 Strategic Preparedness and Response Plan. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/WHO-WHE-SPP-2022.1, accessed 1 February 2023)

where appropriate, as well as demonstrate transparency and accountability to stakeholders. Key principles during the study were objectivity and data quality. These principles ensured that analysis and recommendations are sufficiently valid and reliable, based on a systematic data collection and analysis process.

Analytical framework and analysis matrix

An analytical framework was developed to ensure data captured was in alignment with the study objectives, clearly articulating and structuring the collection, processing and analysis of data. Indicators were developed to categorize key findings under each criteria. Under each indicator, data were disaggregated by time period, national/sub-national levels and type of coordination mechanism.

Data collection methods and tools

Qualitative and quantitative data collection methodologies were used and included an online mapping exercise, key informant interviews (KII), and secondary data review (SDR), with data triangulation and verification.

Primary data collection

Primary data were collected through an online mapping exercise and KIIs. The team conducted remote in-depth interviews with KIIs, through seven country case studies: Afghanistan; Cox's Bazar, Bangladesh; Colombia; occupied Palestinian territory; Sudan; Syrian Arab Republic and Yemen. The interviews were guided by pre-defined interview guides specific to each KII type, which consisted of open-ended questions. The team conducted a total of 87 remote in-depth interviews, across the seven country case studies. The mapping exercise consisted of a 37-question online questionnaire to which 25 completed responses and six partial responses were received across 31 countries. A detailed description of each data collection method is given below.

Secondary data review (SDR)

An in-depth SDR was conducted to review 1062 documents describing or referring to the health cluster (HC) and coordination structures present within WHO, national health clusters and respective governments in each of the seven countries. Where relevant, global level documents were also reviewed. Data analysis followed a systematic and consistently applied approach.

Limitations

Considering the scope of this study, the lowest level of granularity of information obtained is at the sub-national level. The evidence collected throughout this study cannot be considered statistically representative as it is study using mixed methodologies using quantitative and qualitative data. To mitigate this even though purpose a diverse sampling of countries was chosen based on context. Furthermore, analysis was conducted to determine saturated themes across contexts and validation workshops were conducted in all countries as well as with the Steering Group to ensure findings resonated. This was a study of lessons learned, not a formal evaluation, and therefore not a full assessment of performance.

Conclusions

Criteria 1: What good practices and challenges have emerged within and between different coordination structures for COVID-19 responses and humanitarian health responses?

Theme 1.1: What adaptations have been made to coordination structures throughout COVID-19 responses (at both national and sub-national levels)?

The mapping survey determined what coordination platforms were established both by the government and Ministry of Health (MoH) as well as humanitarian platforms. The establishment of Presidential Taskforces, MoH Task

force or equivalent, as well as inter-ministerial or other groups were mapped and the utilisation of Public Health Emergency Operating Centres for humanitarian coordination platforms taskforces or working groups specific to COVID-19 were mapped for the health cluster, intersectoral cluster coordination group as well as HCT. For both government and health cluster, changes, its extent as well as its appropriateness and if beneficial were asked for key themes: roles and responsibilities of those working in coordination, information management requirements and support to address it, level and type of partner engagement, capacity to conduct coordination, interface with other coordination structures, as well as fundings structures.

Government coordination mechanisms

National level

- The main adaptation found in the online mapping exercise and the country case studies in 2020 was the establishment of national level coordination mechanisms including dedicated taskforces/committees to coordinate COVID-19, activated at the highest decision-making level within government, either under presidential offices or prime minister offices. The case studies showed at the peak of the crisis these mechanisms were meeting up to daily with the rapid adoption of online modalities.
- Other coordination platforms reported to be established were the Ministry of Health task force with external partners (89%), inter-ministerial coordination platforms (74%) as well as others such as for a scientific committee, quarantine management, vaccines-dedicated taskforces.
- Public health emergency operating centres (PHEOC) were used prior to the pandemic and was seen to be used in most settings at national (56%) and subnational level (60%) to support coordination of COVID-19 response.
- Most coordination platforms existed in 2020 and continued to be existing in 2021, although to a lesser extent in the government coordination compared to the humanitarian coordination. This suggests that for future pandemics with a novel pathogen, similar approaches may be required, including coordination for specific technical areas such as a scientific committee, vaccine-dedicated taskforces.
- The establishment of inter-ministerial coordination mechanisms reported across case studies and the online mapping exercise demonstrates that governments recognised the multisectoral nature of the crisis.
- Level and type of partner engagement, roles and responsibilities of those working in coordination and information management requirements or support were the three most frequently reported changes to government coordination mechanisms in the online mapping exercise. Thus, data suggests these areas should considered as important requisites to address to ensure relevant and effective coordination in a future pandemic or outbreak.
- Although significant changes were reportedly made to roles and responsibilities of those working in coordination and partner engagement, these changes were considered to be 'very appropriate' and 'very beneficial' to the response at national level only by a small proportion of respondents (9% and 13% respectively). By contrast, fewer respondents reported significant change was made to information management, but a higher proportion of respondents reported them to be appropriate and beneficial to the response at national level (27% and 36% respectively). This demonstrates that relatively modest changes that are appropriate can have considerable impact.
- For all themes queried in the online mapping exercise, the vast majority of respondents considered the changes to be only "somewhat appropriate" and "somewhat beneficial," suggesting that significant opportunity for improvement remains. Government/MoH capacity to conduct coordination had the lowest proportion of respondents reporting it to be 'very appropriate' and 'very beneficial' (11% and 11% respectively).

- The coordination structures established by governments at sub-national level were generally found to mirror the national level. It was found that coordination structures need to be context specific, with coherence in the structures from national to sub-national level.
- However, changes that occurred (e.g., roles and responsibilities, partner engagement etc) at the national-level changes were reported to have 'partially' occurred at the sub-national level in the online mapping exercise by the majority of respondents. The area where changes were considered to have occurred most substantially was information management and partners engagement where 27% and 20% of respondents respectively reported changes to be 'fully' occurred. This is in contrast to the changes reported to have occurred for MoH capacity to conduct coordination, as 0% of respondents considered changes to have 'fully' occurred. This may indicate capacity for coordination at the sub-national level did not receive sufficient attention or support at sub-national level, given the changes in partner engagement and information management requirements and support needed to address it. Coordination capacity at sub-national level should therefore be reinforced.
- In the online mapping exercise, respondents reported use of public health operating centres (PHEOC), particularly at sub-national level to coordinate the response to COVID-19 especially in 2020 (60% of respondents). Prior to the pandemic, 73% of respondents also reported use of PHEOC to coordinator other public health emergencies.

Humanitarian coordination mechanisms

National level

- In 2020, as with government coordination mechanisms, the study found that humanitarian coordination mechanisms established ad hoc taskforce or thematic working groups dedicated to the coordination of COVID-19 responses. When asked about the establishment of COVID-19 specific coordination structures, the highest percentage of respondents in the online mapping exercise reported the establishment of a COVID-19 working group within the health cluster at national level (58%) in 2020, as well as sub-national level (47%) during 2020. 32% of respondents also reported establishment of a COVID-19 working group within the HCT and 21% reported a COVID-19 working group within ICCG/ISWG. The COVID-working groups within the HC were largely continued in 2021, the working groups in HCT and ICCG/ISWG to a lesser extent. This demonstrates the importance of COVID-19 coordination being integrated and with specific focus even into the highest level of humanitarian coordination.
- Coordination meetings were held frequently, at times on a daily basis at the peak of the crisis and shifted from face-to-face meetings to virtual modalities. This allowed coordination mechanisms to adapt social distancing restrictions and was also acknowledged as being more cost effective. Although the meeting frequency reduced in 2021, COVID-19 was retained as a standing agenda item in health cluster meetings, ensuring that focus was not diminished.
- Humanitarian coordination mechanisms also recognised the multisectoral nature of the crisis and plans were developed accordingly. Note another GHC study is being conducted to examine this further.
- Regarding the different themes asked about in the online mapping exercise and the changes that occurred ℮ most were reported to

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[e] Compared to government coordination the seven themes were explored: roles and responsibilities of staff working in humanitarian coordination, information management requirements and support needed, level and type of partner engagement, capacity to conduct Health

have happened in 2020 but changes continued into 2021 (and to a larger extent compared to government coordination). This particularly applied to the capacity to conduct health cluster coordination and to manage the interface between the health cluster and WHO, suggesting changes can be anticipated to occur over a long period and should be anticipated when managing a novel threat such as SARS CoV-2.

- 'Level and type of partner engagement' and 'information management requirements and support it' were among the three most frequently reported changes for humanitarian coordination structures in the online mapping exercise (79% and 57% respectively). However, both were reported to have the least extensive changes compared to other categories (30% and 31% reported these to be significant changes). Nevertheless, the changes did appear to be beneficial at the national level (47% and 44% reported the changes were very beneficial for partner engagement information management respectively) suggesting that small adaptations can be sufficient to achieve desired effects.

- Despite only 27% of respondents considered changes to the interface between the health cluster and other humanitarian structures as "very appropriate", these changes were sufficient to have a positive impact respectively at a national level, with 50% of respondents reporting that the changes were 'very beneficial'.

- The online mapping exercise found that more than two thirds of WHO country offices operating in humanitarian context established a dedicated COVID -19 IMS. The majority of these mechanisms were established in 2020, but respondents noted that establishment was not always timely or contextualised appropriately.

- Despite only 25% of respondents to the online mapping exercise reporting changes to the interface between the Health Cluster and WHE IMS, these changes were considered to be the most appropriate changes across all areas (83% reporting very appropriate) and considered very beneficial by half the respondents, indicating that that the interface and coordination positively impacted COVID-19 response.

Sub-national level

- Case study findings showed that context-adapted coordination structures were established at sub-national level. In the online mapping exercise, around half the respondents reported a COVID-19 sub-national working group was established in 2020, in line with responses at the national level.

- At sub-national level, the humanitarian coordination architecture in place for covid was reported to be – 'very beneficial' by 32% of respondents compared to 45% at the national level in the online mapping exercise. This indicating that there were some inadequacies at sub-national level.

- Changes across the seven different areas (such as partner coordination etc.) were overall reported to have only 'partially occurred' at the subnational level (responses ranging between 45% to 55%). Interestingly changes were reported to have occurred fully at subnational level regarding capacity to conduct health cluster coordination (50%), partner engagement (42%) which is much higher compared to changes occurring with sub national government regarding information management requirements and support given.

Theme 1.2: What are the enabling factors or bottlenecks to ensure effective interfaces within and between the different coordination structures (at both national and sub-national levels)

Government coordination

- In response to COVID-19, governments developed national responses and preparedness plans (SPRPs) commonly referred to as "pillar response" and established task forces which prioritised COVID-19 responses, mobilised responses around common objectives and enabled structured opportunities for engagement with government. The SPRP 'pillar' approach was seen as enabling to define areas of operations and technical focus needed. For example, vaccination was recognised as a standalone

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Cluster coordination, interface between Health Cluster and other humanitarian structures, interface between Health Cluster and WHO IMS/IMST, and funding for humanitarian health response (not including COVID-19). Again, respondents were also asked when changes happened, how extensive changes were, whether the changes were appropriate, whether the changes were beneficial and whether the changes were applied at sub-national level.

component that required a dedicated pillar to support articulation and coordination.

- The existence and activation of national and sub-national PHEOCs were found to enable coordination with partners and information-sharing.
- Insufficient MoH capacity for coordination, response 'pillars' as well as co-leading health cluster was a significant challenge. This included constraints related to limited technical capacity for example specific response pillars or with coordination; insufficient resources such as information technology (IT) infrastructure and internet connectivity; and lack of skills in information and data management. Communication challenges were exacerbated by the COVID-19 context, including both abilities to coordinate within government and with partners. The shift to online working was also hampered by reliance on technology and connectivity, which were not always reliable or predictable, especially at sub-national level.
- Fragmented coordination structures and lack of clear roles and responsibilities posed a significant challenge, causing duplication of effort and lack of clarity in coordination with and between national and sub-national levels of MoHs. Decisions and information were often not effectively communicated at and to sub-national level levels. Data-sharing issues – including multiple data sources and lack of accurate and reliable data at both national and sub-national level – were linked to fragmented coordination structures and governance structures in some countries. This indicates the importance of reinforcing sub-national governance in MoH and bolstering coordination structures and coordination capacity within MoH at and between national and sub-national levels.
- Perceived lack of transparency and accountability within government structures significantly limited effective coordination with such structures. The key gaps included overlapping roles and responsibilities, lack of clear reporting lines, confused processes and poor communication with/within all relevant ministries, as well as inconsistent information, inaccurate or inadequate data-sharing, and lack of clarity about how and on what basis decisions were being made.

Humanitarian coordination

- The shift to online working and required increases in frequency of meetings were factors that enabled coordination to be intensified and maintained. In some cases, this also facilitated increased participation of partners. However, in some cases this reduced the effectiveness and quality of the communication and engagement. The shift to online working was also hampered by greater reliance on technology and internet connectivity, which were not always reliable or predictable, especially at the sub-national level.
- The national COVID-19 taskforces, working groups and sub-working groups established either under national health clusters (HCs) or other taskforces, were considered essential to the coordination of responses, and provided structure. Guidelines, protocols, and standard operating procedures (SOPs) developed and disseminated by WHO and HCs provided guidance to facilitate joint planning and approaches by health partners. Examples were identified where roles and responsibilities were clear and good collaboration practice between partners on response interventions were identified.
- The multisectoral response plans developed in response to COVID-19 acted as national coordinating documents, provided direction for responses and were important for mobilisation of resources.
- The role of HCs was highly valued in enabling coordination both between partners and with respective ministries of health (MoHs). HCs were active in increasing the frequency of meetings, providing updates to partners, tracking responses and identifying gaps, facilitating partners to fill gaps, disseminating guidance and developing protocols, and producing a range of information management products including multiple dashboards to inform responses.
- Where capacity was increased, coordination was reported to be more effective, especially increasing the structure to include multiple sub-national hubs (e.g., in Yemen).

- Insufficient capacity for coordination in HCs was seen as a challenge for effective coordination given the volume of information and scale of coordination required for COVID-19 response. The most significant gaps in coordination capacity were related to information management, 'double hatting' ((i.e., performing functions for other roles within WHO) of staff performing coordination functions, and insufficient sub-national coordination structures. These capacity gaps undermined the effectiveness of HCs and the scope of the functions they could effectively implement. This highlights the importance of investment in consistent and dedicated coordination structures and capacity at national and sub-national level.
- While partners' engagement in coordination was generally active, some gaps in clear and consistent information-sharing from health partners affected the ability to understand needs and gaps and to plan effectively. The main gaps included lack of timely information-sharing on assessments and planned response activities, frequent necessity to chase partners for information, not all partners having the same mechanisms to collect and share data, and lack of transparency on sharing funding information. This underlines the importance of partner commitments to work collaboratively to fill gaps, minimise duplication, and ensure meaningful inputs are given into cluster coordination tools. Relevant and utilisable tools should be used as well as partners having sufficient skills and capacity to input.
- The increase in coordination structures was found to create some challenges in ensuring coherent coordination. There were sometimes too many forums, overlapping coordination structures, or multiple layers of coordination at different levels. Roles and responsibilities between different mechanisms were not always clear and it was challenging for partners to consistently engage in meetings for all the different structures and forums.
- Coordination was often perceived to be very 'top-down' from the national level. Capacity gaps at sub-national levels, lack of presence and/or inconsistent engagement of national HC staff and senior WHO staff at sub-national level were frequently mentioned challenges. Miscommunication and responses not being timely or appropriate also caused a sense of disconnect and frustration at the sub-national level. This highlights the importance of ensuring that those in coordination roles have the relevant skills and expertise (communication, negotiation, information management etc) and capacity to ensure effective communication with stakeholders as well as between national and sub-national levels.
- Multisectoral coordination was often weak or insufficient, adding another layer of coordination to an already complex coordination architecture. Other clusters (i.e. non-health) did not always know their role, meaning that the multisectoral impacts of COVID-19 were not always fully considered and relevant stakeholders were not always adequately involved in planning and implementation. As a result, other clusters often took their own initiatives to respond and rather than coordinating through the health cluster or government COVID-19 taskforces.

Criteria 2: What good practices or challenges do health cluster partners face to engage with coordination of COVID-19 response at national and sub-national levels?

Theme 2.1: How are health cluster partners engaging in COVID-19 responses in both national MoH country preparedness and response (often called response 'pillars') and health cluster COVID-19 responses?

Government coordination
- *Partners' support to coordination functions, discussions on strategy, technically and operationally support:* Findings indicate that the coordination architecture of COVID-19 responses (i.e., with 'pillars', working groups and taskforces etc) served as a structure of reference (or standard) and the main way in which partners engaged in government coordination where through these taskforces and working groups,

partners provided operational support for the response and on community engagement. Findings show that partners (NGOs) were not often involved in supporting coordination functions for SPRP 'pillar' response at the national level but were involved at co-coordinating or leading working groups to support MoH response at subnational level. Partners were to some extent engaged with discussions on strategy at the national level. However, respondents stressed that in most contexts the establishment of the strategy and decision-making for responses was centralised in government coordination.

Humanitarian coordination

- *Partners' support to coordination functions:* Findings show that partners took on coordination functions for example leading or co-coordinating groups. This was especially seen at sub-national level.
- *Partners' engagement in discussions about strategy*: Findings show that partners were very invested in information-sharing and dedicated time and resources to attend regular meetings which created opportunities to provide input in strategy and planning discussions. However, respondents stressed that in most contexts, the establishment of the strategy and decision-making for responses was very centralised regarding humanitarian coordination. This indicates the importance of bolstering coordination capacity at sub-national level and ensuring that the sub-national level is able to effectively feed into strategic planning at national level.
- *Partners technically supporting the response:* Partners were reported to have sometimes supported with translating information products. However, most respondents indicated that partners were mostly recipients of technical guidelines and trainings.
- *Partners operationally implementing plans:* Partners were active in financial resource mobilisation and respondents indicated that partners adapted their activities and plans when funding permitted and engaged mostly on community engagement for COVID-19 response as well as usual essential health services.

Difference between international and local partners:

- In several contexts, the engagement of international and local partners was considered equal, in the sense that the volume of needs was very high, resources and efforts needed to be pooled, and everyone equally gathered around a unique goal and strategy. However, it was mentioned that some international partners had more experience with advocacy and resource mobilisation, which put them in a better position to access funding and therefore local partners depended on them for their own resources. Additionally, some international partners had more extensive programmes with emergency components and were therefore more able to quickly scale up.

Differences between national level and sub-national level:

- At the sub-national level, partners sometimes took leadership roles in coordination groups supporting government and humanitarian coordination, especially when there was no WHO presence, or if the partner had a particular expertise to bring to the table.

Theme 2.2: What factors enabled or limited meaningful health cluster partner engagement in the coordination of COVID-19 responses in humanitarian settings?

Government coordination

- The main factor that enabled partners engagement in MoH responses was the creation of governmental taskforces, and 'pillars,' which provided clear, official ways to engage operationally with health authorities for both local and international partners.
- The factor which hindered meaningful engagement of partners in MoH responses was that decision-making

was often very centralised, and partners were mostly told what to implement once strategies and plans had been validated by governments rather than being involved in its development. This indicates the importance of bolstering coordination capacity at national and particularly at sub-national level and ensuring that partners are given space to be involved in MoH coordination and planning.

- For both local and international partners, coordination through online communication was challenging, especially in contexts with disrupted electricity supply and poor internet connections.
- Restrictions (e.g., movement, gathering) were also a limiting factor for engagement, especially in the first year of the pandemic when restrictions were more intensive.

Humanitarian coordination

- The main factors which enabled engagement of both international and local partners with Health Clusters at national level were centralised information-sharing channelled through the health cluster which provided a clear picture of needs and ongoing COVID-19 and humanitarian response efforts. The frequency and mode of meetings, gave a more flexible platform for people to participate, share and receive information.
- The need and ability to mobilise funding to meet the increased needs (both for COVID-19 and other humanitarian health response) was also an enabling factor for meaningful engagement of both international and local partners with Health Clusters at national level. International partners had better access to new funding, but respondents indicated that possibility of additional funding (discussed in health clusters) also constituted an incentive for local partners to boost their capacity and increase their engagement. Furthermore, emphasis on community engagement for COVID-19 response was an entry point for partners to engage with health cluster discussions, strategy and response, as they had proximity and knowledge of communities, and existence of coordination structures at sub-national level.
- Receiving updated scientific information or guidance at the sub-national level that was consolidated by WHO and channelled through HCs was seen as good practice and enabled engagement of partners.
- Lack of existing funding or challenges reprogramming existing funding were limiting factors to engagement with humanitarian coordination mechanisms and humanitarian response, which affected mostly local partners who depended largely on international partners to obtain fund and other resources.

Criteria 3: How did the different coordination mechanisms (both within and between them) enable or limit COVID-19 responses, including maintaining essential health services in humanitarian settings?

Theme 3.1: Were health clusters enabled to achieve objectives in the GHRP and HRPs to support COVID-19 responses for humanitarian populations (or wider)?

Government and humanitarian strategic plans

- Different types of strategic planning documents and appeals were established across countries with a health cluster from the start of the pandemic. In 2020 most settings (74%) were reported to have developed a country strategic preparedness and response plan developed by Ministries of Health, and for populations affected by humanitarian crisis 36% of settings had an appeal within the GHRP, 23% had a separate COVID-19 appeal (not within the GHRP or existing HRP), and 45% incorporated response in existing HRPs (e.g., mid-year review or otherwise).
- In 2021 country strategic preparedness response plans decreased (to 55%) and as the GHRP was closed in 2021, COVID-19 response activities were integrated in to HRPs (65%).
- These were overall considered somewhat appropriate for two thirds of respondents in both 2020 and 2021 as well as 71% responding it was only partially successful in ensuring populations affected by humanitarian

crisis received COVID-19 services. This indicates some disconnect between planning and implementation and potentially gaps in ensuring effective coverage of populations affected by humanitarian crisis.

Government coordination: Measures taken to support COVID-19 response including maintaining essential health services for populations affected by humanitarian crisis.

- At the national level, strategic plans provided a policy framework for COVID-19 preparedness and responses. The pillar approach from 2020 planning allowed alignment with global response plans (such as WHO SPRPs) and facilitated the integration of new actors, as indicated by data from the global online mapping exercise.
- In 2021, it was reported that increased coordination between the MoH and HC partners occurred under these plans, and facilitated the development of inclusive joint strategies, particularly in accessing hard-to-reach areas.

Government coordination: Challenges

- Although the findings demonstrate that in many cases the coordination overall worked well, other countries reported that coordination structures to reach populations affected by humanitarian crisis were confusing or considered inadequate in 2020 as well as in 2021. Factors for this were because: they created multiple response frameworks; plans were only devised centrally; coordination with HCs was inadequate; and/or data was not adequately shared (notably on vaccination). This was reported to be largely a result of limited or inconsistent government capacity either technically or for coordination at national and subnational level. Only around a quarter of respondents to the online mapping exercise considered the government coordination structures to be 'very appropriate' and 'very beneficial to the response at both national and sub-national level, indicating that coordination structures require additional strengthening to be more effective.
- From the case studies, most government plans devised a general response to populations without specific mainstreaming of approaches for populations affected by crises such as hard-to-reach populations, displaced people, or refugees. In only one country (Cox's Bazar, Bangladesh) did the study identify a government response plan that referred to refugee populations.
- Delays in planning were identified and the development of the plans did not always match the pace at which the pandemic progressed. Various other sectors did not immediately realize that the pandemic was not simply a health issue and took time to engage. This further demonstrates the importance of having multisectoral preparedness and plans even for novel pathogens to determine strategies for possible scenarios instead of developing them during an emerging crisis. Mechanisms for rapid updates, evolving evidence and changes should also be integrated with in planning to keep a breadth with rapidly emerging needs and possible response.
- Community resistance appears to have been underestimated or neglected in the plans, as plans did not account for the accompanying "infodemic," including rumours and the reluctance of some communities to follow public health advice such as physical distancing or wearing masks. This indicates that focus and attention should be given to how to quickly lead the flow and correct information, invest in mechanisms to dispel myths. But also, to invest and work directly with communities from the outset to understand their fears but work with them to understand what is required to protect themselves, their families and communities in such circumstances.
- There were significant issues obtaining supplies at national but more so at sub-national levels, which undermined the provision of COVID-19 services to populations affected by crisis.

Government coordination: Enabling factors.

Enabling factors specific for to reaching populations affected by humanitarian crises could not be determined by this

study. However, for COVID-19 response for the overall population:

- 2020 strategic planning was regarded as an enabler to multisectoral approaches, as reported in the online mapping exercise by several clusters in many different regions.
- The 2020 and 2021 plans were reported as an enabler for mobilisation of resources, particularly in support of surveillance, diagnosis, and case management facilities.

Humanitarian coordination: Measures taken to support COVID-19 response for populations affected by humanitarian crisis.

- The health cluster coordination mechanism linked to humanitarian strategic plans but also to national government strategic plans for COVID-19 response, which helped ensure alignment of responses, coherence and strengthened coordination, although significant room for improvement remains. This included supporting the maintenance and access to essential health services.
- Guidance and guidelines issued or disseminated by HCs in a timely way, facilitated delivery of COVID-19 response to populations affected by crisis.
- Information was made available to all actors via HCs or other coordination mechanisms in timely manner. Monitoring response frameworks for COVID-19 response were established and reinforced by field verification mechanisms and were implemented via HCs.
- There was a significant drive to strengthen capacity of health cluster partners through training on the various aspects required to address COVID-19-related issues including case management, and IPC.
- Human resources were mobilised to expand health services and duplication was avoided by coordinating with the relevant government and/or health cluster taskforces established at sub-national level.
- The mobilisation of funding was a key priority from the start of the pandemic and continued in 2021, for which was facilitated by the different response plans.
- Partners were actively engaged in the provision of supplies for COVID-19 response to reach populations affected by crisis, and Logistics Working Groups took measures to address supply chain issues.

Humanitarian coordination: Challenges

- Despite the efforts on coordination, duplication of activities was not always addressed.
- Coordinating with some governments proved challenging at times due to their limited capacity and/or lack of accurate and reliable information-sharing.
- There were some decreases in funding for COVID-19 response specific to populations affected by crisis despite intense resource mobilisation efforts in 2021. Where they occurred, these limited (non-COVID-19) vaccination campaigns and limited the capacity to continue delivery of other essential health services.
- The focus on COVID-19 often diverted attention from other health essential health services.
- There were significant supply issues across most case study countries including delivery of PPE equipment and supplies specific to reach populations affected by humanitarian crisis.
- The ability to deliver essential health services and coordinate was hampered by reduced capacity or overloading of existing capacities within humanitarian organisations.
- The delivery of training for aspects on essential health services were disrupted as trainers were already busy implementing activities related to COVID-19 responses.
- Utilisation of essential health services dropped due to fear and stigma, exacerbated by fear and resistance of health staff.

Humanitarian coordination: Enabling factors.

- Health Cluster coordination enabled advocacy for populations affected by humanitarian crisis to have greater access to COVID-19 services including the maintenance and access to essential health services.
- Clarity in 2020 strategic response plans for COVID-19 response for populations affected by crisis (as

articulated in either GHRP, specific COVID-19 appeals or within HRPs depending on country) resulted in successful resources mobilisation Respondents reported this was because it: "Clearly articulated funding requirements for COVID-19 response and was a powerful tool for resource mobilisation".

- When capacity for health cluster coordination was increased, it was reported to have significantly strengthened partner engagement, health cluster functioning, and Health Cluster structures at national and sub-national level.

Humanitarian coordination: Good practice

- Many approaches were described where the delivery of health care was adapted to maintain essential services. For example, this included the use of telemedicine or changes to delivery or frequency of services, as well as COVID safe adaptations in hospitals and isolation of COVID-19 treatment areas.

Theme 3.2: Were health clusters able to adhere to humanitarian principles and protect humanitarian space?

- The study was not able to conclude specific trends across countries for this theme, as most findings under this theme are outliers and varied, Nonetheless, these outliers were reported as they represent the diversity of issues that can be faced in humanitarian contexts. Moreover, the study interview guide was long and key informant's fatigue during the interviews may partly account for the lack of consistent data.

Enabling factors

Impartial/equal access

- Pre-existing health service delivery in health facilities helped ensure access to health services for camp populations especially when there were movement restrictions.
- Pre-existence of integrated programmes (e.g., with health and other sectors) demonstrated that specialized services such as for gender-based violence could be more readily maintained in contexts where movements are restricted, but health activities were prioritised by governments to continue.
- Continuous efforts for humanitarian advocacy by partners, health cluster and HCT help ensure access to COVID-19 services including essential health services by populations affected by crisis.

Humanitarian access

- When there is government will, access can be negotiated, and discussions can be facilitated through existing coordination mechanisms.

Factors which limited or diminished principles

Impartial/equal access

- The study noted a few reports of discrimination where authorities limited access to health services due to factors such as social caste or migration status.

Humanitarian access

- Several countries reported that humanitarian access was restricted/delayed by governments, despite specific exemptions for health services. Moreover, political tensions undermined humanitarian access – in insecure contexts, agencies struggled to reach and operate in areas of high-risk and insecurity, including where the imposition of curfews impacted service delivery. Moreover, access of humanitarian personnel was impeded due to restrictions in visa delivery or the suspension of international staff.

Independence and neutrality

- The study found that in some countries, government interference included bureaucratic and administrative impediments which reduced the ability to maintain humanitarian principles. This is particularly the case when governments require approval of individual projects or insists on being involved in beneficiary selection and/or staff recruitment.

- Concerningly, the study found general reports that humanitarian space (i.e., the social, political and security operating environment which allows for unimpeded access to protection and assistance) progressively diminished during the pandemic. The causes of this were not explored within the scope of this study.

Recommendations

Criteria 1: What good practices and challenges have emerged within and between different coordination structures for COVID-19 responses and humanitarian health responses?

In this section we described the recommendations divided as per the target audience, and further disaggregated for the humanitarian coordination mechanisms, between the global and country level.

To governments:

- Further lessons specific to coordination by governments on COVID-19 pandemic need to be performed to ensure that the work carried out can be used to inform potential future global pandemics or other health crises.
- In many cases, governments required decrees or other binding mechanisms to establish an empowered coordination mechanism. Timely activation of essential coordination mechanisms requires that adequate preparedness activities have occurred (even for a potential pandemic with a novel pathogen) where related decrees are drafted prior to them being required.
- Government authorities should be supported and strengthened to take the lead through designation of clear roles and responsibilities within MoHs. Inter-ministerial coordination in outbreak responses should be strengthened and establish more clarity around roles and responsibilities, lines of accountability and communication between departments, as well as a commitment to transparent and systematic data-sharing.
- Strengthen national and sub-national strategic planning and the linking and feedback between the two levels, with more high-level meetings for planning, resource mobilisation and meaningful engagement of partners.
- Strengthen and reinforce national and importantly sub-national coordination capacity within MoH for coordination and leadership with dedicated resources and specialized personnel. This should be considered within the preparedness phase and health systems strengthening, but also during the response phase for example with surge deployments to support MoH with coordination functions. Increase capacity of PHEOCs with dedicated resources including staff, communications means and tools.
- For future pandemics or similar health crises, activating the highest level of decision-making within coordination bodies appears to be essential. When facing a crisis of this magnitude, governments cannot compromise and must ensure their full and sustained commitment to its management.
- Immediate recognition of the multisectoral nature of crises such as a pandemic is essential, as is use of the SPRP pillar approach to ensuring clarity on technical areas to be focused on and thereby roles and responsibilities.
- Partner engagement within planning processes is critical to ensure diverse and coherent stakeholder representation, thereby engendering appropriate and relevant planning and response. Humanitarian partners are able to reflect the needs and response required to reach often the most marginalised, populations affected by humanitarian crises, and where ministry of health is supported to provide services. Humanitarian partners can therefore be leveraged to provide support for COVID-19 response.
- information management is crucial for coherent and holistic responses and governments need to pay particular attention to these areas, which offer significant opportunities for improvements and impact

without fundamental adaptations.

- Governments must recognize the importance of coordination and invest in related resources and efforts, including having staff trained and specialized in conducting coordination, as well as interacting or communicating with diverse stakeholders. The study highlights information management as one of the key factors in facilitating well-coordinated responses.
- Emphasis should be placed on ensuring that the work implemented at the national level can benefit the sub-national level, where most operations are carried out.

To health cluster at global level:
- Sustain investment in information management resources for the health cluster at national and sub-national level, with tools that are available for effective online working.
- Invest in continued capacity building of Health Cluster Coordinators at national and sub-national levels including specialized skills in negotiation and advocacy. Ensure coordination functions are ring-fenced through dedicated funding at national and sub-national levels and continue to raise awareness of the importance of coordination among all stakeholders. Ensure lines of communication between national and sub-national levels are clarified, including clear expectations for support, guidance, and information-sharing from the national to sub-national levels.
- Strengthen multisectoral coordination for outbreak responses through reinforcing the interface and the strategic engagement between health clusters and inter-cluster coordination groups (ICCGs) as well as relevant sectors. This should also include the prioritization of joint assessments as well as assessment of multisectoral impacts, and clearly agreeing, defining, and communicating the roles of different sectors. Increased engagement with other sectors should be prioritised including (for example): ensuring minimum health standards are mainstreamed, workshops and trainings on integrating with other sectors such as water, sanitation, and health (WASH) occur efficiently. Lastly, strengthen multisectoral communication between national and sub-national levels, ensuring information-sharing is efficient.

To health cluster at country level:
- While country-wide health cluster coordination structures might not always be necessary in humanitarian contexts, the capacity to rapidly scale up and strengthen coordination structures in response to a global pandemic is essential. This requires sufficient surge capacity (i.e., of coordination and data specialized personnel such as data analysis/visualization etc.) and rapid mobilisation of specific funds so that work can be carried out at both national and sub-national levels.
- Invest in sub-national coordination capacity, through maintaining or increasing investment in sub-national coordination structures. Increase advocacy with donors for funding for health cluster architecture at sub national level. Advocate for partners to increase support or take the lead in coordination roles at the sub-national level and support them through training and capacity building on health cluster coordination.
- The time taken that was reported for changes to occur and the capacity for conducting health cluster coordination and/or managing the interface between the health cluster and WHO suggests that further work is required to reduce this interval.
- The focus on COVID-19 preparedness and response should be maintained including when there is a perceived reduction of its threat Given the evolving nature of COVID-19 e.g. emergence of new variants, poor vaccination coverage in humanitarian settings, integration of COVID-19 within a multi-hazard hazard risk analysis for populations affected by humanitarian crisis is critical. Retaining planning for COVID-19 preparedness and response as a standing agenda point during coordination meetings for example appears to have been a good practice that should be continued.
- Health crises such as the COVID-19 pandemic are not simply health issues, and all agencies should recognize

their multisectoral nature, and engage accordingly.

- As seen with government coordination, the level and type of partner engagement and information management requirements and support needed were reported to be the most frequent changes during the past three years, suggesting these two themes are some of the most important aspects that require attention when responding to a pandemic. However, the study also highlights that it is quality of change – rather than the quantity – that can ultimately make a difference.
- Streamline the multiple coordination forums for COVID-19 responses by ensuring clarity in terms of reference for various coordination mechanisms and continue integrating COVID-19 into existing working groups.

To donors:
- Invest in capacitating both MoH and / or Health Clusters for subnational coordination supporting for example surge staff to be seconded.
- When supporting or involved in national planning processes advocate for improved linkages and inputs on planning from the subnational level and clear planning for populations affected by crisis.

Criteria 2: What good practices or challenges do health cluster partners face to engage with coordination of COVID-19 response at national and sub-national levels?

To governments:
- Prioritize the establishment of simple, clear and official strategic structures for partners to engage with: when partners have a structure of reference, it is more straightforward for them to know where and how to contribute, whether operationally or to support coordination functions. Provide partners with a clear official channel to engage with health authorities.
- Ensure regular, accessible meeting opportunities (e.g., in-person, online and hybrid) so partners have flexible channels to share and receive information about specific situations and responses and a predictable platform to participate.
- As written above, ensure partner engagement within planning processes to ensure diverse and coherent stakeholder representation, thereby engendering appropriate and relevant planning and response. Humanitarian partners are able to reflect the needs and response required to reach often the most marginalised, populations affected by humanitarian crises, and where ministry of health is supported to provide services. Humanitarian partners can therefore be leveraged to provide support for COVID-19 response including supporting or co-leading 'pillars' of a country preparedness response plan, providing technical support, operationally supporting or implementing programmes.
- Ensure better transparency in strategic decision-making: when partners invest time and energy to participate in meetings and share information, they expect to see their input influence key decisions in the response. Transparency in the decision-making process can address partners' perceptions about decisions being centralised.

To WHO and health cluster at global level:
- Invest in trainings related to public health emergencies (to WHO), as well as the health cluster coordination system (GHC) such as preparedness trainings, training of trainers (ToT), guidelines and other modalities for capacity building. Partners were very engaged in training at country level and sought guidance for COVID-19 response.
- For future pandemics or outbreaks consider having a pool of trainers available able to deploy to countries,

able also to conduct training of trainers and to support rapid cascading of guidance in a context where information is constantly evolving.

To WHO and health cluster at country level:
- Explore partners' willingness and capacity to engage more actively in the provision of technical trainings for their area of expertise: most respondents indicated partners were at the receiving end of guidelines and trainings. There might be opportunities to disseminate knowledge and experience in a more collaborative way, especially at the local level, where partners were sometimes shown to be engaged in leading coordination groups.
- Maintain one centralised information source – partners indicated that they turned to the health cluster for information, to get a clear picture of the needs, the ongoing response, the gaps, and the opportunities for engagement.
- Ensure consistent data-sharing among health partners by ensuring that information requests to partners are streamlined. At the same time, ensure feedback and follow up to partner requests is timely and consistent, and replicate valued information management products/platforms.
- To health clusters, continuously advocate to health partners about the importance of information-sharing and provide data-sharing templates that are as consistent and simple as possible.
- Prioritize the engagement of partners with strong local pre-existing community linkages, particularly in activities related to community engagement.
- To health clusters, ensure online coordination meetings enable and support dynamic discussion, good exchange of information, and meaningful engagement of partners.

To partners:
- Dedicate time and resources to engaging in coordination at national and subnational level.
- Consider co-coordinating technical working groups, pillars at national or subnational level in areas where you have expertise. Consider supporting MoH where appropriate with basic coordination and planning functions at subnational level where capacities may be constrained. Providing technical and surge capacity can help ensure the integration of the needs of populations affected by crisis, as well as strengthen relations with diverse stakeholders to understand the role and potential capacities of partners.
- Support health clusters by sharing information in a timely manner. Health Clusters support collective response which partners are a member. Sectoral gap analysis and determining needs can only be done through gaining inputs from all members. Coordination and collaboration need to be bi- directional.

To donors:
- Increase repurposing of or additional funding: partners were shown to be flexible and adaptable in their programmes, the main obstacle to their agility was a lack of funding or the inability to redirect existing funding.
- Ensure timely repurposing of funding or direct access to additional funding for local partners who demonstrate sufficient capacity or ability to scale up. National NGOs were often reported as dependent on international NGOs to secure funding during COVID-19 responses.
- Invest in systems that rapidly identify new partners demonstrating capacity to contribute to the response and identify or 'pre-identify' a principal recipient that may work or contract with new partners to rapidly scale up activities.
- Consider investing in partners to support in co-leadership or co-coordination of technical working groups or to support MoH at subnational level with planning where capacities are limited. NGOs are well placed and are already providing such support in many instances, but often lack the human resources or time, or financial resources (for hours worked or level of effort) to support this function.

- Allow partners to invest in the required hardware and software to enable their online connectivity. For example, in context where there is poor connectivity and limited power supply, generators and/or solar power source associated with satellite (when necessary) connection devices should be permitted. This should include funding for training, such as in the use of technology.

Criteria 3: How did the different coordination mechanisms enable or limit COVID-19 responses, including maintaining essential health services in humanitarian settings?

To governments:
- Strategic preparedness and response plans using the pillar approach were shown to be effective and should be used when facing similar pandemics or other health crises in the future. However, they need to be mainstreamed in order to be well understood by actors *prior to any crisis* and dedicated resources need to be mobilised to avoid diversion from the provision of essential health services.
- Moreover, these plans should include dedicated provisions to ensure equitable access for affected populations living in hard-to-reach areas or with a status that may be different to 'host' communities, such as displaced people and/or refugees. This involves understanding barriers they may have and the tailored response that may be required to reach them. These activities should therefore be planned for and costed from the outset.
- Ensure resources are in place for rapid deployment of coordination capacity at both the national and sub-national levels. Ensure existing government systems of outbreak response and routine immunisation, are leveraged for future pandemic response.
- For future pandemics leverage health cluster and humanitarian coordination platforms to engage partners to reach populations affected by crisis
- Investment in understanding supply chains and conducting product quality control in a timely manner, and their integration into customs clearances, are required.
- Community resistance should not be underestimated, and information should be rapidly spread to avoid misinformation, false rumours and/or misconceptions. This requires investment in community engagement activities, as well as multi-modal activities to combat misinformation and raise awareness.

To health cluster at global level:
- For future pandemics clearly define requirements for response in humanitarian strategic plans. In 2020 plans such as GHRP, COVID-19 specific plans, and humanitarian response plans which clearly articulated COVID-19 needs and requirements and engendered resource mobilisation. This was reported to be less clear in 2021.

To WHO and health cluster at country level:
- Health Logistics Working Groups need to be established early on in health crises in order to facilitate the procurement and/or import of essential response supplies and its distribution to subnational level. Where this may be the role of WHO and/or UNICEF to import supplies for Ministry of Health etc, partners are also importing supplies and need support.
- Continued attention needs to be provided to the provision of essential services with continued advocacy. Coordination should identify high priorities and ensure that relevant resources are dedicated, whether in terms of funding, staff and/or supplies.
- Sensitization and training should not only target communities but also target health staff as a priority in any future pandemic in recognition that they are on the frontline of the response.
- Advocacy and humanitarian negotiation for access to populations of crisis should be continuous and

ongoing priorities and not just vital when crises occur. This is particularly relevant to ensuring that health personnel are allowed to continue to deliver essential services at all times.

PART I. BACKGROUND, SCOPE, OBJECTIVES AND METHODOLGY OF THE STUDY

PROJECT BACKGROUND

In response to the unprecedented threat to global public health and socioeconomic stability, particularly in countries affected by humanitarian crises, the Global Health Cluster (GHC) scaled up its country coordination support to provide context-appropriate technical and operational guidance to effectively implement the COVID-19 Strategic Preparedness and Response Plan (SPRP) 2020[6] and the Global Humanitarian Response Plan (GHRP) 2020,[7] and then subsequently the SPRP 2021,[8] as an integral component of 2021 country-level humanitarian response plans (HRPs). These serve both to mitigate the direct impact of COVID-19, and also to maintain the provision of existing humanitarian health action, including essential health services.

The GHC COVID-19 Task Team was established in May 2020 to strengthen the coordination and effectiveness of the Health Cluster response. Its primary objectives include: (1) collating country-level technical, operational and coordination challenges; (2) promoting and supporting adaptation and use of COVID-19 guidance for low-capacity and humanitarian settings; (3) supporting multisector action; (4) capturing and sharing lessons learned and good practices; and (5) advocating to address unmet needs/operational barriers.[9] As such, the GHC COVID-19 Task Team initiated a study to examine lessons learned in regard to the coordination of the COVID-19 response in humanitarian settings. The Operations Partnership was selected to conduct this study.

The study uses pre-defined frameworks for the coordination of preparedness and response to outbreaks in humanitarian settings as a basis for the coordination protocol. These frameworks include the following: the World Health Organization (WHO) Emergency Response Framework,[10] the activation of government Public Health Emergency Operating Centres (PHEOCs),[11] and the Inter-Agency Standing Committee (IASC) Protocol for the Control of Infectious Disease Events.[12] In addition, the adapted protocols put in place to specifically address global pandemics provide key reference documents for this study. These include the IASC System-wide Scale-Up Protocols Adapted to the COVID-19 Pandemic[13] and the GHRP 2020 that was developed to ensure adequate COVID-19 response in humanitarian settings, and to ensure humanitarian assistance continued. At the national level, country

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[6] WHO COVID-19 Strategic Preparedness and Response Plan (SPRP) 2020, 24 February 2020.
[7] Global Humanitarian Response Plan 2020, 25 March 2020.
[8] WHO COVID-19 Strategic Preparedness and Response Plan (SPRP) 2021, 24 February 2021.
[9] See Global Health Cluster COVID-19 Task Team ToR.
[10] WHO, Emergency Response Framework (ERF) 2nd edition, June 2017.
[11] WHO, Handbook for developing a public health emergency operations centre, August 2018.
[12] IASC, Protocol for the Control of Infection Disease Events. Humanitarian System-Wide Scale up and Activation, April 2019.
[13] IASC, System-Wide Scale UP Protocols, Adapted to Respond to the COVID-19 Pandemic, April 2020.

preparedness and response were developed informed by WHO guidance,[14] which were adapted and made relevant for their contexts.

In this context, coordination structures were adapted or created to ensure an appropriate interface to support the COVID-19 response in humanitarian settings within each country, and even after the completion of the GHRP and the incorporation of the COVID-19 response into 2021 country-level HRPs, coordination across structures continues.

OBJECTIVES

The purpose of the study was to better understand and review the coordination of coronavirus disease (COVID)-19 response in humanitarian settings, including the maintenance of essential health services in such contexts. The study aimed to identify good practices, successful strategies, and challenges faced within and between the various coordination structures established to support the COVID-19 response, during and after completion of the GHRP 2020. The study also mapped the coordination structures in place across humanitarian settings, and investigated how they were adapted.

Main study questions

Three areas were examined in detail:
1. What good practices and challenges have emerged within and between different coordination structures for the COVID-19 response and humanitarian health response?
2. What good practices do Health Cluster partners use and what challenges do they face in regard to engaging with the coordination of the COVID-19 response at national and subnational levels? (The findings should also explore the different experiences of national partners/non-governmental organizations (NGOs) and international partners/NGOs.)
3. How did the different coordination mechanisms (both separately and in concert) enable or limit the COVID-19 response, including maintaining essential health services in humanitarian settings?

STUDY METHODS AND LIMITATIONS

Overall approach

A Steering Group was established, comprising key GHC partners, to help define the study objectives, as well as to provide technical input throughout the study, thus ensuring the relevance, appropriateness and quality of the study.

The key components of the study were the following: 1) an online mapping exercise; 2) seven country case studies, for which individual reports were produced; and 3) a global report synthesizing the findings from across all seven countries (this is the present report).

The study applied a comprehensive approach, with the intention of providing analysis that can inform change and development where appropriate, as well as demonstrating transparency and accountability to stakeholders. The phases of the approach were as follows:
1. Inception (i.e., design of an analytical framework, initial document review, design of data collection tools,

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[14] Note that the first draft was published in February 2020. The updated guidance in May 2020 incorporated maintaining essential health services as a critical part of the COVID-19 response and is considered as such throughout this study.

and semi-structured interviews with Steering Group members).
2. Data collection (i.e., an online mapping exercise in 31 humanitarian settings, seven country case studies conducted using key informant interviews (KIIs), and an in-depth secondary data review (SDR) and county-level workshops reviewing country-level findings).
3. Data analysis of full database.
4. Workshop with stakeholders to present global-level findings.
5. Feedback on the draft report.
6. Final global report.

It is of note that individual country reports were also produced.

Analytical framework and analysis matrix[15]

An analytical framework was developed to structure the collection, processing and analysis of data, aligned with the study questions set out above (see Table 1). Indicators were developed to categorize key findings under each criteria. Under each indicator, data were disaggregated by time, national/subnational level, and type of coordination mechanism.

Criteria	Themes	Indicators
Criteria 1 What good practices and challenges have emerged within and between different coordination structures for the COVID-19 response and the humanitarian health response?	Themes 1.1 What adaptations have been made to coordination structures throughout the COVID-19 response (at both national and subnational levels)?	*Indicators 1.1.1:* Number of coordination models mapped (target = 31 countries).
		Indicators 1.1.2: Number of different types of models. Description of adaptations made to coordination models as compared with structures prior to the pandemic at different times during the COVID-19 response (at national and subnational levels). ▪ Initial adaptations ▪ During GHRP 2020 ▪ After completion of GHPR 2020/currently
	Themes 1.2: What are the enabling factors or bottlenecks to ensuring an effective interface within and between the different coordination structures (at both national and subnational levels)?	*Indicators 1.2.1:* Number of enabling factors frequently identified. ▪ Identification of enabling factors ▪ Trends ▪ Outliers (what and why)
		Indicators 1.2.2: Number of bottlenecks frequently identified. ▪ Trends ▪ Outliers (what and why)
Criteria 2 What good practices or challenges do Health Cluster	Themes 2.1: How are Health Cluster partners engaging in the COVID-19 response in both national ministry of health	*Indicators 2.1.1:* Ways in which Health Cluster partners were engaged in the COVID-19 response in both the national MoH country preparedness and response and the Health Cluster COVID-19 response. ▪ Trends

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[15] A full analytical framework can be found in Annex 1.

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partners face to engage with coordination of COVID-19 response at national and subnational levels? (Findings should also explore the different experiences of national partners/NGOs and international partners/NGOs.)	(MoH) country preparedness and response (often called response 'pillars') and the Health Cluster COVID-19 response?	▪ Outliers (what and why) ▪ Good practice examples
	Themes 2.2: What factors enabled or limited meaningful Health Cluster partner engagement in the coordination of the COVID-19 response in humanitarian settings?	*Indicators 2.2.1:* Number of enabling factors frequently identified (national and international)**.** ▪ Trends ▪ Outliers (what and why) ▪ Good practice examples
		Indicators 2.2.2: Number of limiting factors frequently identified (national and international). ▪ Trends ▪ Outliers (what and why) ▪ Good practice examples
Criteria 3 How did the different coordination mechanisms (both within and between them) enable or limit the COVID-19 response, including maintaining essential health services in humanitarian settings?	**Themes 3.1:** Were Health Clusters enabled to achieve their objectives in the GHRP and HRPs to support the COVID-19 response for humanitarian (or wider) populations?	*Indicators 3.1.1:* Types of measures taken within the coordination mechanisms to support the COVID-19 response for populations affected by humanitarian crisis. ▪ Measures taken ▪ Trends ▪ Outliers ▪ Good practices
		Indicators 3.1.2: Ways in which the coordination between mechanisms enabled the continuation of essential services (Pillar 9: operations, referrals, Expanded Programme on Immunization (EPI), routine vaccinations). ▪ Measures taken ▪ Trends ▪ Good practices
	Themes 3.2: Were Health Clusters able to adhere to humanitarian principles and to protect the humanitarian space?	*Indicators 3.2.1:* Ways in which humanitarian principles were enabled or diminished (trends/outliers). ▪ Humanity ▪ Impartiality ▪ Neutrality ▪ Independence

Table 1. Outline analytical framework

Data collection methods and tools

The qualitative and quantitative data collection methodologies used included an online mapping exercise, KII, and an SDR, with an emphasis on data triangulation and verification.

Primary data collection

Primary data were collected through an online mapping exercise and KIIs both at global and country levels.

Online mapping exercise

The Operations Partnership designed the mapping exercise, and it was subject to rigorous review by its Steering

Group. The mapping exercise consisted of a 37-question online questionnaire, targeting 31 humanitarian contexts in which the GHC is currently operational. 25 complete responses and six partial responses were received from these 31 contexts, representing 24 countries. This covers all Health Cluster settings except the Pacific.

Although the mapping exercise was lengthy, it was deemed necessary to gather relevant information. It aimed to map the structure and scope of the coordination mechanisms in place across all 31 GHC settings, and how they have evolved in response to the COVID-19 pandemic. More specifically, it looked at the following:

1) The types of coordination models and structures in place, including humanitarian coordination structures (e.g., humanitarian country teams (HCTs), inter-cluster coordination groups (ICCGs), and Health Clusters), national COVID-19 response coordination structures, and WHO structures (activation of Incident Management Support Teams (IMSTs), role as Cluster Lead Agency).
2) Ways in which coordination structures were adapted and evolved at different stages during the COVID-19 response, including initial adaptations prior to GHRP, adaptations during GHRP 2020, and adaptations after the completion of GHRP 2020.
3) The adaptations that worked well and those that did not, and how much the adaptations improved coordination.
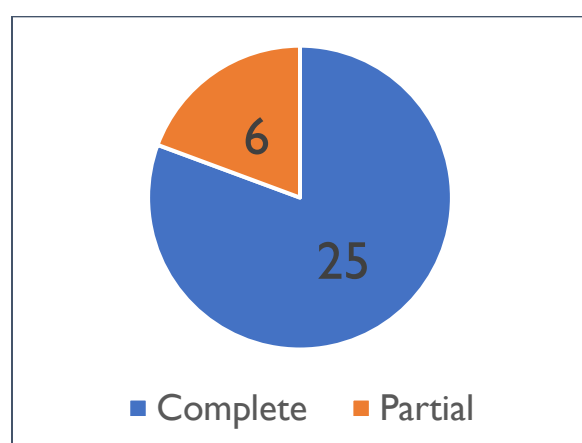
Figure 1. Number of responses to the online mapping exercise

As indicated above, the online mapping questionnaire was sent to 46 respondents from 31 settings, ranging from Health Cluster Coordinators to information managers. Thirty-four responses were received, of which 31 were retained, from 24 countries. Twenty-five responses were complete and six were partial. Some responses were excluded because they were duplicates. The questionnaire was designed using the Alchemer platform and data were extracted to various Excel tables, where they were cleaned and verified. Questions were aggregated in various ways to allow for cross verification. The full analysis and findings of the mapping exercise can be found in the online mapping exercise report.[16]

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[16] See Annex 2. Online mapping of coordination structures report

Country case studies conducted using KIIs

The team conducted a total of 87 remote in-depth interviews with key informants, as part of seven country case studies. Furthermore, workshops were conducted by the study team in each country to present and validate findings; 87 people participated in these workshops.

The country case studies were designed to provide an in-depth review of the coordination structures in each country throughout the COVID-19 response, and to identify good practices and challenges faced in coordination, including maintaining essential health services in humanitarian settings. In consultation with the GHC, seven country case studies were chosen, based on the following criteria: (1) the scale of the crisis; (2) emergency grading; (3) regional diversity; (4) Bureau for Humanitarian Assistance priorities; and (4) where the Operations Partnership has partners in place. The following locations/countries were selected: Afghanistan; Cox's Bazar, Bangladesh; Colombia; the Occupied Palestinian Territory; Sudan; Syria; and Yemen.

The country case studies were guided by terms of reference that were developed using the analytical framework.[17] A maximum of 15 KIIs were conducted in each country. Respondents were selected using a purposive sampling approach to ensure diversity of key informant types and based on the relevance of their position and experience to the study. Informants included the following:

- GHC staff.
- HCT and/or Inter-sector Working Group ISWG members.
- WHO country office staff.
- United Nations agencies.
- MoH staff.
- National and international NGO staff.
- Health Cluster observers.

The interviews were guided by pre-defined interview guides that were specific to each KII type and which consisted of open-ended questions. The interviews focused on the following areas:

- Factors that enabled or limited effective interface within and between the different coordination structures at both national and subnational levels (e.g., key roles, gaps in structure, coordination with other COVID-19-specific task forces).
- The ways in which Health Cluster partners engaged in the COVID-19 response, including both the national MoH country preparedness and response and the Health Cluster COVID-19 response (e.g. differences between national partners, and any development actors and new partners).
- Factors that enabled or limited meaningful Health Cluster partner engagement in the coordination of the COVID-19 response in humanitarian settings (e.g., capacity to attend different meetings, format of meetings, and whether this affected coordination and engagement; the impact of other challenges, such as government-imposed movement restrictions etc.).
- Measures taken within the coordination mechanisms to achieve objectives set out in the GHRPs and HRPs to support the COVID-19 response (e.g., facilitating procurement and supply chain, adapting to the evolving situation and mobilizing resources, technical expertise, key innovations or adaptation of programs, differing priorities of stakeholders and how this affected programming).
- Factors within and between the coordination mechanisms that enabled both the COVID-19 response *and* the continuation of essential health services (e.g., surgery, referrals, routine vaccinations).

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[17] The full terms of reference for the country case studies can be found in Annex 3.

Sample size

Table 2 details the total number of interviews conducted during the study, by country.[18]

Details of KIIs								
Key informant type	Afghanistan	Cox's Bazar, Bangladesh	Colombia	Occupied Palestinian Territory	Sudan	Syria	Yemen	Total
Donor	1	1		1				**3**
Government	1	1	2	2		1	2	**9**
Health Cluster observer	1	1		2	1			**5**
Health Cluster	3	1	1		2	5	2	**14**
International NGO	4	3	1	2		4	2	**16**
National NGO	2	1		2	1	6	2	**14**
United Nations partner	2	2	1	3	1	3	3	**15**
WHO	1	1		1	1	5	2	**11**
Grand total	**15**	**11**	**5**	**13**	**6**	**24**	**13**	**87**

Table 2. **KIIs, by country**

SDR

An in-depth SDR was conducted to review all documents on the Health Cluster and coordination structures, both within WHO, the Health Cluster, and governments in each of the seven countries. Where relevant, documents at global level were also reviewed. The documents reviewed included the following:

- Lessons learned documents (MoH, individual agency, or Cluster).
- International health regulations and associated documentation (e.g. joint external evaluations, etc.).
- Health Cluster bulletins (country and global level).
- Global technical guidance.
- Specific guidance produced by individual countries.
- List of partners, together with the 4Ws regarding their presence (who, what, when and where).
- COVID-19 response plans and policy documents (e.g. point of entry policies, testing, vaccination, government restrictions, oxygen strategies).
- Situation updates (e.g. WHO and United Nations Office for the Coordination of Humanitarian Affairs (OCHA) government restrictions, humanitarian space etc.).
- Funding appeals.
- OCHA and WHO updates.
- Health Resources and Services Availability Monitoring System (HeRAMS) and/or hospital data/WHO bulletins/Health Cluster reports.

The analytical framework guided the SDR and identified information gaps. The SDR process continued throughout the data collection phase, as country-level documentation was accessed incrementally. Over 1,060 documents were collected and processed. The total number of documents reviewed is summarized in Table 3 below. The full document list can be found in Annex 5.

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[18] The full KII list can be found in Annex 4.

Country	Documents reviewed
Cox' s Bazar, Bangladesh	166
Occupied Palestinian Territory	122
Sudan	221
Yemen	90
Afghanistan	61
Colombia	187
Syria	215
Total	1,062

Table 3. Documents examined in the SDR, by country

Country-level workshops

At the country level, data were compiled into individual databases and then analysed. Country-level findings were then presented to stakeholders in workshops, for validation. A total of 87 individuals participated across the seven countries (see Table 4). Internal country-specific reports were thus produced, with feedback from Health Cluster Coordinators and stakeholders.

Country	Number of people participating in country-level workshops
Cox' s Bazar, Bangladesh	14
Occupied Palestinian Territory	8
Sudan	23
Yemen	13
Afghanistan	8
Colombia	10
Syria	8
Total	87

Table 4. Number of people participating in country-level workshops

Data analysis

For the global synthesis report, all data points from countries were compiled and analysed together. Data analysis followed a systematic approach, which was applied consistently. Thus, all of the findings and conclusions set out in this report draw on a systematic data collection and analysis process, as described in Figure 2.

Country databases	Cleaning and sorting data in global database	Analyzing and synthesizing findings	Cross-referencing and developing global findings
1. Qualitative data from KIIs and SDR were entered into seven country case study databases 2. Data were coded in a systematic way by criteria, theme, indicator, coordination mechanism type, type of coordination (within or between coordination structures), time period and national and subnational levels, aligned with the analytical framework	1. Data entry was reviewed 2. Country databases were combined into one global database 3. For each indicator, data were sorted and exported into pivot tables 4. Data were disaggregated by national/subnational level, coordination mechanisms and time period, and then categorized using key theme identification	1. Recurrent key themes were identified and ranked based on frequency 2. The most frequent key themes were analyzed and synthesized into key findings under each theme and indicator	1. Findings were cross-referenced across countries to identify global findings 2. Overall findings were identified per indicator and topic based on the analytical framework 3. Findings were cross-referenced with relevant findings from the online mapping exercise 4. Findings were summarized into a report

Figure 2. Data analysis process

Data points identified

Table 5, 6 and 7 detail the number of data points collected across the different study criteria and respective countries, for the SDR and KIIs.

Country	Criteria 1	Criteria 2	Criteria 3	Total
Afghanistan	482	223	360	1,065
Cox's Bazar, Bangladesh	460	159	169	788
Colombia	125	76	132	333
Occupied Palestinian Territory	137	40	124	301
Sudan	348	127	137	612
Syria	252	102	282	636
Yemen	411	154	288	853
Total	**2,215**	**881**	**1,492**	**4,588**

Table 5. Data point totals, by country and criteria

Country	Criteria 1	Criteria 2	Criteria 3	Total
Afghanistan	92	40	105	237
Cox's Bazar, Bangladesh	123	7	15	145
Colombia	38	18	34	90
Occupied Palestinian Territory	49	6	22	77
Sudan	147	19	73	239
Syria	51	11	101	163
Yemen	100	30	25	155
Total	**600**	**131**	**375**	**1,106**

Table 6. Data points for SDR, by country and criteria

Country	Criteria 1	Criteria 2	Criteria 3	Total
Afghanistan	390	183	255	828
Cox's Bazar, Bangladesh	337	152	154	643
Colombia	87	58	98	243
Occupied Palestinian Territory	88	34	102	224
Sudan	201	108	64	373
Syria	201	91	181	473
Yemen	311	124	263	698
Total	**1615**	**750**	**1,117**	**3,482**

Table 7. Data points for KIIs, by country and criteria

Limitations and mitigations

The study sought to identify lessons learned; it was not a formal evaluation, and therefore did not constitute a full assessment of performance. The evidence was collated using both quantitative and qualitative methodologies, and thus though statistical correlation cannot be determined, analysis was conducted to determine saturated themes across contexts, and validation workshops were conducted in all countries to ensure the findings resonated with the views of the participants.

Considering the scope of the study, the lowest level of granularity of the information obtained is at the subnational level (usually the state, province, or region).

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PART II. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This section of the report provides both the findings of the study as well as the study's conclusions. The findings are synthesized from the inputs from the global database[19] and analysis matrices,[20] and verified by reference to multiple sources. The conclusions reflect interpretations of the findings, discussions in the validation workshop and analysis by the study team.

The recommendations indicate specific actions that it is proposed should be taken by the GHC and the WHO Health Emergencies (WHE) Programme to address the findings and conclusions of the study. The recommendations were developed within the validation workshop and by the study team. They are categorized by importance and urgency, and actions are proposed at global, regional and country levels where appropriate.

The subsequent sub-sections are structured by the three criteria, with findings, conclusions and recommendations provided under each theme and indicator.

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[19] See Annex 6.
[20] See Annexes 7–9: data analysis matrixes per indicator.

CRITERIA 1: WHAT GOOD PRACTICES AND CHALLENGES HAVE EMERGED WITHIN AND BETWEEN DIFFERENT COORDINATION STRUCTURES FOR THE COVID-19 RESPONSE AND THE HUMANITARIAN HEALTH RESPONSE?

The following section describes the findings for Criteria 1, structured and articulated under the themes and indicators defined in the analytical framework.

Theme 1.1: What adaptations have been made to coordination structures throughout the COVID-19 response (at both national and subnational levels)?

Finding 1.1.1: Number of coordination models mapped

Where the Cluster system is activated, humanitarian operations are structured around a well-established architecture (see Figure 3) ([Health Cluster Guide, 2020](#)). This is led by the Humanitarian Coordinator and the HCT, which provide the overall strategic direction to the humanitarian community in support of the national response. A formally activated Cluster has specific characteristics and accountabilities. It is accountable to the Humanitarian Coordinator through the Cluster Lead Agency, as well as to national authorities and to people affected by the crisis.
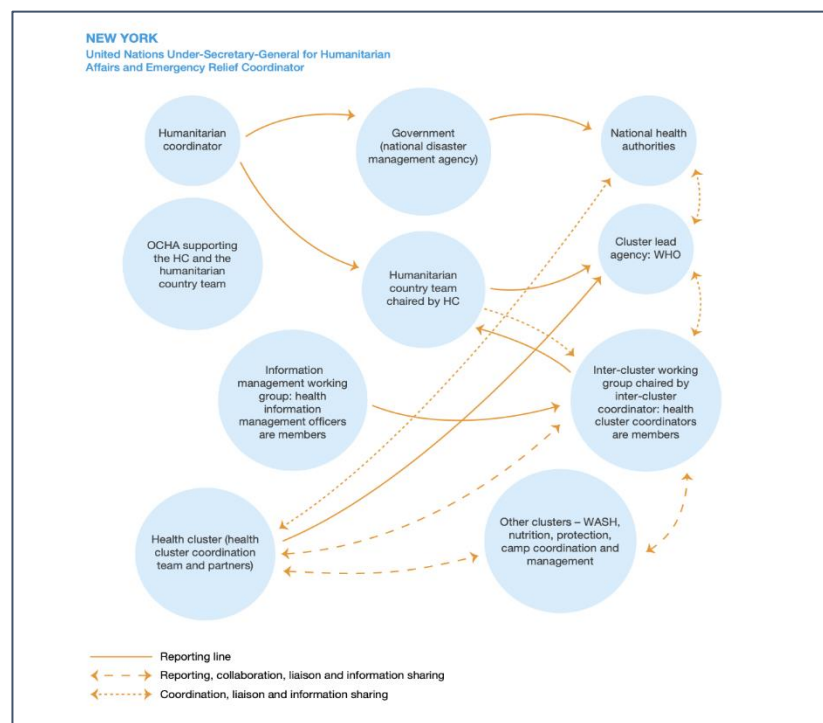
*Figure 3. **Formally activated Health Cluster within the wider humanitarian coordination architecture (Health Cluster Guide 2020)***

However, to ensure it is adequate for the prevailing context, some countries adapt their coordination structure. For example, in Cox's Bazar, Bangladesh, there is a Strategic Executive Group, based in Dhaka, which is co-chaired by the Resident Coordinator, International Organization for Migration and the United Nations High Commission for Refugees, in lieu of the recommended HCT. In Syria, due to the regional nature of the crisis and the need for multiple cross-border operations, the United Nations has established the Syria Crisis Coordination Committee.

Humanitarian coordination mechanisms/architecture in place at different times during the COVID-19 pandemic

Nearly[21] all settings had an activated Health Cluster or health sector working group prior to the pandemic, with only Honduras and Madagascar activating these structures after its onset (in 2020 and 2022, respectively),[22] and thus the number of Health Clusters or health sector working groups increased over time.[23] The presence of NGO forums also increased over time, from 79% of countries having them before 2020 to 84% having them in 2022. In regard to the coordination of the COVID-19 response taking place within the humanitarian architecture, it is seen that this decreased over time. COVID-19 working groups within the Health Cluster decreased, from 58% of countries having them in the first year of the pandemic down to 42% of countries having them in 2022. COVID-19 working groups within the inter-sector coordination group were present in 21% of the countries in 2020 but only in 11% of countries in the next year. COVID-19 working groups within HCTs were present in 32% of countries in 2020 but were reported in only 16% of countries from 2021 onward (see Figure 4).
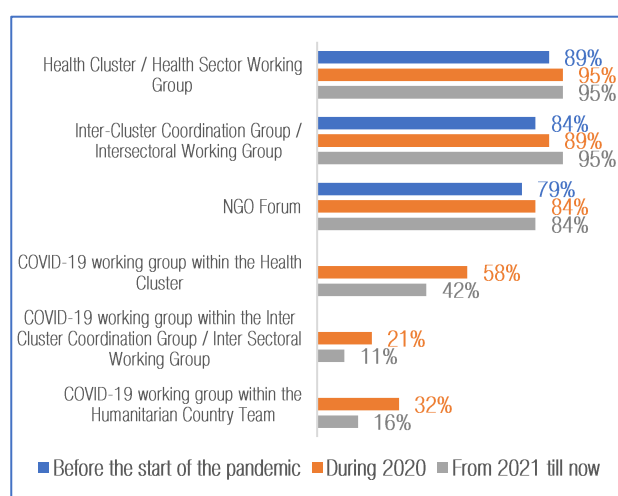
Figure 4. National humanitarian coordination mechanisms
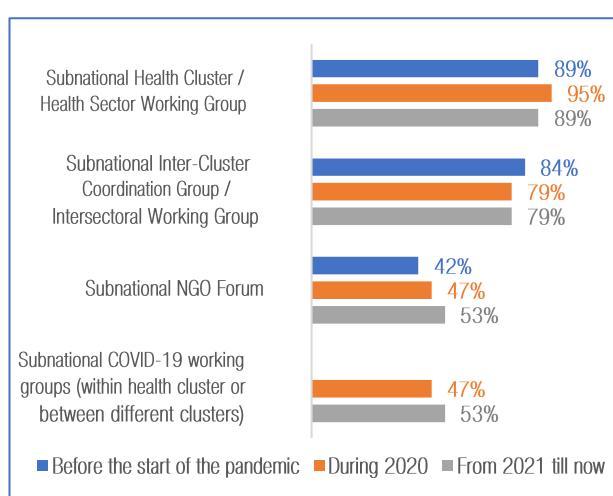
Figure 5. Subnational humanitarian coordination mechanisms

At the subnational level, Health Clusters or health sector working groups were reported as being present in all countries with the equivalent national structure (89%) both before and after the pandemic started. The proportion of countries with subnational inter-cluster/inter-sectoral coordination slightly decreased from 84% before the pandemic down to 79% in 2021. The number of subnational NGO forums increased over time, from 42% of countries up to 53%. Specific to the subnational coordination of the COVID-19 response for populations affected by crisis,

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[21] One country did not report the cluster at national level since it only exist at subnational level

[22] https://healthcluster.who.int/publications/m/item/health-cluster-dashboard-q1-march-2023

[23] Note that the GHC supports the Asia-Pacific Regional Coordination Mechanism, which covers 21 country islands and areas. There is no activated Health Cluster in Lebanon but there is a health sector coordination body.

interestingly as well as subnational COVID-19 working groups either within the Health Cluster or between clusters increased from 47% to 53% (see Figure 5).

Appropriateness and benefit of the humanitarian coordination architecture in place
There was a clear difference in regard to respondents' perceptions of the benefits of the humanitarian coordination structure at the national level, as compared to at the subnational level, with the former scoring higher. More than half (55%) of the respondents identified the national humanitarian coordination structures in place as very appropriate in regard to addressing the evolving situation, and 45% as somewhat appropriate. However, although 45% reported that these structures were very beneficial to the response and 48% somewhat beneficial, at the subnational level only 32% found them to be very beneficial (with 58% stating that they were somewhat beneficial, and 3% reporting them as not being beneficial). At the subnational level, a large majority of respondents (58%) reported that coordination structures were somewhat beneficial and 32% that they were very beneficial. Only 3% (one respondent) reported that the subnational coordination structures were not beneficial. This indicates that efforts at the subnational level need strengthening.

Comments made by respondents during the global online mapping exercise further indicated that the establishment of dedicated working groups/task forces "for each pillar of the response at national level" (the Regional Office for the Eastern Mediterranean (EMRO), the South-East Asia Regional Office (SEARO) and the Regional Office for Africa (AFRO)) was very useful for the response. However, others reported that they felt that the coordination structure was too fragmented, preventing actors from leveraging the existing architecture (EMRO). Consequently, this affected the synchronization of interventions between the national and subnational levels (AFRO) and/or created conflict between the humanitarian response and the COVID-19 response (AFRO). Moreover, respondents reported that there was a lack of capacity, notably at the subnational level (EMRO/AFRO), that was further aggravated by the insecurity prevailing in some countries, which prevented some health personnel from remaining at their duty station (EMRO).

Coordination architecture that was in place within and between MoH and government at different times during the COVID-19 pandemic
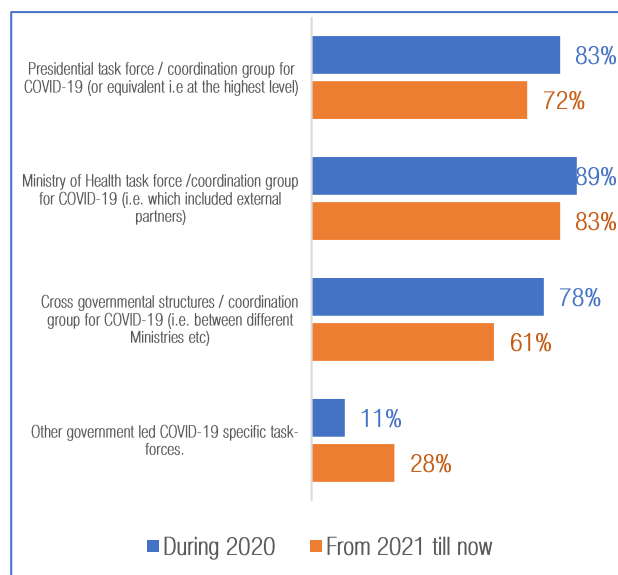
Figure 6. Government COVID-19 coordination mechanisms at the national level
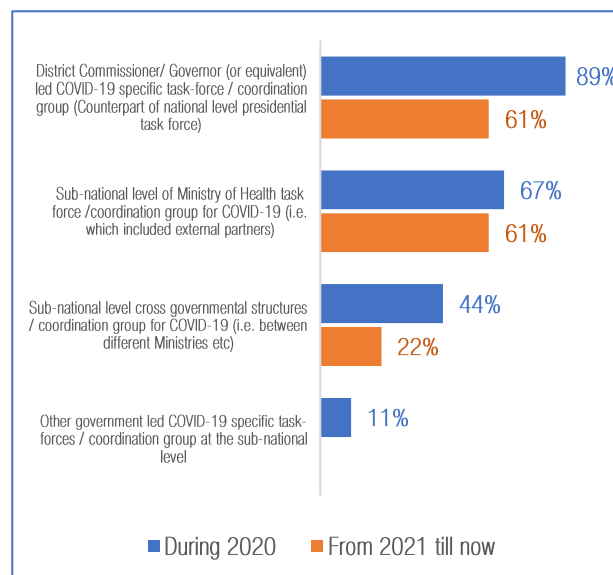
Figure 7. Government coordination mechanisms at the subnational level

A variety of high-level task forces specific to the COVID-19 response were established by governments at the national level, including presidential task forces (or equivalent), which were present in 83% of countries, and MoH tasks forces for the COVID-19 response, which were present in 89% of countries, though the number of these reduced slightly in 2021. Other government coordination mechanisms reported to be present in 2020 were scientific committees and COVID-19 vaccination task forces, as well as the use of the 'One Health' platform.

At the subnational level, it is of note that in the case studies key informants reported that during 2020 mirroring structures were established at the subnational level to ensure that coordination was mainstreamed from the national to the subnational level. As can be seen from the mapping exercise, district commissioner-/governor-led task forces or coordination groups for COVID-19 were as present at the subnational level in 2020 (89% of respondents reported their existence) as were presidential task forces at the national level. However, by 2021 these were much less prevalent than the national level structures.

Interestingly, fewer MoH task forces were reported at the subnational level (67% of respondents) as compared to the national level (89%), though those that existed remained present in 2021.

Subnational cross-governmental structures/coordination groups were reported by 44% of respondents in 2020, but by only 22% in 2021. Other types of coordination mechanisms that were identified only in 2020 were ministry of interior-led quarantine taskforces and COVID-19 control and emergency response teams*.*
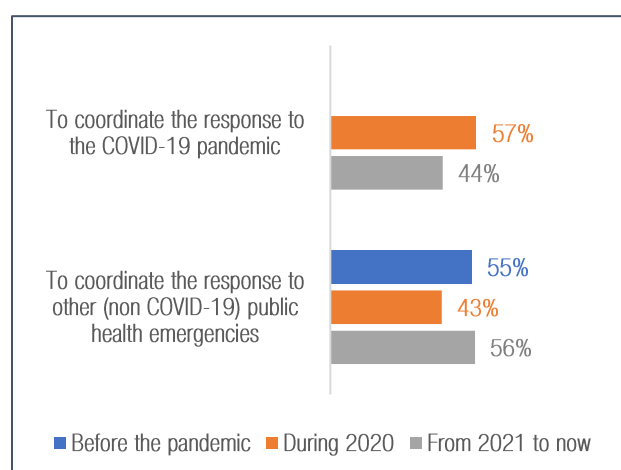
Figure 8. Use of PHEOCs at national level
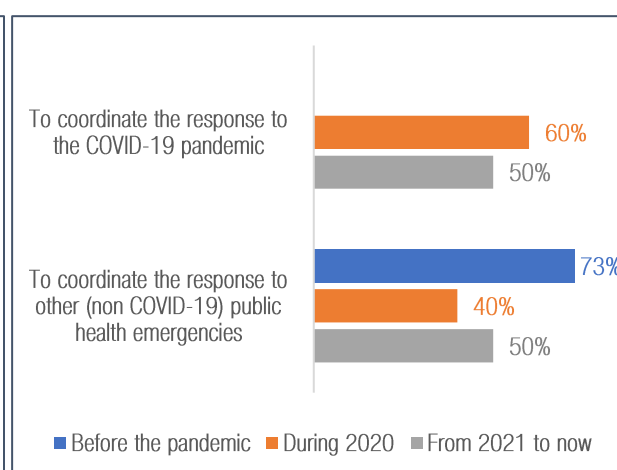
Figure 9. Use of PHEOCs at subnational level

PHEOCs were reported to be used extensively across countries for the COVID-19 response, both at national and subnational levels. For the non-COVID-19 response prior to the pandemic, Emergency operating Centres (EOCs) were widely used (and more so at the subnational level), but their use dropped significantly in 2020.

Figure 8 shows that 57% of respondents reported the use of a PHEOC to coordinate the COVID-19 response in 2020 at the national level, with a decrease to 44% from 2021 onward. Interestingly, the use of a PHEOC to coordinate non-COVID-19-related health emergencies at the national level decreased in 2020 compared with pre-pandemic levels; however, it slightly increased in 2021, back to pre-pandemic levels. Furthermore, Figure 9 shows that, pre-pandemic, PHEOCs were used extensively (73%) to coordinate non-COVID-19 health emergencies at the subnational level. However, this practice decreased in 2020 (40%) but then slightly increased in 2021 (50%).

Appropriateness and benefit of the government coordination architecture in place
Government coordination mechanisms were considered only somewhat appropriate and only somewhat beneficial to the response at national and subnational levels by most respondents to the online mapping exercise. Only 25% of the respondents felt that the government coordination mechanisms were very appropriate (mainly those from the AFRO and EMRO regions), and nearly two-thirds (71%) felt they were somewhat appropriate, with 4% scoring them as not appropriate. Similarly, only 27% of respondents felt that the government coordination structures were beneficial to the response at the national level and 72% felt that they were somewhat beneficial. Similar results were obtained for the subnational level, with 24% of the respondents reporting that these structures were very beneficial, 72% reporting they were somewhat beneficial, and 4% reporting they were not beneficial.

This perception should be compared to the one reported for the humanitarian architecture at the national level, which 55% of respondents perceived as very appropriate, and which 45% and 32% judged as very beneficial at national and subnational levels, respectively. This indicates the importance of reinforcing government coordination structures to ensure they are sufficient to coordinate on the scale required during a pandemic.

In the global online mapping exercise, respondents reported that the changes in the government coordination architecture gave legitimacy to the response activities, particularly those related to quarantine and public health measures (EMRO). Respondents also said that the changes provided the opportunity to use a 'One Health' committee when PHEOCs were not present (AFRO). When PHEOCs did exist, the changes allowed for the

coordination of responses until other mechanisms were put in place (AFRO). Finally, the changes in coordination architecture gave MoH leadership of the COVID-19 response (EMRO). However, what did not reportedly work well was the lack of involvement of ministries/departments other than health (AFRO). A lack of government coordination structures at the subnational level was also reported (AFRO).

Use of IMSTs within WHO

Respondents were asked about the existence of IMSTs within WHO after the pandemic started. WHO IMSTs are an internal function (articulated in the 2017 WHO Emergency Response Framework) that enable WHO country offices to respond better to emergencies. Moreover, respondents were asked whether there was a dedicated cell to support the COVID-19 response. 20 out of 24 countries (83%) reported having established an IMST for COVID-19. 16 of the countries activated the team during 2020 and one country did so in 2021. Ten of those countries with a COVID-19 IMST also had an IMST that was activated for a different crisis.

Finding 1.1.2: Adaptations identified (trends and outliers)

Findings include a description of the adaptations made to coordination models as compared to structures prior to the pandemic at different times during the COVID-19 response (at national and subnational levels).

Areas of change for both government and humanitarian coordination mechanisms
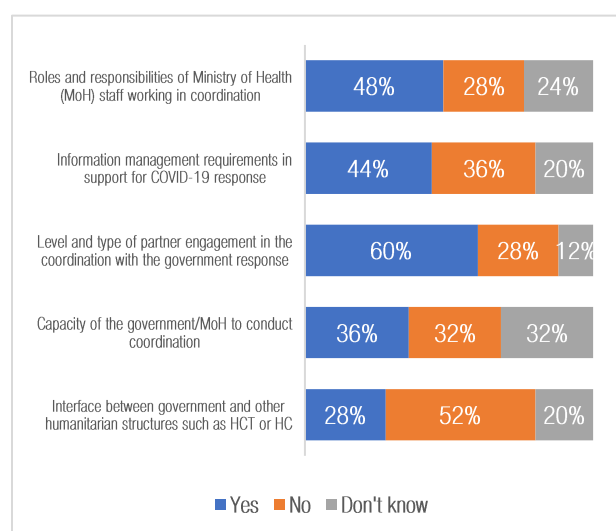
Figure 10. Were there any changes in the following areas for government coordination mechanisms?
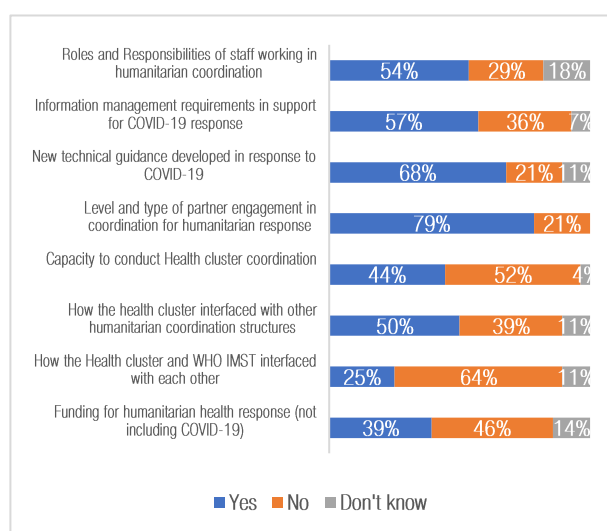
Figure 11. Were there any changes in the following areas for humanitarian coordination mechanisms?

For both government and humanitarian coordination mechanisms, changes to partner engagement and information management were among the three most cited changes referred to by respondents. As shown in Figure 10, in regard to the government coordination of the COVID-19 response, the most frequently reported changes were changes in partner engagement with MoH (60%), followed by changes in the roles and responsibilities of MoH staff working in coordination (48%), and changes in the information management requirements in support needed (44%). The least often mentioned changes included changes to the interface between government and other humanitarian structures (28%), followed by changes to the government/MoH capacity to conduct coordination (36%). Figure 11 for humanitarian coordination of the COVID-19 response shows that changes to partner engagement was the most frequently mentioned change (reported by nearly 80% of respondents), followed by the development of technical guidance (68%) and changes to the information management requirements or support needed (57%). Also, 54% of respondents reported that the roles and responsibilities of staff working in humanitarian coordination changed, and

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50% reported that the interface between the Health Cluster and other humanitarian structures changed. *Thus, it appears that these two themes were considered to be some of the most important aspects that needed change to ensure adequate coordination.*

When did these changes occur?
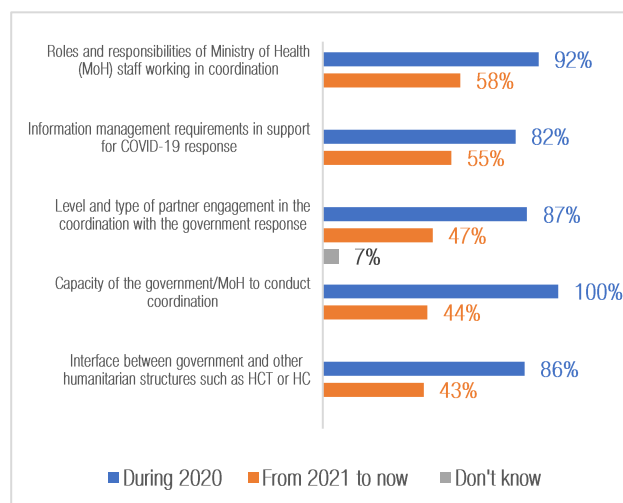
Figure 12. When were changes made at national level for the government's coordination mechanisms?
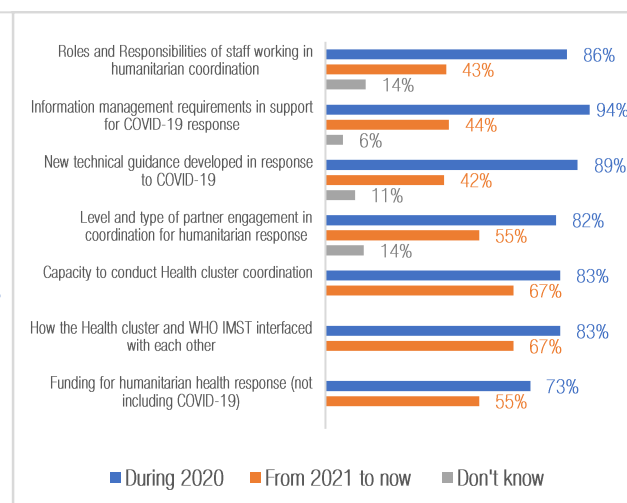
Figure 13. When were changes made at national level for the humanitarian coordination mechanisms?

Most changes occurred in 2020 for both government and humanitarian COVID-19 coordination and response mechanisms, but changes continued to be reported in 2021 to a larger extent for humanitarian coordination – notably for the capacity to conduct Health Cluster coordination and the interface between Health Clusters and WHO. For government coordination mechanisms, Figure 12 shows that all respondents reported that in 2020 changes were made to government capacity to conduct coordination. 92% of respondents reported that the roles and responsibilities of government staff working in coordination changed in 2020, and this was followed by 87% reporting changes to partner engagement with government. Changes to the interface between government and other humanitarian coordination structures followed slightly behind, with 86% reporting these changes, as well as changes to information management requirements in support for the COVID-19 response (82%). In regard to humanitarian COVID-19 coordination and response mechanisms, Figure 13 shows that between 73% and 94% of respondents reported that changes occurred during 2020 across all areas. Changes to and adaptation of these mechanisms continued into 2021 to a much larger extent than did changes to government structures, with between 42% and 67% of respondents reporting changes in 2021, with changes in the capacity to conduct Health Cluster coordination, the interface between the Health Cluster and WHO, followed by partner engagement and funding for humanitarian health response not including COVID-19 being reported the most (at 67%, 67%, and 55%, respectively) in 2021.

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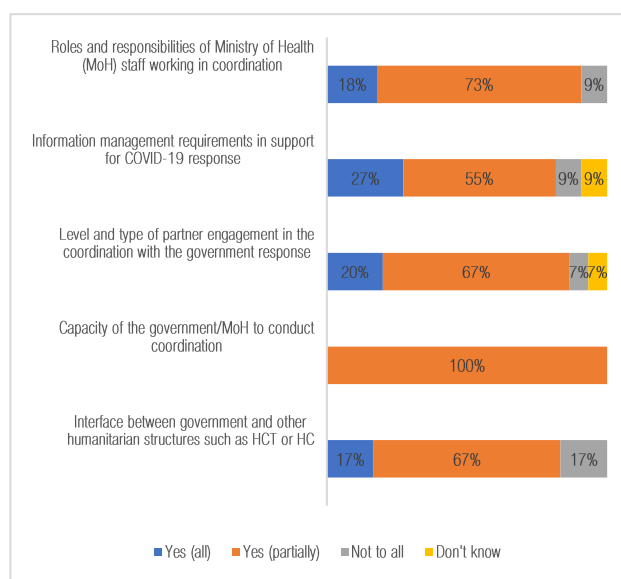
Figure 14. Did the changes identified also occur at subnational level for government coordination mechanisms?
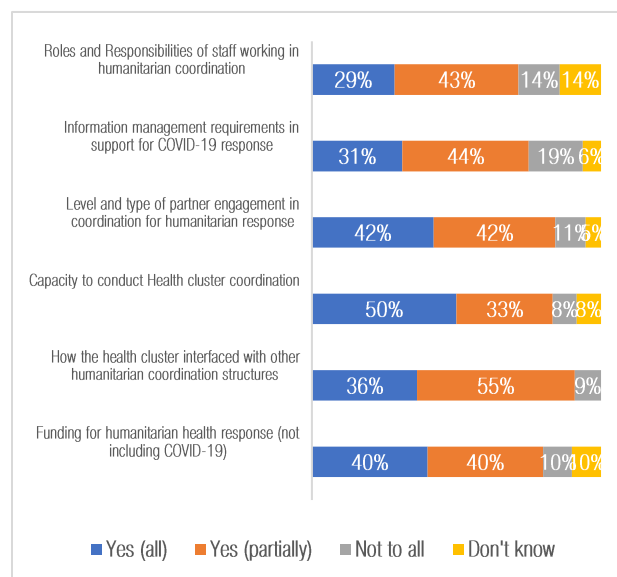
Figure 15. Did the changes identified also occur at subnational level for humanitarian coordination mechanisms?

Overall, in relation to government coordination mechanisms at the subnational level, only a few respondents considered that changes fully occurred across all five themes. The most frequently reported changes that occurred were changes in information management requirements or the support needed for the COVID-19 response (27%), followed by changes in partner engagement (20%) and in the roles and responsibilities of MoH staff (18%). Interestingly, all respondents considered that there changes in government capacity to conduct coordination at the subnational level occurred only partially, as shown in Figure 14.

In regard to the humanitarian health response, respondents more frequently reported changes to this response at the subnational level than reported changes in government coordination mechanisms at this level, but the prevalence of these changes was still lower than for changes at the national level. Where respondents felt the identified changes had been implemented the most were in regard to the capacity to conduct Health Cluster coordination (50%), followed by partner engagement (42%) and funding for the humanitarian health response (i.e. not including COVID-19) (40%). Note that the development of technical guidance and the interface between the Health Cluster and WHO (IMST) were not included since these only relate to the national level. However, other data from the global online mapping exercise indicate that the operations were not pushed down to field level "as per the ERF WHO Emergency Response Framework guidance", with the field level being a recipient only. The effort was not translated at the subnational level due to poor capacities at this level. Moreover, it was reported that interventions were not synchronized between the national and subnational levels, due to political divides (EMRO).
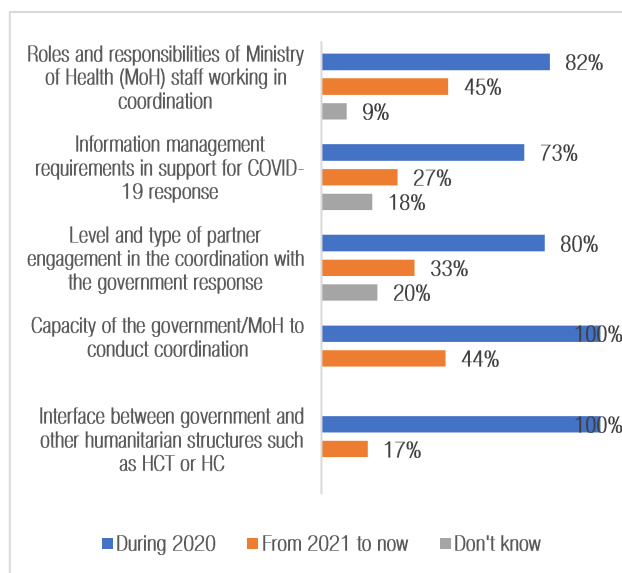
Figure 16. When did the changes occur at the subnational level for the government coordination mechanisms?
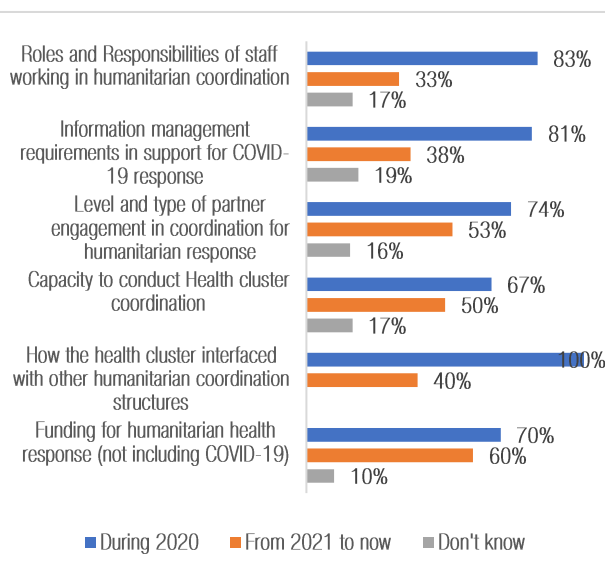
Figure 17. When did the changes occur at the subnational level for the humanitarian coordination mechanisms?

For both coordination mechanisms, changes occurred in 2020 and continued to a lesser degree in 2021, as shown in Figure 16 and Figure 17.

How extensive, appropriate and beneficial were these changes?

The extent of changes within government coordination mechanisms was reported to vary, with from 14% to 33% of respondents reporting significant changes across the five areas (see Figure 18). The roles and responsibilities of staff working in coordination were reported to have seen the greatest change, with 58% reporting significant changes occurring in this area. Across the five themes, overall, the changes were thought to be somewhat appropriate (see Figure 20), with areas being scored as very appropriate by only between 11% and 29% of respondents in each case; a similar picture was seen with regard to how beneficial these changes were at the national level (Figure 22).

Overall humanitarian coordination mechanisms were perceived to have experienced more extensive changes as compared to government coordination mechanisms, with significant changes being reported by between 29% and 82% of respondents across seven themes (see Figure 19). The highest reported changes were changes to funding of the (non-COVID-19) humanitarian health response. However, perspectives on the appropriateness of the changes varied across the themes, ranging between 27% and 83% of respondents reporting them as very appropriate (see Figure 21). However, the changes were thought to be very beneficial by half of respondents for the majority of themes (Figure 23).
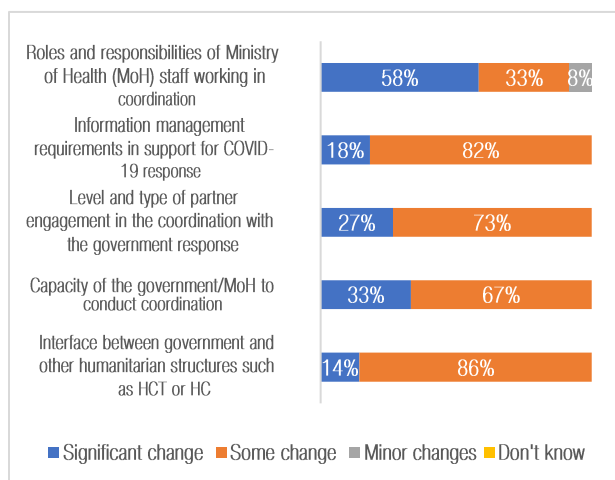
Figure 18. Extensiveness of the changes at national level for the government's coordination mechanisms
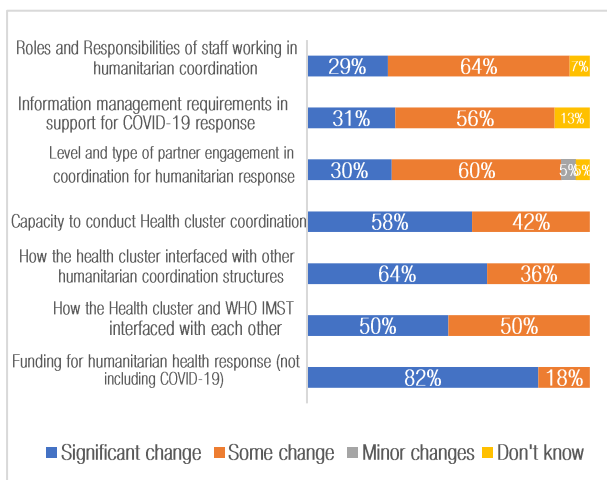
Figure 19. Extensiveness of the changes at national level for the humanitarian coordination mechanisms
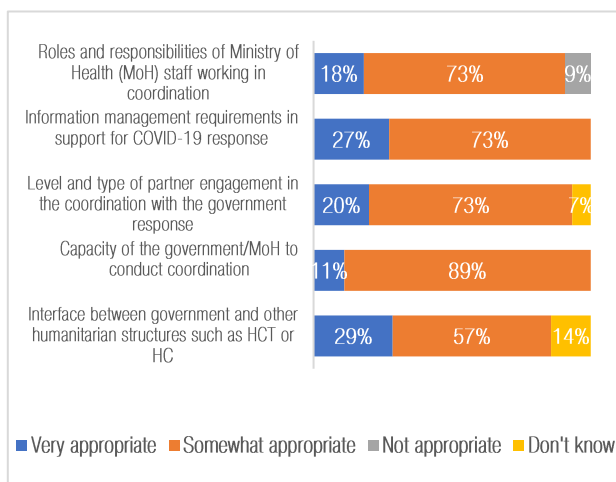
Figure 20. Appropriateness of the changes in relation to the evolving situation/increased need at national level for the government coordination mechanisms
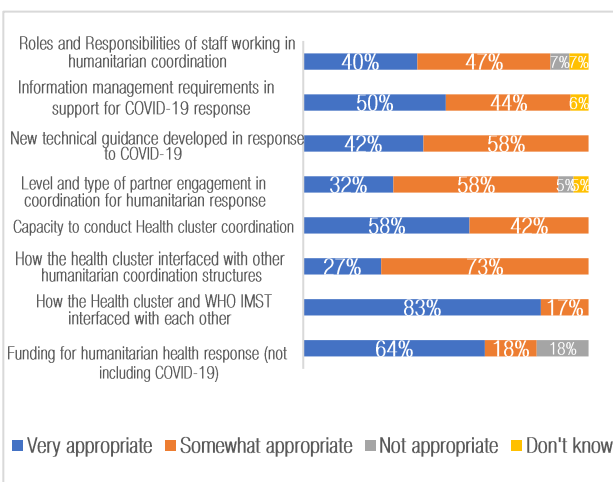
Figure 21. Appropriateness of the changes in relation to the evolving situation/increased need at national level for the humanitarian coordination mechanisms
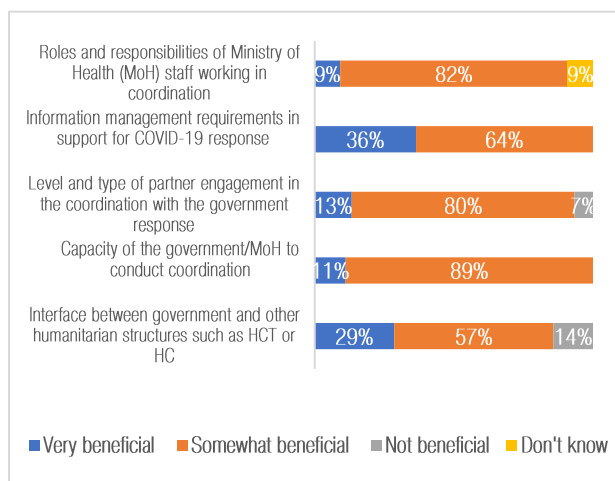
Figure 22. How beneficial were these changes to responses at the national level for the government coordination mechanisms?
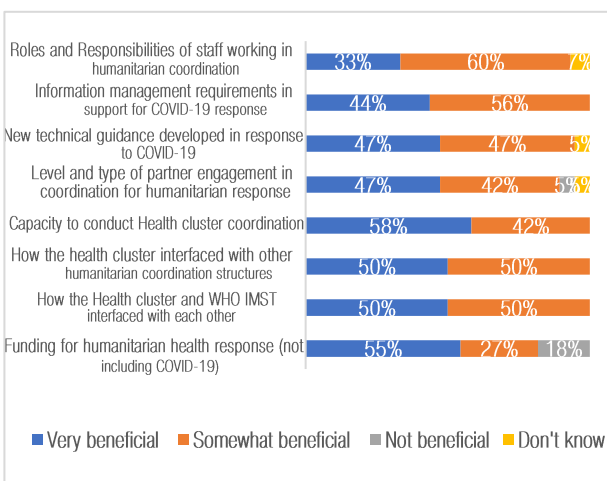
Figure 23. How beneficial were these changes to the response at national level for the humanitarian coordination mechanisms?

Analysis of areas of change for government and humanitarian coordination mechanisms for the COVID-19 response from the mapping exercise

Roles and responsibilities of staff working in the coordination of the COVID-19 response
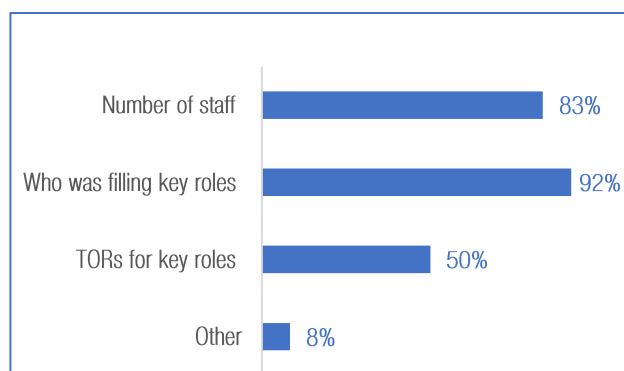
Figure 24. Roles and responsibilities of MoH staff working in the coordination of the COVID-19 response
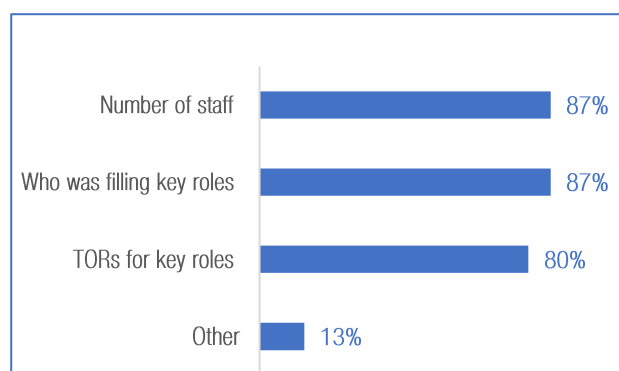
Figure 25. Roles and responsibilities of staff working in humanitarian coordination

As stated previously, respondents reported that changes occurred in almost half of the countries in regard to both government and humanitarian coordination mechanisms for the COVID-19 response: 48% (Figure 11) and 54% (Figure 10), respectively. These changes were reported to have occurred much less at the subnational level (18% and 29% for government and humanitarian coordination mechanisms, respectively) (see Figure 15 and Figure 14).

The roles and responsibilities of staff working in coordination were reported to have seen the greatest change, with 58% reporting significant changes occurring in this area. Most respondents only thought of these changes as 'somewhat appropriate', and 9% reported them as being inappropriate (the only category to be rated as such). Only 9% reported these changes as being very beneficial at the national level. This reflects the fact that governments and MoHs face considerable pressure in regard to performing coordination functions, and they need investment and strengthening to be able to achieve greater impact. (This is further explored in the discussion of Criteria 3. Theme 3.1, Indicator 3.1.1.). Figure 24 shows that most of the changes that occurred related to who was filling key roles (reported by 92% of respondents) and the number of staff (83%), with 50% reporting that the terms of reference for key roles changed.

In regard to the government coordination mechanisms, it was also reported (in the open questions in the mapping exercise) that the closure of some health facilities due to the deployment of their staff to COVID-19-related positions (EMRO) created challenges. Moreover, salaries for additional staff had to be sustained by partners for a long time (AFRO). In addition, a decrease in motivation was also witnessed among staff working during the pandemic when new people were appointed to handle the COVID-19 responses. Moreover, it was reported that there was increased stress among deployed staff as they were afraid of getting infected (EMRO).

In relation to humanitarian coordination mechanisms, changes to the roles and responsibilities of staff in relation to coordination were reported by only 29% of respondents as being significant (lower than that for counterparts in the MoH or government). 40% thought these changes were very appropriate. However, 7% reported that they were inappropriate and only 33% considered that they were very beneficial (the lowest scoring). As such, although overall the changes were considered positive, there is a need to strengthen adaptations of, and changes to roles and responsibilities (see Figure 17, 19 and 21). Like for government coordination mechanisms for coordination of the

COVID-19 response, the major changes reported related to who was filling key roles, the number of staff and the terms of reference for key roles (reported by 87%, 87%, and 80% of respondents, respectively) (see Figure 25) for the humanitarian coordination mechanisms.

It was reported that what worked well was deploying dedicated resources for the COVID-19 response, such as staff who, although they may have been supporting other areas, had technical capacity to support the COVID-19 response and were deployed or seconded to country teams (EMRO), or where separate teams were established to manage the COVID-19 response (AFRO). Such surge mechanisms were also confirmed through the KIIs.

However, for humanitarian coordination mechanisms for the COVID-19 response, it was also reported that, due to the need to support the COVID-19 response, staff work was redirected, and this left gaps in other areas of health responses (EMRO). Furthermore, the turnover of staff affected the coordination of the COVID-19 health response. Lastly, the COVID-19 response substantially increased the staff workload (EMRO/AFRO), with mixed functions or the doubling or tripling of staff responsibilities (EMRO), particularly at the subnational level.

Information management requirements in support to the COVID-19 response
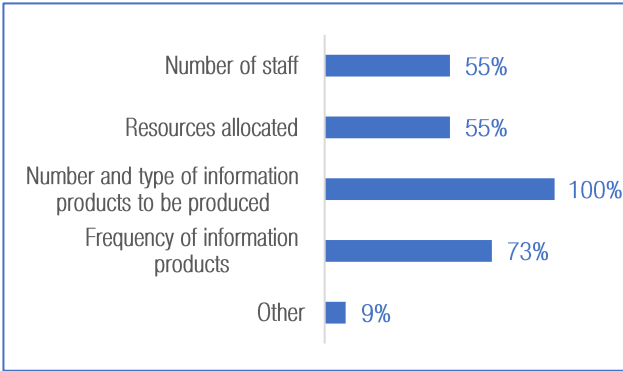
Figure 26. MoH information management requirements
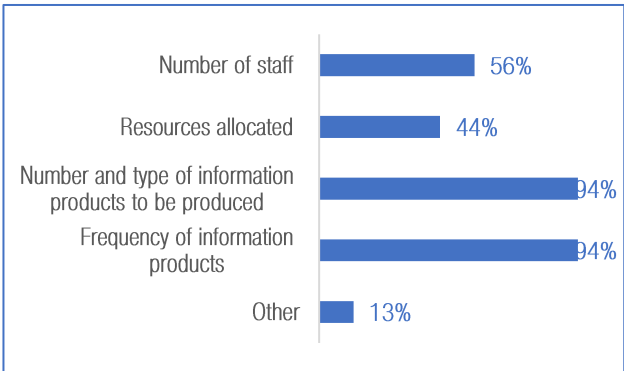
Figure 27. Humanitarian coordination information management requirements

As stated previously, changes to the information management requirements or the support needed for the COVID-19 response occurred in regard to both government and humanitarian coordination mechanisms, (reported by 44% and 57% of respondents, respectively, see Figure 11 and Figure 10). Furthermore, both saw little change at the subnational level, with 27% and 31% of respondents reporting change at the subnational level, respectively (Figure 15 and Figure 14).

However, for government coordination mechanisms, only 18% reported these changes to be significant, only 27% reported them to be very appropriate, while a slightly larger proportion (36%) considered the changes to be very beneficial (see Figure 18, Figure 20, Figure 22).

The main changes that occurred related to the number and type of information products produced, as well as the frequency with which they were produced (reported by 100% and 73% of respondents, respectively). However, changes in the number of staff, as well as resources allocated, were only reported by 55% of respondents (see Figure 26).

It was reported that what worked well for government coordination mechanisms was that cluster partners were better informed about the progress of the disease and the response (EMRO/SEARO). Moreover, COVID-19 data

collection and dissemination improved regarding needs and the required response. Also, joint monitoring of the situation was conducted at both the national and subnational levels (Pan American Health Organization (PAHO)).

What did not work well was that MoH capacity was limited and the distribution of resources within countries was unequitable (EMRO). There were also difficulties in data collection: for example, case management-related data never became available (EMRO). Finally, it was reported that the means of verification were limited and that a lot of fake news was spread (AFRO).

In regard to humanitarian coordination mechanisms for the COVID-19 response, changes to information management requirements or the support needed for the COVID-19 response were the least reported, with only 31% reporting significant change. However, 50% thought that these changes were very appropriate and 44% that they were very beneficial (see Figure 19, Figure 21 and Figure 23), thus suggesting that minor changes to, or adaptations of, information management requirements or the support required for the COVID-19 response worked well within humanitarian coordination structures.

Similar to government coordination mechanisms for the COVID-19 response, changes were reported in regard to the number and type of information products produced, as well as the frequency with which they were produced (94% and 94%, respectively), with only 56% and 44%, respectively, reporting that the number of staff and resources allocated changed (see Figure 27).

For humanitarian coordination mechanisms for the COVID-19 response, it was reported that information products helped draw a better epidemiological picture (EMRO), detect new health issues (PAHO), project the pandemic waves, and support preparedness, including developing guidance. They further helped the response planning and helped to identify gaps (EMRO/EURO/AFRO/SEARO), thanks to the products becoming more frequent and more granular (as also confirmed by KIIs), at both the national and subnational levels. Finally, response monitoring also improved for essential health service delivery (SEARO), which was useful for stakeholder planning purposes (EMRO).

What did not work well was that access to information was at times difficult due to restrictions imposed by some MoHs (EMRO). Also, there was hesitancy among some partners about sharing information on time. Moreover, it was also reported that at times the workload became difficult to manage (AFRO) and too many information products were required, putting a burden on the limited information management staff and technical officers (SEARO) and increasing their working hours.

Interface with other humanitarian structures
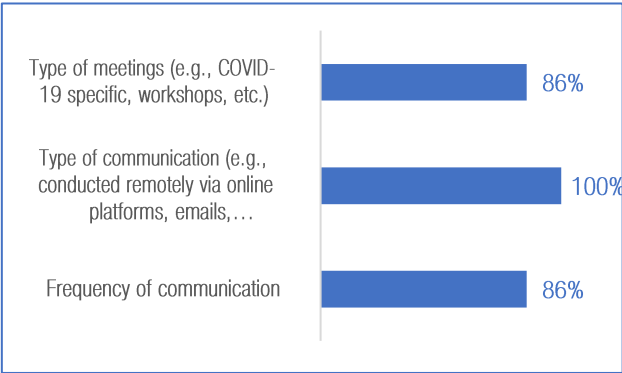
Figure 28. Interface between government and other humanitarian structures
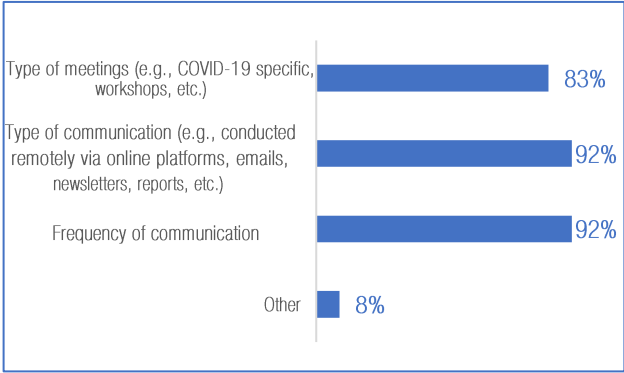
Figure 29. Health Cluster interface with other humanitarian coordination structures

Only a low proportion of respondents reported any changes occurring to the interface between government and other humanitarian structures (such as with Health Cluster or HCT) (28%), as compared to 50% reporting changes to the interface between the Health Cluster and other humanitarian structures (see Figure 10 and Figure 11). This same disparity was seen at the subnational level, with 17% and 40% of respondents reporting changes to the interface between government or the Health Cluster with other humanitarian structures, respectively (Figure 14 and Figure 15).

The interface between the government and other humanitarian structures, such as the Humanitarian Coordination Teams or Humanitarian Coordinator, saw the least reported significant change (14%), but they had the highest rating as very appropriate. Interestingly, mixed results were seen as regards whether or not these changes were beneficial, with a high proportion reporting the changes to be very beneficial (29%) but 14% reporting that they were not beneficial (see Figure 18, Figure 20 and Figure 22). The type of change most commonly reported was to the type of communication, followed by the type and frequency of communication about the government coordination mechanisms (see Figure 28). These dynamics are further explored in the discussion of Criteria 3, Theme 3.1, Indicator 3.1.1.

In regard to humanitarian coordination, the extent of change regarding the interface between the Health Cluster and other humanitarian structures was reportedly high, with 64% reporting significant changes (the second highest out of the different areas). However, only 27% perceived these changes as being very appropriate (the lowest scoring), though 50% considered them to be very beneficial. This suggests that although there was a positive impact of the interface between, and collaboration by, the Health Cluster and other humanitarian structures, the mechanisms or platforms established for this need to be improved and strengthened, and perhaps made easier and more efficient (see Figure 19, Figure 21 and Figure 23). Figure 29 shows that the most commonly reported changes here were changes to the type and frequency of communication, followed by changes to the types of meetings.

Respondents additionally reported that for humanitarian coordination, the increased interaction between Health Clusters and other clusters, such as protection, education, etc., improved coordination between different sectors, with better integration of activities for greater efficiency (AFRO). However, it was also reported that, due to coordination fragmentation (multiple frameworks), though health sector work improved it was still very siloed across the response (EMRO).

Capacity to conduct coordination
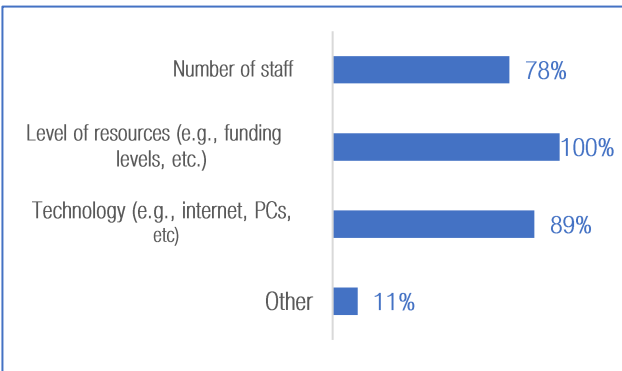
Figure 30. Capacity of the government/MoH to conduct coordination
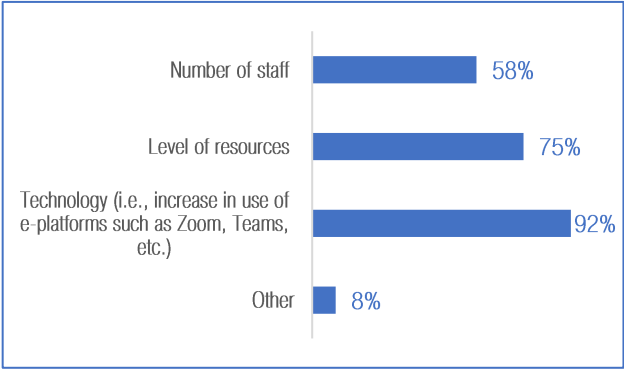
Figure 31. Capacity to conduct Health Cluster coordination

Respondents reported that changes occurred to the capacity to conduct coordination for both government and

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humanitarian coordination mechanisms (36% and 44%, respectively) (see Figure 10 and Figure 11). However, at the subnational level, all (100%) respondents reported that only partial changes had occurred at the subnational level for government coordination mechanisms, whereas 50% reported full changes at this level for humanitarian coordination mechanisms (Figure 14 and Figure 15).

In regard to government coordination mechanisms, this theme saw the second highest reported extensive change, with 33% of respondents stating that significant changes had occurred. However, only 11% considered these changes as being very appropriate, and only 11% as being very beneficial, at the national level (see Figure 18, Figure 20 and Figure 22), again reflecting the fact that there is a need for investment and support to this area. The changes that were made were to the level of resources dedicated to coordination, the use of technology (e.g. internet, PCs etc.). Only 78% of respondents report that there were changes to the number of staff (Figure 30).

On the humanitarian coordination side, capacity to conduct Health Cluster coordination was reported to have seen significant changes in many settings (by 58% of respondents). A similar proportion perceived these changes to be very appropriate and very beneficial (see Figure 19, Figure 21 and Figure 23). This reflects positively on the impact of the changes made. The most common changes made were to the use of technology and the level of resources, whereas the least common were changes to the number of staff, reported by 58% of respondents (Figure 31), thus perhaps reflecting the fact that pre-COVID-19 staffing for coordination was almost adequate to incorporate a new shock (such as COVID-19).

In open-ended responses, the use of technology was reported to have enabled the Cluster to continue the coordination: for example, using online forums and thereby expanding participation to the subnational level and to non-typical attendees, such as academics and remote actors (EMRO). Moreover, the presence of a dedicated HC coordination team at national and subnational levels (EURO/EMRO) allowed the Health Cluster to perform its work. The use of online modalities also decreased the cost of coordination, as many activities were moved online, allowing for more regular and frequent Health Cluster coordination meetings at both national and subnational levels (EMRO). In contrast, the use of remote and online meetings affected partners' networking negatively. Moreover, the online modality hindered discussion, with the tendency being to only provide updates, limiting the engagement of partners; at times, connectivity issues were also faced (EMRO).

Interface between the Health Cluster and WHO (IMST/Incident Management Support (IMS))
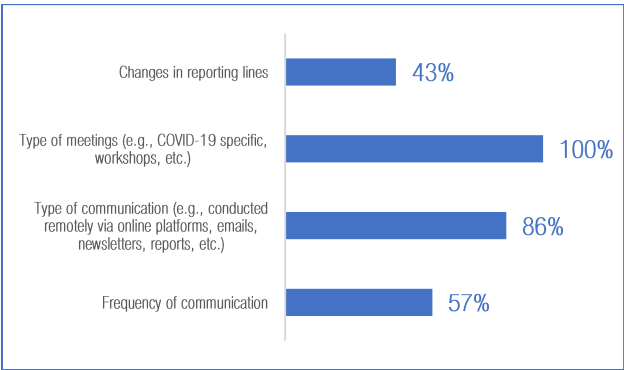
Figure 32. Health Cluster and WHO IMST interface with each other

As stated previously, more than two-thirds of WHO country offices operating in humanitarian contexts established a dedicated COVID-19 IMST. 25% of respondents reported that there were changes to the interface between the

Health Cluster and WHO (IMST/IMS) (Figure 10), 50% of whom reported that these changes were significant (Figure 19). Interestingly, these changes were deemed very appropriate by 83% of respondents (with this category achieving the highest response) and were also considered to be very beneficial at the national level by 50% of respondents (see Figure 21 and Figure 23). Figure 32 shows that all respondents reported that the type of meetings changed, followed by the type of communication and their frequency, with a change in reporting lines reported by only 43% of respondents. This is further explored in the discussion of Criteria 3, Theme 3.1, Indicator 3.1.2.

Funding for the non-COVID-19 response
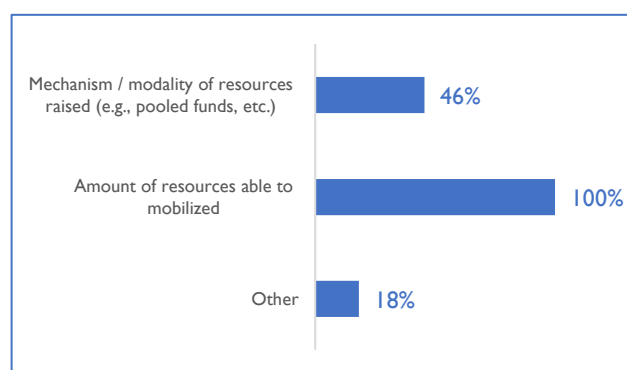
Figure 33. Funding for the humanitarian health response (not including COVID-19)

39% of respondents reported that changes occurred to the funding for the non-COVID-19 humanitarian health response (Figure 10). This change was the most frequently reported with extensive changes, with 82% reporting significant change (Figure 19). 64% reported these changes as being very appropriate and 55% as being very beneficial, while 18% considered them to be inappropriate and 18% to be not beneficial. Thus, despite good practice occurring in some contexts, challenges to funding the non-COVID-19 humanitarian health response still occurred in nearly one-fifth of Health Cluster settings. This is explored further in the discussion of Criteria 3, Theme 3.1, Indicator 3.1.1.

Figure 33 shows that the most commonly reported change was to the amount of resources that were able to be mobilized, followed by a change to the mechanisms/modalities of the resources raised.

In the open-ended questions within the mapping exercise, other aspects that were reported included the fact that it was necessary to take into consideration the COVID-19 response when responding to other emergencies, and that, as such, other responses plans had to be developed. Furthermore, respondents stated that proactive advocacy for resource mobilization (EMRO) and the integration of COVID-19 into other emergency responses (AFRO) was well managed. In some cases, integration of the COVID-19 response into other emergency responses helped to improve the health system in general, as well as rationalize the use of resources (EMRO). Conversely, however, other respondents stated that the massive investment in COVID-19 came at the expense of other essential health services (EMRO). Moreover, there was no subnational architecture and parallel coordination mechanism to manage emergencies and COVID-19, and no plan for transitioning responsibilities to regular health systems (AFRO). These responses further reiterate the mixed picture that was observed regarding resource mobilization for the non-COVID-19 humanitarian health response.

Development of technical guidance
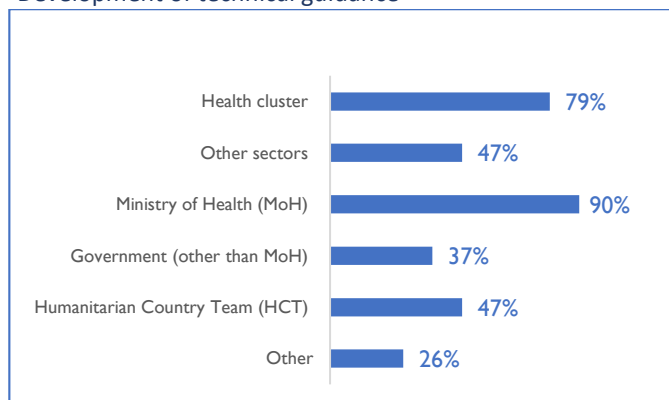
Figure 34. Technical guidance(s) developed in response to COVID-19

68% of respondents reported that new technical guidance was developed in response to COVID-19 at the country level (Figure 10). Figure 34 shows that technical guidance was mainly developed by MoHs (90%), followed by the Health Cluster (79%) and other sectors or HCTs (both 47%). This guidance was reported to be very appropriate to the evolving situation/increased need at the national level by 42% of respondents. Furthermore, 47% of respondents considered it very beneficial for populations affected by humanitarian crises.

In the open-ended questions for the mapping, some respondents reported that during 2020 guidelines were developed through the collation of scientific evidence provided by scientific institutions such as the Centres for Disease Control and Prevention or WHO Headquarters. They were further informed by data collected on the ground, which were used to guide the development of country-specific guidance, which was then disseminated by the health actors. The case studies suggested that scientific committees were used to inform the development guidelines, but that this was mostly channelled through WHO or the Health Cluster. At times, MoH scientific committees were also formed.

"Any guidelines issued by the MoH were implemented in a timely manner in the department. Strategies were adapted to the territory, at the level of education and the language of the territory. This made it possible to reach the population in an educational way and to ensure that this information was appropriated and internalized by the population." – KII, Colombia

"At the country level there was were different forums created by the ministry: technical advisory groups to engage with academia and the private research sector, public health experts from national institutions. They were also gathering information from universities when the vaccine was introduced. The universities were proactive for this engagement." – KII, Occupied Palestinian Territory

Although no specific committees were identified at the subnational level in Syria, it is interesting to note that in the absence of a national-level committee due to the political fragmentation, the diaspora was used to channel scientific information.

Respondents to the global online mapping exercise also reported that guidance, such as Information, Education and Communication materials, was simple and clear, tailored for use by the general public, and helped sensitize communities on how to protect themselves (EMRO). It was also felt that strong involvement from MoH from the start helped to bring about a sense of national ownership regarding surveillance and case management (EMRO). Finally, the development of various guidelines helped guide the response to COVID-19 (AFRO). What did not work well was that the guidance provided was not always consistent across agencies or areas within the same country and was sometimes not updated rapidly as the pandemic evolved; and, in some cases, guidance was not contextualized sufficiently for populations affected by humanitarian crises (EMRO/AFRO). Also, it was reported that there was limited enforcement of guidelines, due to a lack of sufficient monitoring (EMRO).

Analysis of areas of change for government and humanitarian coordination mechanisms for the COVID-19 response and the non-COVID-19 response from the case studies

Government coordination mechanisms for the COVID-19 response and the non-COVID-19 response
The following are further adaptations that were identified through the analysis of the country case study data, as well as the SDR. The findings are aligned with the eight categories of adaptations for the humanitarian coordination mechanisms and the five categories of adaptations for the government coordination mechanisms. The findings are disaggregated by time period and administrative level, where appropriate.

During 2020
National level

Category	Adaptations	Analysis
Capacity to conduct coordination	*Coordination structures for response to COVID-19 were established, such as national-level committees or taskforces under presidential office or prime minister's offices, as well as inter-ministerial committees, and they met up to daily during the peak of the crisis.*	At national level, most governments established COVID-19 dedicated coordination mechanisms at the highest decision-making level. These bodies aimed to provide strategic oversight and to support operational-level committees and/or taskforces. The creation of inter-ministerial task forces/committees also demonstrated a recognition that the COVID-19 response required a multisector approach. These coordination mechanisms were reported to be meeting daily at the peak of the crisis. "At the MoH level, each committee will convene daily meetings and select the highest-level priority from the list of priorities highlighted in this plan to follow." − SDR, Afghanistan

Roles and responsibilities	*The pillar approach provided a clearer distribution of roles and responsibilities.*	The pillar approach was found to provide for a clear distribution of roles and responsibilities for the coordination of the response, and it further facilitated the allocation of leadership roles for the Health Cluster partners. "Then we had a coordination group for each pillar. Of the nine pillars, we added a vaccination pillar later, and there was an agency in charge of each pillar, and the meetings and updates were done accordingly." − KII, Sudan
Capacity to conduct coordination	*Adoption of virtual/online meeting modalities, which caused some challenges*	Governments adopted the use of virtual/online meeting modalities, which caused some challenges. In some countries key informants reported that government staff had limited knowledge of online platforms and required training to facilitate this approach. Furthermore, several countries reported issues with infrastructure and network connectivity preventing meetings from being conducted smoothly. "The government officers had less experience with the internet, which was challenging in terms of meetings. So, the government officials needed to be trained and help facilitate their active participation online." − KII, Yemen

Table 8. Government coordination adaptations at national level during 2020

Subnational level

Category	Adaptations	Analysis
Capacity to conduct coordination	*Committees or taskforces replicating national-level committees were established*.	At the subnational level, structures were established that replicated the national level structures in an attempt to ensure that the government coordination structure was mainstreamed from the national level to the subnational level. "Structure: replicated at the governorate level. At national and sub national level, all bodies were formed." − KII, Syria

Table 9. Government coordination adaptations at subnational level during 2020

From 2021 onward

Insufficient data were available to identify key findings at either national or subnational level for government coordination mechanisms.

Humanitarian coordination mechanisms for the COVID-19 response and the non-COVID-19 response

During 2020

Category	Adaptations	Analysis
Capacity to conduct coordination	*Multisector approach was recognized as necessary, and plans were developed accordingly.*	COVID-19 was recognized as a multisector issue and therefore rather than adopting a vertical approach many governments initiated multisector planning. "Therefore, Inter-Cluster Coordination Team ICCT developed a three-month COVID-19 response plan looking at multisector response approaches, in an effort to reconcile with what we had

		projected at the start of the year because HRPs are both backward-looking and forward-looking." – KII, Afghanistan
Capacity to conduct coordination	Vaccination became a prominent activity, with a separate pillar.	Prior to the pandemic, vaccination was included as a routine activity within EPI. However, as a result of COVID-19, and the prominence of the vaccine, it became a separate pillar (Pillar 10) relating to organizing strategy, decision-making and approaches regarding choice of vaccines, supplies, vaccination campaign, etc. "Before the pandemic, vaccination was only an EPI or expanded activity, but it has now become a whole organization-wide response in all departments – finance and admin also represented. A more structured coordination." – KII, Yemen
Capacity to conduct coordination	Virtual work enabled more cost-effective coordination due to a reduction in transportation costs.	Due to the restrictions imposed by COVID-19 and the need to protect staff, meetings were conducted virtually. This enabled home-based work and provided opportunities for the continued delivery of training, which reduced transportation costs. "Positive impact of virtual working is that different mechanisms were explored and how they could be made more effective, transportation costs were reduced, reduced carbon footprint." – KII, Afghanistan "Due to the work required and the tight deadlines expected, the Technical Working Group will be held on biweekly (every two weeks) basis as routine frequency." – SDR, Cox's Bazar, Bangladesh "Good practice: learning to work virtually." – KII, Colombia
Capacity to conduct coordination	Meeting frequency was upgraded and meetings evolved from face-to-face meetings to virtual meetings.	One of the most significant adaptations identified by respondents was the use of virtual/remote meetings, as well as increased frequency of meetings, aligned with increased coordination requirements. "Yes, online meeting was innovative. It wasn't that much used or popular before COVID-19." – KII, Sudan
Capacity to conduct coordination	COVID-19 taskforces and/or thematic working groups were established.	Many taskforces and/or thematic working groups were established to support the coordination of the COVID-19 response, and these were aligned with the pillar approach. "The Health Cluster helped established thematic working groups for laboratories, risk communication, case management, infection prevention and control, and supported through developing terms of reference, membership and a schedule of meetings. It initiated the first meeting and then continued to provide secretariat support to all thematic working groups." – KII, Yemen

Table 10. Humanitarian coordination adaptations at national level during 2020

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Subnational

Category	Adaptations	Analysis
Capacity to conduct coordination	*Coordination structures were adapted based on the context, such as camp-level coordination or the creation of core inter-cluster groups dedicated to the COVID-19 response. Meeting frequency and the use of virtual means increased as well.*	At subnational level, coordination structures were adapted based on the specific context. In line with the national level, meeting frequency was increased to meet increased coordination requirements, and the use of virtual meetings was adopted. " The creation of a core inter-cluster coordination group … was more effective than the usual ICCG in Occupied Palestinian Territory." − KII, Occupied Palestinian Territory "The structure did not really change, but the frequency of meetings increased." − KII, Syria "Meetings were shifted to online meetings. In the early years, mostly COVID-19 was discussed, a lot of activities were set aside." − KII, Syria

Table 11. Humanitarian coordination adaptations at subnational level during 2020

From 2021 onward

National

Category	Adaptations	Analysis
Capacity to conduct coordination	*While the frequency of coordination meetings declined, the focus on COVID-19 was maintained, with the topic being kept as a standing agenda point.*	At national level, from 2021 onward the need for very frequent meetings decreased and therefore meeting frequency was reduced from weekly to monthly and to sometimes only *ad hoc* meetings. However, COVID-19 was retained as a standing agenda point in HCT and Health Cluster meetings. Many countries have now adopted a hybrid approach, combining face-to-face meetings with remote meetings. "Meetings have been scaled from weekly to monthly, as there is barely anyone in centres, and very few COVID-19 cases." − KII, Cox' s Bazar, Bangladesh

Table 12. Humanitarian coordination adaptations at national level from 2021 onward

Subnational

Category	Adaptations	Analysis
Capacity to conduct coordination	*Meeting frequency declined at subnational level.*	At subnational level, meeting frequency was also reduced, in line with the reduced need. " The frequency changed of meetings from monthly to weekly at national level, and now it is back to monthly, of which donors are a part, which is very good." − KII, Syria

Table 13. Humanitarian coordination adaptations at subnational level from 2021 onward

Conclusions for Theme 1.1: What adaptations have been made to coordination structures throughout the COVID-19 response (at both national and subnational levels)?

The mapping survey identified the coordination platforms established by both governments and MoHs, as was well as humanitarian platforms. The establishment of presidential taskforces and MoH task forces (or equivalent), as well as inter-ministerial or other groups, was mapped and the utilization of PHEOCs for humanitarian coordination platforms taskforces or working groups specific to COVID-19 were mapped for the Health Cluster, inter-sectoral cluster coordination group as well as HCT. For both government and the Health Cluster, the survey investigated the changes that took place for key themes, their extent, as well as how appropriate and beneficial they were. The themes were the roles and responsibilities of those working in coordination, information management requirements in support to the COVID-19 response, the level and type of partner engagement, the capacity to conduct coordination, the interface with other coordination structures, as well as fundings structures.

Government coordination mechanisms

National level

- The main adaptation identified by the online mapping exercise and the country case studies, in relation to 2020, was the establishment of national-level coordination mechanisms, including dedicated taskforces/committees to coordinate the COVID-19 response, activated at the highest decision-making level within government, either under presidential offices or prime minister offices. The case studies showed that at the peak of the crisis these mechanisms were found to be meeting up to daily, and that online modalities were rapidly adopted.
- Other coordination platforms reported to be established were MoH task forces with external partners (89%), inter-ministerial coordination platforms (74%), as well as others, such as scientific committees, quarantine management task forces, and vaccine-dedicated taskforces.
- PHEOCs were used prior to the pandemic and were reported to be used in most settings at national (56%) and subnational (60%) levels to support coordination of the COVID-19 response.
- Most coordination platforms existed in 2020 and continued to be present in 2021, although to a lesser extent for government coordination as compared to humanitarian coordination. This suggests that for future pandemics involving a novel pathogen, similar approaches may be required, including coordination for specific areas, such as a scientific committee and vaccine-dedicated taskforces.
- The establishment of inter-ministerial coordination mechanisms reported across the case studies and the online mapping exercise demonstrate that governments recognized the multisector nature of the crisis.
- The three most frequently reported changes to government coordination mechanisms in the online mapping exercise were changes to the level and type of partner engagement, to the roles and responsibilities of those working in coordination, and to the information management requirements in support to the COVID-19 response. This suggests that these areas should be considered as important requisites that need to be addressed to ensure relevant and effective coordination in a future pandemic or outbreak.
- Although significant changes were reportedly made to the roles and responsibilities of those working in coordination and partner engagement, these changes were considered to be "very appropriate" and "very beneficial" to the response at the national level only by a small proportion of respondents (9% and 13%, respectively). By contrast, although fewer respondents reported that significant changes were made to information management, a higher proportion of respondents reported these to be appropriate and beneficial to the response at the national level (27% and 36%, respectively). This demonstrates that relatively modest changes that are appropriate can have considerable impact.
- For all if the themes investigated by the online mapping exercise, the vast majority of respondents

considered the changes to be only "somewhat appropriate" and "somewhat beneficial", suggesting that significant opportunity for improvement remains. Changes to government/MoH capacity to conduct coordination saw the lowest proportion of respondents reporting that they were "very appropriate" and "very beneficial" (11% and 11%, respectively).

Subnational level

- The coordination structures established by governments at the subnational level were in general found to mirror those at the national level. It was found that coordination structures need to be context-specific, with coherence in the structures from national level to subnational level.

- However, in the online mapping exercise, changes reported to have occurred at the national level (e.g. to roles and responsibilities, to partner engagement etc) were also reported by the vast majority of respondents to have "partially" occurred at the subnational level. The area where the most substantial changes were considered to have occurred was to information management and partner engagement, for which 27% and 20% of respondents, respectively, reported that changes "fully" occurred. However, this is in contrast to the picture for changes reported to have occurred to MoH capacity to conduct coordination, with 0% of respondents considering that such changes "fully" occurred. This may indicate that capacity for coordination at the subnational level did not receive sufficient attention or support at the subnational level, given the changes in partner engagement and information management requirements. Coordination capacity at the subnational level should therefore be reinforced.

- In the online mapping exercise, respondents reported the use of PHEOCs, particularly at subnational level, to coordinate the response to COVID-19, especially in 2020 (60% of respondents). 73% of respondents also reported the use of PHEOCs to coordinate other public health emergencies prior to the pandemic.

Humanitarian coordination mechanisms

National level

- In 2020, as for government coordination mechanisms, the study found that humanitarian coordination mechanisms established *ad hoc* taskforces or thematic working groups dedicated to the coordination of the COVID-19 response. When asked about the establishment of COVID-19-specific coordination structures, the highest percentage of respondents in the online mapping exercise reported the establishment in 2020 of a COVID-19 working group within the Health Cluster at national level (58%), as well as subnational level (47%), during 2020. 32% of respondents also reported the establishment of a COVID-19 working group within the HCT and 21% reported a COVID-19 working group being set up within an ICCG/ISWG. The COVID-19-working groups within the Health Cluster were largely continued in 2021, but the working groups in the HCT and ICCG/ISWG continued to a lesser extent. This demonstrates the importance of COVID-19 coordination being integrated and being a specific focus even at the highest level of humanitarian coordination.

- Coordination meetings were reported to have increased in frequency up to a daily basis at the peak of the crisis and to have shifted from face-to-face meetings to virtual modalities. This allowed coordination mechanisms to adapt social distancing restrictions and was also acknowledged as being more cost-effective. Although the meeting frequency declined in 2021, COVID-19 was retained as a standing agenda item in Health Cluster meetings, ensuring that the focus was not diminished.

- Humanitarian coordination mechanisms also recognized the multisector nature of the crisis and plans were developed accordingly. (Note that another GHC study is being conducted to examine this further.)

- Regarding the different themes investigated by the online mapping exercise and the changes that occurred,[x] most were reported to have happened in 2020 but changes continued into 2021 (and to a larger extent for humanitarian coordination as compared to government coordination). This particularly applied to the capacity to conduct Health Cluster coordination and to manage the interface between the Health Cluster and WHO, suggesting that it should be anticipated that changes may occur over a long period when managing a novel threat such as COVID-19.
- "Level and type of partner engagement" and "information management requirements in support to the COVID-19 response" were among the three most frequently reported areas that saw change, for humanitarian coordination structures, in the online mapping exercise (by 79% and 57% of respondents, respectively). However, both were reported to have seen the least extensive changes as compared to other categories (only 30% and 31% reported these as seeing significant changes). Nevertheless, the changes did appear to be beneficial at the national level (47% and 44% reported that the changes to partner engagement and information management were very beneficial, respectively), suggesting that small adaptations can be sufficient to achieve desired effects.
- Despite the fact that only 27% of respondents considered the changes to the interface between the Health Cluster and other humanitarian structures to be "very appropriate", these changes were sufficient to have a positive impact at the national level, with 50% of respondents reporting that the changes were "very beneficial".
- The online mapping exercise found that more than two-thirds of WHO country offices operating in humanitarian contexts established a dedicated COVID-19 IMS, and the majority of these mechanisms were established in 2020, but respondents noted that establishment was not always timely or contextualized appropriately.
- Despite only 25% of respondents to the online mapping exercise reporting changes to the interface between the Health Cluster and WHE IMS, these changes were considered to be the most appropriate changes across all areas (with 83% of respondents reporting them to be very appropriate) and were considered very beneficial by half the respondents, indicating that the interface and coordination positively impacted the COVID-19 response.

Subnational level
- The case study findings show that context-adapted coordination structures were established at the subnational level. In the online mapping exercise, around half of the respondents reported that a COVID-19 subnational working group was established in 2020, in line with responses at the national level.
- At the subnational level, the humanitarian coordination architecture in place for COVID-19 was reported to be "very beneficial" by 32% of respondents, as compared to 45% at the national level, in the online mapping exercise. This indicates that there were some inadequacies at the subnational level.
- Changes across the seven different areas (such as partner coordination etc.) were overall reported to have only "partially occurred" at the subnational level (with responses ranging between 45% and 55%). Interestingly, changes were reported to have occurred fully at the subnational level for capacity to conduct

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[x] As compared to government coordination, the following seven themes were explored: roles and responsibilities of staff working in humanitarian coordination, information management requirements and support needed, level and type of partner engagement, capacity to conduct Health Cluster coordination, interface between Health Cluster and other humanitarian structures, interface between Health Cluster and WHO IMS/IMST, and funding for humanitarian health response (not including COVID-19). Again, respondents were also asked when changes happened, how extensive changes were, whether the changes were appropriate, whether the changes were beneficial, and whether the changes were applied at the subnational level.

Health Cluster coordination (50%) and partner engagement (42%), which is much higher as compared to changes occurring within subnational governments regarding information management requirements and support given.

Theme 1.2: What are the enabling factors or bottlenecks to ensuring an effective interface within and between the different coordination structures (at both national and subnational levels)?

Finding 1.2.1: Number of enabling factors frequently identified

The table below summarizes the most frequently identified factors which enabled effective interface within and between the different coordination structures (at both national and subnational levels).

Government coordination mechanisms
National level

Cat.	Change identified	Analysis
Partners	*Engagement of partners in government response planning was cited as a good practice*	In some countries, key informants reported that the government was proactive in engaging partners in response planning. In some countries, examples of proactive collaboration on joint initiatives were cited: for example, guidance on COVID-19 vaccine roll-out and rapid assessment tools to assess the impacts of the pandemic on essential health services. In other countries, technical support from partners was identified as an enabling factor for government coordination, such as technical support and guidelines from WHO. "MoPH asks for contribution s from health partners for the preparedness plan." – KII, Occupied Palestinian Territory
Political will	*Commitment, political will and recognition of the importance of COVID-19 response were identified as factors which enabled coordination*	Respondents reported that commitment from government was a factor that enabled coordination. This was demonstrated through engagement in regular meetings, proactive engagement, sharing of information, allocation of funding, demonstrating flexibility regarding operations and activities, and being open to support and suggestions. "In the south, the openness of MoH was an enabling factor to the coordination. They were open to support and suggestions and committed to ensuring response and vaccine deployment was successful." – KII, international partner, Yemen
Structure	*Establishment of high-level government task forces and/or committees provided a structure for the COVID-19 response and provided the opportunity to engage with government at different levels*	At the national level, respondents reported the establishment of national high-level task forces and/or committees which prioritized the COVID-19 response, provided a structure for mobilizing the COVID-19 response and bringing ministries together for planning and implementation of the COVID-19 response, as well as providing opportunities to engage with government at different levels. "At national level, there is the International Development Committee, which leads and provides regular outbreak updates on activities and the evolution of the situation. Some government multi-coordination structures has have been formed and they provide leadership and help identify, at national level,

| | | medical-related human resources gaps and responding to COVID-19." – KII, Cox Bazar, Bangladesh |

Table 14. Government coordination – national level – change identified

Subnational level

Cat.	Change identified	Analysis
PHEOC	*Where a PHEOC existed, it was utilized for coordination of the response*	KII respondents, as well as data from the mapping exercise, show that PHEOCs were utilized for coordination of the response, which enabled coordination with partners and leadership by MoH. Data show that PHEOCs were utilized for coordination of the response at the national level but were used more frequently at the subnational level. "WHO also made a good coordination, ensuring the communication with the EOC Emergency Operation Centre, which is responsible for COVID-19 intervention from the side of de facto authorities." – KII, Afghanistan

Table 15. Government coordination – subnational level – change identified

Humanitarian coordination mechanisms

Cat.	Change identified	Analysis
Approach	*The existence of multisector COVID-19 response plans provided a basis for the response, helped guide the response and provided common objectives*	Response plans were national coordinating documents which recognized the multisector impact of COVID-19 and provided a common plan and structure for the response. "At least we managed to articulate the response – an agreement over the nine pillars, the overall framework, activities. At the strategic level, we articulated the response, and it wasn't left to convenience for each organization." – KII, Sudan
Guidance	*Development and dissemination of guidance and the provision of technical guidance from WHO enabled coordination and common approaches in response interventions*	Development and dissemination of protocols and best practice guidelines, often through the Health Cluster, including technical recommendations, were critical in the development of planning, supported common approaches, and provided important guidance for partners. Partners cited case management, infection prevention and control (IPC) and referral protocols. "Dissemination of protocols and best practice guidelines from WHO, including technical recommendations, were distributed to the Health Cluster, lots of studies and scientific materials were shared and free training offered on treatment protocols." – KII, Yemen
Guidance	*Sharing and the use of scientific information was valued for response planning and implementation at national level*	Information sharing from scientific committees was valued and considered enabling for response planning and prioritization. Scientific knowledge was reported to be shared, discussed and utilized in different working groups. " A scientific committee was implemented, and MoH and cluster started implementing activities based on the advice from the committee." – KII, Yemen

Information management	*Effective information management and data sharing enabled coordination within the Health Cluster*	Information management systems were developed during the pandemic, to provide more timely and aggregated data and to inform partners on the needs, gaps, and various COVID-19 case data and response information. Respondents reported effective use of COVID-19 dashboards to provide information. "To overcome the challenge of duplication and miscoordination between two surveillance systems, one good practice was establishing a new temporary COVID-19 dashboard, with all partners having access". – KII, Syria
Information management	*Where there was data sharing by MoH in response to COVID-19 it was identified as a factor which enabled good coordination with government*	In some countries, increased willingness to share data was identified as a factor which enabled coordination with government. However, as reported in regard to Indicator 1.2.2, there were significant challenges related to the accuracy, reliability and transparency of the data shared in many countries. "Cluster meetings forced MoH to be on the ground and part of the coordination mechanism and pushed MoH to present the data that they had, strengthening their reporting and formats for collecting and reporting data. It wasn't always strong, but the existence of a system and strategy was positive." – KII, Yemen
Interface between Health Cluster and MoH	*There were many examples of increased coordination between the Health Cluster and MoH*	In some countries, increased coordination between MoH and the Health Cluster was identified: for example, more buy-in and increased commitment from MoH, more fluid communication, and increased frequency of meetings. " The whole situation forced us to sit together and discuss. The emergency response at large was on steroids. Things accelerated, we could bypass bureaucratic procedures, and were able to get some agreements with the government to facilitate many things. We were able to agree on structure, approach, pillars, priorities, guidelines, plans and strategies, and get agreements faster to facilitate many things." – KII, Sudan
Interface between Health Cluster and	*Good communication with and support from GHC and/or region was a factor which enabled coordination of the response*	In some countries, support from GHC or the region, and effective communication, were cited as factors which enabled coordination. "Good links with EMRO office of WHO and Headquarters, especially regarding deployment of tools and training and best practice guidelines and protocols." – KII, Yemen
Partners	*Active engagement of Health Cluster partners in coordination, especially regarding information and data sharing, enabled coordination at national and subnational levels*	The commitment of Health Cluster partners to actively coordinate and engage in coordination was identified as a factor which enabled coordination. Examples that were most frequently cited were engagement in coordination meetings and increased information sharing, which supported identification of response gaps. Increased engagement of the International Committee of the Red Cross (ICRC) and Médecins Sans Frontières (MSF) observers was also noted. "Yes, we received it and channelled to everyone. We managed somehow to gain some level of trust to have partners share these inputs with us, and then we share back information from the broader system we had." – KII, Sudan "At the subnational level, partners were also able to gather information that

		could be fed at the national level. Data in terms of figures of cases and fatalities were difficult to have, especially in the north. So, partners at the grassroots level were able to get some unofficial estimates that could give some kind of understanding on what we were dealing with and what the needs were." – KII, Yemen
Resources	*When there was an increase in resources and capacity dedicated to the Health Cluster, it enabled the Health Cluster to coordinate more effectively, at both national and subnational levels*	Respondents cited increases in resources to the Health Cluster, and increased capacity in the Health Cluster structure, as important factors which enabled more effective coordination. The most frequently cited examples were additional information management resources and increased capacity for subnational coordination structures. "More resources within the Health Cluster ensured better and faster information management. This model should be replicated, and improvements have been sustained until now – but sustainability is dependent on resource allocation." – KII, Afghanistan
Roles and Responsibilities	*The leadership role of the Health Cluster was important in ensuring effective coordination between partners and MoH*	Respondents cited the leadership role played by the Health Cluster as an enabling factor in the coordination of Health Cluster partners and coordination with MoH authorities at both national and subnational levels. The examples given regarding the effective role of the Health Cluster included increased frequency of meetings, the provision of regular updates, the dissemination of guidance and protocols, the mobilization of resources, mapping needs, as well as identifying gaps and coordinating implementing partners to fill gaps. "Whenever there was an update for the preparedness plan or response plan by the Health Cluster, drafts were shared so partners could comment, which provided initial thinking and information. This created a good flow of information and the opportunity to engage." – KII, Syria
Roles and Responsibilities	*Division of roles and responsibilities between health partners on response interventions, including complementarity between roles of different partners, enabled good coordination*	Effective division of roles and responsibilities between health partners on response interventions, including complementarity between the roles of different partners, helped fill gaps and prevent duplication. " There was quite good interaction and communication between humanitarian partners in the Health Cluster. Mapping on which partners would support which areas, and what support would be provided by other partners. There was complementarity in activities, such as one partner would pay incentives and one would do capacity building for the staff in health facilities." – KII, Yemen
Structure	*Establishment of inter-agency, multisector high-level COVID-19 task forces enabled coordination between humanitarian partners at strategic level and facilitated the development of response plans*	It was considered important that inter-agency, multisector national-level COVID-19 taskforces were established to enable strategic coordination on COVID-19 response and development of response plans. "The task force clearly defined roles and responsibilities, and for the sub-working group Health Cluster, under pillars … The process of developing planning and implementation was well coordinated by the Health Cluster and task force." – KII, Syria

Table 16. Humanitarian coordination – national level – change identified

Subnational level

Cat.	Change identified	Analysis
Structure	*Utilizing existing humanitarian architecture and coordination mechanisms, and not creating parallel structures, was considered a factor which enabled coordination at national and subnational levels*	Respondents considered it important that the existing humanitarian coordination architecture was utilized for the COVID-19 response: for example, the subnational Health Cluster architecture. " We used existing coordination mechanisms and didn't create a parallel structure – all within the humanitarian coordination." – KII, Syria
Structure	*Articulation and organization of the response under the pillars and establishment of new or adjusted working groups provided a clear structure which enabled partner engagement on different areas of response at technical and operational levels*	The creation of new working groups, either under the Health Cluster or task forces, or the modification of existing working groups so that they would be more relevant and responsive to the COVID-19 response, was considered a good practice. The technical working groups cited most often were groups on case management, IPC and risk communication and community engagement (RCCE). The working groups enabled partner engagement and were effective forums for sharing information, planning and developing common approaches, developing and sharing guidelines and standard operating procedures, developing strategies, and sharing information. A clear division of roles and responsibilities within pillars of response, and effective collaboration between partners, were also cited, including on case management. "Technical working subgroups were good, e.g. RCCE, vaccination and reproductive health, where partners could raise issues." – KII, Yemen

Table 17. Humanitarian coordination – subnational level – change identified

Finding 1.2.2: Number of bottlenecks frequently identified

The table below summarizes the most frequently identified bottlenecks which hindered effective interface within and between the different coordination structures (at both national and subnational levels).

Government coordination mechanisms

Cat.	Bottleneck identified	Analysis
Capacity to conduct coordination	*Lack of or limited MoH capacity for coordination was a significant challenge*	Respondents cited a lack of MoH capacity to lead coordination forums as a significant challenge affecting the effectiveness of government coordination, and interface with it. Insufficient technical and human resources affected MoHs' ability to co-chair working groups or to substantially engage in coordination of the pillars of response, beyond participation in meetings. High turnover of MoH staff, insufficient dedicated staff, and a lack of equipment and infrastructure to ensure coordination with relevant partners were issues frequently raised. Technical capacity and information management and data management capacity were also cited as limited. " The capacity of MoH was low and human resources and technical resources

		were not sufficient, so WHO and UNICEF had to take up the bulk of the work." – KII, Yemen
Capacity to conduct coordination	*A structural weakness in government coordination resulted in ineffective inter-ministerial coordination*	The lack of effective coordination both within MoHs and between different ministries was cited as a structural weakness in government coordination. Examples included gaps in commitment and engagement between different units and sectors within MoHs to coordinate on pillars such as RCCE, and a lack of coordination between different ministries, such as on points of entry, and between MoHs, ministries of interior, and ministries responsible for humanitarian affairs. The lack of involvement of other ministries/departments was also raised in the online survey. "Within the government structure, there were structural weaknesses which hindered the coordination of the response, such as policy issues and the role of various bodies not being clearly defined." – KII, Afghanistan
Capacity to conduct coordination	*Online working, because of government restrictions, hampered MoH ability to coordinate*	While remote and online working were often cited as adaptations that enabled coordination to function and overcome the restrictions and distancing measures imposed to control the spread of COVID-19, they were also cited as a challenge to effective coordination with the MoH. This was due to limited experience of using online platforms, the preference of government officials for meeting in person, a lack of adequate equipment and IT infrastructure, and poor internet connections, which particularly affected the subnational level. The level of engagement by MoH officials and the presence of decision-makers in coordination meetings were also reported to be negatively affected. "The government officers had less experience with the internet, which was challenging in terms of meetings. So, the government officials needed to be trained and help facilitate their active participation online." – KII, Yemen
Information management	*Lack of reliable and accurate data from government was a huge challenge to effective coordination and negatively impacted response planning and prioritization*	A lack of reliable and accurate case data was frequently raised as a significant issue that hampered effective coordination and negatively affected response efforts. The lack of willingness to share case data, and the significant issues of underreporting and the lack of reliability in case data, resulted from a lack of appropriate surveillance mechanisms. This was due to a lack of equipment and materials and a lack of qualified staff in data collection and analysis, as well as issues with the consistency of data collection, weaknesses in the health information systems, and insufficient effective coordination between national and subnational levels. "Availability and reliability of information and specific data at the governorate level, and the link with the national level, were one of the main challenges. There was also a significant gap in information sharing and coordination with the humanitarian and development actors from the Prime Minister's Office, especially to properly consolidate and address needs and requests coming from the governorate and local government units LGUs ." – SDR, Occupied Palestinian Territory

Cat.	Bottleneck identified	Analysis
Tools and processes	*Lack of transparency, accountability and clearly defined roles and responsibilities at both national and subnational levels complicated both the response and coordination with line ministries*	Limited MoH capacity was linked to a lack of transparency and accountability. Coordination was hindered by roles and responsibilities overlapping or being poorly defined, opaque lines of accountability, a lack of clarity and transparency in decision-making processes, and coordination being dependent on personal relationships. Some examples included a lack of clarity in the roles of different coordination structures established for the COVID-19 response, a lack of effective mechanisms to track resources, a lack of transparency regarding bilateral support being provided to governments, the diversion of resources, insufficient and inaccurate data sharing or a lack of data sharing, conflicting information, as well as a lack of clarity in processes and how decisions were being taken. "Accountability and transparency – government didn't have effective mechanism s to track resources provided to the country by international donors and partners. Most financial aid was contracted out, as the government was unable to manage the funds, e.g. support from Asian Development Bank funds contracted to WHO and UNICEF." – KII, Afghanistan

Table 18. Government coordination – national level – bottlenecks

Subnational level

Cat.	Bottleneck identified	Analysis
Structure	*Fragmented coordination structures were often linked to, or were often exacerbated by, the fragmented governance in some case study countries*	The fragmented governance structures in countries such as Yemen and Syria were a significant hindrance to effective government coordination, which exacerbated the issues described above regarding roles and responsibilities and lack of transparency. Coordinating in these contexts was especially challenging due to the need to coordinate with multiple governance entities with a lack of unified position, a lack of unified guidance, often conflicting priorities, politicized decision-making, and huge sensitivities regarding data sharing or a lack of willingness to share data and a lack of collaboration between health authorities. "From a political point of view, there is a lack of collaboration between local authorities and MoH; e.g. test s should have gone to Damascus, but this was very challenging to ensure." – KII, Syria

Table 19. Government coordination – subnational level – bottlenecks

National level

Cat.	Bottleneck identified	Analysis
Capacity to conduct coordination	*Capacity gaps in Health Cluster at both national and subnational levels*	Respondents reported gaps in capacity in the Health Cluster at national and subnational levels, which affected the effectiveness of coordination. Insufficient human resources, including a lack of information management capacity and a lack of adequate scale-up of coordination resources in response to the increase in coordination activities required during COVID-19, were cited. Double hatting was identified in many countries as a significant issue, with Health Cluster Coordinators often responsible for other functions within WHO. The online mapping exercise also found that there was a lack of coordination capacity at subnational level (EMRO/AFRO), including insufficient frequency of meetings and senior WHO staff not being present in subnational locations. Processes and tools to strengthen the coordination of activities, such as partner mapping exercises, were perceived to be much more effective at national level and were not replicated effectively or translated at the subnational level. "One factor that has hindered better coordination has been the lack of staff in the national Health Cluster, as the team is too small. This is also the case at the local level, where the teams are also insufficient." – KII, Colombia
Coordination mechanisms	*Centralized and top-down coordination, with insufficient capacity at subnational level*	Coordination was perceived by many respondents as very top-down from the national level. Respondents reported that the coordination structures functioned much more effectively at national level but that at the subnational level there were capacity gaps, there was a lack of presence of and engagement by national cluster staff and senior WHO staff, there was miscommunication, and messages were not conveyed effectively regarding plans and strategy, leading to misalignment of approaches. Misunderstanding and frustration were also identified as being a result of issues referred from the subnational level not being responded to in a timely or appropriate way. "Coordination is perceived as top-down from Sana'a, and people are very frustrated because people don't think Sana'a understands what how they are living and Sana'a doesn't know the field, Sana'a people don't go out … The further you are from centre, the more remote you are, the more misunderstanding s and frustration there is. They perceive it is top-down and when the subnational level refers back their issues, they get lost; it takes ages for them to get answers when they receive it. The system, the structure and the communication are not good." – KII, Yemen
Structure	*Fragmented coordination structures were often linked to, or were often exacerbated by, the fragmented governance in some case study countries*	Fragmented coordination structures were identified at the subnational level. For example, respondents reported complicated bureaucracies in local authorities, hampered by internal political divisions and weak coordination capacity, as well as a lack of, or fragmented, structures at subnational level, causing duplication or a lack of clarity in coordination interface and coordination platforms. Communication challenges were reported between central and subnational levels within MoHs, with decisions and information not effectively communicated at subnational level. Respondents also identified the centralized nature of response planning, with little discussion with or inclusion of partners and disparity between

| | | humanitarian response priorities and planning compared to what the subnational-level government authorities were requesting from central government.

" The field implementation level was heavily affected by the fragmentation of the subnational authorities: for example, Aleppo Health Directorate has more than five directorates covering Aleppo, and not all were involved or aware of coordination structures and mechanisms because they were assigned indirectly by Turkish authorities without consideration for logical or appropriate criteria which should be considered for these positions and structures. They are decisions and appointments based on political criteria and criteria related to loyalty to Turkish authorities. Therefore, we couldn't coordinate efficiently or effectively with the health directorates and local authorities, either in the field or in Gaziantep. Coordination on the planning level was almost zero as they didn't want to share information with the Health Cluster and United Nations agencies." – KII, Syria |
|---|---|---|
| *Capacity to conduct coordination* | *Gaps in Health Cluster coordination capacity limited the scope and effectiveness of the Health Cluster* | Respondents in both the online mapping exercise and the case studies reported that capacity gaps limited the scope and effectiveness of the Health Cluster in regard to fulfilling coordination functions beyond information sharing and bringing partners together in meetings, even though this was highly valued. Examples given included limited oversight as to how many partners were active, how many partners had what capacity, and how many partners were able to deliver which supplies, limited understanding of gaps; as well as delays in resolving partner operational issues.

"As cluster lead agencies, there could have been additional capacities put in place, such as information management and roving field capacity, to be able to spot check in real time and monitor the health aspects of the response and operational partners." – KII, Afghanistan |
| *Technical guidance* | *Gaps in WHO's technical capacity and guidance* | Gaps in technical capacity within WHO were also reported. For example, there were delays in the recruitment of technical staff to oversee response pillars, which impacted the coordination between Health Clusters and WHO, and resulted in staff double- and triple-hatting. Technical staff in WHO were also reportedly double-hatting, and, in general, burdensome workloads and the reliance on only a few staff were cited as significant challenges. |
| *Capacity to conduct coordination* | *Government restrictions negatively affected coordination and response efforts* | The restrictions imposed by governments in many countries were cited as being detrimental to coordination and as having a negative impact on response efforts. Restrictions affected the ability to conduct coordination meetings, reduced access to communities, and hampered monitoring efforts and the ability to verify what was being reported. Quarantine regulations and border closures also affected the ability to travel within countries and the ability to bring additional staff into a country. Respondents in some countries also identified the political influence of government, including in the interference in the hiring of staff, irregular access to communities, and limited ability to monitor and verify on the ground.

"Access constraints, both those set by the government, communities, and GAOs (Grupos Armados Organizados), hindered the proper interface. Humanitarian assistance continued to move, but there was an increase in the power of armed groups." – KII, Colombia |

Information management	*Insufficient proactive information sharing from partners*	Although it appears that partner engagement increased, some countries in the online mapping reported that there was still a "limited engagement with the partners particularly before July 2021" (EMRO) and that it was "challenging to mobilize partners in difficult humanitarian settings" (AFRO). Case study respondents also cited a lack of proactive engagement from partners in coordination, including a lack of timely information sharing regarding activities or planned assessments, the frequent need to chase up data and requests to attend meetings, a lack of transparent sharing of information on funding, and a lack of proactive engagement in coordination beyond providing updates. "Proactivity on behalf of partners was a big challenge − having to chasing them for data for RCCE, chase them to attend taskforce meetings and ad hoc meetings and to ensure they were sharing data." − KII, Syria
Roles and responsibilities	*Lack of commitment to response objectives based on needs and gaps*	Linked to insufficient capacity, and insufficient engagement, government authorities' priorities and demands at national and subnational levels were in some cases reported to conflict with humanitarian COVID-19 response plans and HRPs. "Capacity is limited at provincial level and couldn't even identify needs and priorities; e.g. in some provinces where there is a health response, the MoH will come with priorities which are not aligned with the HRP − e.g. the provision of primary healthcare through mobile teams to increase access was not an accepted idea for MoH, who which wanted to only establish fixed health facilities. These examples demonstrate we were not on the same page as MoH, but it didn't mean we couldn't work with them and spending time to respond to the issues". − KII, Afghanistan
Coordination mechanisms	*Lack of multisector coordination*	Inter-sectoral collaboration was identified as a challenge that was worse where pre-COVID-19 multisector collaboration was limited. The challenges identified were a lack of recognition of the multisector impact of COVID-19, a lack of effective infection prevention mainstreaming in other programs, and inconsistent approaches and strategies being pursued by sectors without coordination through pillars and COVID-19 taskforces: for example, RCCE approaches, such as the recruitment of community health workers, and a lack of coordination on the availability and use of personal protective equipment (PPE). Other gaps in multisector coordination included gaps regarding mainstreaming protection, gender and disability, and communication with people inside quarantine facilities. "On the other hand, the regular ICCG meetings were considered as having no impact on the overall response and only served to share information. Clusters Coordinators stressed that these meetings added more burden on top of the already heavy workload. OCHA should explore possibility of changing the modality of regular ICCG meetings and potentially provide briefings on behalf of the clusters." − SDR, Occupied Palestinian Territory
Funds mobilization	*Limited funding mobilized for response efforts*	Limited or insufficient funding was identified in most countries as a significant constraint which limited response efforts and limited partner involvement. Many respondents cited the weak, fragile and underfunded health sector as an underlying factor. "The availability of resources to provide, especially for the emergency response,

Cat.	Bottleneck identified	Analysis
Structure		was limited. Some partners may have wanted to do more than what they could due to limited availability or resources." – KII, Cox' s Bazar, Bangladesh
	Multiple and/ or overlapping humanitarian coordination structures was a challenge to clear coordination	The case study respondents reported that in some cases multiple forums, overlapping coordination structures, and multiple layers of coordination at different levels were a hindrance to coordination. The roles and responsibilities between different mechanisms were not always clear and partners reported that it was challenging to consistently engage in meetings for all of the different structures. In countries where governance and coordination were already fragmented, such as Syria, this challenge was more significant: for example, a lack of clearly defined relationships, lines of communication and management lines between different coordination structures operating in North-East Syria (NES). Respondents stressed the need to ensure that existing coordination structures are supported with capacity and resources, ensuring terms of reference for different structures are clear, without overlapping roles and responsibilities, and that data are shared consistently and regularly updated through online dashboards. Some suggested that it was important not to maintain separate COVID-19 task forces and multiple working groups for different diseases but rather that COVID-19 should be incorporated into a multi-hazard approach to outbreak response. " The biggest issue is still how we coordinate between x border and x line from Damascus and how we coordinate between two parties working in the same area." – KII, Syria
Capacity to conduct coordination	*Online and virtual working reduced the effectiveness of coordination*	While respondents reported that the transition to online and virtual working was an effective way to enable coordination to continue, respondents reported frequent challenges regarding the ability of partners to engage and participate in coordination meetings, due to internet connectivity issues, especially at the subnational level. Respondents also reported reductions in the quality of engagement and effectiveness in online meetings as compared with face-to-face meetings, with discussion often limited to sharing updates rather than being a dynamic discussion. Some coordination meetings were reported to be too large to be effective online, or agenda items were deemed too sensitive to be discussed in large coordination forums.

Table 20. Humanitarian coordination – national level – bottlenecks

Subnational level

Cat.	Bottleneck identified	Analysis
Technical guidance	*Issues related to clarity, consistency and timeliness of guidance negatively affected coordination*	Respondents cited delays in recommendations and guidance being provided by WHO, including in regard to treatment and clinical protocols, case definition and case management. Issues included the fact that consistent case management was challenging because protocols frequently changed, scientific information was not always well translated and communicated, and coordination and response efforts faced significant issues, especially at the beginning of the pandemic, regarding a lack of clarity in scientific information on the virus, and a huge volume of misinformation.

Table 21. Humanitarian coordination – subnational level – bottlenecks

Conclusions for Theme 1.2: What are the enabling factors or bottlenecks to ensuring effective interfaces within and between the different coordination structures (at both national and subnational levels)?

Government coordination

- In response to COVID-19, governments developed national responses and preparedness plans (SPRPs), commonly referred to as "pillar response", and established task forces, which prioritized the COVID-19 response, mobilized responses around common objectives and enabled structured opportunities for engagement with government. The SPRP "pillar" approach was seen as an enabler that helped to define areas of operations and the technical focus needed. For example, vaccination was recognized as a standalone component that required a dedicated pillar to support articulation and coordination.

- The existence and activation of national and subnational PHEOCs were found to enable coordination with partners and information sharing.

- Insufficient MoH capacity for coordination, response "pillars", as well as co-leading the Health Cluster, was a significant challenge. This included constraints related to limited technical capacity, such as limited capacity for specific response pillars or coordination; insufficient resources, such as IT infrastructure and internet connectivity; and a lack of skills in information and data management. Communication challenges were exacerbated by the COVID-19 context, including both the ability to coordinate within government and with partners. The shift to online working was also hampered by the reliance on technology and connectivity, which were not always reliable or predictable, especially at the subnational level.

- Fragmented coordination structures and a lack of clear roles and responsibilities posed a significant challenge, causing duplication of effort and a lack of clarity in coordination with and between the national and subnational levels of MoHs. Decisions and information were often not effectively communicated at and to the subnational level. Data sharing issues – including multiple data sources and a lack of accurate and reliable data at both national and subnational levels – were linked to fragmented coordination structures and governance structures in some countries. This indicates the importance of reinforcing subnational governance in MoHs and bolstering coordination structures and coordination capacity within MoHs, at and between national and subnational levels.

- A perceived lack of transparency and accountability within government structures significantly limited effective coordination with such structures. The key gaps included overlapping roles and responsibilities, a lack of clear reporting lines, confused processes and poor communication with/within all relevant ministries, as well as inconsistent information, inaccurate or inadequate data sharing, and a lack of clarity about how and on what basis decisions were being made.

Humanitarian coordination

- The shift to online working and the required increase in the frequency of meetings were factors that enabled coordination to be intensified and maintained. In some cases, this also facilitated increased participation of partners. However, in some cases this reduced the effectiveness and quality of the communication and engagement. The shift to online working was also hampered by greater reliance on technology and internet connectivity, which were not always reliable or predictable, especially at the subnational level.

- The national COVID-19 taskforces, working groups and sub-working groups established either under national Health Clusters or other taskforces were considered essential to the coordination of responses, and provided a structure. Guidelines, protocols, and standard operating procedures developed and disseminated by WHO and Health Clusters provided guidance to facilitate joint planning and approaches by

health partners. Examples were identified of cases where roles and responsibilities were clear and good collaboration practices took place between partners on response interventions.

- The multisector response plans developed in response to COVID-19 acted as national coordinating documents, provided direction for responses, and were important for the mobilization of resources.

- The role of Health Clusters was highly valued in enabling coordination both between partners and with respective MoHs. Health Clusters were active in increasing the frequency of meetings, providing updates to partners, tracking responses and identifying gaps, facilitating partners to fill gaps, disseminating guidance and developing protocols, and producing a range of information management products, including multiple dashboards to inform responses.

- Where capacity was increased, coordination was reported to be more effective, especially where the structure was expanded to include multiple subnational hubs (e.g. in Yemen).

- Insufficient capacity for coordination in Health Clusters was seen as a challenge for effective coordination, given the volume of information and the scale of coordination required for the COVID-19 response. The most significant gaps in coordination capacity were related to information management, double hatting of staff performing coordination functions, and insufficient subnational coordination structures. These capacity gaps undermined the effectiveness of Health Clusters and the scope of the functions they could effectively implement. This highlights the importance of investment in consistent and dedicated coordination structures and capacity at national and subnational levels.

- While partners' engagement in coordination was generally active, some gaps in regard to clear and consistent information sharing from health partners affected the ability to understand needs and gaps, and to plan effectively. The main gaps included a lack of timely information sharing on assessments and planned response activities, the frequent need to chase partners for information, not all partners having the same mechanisms for collecting and sharing data, and a lack of transparency on sharing funding information. This underlines the importance of partner commitment to working collaboratively to fill gaps, minimize duplication, and ensure meaningful inputs are given in regard to cluster coordination tools. Relevant and utilizable tools should be used, and partners should have sufficient skills and capacity to provide inputs.

- The increase in coordination structures was found to create some challenges in regard to ensuring coherent coordination. There were sometimes too many forums, overlapping coordination structures, or multiple layers of coordination at different levels. The roles and responsibilities between different mechanisms were not always clear and it was challenging for partners to consistently engage in meetings for all the different structures and forums.

- Coordination was often perceived to be very "top-down" from the national level. Capacity gaps at subnational levels, a lack of presence, and/or inconsistent engagement of national Health Cluster staff and senior WHO staff at subnational level, were frequently mentioned challenges. Miscommunication and responses not being timely or appropriate also caused a sense of disconnect and frustration at the subnational level. This highlights the importance of ensuring that those in coordination roles have the relevant skills and expertise (communication, negotiation, information management etc.) and capacity to ensure effective communication with stakeholders, as well as between national and subnational levels.

- Multisector coordination was often weak or insufficient, adding another layer of coordination to an already complex coordination architecture. Other clusters (i.e. non-health) did not always know what their role was, meaning that the multisector impacts of COVID-19 were not always fully considered, and relevant stakeholders were not always adequately involved in planning and implementation. As a result, other clusters often took their own initiative to respond, rather than coordinating through the Health Cluster or government COVID-19 taskforces.

Recommendations for Criteria 1

In this section we described the recommendations divided as per the target audience, and further disaggregated for the humanitarian coordination mechanisms, between the global and country level.

To governments:

- Further lessons specific to coordination by governments on COVID-19 pandemic need to be performed c, to ensure that the work carried out can be used to inform potential future global pandemics or other health crises.

- In many cases, governments required decrees or other binding mechanisms to establish an empowered coordination mechanism. Timely activation of essential coordination mechanisms requires that adequate preparedness activities have occurred (even for a potential pandemic with a novel pathogen) where related decrees are drafted prior to them being required.

- Government authorities should be supported and strengthened to take the lead, including through designation of clear roles and responsibilities within MoHs. Strengthen inter-ministerial coordination in outbreak responses and establish more clarity around roles and responsibilities, lines of accountability and communication between departments, and a commitment to transparent and systematic data-sharing.

- Strengthen national and sub-national strategic planning and the linking and feedback between the two levels, with more high-level meetings for planning, resource mobilisation and meaningful engagement of partners.

- Strengthen and reinforce national and importantly sub-national coordination capacity within MoH for coordination and leadership with dedicated resources and specialized personnel. This should be considered within the preparedness phase and health systems strengthening, but also during the response phase for example with surge deployments to support MoH with coordination functions. Increase capacity of PHEOCs with dedicated resources including staff, communications means and tools.

- For future pandemics or similar health crises, activating the highest level of decision-making within coordination bodies appears to be essential. When facing a crisis of this magnitude, governments cannot compromise and must ensure their full and sustained commitment to its management.

- Immediate recognition of the multisectoral nature of crises such as a pandemic is essential, as is use of the SPRP pillar approach to ensuring clarity on technical areas to be focused on and thereby roles and responsibilities.

- Partner engagement within planning processes is critical to ensure diverse and coherent stakeholder representation, thereby engendering appropriate and relevant planning and response. Humanitarian partners are able to reflect the needs and response required to reach often the most marginalised, populations affected by humanitarian crises, and where ministry of health is supported to provide services. Humanitarian partners can therefore be leveraged to provide support for COVID-19 response.

- information management is crucial for coherent and holistic responses and governments need to pay particular attention to these areas, which offer significant opportunities for improvements and impact without fundamental adaptations.

- Governments must recognize the importance of coordination and invest in related resources and efforts, including having staff trained and specialized in conducting coordination, as well as interacting or communicating with diverse stakeholders. The study highlights information management as one of the key factors in facilitating well-coordinated responses.

- Emphasis should be placed on ensuring that the work implemented at the national level can benefit the sub-national level, where most operations are carried out.

To health cluster at global level:
- Sustain investment in information management resources for the health cluster at national and sub-national level, with tools that are available for effective online working.
- Invest in continued capacity building of Health Cluster Coordinators at national and sub-national levels including specialized skills in negotiation and advocacy. Ensure coordination functions are ring-fenced through dedicated funding at national and sub-national levels and continue to raise awareness of the importance of coordination among all stakeholders. Ensure lines of communication between national and sub-national levels are clarified, including clear expectations for support, guidance, and information-sharing from the national to sub-national levels.
- Strengthen multisectoral coordination for outbreak responses through reinforcing the interface and the strategic engagement between health clusters and inter-cluster coordination groups (ICCGs) as well as relevant sectors. This should also include the prioritisation of joint assessments as well as assessment of multisectoral impacts, and clearly agreeing, defining, and communicating the roles of different sectors. Increased engagement with other sectors should be prioritised including, for example, ensuring minimum health standards are mainstreamed, workshops and trainings on integrating with other sectors such as water, sanitation, and health (WASH) in a more efficient way. Lastly, strengthen multisectoral communication between national and sub-national levels, ensuring information-sharing is efficient.

To health cluster at country level:
- While country-wide health cluster coordination structures might not always be necessary in humanitarian contexts, the capacity to rapidly scale up and strengthen coordination structures in response to a global pandemic is essential. This requires sufficient surge capacity (i.e., of coordination and data specialized personnel such as data analysis/visualization etc.) and rapid mobilisation of specific funds so that work can be carried out at both national and sub-national levels.
- Invest in sub-national coordination capacity, through maintaining or increasing investment in sub-national coordination structures. Increase advocacy with donors for funding for health cluster architecture at sub national level. Advocate for partners to increase support or take the lead in coordination roles at the sub-national level and support them through training and capacity building on health cluster coordination.
- The time taken that was reported for changes to occur and the capacity for conducting health cluster coordination and/or managing the interface between the health cluster and WHO suggests that further work is required to reduce this interval.
- The focus on COVID-19 preparedness and response should be maintained, including when there is a perceived reduction of its threat Given the evolving nature of COVID-19 e.g., emergence of new variants, poor vaccination coverage in humanitarian settings, integration of COVID-19 within a multi-hazard hazard risk analysis for populations affected by humanitarian crisis is critical. Retaining planning for COVID-19 preparedness and response as a standing agenda point during coordination meetings for example appears to have been a good practice that should be continued.
- Health crises such as the COVID-19 pandemic are not simply health issues, and all agencies should recognize their multisectoral nature, and engage accordingly.
- As seen with government coordination, the level and type of partner engagement and information management requirements and support needed were reported to be the most frequent changes during the past three years, suggesting these two themes are some of the most important aspects that require attention when responding to a pandemic. However, the study also highlights that it is quality of change – rather than the quantity – that can ultimately make a difference.
- Streamline the multiple coordination forums for COVID-19 responses by ensuring clarity in terms of

reference for various coordination mechanisms and continue integrating COVID-19 into existing working groups.

To donors:

- Invest in capacitating both MoH and / or Health Clusters for subnational coordination supporting for example surge staff to be seconded.
- When supporting or involved in national planning processes advocate for improved linkages and inputs on planning from the subnational level and clear planning for populations affected by crisis.

CRITERIA 2: WHAT GOOD PRACTICES OR CHALLENGES DO HEALTH CLUSTER PARTNERS FACE TO ENGAGE WITH COORDINATION OF COVID-19 RESPONSE AT NATIONAL AND SUB-NATIONAL LEVEL

The findings here also explore the different experiences of national partners/NGOs and international partners/NGOs. The following section describes the findings for Criteria 2, structured and articulated under the themes and indicators defined in the analytical framework.

Theme 2.1: How are Health Cluster partners engaging in the COVID-19 response in both national MoH country preparedness and response (often called response "pillars") and the Health Cluster COVID-19 response?

Finding 2.1.1: Ways in which Health Cluster partners engaged in COVID-19 response in both national MoH country preparedness and Health Cluster COVID-19 response

The following findings combine the results from both the global online mapping exercise and the seven country case studies. The ways in which partners engaged are grouped into the following categories, as per the areas of focus in the analytical framework questions:

- Level and type of partner engagement.
- Partner support to coordination functions.
- Partner engagement in discussion about strategy.
- Partners technically supporting the response.
- Partners operationally implementing plans.

Level and type of partner engagement – findings from the mapping exercise
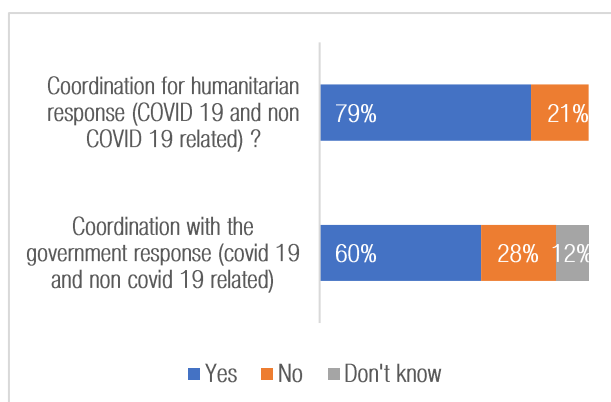
Figure 35. Any change reported regarding the level and type of partner engagement with different coordination mechanisms
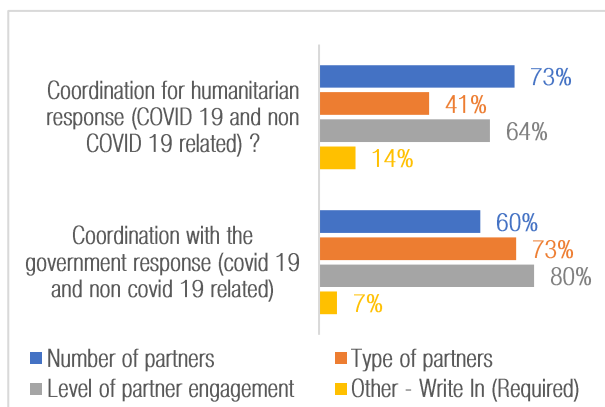
Figure 36. Areas of change regarding the level and type of partner engagement with different coordination mechanisms
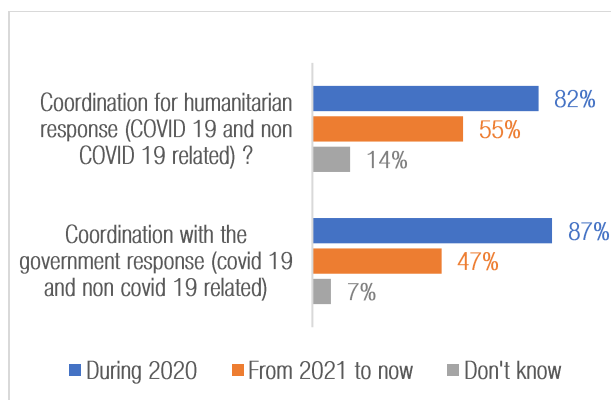
Figure 37. When were changes made at national level?

As stated previously (Figure 10 and Figure 11), but also reiterated here (Figure 35), respondents reported that changes occurred with regard to partner engagement with both humanitarian coordination mechanisms as well as government coordination, though the latter was slightly more common (79% of respondents, as compared to 60%). Figure 36 shows that the most frequently reported changes for the humanitarian coordination mechanisms were changes to the number of partners (74%), followed by changes to the level of partner engagement (64%) and the type of partners (41%). The most frequently reported changes for the government coordination mechanisms were changes to the level of engagement from partners (80%), followed by changes to the type of partners (73%) and the number of partners (60%).

Most changes regarding partner engagement were made in 2020 for both government and international coordination mechanisms, as shown in Figure 37, and these changes continued in 2021, although to a lesser degree for the engagement with government coordination mechanisms.
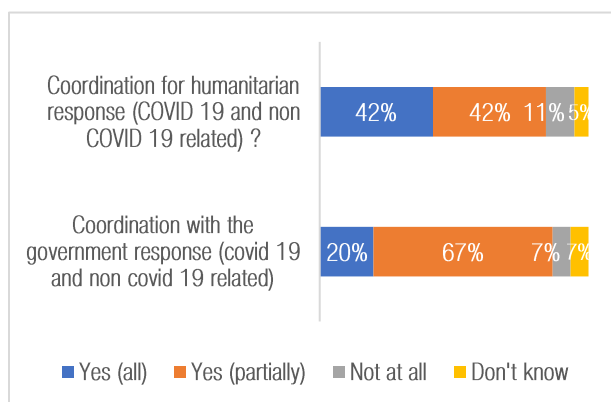
Figure 38. Did the changes identified to partner engagement also occur at subnational level?
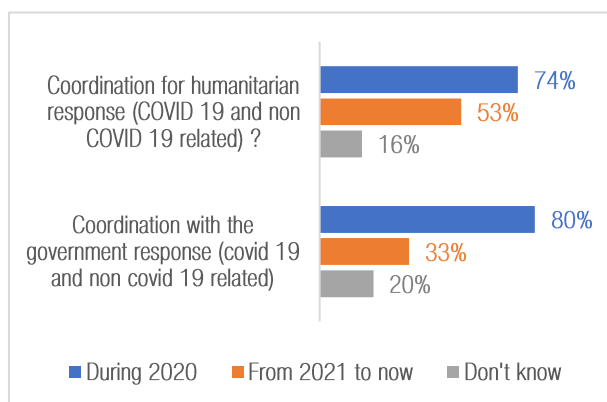
Figure 39. When did the changes to partner engagement occur at subnational level?

Subnational changes to partner engagement were reported to have happened at a much lower rate for government coordination mechanisms for the COVID-19 response as compared to for humanitarian coordination mechanisms (reported by 20% of respondents, as compared to 42% of respondents) (see Figure 38). Figure 39 shows that these changes occurred predominantly in 2020 but also continued into 2021 and after, although to lesser degree for government coordination mechanisms. Overall, this indicates that partner engagement was not strongly cascaded at subnational level.

Extent of change, appropriateness and benefit
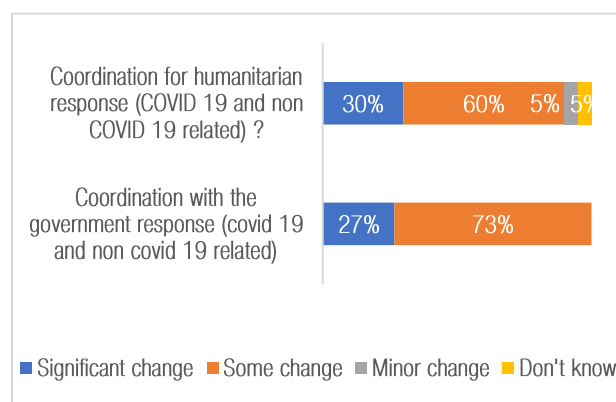
Figure 40. Extent of the changes at national level
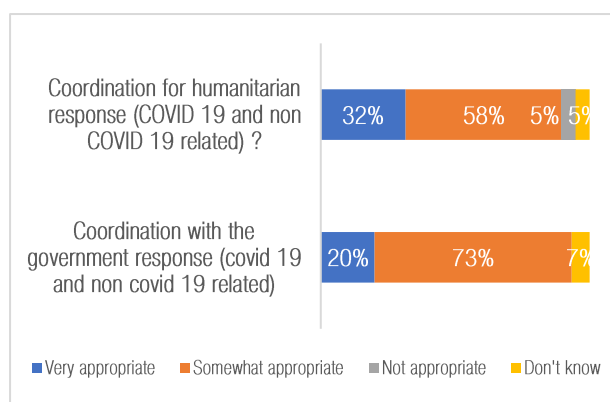
Figure 41. Extent to which changes were felt to be appropriate to the evolving situation/increased need at national level
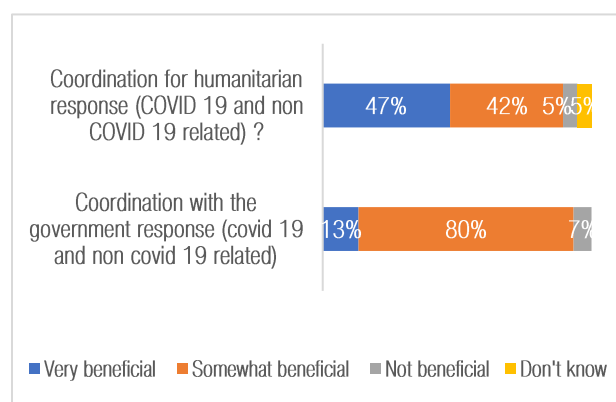
Figure 42. How beneficial were the changes to the response at national level?

As stated previously (Figure 10 and Figure 11), but also reiterated in Figure 35, respondents reported that changes occurred with regard to partner engagement with both humanitarian coordination mechanisms as well as government coordination, though the latter was slightly more frequent (reported by 79% of respondents, as compared to 60% of respondents).

With regard to humanitarian coordination mechanisms, as stated earlier, the highest prevalence of changes occurred regarding the number and level of partner engagement (Figure 36). However, the changes were reported to be significant in only 30% of settings (Figure 40) (and was also one of the three lowest reported changes, as seen in Figure 19). 32% of respondents reported these changes to be very appropriate, but 5% reported them to be inappropriate (Figure 41). Furthermore, these changes were felt to be very beneficial by 47% of respondents, though, again, 5% thought they were not beneficial (Figure 42). This shows that a variety of mechanisms and contexts existed, with varying levels of suitability and with mixed impact.

Interestingly, in regard to government coordination mechanisms, though 60% of respondents reported that changes had occurred (Figure 35), the extent of change was reported to be low, with only 27% reporting changes as being significant (Figure 40). Moreover, only 20% thought changes were very appropriate (Figure 41) and 13% thought they were very beneficial (Figure 42). Given the need to scale up, maximize surge capacity and work with partners during emergencies, these findings are concerning. Governments need support to put further emphasis on ensuring meaningful partner engagement within their coordination mechanisms.

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Partner engagement at national and subnational levels, and types of partner for both coordination mechanisms

At the national level there was an increase in partner engagement, particularly from national partners, for both government and humanitarian coordination mechanisms. In the case studies, key informants reported that for both government and humanitarian coordination mechanisms there was greater partner engagement at national level, particularly from national partners. However, although partner engagement appears to have increased, data from the mapping exercise show that some countries reported that there was still "*limited engagement with the partners particularly before July 2021*" (EMRO) and that it was "*challenging to mobilize partners in difficult humanitarian settings*" (AFRO). Furthermore, many local NGOs still acted independently (EMRO). In other countries, respondents in the mapping exercise/case studies reported that some partners had to terminate their operations as they were unable to adjust to the change in context (EMRO).

At the subnational level, for both coordination mechanisms, the level of partner engagement was reportedly higher, and especially gave recognition to the importance of the perspective of community leaders, who were included in subnational coordination in some countries.

" *There is a lot of engagement of national partners. National partners found themselves with new opportunities to be more active in the response, especially with work with the communities and community sensitization RCCE , for hard-to-reach communities and working with communities on treatment and vaccination acceptance. You ' ll find an increase in engagement with national health partners. Historically, they did not exist beyond contracting to implement certain programs. With COVID, their status improved. But now this has reversed again, follow the money, it decreased, so this also affected that temporary improvement. " – KII, Sudan (humanitarian coordination mechanism)*

International partners were engaged to a greater extent in the response because they had larger pre-existing programs with emergency response components, and greater human and technical capacity, which enabled them to scale up. KIIs reported that international partners provided operational support to health facilities, including logistics support, incentives, and key equipment, whereas local partners were largely dependent on international organizations for funding.

"*There is the ICRC, MSF, IMC, IRC and SCI and these are the only ones with the capacity to respond to emergencies. They had emergency teams and programs big enough with existing emergency components, so they were able to absorb. " – KII, Yemen*

Partner engagement in government coordination mechanisms at the strategic, technical and operational level (findings from the case studies)

Partner engagement with government coordination mechanisms
Limited data were available regarding the engagement of partners with government coordination mechanisms, aside from reported attendance at various coordination meetings called by relevant ministries.

Partner support to coordination functions

It is of note that there were no clear findings about partners supporting coordination functions.

Partner engagement in discussions about strategy

Partners engaged in discussions on strategy and technical approaches through the pillar approach. For both international and local partners, the architecture of the response (pillars, working groups, and task forces) served as a structure of reference, and a standard for engagement. Pillars provided partners with a structured way to engage and be consulted. Key informants reported that across national and subnational levels, ministerial task forces brought together health partners to discuss the response strategy under the pillars, share information, work on technical approaches, and participate in revising plans and developing strategic documents.

"At least we managed to articulate the response. An agreement over the nine pillars, the overall framework, activities. At strategic level we articulated the response, and it wasn't left to convenience for each organization. And with time, people felt obliged to follow those structures." – KII, Sudan

Partners technically and operationally supporting the response

Partners engaged in technical and operational support through task forces and working groups. Engagement in working groups/task forces included technical discussions, as well as providing a platform to share updates about the response, to discuss implementation challenges faced, and to participate in revising plans and developing strategic documents. Respondents to the global online mapping exercise indicated that enhanced collaboration among organizations responding to COVID-19 (EMRO), as well as the increased engagement of partners, in both technical and financial aspects (AFRO), helped reduce the pressure on the MoH response (EMRO).

"The task force really engaged with NGOs and United Nations. So just like we're doing now, the government really engaged international NGOs and United Nations agencies to be part of the SPRP, and this is when they tried to look at the pillars and map out in areas where there are cases." – KII, Sudan

Partner engagement in humanitarian coordination at strategic, technical and operational levels (findings from the case studies)

Partner engagement with humanitarian coordination mechanisms

The SDR and KIIs highlighted partners' motivation, engagement in coordination, willingness to contribute, and dedication to communities. High attendance by health partners in coordination meetings was reported, with most organizations being represented. Online meetings facilitated participation and the need for information about COVID-19 and how to best manage it was a key driver of participation. Many partner respondents considered that their contributions and feedback were valued and taken on board by coordination bodies. At the national level,

partners engaged through information sharing: for example, through WhatsApp groups, dashboards, 4Ws, 5Ws[y], etc., and they were asked to contribute information about needs, their capacity, the context, the progress of the response etc.

> *"Coordination of humanitarian partners was really good – partners willing to work and utilizing available funds as best they could."* *– KII, Afghanistan*

> *"We were invited to all the meetings and had joint meetings with Gaza through Zoom. Most meetings were remote, and after one year we met face to face. Our collaboration was taken seriously."* *– KII, Occupied Palestinian Territory*

Partner support to coordination functions

At the national level, partners were not engaged in leading coordination functions but engaged actively in the coordination mechanism (see above). At the subnational level, health partners sometimes took the lead in coordination structures and/or working groups, especially if there was no WHO presence, or if an NGO (international or local) had strong expertise (for example, in case management).

> *"The partners were involved at all levels of coordination. They were involved in resource mobilization, in case management, the establishment of COVID-19 labs and isolation – also in the coordination of response at subnational level." KII, Afghanistan,*

Partner engagement in discussions about strategy

Partners had limited roles in shaping strategy at national level but were engaged through following guidelines and implementing response activities aligned with strategic plans and common priorities. At the national level, across several contexts there was an emphasis on partners working toward common objectives and a focus on alignment with Health Cluster and MoH strategies and avoiding duplication. Decision-making was considered very centralized, with partners making limited contributions to program strategy design, but focusing on implementation, following guidance and translating strategy into operational activities on the ground. At the subnational level, partners were aligned with the unified strategic plans and focused on common objectives. Partners followed and implemented technical guidelines provided by reference entities (WHO, governments, the Centres for Disease Control and Prevention, etc.), in the form of protocols, training, guidelines, and standard lists.

> *"They just received the info and followed it, and they believed who oversaw it. It was appreciated and there was not much discussion on it."* *– KII, Sudan*

> *"Prior to COVID-19, partners were more independent on their operational priorities … We*

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[y] 5Ws = Who, What, When Where and Whom

manage to have regular meetings and decisions were taken in a collaborative way with the partners and developed the response plan collectively, so all the activities were more unified … We had unified guidelines, unified training, unified protocols and unified list of medical supplies, so there was a standardized approach for all the Health Cluster partners." – KII, Syria

At the subnational level, partners were actively engaged in discussions on the adaptation of programs in response to COVID-19 through working group and task force meetings. In this way, the study found that the response helped to distribute specific tasks among different partners based on expertise and experience, to build partnerships, and to limit the sense of competition for funding. Having this structured approach to consulting with partners made partners feel that their contributions and feedback were being taken seriously by coordination bodies.

"WHO and Health Cluster restructured the response through the activation of a COVID-19 task force." – KII, Syria

"We had the Health Cluster meetings and regular updates from those meetings, and technical documents, guidance, protocols, etc. are also shared during the meeting. " – KII, Sudan

Partners technically and operationally supporting the response

Due to strong pre-existing links with communities, partners were able to engage in community-related aspects of the response. For example, they were able to develop messages tailored to different communities and contexts, as well as to report concerns and challenges from the field level. At the subnational level, partners had the most significant role in RCCE and awareness raising. Partners had stronger pre-existing links with communities, which put them in a strong position to engage in community-related aspects of the response. Partners had strong technical expertise in community engagement and risk communication, and they were technically capable in regard to managing misinformation and disinformation and bringing forward solutions to MoHs/the Health Cluster etc., based on normative strategies but adapted to the context. Partners were especially engaged in RCCE planning and implementation, due to pre-existing links with communities. At the subnational level, partners played a significant role in implementing these activities.

"Partners played a significant role in mitigation measures, RCCE and risk mitigation in community. " – KII, Yemen

At the subnational level, partners reported being very engaged in information sharing, sometimes having the central role of translating material in order to facilitate information sharing with local actors. Partners at the subnational level were responsible for translating materials and guidelines and disseminating information to local actors.

"For example, for me I translated the info graphs that were shared from health working

Key informants reported that partners showed flexibility in their mandates, approaches and operations, to adapt to the context, new priorities, and the restrictions in place. Respondents to the online mapping exercise reported that "some organizations expanded their scope of work and role within the health sector" (EMRO) – for example, more NGOs engaged in hospital-level support (EMRO) – and that "partners made themselves more available, including partners from other sectors of intervention" (AFRO). It was also reported that in some countries there was an increase in the participation and engagement of local partners operationally.

"All partners modified or adapted their responses to continue service delivery considering of COVID-19." – KII, Afghanistan

However, the study also found that in some cases the engagement of partners in different forums (working groups, task forces) was dependent on their specific expertise and past experience. This was cited as a factor which enabled more efficient coordination, because only relevant actors were engaged in different areas and phases of the response.

"Engagement is determined by the scope of work and the mandate." – KII, Syria

"The partners were involved … in resource mobilization, in case management, establishment of COVID-19 labs, isolation." – KII, Afghanistan

Partners were actively engaged in training, often facilitated by the Health Cluster, to ensure staff and focal points had appropriate information and guidelines to participate effectively in the response. KII respondents reported the highest training participation at national level occurred in 2020, at the beginning of the pandemic, when the need for information and training was most significant. Partners at national and subnational levels participated in training to support response implementation capacity.

"WHO supported building the capacity of 51 health workers in 20 TFCs in Aden, Lahj, AL Dhele'e, Hadramout, Abyan and Shabwa. Moreover, 191 health workers from 86 district health offices were trained to scale up 72 nutrition surveillance sites." – SDR, Yemen

Conclusions for Theme 2.1: How are Health Cluster partners engaging in the COVID-19 response in both the national MoH country preparedness and response (often called response "pillars") and the Health Cluster COVID-19 response?

Government coordination

- *Partners' support to coordination functions, discussions on strategy, and technical and operational support:* The study findings indicate that the coordination architecture of the COVID-19 response (i.e. with "pillars", working groups and task forces, etc.) served as a structure of reference (or standard) and that the main way in which partners engaged in government coordination was through these task forces and working groups, with partners providing operational support for the response and on community engagement. Findings show that partners (NGOs) were not often involved in supporting coordination functions for the SPRP "pillar" response at the national level but were involved in co-coordinating or leading working groups to support the MoH response at subnational level. Partners were to some extent engaged with discussions on strategy at the national level. However, respondents stressed that in most contexts the establishment of the strategy and decision-making for responses was very centralized in government coordination.

Humanitarian coordination

- *Partner support to coordination functions:* The study findings show that partners took on coordination functions in regard to humanitarian: for example, leading or co-coordinating working groups. This was especially seen at the subnational level.
- *Partner engagement in discussions about strategy*: The findings show that partners were very invested in information sharing, and dedicated time and resources to attending regular meetings, which created opportunities to provide input into strategy and planning discussions. However, respondents stressed that in most contexts the establishment of the strategy and decision-making for responses was very centralized regarding humanitarian coordination. This indicates the importance of bolstering coordination capacity at the subnational level and ensuring that the subnational level is able to effectively feed into strategic planning at the national level.
- *Partners technically supporting the response*: Partners were reported to have sometimes supported with translating information products. However, most respondents indicated that partners were mostly recipients of technical guidelines and trainings.
- *Partners operationally implementing plans:* Partners were active in financial resource mobilization for programming and respondents indicated that partners adapted their activities and plans when funding permitted and engaged mostly in community engagement for the COVID-19 response, as well as usual essential health services.

Difference between international and local partners

- In several contexts, the engagement of international and local partners was considered equal, in the sense that the volume of needs was very high, resources and efforts needed to be pooled, and everyone gathered equally around a unique goal and strategy. However, it was mentioned that some international partners had more experience with advocacy and resource mobilization, which put them in a better position to access funding, and therefore local partners depended on them for their own resources. Additionally, some international partners had more extensive programs with emergency components and were therefore better able to quickly scale up.

Differences between national level and subnational level

- At the subnational level, partners sometimes took on leadership roles in coordination groups supporting

government and humanitarian coordination, especially when there was no WHO presence, or if the partner had particular expertise to bring to the table.

THEME 2.2: What factors enabled or limited meaningful Health Cluster partner engagement in the coordination of the COVID-19 response in humanitarian settings?

Finding 2.2.1: Number of enabling factors frequently identified (national and subnational levels)

The table below summarizes the factors most frequently identified as enabling meaningful Health Cluster partner engagement in both government and humanitarian coordination, at both national and subnational levels.

Government coordination

National level − Local and international partners

Cat.	Enabling factors	Analysis
Structure	*The establishment of government task forces enabled partner engagement*	Respondents cited the establishment and regular meetings of government task forces as beneficial for engagement because it clarified who to share information with and provided clarity on roles and responsibilities. " The most useful step was the response … led by the president and the task force, which facilitated international and national partners to be brought into the response." − KII, Afghanistan
Structure	*The pillar structure and technical working groups enabled partner engagement*	Respondents indicated that both international and local partners were able to engage actively in the response at both national and subnational levels, due to the pillar approach. According to respondents, the response was well-structured, with a clear strategy and dedicated working groups, which helped partners to engage where their capacity and expertise was most relevant. At the subnational level, working groups helped to distribute specific tasks, bring actors together and distribute roles based on partner expertise, build good partnerships, and limit the sense of competition for funding. "Partner roles and prioritization was agreed in the coordination mechanism, including pillar meeting s led by WHO and including UNICEF, and the coordination between them was very good." − KII, Yemen "WHO had a structure for each pillar; they had someone responsible for each pillar, and we knew exactly who to ask. Structure was important for clarity in communication lines, and clarity in roles and responsibilities." − KII, Syria

Table 22. Government coordination − national level − Both local and international partners − enabling factors

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National level – Local and international partners

Cat.	Enabling factors	Analysis
Interface	Frequency of coordination meetings and online modalities enabled partner engagement	Respondents often cited the high frequency of meetings as a factor which facilitated engagement. Online communication and meetings also provided a flexible way for partners to attend discussions and participate, when relevant and when their operations permitted. " The frequency of meetings increased, which increased partner engagement." – KII, Syria "Yes, the change to online modality made it more beneficial to all partners and NGOs to attend actively." – KII, Yemen
Information management	*Information sharing by the Health Cluster, including dissemination of guidelines, enabled partner engagement*	The Health Cluster was often cited as a main source of information for partners. Data collection was shared, dissemination of findings and action points was timely, partners were given time to provide feedback, WhatsApp groups were updated daily, and the online dashboard made it possible to follow capacity and cases. Health Cluster respondents noted that partners were active in providing information, which in turn contributed to the quality of information products that could be redistributed. The Health Cluster also shared material about the virus, manuals for case management, training, safety, etc., which was valued by partners. Respondents highlighted that the need for reliable information and official guidelines on how to manage COVID-19 and how to adapt operations to the pandemic prompted high attendance in coordination meetings. "The different NGO s are active and aware what WHO and UNICEF are planning to do. The Health Cluster has a very important role as the source of information for the partners." – KII, Afghanistan "COVID itself was a new disease, not well known; the sector members became more anxious to know about it. In the beginning, the attendance of the sector partners in all the forum was at 100%, and continued, because every time there was new updates, guidance, guidelines, etc." – KII, Sudan
Roles and responsibilities	*Consultation with partners enabled them to provide input into strategy and planning discussions*	Respondents indicated that there was space for partners to contribute, provide inputs, and share challenges. Their understanding of the needs was the basis on which strategy was developed, and the coordination structure valued their contribution. " There was equal opportunity for all partners to contribute and provide inputs." – KII, Afghanistan
Resource	*Access to new funding and ability to repurpose existing*	Respondents at national and subnational levels reported that the allocation of new funding or the repurposing of existing funding enabled partners to engage in the response. Some respondents indicated that international partners were

| | | able to mobilize more funding than national partners, which was a factor which enabled greater engagement. Some respondents indicated that access to new funding was an incentive for partners to develop appropriate capacity and a response structure.

"Knowing that most of our local NGOs don't have much of the resources, international NGOs could mobilize quickly. In the beginning, in 2020, there were shortages of PPE materials even in Khartoum. But international NGOs could procure and get resources in, and United Nations agencies got resources from what they had in Darfur; international NGOs who had extra resources ... were able to share with local NGOs and other partners." − KII, Sudan |
|---|---|---|
| *Information management* | *funding/resources enabled partner engagement at national and subnational levels* | |
| | *Information management and information management systems enabled partner engagement* | Information management systems were developed during the pandemic, to provide more timely and aggregated data and to inform partners about the needs and the response. Respondents mentioned that this enabled data-informed adjustments to be made to strategy and activities.

"Information management system improved a lot during this time − at central level, there was more guidance, tools and platforms to collect, analyse, disseminate and utilize the data, with reflections and feedback given to implementing partners, and strategies were modified on this basis." − KII, Afghanistan |
| *Capacity* | *Strategic capacity, and emergency expertise and experience enabled partners to play a greater role in coordination* | It was reported that partners with greater capacity were able to absorb the shock of the emergency more effectively. In some contexts, respondents reported that partners with experience of working in chronic emergencies were able to adapt to the COVID-19 emergency, and that if staff had strong strategic capacity and were able to engage to a larger extent in coordination mechanisms.

"MSF and ICRC were in the field, and IRC and SCI are massive in south Yemen, so they could respond. It was easier for these actors to absorb the shock of the crisis because they had the capacity and could respond quickly." − KII, Yemen |
| *Roles and responsibilities* | *Partnerships enabled partner engagement* | Partners found complementarity, built on what already existed in each organization, discussed joint initiatives, and applied for pooled funding when relevant and possible.

"People sat together discussed and initiated initiatives and applied together, e.g. for pooled funding." − KII, Sudan |

Table 23. Humanitarian coordination – national level – Both local and international partners – enabling factors

Cat.	Enabling factors	Analysis
Strategy	*The emphasis on community engagement enabled partner engagement*	Due to the importance of RCCE for the COVID-19 response, partners with close proximity to and existing links with communities had opportunities for increased engagement and funding. "National partners found themselves with new opportunities to be more active in the response, especially with work with the communities and community sensitization RCCE , for hard-to-reach communities and working with communities on treatment and vaccination acceptance." – KII, Sudan
Structure	*The establishment of local-level coordination structures and information sharing enabled partner engagement*	Respondents cited local coordination groups/forums as a factor which increased engagement. Having coordination opportunities closer to the areas of operation made engagement more meaningful and practical. Partners reported beneficial information sharing, allowing them to understand and monitor the needs, and discuss which approaches were effective and should be followed and replicated. Information products (minutes, presentations, etc.) also provided partners with material to write proposals for funding. " A subnational cluster was set up, which took coordination away from just the national level and also gave it to the provinces and governorates, which also contributed to improving and increasing meaningful engagement." – KII, Syria

Table 24. Humanitarian coordination – subnational level – Both local and international partners – enabling factors

Finding 2.2.2: Number of limiting factors frequently identified (national and subnational levels)

The table below summarizes the factors most frequently identified as limiting meaningful Health Cluster partner engagement in both government and humanitarian coordination, at both national and subnational levels.

Government coordination

National level – Local and international partners

Cat.	Limiting factors	Analysis
Decision-making	*Centralized decision-making by the government limited partner engagement in strategy development*	Respondents indicated that government validation and centralized decision-making limited partner engagement in planning and the response. There was limited involvement of partners in strategy development. In some countries, differences in priorities or response strategies between partners and the MoH was also reported. "But when it comes to planning, the problem was it was very centralized. Plans from MoH were provided with no discussion, launched and you have to implement it." – KII, Sudan
Structure	*Bureaucracy within local authorities limited partner engagement*	In Afghanistan in 2021, respondents from local NGOs indicated that lengthy bureaucratic processes were a factor which limited partner engagement and activities. In Yemen, respondents also referred to administrative hurdles in relation to issues, such as obtaining visas. "There is the issue of restrictions in humanitarian services. MoH authorities are requesting for Memorandums of Understanding for the humanitarian

		projects. But some of these projects are only for six months s , and this Memorandum of Understanding takes three months, so these delay the implementation of services and there is a lot of people in need." − KII, Afghanistan
Lack of engagement with civil society/ NGOs	*The lack of NGO inclusion in coordination and planning limited partner engagement*	Coordination and planning were perceived by some respondents as "United Nations-dominated", with limited space for NGO engagement. "The Department of Public Health established coordination teams and limited number of partners were engaged in that − only United Nations agencies, not international NGOs." − KII, Afghanistan

Table 25. Government coordination – national level – Both local and international partners – limiting factors

Humanitarian coordination

National level − Local and international partners

Cat.	**Limiting factors**	**Analysis**
Funding	*Lack of access to funding limited national partner engagement*	Respondents indicated that local partners did not always have direct access to institutional donors, and that access to funding was heavily dependent on international NGOs. The online mapping exercise indicated that the level of participation of some NGOs decreased when they did not receive the expected funding, or after they received the funding (AFRO), and that some organizations lost funding due to the redirection of funds to COVID-19 (AFRO/EMRO). "Most partners have funding issues and are fully reliant on the Syrian humanitarian fund, which is limited, and don't have private funding." − KII, Syria
Capacity	*Limited capacity or lack of relevant capacity limited local partner engagement*	Local partner engagement in the coordination of response activities was limited, due to a lack of, or limited, relevant experience, skills and access to donors. In some cases, international partner engagement was also limited due to limited knowledge of the context and communities, and limited access to some geographic areas. "Partners did not always have the skills and capacity to deal with the pandemic." − KII, Syria
Government restrictions	*COVID-19 restrictions limited partners' physical participation in coordination meetings and limited timely implementation of response activities*	At the beginning of the pandemic, respondents highlighted that government restrictions relating to public health and social measures reduced physical participation in coordination meetings and hindered the timely provision of services. "The guidelines of social distance limitation, in terms of movement, they sometimes worked against some of the service provision." − KII, Cox's Bazar, Bangladesh
Resources	*Poor internet access or resources limited partner engagement in online coordination*	In some contexts, limited capacity, including a lack of IT infrastructure, connectivity, and limited experience with communication tools, negatively affected partners' participation and engagement in coordination forums. In many subnational areas, respondents indicated that the lack of a stable internet connection limited partner engagement in online coordination

Cat.		
		discussions. "There was no clear mechanism to allow people and facilitate engagement in these activities. No practical arrangement (space, connection, computers) was facilitated for people to have equal access to communication, especially laptop s and the internet at home." – KII, Occupied Palestinian Territory "Online meetings were challenging, … and they were not as effective as face-to-face meetings . There was more hesitancy and delay in taking decisions." – KII, Syria
Decision-making	*The requirement for permissions, which were often centralized, for partner response activities limited the ability to implement in a timely manner*	Several respondents reported that partners struggled to engage effectively and in a timely way due to the requirement for activities to be validated by centralized government bureaucracies. " The challenge was also to have timely activities because any kind of surveys or any kind of guidance, everything needed to pass through the government, to be approved or reviewed by the government. Without the validation, nothing can be taken forward." – KII, Cox' s Bazar, Bangladesh
Guidance	*Restrictive or inconsistent guidelines limited partners' ability to implement response activities*	Respondents indicated that guidelines were sometimes very restrictive, were subject to frequent changes, and were sometimes contradictory, making it difficult for partners to implement activities. "The other factors that could have hindered meaningful engagement included , for example, to access the camps different guidelines were provided to different agencies." – KII, Cox' s Bazar, Bangladesh
Security/ political instability	*Security issues and/or political instability limited partners' access, engagement and response*	In some contexts, respondents indicated that insecurity and political instability limited partner engagement in response activities. "The political dynamic in Sudan, the insecurity frequently reported in Darfur, uprisings , protests, violence in the streets, some intercommunal conflict here and there, changes in the authorities – sometimes it affected the movement of the humanitarian actors. Plus, there were restrictions in funding after the coup (October 2021). All limited the humanitarian space and partners' ability to meet the public demand for health services." – KII, Sudan

Table 26. Humanitarian coordination – national level – Both local and international partners – limiting factors

Subnational level – Local and international partners

Cat.	Limiting factors	Analysis
Capacity	*Lack of partner coordination capacity limited partner engagement*	Respondents indicated that low partner capacity limited their engagement. At the subnational level, this included a lack of experience with public health emergencies and with the humanitarian coordination system. "Most partners are local and have limited exposure to public health emergencies and limited capacity. Most NGOs are run by clinicians without public health experience and less exposure to public health emergencies." – KII, Syria

		"Many partners new to the health system and the Health Cluster coordination platform, but they are learning." − KII, Syria
Resources	Lack of access to funding limited local partner engagement	Respondents reported that local partners did not always have direct access to institutional donors and funding and were dependent on international NGOs to access resources and implement activities. They also cited a lack of flexibility by donors to enable funding to be repurposed to the COVID-19 response. "The circumstances at the beginning, the Health Cluster relied on organizations that had the capacity to respond under the different pillars, but at that time local organizations had to wait more than six months for resource allocation to be revised and adjusted to support the new activities that were conducted." − KII, Syria "Knowing that most of our local NGOs don't have much of the resources, international NGOs could mobilize quickly." − KII, Sudan
Access	Access challenges limited partner engagement and/or ability to work consistently across locations	Access challenges were often cited as a limiting factor for partners in regard to responding to the needs in a coordinated and consistent way. "Because of the geography is too large in Sudan, the population is scattered and access is challenging." − KII, Sudan
Information management	Lack of information sharing and information management challenges at subnational level limited partner engagement	At the subnational level, some respondents indicated that the lack of information sharing, or a common information management system made it more difficult to have a consistent overview (nationally and sub nationally), so that partners could follow consistent processes. " There is no common health information management system for partners to follow − each partner has their own data collection system, which is challenging, as there is inconsistency. MoH has a tool which they use to manage data in the rest of the country, so there is consistency, but NES is not included." − KII, Syria
Security/ political instability	Security issues and/or political instability limited partner engagement and response	In some contexts, respondents indicated that insecurity and political instability were factors which limited engagement in the response. " There were not enough coordination sessions to respond to the challenges that were being raised by NGOs, such as whether it was safe for them to be in specific locations."− KII, Afghanistan, international NGO "International NGOs working cross-border (were) constrained by security and access issues, so international NGOs weren't physically present continuously or consistently on the ground, and so they're reliant on a few local NGOs." − KII, Syria

Table 27. Humanitarian coordination – subnational level – Both local and international partners – limiting factors

Conclusions for Theme 2.2: What factors enabled or limited meaningful Health Cluster partner engagement in the coordination of the COVID-19 response in humanitarian settings?

Government coordination

- The main factor that enabled partner engagement in MoH responses was the creation of governmental task forces and "pillars", which provided clear, official ways to engage operationally with health authorities, for both local and international partners.
- A factor which hindered the meaningful engagement of partners in MoH responses was that decision-making was often very centralized, and partners were mostly told what to implement once strategies and plans had been validated by governments, rather than being involved in their development. This indicates the importance of bolstering coordination capacity at the national level, and particularly at the subnational level, and of ensuring that partners are given space to be involved in MoH coordination and planning.
- For both local and international partners, coordination through online communication was challenging, especially in contexts with disrupted electricity supply and poor internet connections.
- Restrictions (e.g. on movement or gatherings) were also a limiting factor for engagement, especially in the first year of the pandemic, when restrictions were more intensive.

Humanitarian coordination

- The main factors which enabled the engagement of both international and local partners with Health Clusters at the national level were centralized information sharing, channelled through the Health Cluster, which provided a clear picture of needs and ongoing COVID-19 and humanitarian response efforts. The increased frequency and online mode of meetings gave a more flexible platform for people to participate, share and receive information.
- The need and ability to mobilize funding to meet the increased needs (both for COVID-19 and for other humanitarian health responses) was also an enabling factor for the meaningful engagement of both international and local partners with Health Clusters at the national level. International partners had better access to new funding, but respondents indicated that the possibility of obtaining additional funding (discussed in Health Clusters) also constituted an incentive for local partners to boost their capacity and increase their engagement. Furthermore, the emphasis on community engagement for the COVID-19 response was an entry point for partners to engage with Health Cluster discussions, and the Health Cluster strategy and response, as they had proximity to and knowledge of communities, and had coordination structures at the subnational level.
- Receiving updated scientific information or guidance at the subnational level that was consolidated by WHO and channelled through Health Clusters was seen as good practice and enabled the engagement of partners.
- A lack of existing funding or challenges in reprogramming existing funding were limiting factors to engagement with humanitarian coordination mechanisms and the humanitarian response, and mostly affected local partners, who depended largely on international partners to obtain funds and other resources.

Recommendations for Criteria 2

To governments:

- Prioritize the establishment of simple, clear and official strategic structures for partners to engage with: when partners have a structure of reference, it is more straightforward for them to know where and how to contribute, whether operationally or to support coordination functions. Provide partners with a clear

official channel to engage with health authorities.

- Ensure regular, accessible meeting opportunities (e.g., in-person, online and hybrid) so partners have flexible channels to share and receive information about specific situations and responses and a predictable platform to participate.
- As written above, ensure partner engagement within planning processes to ensure diverse and coherent stakeholder representation, thereby engendering appropriate and relevant planning and response. Humanitarian partners are able to reflect the needs and response required to reach often the most marginalised, populations affected by humanitarian crises, and where ministry of health is supported to provide services. Humanitarian partners can therefore be leveraged to provide support for COVID-19 response including supporting or co-leading 'pillars' of a country preparedness response plan, providing technical support, operationally supporting or implementing programmes.
- Ensure better transparency in strategic decision-making: when partners invest time and energy to participate in meetings and share information, they expect to see their input influence key decisions in the response. Transparency in the decision-making process can address partners' perceptions about decisions being centralised.

To WHO and health cluster at global level:
- Invest in trainings related to public health emergencies (to WHO), as well as the health cluster coordination system (GHC) such as preparedness trainings, training of trainers (ToT), guidelines and other modalities for capacity building. Partners were very engaged in training at country level and sought guidance for COVID-19 response.
- For future pandemics or outbreaks consider having a pool of trainers available able to deploy to countries, able also to conduct training of trainers and to support rapid cascading of guidance in a context where information is constantly evolving.

To WHO and health cluster at country level:
- Explore partners' willingness and capacity to engage more actively in the provision of technical trainings for their area of expertise: most respondents indicated partners were at the receiving end of guidelines and trainings. There might be opportunities to disseminate knowledge and experience in a more collaborative way, especially at the local level, where partners were sometimes shown to be engaged in leading coordination groups.
- Maintain one centralised information source – partners indicated that they turned to the health cluster for information, to get a clear picture of the needs, the ongoing response, the gaps, and the opportunities for engagement.
- Ensure consistent data-sharing among health partners by ensuring that information requests to partners are streamlined. At the same time, ensure feedback and follow up to partner requests is timely and consistent, and replicate valued information management products/platforms.
- To health clusters, continuously advocate to health partners about the importance of information-sharing and provide data-sharing templates that are as consistent and simple as possible.
- Prioritize the engagement of partners with strong local pre-existing community linkages, particularly in activities related to community engagement.
- To health clusters, ensure online coordination meetings enable and support dynamic discussion, good exchange of information, and meaningful engagement of partners.

To partners:
- Dedicate time and resources to engaging in coordination at national and subnational level.

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- Consider co-coordinating technical working groups, pillars at national or subnational level in areas where you have expertise. Consider supporting MoH where appropriate with basic coordination and planning functions at subnational level where capacities may be constrained. Providing technical and surge capacity can help ensure the integration of the needs of populations affected by crisis, as well as strengthen relations with diverse stakeholders to understand the role and potential capacities of partners.
- Support health clusters by sharing information in a timely manner. Health Clusters support collective response which partners are a member. Sectoral gap analysis and determining needs can only be done through gaining inputs from all members. Coordination and collaboration need to be bi- directional.

To donors:
- Increase repurposing of or additional funding: partners were shown to be flexible and adaptable in their programmes, the main obstacle to their agility was a lack of funding or the inability to redirect existing funding.
- Ensure timely repurposing of funding or direct access to additional funding for local partners who demonstrate sufficient capacity or ability to scale up. National NGOs were often reported as dependent on international NGOs to secure funding during COVID-19 responses.
- Invest in systems that rapidly identify new partners demonstrating capacity to contribute to the response and identify or 'pre-identify' a principal recipient that may work or contract with new partners to rapidly scale up activities.
- Consider investing in partners to support in co-leadership or co-coordination of technical working groups or to support MoH at subnational level with planning where capacities are limited. NGOs are well placed and are already providing such support in many instances, but often lack the human resources or time, or financial resources (for hours worked or level of effort) to support this function.
- Allow partners to invest in the required hardware and software to enable their online connectivity. For example, in context where there is poor connectivity and limited power supply, generators and/or solar power source associated with satellite (when necessary) connection devices should be permitted. This should include funding for training, such as in the use of technology.

CRITERIA 3: HOW DID THE DIFFERENT COORDINATION MECHANISMS (BOTH WITHIN AND BETWEEN THEM) ENABLE OR LIMIT THE COVID-19 RESPONSE, INCLUDING MAINTAINING ESSENTIAL HEALTH SERVICES IN HUMANITARIAN SETTINGS?

The following section describes the findings for Criteria 3, structured and articulated under the themes and indicators defined in the analytical framework.

Theme 3.1: Were Health Clusters enabled to achieve the objectives in the GHRP and HRPs to support the COVID-19 response for humanitarian (or wider) populations?

Finding 3.1.1: Type of measures taken within the coordination mechanisms to support the COVID-19 response for populations affected by humanitarian crisis

The following findings combine the results from both the global online mapping exercise and the seven country case studies. The study examines if measures were taken within the coordination mechanisms to support the COVID-19 response for populations affected by humanitarian crisis, and whether populations in humanitarian settings were reached by/able to access COVID-19 services. The study first examines the strategic planning and then groups the measures taken within the coordination mechanisms to support the COVID-19 response into the following categories, as per the areas of focus in the analytical framework questions:

- Leveraging partnerships.
- Adapting health programs.
- Collectively identifying and filling gaps and reducing/avoiding duplication.
- Mobilizing resources.
- Challenges regarding coordination between mechanisms to support the COVID-19 response for populations affected by humanitarian crisis.
- Good practices regarding coordination between mechanisms to support the COVID-19 response for populations affected by humanitarian crisis.
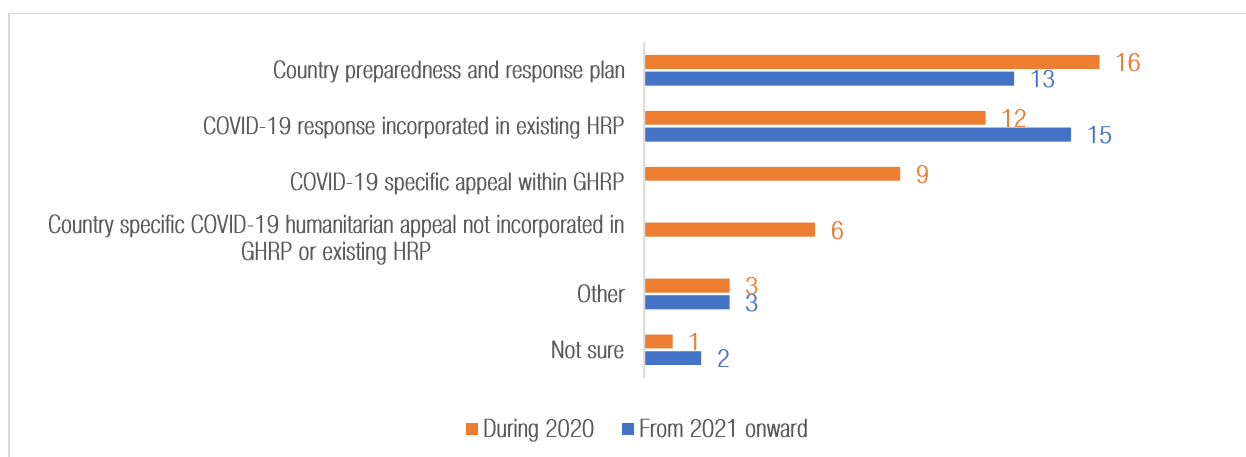
Figure 43. Types of strategic plan created in response to the COVID-19 pandemic (total countries is 24)

Strategic planning for COVID-19

Multiple strategic and fund-raising documents were developed to ensure COVID-19 preparedness and response, both at the national level but also specific to reaching populations affected by crisis. As shown in Figure 43, in 2020, 16 countries developed a national COVID-19 preparedness and response plan (e.g. one developed by the MoH). To ensure populations already affected by humanitarian crises received COVID-19 services, and to ensure adequate preparedness and response occurred, humanitarian appeals also included COVID-19 actions. Six of the 21 countries with an HRP launched their COVID-19 response plans independently from the existing HRP or the GHRP, nine countries incorporated their response plan into the GHRP, and 12 incorporated it into the existing HRP. Other strategic plans identified in 2020 included multisector COVID-19 response plans or regional preparedness plans, like the Pacific JIMT Preparedness and Response Plans. In 2021, no GHRP was launched, and COVID-19 response planning for populations affected by humanitarian crisis were meant to have been fully integrated into humanitarian response plans (i.e. HRPs) at this time, and/ or meant to have been covered in national preparedness and response plans. 15 countries (three more than the previous year) incorporated their plans for populations affected by crisis in the existing HRP in 2021. Of note is the fact that in 2021, 13 national COVID-19 preparedness and response plans existed. Other types of strategic plans were also identified, like MoH COVID-19 National Deployment and Vaccination Plans (NDVPs) (for COVID-19 vaccination) or updated WHO response plans.
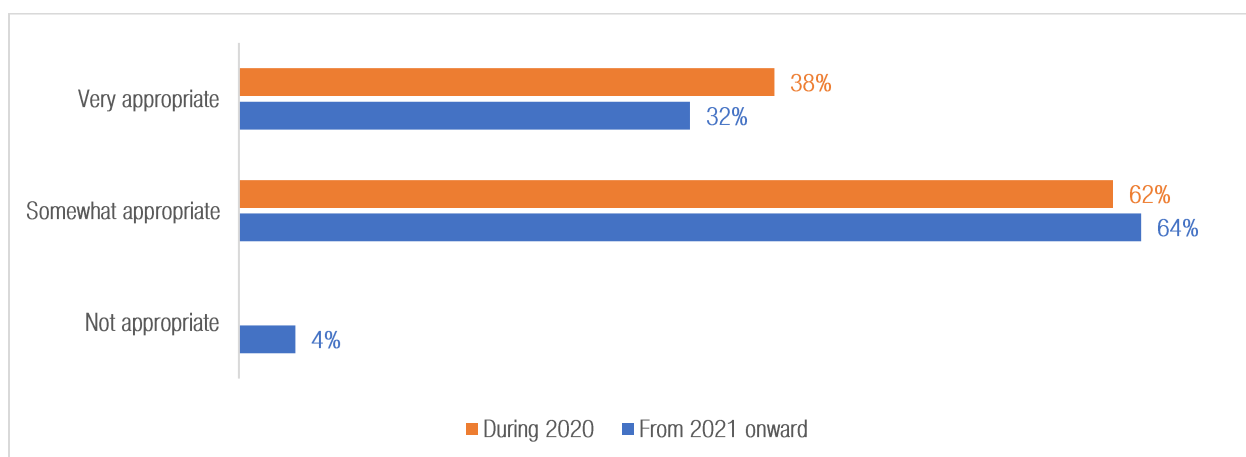
Figure 44. Were these strategic plans appropriate?

Only one respondent judged the 2021/2022 plans to be not appropriate. There was no significant difference in

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perceived appropriateness between countries where the plans were part of the HRP or other response plans (GHRP or country-specific plans). The appropriateness of strategic plans was generally reported to be good, with a slight decrease in the number of respondents perceiving the plans to be very appropriate between 2020 and 2021/2022, from 38% to 32% (Figure 44).
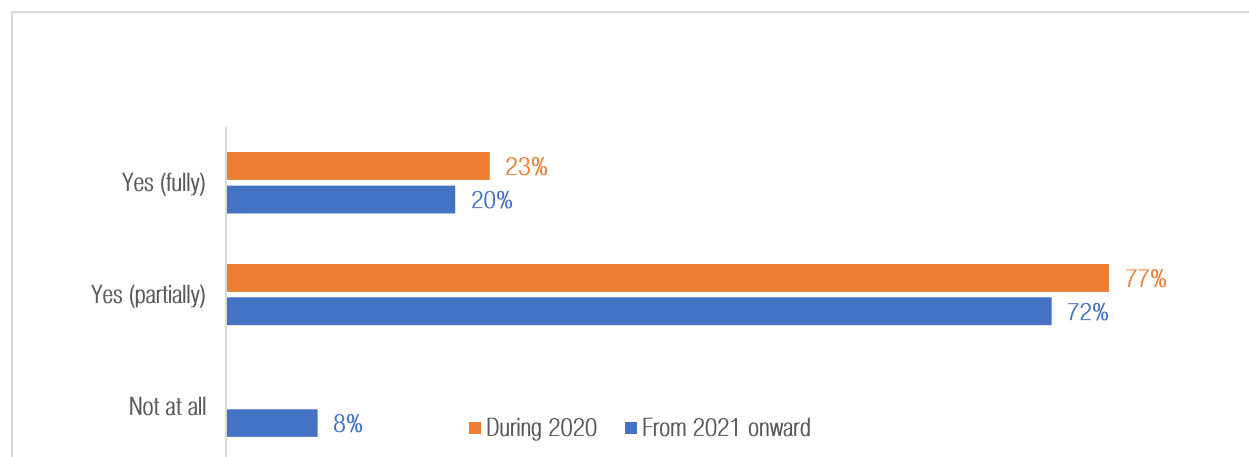

Figure 45. Were these strategic plans successful in ensuring populations affected by humanitarian crisis received COVID-19 services, particularly at subnational level?

However, with regard to reaching populations affected by humanitarian crisis, particularly at the subnational level, only a small proportion of respondents (23%) considered the strategies to have been fully successful in doing so in 2020. Of these, four out of six countries had a COVID-19 response reflected within the HRP, one was part of the GHRP, and all had a specific country response plan developed by the MoH. The perceived success was even lower in 2021, with only 20% of respondents reporting the strategies as being fully successful in reaching populations affected by crisis. All of these had COVID-19 integrated within HRPs and four out of five countries had a specific country response plan developed by the MoH. A significant majority of respondents (77% in 2020 and 72% in 2021/2022) considered that the strategic plans were only somewhat successful in ensuring that populations affected by humanitarian crisis received COVID-19 services, particularly at subnational level, indicating that there is still significant room for improvement (Figure 45).

Year	Worked well	Did not work well
2020	It was frequently mentioned that strategic plans were able to facilitate resource mobilization successfully, because the strategic plans "clearly articulated funding requirements", and that they "were a powerful tool for resource mobilization"	Resources were insufficient in some countries, which caused supply gaps, and there was a lack of laboratory facilities (EMRO/AFRO)
	Enabled a multisector approach, collaboration and joint planning and prioritization (EMRO, SEARO and AFRO)	Multiple response frameworks created confusion, leading to fragmentation, duplication, or gaps (EMRO/AFRO)
		The multisector impact of COVID-19 and the need for a multisector response was not immediately recognized (EMRO), creating delays in response time in other sectors

			The timeliness of the implementation of plans was sometimes inadequate (Western Pacific Regional Office) or was not sufficiently adapted to the evolution of the pandemic (EMRO)
	Facilitated the integration of new actors and were specific and relevant (EMRO)		
2021	Enabled the mobilization of resources for activities such as surveillance, diagnosis, and case management facilities (EMRO and AFRO regions)		The strengthening of community awareness was not sufficient to tackle the "infodemic" – rumours and community resistance to public health advice, such as physical distancing or wearing masks (EMRO region)
	Provided a clear basis for MoH vaccination activities and partner support (EMRO region)		Engagement could have been improved and more inclusive: for example, plans were developed centrally between United Nations agencies and federal MoHs (EMRO region)
	HRPs enabled better coordination between MoH and various cluster partners, including regular engagement with health partners, ICCT and HCT on the COVID-19 situation and response (EMRO region)		Funding was insufficient to meet the requirements of the COVID-19 response because there was too much focus on vaccine procurement (EMRO and AFRO region)
	HRPs enabled the development of joint strategies, particularly in regard to accessing hard-to-reach areas, as well as a better inclusion of national and local partners (AFRO region)		Coordination mechanisms between MoH and Health Cluster partners were not adequately adapted (AFRO region)

Table 28. Things reported to have worked well (or that did not work well) for the different strategic plans

Government coordination mechanisms (case study data)

At the national level, strategic plans provided a policy framework for COVID-19 preparedness and response that reached the entire population in principle, including populations affected by crisis. Where there was a strong multisector or whole-of-government approach, and where subnational planning was integrated in national plans, this was considered good practice in regard to enabling populations affected by crisis to be reached. For example, the study found that in Afghanistan a strategic response and preparedness plan was developed for COVID-19 preparedness and response using a whole-of-government approach and ensuring inputs from the subnational level, ensuring the needs of populations affected by crises were incorporated. This was designed with engagement from relevant ministry departments at both national and subnational levels, with the engagement of other line ministries, partners, and agencies at the national level. At the subnational level, the provincial governors in each province were directed to develop their own work plans or provincial plans to enable decentralized decision-making. Given the large-scale humanitarian needs across Afghanistan, this was thought to be good practice.

Humanitarian coordination mechanisms (case study data)

The role of coordination mechanisms in strategic planning supported alignment and delivery of the response. Strengthened coordination and collaboration supported strategy development and planning, facilitated lesson learning to feed into response plans, and enabled updates and information sharing to inform the ongoing response to reach populations affected by humanitarian crises with COVID-19 services. Many key informants specifically mentioned the value in regard to identifying gaps and avoiding duplication, although this was not always successful. In Cox's Bazar, a key informant reported that coordination mechanisms supported the delivery of an effective response plan and facilitated key trainings, including IPC trainings.

Leveraging partnerships

Government coordination mechanisms

Criteria 2 relates to how Health Cluster partners were able to engage with government coordination mechanisms, and the contributions they made. The study findings show that partners (NGOs) were not often involved in supporting coordination functions for the SPRP "pillar" response at the national level but were involved in co-coordinating or leading working groups to support the MoH response at the subnational level. The main way in which partners engaged in government coordination was through these task forces and working groups, with partners providing operational support for the response and on community engagement (see Conclusions for Theme 2.1).

Humanitarian coordination mechanisms

Further to the findings on Criteria 2, the study notes that some multisector joint planning for the COVID-19 response for populations affected by crises occurred and was useful in guiding the response and setting out the responsibilities across partners and sectors. In Afghanistan, multisector plans were developed for the COVID-19 response under the leadership of the ICCT (SDR) and there was clarity on the roles and responsibilities of partners (KII). In the Occupied Palestinian Territory, having a clear COVID-19 work plan under the HRP, and its funding appeal, were helpful in initiating the response from cluster partners, and provided clear leadership (KII).

Adapting health programs

Government coordination mechanisms

No common trends were identified regarding adapting health programs. Some interesting outlying examples can be cited. In Sudan, the federal MoH rolled out several tools to support the response, including for populations affected by humanitarian crisis. For example, they piloted a COVID-19 community-based surveillance system in one locality in Khartoum, which was established in order to understand COVID-19 transmission. The federal MoH also developed a rapid assessment tool to assess the impact of the COVID-19 pandemic on access to essential health services at facility level. This supported policy formulation and decision-making processes and supported the ability of the health system to continue to deliver safe health services (SDR, Sudan).

Humanitarian coordination mechanisms

The Health Cluster facilitated the development of guidelines to ensure programs were adapted so as to be relevant for, and to reach, populations affected by crisis, as well as facilitating their translation into local languages. This was also reflected in the online global mapping, where 79% of respondent reported that Health Clusters developed guidance (see Figure 34).

Collectively identifying and filling gaps and reducing/avoiding duplication

Government coordination mechanisms

Multiple tools were used to identify needs and fill gaps, including for populations affected by crisis. Case data and trends on population movement were made available to all actors via MoHs, supported by WHO, in a timely and disaggregated way, to inform the response strategy and priorities. Up-to-date information at the most granular level was found to be essential and was provided by various coordination structures. This helped in understanding trends for areas with populations affected by humanitarian crisis or also in need of humanitarian assistance. For example, in Syria this was done by WHO, with the use of an online dashboard, weekly sitreps, an online surveillance tool, and service mapping. These resources were developed through WHO technical support to the MoH.

In a number of countries, including Syria and Sudan, daily updates on COVID-19 cases, the response and measures taken, were shared and made accessible to health partners and the whole humanitarian community. Reports often included data on population movements across country entry points, confirmed and suspected COVID-19 cases, the distribution of cases across states, and quarantine centres.

Humanitarian coordination mechanisms

Disaggregated information was made available to all actors via the Health Cluster or other coordination mechanisms in a timely way. Up-to-date information at the most granular level was found to be essential and was provided by various coordination mechanisms, including the Health Cluster, in order to identify and fill in gaps in regard to reaching populations affected by humanitarian crisis with COVID-19 services. The study found that, in addition to monthly Cluster bulletins, the 4Ws, HeRAMS analysis, and infographics in support of technical working groups, the Health Cluster information management team often created public dashboards to monitor and follow up on COVID-19 cases. The dashboards provided a range of information including on available resources, such as treatment-dedicated hospitals, laboratory and testing, bed capacity, and the tracking of supplies. Rapid information sharing with government officials and partners was recognized as a priority throughout the response.

> *"Service mapping was enabling us to see which partners were responding where, and to make a comparison of the availability of services and identifying in which geographic areas there were gaps. Coordination enhanced our ability to see the full picture in NES and respond to the whole community of NES." – KII, Syria*

An interesting outlying example was when the ICCG in Sudan made changes to strengthen information sharing and data management to reduce discrepancies in needs projections by Clusters using different methodologies during Humanitarian Needs Overview development and the need for project-level monitoring. An oversight mechanism for data collection, analysis, and sharing under the Inter-Sector Coordination Group and the Information Management Working Group was established, working in coordination with Cluster leads and other partners.

Despite the efforts of the humanitarian coordination structures, gaps in services occurred and the duplication of activities was not always addressed. Although gaps in service delivery were identified by the coordination structures in many countries – for example, in Syria – this did not always result in a timely response to address them. This was due to several factors, including access constraints and a lack of coverage in some geographic areas.

Furthermore, coordination was not always sufficient to avoid the duplication of some activities, such as community

awareness initiatives. "To avoid duplication nothing much was done, the huge need was in Der ez Zor, and anyone willing to go was going, no one was checking duplication" – KII, Syria.

> "*Some duplication happened in the awareness activities, but in the treatment and case management there were was no duplication because the service was low and was not enough to cover the needs.*" – KII, Syria

Mobilizing resources

Government coordination mechanisms
Governments were active in mobilizing funding for the response. For example, the governments of Afghanistan and Yemen were active in mobilizing funding for the response. In Yemen, the government launched a government appeal and reached out to neighbouring Arab nations for funding, such as Saudi Arabia, Kuwait, and the United Arab Emirates. Given the huge needs across Yemen, where 66% of the population are in need of humanitarian assistance, ensuring adequate funding for the national response inevitably ensure funding to reach populations affected by crisis.

> "*The government appealed to the neighbouring countries which donated to WHO, to disperse funding for the response.*" – KII, Yemen

Humanitarian coordination mechanisms
The different humanitarian response plans (i.e. GHRP, specific humanitarian appeals for COVID-19, HRPs with COVID-19), helped mobilize funding. In 2020, the study found that donors were committed to the COVID-19 response for populations affected by humanitarian crises: for example, in the Occupied Palestinian Territory the inter-agency humanitarian response plan for COVID-19 received up to 86% of its requirement, although some funding was repurposed. It was also found that donors worked strategically to meet funding requirements to ensure delivery of the COVID-19 response, but also essential health services for populations affected by crisis. For example, in Afghanistan the World Bank provided funding to support the delivery of basic health services, while humanitarian donors provided funding for the COVID-19 response.

Coordination mechanisms also supported the identification of gaps in funding that donors could easily support, as reported by key informants in Cox's Bazar, Bangladesh.

In some countries, existing humanitarian funding was repurposed to support the COVID-19 response, while in others additional funding was released for critical activities, such as the provision of WASH services in health facilities, and new allocations were made for pre-identified partners.

In 2021, the Health Cluster continued to play a key role in resource mobilization to maintain COVID-19 facilities even in HRPs. The global online mapping exercise showed that the 2021 plans were felt to have enabled more resources particularly for surveillance, diagnosis, and case management facilities (EMRO/AFRO). However, not all countries felt that funding was sufficient in 2021. For example, in Afghanistan, hospitals closed due to funding constraints, but some small facilities were able to continue providing their services with Japanese funding.

> *"WHO was able to also obtain some funding from the World Bank for the COVID-19 response. The COVID-19 response was donor-driven; about 95% was from donors. Advocacy also helped in bringing in more funds through WHO; partners raised some funding, including MSF."* – KII Yemen

> *"A number of significant financial contributions to the Occupied Palestinian Territory Inter-agency Response Plan for COVID-19 were announced during the reporting period. Some of these contributions entailed the reprogramming of funds previously allocated or pledged for other interventions… Overall, since its launch on 27 March, $29.3 million have been raised for the implementation of the Inter-Agency Response Plan, covering 86% of the amount requested $34 million ."* – SDR, Occupied Palestinian Territory

Other trends identified in relation to humanitarian coordination mechanisms

Capacity for coordination

As identified in the online global mapping, there were changes in the capacity to conduct Health Cluster/humanitarian coordination. The most frequently reported changes were changes to the use of technology (92%), followed by changes to the level of resources (75%) and the number of staff (58%), as shown in Figure 30. However, in the case studies there were examples of coordination capacity being strengthened in some locations where additional resources were provided to reinforce the COVID-19 response, especially at the subnational level. For example, in Syria, at the beginning of the COVID-19 response there was only a small team for Health Cluster coordination in place and they faced significant challenges in retaining staff. However, additional human resources were identified to support the response, although some staff were required to double-hat. Similarly, in Yemen, additional staff were provided to support the development of contingency planning and staff were repurposed to support the COVID-19 response and allocated to the different pillars. In Afghanistan, it was reported that there was a significantly strengthened Health Cluster structure in 2022 at national and subnational level, which strengthened coordination for, and the linking of, services for the COVID-19 response for populations affected by crises.

> *"Subnational coordinators were recruited to support the context, some double-hatting and others dedicated to support Health Cluster coordination at subnational level."* KII Syria

> *"This additional coordination capacity is significantly helping to identify gaps in COVID-19 service provision and fill gaps in Afghanistan."* – KII, Afghanistan

Capacity strengthening

There was a significant focus on strengthening the capacity of partners providing services to populations affected by crisis, through training on a range of areas required to address COVID-19. Training was specifically identified as a key measure facilitated by coordination mechanisms. For example, within the Health Cluster in the Occupied Palestinian Territory, trainings included training on case management, diagnosis and treatment, online training for Intensive Care Unit (ICU) staff, training on IPC, training of trainers, training on surveillance (including data collection, point of entry and contact tracing), and training on RCCE (including risk communications and reproductive health during a

pandemic). In Cox's Bazar, training was provided on protection in isolation and treatment centres.

"We managed to train more than 5,000 through standardized training of trainers training for 400 facilities and hugely expanded IPC. All partners were brought together to be trained." – KII, Syria

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Human resources were mobilized to expand health services to reach populations affected by humanitarian crisis with COVID-19 services, and duplication was avoided by coordinating with the coordination task forces established at subnational level. Human resources were mobilized to increase capacity in hospitals and to expand community-based activities for the health response. This was supported by health partners, which in some instances included the deployment of rapid response teams to provide health services. The increased capacity ensured increased access to COVID-19-related health services by populations affected by humanitarian crises.

"The United Nations and partners are urgently expanding hospital capacity in key population centres. This includes establishing 21 new ICUs in COVID-19-designated hospitals, adding to 38 existing ICUs, deploying two high-capacity mobile field hospitals with nearly 100 beds, and providing salaries to front line healthcare workers." – SDR, Yemen

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Monitoring implementation

Monitoring frameworks for the COVID-19 response for populations affected by humanitarian crisis were established in many Health Cluster settings and were reinforced by field verification. To maintain accountability in regard to the range of organizations, committees and working groups engaged in the implementation of the COVID-19 response, Health Clusters established a monthly response monitoring framework that incorporated measurements and mechanisms, such as 4Ws and key performance indicators. Field verification mechanisms were also established to communicate with field focal points and local authorities to verify information and data shared regarding the accessibility, availability and quality of health services.

"In Syria, a field verification mechanism was used to communicate with field focal points from local authorities to verify information about the accessibility, availability and quality of health services and verify with different reports." – KII, Syria

"In Yemen, the Health Cluster regularly conducting monitoring. Subnational coordinators were undertaking monitoring visits to different health facilities, visiting partners projects, trying to identify gaps and duplication." – KII, Yemen

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Advocacy

Advocacy was prioritized as a keyway to promote access to services for populations affected by crisis. In Sudan, it was recognized that advocacy would be required to support initiatives seeking to improve access to services for populations affected by humanitarian crises. Therefore, the 2020 HRP for Sudan included an advocacy strategy, to

facilitate a coherent approach to HCT advocacy for improved access.

Procurement of supplies

The provision of supplies and support to procurement processes and supply chain, such as the facilitation of customs clearance, were recognized as valuable inputs by coordination mechanisms such as Health Clusters across all case study countries. Support included the procurement of key supplies, including PPE, medical supplies and equipment (including diagnostic equipment for laboratories), oxygen, IPC and WASH supplies, and vaccines. Support was also provided by the Logistics Cluster or Logistics Working Group (LWG) to ensure supplies reached the last mile and populations affected by crisis. For example, the LWG established a customs sub-working group tasked with identifying practical solutions to customs delays faced by partners in Afghanistan. In Sudan, partners were able to utilize the WHO partnership supply portal in collaboration with the World Food Programme.

"The LWG has started its work to address logistics issues during the COVID-19 response. During the reporting period, the LWG established a Customs sub-working group tasked to identify practical solutions to Customs delays, and to create a subgroup to manage the issues related to Customs." – SDR, Afghanistan

Challenges regarding coordination between mechanisms to support the COVID-19 response for populations affected by humanitarian crisis

Cat.	Challenges	Details and examples
Coordination with authorities	Coordinating with some governments was challenging due to limited capacity, differing priorities and/or a lack of transparent information sharing	Challenges ranged from a lack of transparent information sharing on vaccination and coverage (Occupied Palestinian Territory), to ineffective tracking of supplies and donations from different partners and bilateral donors, as well as a lack of transparency in sharing the information to provide a comprehensive overview of the support provided. In Syria, challenges resulted from the presence of dual authorities with limited coordination capacity and fragmented structures, and in Afghanistan, deterioration in the cooperation between the *de facto* authorities and WHO was highlighted, particularly when NGOs were stopped from working.

Table 29. Coordination between mechanisms to support the COVID-19 response for populations affected by humanitarian crisis – challenges.

Of note, lack of government capacity for coordination, different strategic priorities were the challenges identified for the different coordination mechanism that hindered essential health service delivery (specifically) and are interrelated here.

Other challenges reported in the case studies regarding coordination between the government and humanitarian mechanisms to support reaching populations with the COVID-19 response were more programmatic, i.e. they reflected challenges in ensuring populations affected by crisis were reached or could access COVID-19 services: for

example, programmatic issues e.g. constraints due to supply, overall pandemic response rather than ways of working between the two coordination platforms.

Government coordination – national and subnational levels

Cat.	Challenges	Details and examples
Insufficient supplies	*There were significant issues in obtaining supplies at national level, impacting their availability at subnational levels, including for populations affected by crisis*	Several countries reported challenges with supplies, including insufficient PCR equipment and testing kits. In Syria, this resulted in cases not being tested. In Yemen, there was a need to set up separate facilities designated for COVID-19. In Sudan, there was a lack of fuel for health awareness vehicles, goods, vehicles were stuck at entry points, and there were insufficient supplies of diagnostic equipment. In the Occupied Palestinian Territory there were issues with procurement and the importation of essential items. Thus, populations affected by crises within these countries were unable to access appropriate diagnostics, tools or services.
Resource mobilization	*Mobilization of funding was an issue, resulting in diversion of resources from essential services or limited capacity for implementation of crucial activities, such as community engagement*	Some countries reported challenges regarding funding: for example, in Afghanistan the government diverted funding from larger projects to support the COVID-19 response, and in Sudan the MoH reported a lack of funding for community engagement activities. Give the large humanitarian needs across these countries, this created challenges in providing COVID-19 services to populations also affected by crises.
Government restrictions	*Disruption of health services due to the imposition of mitigation measures, and restrictions on access, impacted service delivery*	Countries reported a disruption to health services during the COVID-19 response, including for populations affected by crisis. In Sudan this was in part due to the closure of private health facilities as part of mitigation measures to stop the spread of COVID-19. Further disruption was identified in hospitals and other health facilities in Sudan as routine services were affected by sporadic closures following confirmation of COVID-19 cases and the unavailability of medical staff. Government restrictions on who could conduct activities also limited the response. In Syria, for example, the MoH did not allow other actors to provide vaccinations, which limited access to vaccinations in hard-to-reach areas, especially in NES.

Table 30. Government coordination mechanisms – national and subnational levels – challenges

Humanitarian coordination – national and subnational levels

Cat.	Challenges	Details and examples
Resource mobilization	*Reduction in funding in 2021 limited (non-COVID-19) vaccination campaigns, although it was reported that the significant focus on COVID-19 vaccination also limited the capacity to continue to delivery other essential health services*	In 2021, some countries reported that the reduction in funding caused the suspension of (non-COVID-19) vaccination campaigns, or the downsizing of the support provided by WHO. In some cases, this was despite the significant level of resource mobilization previously reported. Funding was found to be insufficient in several countries because there was too much focus on the provision of COVID-19 vaccines (EMRO/AFRO), and in some cases the massive investment in COVID-19 was at the expense of other essential services (EMRO), as reported by respondents to the global online mapping exercise.

Furthermore, it was also reported that there was a lack of sufficient funding to ensure COVID-19 vaccination reached populations affected by humanitarian crises once vaccines became available (after global stock outs).

"Despite the availability of COVID-19 vaccines, lack of financial support is |

	hindering the operational capacity for wide vaccination coverage, risking future increases in COVID-19 cases." – SDR, Sudan

Table 31. Humanitarian coordination mechanisms – national and subnational levels – challenges

Good practices regarding coordination between mechanisms to support the COVID-19 response for populations affected by humanitarian crisis

The study was not able to identify conclusive trends regarding good practices in regard to government and humanitarian coordination mechanisms. Nonetheless, several outliers were considered important enough to report. These are discussed below.

Government coordination
Interesting examples and outliers at national and subnational levels:

Cat.	Good practices	Details and examples
Procurement of supplies	*Increased cooperation between neighbouring countries facilitated the delivery of supplies*	Strong cooperation efforts between the government of the Occupied Palestinian Territory and Israel in the COVID-19 response enabled the coordinated delivery of supplies, including the entry of 10,000 testing kits through Ben Gurion airport, although this cooperation did not last long (SDR, Occupied Palestinian Territory). The government provided key supplies and training in support of the COVID-19 response: for example, PPE. In Yemen, the MoH collaborated with neighbouring countries. "The government appealed to the neighbouring countries which donated to WHO, to disperse funding for the response." – KII, Yemen
Information management	*Some governments increased information sharing and facilitated access to information to support the implementation of activities*	In response to COVID-19, some governments provided COVID-19 response data and information to inform the response and partner activities. In Sudan the federal MoH provided regular situation updates, as well as details on caseloads, and identified challenges, which enabled the Health Cluster and partners to have a better understanding of the context and gaps in regard to reaching populations affected by crises with the COVID-19 response. In some instances, governments directly provided information to facilitate program activities, such as in the Occupied Palestinian Territory, where the government ensured partners were provided with key information to facilitate contact tracing. "The MoH provided contact information on patients who were contact cases, which enabled screening and follow-up." – KII, Occupied Palestinian Territory

Table 32. Government coordination mechanisms – national and subnational levels – good practices

Cat.	Good practices	Details and examples
Advocacy	*Coordination enabled effective advocacy to allow communities to access COVID-19 services, including vaccines for internally displaced persons (IDPs) and refugees*	Health Clusters focused on advocacy and increased coordination with MoHs to enable populations affected by crisis to access COVID-19 services. For example, in Yemen, advocacy was successful in increasing access for populations affected by humanitarian crisis to referrals for further treatment or to ICU units. Furthermore, coordination by the Health Cluster highlighted the needs of the affected population and worked to ensure that IDPs and refugees could access COVID-19 vaccines.
Mobilization of resources	*Strategic planning enabled resource mobilization as it was felt that it provided a clear articulation of the funding requirements*	The 2020 humanitarian strategic plans for the COVID-19 response, such as GHRP, were a tool which was considered particularly successful in facilitating resource mobilization. *"Clearly articulating funding requirements … was a powerful tool for resource mobilization."* – (Online mapping - EMRO)

Table 33. Humanitarian coordination mechanisms – national and subnational levels – good practices

Finding 3.1.2: Ways in which coordination between mechanisms enabled the continuation of essential services (Pillar 9 – operations, referrals, EPI, maternal and new-born health, child and adolescent health, older people, sexual and reproductive health services, nutrition, noncommunicable diseases and mental health)

The following findings combine results from both the global online mapping exercise and the seven country case studies. The study reviewed the measures taken within the coordination mechanisms to support a COVID-19 response that supported the continuation of essential services (Pillar 9). The sections below discuss these measures, followed by challenges, enabling factors and good practices.

Measures taken to enable the continuation of essential health services

In the global online mapping (Figure 9), a little more than half the respondents reported the use of the PHEOC to coordinate the COVID-19 response in 2020, with a decrease to less than half from 2021 onward. Further to that, Figure 8 shows that 60% of respondents reported that PHEOCs were used to coordinate the COVID-19 response at the subnational level in 2020. This fell to 50% in 2021.

Measures were taken to strengthen Emergency Operations Centres and coordination bodies at national and subnational levels. For example, in Sudan plans aimed to strengthen the support of the Emergency Operation Centres and coordination mechanisms at the national level and targeted subnational levels. This included using a rapid response mechanism, revolving medical supplies, establishing an early warning system outbreak/emergency response, support for emergency preparedness and response capacity, and the use of sustainable solutions, such as solar power, integrated into the approach.

Another aspect that was identified, but not as a common trend, in Sudan: clear plans were made to improve monitoring and analysis, particularly for ascertaining severity of need, identifying and prioritizing inter-sector needs, and conducting field-based monitoring, including joint visits. For example, clusters and partners provided quarterly

details of activities conducted and beneficiaries reached to allow for an interactive, real-time snapshot of achievements. This improved ongoing response monitoring and enable adaptations to be in line with the evolving context. Measures were put in place to improve monitoring and analysis of needs and support appropriate prioritization.

"The analysis of severity around the impact of shocks places people in need at the centre of the analysis, instead of looking at people's severity of need through the lens of individual sectors." – SDR Sudan

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Challenges regarding coordination that hindered the continuation of essential health services

Government coordination

National and subnational levels

Cat.	Challenges	Details and examples
Capacity	*Coordination between mechanisms was hindered when there was limited or inconsistent government capacity*	Coordination between the Health Cluster and governments was challenging for example, in Afghanistan, where there was a lack of capacity following the political changes in 2021 and where negotiations to implement health interventions took place on a case-by-case basis. In Syria there was a need to repeat approvals for health interventions, which took up to 12 weeks.
Strategy	*Divisions and differing priorities increased, and hindered coordination of the response*	Outlier: In Sudan, differing priorities of the government and humanitarian community hindered coordination and the response. "While historically, there was always difference in the humanitarian and government's approach, during the COVID-19 response these differences were much greater, and there "was a rift". The government wanted to address the whole health system, as they saw it as a funding opportunity to revamp/reinvent the health system. From the humanitarian perspective, this was not the time to do this, there was a need for focus on key areas. So, the nine pillars were in place, but addressed differently, as they focused on doing more. KII Sudan "It is clear from the after-action reviews and monitoring that this approach meant that we were not focused enough, and result was disappointing, with lethal outcomes to the population. With time, there was some level of discourse between the government and agencies, and agencies were happy to entertain government's demands to an extent, when it did not impact on neutrality or impartiality, but it did not work well for many people." – KII Afghanistan

Structure	*Political challenges and government bureaucracy prevented service delivery*	Outlier: Service delivery was affected by political changes and bureaucracy: for example, in Afghanistan, permissions were required from the MoH to reopen health facilities, the *de facto* authorities took over the running of some health facilities and bans on female humanitarian staff by the authorities in certain districts resulted in the suspension of Mobile Health and Nutrition Teams (MHNTs) and affected partners' capacity to deliver essential health services. "Direct interference and the ban on female humanitarian staff by the authorities in certain districts has resulted in the suspension of MHNTs, and thus affected partners' response capacity (severity: 4), as the de facto authorities don't allow women in the staff." – SDR Afghanistan

Table 34. Government coordination – National and subnational levels – Challenges

Humanitarian coordination

National and subnational levels

Cat.	**Challenges**	**Details and examples**
Capacity	*Utilization of health services fell due to fear and stigma, exacerbated by fears and resistance of health staff*	Resistance and fear among service providers, especially at the beginning of the pandemic, hindered the continuation of essential health services. To address this, countries focused on building trust among health workers, emphasizing that COVID-19 was like any other infectious disease. Measures focused on building confidence in protective measures, and the provision of training on IPC.

Table 35. Humanitarian coordination – National and subnational levels – Challenges

Enabling factors regarding coordination that enabled the continuation of essential health services

No common trends were identified in the dataset for both government and humanitarian coordination mechanisms, but a few outliers were identified.

Government coordination

Insufficient data were available to draw key findings.

Humanitarian coordination

National and subnational levels

Cat.	**Enabling factors**	**Analysis**
Strategy	*When multisector approaches were used, it strengthened the COVID-19 response*	Outlier: Taking a multisector approach strengthened the response and strengthened collaboration – such as in Sudan between the health, WASH and nutrition sectors to support a multisector approach, including the provision of safe water and hygiene.
Strategy	*The integration of COVID-19 services into existing health structures helped to ensure that health needs were covered*	Outlier: The integration of COVID-19 services into the existing health system was an approach taken in Afghanistan, where COVID-19 facilities were integrated into the national, provincial, or regional infectious disease hospitals to support ongoing access to healthcare.

Table 36. Humanitarian coordination – National and subnational levels – Enabling factors

Good practices that facilitate the coordination between mechanisms to enable the continuation of essential services

No common trends were identified in the dataset for both government and humanitarian coordination mechanisms, but a few outliers were identified.

Government coordination

Insufficient data were available to draw key findings.

Humanitarian coordination

National and subnational levels

Cat.	Good practices	Details and examples
Roles and responsibilities	*There was good coordination and clarity of roles*	Clarity on roles and responsibilities facilitated coordination and reduced duplication, and where there were issues the coordination mechanisms were able to identify them. For example, mandates were clear, such as WHO's role being focused on service delivery, capacity building and providing operational support, whereas UNICEF's role related to community engagement and social mobilization.
Technology	*There was innovative use of technology to support the implementation of the response*	Technology, such as satellite imagery and a range of applications, was used by the Health Clusters and WHO to identify needs in hard-to-reach areas in Afghanistan.
Partners	*Local experts were used to provide ICU services, which facilitated the reopening of health facilities*	"WHO used local experts to provide training in ICU services, which facilitated the reopening of health facilities." – KII, Afghanistan

Table 37. Humanitarian coordination – National and subnational levels – Good practices

Conclusions for Theme 3.1: Were Health Clusters enabled to achieve the objectives in the GHRP and HRPs to support the COVID-19 response for humanitarian (or wider) populations?

Government and humanitarian strategic plans

- Different types of strategic planning documents and appeals were established across countries with a Health Cluster from the start of the pandemic. In 2020, most settings (74%) were reported to have developed a country strategic preparedness and response plan (developed MoHs), and for populations affected by humanitarian crisis 36% of settings had an appeal within the GHRP, 23% had a separate COVID-19 appeal (not within the GHRP or existing HRP), and 45% incorporated the response in existing HRPs (e.g. mid-year review or otherwise).

- In 2021, the prevalence of country strategic preparedness response plans decreased (to 55%) and as the GHRP was closed in 2021, COVID-19 response activities were integrated into HRPs (65%).

- These were, overall, considered somewhat appropriate by two-thirds of respondents in both 2020 and 2021, but 71% reported that they were only partially successful in ensuring populations affected by humanitarian crisis received COVID-19 services. This indicates some disconnect between planning and implementation, and potentially gaps in ensuring effective coverage of populations affected by humanitarian crisis.

Government coordination: measures taken to support the COVID-19 response, including maintaining essential health services for populations affected by humanitarian crisis

- At the national level, strategic plans provided a policy framework for COVID-19 preparedness and responses. The pillar approach from 2020 planning allowed alignment with global response plans (such as WHO SPRPs) and facilitated the integration of new actors, as indicated by data from the global online mapping exercise.
- In 2021, it was reported that increased coordination between MoHs and Health Cluster partners occurred under these plans, and facilitated the development of inclusive joint strategies, particularly in regard to accessing hard-to-reach areas.

Government coordination: challenges

- Although the findings demonstrate that in many cases the coordination overall worked well, some countries reported that coordination structures used to reach populations affected by humanitarian crisis were confusing or considered inadequate in 2020, as well as in 2021. The reasons for this included that they created multiple response frameworks, plans were only devised centrally, coordination with Health Clusters was inadequate, and/or data were not adequately shared (notably on vaccination). This was reported to be largely a result of limited or inconsistent government capacity, either technically or for coordination at national and subnational levels. Only around a quarter of respondents to the online mapping exercise considered the government coordination structures to be "very appropriate" and "very beneficial" to the response at both national and subnational levels, indicating that coordination structures require additional strengthening to be more effective.
- From the case studies, most governments plans set out a general response to populations without specific mainstreaming of approaches for populations affected by crises, such as hard-to-reach populations, displaced people or refugees. In only one location (Cox's Bazar in Bangladesh) did the study identify a government response plan that referred to refugee populations.
- Delays in planning were identified and the development of the plans did not always match the pace at which the pandemic progressed. Various other sectors did not immediately realize that the pandemic was not simply a health issue and took time to engage. This further demonstrates the importance of having multisector preparedness and plans even for novel pathogens, to determine strategies for possible scenarios, instead of developing them during an emerging crisis. Mechanisms for rapid updates, evolving evidence and changes should also be integrated within planning to keep abreast with rapidly emerging needs and possible responses.
- Community resistance appears to have been underestimated or neglected in the plans, as plans did not account for the accompanying "infodemic," including rumours and the reluctance of some communities to follow public health advice, such as physical distancing or wearing masks. This indicates that focus and attention should be given to how to quickly lead the flow and correct information, and to investing in mechanisms to dispel myths. Also, there is a need to invest in working directly with communities from the outset to understand their fears, but also to work with them to understand what is required to protect themselves, their families and communities in such circumstances.
- There were significant issues in regard to obtaining supplies at the national level, but more so at the subnational level, which undermined the provision of COVID-19 services to populations affected by crisis.

Government coordination: enabling factors

Enabling factors specific to reaching populations affected by humanitarian crises could not be determined by the study. However, in regard to the COVID-19 response for the overall population, the following was found:

- The 2020 strategic planning was regarded as an enabler for multisector approaches, as reported in the online mapping exercise by several Clusters in many different regions.
- The 2020 and 2021 plans were reported to be an enabler for the mobilization of resources, particularly in support of surveillance, diagnosis, and case management facilities.

Humanitarian coordination: measures taken to support COVID-19 response for populations affected by humanitarian crisis

- The Health Cluster coordination mechanism linked to humanitarian strategic plans but also to national government strategic plans for the COVID-19 response, which helped ensure alignment of responses and coherence, and strengthened coordination, although significant room for improvement remains. This includes supporting the maintenance of, and access to, essential health services.
- Guidance and guidelines issued or disseminated by Health Clusters in a timely way facilitated the delivery of the COVID-19 response to populations affected by crisis.
- Information was made available to all actors via Health Clusters or other coordination mechanisms in a timely manner. Monitoring response frameworks for the COVID-19 response were established and reinforced by field verification mechanisms and were implemented via Health Clusters.
- There was a significant drive to strengthen the capacity of Health Cluster partners through training on the various aspects required to address COVID-19-related issues, including case management and IPC.
- Human resources were mobilized to expand health services and duplication was avoided by coordinating with the relevant government and/or Health Cluster task forces established at subnational level.
- The mobilization of funding was a key priority from the start of the pandemic and continued in 2021 and was facilitated by the different response plans.
- Partners were actively engaged in the provision of supplies for the COVID-19 response to reach populations affected by crisis, and LWGs took measures to address supply chain issues.

Humanitarian coordination: challenges

- Despite the efforts on coordination, the duplication of activities was not always addressed.
- Coordinating with some governments proved challenging at times due to their limited capacity and/or lack of accurate and reliable information sharing.
- There were some decreases in funding for the COVID-19 response specific to populations affected by crisis, despite intense resource mobilization efforts in 2021. Where this occurred, it limited (non-COVID-19) vaccination campaigns and limited the capacity to continue the delivery of other essential health services.
- The focus on COVID-19 often diverted attention away from other health essential health services.
- There were significant supply issues across most case study countries, including in regard to the delivery of PPE equipment and supplies to reach populations affected by humanitarian crisis.
- The ability to deliver essential health services and to coordinate was hampered by reduced capacity or overloading of existing capacities within humanitarian organizations.
- The delivery of training for aspects of essential health services was disrupted as trainers were already busy implementing activities related to the COVID-19 response.
- The utilization of essential health services fell due to fear and stigma, exacerbated by the fears and resistance of health staff.

Humanitarian coordination: enabling factors

- Health Cluster coordination enabled advocacy for populations affected by humanitarian crisis to have greater access to COVID-19 services, including the maintenance of and access to essential health services.
- Clarity in 2020 strategic response plans for the COVID-19 response for populations affected by crisis (as

articulated in either the GHRP, specific COVID-19 appeals, or within HRPs, depending on the country) resulted in successful resource mobilization. Respondents reported this was because it "Clearly articulated funding requirements for COVID-19 response and was a powerful tool for resource mobilization". (Online mapping – EMRO)

- When capacity for Health Cluster coordination was increased, it was reported to have significantly strengthened partner engagement, Health Cluster functioning, and Health Cluster structures at national and subnational levels.

Humanitarian coordination: good practice

- Many approaches were described whereby the delivery of healthcare was adapted to maintain essential services. This included, for example, the use for telemedicine or changes to the delivery or frequency of services, as well as COVID-19-safe adaptations in hospitals and the isolation of COVID-19 treatment areas.

Theme 3.2: Were Health Clusters able to adhere to humanitarian principles and protect the humanitarian space?

Finding 3.2.1: Ways in which humanitarian principles were enabled or diminished (humanity, impartiality, neutrality, independence)

Challenges relating to the ways in which humanitarian principles were enabled or diminished (humanity, impartiality, neutrality, independence)

Data were only available on humanitarian coordination at the national and subnational levels.

Cat.	Challenges	Details and examples
Humanitarian access	*Humanitarian access was restricted/delayed by government, despite exemptions for health services*	The study found that in several countries, restrictions hampered or delayed the delivery of humanitarian programs. For example, in Cox' s Bazar, Bangladesh, the approval of projects was delayed and access to camps was challenging. In the Occupied Palestinian Territory, attempts to conduct monitoring were hampered by Palestinian authorities' restrictions and security system. Access by humanitarian personnel was also impeded by restrictions to visas, and the suspension of international staff. "The government placed a ban on humanitarian restriction to engage with refugee s . However, at ground level, law enforcement interpreted things differently, they only saw health providers as doctors in white coats and referrals as ambulances. So, the impact on health provision – given most (except Community health volunteers) lived outside the camps – was hard and was a demotivator and impacted on service delivery." – KII, Cox' s Bazar, Bangladesh
Humanitarian access	*Political and security tensions diminished humanitarian access and organizations struggled to reach and operate in high-risk areas*	Political tensions between different factions in Sudan and Yemen impacted humanitarian access and in insecure areas organizations struggled to operate. In Syria, because of insecurity, some areas had strict curfews, which limited the opportunity to deliver health services. "High-risk areas are very hard to reach by humanitarian actors." – KII, Sudan

Humanitarian principles	*Government interference reduced the ability to maintain humanitarian independence and neutrality*	In Afghanistan, a high level of interference in programming was reported, with authorities attempting to influence the selection of beneficiaries and the selection of staff in NGOs. Moreover, there was a lack of understanding and acceptance on the part of the authorities regarding humanitarian response principles and NGO practices, which resulted in some NGOs being prevented from working.

Table 38. Humanitarian coordination – challenges

Enabling factors in regard to ways in which humanitarian principles were enabled or diminished (humanity, impartiality, neutrality, independence)

Data were only available on humanitarian coordination at national and subnational levels.

Cat.	Enabling factors	Details and examples
Strategy	*Pre-existing health service delivery was a factor which enabled access to health services for camp populations*	For example, in Syria and Yemen, IDPs had pre-existing access to dedicated humanitarian facilities within camps, whereas other areas were dependent on government health services, which were often not functional.
Strategy	*Pre-existence of integrated programs under health enabled continued access to specialized services, such as gender-based violence (GBV) services*	Movement restrictions caused protection services to be suspended. The pre-existence of integrated health programs, including women-friendly spaces offering GBV services, enabled continued access to these services.
Advocacy	*Sustained humanitarian advocacy by coordination mechanisms supported equal/impartial access*	Consistent advocacy and low-profile negotiations were conducted, facilitated by the Health Cluster, allowing for solutions to be found. "This was very successful, low-profile quiet diplomacy which worked very well and managed to build a good rapport with all stakeholders. This was very successful in getting the vaccine going and keeping it up and running." – KII, Syria

Table 39. Humanitarian coordination – enabling factors

Good practices

Data were only available on humanitarian coordination at national and subnational levels.

Cat.	Good practices	Details and examples
Strategy	*Approaches to delivery of healthcare were adapted to maintain services*	Adaptations to the delivery of healthcare were made to maintain services. These included the use of telemedicine, the use of hotlines (a psychological helpline to provide remote support), the use of an online system to support people with chronic diseases, mobile sample collection for hard-to-reach areas, and home-based care. In Cox's Bazar, existing infrastructure was used, including transit centres with quarantine facilities, with the same systems for processing refugees as were used pre-COVID-19. In Sudan, strategies were put in place to reduce exposure for patients with chronic diseases and malnourished children,

	to reduce health facility visits. These included the provision of two-week supplies and the delivery of supplies by community health workers.

Table 40. Humanitarian coordination – good practices

Conclusions for Theme 3.2: Were Health Clusters able to adhere to humanitarian principles and protect the humanitarian space?

- The study was not able to come to a conclusion regarding specific trends across countries for this theme, as most findings under this theme were outliers and varied. Nonetheless, these outliers are reported as they represent the diversity of issues that can be faced in humanitarian contexts. Moreover, the study interview guide was long and key informant fatigue during the interviews may partly account for the lack of consistent data.

Enabling factors

Impartial/equal access

- Pre-existing health service delivery in health facilities helped ensure access to health services for camp populations, especially when there were movement restrictions.
- The pre-existence of integrated programs (e.g. in health and other sectors) demonstrated that specialized services, such as for GBV, could be more readily maintained in contexts where movements were restricted but where the continuation of health activities was prioritized by governments.
- Continuous efforts in regard to humanitarian advocacy by partners, Health Clusters and HCTs helped ensure access to COVID-19 services, including essential health services, by populations affected by crisis.

Humanitarian access

- When there is government will, access can be negotiated, and discussions can be facilitated through existing coordination mechanisms.

Factors which limited or diminished humanitarian principles

Impartial/equal access

- The study noted a few reports of discrimination, where authorities limited access to health services due to factors such as social caste or migration status.

Humanitarian access

- Several countries reported that humanitarian access was restricted/delayed by governments, despite specific exemptions for health services. Moreover, political tensions undermined humanitarian access – in insecure contexts, agencies struggled to reach and operate in areas with high risk and insecurity, including where the imposition of curfews impacted service delivery. Moreover, access of humanitarian personnel was impeded due to restrictions in visa delivery or the suspension of international staff.

Independence and neutrality

- The study found that in some countries, government interference included bureaucratic and administrative impediments which reduced the ability to maintain humanitarian principles. This was particularly the case when governments required approval of individual projects or insisted on being involved in beneficiary selection and/or staff recruitment.

Diminished humanitarian space

- Concerningly, the study found general reports that the humanitarian space (i.e. the social, political and security operating environment that allows for unimpeded access to protection and assistance) progressively diminished during the pandemic. The causes of this were not explored within the scope of this study.

Recommendations for Criteria 3: How did the different coordination mechanisms enable or limit the COVID-19 response, including maintaining essential health services in humanitarian settings?

To governments:

- Strategic preparedness and response plans using the pillar approach were shown to be effective and should be used when facing similar pandemics or other health crises in the future. However, they need to be mainstreamed in order to be well understood by actors *prior to any crisis* and dedicated resources need to be mobilised to avoid diversion from the provision of essential health services.
- Moreover, these plans should include dedicated provisions to ensure equitable access for affected populations living in hard-to-reach areas or with a status that may be different to 'host' communities, such as displaced people and/or refugees. This involves understanding barriers they may have and the tailored response that may be required to reach them. These activities should therefore be planned for and costed from the outset.
- Ensure resources are in place for rapid deployment of coordination capacity at both the national and sub-national levels. Ensure existing government systems of outbreak response and routine immunisation, are leveraged for future pandemic response.
- For future pandemics leverage health cluster and humanitarian coordination platforms to engage partners to reach populations affected by crisis
- Investment in understanding supply chains and conducting product quality control in a timely manner, and their integration into customs clearances, are required.
- Community resistance should not be underestimated, and information should be rapidly spread to avoid misinformation, false rumours and/or misconceptions. This requires investment in community engagement activities, as well as multi-modal activities to combat misinformation and raise awareness.

To health cluster at global level:

- For future pandemics clearly define requirements for response in humanitarian strategic plans. In 2020 plans such as GHRP, COVID-19 specific plans, and humanitarian response plans which clearly articulated COVID-19 needs and requirements and engendered resource mobilisation. This was reported to be less clear in 2021.

To WHO and health cluster at country level:

- Health Logistics Working Groups need to be established early on in health crises in order to facilitate the procurement and/or import of essential response supplies and its distribution to subnational level. Where this may be the role of WHO and/or UNICEF to import supplies for Ministry of Health etc, partners are also importing supplies and need support.
- Continued attention needs to be provided to the provision of essential services with continued advocacy. Coordination should identify high priorities and ensure that relevant resources are dedicated, whether in terms of funding, staff and/or supplies.

- Sensitization and training should not only target communities but also target health staff as a priority in any future pandemic in recognition that they are on the frontline of the response.
- Advocacy and humanitarian negotiation for access to populations of crisis should be continuous and ongoing priorities and not just vital when crises occur. This is particularly relevant to ensuring that health personnel are allowed to continue to deliver essential services at all times.

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LIST OF ANNEXES

Annex 1. GHC COVID-19 coordination study - analytical framework

Annex 2. Online mapping of coordination structures report

Annex 3. The terms of reference for the country case studies

Annex 4. The key informant list

Annex 5. The documents reviewed list

Annex 6. Database

Annexes 7–9. Data analysis matrixes per criteria.