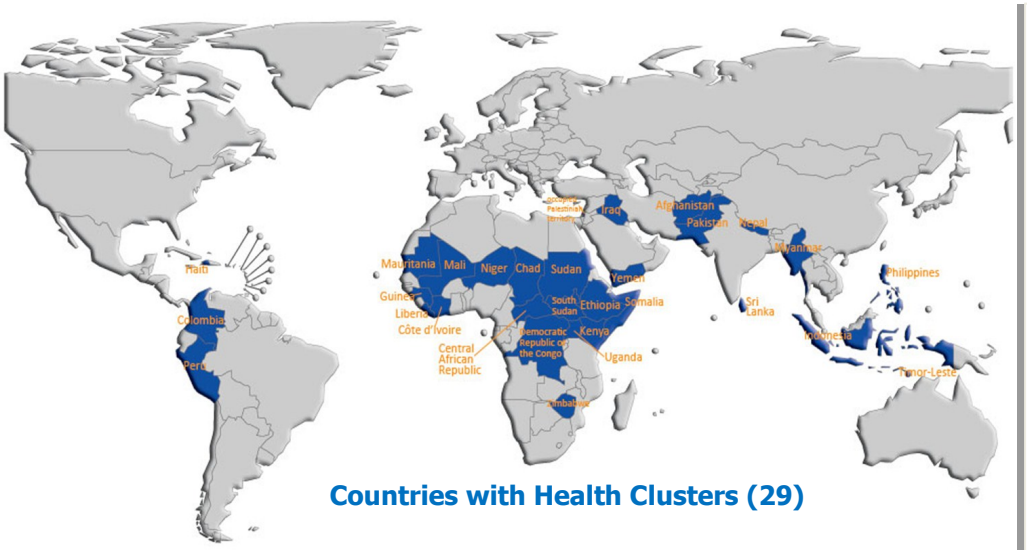
Global Health Cluster Newsletter

March 2013



Countries with Health Clusters (29)

What's new from the Global Health Cluster?

GHC work plan 2013. *The GHC core group held a teleconference on February 19th to finalize the GHC Work-plan for 2013. In line with the decision made in December's meeting, the GHC will focus this year on 4 strategic priorities; i) Developing mechanisms to ensure surge for key health cluster functions; ii) Support the implementation of the Cluster Performance Monitoring in a minimum of 10 countries in 2013; iii) improve Information management at country Health Cluster level; and iv) improve emergency response and recovery through strengthened country-level preparedness.*

New member in the GHC. *In December 2012, Medair, a humanitarian Non-Governmental Organization based in Switzerland, expressed interest to become a full member of the GHC. The GHC Core group examined Medair's application and concluded that the NGO fulfills all the GHC membership criteria, as it is active in the area of providing health services in countries with fragile situations and in areas affected by or recovering from humanitarian crises; and also thanks to its significant global engagement and proven record of quality involvement in the health response in emergencies. Medair became the 40th Member of the GHC on February 6th.*

Cluster Performance Monitoring process CPMp. *Monitoring performance at national and sub-national level in both sudden onset and protracted crises is necessary to ensure that clusters are efficient and effective coordination mechanisms, fulfilling the core cluster functions, meeting the needs of constituent members, and supporting the delivery of health services to affected populations.*

The roll-out of the CPMp in countries with active Clusters and Cluster like coordination mechanisms is a priority for the IASC as stated in the "Reference Module for Cluster Coordination at the country level". Indeed, for 2013, the IASC is planning a synergized roll -out of the coordination performance monitoring process across all clusters in five countries (OPT, South Sudan, Afghanistan, The pacific/Fiji and Philippines). During the week of March 11th the process was launched in the occupied Palestinian Territory and in South Sudan with the participation of the Health Sector/Cluster.

The Global Health Cluster plays a prominent role in supporting the launching of the process at country level by; i) providing technical support to the country cluster teams; ii) providing a technical platform for the implementation of the online questionnaires to be completed by cluster partners and cluster coordinators; iii) overseeing the generation of an automatized report after the completion of the surveys. The GHC also supports the process by advocating for partners' active participation in the CPMp and by ensuring representation by relevant senior staff in the final country-level meeting to discuss the results and formulate recommendations for cluster improvement. In line with the GHC Work-plan for 2013, the Global Health Cluster plans to support the process in at least 10 countries including the countries where the IASC is planning a joint roll-out of the process.

The Global Health Cluster (GHC)

The Global Health Cluster (GHC) was established in 2005, as part of the humanitarian reform process. Currently, the Global Health Cluster is made up of 40 international humanitarian health organizations, and 5 observers.

The active GHC members are represented by 6 UN agencies, 24 International Non-Governmental Organizations, 4 donor agencies, 2 academic institutes, 2 International organizations (IFRC and IOM) the CDC and the Public Health Agency of Canada.

The Global Health Cluster Mission

To build consensus on health priorities and related best practices, and strengthen system-wide capacities to ensure an effective and predictable response

The GHC objectives 2012-2013

1. Ensure a health cluster team is in place within 72 hours from the cluster activation date

2. Monitor and report on health cluster leadership functions, and promote best practices

3. Demonstrate progress towards satisfactory health outcomes and service availability to affected populations

Upcoming events

GHC Core group Meeting
Geneva, 10 -11 April

The Health Cluster Forum
Venue TBD, 17 -19 June

GHC meeting
Venue TBD, 20 – 21 June

Country Health Clusters

New HCC in Mali, ***Ms. Chantal Calvel*** *formerly HCC Haiti, was deployed for 2 months as HCC Mali. (April 15th)*

Global initiatives with Health Cluster implications

Cluster Performance Monitoring process in Somalia: *The process started in December 2012 and the questionnaires for the surveys were shared with partners and the Health Cluster Coordinators at national and sub-national level. The cluster description forms (duly filled by coordinators) provided excellent information on the architecture of the cluster, its partners, strategic and technical working groups, and for the national cluster, web links to all the 'products of the cluster. The survey results were available by mid-January, and shared with all partners. For both national and subnational (south-central Somalia) all cluster functions scored at least satisfactory or good. The meeting to discuss these results was held in the first week of March 2013, with the participation of Cluster partners in Nairobi and Mogadishu, a GHC representative (Dr Griekspoor), and a representative from ECHO. In Mogadishu, the meeting was also attended by the State Minister of Social Services and Human Development, as well as the head of the Directorate of Health.*

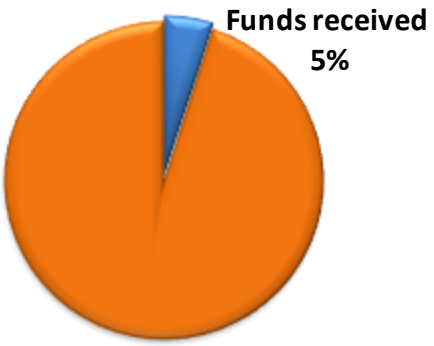
Update on the Transformative Agenda. *The 84th meeting of the IASC Working Group was held in Washington on March 18-19, during which progress with the Transformative Agenda (TA) was reviewed. Generally, attendees were positive about the progress made on the normative work of the TA. Five "Level 3" protocols have been finalized and disseminated, with the remaining four to be completed within the next two months. Related systems and processes have been strengthened, including an expansion of the Humanitarian Coordinator pool and the conduct of several table top exercises to test the TA procedures. Moreover, there have been three successful field missions to South Sudan, Chad and Myanmar to review applicability of the TA and to support country teams in its application. Nonetheless, attendees acknowledged the challenges faced and the shortcomings in implementation of the TA protocols following the Level 3 declaration for Syria on January 15. While government opposition and the security situation have restricted some aspects of implementation (e.g. appointment of Senior HC), several measures within the Level 3 Protocols should have been implemented by this stage, e.g. MIRA development of strategic statement, CERF allocation, etc. Implementation of the TA will be a major priority for the Working Group and Emergency Directors' Group over the coming 12 months. A dissemination, implementation and institutionalization strategy is currently being finalized; a major system-wide simulation exercise is planned for late June; and steps are underway to adapt the TA to slow onset and protracted crises.*

Updates from ongoing crises

Syria and neighboring countries. *March 15th marks two-years since the start of the political unrest in Syria. As a result of the conflict, 70 000 individuals have lost their lives, an estimated 350'000 persons have been injured and over 1 million Syrians have fled their homes due to insecurity, fear, or as a precaution and sought refuge in neighboring countries. The health system has been severely disrupted, along with the health care infrastructure (36% of hospitals and 7% of health centers are out of service), the workforce is heavily affected with 70% of health workers facing difficulties in accessing their work place. Access to essential medicines and medical supplies has also been severely impacted, as the Syrian pharmaceutical industry which was covering up to 90% of the Syrian needs is at a standstill due to the crisis. The disrupted health system has a direct impact on the provision of primary and secondary health care (preventive and curative), including support for chronic diseases, reproductive health, infant and child health, nutrition, mental health services, and support for people with disabilities.*

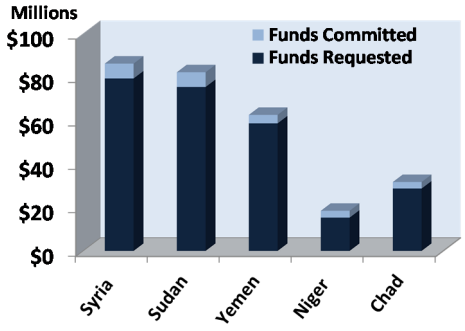
The health sector group under the leadership of WHO Syria has supported the provision of basic health care services to over 1.4 million people through supporting mobile clinics and through supporting national NGO partners 331000 medical interventions have been performed. The Health working Group partners have also supported the MoH for the vaccination of 1.5 million children against Polio and 1.3 million children against Measles.

Humanitarian health financing overview 2013

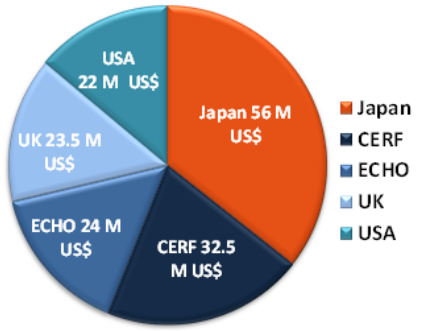


Funds Requested US$ 665 .5 million
Funds received US$ 34.4 million

Humanitarian health financing Top Five recipient countries



Humanitarian health financing Top five donors to health appeals



Source: FTS – 26 March 2013

Severe shortages in life-saving medicines inside Syria

*Pharmaceutical experts and health professionals from WHO and the Syrian health authorities met in Amman to address critical shortages in medicines and medical supplies in Syria. They initiated a process to compile an updated Essential Medicines List based on disease profiles, current gaps and critical needs. The funding gap for procuring life-saving emergency medicines, medical supplies, and medical consumables on the Essential Medicines List for a period of one year alone is estimated at **US$ 467 million**.*

This newsletter is a product of the GHC's Editorial Review team
It is developed and distributed every two months to global, regional and country health partners and stakeholders
For more information please contact: Dr Ahmed ZOUITEN, zouitena@who.int