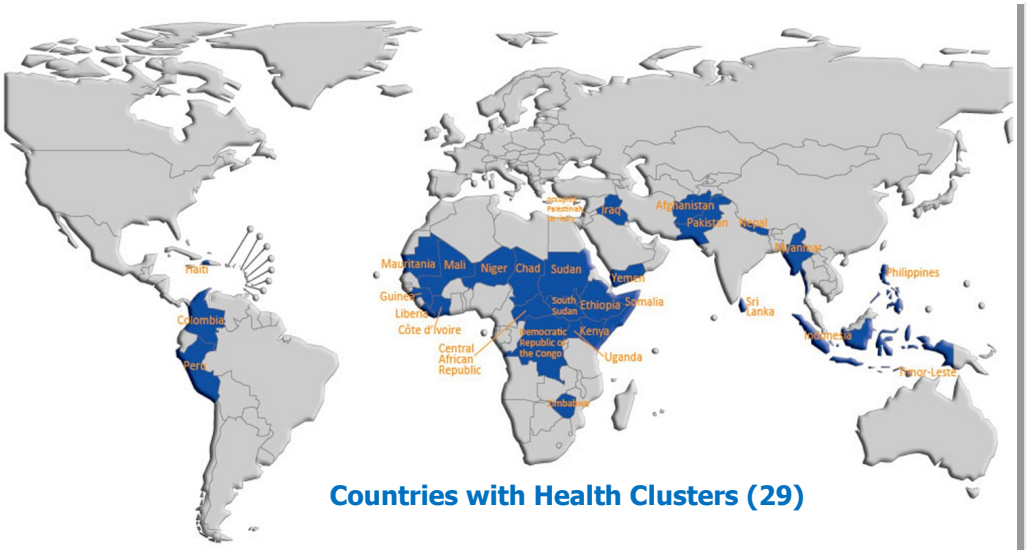
# Global Health Cluster Newsletter

## *May 2013*




**Countries with Health Clusters (29)**

## What's new from the Global Health Cluster?

**GHC Core Group Meeting April 2013.** *The Global Health Cluster Core Group meeting was hosted by the International Organization for Migration, IOM on 11—12 April. The meeting was an opportunity to discuss a number of subjects relevant to the GHC including; i) updates on humanitarian program cycle work and latest developments and processes of the Transformative Agenda, ii) presentation of the preliminary results of the GHC partners' capacity survey , iii) update on surge model, iv) cluster performance monitoring roll out, v) information management strengthening within the Health Cluster, iv) review of the concept paper for the upcoming Health Cluster Forum (17-19 June 2013) and planning and agenda of the next GHC meeting (20-21 June 2013), iv) discussion on roles and responsibilities of the GHC Core Group members. The Core Group also discussed the engagement of its members in each of the activities listed in the GHC work-plan for 2013*

**Global Health Cluster Partners' Survey report.** *As part of the GHC coordination role, and in order to promote predictability and effectiveness in future health responses to emergencies, the secretariat of the GHC conducted a survey to take stock of the resources and capacities available to different partners in the GHC, and that can be mobilized in the wake of a large scale emergency.*

*The total response rate to the GHC Partners Capacity Survey was 83% with 33 respondents among the 40 GHC partners. 79 % (26/33) of respondents identified their organization as an operational entity, while 21% (7/33) self-declared as non-operational.*

*All of the 26 operational GHC partners responding to the survey had field presence in at least 5 countries and in at least 2 WHO regions. The highest representation was among IFRC and UN agencies (WHO, UNICEF and UNFPA) with offices in 66 of the countries of concern for WHO, while among the NGO partners the average presence in countries was 19 ranging from 36 country representations for MDM to as low as 5 for another partner. With regards to the presence of the GHC partners in the countries with active Health Clusters, IFRC and UN agencies were represented in all the countries, while the NGO partners had the highest representation in DRC, Kenya, Ethiopia, Somalia, Sudan (North and South), Pakistan and Myanmar with an average between 10 and 13 NGO members. The presence in Mali, Chad, Haiti, Uganda, Yemen, Afghanistan, Nepal, and Bangladesh ranged between 7 and 10. In countries like Mauritania, Niger, Iraq and Djibouti, the representation ranged between 0 and 3 NGO partners.*

*Seven non-operational GHC partners completed the survey, they were 4 NGOs, 2 donors and 1 academic institution. Apart from the 2 donor agencies, the GHC non-operational partners, identified the following activities as their main mission: academic/research, advocacy, education and policy. The non-operational GHC members could support the GHC through health technical expertise, needs assessment, information management and Health Cluster coordination.* **For more information on the Global Health Cluster Partners' Survey report, please visit the GHC page on the WHO website**

### *The Global Health Cluster (GHC)*

*The Global Health Cluster (GHC) was established in 2005, as a component of the humanitarian reform process. Currently, the Global Health Cluster is made up of 41 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, 3 academic institutes, 2 International organizations (IFRC and IOM) the CDC and the Public Health Agency of Canada.*

### *The Health Cluster's goal during Emergencies*

*To prevent and reduce excess mortality, morbidity and disability. Moreover, the cluster aims to restore the delivery of, and promote equitable access to, preventive and curative health care as quickly as possible, in as sustainable a manner as possible.*

### *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*

***The Health Cluster Forum***
*Hammamet, Tunisia, 17 -19 June*

***The 15th GHC meeting***
*Hammamet, Tunisia, 20 – 21 June*

### *Country Health Clusters*

*New HCC in Mali,* ***Dr. Ernest Dabire*** *was hired as HCC Mali starting April 2013*

*New HCC in South Sudan:* ***Dr. Julius Wekesa*** *was hired as HCC South Sudan starting mid-May 2013*

*New Regional Health Sector Coordinator in the Emergency Support team for Syria* ***Dr. Iliana Mourad*** *joined the team as of mid-May 2013*

## Global initiatives with Health Cluster implications

**Cluster/Sector Performance Monitoring process in Palestine:** *On May 8, a joint video conference between West Bank and Gaza was conducted mainly to discuss the findings of the Health Sector Performance Monitoring process in Palestine. The WHO acting head of office and an MoH representative opened the meeting and participated actively in the discussion. OCHA was represented by the head of office in Palestine who participated in facilitating the discussion together with the Sector coordinator in West Bank Yousef Muhaisen and in Gaza Dr Abelnaser Soboh. 40 professionals representing 24 different partner agencies attended the meeting*

*The Health Sector coordinator presented the findings of the health coordination performance survey that was conducted online. The participation rate was around 72%, and the Cluster/Sector functions were mostly rated as satisfactory or good, with the exception of the "Application and adherence to existing standards and guidelines" that was rated as unsatisfactory. The participants then reviewed the performance status of the sector functions and identified what worked well to document "good practice" and also recommended actions to improve the function that scored below satisfactory threshold .*

**The 4th Session of the Global Platform for Disaster Risk Reduction.** *The world's foremost gathering of stakeholders committed to reducing disaster risk and building the resilience of communities and nations was held in May. Over 3500 delegates reported on progress on implementing the Hyogo Framework for Action and gave their inputs for a new framework for disaster risk reduction to be adopted in 2015. Major outputs of the conference, including the Chair's summary and the High Level Communiqué, reflected an increasing emphasis on actions to improve health outcomes for communities at risk of emergencies. Three major health events were held: 1) Thematic Platform on Emergency and Disaster Risk Management for Health, 2) the Feature Event on The Health Imperative for Safer and Resilient Communities and 3) a Side Event on Safer Hospitals - Essential Priorities for Disaster Risk Management and Community Resilience. Specific actions directly arising from these sessions include a revised action plan for the thematic platform and an updated action plan for the safe hospitals initiative.*
*WHO also presented 10 key messages for enhancing the post-2015 framework for disaster risk reduction, and invites input from all partners to strengthen the health inputs to the ongoing dialogues on the future of DRR. Progress reports and resource materials made available by WHO at the Global Platform can be found at: http://www.who.int/hac/techguidance/preparedness/. Global Platform reports are available at: http://www.preventionweb.net/globalplatform/2013/.*

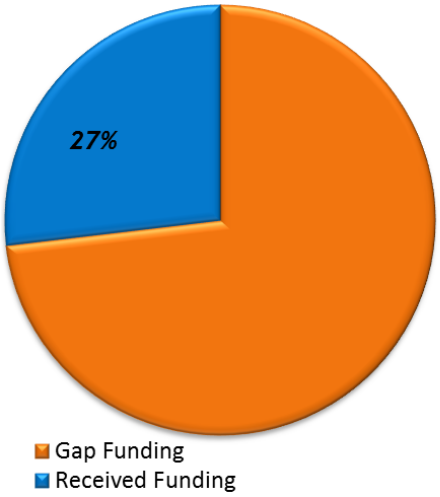
## Updates from ongoing crises

***Central African Republic (CAR):*** *Following the coup of 24 March 2013 by rebel group Seleka toppling Bozizé regime, security significantly deteriorated in the Central African Republic, and has caused a major humanitarian crisis affecting an estimated 4.5 million people. Frequent attacks on civilians have forced tens of thousands of people to flee their homes. Many remain internally displaced, while others have fled to neighboring countries.*

*The health structure in the CAR is extremely weak due to years of armed conflict and political instability, and the recent events have placed additional strain on the humanitarian conditions and especially on the health sector.*

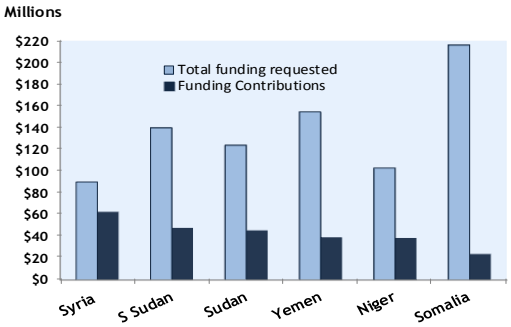
*Since the beginning of the crisis, the Health Cluster in CAR is coordinating the health response together with the Ministry of Health, and has had to attend to the population's most basic health needs including access to immediate life-saving health care, access to emergency obstetric care and treatment of injuries resulting from conflict, as well as care for the treatment of endemic diseases, epidemics and immunization. The Health Cluster also had to coordinate a response to a measles outbreak that was declared in Bangui last month, with 76 suspected measles cases in the capital so far and eight confirmed cases. A committee composed of the Ministry of Health (MoH), WHO, UNICEF and Merlin was formed and continues to coordinate a vaccination campaign to respond to the measles outbreak.*

### *Humanitarian health financing overview 2013*

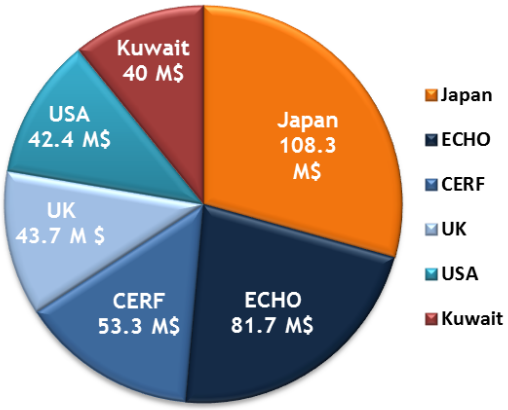



*Funds Requested US$ 665.5million*
*Funds received US$ 178.7 million*

### *Humanitarian health financing Top Five recipient countries*




### *Humanitarian health financing Top donors to health appeals*




*Source: FTS – 26 March 2013*

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
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