

# **Towards a Meaningful Engagement of Local and National Actors in the Health Cluster**

**Health Cluster Localization Strategy**



**June 2024**

## Acknowledgments

This strategy was developed by the Global Health Cluster with support from multiple contributors. Special thanks are given to the GHC Steering Group on Localization who helped oversee and guide the work that was performed.

### Members of the Steering Group

Jameel Abdo, Tamdeen Youth Foundation, Yemen; Mikias Girma Demalash, Fayaa Integrated Developemnt Organization (FIDO), Ethiopia; Mahamane Maiga, Aide au Sahel- Mali (ASM), Mali; Mariam Abdelkerim Spijkerman, International Organization of Migration (IOM); Elia Badjo, Health Cluster Democratic Republic of Congo; Ann Fortin, Health Cluster Myanmar; Mukesh Prajapati Health Cluster South Sudan; Francis Tabu, Virginie leFevre, Eba Pasha, Global Health Cluster.

We would also like to thank Health Cluster Ethiopia and Northwest Syria where with partners case studies were conducted to learn lessons and inform this strategy. Furthermore we would like to thank all Health Cluster coordinators who reviewed or participated in group discussions to give feedback to this document.

June 2024



*The World Health Organization is Cluster Lead Agency for the Health Cluster*  
Front cover photo credit: © WHO / Martha Tadesse

## List of Acronyms

AAP	Accountability to Affected Population
ABC	Area-Based Coordination
CBPF	Country-based Pooled Fund
CSO	Civil Society Organization
CSS	Capacity Sharing and Strengthening
GB	Grand Bargain
GHC	Global Health Cluster
HCT	Humanitarian Country Team
HMIS	Health Management Information systems
HRP	Humanitarian Response Plan
HSSP	Health Sector Strategic Plan
IASC	Inter-Agency Standing Committee
IBP	Issue-Based Planning
INGO	International NGO
L/NA	Local and National Actor
MoH	Ministry of Health
NNGOs	National Non-Governmental Organizations
NGOs	Non-Governmental Organizations
PSEA	Protection against Sexual Abuse and Exploitation
PWD	Persons with Disabilities
SAG	Strategic Advisory Group
TOR	Terms of Reference
TWG	Technical Working Group
UN	United Nations agencies
WHO	World Health Organization
WLO	Women-Led Organization

# Contents

<b>ACKNOWLEDGMENTS</b>	<b>1</b>
<b>LIST OF ACRONYMS</b>	<b>2</b>
<b>A. BACKGROUND</b>	<b>4</b>
<b>B. PRINCIPLES</b>	<b>11</b>
<b>C. STRATEGIC GOAL AND PRIORITIES</b>	<b>15</b>
<b>STRATEGIC PRIORITIES AND APPROACHES FOR NATIONAL AND SUB-NATIONAL HEALTH CLUSTERS</b>	<b>16</b>
Strategic Priority 1	
Leadership, Accountability, and Monitoring: Empower L/NA to take on and effectively fulfil leadership functions at national and sub-national Health Cluster coordination platforms	16
Strategic Priority 2	
Enhance Equitable Representation, Participation, and Visibility in the Health Cluster.	19
Strategic Priority 3	
Empower L/NA to Access and Control Resources that are Fundamental to their Meaningful Engagement in the Health Cluster.	20
<b>STRATEGIC PRIORITIES AND APPROACHES FOR THE GLOBAL HEALTH CLUSTER</b>	<b>22</b>
Strategic Priority 1	
Leadership: Empower L/NA to effectively fulfil Health Cluster coordination functions at the Global Health Cluster	22
Strategic Priority 2	
Enhance Equitable Representation, Participation, and Visibility in the Global Health Cluster.	23
Strategic Priority 3	
Advocate for L/NA's Access to Resources for Meaningful Engagement in the Health Cluster.	24
<b>ANNEXES</b>	<b>25</b>

# Background

## Introduction

The World Health Organization (WHO) is the Global Health (GHC) Cluster Lead Agency (CLA) responsible for coordinating the Health Cluster response within the Inter-Agency Standing Committee (IASC) Cluster system, with specific accountabilities for cluster performance to the Humanitarian Coordinator and the Emergency Relief Coordinator at the country level and the global level respectively.

The Global Health Cluster promotes and supports global and country-level collective action to ensure more effective, efficient, and predictable humanitarian health action<sup>1</sup>. In this effort, L/NAs play a significant role in providing humanitarian assistance and recovery efforts for communities affected by crises. The benefits of Local and National Actors (L/NAs) are clear, given their valuable assets in crisis response and recovery due to their knowledge, experience, trust, and proximity to affected communities<sup>2</sup>.

The GHC is dedicated to advancing a meaningful engagement of L/NA in the Health Cluster at the country and global levels. It placed utmost significance on localization as a strategic priority in its 5-year strategic plan<sup>3</sup>.

## Purpose

The Health Cluster localization strategy provides a practical and holistic approach to ensure the meaningful engagement of L/NAs in the Health Cluster coordination mechanism both in country-level Health Clusters and within the Global Health Cluster. It outlines prioritized actions to strengthen participation, representation, and leadership in line with Inter-Agency Standing Committee (IASC) Guidance<sup>4</sup>. Furthermore, it takes into account the dimensions of accountability, capacity sharing and strengthening, resourcing for coordination, and visibility as well as ensuring linkages with preparedness, response, humanitarian, development, and peace collaborations.

---

<sup>1</sup> World Health Organization. Health Cluster guide: A practical handbook. Geneva; 2020. License: CC BY-NC-SA 3.0 IGO.

<sup>2</sup> INGOs and the Localization Agenda. Humanitarian Academy for Development.

<https://had-int.org/ingos-and-the-localisation-agenda/>

<sup>3</sup> Global Health Cluster Strategy 2020-2025. [healthcluster.who.int.](https://healthcluster.who.int/) ; 2024.

<https://healthcluster.who.int/publications/m/item/global-health-cluster-strategy-2020-2025>

<sup>4</sup> IASC Guidance on Strengthening Participation, Representation and Leadership of Local and National Actors in IASC Humanitarian Coordination Mechanisms; July 2021.

<https://interagencystandingcommittee.org/operational-response/iasc-guidance-strengthening-participation-representation-and-leadership-local-and-national-actors>

The cluster has a role in strengthening the national coordination mechanisms, as well as ensuring the promotion of civic space<sup>4,5</sup>. While this strategy will mainly focus on the role of civil society organizations within the Health Cluster, it is flexible to be adapted to address gaps in the involvement of national or local authorities.

The recommendations directly contribute to the Global Health Cluster's (GHC) 5-year strategic plan (strategic priority 1.3 and 4.2 related to localization)<sup>3</sup> and complement the World Health Organization (WHO) Localization Strategy<sup>6</sup>.

### **Target Audience**

This strategy is primarily for the Health Cluster to utilize and is relevant for both Health Cluster coordination teams as well as partners at the country and global levels. Throughout humanitarian coordination, all partners must play their collective role in realizing the commitments for a meaningful engagement of L/NAs.

### **Development of the Health Cluster Localization Strategy**

The development of the strategy was overseen and driven by a Steering Group established by GHC comprising of National NGOs involved in Health Clusters at country level, Health Cluster Coordinators as well as other GHC partners. Utilizing an Issue-Based Planning (IBP) model<sup>7</sup> a mixed-method scoping analysis was performed that included a desk review of more than 50 documents, a cross-sectional survey with all Health Cluster Coordinators, two country case studies where over 40 Key informant interviews and three Focused Group Discussions (FGD) were conducted to assess the status, obstacles, opportunities, and best practices for strengthening the representation, participation, and leadership of L/NAs within the Health Cluster<sup>8</sup>. The final strategy was reviewed by both Health Cluster Coordinators and the GHC Steering Group.

### **Implementation Period**

The Health Cluster Localization Strategy is a 5-year plan spanning 2024-2028, accompanied by a 2-year (2024-2025) Action Plan and Monitoring framework for the country and Global Health Cluster. In 2025, the GHC will review the progress on L/NA engagement and evaluate the strategy's effectiveness to inform operational priorities for the final 3 years.

### **Global Commitments on Localization**

Although progress is there, much work remains to be done to achieve the Grand Bargain goal of increasing the effectiveness and efficiency of humanitarian interventions through local capacity<sup>9</sup>. Prioritizing L/NA capacity and access to quality funding is necessary to achieve the Grand Bargain localization commitments (see Box 1), including Core Commitment 2.3 (Workstream 2), which seeks to support and complement national coordination mechanisms while involving local and national responders in international coordination mechanisms in conformity with humanitarian principles.

---

<sup>5</sup> IASC Cluster Coordination Reference Module; 2015. <https://interagencystandingcommittee.org/iasc-transformative-agenda/iasc-reference-module-cluster-coordination-country-level-revised-july-2015>

<sup>6</sup> By May 2024, WHO was in the final stages of developing the organization's Localization Strategy

<sup>7</sup> Mulligan P, Hatten K, Miller J. From issue-based planning to Hoshin: Different styles for different situations. *Long Range Planning*. 1996;29(4):473-484. [https://doi.org/10.1016/0024-6301\(96\)00039-8](https://doi.org/10.1016/0024-6301(96)00039-8)

<sup>8</sup> The report from the desk review and case studies is annexed to this document.

<sup>9</sup> The Grand Bargain is a unique agreement between some of the largest donors and humanitarian organizations (currently 67 signatories) who have committed to get more means into the hands of people in need and to improve the effectiveness and efficiency of the humanitarian action (World Humanitarian Summit, Istanbul 2016).

### Box 1: Grand Bargain Localization Commitments

**Commitment 2.1:** Increase and support multiyear investments in the institutional capacities of local and national responders, including preparedness, response, and coordination.

**Commitment 2.2:** Understand better and work to remove or reduce barriers that prevent organizations and donors from partnering with local and national responders in order to lessen their administrative burden.

**Commitment 2.3:** Support and complement national coordination mechanisms where they exist and include national and local responders in international coordination mechanisms as appropriate and in keeping with humanitarian principles.

**Commitment 2.4:** Achieve by 2020 a global, aggregated target of at least 25% of humanitarian funding to local and national responders as directly as possible to improve outcomes for affected people and reduce transaction costs.

**Commitment 2.5:** Develop, with the Inter-Agency Standing Committee (IASC), and apply a localisation marker to measure direct and indirect funding to local and national responders.

**Commitment 2.6:** Make greater use of funding tools that increase and improve assistance delivered by local and national responders such as UN-led country-based pooled funds (CBPFs), the IFRC Secretariat's Disaster Relief Emergency fund (DREF), and other pooled funds.

**Grand Bargain Enabling Priorities:**

*Funding:* A critical mass of quality funding is reached that allows an effective and efficient response, ensuring visibility and accountability. *Localization:* Greater support is provided for the leadership, delivery capacity of local responders, and the participation of affected communities in addressing humanitarian needs. ([Grand Bargain 2.0, June 2021](#))

Commitment 2.3 provides the policy backdrop to the IASC Policy Guidance for the clusters to strengthen the engagement of L/NA in the humanitarian coordination mechanism<sup>4</sup>. As a signatory to the Grand Bargain, WHO adheres to the GB commitments and the IASC policy to frame its localization strategies.

### Barriers to the engagement of Local and National Actors (L/NA)

Although there has been some progress in mainstreaming locally-led actions into the humanitarian system, the challenges remain significant. The barriers are broad and complex but include primary obstacles related to political factors, risks in armed conflict settings, and policy barriers, particularly regarding access to funding for L/NAs<sup>10,11,12</sup>. There are other factors related to varying levels of institutional commitment, perceptions of low local capacity<sup>13</sup> and challenges in the coordination structures and practices that exacerbate existing inequities and conceptual barriers that further

<sup>10</sup>Elkahlout G, Milton S, Yaseen T, Raweh E. Localisation of humanitarian action in War-torn Countries: The experience of local NGOs in Yemen. International Journal of Disaster Risk Reduction. 2022;75:102921. <https://doi.org/10.1016/j.ijdrr.2022.102921>

<sup>11</sup>Kool LD, Pospisil J, van Voorst R. Managing the humanitarian micro-space: the practices of relief access in Syria. Third World Quarterly. Published online March 29, 2021;1-18. <https://doi.org/10.1080/01436597.2021.1896359>

<sup>12</sup>Ed Schenkenberg Emergency Gap Series 03: The challenges of localized humanitarian aid - World | Relief Web. reliefweb.int. Published November 25, 2016 <https://reliefweb.int/report/world/emergency-gap-series-03-challenges-localised-humanitarian-aid>

<sup>13</sup>Sharing good practices and learnings on localisation – workshop hosted by Shifting the Power project and the CHS Alliance. CHS Alliance. Published April 3, 2018. <https://www.chsalliance.org/get-support/article/sharing-good-practices-and-learnings-on-localisation-workshop-hosted-by-shifting-the-power-project-and-the-chs-alliance/>

# Current status of local and national actors in the health cluster



## L/NA Representation in the Health Cluster

- Nearly half (46%) of the 763 Health Cluster partners who have submitted projects into the HRP are NNGOs.
- About half (49%) of the 1791 partners that Health Clusters coordinate with, are NNGOs



## Sharing Leadership: Health Cluster Co-Coordination

- 60% of Health Clusters had Health Cluster Co-coordinators at the national level, all from INGO and/ or MoH. There were no Co-coordinators from NNGOs at the national level
- 10% of the 120 Sub-national Health Clusters had Sub National Health Cluster Co-Coordiators from NNGOs, 41% from MoH, 13% from INGOs



## Inclusion of L/NAs in the strategic decision-making

- 60% of the Health Clusters had a Strategic Advisory Group (SAG).
- 25% of SAG members were from NNGOs, 25% from INGO 25%, 32% from UN, 5% from MoH, 3% Donors, 9% Observers
- Women-led Organizations (WLO) accounted for only 4.8% of all L/NA in SAG



## Co-chairing of Technical Working Groups

- 14% of the 93 TWG were co-chaired by NNGOs
- 29% by INGOs
- 73% by UN agencies

*Often, a TWG is co-chaired by more than one organization.*

Figure 1: Status of Health Cluster coordination from Survey with Health Cluster Coordinators, January 2024



### Box 2: Common Barriers to Localization

- Limited Funding to L/NA: Quantity and Quality
- Political Barriers/Risk: Restrictions, threats to ethical response
- Inaccessible Humanitarian Coordination Platform: language barriers, physical access, fitness for purpose
- Lack of Commitment and prioritization: low incentive
- Power imbalance: dominance by INGO/UN, skewed strategic decision-making power.
- Weak linkages exist between the Global-national-subnational coordination platforms.
- Perception of low local capacity by international actors: Technical capacity for coordination and upholding humanitarian principles
- Competitions driven by Legitimacy and Visibility

complicate the translation of localization into practice<sup>14,15,16</sup>. The recurrent barriers and enablers for localization in humanitarian coordination are summarized in Box 2 and are explored in a separate baseline analysis report. Figure 1 highlights current status within country level Health Clusters.

### Defining Localization

There is no single agreed upon definition of localization. See Box 3 which describes those used by different actors. In this strategy, the Health Cluster defines localization as

*“a collaborative and dynamic process for an equitable and meaningful engagement of Local and National Actors (including local public institutions) in the Health Cluster aimed at achieving a locally led health response in line with the humanitarian principles.”*

The Health Cluster definition derives from aspects delineated in the Grand Bargain commitments on coordination, the IASC Localization Guidance<sup>4</sup>, the International Council of Voluntary Agencies (ICVA)<sup>17</sup>, Groupe Urgence Rehabilitation Development Association<sup>18</sup>, the Pacific Islands Association of Non-Governmental Organizations<sup>19</sup> and the Organization for Economic Cooperation and Development<sup>20</sup>. The Health Cluster definition emphasizes that localization is a continual process where the specific actions needed to empower L/NAs to engage equitably in humanitarian health response may change over time depending on evolution of the context and roles different stakeholders have.

---

<sup>14</sup>Charter for Change: From commitments to action Progress Report, 2018-2019 - World | ReliefWeb. reliefweb.int. Published September 20, 2019. <https://reliefweb.int/report/world/charter-change-commitments-action-progress-report-2018-2019>

<sup>15</sup>NGO Coordination Structures and the Localization Debate Recommendations Paper. <https://www.interaction.org/wp-content/uploads/2021/01/NGO-Coordination-Structures-and-the-Localization-Debate.pdf>

<sup>16</sup>Alcayna, T. and Al-Murani, F. 2016. Local and international collaboration in urban humanitarian responses: perspectives from the Philippines, Colombia and South Sudan. IIED Working Paper. IIED, London. <http://pubs.iied.org/10802IIED>

<sup>17</sup>International Council of Voluntary Agencies (ICVA), 2019. Unpacking Localization. <https://www.icvanetwork.org/uploads/2021/08/Unpacking-Localization-ICVA-HLA.pdf>

<sup>18</sup>Groupe Urgence Rehabilitation Development Association. Aid localisation. <https://www.urd.org/en/theme/aid-localisation/>

<sup>19</sup>Going Local Achieving a More Appropriate and Fit-For-Purpose Humanitarian Ecosystem in the Pacific.; 2017. <https://humanitarianadvisorygroup.org/wp-content/uploads/2020/12/ARC-Localisation-report-Electronic-301017.pdf>

<sup>20</sup>Localising the Response. World Humanitarian Summit Putting Policy into Practice. The Commitments Into Action Series <https://www.Oecd.Org/Development/Humanitarian-Donors/Docs/Localisingtheresponse.Pdf>

### Box 3: Definitions used by different organizations to describe localization

- “A process through which a diverse range of humanitarian actors are attempting, each in their own way, to ensure local and national actors are better engaged in the planning, delivery, and accountability of humanitarian action, while still ensuring humanitarian needs can be met swiftly, effectively and in a principled manner” (International Council of Voluntary Agencies)
- A collaborative process that aims to prioritize local actors, Civil Society Organizations (CSO), and local public institutions in the humanitarian system and response (Group Urgence Rehabilitation Development Association)
- A process of recognizing, respecting and strengthening the independence of leadership and decision making by national actors in humanitarian action, in order to better address the needs of the affected population” (Australian Red Cross, Pacific)
- Localising humanitarian response is a process of recognising, respecting and strengthening the leadership by local authorities and the capacity of local civil society in humanitarian action, in order to better address the needs of affected populations and to prepare national actors for future humanitarian responses. (OECD, 2017)

**Health Cluster proposed definition: “A collaborative and dynamic process for an equitable and meaningful engagement of Local and National Actors (including local public institutions) in the Health Cluster aimed at achieving a locally led health response in line with the humanitarian principles.”**

### Defining a Local and National Actor

The Health Cluster adopts the definitions of L/NA provided by the IASC Guidance for localization in humanitarian coordination (See Box 4).<sup>21</sup> The IASC definition provides a harmonized categorization ensuring reliability in measurement and consistency in communicating localization indices across the different clusters, operations, and policy stakeholders.

The IASC criterion has limitations and context-based definitions may be necessary<sup>22</sup>. When a context-based definition of L/NA is considered in a particular operation, the GHC strongly recommends that the modified criteria be reviewed collectively (involving L/NAs) to determine barriers, challenges or opportunities organizations needing to be addressed to maintain the principle of equity. The context-based criteria for defining an L/NA should not unfairly include and exclude organizations in the category of L/NA. It should consider national policy/criteria where they exist and focus on identifying those local organizations that face the highest barriers to meaningful engagement in the Health Cluster.

In coordinating a health response, out of necessity, the Health Cluster partners may also coordinate with de facto authorities who are not explicitly defined in the IASC Criteria. In such circumstances, the Health Cluster should be guided by the country’s Humanitarian Country Team framework of engagement.

The GHC promotes that where appropriate and possible national and local health authorities should be actively encouraged to co-chair Health Cluster meetings from an early stage.

<sup>21</sup> IASC Humanitarian Financing Task Team. Definitions Paper: Localisation Marker Working Group; 24 January 2018.

[https://interagencystandingcommittee.org/sites/default/files/migrated/201801/hfft\\_localisation\\_marker\\_definitions\\_paper\\_24\\_january\\_2018.pdf](https://interagencystandingcommittee.org/sites/default/files/migrated/201801/hfft_localisation_marker_definitions_paper_24_january_2018.pdf)

<sup>22</sup> For example, local organizations may need to register in neighbouring countries to ensure cross-border support

#### Box 4: IASC Definition of L/NA

**1. Local and national non-state actors** are “Organizations engaged in relief that are headquartered and operating in their own aid recipient country and which are not affiliated to an international NGO”.

Note: “A local actor is not considered to be affiliated merely because it is part of a network, confederation or alliance wherein it maintains independent fundraising and governance systems” (text endorsed by GB signatories). Local and national non-state actors include,

*1.1 National NGOs/Civil Society Organizations (CSOs):* National NGOs/CSOs operating in the aid recipient country in which they are headquartered, working in multiple subnational regions, and not affiliated with an international NGO. This category can also include national faith-based organizations.

*1.2 Local NGOs/CSOs:* Local NGOs/CSOs operating in a specific, geographically defined, subnational area of an aid recipient country, without affiliation to an international NGO/CSO. This category can also include community-based organizations and local faith-based organizations.

*1.3 Red Cross/Red Crescent National Societies:* National Societies that are based in and operating within their own aid recipient countries.

*1.4 Local and national private sector organizations:* Organizations run by private individuals or groups as a means of enterprise for profit, that are based in and operating within their own aid recipient countries and not affiliated to an international private sector organization.

**2. National and sub-national state actors** are “State authorities of the affected aid recipient country engaged in relief, whether at local or national level” (text endorsed by GB signatories). This includes:

*2.1 National governments:* National government agencies, authorities, line ministries, and state-owned institutions in aid recipient countries e.g. National Disaster Management Agencies (NDMAs). This category can also include federal or regional government authorities in countries where they exist.

*2.2 Local governments:* Sub-national government entities in aid-recipient countries exercising some degree of devolved authority. See the [IASC HFTWG](#) for details of definitions that are not included in the above categorization

# Principles

The principles outlined here represent the overarching commitments that should govern the work of all organizations in the humanitarian response to ensure localization and the engagement of L/NAs. These are relevant for all Health Cluster partners including United Nations agencies (UN), International NGOs, and L/NAs.

The principles emphasize resolutely seeking the value and comparative advantage of different partners, understanding complementarity without under- or overestimating the partners' roles.

## Box 5: A Summary of Principles for a Meaningful Engagement of L/NA.

1. Adherence to the Humanitarian Principles and Commitments.
2. Equitable Partnership
3. Contextualization
4. Capacity Sharing and Strengthening
5. Risk Sharing and Risk Management
6. A multidimensional lens to L/NA participation, representation, and leadership in coordination.
7. Gender mainstreaming: Inclusion of Marginalized L/NAs

## 1. Adherence to the Humanitarian Principles and Commitments.

Humanitarian response is steered by International Human Rights Law, International Humanitarian Law and other key instruments<sup>23</sup>. The humanitarian principles of neutrality, impartiality, independence, and humanity<sup>24</sup> form the bedrock of the various interconnected humanitarian standards and commitments that ensure that the humanitarian response effectively upholds the fundamental rights and dignity of affected people and communities during a crisis.. All humanitarian actors, including L/NAs participating in the Health Cluster, must adhere to these principles, and provide assistance without discrimination i.e. regardless of age, gender, ethnicity, religious beliefs, political affiliation or any other characteristic or status. Furthermore, all partners must apply commitments for the Centrality of Protection<sup>25</sup>,<sup>26</sup> and specific frameworks for Accountability to Affected Population (AAP)<sup>27</sup>, Protection

<sup>23</sup> For further information see Annex I, IASC Policy on Protection in Humanitarian Action IASC 2016 and Annex I, The Sphere Handbook, Sphere 2018

<sup>24</sup> UN General Assembly Resolutions 6/182 and Res 58/114; 2004

<https://emergency.unhcr.org/sites/default/files/General%20Assembly%20Resolution%2058-114.pdf>

<sup>25</sup> IASC Principals' Statement, The Centrality of Protection in Humanitarian Action. Geneva: Inter-Agency Standing Committee; 2013

<https://interagencystandingcommittee.org/protection-priority-global-protection-cluster/documents/iasc-policy-protection-humanitarian-action>

<sup>26</sup> See also IASC Policy on Protection in Humanitarian Action. Geneva: Inter-Agency Standing Committee; 2016

<https://interagencystandingcommittee.org/protection-priority-global-protection-cluster/documents/iasc-policy-protection-humanitarian-action>

<sup>27</sup> IASC Revised AAP Commitments on Accountability to affected People and Protection from Sexual Exploitation and Abuse. Geneva: Inter-Agency Standing Committee; 2017 (originally developed in 2011) [https://interagencystandingcommittee.org/system/files/iasc\\_caap\\_endorsed\\_nov\\_2017.pdf](https://interagencystandingcommittee.org/system/files/iasc_caap_endorsed_nov_2017.pdf),

against Sexual Abuse and Exploitation (PSEA)<sup>28</sup>. This list is not exhaustive<sup>28</sup>. Both international and local organizations must consider these commitments when assessing capacity and performance to guarantee that humanitarian assistance is of the highest quality and that actors are held accountable and responsible.

## **2. Principles of Equitable Partnership.**

The focus of the localization agenda is to seek and establish complementarity. The Health Cluster fosters relationships between partners based on equality, transparency, a result-oriented approach, and complementary actions<sup>29</sup>. Partners assuming leadership roles in the cluster will also fulfill their coordination mandates in the spirit of equitable partnership, maintaining impartiality, autonomy, and independence from funding relationships or other sources of influence. A performance-based approach shall form the basis of leadership delegation. To ensure equitable opportunities for leadership, the Health Cluster shall collaboratively develop and create a plan for shared leadership, such as co-coordination, membership of Strategic Advisory Groups, etc (see Section C), emphasizing milestones, monitoring frameworks, and rotation plans.

## **3. Capacity Sharing and Strengthening (CSS)**

Effective complementary partnerships between Health Cluster actors can be achieved through capacity sharing and strengthening. Overall, CSS should empower L/NAs to a) take up leadership, b) navigate international humanitarian systems including access to funding, and c) provide people-centered and quality services while strengthening the mainstreaming of AAP. Actors should consider the following principles to maximize the impact of any interventions to share and strengthen capacity in the Health Cluster:

*Early and adequate CSS investment:* CSS initiatives should be proactively planned as early as possible in the humanitarian response, not as a secondary and independent/isolated pre-condition to the partnership between local and international actors in the Health Cluster. Funding agencies should allocate adequate resources to support CSS early in a response.

*Mutual respect and recognition of capacity:* Local and international actors should collaboratively define a shared priority for capacity sharing and strengthening and avoid biased perceptions that generalize low local capacity. This includes mutually assessing strengths/gaps to prioritize capacity needs.

*Accountability and Monitoring for CSS:* Based on prioritized needs, actors should jointly develop a CSS framework that specifies expected results, roles, accountability, and monitoring based on agreed indicators and milestones.

## **4. Contextualized Approaches**

In each operation, the priorities, operational response and approach may differ given local dynamics such as conflict, and cultural, political, and economic factors. As such, the local realities will shape the interventions to enhance the engagement of L/NAs in the Health Cluster. A consultative engagement between the country and global cluster may be necessary to achieve a mutual understanding of expectations and feasibility.

---

<sup>28</sup> See also Core Humanitarian Standards; 2024 <https://www.corehumanitarianstandard.org/the-standard>

<sup>29</sup> Principles of Partnership a Statement of Commitment Endorsed by the Global Humanitarian Platform; 12 July 2007. <https://interagencystandingcommittee.org/sites/default/files/migrated/2021-12/Principles%20of%20Partnership%20%28by%20Global%20Humanitarian%20Platform%29.pdf>

Each country Health Cluster should jointly with partners tailor a localization action plan guided by the Health Cluster Localization Strategy to ensure that the local implementation approach and milestones meet the specific needs, existing capacities, local realities, and cluster priorities.

## **5. Risk Sharing and Risk Management: Staff Safety, Security, and Wellbeing**

Health care and health care workers should be protected against attacks, threats, violent obstruction of their work, and any interference with obligations to provide care to the wounded and sick<sup>30</sup>, <sup>31</sup>. States are obliged to ensure the right to healthcare especially during crisis. All partners should carefully evaluate any threat they or their implementing partner may face<sup>32</sup>.

*Equitable distribution of risk and duty of care:* Where access to crisis-affected people is limited due to safety and security risks, such as in armed conflicts or restrictions from local authorities, the operational decisions to place or support L/NA and their staff to remain closer to the center of the crisis must be taken after a balanced evaluation of benefits against risks. Mitigation measures should be introduced to avoid exposing staff to excessive risk that endangers their wellbeing. The positioning of L/NA should not lead to an unacceptable transfer of safety risks.<sup>33</sup>

*Principled advocacy:* Advocate for parties to the conflict to uphold their obligations under the International Humanitarian Law to protect health workers and infrastructures. Provide timely and equitable access to safety and security risk analysis, mitigation, and contingency plans for L/NA to make informed choices and implement appropriate prevention measures.

*Equitable initiatives that ensure staff safety and well-being.* Support strategies that promote these including protecting health workers from physical and biological hazards, such as access to Personal Protective Equipment (PPE)<sup>34</sup>, assessing and minimising occupational psychosocial risks to reduce emotional distress e.g. around job demands, social support, physical environment and safety, team cohesion and job security<sup>35</sup>.

Note, that measures for better fiduciary risk analysis and management are recognized as essential elements of a partnership but lie outside the scope of this strategy.

## **6. Multidimensional lens to strengthen the engagement of L/NA in the Health Cluster**

Funding obstacles tend to dominate the localization discourse. However, actors should ensure broader dimensions to be addressed to ensure a holistic approach to localization. This includes integrating aspects such ensuring visibility, adequate monitoring and evaluation, resourcing for coordination.

---

<sup>30</sup> Global Health Cluster and Global Protection Cluster Joint Operational Framework for Health and Protection; 2023.

<https://healthcluster.who.int/publications/m/item/health-and-protection-joint-operational-framework>

<sup>31</sup>World Health Organization. Stopping attacks on health care. <https://www.who.int/activities/stopping-attacks-on-health-care#:~:text=Attacks%20on%20Health%20Care%20initiative,Provide.&text=WHO's%20Attacks%20on%20Health%20Care,disruption%20from%20acts%20of%20violence.>

<sup>32</sup> Sphere Handbook; 2018

<sup>33</sup> European Civil Protection And Humanitarian Aid Operations. Remote Management. <https://www.dgecho-partners-helpdesk.eu/ngo/actions-implementation/remote-management>

<sup>34</sup>World Health Organization. Keep health workers safe to keep patients safe; September 2020. <https://www.who.int/news/item/17-09-2020-keep-health-workers-safe-to-keep-patients-safe-who>

<sup>35</sup> World Health Organization. Guidelines on Mental Health at Work; 2022. <https://www.who.int/publications/i/item/9789240053052>

## **7. Inclusion of Marginalized L/NAs (WLO, Organizations for People with Disability/PWD, Gender Diverse Groups) in the Health Cluster**

Women-led organizations (WLO), organizations for Persons with Disabilities (PWD), and gender-diverse groups are disproportionately affected by the preexisting obstacles to a meaningful engagement of L/NA in the humanitarian systems despite the recognition of their potential significance and contributions.

In mainstreaming localization, the Health Cluster will apply a gender analysis dimension and the IASC guidance for the engagement of organizations for PWD and WLO in humanitarian responses to ensure their equitable representation in the Health Cluster leadership and decision-making platforms<sup>36</sup>. This approach ensures that barriers unique to these marginalized groups of L/NAs are factored into the interventions to advance their full engagement in the Health Cluster.

---

<sup>36</sup> IASC Guidance on Engagement, Participation and Decision-Making by Women-Led Organizations in Humanitarian Action; March 2024. <https://interagencystandingcommittee.org/iasc-reference-group-gender-and-humanitarian-action/iasc-guidance-engagement-participation-and-decision-making-women-led-organizations-humanitarian>

# Strategic goal and priorities

## Strategic Goal

The Health Cluster is dedicated to achieving a positive transformation towards a more robust engagement of L/NAs in the Health Cluster and has set out five overarching commitments to ensure this (see Box 6). These commitments express the desired results from the Health Cluster strategy with the objective to ensure shared leadership, the involvement of L/NAs in strategic decision-making, empowerment of L/NAs for improved access and influence resource allocation, fostering an inclusive and accessible Health Cluster coordination platform, and acknowledging and respecting the capacities and strengths of L/NAs.

The outcomes will be realized through the development of a context-based action plan at the country level, aligned with the strategic-actions outlined below. The GHC will track these commitments' progress and outcomes through a result-monitoring framework accompanying this strategy.

### Box 6: Health Cluster Strategic Commitments for Localization by end of 2025

#### 1. >65% of Health Clusters will develop a Localization Action Plan

#### 2. The Health Clusters share Coordination leadership with L/NA

- Increase the proportion of L/NA Co-coordinating the Health Cluster at national level to 30%, sub-national level to 50%

#### 3. L/NAs have equal power in the Health Cluster's strategic decision-making.

- >80% of the Health Cluster will have SAG, each having L/NA represented.
- L/NAs will account for 30% of all SAG.

#### 4. All Health Clusters create an environment for L/NA to participate equitably, recognize, respect, and value their contributions and strengths.

- > 80% of L/NAs in each cluster setting report they are engaging as equal partners and can participate actively in coordination mechanisms.

#### 5. Access and Control of Resources- Empower L/NA capacity for resource mobilization, and influence equitable prioritization and allocation of resources in the Health Cluster.

- >40% of funds allocated by the Health Cluster (e.g. projects selected for country-based pooled fund mechanisms) will be dedicated directly to L/NAs.

*\* L/NA refers to national and local NGOs*



The GHC has identified three overarching strategic priorities to enhance L/NA engagement in Health Cluster coordination that are relevant at sub-national, national, and global levels. Given the differences in operational setups, resources, and mandates, we provide strategic recommendations for each priority area, separately targeting the country-level clusters (including national/sub-national structures) and the Global Health Cluster.

## Strategic priorities and approaches for National and Sub National Health Clusters

### Strategic Priority 1

**Leadership, Accountability, and Monitoring: Empower L/NA to take on and effectively fulfil leadership functions at national and sub-national Health Cluster coordination platforms**

GHC promotes supporting national coordination mechanisms including national or local health authorities to co-chair Health Cluster meetings where appropriate based on the local context and policy, e.g., existing capacity, willingness, adherence to the humanitarian principles, and the engagement frameworks defined by the Humanitarian Country Team (HCT).

Strategic priority 1 centers around the sharing of Health Cluster leadership with a specific focus on mainly targeting national/local NGOs and CSOs. The Health Cluster has a role to play to protect and promote civic space<sup>4,37</sup>. Furthermore, their (CSO) inclusion in decision-making is essential to achieving universal health equity and Universal Health Coverage (UHC).<sup>38,39</sup> By promoting equitable L/NA participation and leadership in the Health Cluster, we expand the entry points for social participation that support the active engagement of people, and communities in the decision-making processes, including the design, delivery, and review of health interventions to ensure better responses to individual and community health needs, while fostering trust as part of a whole-of-society approach<sup>40</sup>. The participation of all stakeholders, including L/NAs, shall be governed by the principles set out in

<sup>37</sup> United Nations Guidance Note. Protection and Promotion of Civic Space; September 2020.

[https://www.ohchr.org/sites/default/files/Documents/Issues/CivicSpace/UN\\_Guidance\\_Note.pdf](https://www.ohchr.org/sites/default/files/Documents/Issues/CivicSpace/UN_Guidance_Note.pdf)

<sup>38</sup> World Health Organization, 154<sup>th</sup> Session for Executive Board. Universal Health Coverage Report by the Director-General; December 2023. [https://apps.who.int/gb/ebwha/pdf\\_files/EB154/B154\\_6-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/EB154/B154_6-en.pdf)

<sup>39</sup> World Health Assembly (WHA) Social Participation for Universal Health Coverage, health and well being (2024) WHO Doc WHA77.2 [https://apps.who.int/gb/ebwha/pdf\\_files/WHA77/A77\\_R2-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_R2-en.pdf)

Section B above to mitigate any risk or harm resulting from engaging in the Health Cluster coordination mechanisms<sup>39</sup>.

Furthermore, involving the L/NAs early in the governance of the Health Cluster enhances the effective transition and deactivation of the Health Cluster in the long term. Below are the recommended strategic actions for Strategic Priority 1.

### **1.1 Scaleup Health Cluster co-coordination responsibility with L/NAs**

As per IASC and GHC guidance, it is good practice to have NGO Co-coordination to engender the Health Cluster's commitment to enhance and share capacity with L/NA. The Health Cluster will create leadership opportunities and strengthen the capacity for L/NA to take up the Co-Coordination roles of the Health Cluster based on firm commitments to the principles outlined in section B above. The key actions include,

- Assess and determine the feasibility of co-coordination and ensure the decision to share governance with L/NAs reflects the interest of the wider group of partners. Ideally, the Health Cluster decision on co-coordination should be made through a more comprehensive stakeholder consultation process or an established cluster decision-making body, e.g., SAG.
- When the Health Cluster considers co-coordination, it must explore appropriate models for co-coordination, e.g., WHO-led Health Cluster with L/NA Co-Coordinator, WHO-led Health Cluster with Ministry of Health (MoH)/Local coordinating authority co-chair, and WHO-led Health Cluster with Co-coordinators from an INGO and L/NA.
- Encourage rotational leadership based on a reasonable schedule agreed upon by partners to increase the benefits from leadership opportunities and to widen capacity sharing and strengthening, thus also avoiding the dominance of specific groups or agencies.
- Develop a context-specific Health Cluster leadership plan and model based on the assessed capacity. Clearly define accountabilities, and responsibilities, and mutually agree on milestones for performance monitoring, and required support/resources.

### **1.2 Engage with other local/decentralized coordination mechanisms where they exist**

Recognizing that often L/NAs operate closest to the center of the crisis- far from nationally based coordination platforms, the Health Cluster will strengthen linkages to local coordination platforms.

- The Health Cluster coordination teams are encouraged to ensure the Health Cluster's leadership is proactively part of the local coordination structure, e.g., those led by the local authorities based on local engagement frameworks.
- The strategy envisions Area-Based Coordination mechanisms to scale up as part of cluster response. Sharing leadership and governance through a co-coordinator can ensure the Health Cluster leadership representation in decentralized coordination platforms closer to the L/NAs at the sub-national levels.

### **1.3 Increase the role of L/NAs in the Health Cluster's strategic decision-making process**

To ensure L/NAs actively drive the strategic decision-making processes in the Health Cluster,

- A Steering Committee or Strategic Advisory Group (SAG) should be formed to enhance the ability for inclusive strategic leadership as per IASC<sup>5</sup> and GHC guidance<sup>1</sup>
- Ensure equitable representation of L/NAs in the Health Cluster's key decision-making platforms, particularly the SAG. Collaboratively review selection/eligibility criteria to reflect equitable inclusion of L/NAs.

- Health Cluster leadership shall emphasize localization as a policy agenda and track progress through systematically monitoring the localization action plan. Conduct regular joint reviews with L/NAs and the SAG and allocate appropriate support.
- Reflect the commitments for locally led actions in the Health Cluster strategy, Humanitarian Response Plan (HRP), and other strategic documents.
- Incorporate L/NA contribution, capacity, experience, and needs into thematic technical groups and other decision support bodies within the Health Cluster. Involve L/NAs with demonstrated capacity to lead various Technical Working Groups, Taskforces, and localization committees where they exist.

#### **1.4 Strengthen the monitoring and learning processes to improve the engagement of L/NA in the Health Cluster**

More information on localization in the health sector is required.<sup>40</sup> The Health Cluster will establish mechanisms to capture and document data emerging from the implementation process to monitor the progress and effectiveness of the interventions. The information generated through this process will aid the learning to improve further design and adaptation of practical approaches. In addition, the GHC will support learning processes at the country level to increase awareness about localization and understanding of L/NA roles as a partner to strengthen their engagement in the Health Cluster.

- Knowledge creation: Health Clusters will establish a robust and objective monitoring framework to track the progress and results of the localization process. The framework shall comprehensively capture data from various sources, e.g., analysis of implementation indicators, operational research, case studies, and evaluations to inform L/NA engagement processes in the Health Cluster. Indicators will also inform GHC monitoring measuring performance to reach targets. Health Clusters will also share learning and good practice e.g. in health cluster meetings or technical sessions.
- Regularly analyze the data and disseminate the information to inform strategic priorities and adaptations needed and to influence change in behavior, attitudes, and practice.
- Provide need-based localization training as part of capacity strengthening and sharing. Simultaneously, coordinate with GHC to facilitate access to existing learning Information, Education, and Communication materials.
- Share capacity by building a network with L/NAs who demonstrated capacity to support the Health Cluster response e.g., in acute events through L/NA who have received training on disease outbreak preparedness, Risk Communication, and Community Engagement, mainstreaming AAP,<sup>41,42</sup>.

<sup>40</sup> Murdie A, Barney M. Localizing the NGO Delivery of Health from the Outside In. *Daedalus*. 2023;152(2):181-196. <https://www.jstor.org/stable/48728679>

<sup>41</sup> READY Initiative – Augmenting global capacity for outbreak readiness. [www.ready-initiative.org](http://www.ready-initiative.org). <https://www.ready-initiative.org/>

<sup>42</sup> Women-Led Organizations' (WLOs) Leadership in GBV Coordination Resource Package - 2023 | Gender-Based Violence Area of Responsibility. [gbvaor.net](https://gbvaor.net). <https://gbvaor.net/node/1834>

## Strategic Priority 2

### Enhance Equitable Representation, Participation, and Visibility in the Health Cluster.

The Health Cluster aims to establish a coordination platform where every participant is valued based on the principle of equitable partnership and practices for a well-managed cluster. It will endeavor to engage all relevant L/NAs to achieve diversity, publicly recognize and respect L/NAs and their work, listen to all partners' voices, and promote transparency and trust through the following actions.

#### 2.1 Diversify representation of L/NA in the Health Cluster

- Conduct a comprehensive mapping of L/NAs, including diverse groups, e.g., WLO, through basic partner mapping techniques that confer broader coverage. The aim is to identify a representative proportion of L/NAs in each Health Cluster operation.
- Actively reach out to more extensive L/NA networks e.g., local NGO forums, and peer-to-peer groups to raise awareness about the existing Health Cluster coordination platforms, highlighting the different structures/platforms and the benefits of coordination, including dissemination of the Health Cluster strategic plan, funding information, and other health information products.
- Identify and engage with L/NAs that may be focused on development and recovery programs to fortify the humanitarian-development-peace linkage. Further, collaborate with the stakeholders in the Private Sector.
- Recognize, and actively work with diaspora NGOs or networks that may be directly providing and supporting health services. Strengthen diaspora engagement in the humanitarian response by mapping the diaspora networks/groups, organizing an information sharing forum about the Health Cluster response, opportunities, and mechanisms through which the diaspora can contribute their voices, input, and resources; and establishing communication channels.

#### 2.2 Ensure effective participation of L/NAs in Health Cluster coordination mechanisms

- Utilize accessible communication strategies and techniques that promote inclusive participation, e.g., need-based use of local language, translation of crucial tools, virtual meeting options, document repositories, and accessible public health data and information.
- In addition to the Health Cluster coordination meetings, identify alternative mechanisms/best approaches to effectively capture L/NA voices, e.g., dedicated agenda in the Health Cluster meetings, floor time for L/NAs, bilateral consultations, and dedicated work streams.

#### 2.3 Increase the visibility of L/NA in the Health Cluster

- Enhance the visibility of L/NAs in the Health Cluster by appropriately acknowledging their work.
- Include L/NA contributions and products into the relevant Health Cluster information materials, e.g., Health Cluster bulletin and donor briefing notes, among others, to highlight the strengths, challenges, and impact of L/NAs in the Health Cluster. Partners should factor in local safety/security conditions and donor guidance in communication branding and visibility.

#### 2.4 Strengthen the linkage between the sub-national, national, and global Health Clusters

Ensuring the voices of L/NAs are heard at all levels of the Health Cluster will improve the quality of the decisions and policies while enhancing the relevance of the Health Cluster response coordination and promoting L/NA participation.

- The coordination team should ensure a closed communication loop between the different coordination structures at the national and sub-national levels. The voices and perspectives of L/NAs participating in the sub-national platforms should be sought and factored into strategic

decision-making at national and international levels. Likewise, updates and strategic information must be disseminated from international, and national platforms to sub-national actors and vice-versa.

- Where appropriate, country teams support two-way exposure of the work of L/NAs to the GHC and vice versa through information exchange sessions such as webinars and Health Cluster partner meetings.

### **Strategic Priority 3**

#### **Empower L/NA to Access and Control Resources that are Fundamental to their Meaningful Engagement in the Health Cluster.**

L/NAs' access to adequate, flexible, long-term funding is an enabling priority to achieving the Grand Bargain aspirations of local participation in the humanitarian systems. The Health Cluster is committed to establishing a conducive environment that promotes initiative for more direct access to funding for L/NAs and empowers governance of funds managed through the Health Cluster (e.g., CBPFs).

#### **3.1 Include L/NAs in all aspects of the humanitarian program cycle**

Ensure all stakeholders, including L/NAs, understand and meaningfully engage in the HNO/HRP process, i.e., needs assessment, analysis, strategy development, and prioritization. This will ensure partner programming and project development for Health Cluster response is cohesive and in line with the strategic priorities increasing the likelihood for donor support or partnerships with other actors.

#### **3.2 Include L/NAs in funding decision-making and control of vital resources**

Empower L/NAs to contribute to and drive funding decisions within the Health Cluster.

- Set up processes and mechanisms that enable transparent and collective governance of funding allocations that is under the Health Cluster, such as having a designated decision-making body to oversee strategic prioritization, project selection and funding distribution. Ensure that L/NAs are part of these governance processes and that their perspectives and input are duly factored.

#### **3.3 Strengthen L/NA capacity for resource mobilization**

Empower L/NA to independently mobilize resources. A strong institutional capacity will place the L/NAs in a better position to meet some of the donor requirements and improve their resource mobilization efforts. Institutional systems strengthening requires a multi-stakeholder investment to avail the necessary resources and expertise. The Health Cluster will,

- Support project development to ensure technically sound HRP project proposals that can facilitate independent resource mobilization. Health Cluster will readily provide project development information packages, e.g., situation analysis, donor guidelines and templates, donor information matrix, analysis of the Health Management Information Systems (HMIS) data, and Health Sector Strategic Plans (HSSP). During the implementation stage, the health cluster coordinators are encouraged to initiate local dialogue to rally the partners to address prioritized capacity gaps. The cluster should advocate for funding targeted to capacity-sharing and strengthening initiatives as well.
- Taking advantage of the cluster as a multiagency platform, the Health Cluster leadership will identify or map out partners able to support L/NAs to strengthen capacity for project management, proposal writing, monitoring, reporting and evaluation, humanitarian principles, organizational

governance, strategic planning, and resource mobilization. The Health Cluster will also coordinate partner orientation on up-to-date policies and new standards as they become available.

- Engage with the private sector to contribute required technical expertise, in-kind resources, and funding.

### **3.4 Enhance donor advocacy**

- Advocate for donors to ensure that funding to partners promotes their active engagement and participation in the Health Cluster.
- Advocate for donors to invest in L/NA capacity for Health Cluster co-leadership roles.
- Advocate for other donors to augment quality funding granted to L/NAs, including through pooled fund mechanisms as one pathway that enables better access to funding for L/NAs while concurrently empowering coordination systems and their role in it.
- Promote funding tracking in the Health Cluster to assess the proportion of funds directed to L/NAs directly and indirectly. To do this, the Health Cluster must advocate with the major donors, UN, and INGOs (often sub-contracting L/NAs) to report timely and reliably on the Financial Tracking Services (FTS) and other national funding tracking mechanisms where they exist. At the same time, L/NAs should be engaged in identifying accessible reporting mechanisms to track L/NA funding- all in the spirit of monitoring for advocacy.

# Strategic priorities and approaches for the Global Health Cluster

To iterate, the three strategic priority areas for a meaningful engagement of the L/NA in the Health Cluster coordination described in the preceding sections remain relevant to the GHC Coordination. Below are recommended strategic actions to strengthen the representation, participation, and leadership of the L/NA at the GHC level.

## Strategic Priority 1

**Leadership: Empower L/NA to effectively fulfil Health Cluster coordination functions at the Global Health Cluster**

### **1.1 Increase the role of L/NA in the strategic governance of the Global Health Cluster**

Increasing L/NA representation in the various strategic decision-making bodies at the GHC, such as the SAG, Technical WGs, and Task Teams (e.g., for Quality Improvement, Sexual and Reproductive Health), is essential for advancing the inclusion of L/NAs in the policy and strategic dialogue at the global platform.

- The GHC will explore opportunities to enlist L/NAs in the SAG. The process shall entail a review of the ToR including membership composition and eligibility criteria.<sup>43</sup>
- GHC will also explore opportunities for L/NA engagement and leadership in Working Groups and Tasks teams.

### **1.2 Ensure strong technical support for implementation and learning processes for L/NA engagement in the Health Cluster**

The GHC technical support to the Health Cluster at the country level including ensuring shared learning is vital for accelerating the implementation of this strategy. Through this the GHC will thus inevitably increase awareness about the role of L/NAs as Health Cluster partners - thereby also indirectly engendering an enabling environment to improve L/NA participation at the country and global level.

- Dedicate resources to support country Health Clusters with full technical support, including country field missions required to effectively roll out and sustain the implementation of the contextualized action plans. Develop tools such as facilitation modules that support the country's readiness to roll out the localization strategy.

---

<sup>43</sup> Global Health Cluster Strategic Advisory Group - Terms of Reference; March 2021. <https://healthcluster.who.int/publications/m/item/global-health-cluster-strategic-advisory-group-terms-of-reference>

- Support shared learning by strengthening access to information and educational materials relevant to L/NA engagement in the Health Cluster. Create a localization information repository where learning materials, e.g., case studies, indicator tracker/dashboard, evaluation reports, other learning platforms, a translated localization strategy and implementation support tools, training guides, templates/ToR are accessible through the Global Health Cluster website.
- Conduct an End-line evaluation of the implementation and effectiveness of the GHC localization strategy in 2025 to inform the review and further planning.

## Strategic Priority 2

### Enhance Equitable Representation, Participation, and Visibility in the Global Health Cluster.

#### 2.1 Increase and diversify L/NA representation in the GHC partners forum

- In consultation with partners at the country and global level and with oversight from the GHC SAG, review existing criteria for membership in the GHC<sup>44</sup> to bring on board more L/NA that can engage actively at the global level. Collaborate with the country's Health Clusters and L/NA partners as potential entry points to map out potential L/NAs from the national and regional networks. Based on the agreed criteria, identify L/NA representation to the GHC through a transparent selection process (EOI and vetting).
- Recognizing the important contributions of the diaspora to the humanitarian response, GHC should consider mechanisms to engage with diaspora networks. The engagement process can involve a mapping exercise, establishing a communication channel, and disseminating relevant information about the Health Cluster operations, coordination, and opportunities for collaboration.

#### 2.2 Foster effective participation of L/NA in GHC platforms

- Apply accessible communication strategies and techniques that foster inclusive participation at the GHC partners meeting, SAG, and Task Teams by considering local language, translation of crucial tools, virtual meeting options, and accessible document repository. Minimize language barriers during the GHC partners' meeting by providing translators and translating key documents.
- Advocate and mobilize resources targeted to support L/NAs (to participate physically in the GHC partner meetings, global/regional donor meetings, IASC events, and Task Force where relevant).

#### 2.3 Promote the visibility of L/NA globally

- Promote the visibility of the collective contributions of L/NAs through regular global analysis to demonstrate the impact of L/NAs in the Health Cluster response. Collate, analyze, and disseminate Health Cluster response indicators segregated by type of partner.
- Promote L/NAs in the GHC communication materials, e.g., GHC Annual reports, policy briefs, and GHC websites, to increase global awareness about the L/NA contribution and impact on Health Cluster response.

<sup>44</sup> Global Health Cluster. Membership Policy of the Global Health Cluster; December 2015.  
<https://healthcluster.who.int/publications/m/item/membership-policy-of-the-global-health-cluster>



## **2.4 Bridge the different levels/layers of coordination across the Health Clusters- from global to country and vice versa**

- Ensure adequate engagement with field-based partners through a two-way information exchange and regular GHC support visits. Work with the country's Health Clusters to actively solicit L/NA inputs to inform relevant global issues and appropriate feedback/response is provided.
- Promote visibility and understanding of the role of the GHC in country-level Health Clusters to support LNA understanding of cluster mechanisms. Use multiple approaches, including already mentioned development training packages and tools, provision of Health Cluster support through missions or virtual engagement, e.g., with SAG, Health Cluster meetings also, but strengthen global communications to be in different languages for country clusters to be able to share with partners.

### **Strategic Priority 3**

#### **Advocate for L/NA's Access to Resources for Meaningful Engagement in the Health Cluster.**

Noting the significance of quality funding in achieving the desired level of L/NA engagement, GHC will continue high-level evidence-based advocacy for quality funding with a particular focus on increasing access for L/NAs.

### **3.1 Perform advocacy for adequate investment in leadership and engagement of LNAs**

Achieving the optimal capacity for a locally led response requires adequate and quality funding. To support resource mobilization for the Health Cluster, GHC will

- Advocate for funding to support capacity-strengthening on humanitarian response coordination and expansion of locally-led Health Cluster response. While opening the space to engage more L/NA is desired, stakeholders must be aware and willing to invest in the costs of attaining adequate capacity e.g., staff to fulfill the co-ordination roles, logistical support to participate in the coordination activities, and training.
- Advocate for a funding strategy that empowers the cluster leadership and directs funds to L/NAs e.g., augmenting the CBPF mechanism that empowers L/NAs and strengthens the cluster's resource governance capacity.
- In collaboration with the Country teams, ensure the Health Cluster is represented at relevant global to raise awareness about the Health Cluster localization processes and muster additional funding support.

# Annexes

## **Annex 1**

Localization in the Health Cluster Coordination: A Baseline Analysis of the Barriers, Enablers, and Good Practices (Jan-February 2024)

## **Annex 2**

Localization Strategy: Implementation Plan and Result Monitoring Framework