Global Health Cluster Partner Meeting

19-20 June 2024
Virtual

Note for the Record

Meeting objectives

1. Provide a structured platform for sharing information and learning about the needs of country health clusters
2. Provide a forum for presenting technical updates relevant to improving effective humanitarian health response
3. Provide a platform for discussing ongoing emergency responses in cluster countries to improve coordinated response, information flow, and learning.

All presentations can be found here.

DAY 1: 19 June 2024

Welcome and Introduction; agenda overview (Linda Doull, GHC Coordinator, and Gabriele Rossi, SAG Co-Chair),
L Doull welcomed partners to the online meeting, acknowledged the challenges of convening virtually, and provided housekeeping instructions. G. Rossi thanked participants, outlined the agenda for the day as well as previewed the topics for the following day.
Session1; Opening remarks and update from the WHO Health Emergencies Programme (Dr Mike Ryan, Executive Director, WHO Emergencies and Mr Altaf Musani, Director, Health Emergency Interventions)- Chair: Gabriele Rossi, Medair (SAG co-chair)
Altaf Musani addressed the issue of IASC scale-ups and humanitarian response, noting that the humanitarian system has struggled to handle the high volume of emergencies in 2023/4. He spoke of the system's limitations, focusing on the critical need for increased financing, operational space, and political will. Observations from the Emergency Directors Group (EDG)underscored the necessity for development partners to engage more deeply in humanitarian environments, recognizing the importance of the humanitarian-development nexus. Moving on to the World Health Assembly, he outlined the key papers presented namely one on the health situation in Ukraine and neighbouring countries, the legacy paper on the health situation in the occupied Palestinian territories and Syrian Golan Heights and the situation in the occupied Palestinian territories since 7 October 2023. He noted the significant political debate about these papers, which detracted from their technical merit and shifted focus to the political actions surrounding these situations. Despite this, the importance of the Health Cluster partnership and healthcare delivery in various settings was acknowledged and emphasized. A. Musani discussed the increasing risk appetite among humanitarians due to various crises in 2024, such as those in Gaza, Sudan, Ethiopia, Mozambique, Myanmar, and Haiti, where healthcare systems are under attack. He highlighted the deliberate and systematic attacks on healthcare and the degradation of international humanitarian law. He further highlighted the ongoing need for supplies and support for localized humanitarian efforts, expressing concerns about the potential risks of overemphasizing localization, which might lead to the shutdown of these efforts. He stressed the importance of protecting healthcare systems and ensuring necessary supplies reach conflict areas. He cited the work in Gaza, where efforts were made to increase bed capacity and healthcare availability despite frequent attacks. Continuous assessments and operations reviews were deemed essential, referencing the Inter-Agency Humanitarian Evaluations in Afghanistan and Ethiopia and pointing out the successes and failures in those contexts. He emphasized the need for stronger international collaboration and political advocacy to safeguard healthcare systems in conflict zones. He also highlighted the increasing workload and exhaustion among humanitarians post-COVID, calling for more support and recognition of their efforts. **Dr. Mike Ryan** acknowledged the constraints and dangers humanitarian workers face and the increasing financial hardships affecting all levels of their operations. He highlighted the significant impacts of geopolitical divisions and post-COVID economic downturns, noting that the growing

needs are outpacing available resources. He emphasized the struggle to maintain core capabilities within organizations beyond just operational funding. He acknowledged the need for strategic changes in prioritization and collaboration to make limited resources go further. He also provided an overview of the recent World Health Assembly, noting the political challenges, particularly regarding Gaza and Ukraine, and the controversy around gender responsiveness. Despite these difficulties, there were some successes, such as agreement on changes to the International Health Regulations, which support international mechanisms for health information sharing. He expressed disappointment over the lack of agreement on the Pandemic Treaty but remained hopeful for progress in upcoming negotiations. He mentioned other significant resolutions on climate and health, natural disasters, biosafety and biosecurity. The Global Health and Peace Initiative received positive reactions, although no specific decisions were made. He stressed the importance of continued efforts in these areas.
Dr. Ryan emphasized the challenging months ahead regarding humanitarian space and financing. He underscored the need for localized responses that provide better value for money and resilience at the community level. He called for high-level discussions on sustaining financing and political attention and evolving the way humanitarian work is conducted to maximize the impact of limited resources. He concluded by reiterating the importance of the Health Cluster in these efforts and wishing everyone good luck with their ongoing work.

Key discussion points	**Key actions/Recommendations**
Challenges of responding to humanitarian needs in areas with restricted access or de facto authorities not recognized by governments. This was discussed in the context of Syria and Sudan. Organizations like the UN must balance legal and humanitarian mandates in complex crises. Examples given were Sudan and the potential genocide in Darfur. Obstructions to aid delivery posed by some state actors who may be perpetrating conflicts or diverting assistance. The cases mentioned included Gaza, Ethiopia and Sudan. Importance of principled humanitarian action and maintaining independence, even if it creates tensions with governments obstructing assistance.	Organizations need to be bolder in speaking out against abuse and manipulation by governments to protect humanitarian space and access. Directly supporting vulnerable populations where possible despite non-recognized authorities. Flying the humanitarian flag and standing together as a community during challenging times ahead.

Session2: Country Cluster Operations: Navigating challenges and adapting health services in high-risk conflict settings
(Ms Fikr Shalltoot, Director, Medical Aid for Palestinians (MAP), Gaza) and (Ms Melanie Kempster, Director, Global Health and Nutrition, Relief International (RI) -Chair: Penn Amaah, Health Cluster Coordinator, Ukraine (SAG member)
(**Watch session here**)

Occupied Palestinian Territory: F. Shalltoot presented healthcare challenges in Gaza. She discussed how MAP provides emergency medical care, supports hospital development, and trains local healthcare workers. Despite facing difficulties due to Israeli restrictions, her organization has

responded actively to the current crisis by deploying medical teams, procuring supplies, and rehabilitating damaged health facilities—delivering over $12 million in aid. She explained that ensuring safety remains a major challenge, as healthcare workers are at risk of attacks, with over 500 killed or detained. While MAP takes measures like staff accommodation and deconfliction, the volatile security situation means the safety of staff cannot be guaranteed without collective international efforts. Local partners face even greater constraints as displaced staff lack fuel and safe workspaces. She explained MAP continues responding through adaptation, but the humanitarian crisis in Gaza requires a coordinated, advocacy-supported approach to overcome obstacles to aid provision.

Sudan: **M Kempster** presented on the current conflict and humanitarian crisis. She noted that while the conflict began over a year ago, it has taken time to gain widespread attention. Sudan is facing a severe socioeconomic crisis, with high inflation, widespread food insecurity, and 3.6 million malnourished children. Relief International's major challenge is shortages in medical supplies due to constraints on the UN's common supply pipeline and restricted cross-border access. She explained that RI has implemented buffer stocks, cross-border procurement from Chad, and local market purchases when urgent needs arise to address this. Other challenges include staff safety and duty of care, given volatility. RI has focused on a localized model using 98% local staff to allow continued operations. Mobile outreach and integrated community healthcare have also helped increase access. The quality of services has been affected by non-functional health facilities and lack of staff after displacements. RI delivers integrated healthcare and aims to strengthen health systems resilience long-term. Coordination challenges include staff turnover and the lack of contextual knowledge which slows the response. She emphasized the need for decentralized coordination and strengthened local capacity and health information systems.

Key discussion points	**Key actions/recommendations**
Challenges facing healthcare delivery in conflict settings like Gaza and Sudan, including access restrictions, supply issues, staff safety, and damaged infrastructure. Organizational adaptations to these challenges through measures like local procurement, cross-border solutions, integrated service models, and localized operations using local staff. Coordination difficulties posed by staff turnover, communications problems, and the need for decentralized approaches. Importance of resilience in health systems design, including diversified supply chains, buffer stocks, mobile services, and strengthened local capacity. Safety concerns for humanitarian workers and ensuring duty of care obligations amid volatile security situations.	Consider clinical training for emergency response staff if service expansion is planned. Advocate collectively for improved humanitarian access and protection of aid workers. Adopt decentralized coordination approaches and strengthen local health systems.

Maintaining humanitarian principles of neutrality and independence when delivering aid in complex environments	
Session 3: USAID Study about Data & Attacks on Health (Mr Steven Hansch, Consultant, USAID/BHA)- Chair: Sacha Bootsma, Health Cluster Coordinator, Ethiopia (SAG member) **(Watch session here)**	
S. Hansch presented findings from a USAID/BHA commissioned study on the perceptions and behaviours of frontline health workers in conflict zones. The study examined how humanitarian organizations collect, analyse, and use data on attacks and security threats. It found that NGOs prioritize information on threats over actual attacks. Local staff were considered the most reliable source of risk information. The presentation highlighted the proliferation of communities for real-time data sharing, such as WhatsApp groups. However, these groups have issues with trust and information verification. The study also found challenges with inconsistent data definitions, lack of standard indicators, and underreporting of attacks on local health workers.	
Key discussion points	**Key actions/recommendations**
There are challenges with collecting reliable data on attacks on healthcare in countries like Ethiopia, where there is a reluctance to report due to a lack of trust in authorities. Emphasis on the need to consider data on attacks on broader infrastructure like WASH and shelter, not just healthcare. Debate around creating common standards and indicators across sectors to improve data collection and response. Challenges in documenting threats versus actual attacks and issues with information-sharing platforms like WhatsApp groups.	Consider how to operationalize the study's recommendations, particularly those regarding developing an early warning system and unified data sharing platforms. Advocate for more robust implementation and use of the WHO Surveillance System for Attacks on Health in places like Ethiopia, for example, to address underreporting issues. Support cross-platform data sharing and leverage AI for verification. Build partnerships to address operational data gaps and strengthen early warning systems for attacks on healthcare infrastructure.

DAY 2: 20 June 2024

Welcome/recap/agenda (Gabriele Rossi) (**Watch session here**)
G. Rossi opened the second and final day of the Global Health Cluster Partner Meeting by greeting attendees and expressing gratitude for the meaningful discussions the previous day. He highlighted key points from the discussions, emphasizing the importance of delivering a sustainable primary health care package in fragile settings and the need for a robust risk appetite to operate in challenging contexts. He noted insightful examples from various regions, focusing on adaptation and navigating challenges in places like oPt and Sudan, which involved localization, mobile clinics, and multisectoral approaches.
Session4: Localization (Dr Eba Pasha, Technical Officer, GHC; Francis Tabu, Consultant, GHC; Mr Jameel Abdo, CEO, Tamdeen Youth Foundation, Yemen; Dr Mikyas Girma Demelash, Emergency Relief Program Director, Fayyaa Integrated Development Organization (FIDO) Ethiopia; Mr Elia Muhindo Badjo, Information Management Officer, Health Cluster DRC; Ms Virginie Lefevre, Consultant, GHC)- Chair: Gabriele Rossi, Medair (SAG co-chair)
E. Pasha opened the session by providing context on the localization agenda. She explained that it has gained momentum since 2016 with agreements like the Grand Bargain and is included in the GHC's 2020-2025 strategy and program of work. She outlined the work plan developed over the past year, which included the strategy development process of gathering evidence through surveys, case studies and country missions and the rollout of the strategy until 2025. She also shared some baseline statistics from a survey conducted in January 2024, that showed high engagement of national partners in health clusters but a need for greater national NGO representation in coordination roles at various levels. **J. Abdo** discussed the localization barriers identified in the baseline assessment. He explained that limited and inflexible funding for local actors was a challenge, as well as political restrictions and obstacles that can impact principled humanitarian response. He also mentioned that localization efforts face barriers from donor restrictions on which organizations can work, especially in conflict areas. Accessibility issues with humanitarian coordination platforms due to language and physical barriers were another challenge raised. Despite progress, a lack of commitment and prioritization to localization was also identified, along with funding requirements that local actors struggle to meet and a lack of representation at national and sub-national levels. Power imbalances in partnerships and coordination platforms that are still donor-dominated were another barrier mentioned. **F. Tabu** outlined the strategic approach of the localization strategy. He underlined that the strategy aims to guide holistic engagement with local actors beyond just funding to include participation, representation, and leadership capacities. He clarified that localization, as defined within the Health Cluster, is an iterative process aimed at enhancing the involvement and impact of local actors. He stressed the importance of adhering to humanitarian principles and promoting equitable partnerships between international and local entities. Capacity strengthening was highlighted as crucial, not as a barrier but as an opportunity to foster complementarity and effective responses. He underscored the multi-dimensional nature of localization, encouraging a focus beyond funding to achieve meaningful and efficient outcomes.

M. Girma Demelash outlined five key commitments for the Global Health Cluster to be achieved by the end of 2025. They include developing a Localization Action Plan and ensuring that national NGOs hold 30% of national and 50% of sub-national coordinating roles. Decision-making structures will be adjusted so that 30% of Strategic Advisory Group members are local or international actors. The Cluster will also foster equal participation of local actors in over 80% of cases and allocate more than 40% of country-based pooled funds to them. Strategic actions involve increasing local coordination roles, early involvement in cluster activities, decentralizing coordination mechanisms, inclusive decision-making, and implementing a monitoring framework to track progress and share best practices.

E. Badjo discussed strategic priority two about managing health clusters well. He stated that the priority has three key actions: increasing representation of local actors through outreach to ensure the inclusion of women-led organizations and those serving people with disabilities. A second action is ensuring effective participation by reducing barriers to communication through translation. The third action is increasing the visibility of local actors by providing public recognition of their work, such as supporting outbreak response and last-mile delivery of medical supplies. **F Tabu** followed up with an examination of priority three around funding localization. He explained the health cluster commits to engaging local actors in humanitarian program cycle activities like needs assessment and prioritization to design projects better. The aim is also for increased funding decision transparency. Advocating that donors view country-based pooled funds as a tool to support local actors proactively was mentioned. Finally, he added that the Cluster seeks to use its role as a convener to strengthen local actors' independent resource mobilization capacity and advocacy for earmarked health funding allocations.

V. Lefevre outlined the next steps to operationalize the localization strategy. She stated the English version would be translated into French, Arabic and Spanish. The strategy would be disseminated through webinars and an upcoming closed session with health cluster coordinators. Tools like checklists, terms of reference templates, and workshops will be developed. Capacity-strengthening opportunities such as simulation exercises would also be adapted for local actors. Finally, a results framework will be used to regularly monitor implementation progress.

Key discussion points	**Key actions and recommendations**
The survey respondents identified low capacity as a barrier, both in terms of technical coordination capacity and resource mobilization, but perceptions of capacity can be influenced by biases. Maintaining impartiality is challenging for all actors, given perceptions of bias towards authorities, member states, or foreign policy interests. Local actors are less able to operate flexibly across contexts. Strengthening individual capacity on humanitarian principles for all actors and recognizing local actors' access advantages in hard-to-reach areas. Local and international actors view capacity differently - locals prioritize operational viability in difficult contexts, while internationals focus on	Support to country-specific advocacy efforts and inform donors about the importance of investing in processes that will lead to great involvement of local stakeholders in response action. Translating and disseminating the strategy in multiple languages through webinars and a health cluster coordinator session Developing tools like checklists and templates to operationalize the strategy A localization strategy results monitoring framework will be developed to monitor progress, effectiveness, and impact of the localization efforts Increasing local actor representation in coordination and leadership roles like SAGs

technical compliance. Funding arrangements also influence this dynamic.	Reducing barriers to local actor participation through translation and recognition of their work Engaging local actors in needs assessment and prioritization to strengthen project design and resource mobilization
Session 5: Climate Change and Health (Ms Linda Doull, GHC Coordinator and Mr Paul Knox Clark, Consultant, International Medical Corps) (**Watch session here**)**-** Chair: Peter Gan Kim Soon, Malaysian Medical Relief (SAG member)	
L Doull described the significant health impacts of climate change and the necessary strategies to address them. Highlighting the WHO's priorities and preparation for COP 29, she noted the increasing frequency and intensity of climate-related crises affecting health. At a recent World Health Assembly strategic dialogue, key figures emphasized the urgent need for mitigation. She referenced an article in the Journal of Global Health on the life-stage impacts of climate change and the importance of an all-hazards approach. She cited WHO's public health analysis on El Niño, identifying high-risk areas needing comprehensive responses. Despite strategic intention, proactive WHO approaches remain limited, focusing on resilient communities and health systems, including adaptable health services and workforce resilience. She also referenced the upcoming IASC climate crisis roadmap launch, which outlines six priority areas for alignment and coordination; each cluster is expected to reflect on how it will incorporate each priority in its action. She emphasized learning from existing cluster partner initiatives to guide future efforts. **P. Knox Clark** presented the International Medical Corps' approach to addressing climate change impacts on health, focusing on preparation, programmatic responses, organizational implications, and lessons learned. IMC emphasizes a ground-up design, encouraging country offices to assess local climate risks and integrate small steps into existing programs or develop climate-specific initiatives. This includes both "climate-proofing" and "climate-adaptive programming." He noted that IMC focuses on building evidence and learning, prioritizing programmatic interventions over high-level advocacy. Senior leadership supports this agenda with an innovation fund for country-level experimentation. He shared some of activities in Mali, Pakistan, Zimbabwe, and Somalia which include flood-resilient infrastructure, water conservation, and heat risk management. He highlighted the importance of facility and WASH resilience, preparedness planning, and integrating climate risk into health systems. He emphasized the need for localization, collective advocacy, and recognizing health sector contributions to climate resilience. Challenges include limited funding and the need for greater engagement from health ministries and donors.	
Key discussion points	**Key actions and recommendations**
The varied approaches that organizations like IMC and Action Contre la Faim are taking to address climate change through country-level risk assessments, integrating responses into existing programs, and developing climate-specific initiatives. Challenges around perceived limited climate funding options for health work in fragile contexts, as well as gaps in early warning systems and funding mechanisms for anticipatory action.	Recommendation to further explore connecting philanthropy funding sources to climate action initiatives in humanitarian settings to help address limited funding challenges. The need for the Global Health Cluster to develop a more coherent and proactive approach to supporting country health clusters in crisis situations exacerbated by climate change.

The need to build climate resilience in health systems and facilities through preparedness planning, infrastructure improvements, and linking to early warning systems. The importance of evidence-based programming, localization, collective learning and multisectoral approaches to effectively address climate change. Barriers and opportunities around issues like decarbonization efforts, meaningful climate engagement, and the Global Health Cluster's role in supporting country responses.	
Session 6: Child Health in Emergencies: scaling up high impact interventions for new-born and child survival in humanitarian health responses (Dr Anshu Banerjee, Director, Maternal, New-born, Child and Adolescent Health and Ageing, WHO; Mr James McQuen Patterson, Senior Advisor, Health Emergencies UNICEF; Ms Donatella Massai, Consultant, GHC; Ms Seda Akpinar, Technical Advisor, Early Childhood Development, International Rescue Committee; Dr Bina Valsangkar, Principal Maternal New-born Advisor Jhpiego; Moses Kenyi Taban, Health Specialist, UNICEF; Ms Megan Gayford, Nutrition Specialist, Emergencies, UNICEF - Chair : James McQuen Patterson, UNICEF (SAG member) (**Watch session here**)	
D. Massai presented the results of a baseline assessment on integrating the nurturing care framework for children in humanitarian settings. The assessment included a desk review of humanitarian response plans and an online survey of Health Cluster Coordinators. The survey found that most agreed that progress had been made in integrating nurturing care, but not all agreed. A review of response plans found that while the nurturing care framework was not explicitly named, many activities aligned with its actions and components. Integration challenges included the need for coordination, funding, awareness and competing priorities in difficult contexts. The next steps identified were enhancing intersectoral coordination, developing tools and training, and advocating for dedicated funding and policies to better support the integration of the nurturing care framework. **S. Akpinar** presented examples of early childhood development programs that focus on responsive caregiving and integrating with health actors. She described how In Cox's Bazar, Bangladesh, an ECD program was implemented with Rohingya refugees during COVID-19 through weekly messages on health, nutrition and caregiving delivered by phone. This led to increases in health clinic visits and caregiver-child engagement. In Venezuela, an ECD program was co-designed with a local health partner to improve communication and interaction between mothers and children. It resulted in gains in the use of homemade toys, reading with babies, and more information on breastfeeding and hygiene. In the Middle East, NGO and Simsim teams worked with Ministries of Health in Jordan and Iraq to expand nurturing care through primary health centers using materials like visuals and play areas. This shifted health workers' mindsets to see the whole child and build rapport with caregivers. **B. Valsangkar's** presentation focused on the challenges and efforts in scaling up Kangaroo Mother Care (KMC) in humanitarian settings. She represented the Interagency Working Groups' KMC and Humanitarian Settings Task Team, which aims to accelerate KMC implementation. The Task Team builds on previous work by the Maternal New-born Health sub-working group and Spring Impact, which explored barriers and enablers for KMC. She explained that the task team contributed to WHO's updated KMC practice guide by providing practical recommendations based on	

barriers identified through interviews, focus group discussions, and literature review. Future priorities include creating demonstration sites, compiling KMC resources, and developing a policy brief on operationalizing KMC in humanitarian contexts.

M. Taban presented the Boma Health Initiative in South Sudan, a national community health program launched in 2017. The initiative addresses significant access challenges in the country, where many people live in remote rural areas with limited health services. Health committees select Boma health workers and provide services to 40 households each. They conduct outreach, surveillance, and first response. 52% of required workers have been trained so far. Utilization of under-five services at the community level has increased and is now similar to health facility levels, improving access. Some of the challenges he outlined included financing, logistics, coordination, and data use. The initiative is an effective model but scaling up is hindered by duplication and lack of synergies between stakeholders. He suggested strengthening multi-donor engagement to address challenges and maximize resources.

M. Gayford discussed the new WHO guidance for treating wasting in children, focusing on prevention and community-based interventions. The guidance emphasizes prevention strategies and management of infants under six months. It recommends that all children suffering from wasting receive a health assessment, including those who are moderately affected. At-risk infants under six months need to be identified early and treated often with the mother. The guidance also notes that not all moderately wasted children require specialized therapeutic foods. She outlined a new strategic approach between WFP and UNICEF to shift focus more towards prevention interventions addressing the root causes of wasting at the community and household levels through food/cash assistance and WASH programs.

A. Banerjee, at the end of the presentations, reflected on several key points. He noted that the new WHO guidelines differentiate where acute malnutrition can be managed based on underlying risk factors and context, allowing some cases to be treated as outpatients rather than inpatients if there are no risks. He stated that community health workers can deliver many interventions, such as KMC, with linkage to primary health facilities, but ensuring their competency is essential. KMC, he also noted, is a sustainable approach that does not require much infrastructure and can strengthen social bonds, reducing complications. He pointed to the midwives and nurses based in communities and their contribution to improving child health outcomes. He emphasized the need for better integration between the nutrition and health sectors to address the causes of malnutrition and mortality holistically.

J. McQuen Patterson, in his concluding remarks, noted that with more acute and protracted crises expected due to climate change and conflict, child health interventions must be highly effective to prevent excess mortality and achieve SDG targets. He noted that adaptation is an important consideration for interventions in humanitarian settings, such as how kangaroo mother care can be implemented and whether communities could treat acute malnutrition in some crises. He stated that health partners should identify good practices and support adaptive, responsive health systems to address changing child health needs in emergencies. He also said that localization and integration with other sectors must be considered to strengthen child health responses in humanitarian situations; he noted that even though some high-impact areas were not discussed, immunization remains critically important alongside other interventions.

Key discussion points	**Key actions and recommendations**
Integrating the nurturing care framework and approaches into humanitarian health responses, including challenges, opportunities and progress made.	Enhance coordination between health, nutrition, WASH and other sectors to address malnutrition in an integrated way.

Adapting guidance and programs to be feasible, effective, and responsive to crises through continuous learning and flexibility within health systems. Localization and building the capacity of local partners to lead responses with collaborative support from other actors. Using data, evidence, monitoring and evaluation to iteratively strengthen implementation and integration of child health interventions in emergencies over time.	Advocate for dedicated funding and policies to strengthen the implementation and localization of child health responses. Promote engagement of local partners in coordination mechanisms like the nutrition cluster.
Closing session: (Gabriele Rossi, GHC SAG and Linda Doull, Coordinator, GHC) (**Watch session here**)	
G. Rossi emphasized the importance of the WHA Resolution on maternal and child health, focusing on reorienting health systems towards primary care in fragile humanitarian settings through community collaboration and evidence-based interventions like malaria vaccines. He stressed achieving SDG 3.2 and 4.1, particularly in safe abortion care. He highlighted sustainable primary care delivery with integrated, community-engaged approaches amidst climate change challenges. He underscored the need to enhance resilience in health services and communities to address future shocks effectively. He praised the Global Health Cluster Localization Strategy's goal to increase local and national actor involvement to 30% and 50%, respectively, by 2025. He echoed Dr. Mike Ryan's call for efficiency and mutual support within to ensure prompt responses to health emergencies. He thanked attendees for their contributions. **L. Doull** expressed gratitude for the engagement in the discussions, acknowledging the challenges highlighted by recent reviews and emphasizing the continued importance of the Global Health Cluster in delivering services, especially in complex settings like oPT and Sudan. She noted the Health Cluster's recognition at global forums and outlined ongoing initiatives to enhance service quality and adaptability. She announced plans for an external evaluation of the Global Health Cluster, a first-time endeavor to optimize coordination and effectiveness. She encouraged participants to contribute to this evaluation process and closed by thanking everyone for their valuable contributions and looking forward to future collaborations.	

Annex 1: List of Participants

Organizations	Participants
Action Contre la Faim	Brigitte Tonon
Action Contre la Faim	Fabienne Rousseau
Action Contre la Faim	Tiphaine Jachna
AICPD	Ossama Rasslan
ALIGHT	Heather Lorenzen
Americares	Cora Nally
CARE	Allison Prather
CARE	Cecilliah Mbaka
Centre for Disease Control and Prevention -US (CDC)	Andrew Boyd
Columbia University	Rachel Moresky
Concern	Sinead O'reilly
CoreGroup	Chantal McGill
Corus International	Dennis Cherian
Democratic Republic of Congo (DRC) -Health Cluster	Elia Badjo
Elrha	Gillian McKay
Ethiopia -Health Cluster	Richard Lang'at
Ethiopia -Health Cluster	Sacha WHO
European Commission Directorate for Humanitarian Aid (ECHO)	Elena Velilla
European Commission Directorate for Humanitarian Aid (ECHO)	Fernando Fernandez
European Commission Directorate for Humanitarian Aid (ECHO)	Ian Van Engelgem
Fayyaa Integrated Development Organization (FIDO)	Mikiyas Girma
FHI360	Audrey Rangel
GIZ	Tanja Cohrs

Organizations	Participants
Global Health Cluster	Andrea King
Global Health Cluster	Anoni Ros Martinez
Global Health Cluster	Betina Petry Nectoux
Global Health Cluster	Donatella Massai
Global Health Cluster	Eba Pasha
Global Health Cluster	Francis Tabu
Global Health Cluster	Heiko Hering
Global Health Cluster	Kamal Olleri
Global Health Cluster	Linda Doull
Global Health Cluster	Luis Aguilar
Global Health Cluster	Veronic Verlyck
Global Health Cluster	Virginie Lefevre
GOAL	Marie Hallissey
Harvard Health Initiative	Lea Sinno
Harvard Health Initiative	Michelle Niescierenko
Harvard Health Initiative	Sean Kivlehan
Hope Worldwide	Charles Ham
IMC	Julie Taft
International Council of Nurses	Hoi Shan Fokeladeh
International Federation of the Red Cross (IFRC)	Bronwyn Nichol
International Federation of the Red Cross (IFRC)	Gregory Hynes
International Medical Corps	Jill John-Kall
International Medical Corps	Mary Pack
International Medical Corps (Adaptive Initiative)	Paul Knox Clarke
International Organization for Migration (IOM	Hannah Garrity
International Organization for Migration (IOM)	Haley West

Organizations	Participants
International Rescue Committee	Seda Akpinar
IPAS	Demeke Desta Biru
IPPF	Valerie Dourdin
Jhpiego	Bina Valsangkar
Jhpiego	Murali Krishna
Jhpiego	Zinat Begum
John Snow, Inc	Anne Marie Hvid
Malteser International	Edo Lihic
Malteser International	Kathrin Stommel
MAP UK	Fikr Shalltoot
Medair	Gabriele Rossi
Medical Teams International	Cecilia Lopez
Medical Teams International	Joy Wright
Mercy Malaysia	Masniza Mustaffa
Mercy Malaysia	Peter Gan Kim Soon
Mercy Malaysia	Shoji Endo
PathFinder	Jimmy Nzau
Premiere Urgence	Aude morille
Project Hope	Arlan Fuller
Relief International	Colleen Gallagher Thomas
Relief International	Melanie Kempster
Samaritan's Purse Internationl	Damilola Toki
Samaritan's Purse Internationl	Kelly Hormez
Samaritan's Purse Internationl	Melanie Wubs
Samaritan's Purse Internationl	Shannon Hamilton
Save the Children	Laura Cardinal
Save the Children	Sarah Ashraf
Sphere Standards	Romain Benicchio
Sphere Standards	William Anderson

Organizations	Participants
Tamdeen Youth Foundation	Jameel Abdo
Terres des Hommes Foundation	Iveth J. González
The Global Fund	Daniel de la Torre
Ukraine-Health Cluster	Penn Amaah
UNHCR	Maina Allen
UNHCR	Mike Woodman
UNHCR	Sandra Harlass
UNICEF	Moses Taban
UNICEF	James McQuen Patterson
UNICEF	Megan Gayford
USAID	Steven Hansch
USAID	Elizabeth Glidden
USAID	Gloria Nabaasa
USAID	Jennifer Leigh
USAID	Justin Pendarvis
USAID	Kathy Downs
USAID	Kerrien Simmonds
USAID/BHA	Trina Helderman
World Health Organization/UHL	Sheila Manji
World Health Organization/UHL	Queen Dube
World Health Organization/UHL	Anshu Banerjee
World Health Organization/WHE	Altaf Musani
World Health Organization/WHE	Mike Ryan
World Health Organization/WHE	Samuel Petragallo
World Health Organization/WHE	Teresa Zakaria