



## Introduction

Since the beginning of the implementation of the Humanitarian Reforms in September 2005, WHO and partners have been working together both at the global/regional and country levels to improve the effectiveness, predictability and accountability of humanitarian health action. At the global/regional level, health partners are working to strengthen their individual and collective capacities to respond better and faster. At country level, health partners are working to jointly assess and analyze information, prioritize the interventions, build an evidence-based strategy and action plan, monitor the health situation and the health sector response, adapt/re-plan as necessary, mobilize resources and advocate for humanitarian health action.

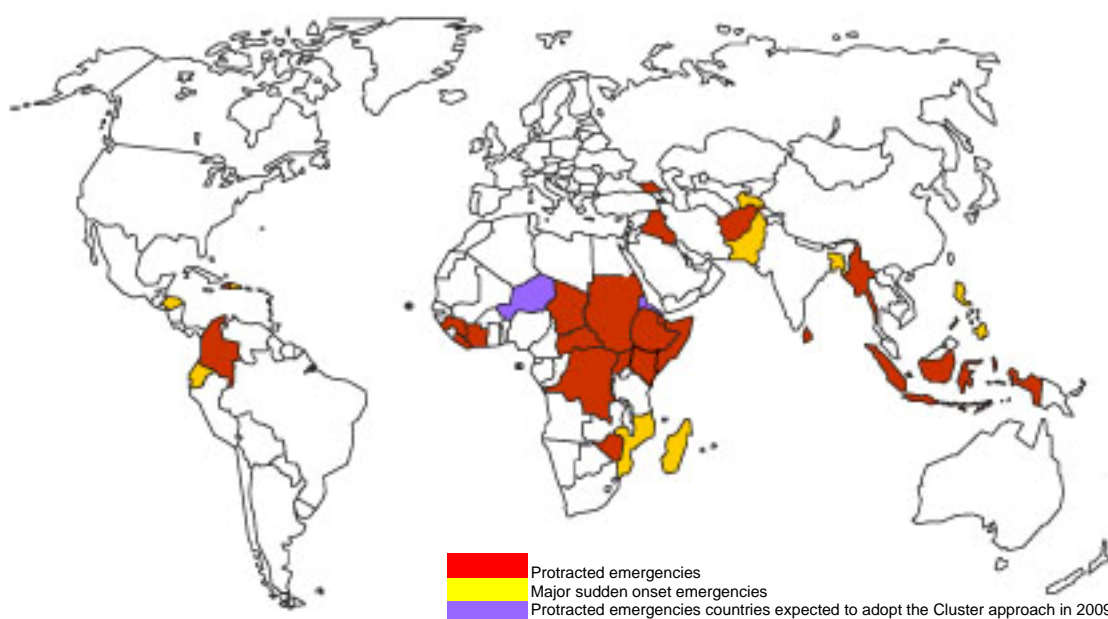
WHO takes its leadership of the health cluster seriously and has worked diligently to deliver on this commitment at all levels of the

Organization. GHC partner agencies and organizations continue to demonstrate their commitment to the cluster approach through participation in the GHC as well as through their own internal efforts to mainstream their cluster roles and responsibilities.

2009 was the first year without a consolidated global cluster appeal or a consolidated global cluster report. However, the Global Health Cluster was able to continue its activities this year with a generous contribution from ECHO together with significant support of staff time and other contributions from WHO and GHC partners.

This report aims not only to account for the work of the Global Health Cluster during 2009, but also to reflect on the successes and challenges in humanitarian health that are shaping GHC priorities for 2010.

### Countries Using the Cluster Approach



## SECTION 1: THE GLOBAL HEALTH CLUSTER: BUILDING COMMON APPROACHES AND CAPACITIES FOR MORE EFFECTIVE HUMANITARIAN HEALTH ACTION

### 1.1 Global Cluster Partners

As of the end of 2009, there are 36 partners of the Global Health Cluster: African Humanitarian Action, American Refugee Council, CARE, Catholic Relief Service, Center for Disease Control, Columbia University, Concern Worldwide, DFID, ECHO, Emergency Relief Agency, FAO, Handicap International, Harvard Humanitarian Initiative, Help Age International, International Federation of the Red Cross and Red Crescent, International Organization for Migration, International Centre for Migration and Health, International Council of Nurses, International Medical Corps,

International Rescue Committee, Johns Hopkins University Center for Refugee and Disaster Response, Marie Stopes International, Medecins du Monde, Merlin, Save the Children UK, Save the Children USA, Terre des Hommes, UNFPA, UNHCR, UNICEF, US Bureau of Population Refugees and Migration, US Office of Foreign Disaster Assistance, World Association for Disaster and Emergency Medicine, Women's Refugee Commission, World Vision International and the World Health Organization as Cluster Lead Agency.

### 1.2 The Strategic Framework of the Global Health Cluster

In 2008, the Global Health Cluster developed a "Strategic Framework of the Global Health Cluster 2009-2011" to clarify and guide its work and to articulate its vision, mission, guiding principles and strategic priorities. This document provides the framework within which the GHC works. Some of the key elements are highlighted here below.

The Vision of the GHC: Optimized health outcomes through timely, effective, complementary and coordinated action before, during and after crises.

The Mission of the GHC: Build consensus on humanitarian health priorities and related best

practices, and strengthen system-wide capacities to ensure an effective and predictable response.

The Guiding Principles of the GHC: (1) Commitment and Voluntary Cooperation, (2) Partnership, (3) Community Participation, (4) Tapping and Building National Capacities and (5) Supporting National Authorities.

The Four Strategic Priorities guide the work of the GHC and provide a structure in which to examine accomplishments and challenges over time. The four Strategic Priorities and the achievements made against each of them during 2009 are described in the following section.

### 1.3 The Work of the Global Health Cluster

**Strategic Priority 1: Build capacities within country clusters to design, implement and monitor an effective, evidence-based humanitarian health response**

The GHC completed the following activities in 2009 for Strategic Priority 1:

- The GHC training and workshop curricula were revised to include the latest GHC guidance and tools and more learning on accountability within the cluster approach

through a clear division of responsibility between partners, Health Cluster Coordinators and the Cluster Lead Agency, the Humanitarian Principles, the Principles of Partnership, the development of a health strategy, prioritization of health projects with partners, resource mobilization

through mechanisms such as the CERF, and how to better serve and build on national preparedness efforts and national systems and priorities.

- 51 Health Cluster Coordinators were trained and assessed by the GHC in 2009 in order to expand the HCC roster in addition to the 40 trained in 2008.
- Two workshops for senior emergency managers of GHC partner organizations were conducted to build their knowledge and capacities to participate more fully in health clusters at country level and to promote the use of the GHC guidance and tools and indicators at country level.
- The Health Cluster Guide was finalized and delivered widely to health partners and to other clusters. The Health Cluster Guide is a commonly agreed roadmap to guide humanitarian health action, to clarify roles and responsibilities among health actors and to increase the predictability of humanitarian health action. Starting in December 2009, the Health Cluster Guide is being promoted and used at country level for a 12 month period; during this time all comments and suggestions will be recorded and taken into consideration in the formulation of the final version of the Health Cluster Guide due at the end of 2010.
- The 25 Health Cluster Core Indicators (page 173 of the Health Cluster Guide) were finalized and widely disseminated to health partners. These indicators are being used by country health clusters to determine whether the health situation in any given country is meeting acceptable standards in various areas of health and to help identify gaps that require priority action from the health cluster. It is only when health cluster partners systematically document and use these indicators in the field that the health clusters will have a more strategic role, that partnerships will be strengthened, and that clusters will become much more than an information sharing platform. They are being linked to discussions on the Sphere revisions.
- The Inter-Sectoral Rapid Assessment Tool (IRA) was finalized and widely disseminated to health partners for use at country level by the health cluster. The IRA was developed together with the WASH and Nutrition clusters at global

level. Since its development, the GHC is actively promoting the IRA at country level and also in the various global level IASC task forces (NATF and IMTF) as a multisectoral tool that covers the key life saving interventions and that can be used during the first one to two weeks of the onset of an acute crisis

- The Health Resource Availability Mapping System (HeRAMS) was finalized and made available to country health clusters. This assessment & monitoring tool is already being used in three countries (in Sudan in Darfur and Southern Sudan and in occupied Palestinian territory for data collection and analysis and in Afghanistan for analysis of existing data). This monitoring tool is being used as a key asset to improve coordination among the health cluster partners in the field by guiding the ongoing identification of gaps in service delivery, the prioritization of geographical areas and interventions among cluster partners and the planning and delivery of services.
- Joint Country Missions were conducted to Sudan and Pakistan to provide technical support on cluster functioning, to promote the GHC guidance and tools, and to assist the country clusters in identifying gaps and developing a cluster-wide strategy and action plan to address them. Similar Joint Country Missions took place in 2008 to Afghanistan, Ivory Coast, Chad and CAR.
- The GHC held two annual meetings: one in Geneva in June and one in Nairobi in November. The meeting in Nairobi benefitted from the experiences of the health clusters in Somalia and Kenya and also provided an opportunity for the GHC to build awareness of what it can provide to country clusters to facilitate their work and strengthen capacities.
- The GHC held teleconferences as required on specific countries such as Zimbabwe and Sudan and on specific issues such as H1N1. Recognizing the important role of the GHC, the WHO Director General joined its teleconference on H1N1 to provide the latest information and to call for joint action.

## **Strategic Priority 2: Ensure supplementary human and material resources are readily accessible to country clusters**

The GHC completed the following activities in 2009 for Strategic Priority 2:

- The GHC expanded the roster of Health Cluster Coordinators with emphasis on candidates for clusters in Africa, the Americas and the Middle East.
- WHO ensured that kits of medical supplies and equipment were available, used and replenished in 5 regional logistics facilities

at the UN Humanitarian Response Depots for use by health partners. Priorities for supplies are determined by the country health cluster. Supplies are drawn down by country clusters as per the needs outlined in their joint action plan, subject to availability other competing demands from other country clusters on the regional stock. GHC partners have been invited to store their own supplies in the UNHRD.

## **Strategic Priority 3: Specify humanitarian health priorities and coordinate global actions to address them**

The GHC completed the following activity in 2009 for Strategic Priority 3:

- The GHC held open discussions on policy issues of common concern. An exchange of information, ideas and experiences within the GHC lead to consensus on the

first policy brief of the GHC which will be issued in early 2010 on User Fees for Health Services in Humanitarian Settings. This and other forthcoming GHC policy briefs will be widely disseminated and promoted to facilitate decisions within the country clusters on key policy issues.

## **Strategic Priority 4: Monitor and evaluate the progress and effectiveness of the health cluster at global and country levels over time**

The GHC completed the following activities in 2009 for Strategic Priority 4:

- Findings from the Joint Country Missions, feedback from WHO country representatives, cluster partners and Health Cluster Coordinators and information from continuous monitoring of country clusters have been used through-

out 2009 by the GHC to revise its work plan and to improve the quality of its activities.

- GHC monitoring of country cluster implementation provided information on successes and challenges of country clusters and specific capacity building needs that the GHC can aim to address.

### **1.4 Methodology of Work**

The two GHC meetings in 2009 provided the opportunity for the GHC to reflect on progress, to discuss and find solutions to challenges, and to move forward on implementation of its work. Such face-to-face meetings are considered valuable to the GHC because they allow individuals and agencies to understand each other better, provide an open and comfortable forum for discussion and an exchange of ideas and experiences, provide an overall briefing on

the numerous global and country level issues and activities related to the GHC, accelerate decision making and strengthen partnerships.

The two subsidiary bodies of the GHC are the Policy and Strategy Team and the Working Group. The Team provides overall direction to the GHC, develops policy papers in key areas of interest, provides direction to resolve any

issues brought to its attention by the Working Group, oversees the design and execution of the monitoring and evaluation exercises of the GHC and takes any necessary action to respond to findings. The Working Group aims to build the capacities of humanitarian health actors through training and workshops, development and promotion of guidance and tools, and Joint Country Missions.

These two subsidiary bodies of the GHC are co-chaired by one WHO representative and one partner agency representative who equally

share the tasks required to lead the work and ensure compliance with agreed upon deadlines. The four co-chairs meet regularly to ensure overall coherence and consistency of the GHC work and to discuss any necessary modifications to the work plan, timelines and commitments.

The GHC Secretariat, based in WHO/Health Action in Crises in Geneva, supports, facilitates and coordinates the work of the GHC and its two subsidiary bodies and serves as a conduit for information sharing.

## 1.5 Partnerships as the Foundation of the Global Health Cluster

Partnerships between GHC agencies and organizations continue to be strengthened through the ongoing interaction and collaboration within the GHC. Significant progress has been made towards mutual understanding between partners through increasingly frank discussions about internal constraints to implementing the cluster approach. Subjects that were once avoided are now being tackled head-on with a collaborative and problem-solving spirit. The importance of these global partnerships should not be underestimated; common understanding at the global level is beginning to influence working relations and the

effectiveness of the health clusters at country level. This has been demonstrated in clusters in Myanmar, DRC and Pakistan.

It should be noted that the GHC continues to reach out to international health organizations, particularly southern based NGOs, to expand the wealth of knowledge and experience within the GHC.

The main constraint to increased partnership at the global level is capacity limitations, either in terms of human resources, time or financial resources.

## 1.6 The Work of the Global Health Cluster on Inter-Cluster Issues

The GHC was actively involved in many of the inter-cluster issues at the global level including the following:

- As a result of an action point at the retreat of global clusters in March 2009, the GHC developed a draft matrix of roles and responsibilities to facilitate the discussion about the roles and responsibilities of the various actors and bodies at country level in humanitarian situations including the Humanitarian Coordinator, the Humanitarian Country Team, the Inter-Cluster Coordination Group (ICCG), the cluster lead agency representative, the cluster coordinator and partners.
- The GHC has been involved in the exploration of the issue of co-ordination and co-leadership at national and sub-national levels and how the various roles and responsibilities of cluster lead agencies or cluster coordinators might be shared and clarified.

- The GHC supported the development of the curriculum for the inter-cluster workshops organized by OCHA and provided resource persons.
- The GHC was involved in the inter-cluster diagnostic and follow up missions to Darfur and Pakistan.
- The GHC is contributing to the revision of the health chapter and standards of Sphere with the aim to align this document with the adoption of standard definitions of health sub-sectors and health services by level of care presented by the GHC HeRAMS and the Health Cluster Core Indicators.
- WHO as cluster lead agency on behalf of the GHC has been an active member in the conceptual preparations for the Cluster Evaluation Phase II since the beginning.
- WHO as cluster lead agency on behalf of the GHC fully supported the IASC recommendation to send a joint letter from

global cluster lead agencies to country lead agency representatives about their dual responsibilities and was actively involved in the drafting of the final letter.

- The GHC is an active member of the various IASC task forces on information management and needs assessments (including the development and conceptualization of the humanitarian dash board).

## 1.7 The Integration of Cross-Cutting Issues and Cross-Cluster Issues

The GHC has demonstrated its commitment to integrating cross-cutting issues in all its products and work. The recommendations from the reviews conducted by the IASC experts on Age-ing and Gender have been incorporated in the GHC guidance, tools and training curriculum. WHO has tapped its own internal experts in other cross-cutting areas like HIV/AIDS and environment to review GHC products because appointed IASC agencies were not yet able to provide this service.

The GHC has also worked closely with other relevant inter-agency bodies and global clusters to clarify the coordination and integration of cross-cluster issues such as Mental Health and Psychosocial Support and Gender Based Violence in the work of the country clusters.

## SECTION 2: THE COUNTRY HEALTH CLUSTERS: IMPROVING HUMANITARIAN HEALTH ACTION

### 2.1 Joint work of Country Health Clusters

There are now 24 active health clusters in protracted emergency situations and they are all led by WHO at the national level. Over the past four years the cluster approach has been temporarily activated in an additional 11 countries to deal with acute sudden-onset emergencies including three this year in El Salvador, the Philippines and Samoa. In the 24 country health clusters in protracted emergency situations, a WHO staff member has been appointed to fulfil the functions of the Health Cluster Coordinator; 12 of these staff are dedicated, full-time HCC with no other WHO responsibilities. Two of the three temporarily activated clusters for acute emergencies in 2009 also had dedicated HCC.

Regular monitoring of the work of these health clusters, either by WHO geographical desk officers, or by the Global Health Cluster, has indicated slow but steady progress towards improved ways of working in humanitarian health. In many countries, there have been improvements in cluster-wide planning through evidence-based prioritization of gap-filling activities; this is leading to more sound inter-

agency funding appeals with less duplication and more teamwork. Joint needs assessments and analysis have taken place in several countries this year to jointly identify needs. Health Clusters have been working to formulate CHAPs and CAPs. And some countries such as Uganda and Zimbabwe used newly found evidence to modify their sectoral plans. As agreed with donors, all CAPS in 2010 include budgets for the performance of health cluster functions. Most of the 24 health clusters now have contingency plans, particularly for communicable disease outbreaks or natural disasters. And many of the country clusters now align their plans with national emergency policies and systems such as in Guinea and oPt. Health clusters have had success in tapping the expertise of local actors and agencies including local NGOs at the community, provincial and national levels. Cluster implementation will continue to improve with better division of work at the national and sub-national levels between WHO and cluster partners.

Constraints to cluster implementation at country level continue to include funding limitations for the performance of cluster functions such as technical support for assessment and analysis work, the development of common strategies and action plans, joint resource mobilization, advocacy work, monitoring and evaluation of service provision (gap filling), and cluster coordination. Funding is also inadequate to cover the work

of individual cluster partners at national and sub-national levels in many countries. The completion of cluster response plans is often hampered by the withdrawal of funds and partners before early recovery is complete. For example, in Myanmar and Nepal, key partners are closing down operations before response operations have been satisfactorily handed over to development bodies.

## 2.2 The Impact of the Work of the Global Health Cluster on Country Health Clusters

While it is difficult to measure the impact of global clusters on the effectiveness of humanitarian action at country level, there is evidence that the capacity building efforts of the GHC are increasing the ability of partners to work together within a commonly agreed framework to get the necessary work done in a more coherent way.

Trained WHO Representatives leading the effort, trained and experienced Health Cluster Coordinators working with partners, partners

who have been exposed to the Health Cluster Guide and tools, and country clusters that have benefitted from guidance and technical support from Joint Country Missions are all the building blocks for more effective action.

In addition, the visibility that comes from the many voices of the GHC speaking together from a common position is helping to put health where it belongs in the forefront of emergency response and recovery.

## SECTION 3: MAINSTREAMING THE CLUSTER APPROACH WITHIN WHO AND CLUSTER PARTNER ORGANIZATIONS

The work of the GHC has been significantly supported and advanced by the intensive internal efforts of WHO as cluster lead agency and of GHC partner agencies and organizations using their own funding sources to promote understanding of and commitment to the cluster approach.

WHO country representatives are aware of their responsibilities as the representative of the cluster lead agency. WHO now systematically includes cluster roles and responsibilities and the GHC guidance, tools and indicators in all its staff development programs, its WHO representative induction courses, its Public Health Pre-Deployment training course and its Health Cluster Coordinator trainings. WHO regional and country offices are now regularly tapping the GHC roster for HCCs and are using the standard GHC curriculum for their regional training programs. Many job descriptions are being revised to include cluster responsibilities.

And work plans and budgets at the three levels of the organization now systematically include cluster work. WHO continues to increase the quantity and quality of its emergency staff in cluster countries and is opening additional offices as required and where funding allows, as in DRC and CAR.

Similarly, partners of the GHC are integrating their cluster commitments within their own internal training programs and are widely disseminating the Health Cluster Guide, the IRA and the health cluster indicators to their staff.

WHO and partners have contributed significantly to the GHC work by providing staff time and travel costs to participate in the work of the GHC including the meetings, Country Missions and trainings. The generous support of ECHO to the GHC in 2009 made many activities possible; however, all these activities were greatly subsidized by WHO and partners throughout the year.

## SECTION 4: CHALLENGES FOR THE GLOBAL HEALTH CLUSTER AND COUNTRY HEALTH CLUSTERS IN 2010

The pressing challenges to the country health clusters in 2010 are the following:

- Securing sustainable and predictable funding for the country cluster lead agency and to partners for country cluster implementation: staff (including dedicated HCC), joint assessments and analysis, reporting, monitoring and resource mobilization
- Securing sustainable funding for the health interventions of individual partners within the cluster/sector action plan including funding for women's health.
- Improving the presentation of humanitarian health interventions (in CAPs and other appeals) as concrete life-saving action
- Improving the operational role that the country level Inter-Cluster Coordination Group (ICCG) has to play to support and complement the policy work of the Humanitarian Country Team (HCT). The ICCG needs to have a more predictable role across all cluster/sectors through the adoption of clear ToRs and concrete action particularly in steering the needs assessment process, in identifying and monitoring the multisectoral context-specific actions needed to address the relevant cross-cutting issues.

The pressing challenges to the Global Health Cluster in 2010 are the following:

- Increasing advocacy around the importance of health in humanitarian settings
- Increasing funding for the GHC annual work plan to continue to put systems in place and strengthen capacities.
- Improving working methods to encourage more involvement by current NGO and UN partners (that face resource constraints, pressures to complete agency work rather than cluster work, competing priorities in the global arena, participation in multiple global clusters) and a larger representation of southern based partners (that face constraints such as limited human resources to participate regularly, funding for travel and phone calls, poor phone lines to participate in many teleconferences and limited knowledge of English)
- Continue to contribute to the clarification of roles and responsibilities at country level between the HCT, ICCG and individual clusters.
- Better monitoring of country cluster implementation.

## SECTION 5: GLOBAL HEALTH CLUSTER PRIORITIES FOR 2010

Based on experience and learning over the past few years, the GHC is developing a work plan for 2010 that focuses on (1) promoting and supporting systematic use of the Health Cluster Guide, Health Cluster Indicators, the IRA, the HeRAMS and other relevant tools by health cluster partners in the field (2) continuing capacity building through training of WHO representatives, Health Cluster Coordinators and field-based staff of cluster partners, (3) developing more policy briefs to help clusters maneuver around common difficulties such as user fees and civil-military

collaboration and (4) maintaining its active participation in inter-cluster work at the global level to ensure common approaches. The GHC is also looking for innovative working methods to facilitate and encourage more participation from partners and is taking measures to strengthen transparent information sharing and dialogue through smaller and more frequent meetings and a new quarterly bulletin for updates on global issues, progress on the GHC work plan and internal efforts by individual partners in mainstreaming the cluster approach