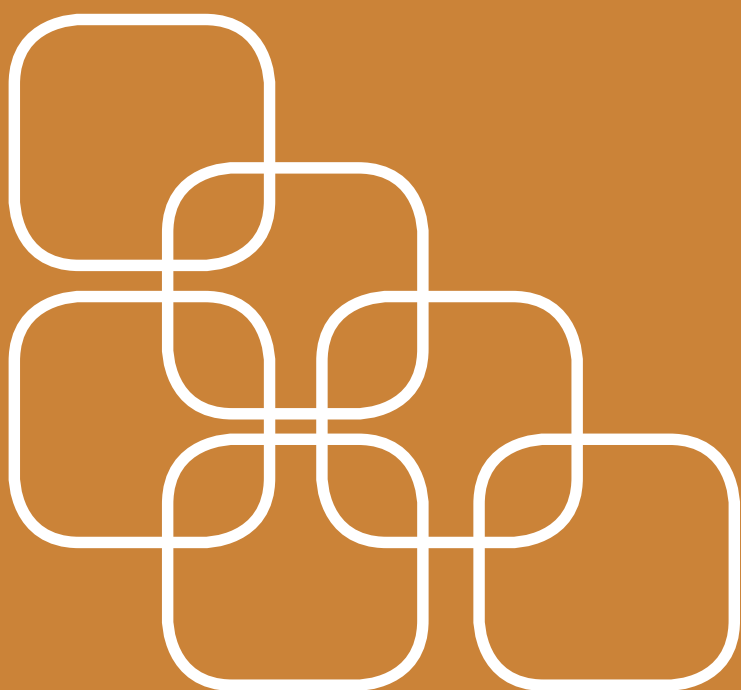


IASC
Inter-Agency Standing Committee

Global
Health Cluster

Global Health Cluster

Report of the work 2010



Introduction

Under the leadership of the World Health Organization (WHO), the Health Cluster brings together United Nations agencies, the Red Cross-Red Crescent Movement, nongovernmental organizations (NGOs), donor organizations and academic centres and institutions committed to responding to health needs in emergencies. Since its inception, it has demonstrated that effective coordination can deliver cost-effective results, by adding to the value of individual agencies and entities involved in humanitarian health responses. The approach supported by the Health Cluster recognizes the value of local knowledge, expertise and advice; promotes lessons learned exercises as well as ongoing review, monitoring, adaptation and evaluation; and seeks to secure effective response capacity in the field, focusing specifically on capacity building at country and local level.

This year's foremost crises in Haiti and Pakistan have stretched the capacity of the international community in all sectors including health. The response and recovery efforts will not diminish any time soon. Both countries will require sustained support to respond to the health needs of affected populations. These are but two of the many severe and prolonged crises affecting communities around the world. Providing sustained support is difficult but it must be achieved.

The Health Cluster has been successful at the global level, but importantly, it has also been successful in establishing country level platforms. As can be seen in the map in Annex 1, 28 countries have activated the cluster approach so far. The support of donors at global and country level has been critical in developing and expanding the work of the Health Cluster and we hope this successful partnership will continue.

Global Health Cluster Partners

Cluster Lead: World Health Organization

UN Partners:

Food and Agriculture Organization of the United Nations; United Nations Population Fund; United Nations High Commissioner for Refugees; United Nations Children's Fund; World Food Programme.

Non-UN Partners:

African Humanitarian Action; American Refugee Committee; CARE International; Catholic Relief Services; Centers for Disease Control and Prevention; Columbia University; Concern Worldwide; Emergency & Relief Agency; European Commission Humanitarian Aid Office; Handicap International; Harvard Humanitarian Initiative; HelpAge International; International Centre for Migration and Health; International Council of Nurses; International Federation of Red Cross and Red Crescent Societies; International Medical Corps; International Organization for Migration; International Rescue Committee; International Council of Voluntary Agencies; Johns Hopkins University Center for Refugee & Disaster Response; Marie Stopes International; Médecins du Monde; Merlin; Office of Foreign Disaster Assistance (USAID); Public Health Agency of Canada; Save the Children; Terre des Hommes; UK Department for International Development (DFID); US Bureau of Population, Refugees and Migration; Women's Refugee Commission; World Association for Disaster and Emergency Medicine (WADEM); World Vision International.

Observers:

International Committee of the Red Cross (ICRC); Interaction; Médecins Sans Frontières; The Sphere Project.

The Global Health Cluster in Action

The ultimate aim of the Global Health Cluster (GHC) is to alleviate the suffering of people caught up in emergencies and crisis situations across the globe. The GHC provides an arena for better coordination of the humanitarian health response and adds value to the individual contributions of partners. The GHC works with country health clusters and provides support to country operations when needed. It recognizes local and national governance, expertise and knowledge, while ensuring national and local capacity building.

The GHC, under the leadership of WHO, is made up of 42 international humanitarian organizations connected with the health response in emergencies and crises. They comprise six United Nations agencies, with WHO as the global lead agency, 32 non-United Nations partners and four non-United Nations observers.

The vision of the GHC is optimized health outcomes through timely, effective, complementary and coordinated action before, during and after crises. Its mission is to build consensus on humanitarian health priorities and related best practices and to strengthen system-wide capacities to ensure an effective and predictable response.

An essential element of the GHC is maximizing the contributions of effective partnerships. This has taken place and it is expressed in the following form:

The GHC meeting, 10-11 June 2010 in Geneva, Switzerland

The meeting, hosted by the International Federation of Red Cross and Red Crescent Societies (IFRC) brought together 70 participants and observers representing 20 out of 39 partner agencies in order to take stock of progress made and discuss the way forward for the GHC in 2010-2011.

The Policy and Strategy Group and the Working Group of the GHC

The two focus groups of the GHC – the Policy and Strategy Group and the Working Group – met three times in 2010 to finalize key documents and establish priorities. Together, these two groups harnessed country, regional, academic and policy expertise to guide the development and implementation of the health cluster approach at country level.

In order to maximize coordination, resources and impact, the GHC has set specific strategic priorities, each with clear goals against which specific actions are agreed and implemented. The impact of each action is monitored and the overall effectiveness is constantly evaluated.

There are two goals specific to this first strategic priority.

Priorities

Strategic Priority 1

is to build capacities within country clusters to design, implement and monitor an effective evidence-based humanitarian health response.

Goal 1.1. A widespread understanding of the Health Cluster within the application of the Humanitarian Reform, Humanitarian Principles and Principles of Partnership influence the design, implementation, monitoring and evaluation of humanitarian health activities.

To achieve this goal, the GHC developed standard orientation packages on the cluster approach, the humanitarian reform, the finance mechanisms and GHC tools and guidance. They can be used at global, national and sub-national levels.

In July 2010, a Help Desk run by the GHC Secretariat was established at the request of global and country level health cluster partners. All queries are treated and/or forwarded to the appropriate entities within one working day based on the Geneva working week and public holidays. In case of emergencies outside of these hours, a mobile number is available.

Available technology and communication means have been used to share and exchange ideas, opinions and actions. Facebook and Twitter accounts were established in addition to the GHC web site. The first three issues of a newsletter were circulated along with all relevant IASC news and updates. Lists and details of contacts are regularly updated.

Goal 1.2. To have standards, best practices, guidance and tools identified, adopted, adapted or developed and promoted by the GHC and to facilitate the planning, delivery and evaluation of humanitarian health action at country level.

To fulfil this goal, 15 000 copies of the publication Health Cluster Guide – a practical guide for country-level implementation of the Health Cluster have been distributed to all cluster countries, GHC partners and WHO Country Offices. The Guide is available in English, French and Spanish.

Other specific tools are available such as the Initial Response Assessment (IRA) and the Health Resources Availability Mapping System (HeRAMS) which have been revised to respond to current needs and capacities at country level.

Strategic Priority 2

is to ensure supplementary human and material resources are readily available to country clusters, as needed.

Goal 2.1. To ensure that GHC rosters are regularly tapped by cluster leads at country level to access qualified Health Cluster Coordinators and other emergency experts for the effective coordination and delivery of health services.

To carry out this goal, the GHC conducted three Health Cluster Coordination Training Courses in 2010; one in Spanish in El Salvador, and three in English in Geneva, Jakarta and Cairo. The Curriculum, developed by the GHC, includes in-depth learning about the role of the Health Cluster Coordinator, the use of specific Health Cluster tools, the humanitarian cluster approach as well as finance mechanisms. More than 190 people have been trained since 2008.

Strategic Priority 3

is to identify specific humanitarian health priorities, based on shared analysis and to coordinate global actions to address them (GHC position papers, aide memoires, strategic guidance), recommending related action.

Goal 3.1. To have open discussion and exchange of information, experience and ideas within the GHC lead to consensus on humanitarian health priorities and coordinated action to address them.

As a result of discussion and exchange of ideas GHC partners have jointly prepared a position paper on “*Removing user fees for primary health care services during humanitarian crises*”. Relying on the Humanitarian Principles which state that humanitarian interventions should be provided “based on needs alone”, should be accessible without discrimination and should be affordable to all, the paper asserts that access to primary health care for the most vulnerable and excluded groups should be free. It also provides guidance on the removal of user fees.

A second paper focuses on coordination between the GHC, civil society and the military. Over the last decade, the military has been increasingly involved in relief activities, sometimes providing direct assistance to crisis-affected populations. From a humanitarian perspective, this poses specific questions regarding the extent to which their involvement has a positive impact and, conversely, whether and how this involvement might affect humanitarian organizations’ ability to respond independently and impartially to the needs of the population. Civil-military coordination problems are particularly relevant for the health sector because of the historical links between health activities and military strategy and the positive impact of a functioning health sector on a country’s stability. The paper also attempts to provide specific guidance to health partners on civil-military coordination during crises.

Strategic Priority 4

is to monitor and evaluate the progress and effectiveness of the health cluster at global and country levels over time.

Goal 4.1. Ensuring that findings and recommendations from continuous monitoring and evaluation result in improvements in the work of the GHC and ultimately in improved humanitarian health action at country level.

By ensuring coordination and improved action at country level and by promoting constant analysis and reflection to reinforce best practices and to respond and adapt to newly identified realities, the GHC adds value to the work of individual partners and maximizes resources and impact of health partners.

An important initiative was the first Health Cluster Coordinators' Lessons Learned Workshop. The Workshop, an initiative of the Global Health Cluster, was held 7-8 June 2010 in Geneva, bringing together 26 former and current Health Cluster Coordinators from all six WHO Regions and GHC partner NGOs. The Workshop focused on health cluster lessons learned regarding good practices, constraints and bottlenecks, with recommendations as to how to embed good practices and overcome identified challenges.

The different phases of an emergency response were discussed, such as pre- and post-deployment and establishing and managing the cluster. The second day provided recommendations on the way forward, Health Cluster tools and learning and capacity building exercises.

Identified lessons learned included:

- Transparency in the allocation and decision making process of pooled funds is essential.
- Cluster Coordination requires a health cluster coordination team including information management capacity.
- The Health Cluster Guide is useful in and is used and appreciated by both Health Cluster Coordinators and partners.

- Country health clusters need to define specific tasks before choosing tools.
- Health Cluster Coordinator training is valuable and should be part of a broader learning strategy with increased involvement of partners as well as a pre-requisite for deployment.
- Partners' briefing and debriefing are valuable for the deployed individual, the organization and the cluster; WHO should intensify efforts in this regard.

Bottlenecks identified included:

- The cluster approach is not yet fully institutionalised within the cluster lead agency and its partners in the GHC.
- Slow release of the funds channelled through the cluster lead agency and inadequate funding for cluster coordination both undermine the cluster approach.

The outcomes included a recommendation that the cluster lead agency should work to ensure the institutionalization of the cluster approach by:

- recognizing the key role of the WHO Head of Country Office in supporting the Health Cluster Coordinator;
- developing standard operating procedures for the implementation and management of the cluster;
- deciding on the level of decision-making depending on the scale of an emergency;
- ensuring all GHC members (including donors) encourage country offices to strongly support the cluster approach.

Recommendations to the GHC on the management of the Health Cluster included:

- defining the human resource needs of the Health Cluster Coordinator teams;
- ensuring sustainable funding for these teams;

- ensuring that the deployment of the Health Cluster Coordinator is based on the roster;
- developing mechanisms with other clusters and partners (WASH, logistics) to use their surge capacity;
- creating surge capacity for assessments within the GHC;
- visiting countries in the early stages of major emergencies to ensure the effective implementation of the cluster;
- highlighting areas of concern and recommending action to be taken by the cluster lead agency.

During the Global Health Cluster meeting held on 10-11 June 2010, the plenary decided that the GHC would review the recommendations and decide on the way forward. The value of the meeting was evident in the decision that the GHC would aim to organize a health cluster coordinators event annually to take stock of the ways the health cluster has been implemented at country level and derive lessons to improve the effectiveness of the response.

Essential to ongoing quality assurance is the *GHC Monitoring Tool for assessing the performance of the health cluster at country level*. The implementation of the Health Cluster at country level is guided by ten core functions indicated in the Health Cluster Guide and in the Guidance Note on using the Cluster Approach to strengthen Humanitarian Response from the Inter-Agency Standing Committee (IASC). A task force consisting of representatives from IMC, Save The Children UK, UNHCR, UNICEF and WHO was established by the Health Cluster Working-Group to develop a monitoring tool for the implementation of the Health Cluster and its performance. The Monitoring Tool of the Performance of the Health Cluster is a self-assessment tool to analyse and manage the Health Cluster implementation process.

The tool allows monitors to identify:

- the level of performance of the Health Cluster's core functions
- actions for improvement
- progress over time

The tool is designed as a management tool to be used by the Health Cluster at country level. The Health Cluster Coordinator (HCC) circulates the tool to all Health Cluster partners within the country. The analysis of the feedback received guides a periodic strategic discussion among all the Health Cluster partners on the performance of the cluster and what improvements are required. Using the tool also improves understanding among the Health Cluster partners on key deliverables and how the cluster is expected to function. If required, such discussion can be externally facilitated, for example during a monitoring mission from the Global Health Cluster.

The monitoring tool should be applied from the second month onwards after the onset of an acute crises or three months after the Health Cluster has been activated in a country with chronic emergencies. It should be updated at least biannually. The report resulting from the monitoring exercise is shared with Health Cluster partners in the country, the respective WHO Regional Office and made available to the Global Health Cluster Secretariat and partners at global level.

The monitoring tool has been tested in Zimbabwe, Yemen, Haiti and DRC and will be rolled-out in 2011 to cluster countries.

These missions related to the first of the four strategic priorities of the Global Health Cluster: "*build capacities within country clusters to design, implement and monitor an effective, evidence-based humanitarian health response*". Global

Health Cluster partners requested that the GHC undertake Joint Country Missions in 2010 to selected countries to support implementation of the Health cluster Functions at national and sub-national levels.

A mission to Yemen was organized in 2010. The team comprised of GHC partners UNICEF, UNFPA and Marie Stoppes International as well as the GHC Secretariat, WHO headquarters and WHO Regional Office for the Middle East.

The specific mission objectives were:

- To develop recommendations for improving the effectiveness of the humanitarian response in health and the implementation of the cluster approach with particular focus on the concerns and challenges of the country cluster;
- To provide the Yemen Health cluster and other interested stakeholders with information and knowledge on humanitarian reform, the cluster approach and the products and services of the GHC that are available to support cluster implementation towards the more effective provision of health services.

The mission reached valuable conclusions. It was clear that Yemen health cluster partners were – and continue to be – keen and supportive of the work of cluster. WHO had done excellent work facilitating the mission and organizing related activities and meetings.

The ongoing humanitarian situation is superimposed on a situation of severe, chronic underdevelopment in the country. This fact was a general comment expressed by all partners and clearly noted during the mission. The cluster is one of the first systematic multi stakeholder platforms established to address the health needs with a primary focus on the humanitarian emergency.

However, it also overlaps with issues arising from chronic underdevelopment.

Although the health cluster in Yemen had been formed recently in response to the conflict in Sa'ada (September 2009), the mission found that there has been substantial progress and achievements forming a firm foundation for future work. There are well appreciated challenges, which include the limited number of partners; the lack of security and capacity limitations (national/sub-national; government/non-government). All contribute to an acute crisis in a context of chronic under-development.

Inter-cluster Work

The GHC is about maximizing the benefits of coordination and collaboration. It recognizes and is based upon the value added to initiatives when all stakeholders, partners and groups work together.

WHO participates in all IASC Principals and Working Group Meetings and is a member of virtually all IASC subsidiary bodies. It also co-chairs the IASC Humanitarian Financing Group (HFG). WHO and the GHC Secretariat participate in all sub-groups, task teams and ad-hoc groups related to the cluster implementation, including the Global Cluster Coordinators' Group.

The GHC participates in most of the inter-cluster missions upon the request of humanitarian country teams (HCT). In 2010, the GHC participated in the missions to Pakistan and Nepal.

The Pakistan HCT requested a follow-up mission to the 2009 Inter-Cluster Diagnostic Mission. The mission included representatives from the GHC, the Protection and Early Recovery Clusters, as well as OCHA and the IASC Secretariat.

Based on IASC guidance notes and on the recommendations of the Inter-Cluster Diagnostic Mission, the mission aimed to help the HCT improve cluster performance. It recommended that:

- the HCT review and perhaps reduce the overall number of clusters in Pakistan (either through merging related ones or by closing others) thus simplifying the operation.
- OCHA use the revision of the Pakistan Humanitarian Response Plan to obtain inter-cluster agreement on the key objectives for each of the plan's pillar, leaving clusters free to review their individual plans and prioritize projects fulfilling the agreed objectives.

Other specific recommendations were made to the Humanitarian Coordinator, representatives of cluster lead agencies sitting on the HCT and cluster coordinators.

The Humanitarian Coordinator in Nepal and the Humanitarian Country Team requested a mission to obtain global level support in moving forward with the HCT's plan of action and priorities for 2010. The mission was led by WHO. The aims of the mission included:

- strengthening understanding among cluster lead agencies, Cluster Coordinators, and government partners regarding their roles and responsibilities in ensuring effective humanitarian action;
- identifying constraints, challenges and gaps in the response capacity and exploring possible support options from the regional/global levels;
- engaging in a strategic dialogue with the RC/HC and HCT on the current and future role and functions of cluster coordination mechanisms in the transition context in Nepal, and considering the potential capacity of the Government of Nepal to possibly play an expanded role in such mechanisms.

Both missions demonstrated the effectiveness of the cluster methodology and in particular the effectiveness of having the GHC able to respond and offer timely support either during a crisis or before the re-emergence of potential triggers in a known delicate environment.

Both the Haiti and Pakistan emergencies, and especially the subsequent Cholera Outbreak in Haiti have revealed the need for advancing inter-programmatic coordination of several clusters for achieving synergistic action. It has been very evident in the response to those emergencies

Cluster Evaluation Phase II

that the joint work of the Health, WASH, Nutrition and Food Security Cluster is necessary for addressing comprehensively the needs of the affected populations. To this end, inter-cluster joint programming and appeals have been prepared both in Pakistan and Haiti and joint missions of the Directors of Emergency of WHO, UNICEF, and WFP have taken place to the above mentioned countries. It is contemplated that during the first trimester of 2011 a meeting of the four global cluster leads and coordinators will take place to produce a common framework for inter programmatic coordination of these four vital areas of the response.

When humanitarian partners created the cluster approach, they established a new methodology which would maximize the impact of humanitarian engagement in crises and take full advantage of the scarce resources available. The cluster approach garners expertise at all levels – from local to global. It puts forward effective coordination as a means to prevent overlap and to make sure all needs are met, while ensuring that no gaps remain in any part of the affected areas or segment of the affected populations.

From the outset of the humanitarian reform, partners recognized that the proof of whether or not the cluster approach could deliver up to expectations needed to be constantly monitored and evaluated to see if the relatively modest cost of the cluster approach would add real value to their work. In 2008-2009, the second phase of the cluster approach was evaluated and the final document and recommendations were presented in April 2010.

The Cluster Evaluation Phase II (CE2) concluded that the benefits of the cluster approach outweigh the costs and that there is potential for clusters to further strengthen coordination and improve effectiveness. This is very encouraging. It indicates that the valuable lessons learned and the service delivery achieved so far are effective and provide a sound basis for future work.

Additionally, the CE2 proposes a series of recommendations to all clusters for improving the approach even further.

May 2010, the GHC commissioned the authors of the CE2 for a health cluster-specific report, to be presented at the GHC Annual Meeting in June 2010. The results of this report are presented in the frame below.

The Health Cluster rates high in several key criteria:

- Clear strategy to systematically engage with national and local health administrations.
- Regular and dynamic communication with stakeholders and the public at large and strong commitment to health surveillance results.
- Strong involvement of the WHO's Health Action in Crises top management in the cluster management, encouraging WHO Heads of Office in the field.
- Strong involvement of the Global Cluster from the beginning. The Health Cluster was the first to produce a cluster handbook.
- Strong linkage and support from the WHO's Health Action in Crises to be systematically and strategically in touch with and supportive of operations.
- Capacity to interact with the financial components of the Reform so that the health components of CAPs and flash appeals are often relatively well-covered.

It has more varied performances in others:

- WHO more often playing "advocacy of last resort" rather than "provider of last resort". Also more affected by security constraints on UN agencies than institutions such as ICRC and MSF, which are at best "engaged observers but not real members" in the cluster.
- Capacity to engage with non cluster members (linked to other factors but affect the Health Cluster).

It demonstrates a reduced ability in others:

- As for many UN agencies, WHO accountability directed more towards its headquarters and executive board rather than to the humanitarian coordinator.
- Lack of "participatory" spirit, i.e. tendency to stick to epidemiological and statistical surveys rather than consult with local populations to identify health practices or specific health issues.

WHO, as Global Lead Agency, and all GHC partners have acknowledged the experiences and needs of individual agencies in the development of current and future priorities together with the recommendations of both the Cluster Evaluation Phase II and the June 2010 Health Cluster Coordinator Lesson Learned Workshop.

In April 2010, the IASC Task Team on the Cluster Approach was asked to create a collective, inter-agency management response to the recommendations made by the CE2. WHO and the GHC Secretariat participated in the Task Team and contributed to the development of the management response to the CE2. Many of the inter-agency management response priorities are being led by the GHC, who has aligned its work with them.

Conclusions

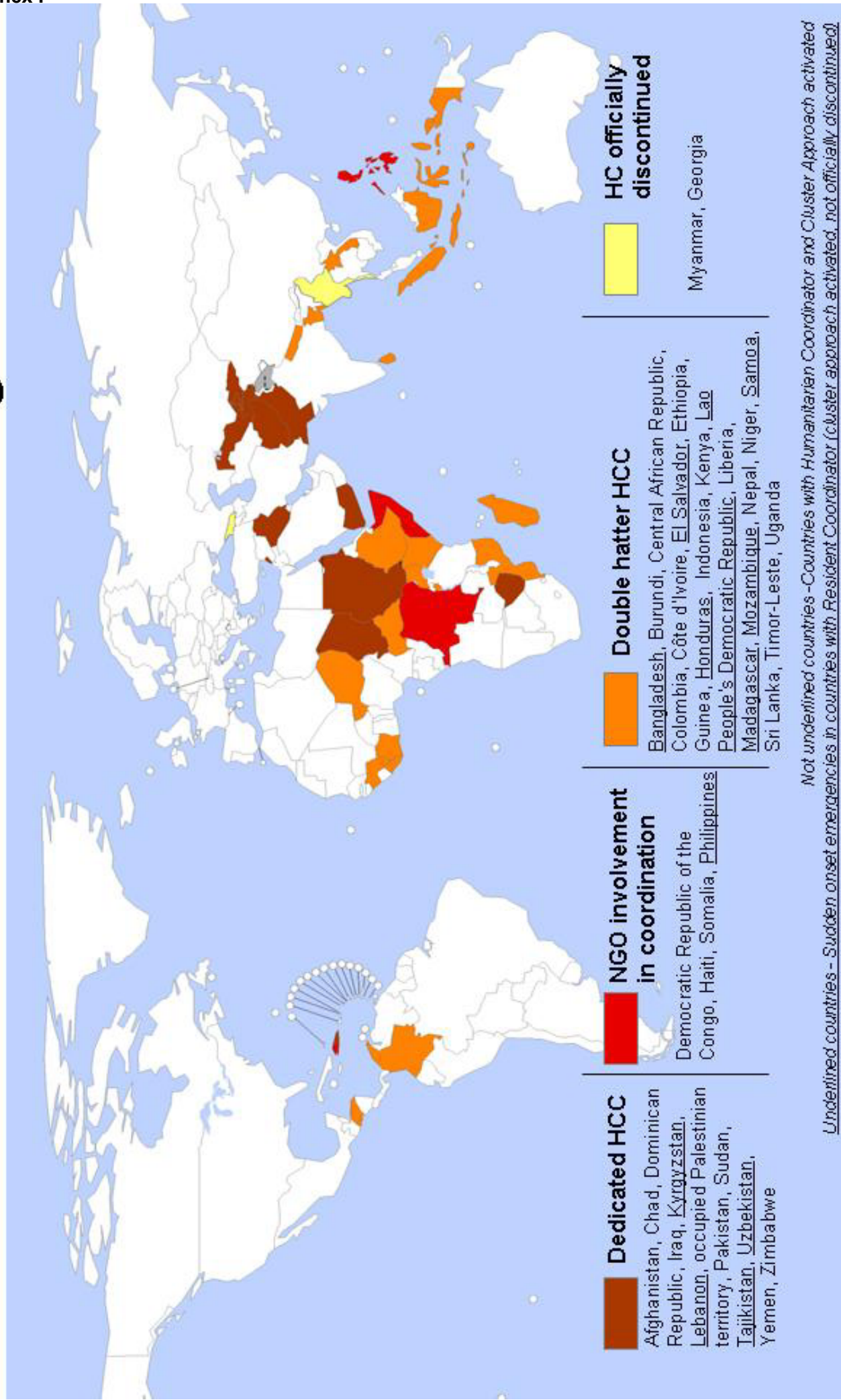
The GHC has been very valuable in the way it has added value to crisis responses by maximizing available resources and skills and avoiding wastage and overlap, both of which can ill be afforded by populations in situations of severe need. Ongoing review, monitoring, evaluation and adaptation have ensured constant responsiveness to challenges and awareness of lessons learned, successes, gaps and areas still needing attention. Challenges remain if such lessons and successes are to be applied even more productively and if gaps and ongoing needs are to be remedied.

More guidance is needed on coordinating large acute emergencies. A change of direction is needed in responding to large scale, sudden onset emergencies. Globally, emergencies and crises are frequent and increasingly complex. Responses must continue to be flexible and based on sound practice and they must enable the best possible use of resources and skills. The approach and effect of the GHC has been demonstrated. It provides a sound basis for going forward to do even better in meeting the needs of people in crisis. Practical coordination is effective. It is essential. It is cost-effective – and it should be adequately resourced.

Practice has shown that it is essential to have a package of tools and guidelines for the coordination of emergency events with clear processes established. These exist in theory but have not been fully accepted and institutionalized. The perfect assessment tool for all situations will be difficult – if not impossible – to produce. But, for the initial, first period of any emergency a rapidly available and applicable assessment tool is essential.

The GHC aims to build consensus on humanitarian health priorities and related best practices and strengthens system-wide capacities to ensure an effective and predictable response. But the GHC and its partners must also work towards ensuring that country health clusters have adequate resources in order to improve the humanitarian response. This is a coordinated partnership and all partners will need resources and support.

Health Cluster Coverage



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.



World Health Organization