Strategic Framework 2012 - 2013

Final, 2 March 2012
Introduction

1. The Global Health Cluster (GHC) was created in 2005, following the United Nations General Assembly Resolution 60/124. This resolution introduced the humanitarian reform process which aims to improve the effectiveness of humanitarian response through greater predictability, accountability and partnership. The key elements of the reform include the Cluster Approach; a strengthened Humanitarian Coordinator (HC) system; more adequate, timely, flexible and effective humanitarian financing; and the development of strong partnerships between UN and non-UN actors. The Global Health Cluster is made up of 38 international humanitarian health organizations and four observers. These members work together to build consensus on health priorities and best practices and to strengthen system-wide capacities for effective and predictable humanitarian response.

2. This paper outlines the third Strategic Framework of the Global Health Cluster covering the period 2012-2013. Taking stock of the GHC progress made since 2005, including its achievements as well as remaining challenges, this paper will present a reconfirmation and/or revision of the GHC vision, mission, guiding principles, strategic priorities and goals. It explains the structure and functioning of the GHC and it describes how resources will be mobilized to fulfill the related annual work plans of the GHC.

3. Furthermore, the updating of this strategy is informed by international policy developments and trends in humanitarian needs. In particular, this strategy is influenced by the five areas for improving the humanitarian response model identified by the Inter-Agency Standing Committee transformative agenda 2012: 1) experienced humanitarian leadership, deployed in a timely and predictable way, 2) more rapid and more effective cluster leadership and coordination, 3) accountability at the head of country office level, 4) better national and international preparedness for humanitarian response, and 5) more effective advocacy and communication and reporting, especially with donors.

4. These priorities are integrated in the strategy, objectives and targets of the health cluster. The strategy includes the role of the GHC in building the readiness of the international health community to respond. Where relevant, the strategy distinguishes between acute and protracted emergencies. Ultimately the Global Health Cluster focuses on demonstrating results in reducing morbidity and mortality within populations affected by humanitarian crises, as well as anticipating health risks and responding to the public health needs of affected populations.

5. In setting the priorities for the next biennium, the GHC members recommended the concentration on work that contributes to saving lives and directly contributes to improving service delivery at country level. The GHC strategy also includes specific and measurable targets and regular follow-up on progress.

Current status, achievements and challenges

6. Since 2005, the Emergency Relief Coordinator has activated the cluster approach in 43 countries and 31 of these clusters, including the health cluster, are still active. In large scale crises, (e.g. 2010 crises in Haiti and Pakistan) there have been more than 300 humanitarian agencies included in the health cluster, which posed enormous coordination challenges.

7. The health cluster has encountered a range of challenges in optimizing its support to affected populations during humanitarian emergencies, and in fully implementing the functions of the health cluster. A number of joint evaluations and lessons learned processes have been
undertaken to look critically at the implementation of the health cluster in countries and the role of the global health cluster. An analysis of reviews from the last four years can be found on the WHO GHC website.¹

Mission statement

8. The health cluster demonstrates optimized cluster performance and health outcomes through timely, effective, complementary and coordinated action preparing for, responding to, and recovering from crises.

Guiding Principles

9. The GHC has defined the following Guiding Principles for its strategy:

**Commitment and voluntary cooperation.** Effective coordination is voluntary and based on each partner’s willingness to join with others in agreeing on priorities and overall response strategies. Each partner adjusts its actions to the particular humanitarian context as well as to other partners’ capacities.

**Partnership.**² Collaborative and complementary partnerships at all levels, based on transparency, mutual understanding and the tapping of comparative advantages and competencies, are essential to improving humanitarian action.

**Community participation and accountability to affected populations.** Community based programming is essential to successful cluster implementation and humanitarian health action. Affected populations must be involved in the actions of the country cluster, and the health cluster will actively seek ways to be accountable to the affected population;

**Support national authorities’ coordination efforts, priorities and building capacities.** Clusters should support and/or complement existing national coordination mechanisms for response, preparedness and recovery. Where appropriate, national health counterparts should be actively encouraged to co-chair cluster meetings as early as possible.

**Adherence to humanitarian principles and respecting the right to health.**³⁴ Health interventions will be based on humanitarian principles and on human rights, which state that humanitarian interventions should be provided based on needs alone, be accessible without discrimination, and be affordable for all. Universal access to Primary Health Care is a fundamental element of any humanitarian health response for populations affected by crises.

Strategic objectives and results for the GHC

10. There are three main strategic objectives for the coming two years:

   i. Ensure that the team to manage the health cluster functions is in place or, in case a team is deployed from outside, is deployed within 72 hours, or as appropriate to the level and/or type of onset of the emergency

   ii. Monitor and report on health cluster coordination functions, and promote best practices

   iii. Demonstrate progress towards agreed health outcomes/impact and service availability to affected populations. Use data for more effective health cluster advocacy

11. Each of these objectives will be specified by measurable targets for expected results. The GHC will formulate a work plan for internal and external accountability and learning objectives. Regular monitoring and evaluation processes will be put in place to measure results. The GHC will gather regular feedback from country clusters through the Global Emergency Management Team (GEMT) and global partners, from an annual Health Cluster Lessons Learned Work Shop and from recommendations of evaluations and missions to adapt its priority activities as indicated.

12. From 2009 to 2011, the GHC mainly focused on its strategic functions (45%) and its operational functions (45%) with the remaining time dedicated to new areas of technical work (10%). In future, the GHC will further shift its focus towards support for operational functions in countries (60%), with somewhat less attention for its strategic functions (30%). Capacity for new areas of technical work will be retained at the previous level (10%).

### Strategic Objective 1: To ensure that the team to manage the health cluster functions is in place or, in case a team is deployed from outside, is deployed within 72 hours, or as appropriate to the level and/or type of onset of the emergency.6

13. The Inter Agency Standing Committee (IASC) calls for experienced humanitarian leadership, deployed in a timely and predictable way. One of the most important challenges is the rapid identification and deployment of sufficiently trained health cluster coordinators, technical experts and support staff to rapidly scale-up and sustain the health cluster and its technical support functions, particularly in the setting of large scale humanitarian emergencies. This has in turn compromised the quality and completeness of rapid needs assessments, sector strategies, appeals and performance monitoring.

14. In any declared emergency, health cluster functions are to be operational within 72 hours. For level 3 emergencies, a surge team needs to be ready to be deployed immediately to reinforce national capacity. For level 1 or 2, national capacity should be in place within this time frame.

15. While WHO is streamlining its internal mechanisms to deploy people rapidly from internal rosters, partners of the GHC are also ready to be part of such teams. However, due to the fact that many people from partner organizations have been trained as Health Cluster Coordinator (HCC) over the last 2 years, clarification and formalization of standby arrangements are needed as only a few people from partner organizations have been trained as Health Cluster Coordinator (HCC) over the last 2 years.

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5 See GHC strategic framework 2009-2011

6 Level 1: national capacity sufficient to meet country needs, Level 2, national capacities surpassed, requiring some international support, Level 3: national capacities overwhelmed, requiring substantial international support
were actually deployed. Another challenge is to ensure continuity of the health cluster team after
the acute phase.

**Target 1.1:** All level 3 emergencies have full qualified experts deployed to perform health cluster
coordination functions, within 72 hours

16. IASC priorities include improved national and international preparedness for humanitarian
response. Risk assessment, watch-lists of high risk countries and early warning systems will help
to anticipate emergencies, inform pre-emptive actions and enable the health cluster to mount a
timely and effectively response. Multi-cluster initial rapid assessments of needs during the first
two weeks are more effective when prepared for adequately at national level. Health cluster
preparedness has included training of health cluster coordinators, the establishment of a roster
and other measures, such as conducting surveillance and preparedness for outbreaks of
communicable diseases during protracted crises and in response to sudden-onset natural
disasters.

17. Guided by good practice in health emergency and disaster preparedness and supporting IASC's
work on preparedness, the GHC together with the GEMT will define a health cluster policy on its
role in preparedness. It will maintain a list of priority countries at increased risk and for early
warning that will be updated regularly, and define protocols for readiness and early action.\(^7\)

**Target 1.2:** To monitor countries at risk, and provide a monthly update, including actions for
readiness

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**Strategic Objective 2: To monitor and report on health cluster coordination functions, and promote
best practices**

18. Ten core functions have been defined by the Global Health Cluster to guide and measure the
work of clusters at country level. Particular emphasis is given to ensure that health partners
jointly assess and analyse information, prioritize interventions, build an evidence-based strategy
and action plan, monitor the health situation and sector response, adapt/re-plan as necessary,
mobilize resources and advocate for humanitarian health action. As lead agency for the cluster at
country level, WHO also has the responsibility to act as provider of last resort.

19. An immediate priority within the context of the demand for increased accountability is the
finalization of the health cluster performance monitoring tool and its application during crises.
The monitoring tool developed in 2011 will be reviewed to determine the best way forward for
the GHC. The GEMT will finalize and implement the tool as quickly as possible.

20. Another issue is the open-ended nature of most health clusters. There is no clear process or
criteria for deactivating the cluster or transitioning to another arrangement following either the
resolution of an acute emergency or its transition to a protracted emergency. This complicates
the transition to more appropriate mechanisms for managing the health needs of the affected
population through either a proper post disaster recovery programme or a programme of work
that is adapted to a protracted emergency and that provides for at least a minimum level of
predictable service delivery.

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\(^7\) In 2008 the former GHC Working Group on Capacity Building for National Stakeholders finalized a GHC
Guidance Note on the Promotion and Advocacy for Stronger National and Local Capacities in Health Emergency
Preparedness and Risk Reduction. This will be reviewed as part of the policy for preparedness.
21. This is closely linked to the role of the MoH in the national health clusters. In principle, the Ministry of Health should at least co-chair the meetings of the health cluster. Where this has not been possible, WHO has chaired the health cluster, often with a non-governmental organization.

**Target 2.1:** Cluster performance is assessed against agreed upon performance criteria in all level 3 emergencies and in at least 50% of active cluster countries, including issuance of recommendations for improvement.

**Strategic Objective 3:** To demonstrate progress towards agreed health outcomes/impact and service availability to affected populations, and use data for more effective health cluster advocacy.

22. One of the constraints identified for the country health clusters is to deliver consistently on the health information function of the health cluster. Reasons behind this are complex and differ from country to country, but include the lack of funding and human resources dedicated to this function, questions about the adoption and use of agreed information for action tools (Initial Rapid Assessment, Health Resource Availability Mapping System and Health Information System), the lack of adherence between cluster partners to agreed common data collection protocols and joint analysis, and constraints to the dissemination of potentially sensitive health data.

23. The ability to implement coordinated initial rapid assessments to identify health needs and risks, and to use this to inform the initial response strategy and action plans are some of the most valued health cluster contributions. The recent developments in the IASC Needs Assessment Task Force, the 2011 operational guidance to improve assessment coordination and the guidance for Multi Cluster Initial Rapid Assessment will all have consequences for the health sector. The GHC and GEMT will need to define these consequences.

24. The GHC and the GEMT need to engage in country-based reviews of the health information function to determine constraints and take subsequent action to improve information management. Depending on the outcome, the GHC and GEMT may update or revise the GHC information for action tools.

**Target 3.1:** Base line data and initial assessment of health needs, risks and capacities is available within 72 hours in 80% of level 2 and 3 emergencies.

25. All health clusters are expected to monitor and share information for action on health sector performance and funding, and formally assess and find solutions to service delivery gaps. As part of our accountability to affected populations, the health cluster needs to demonstrate the effectiveness of the response. The identification of unmet needs, and/or populations and groups at risk that are not reached by the humanitarian interventions is at the core of an effective health cluster advocacy function. The use of sex and age disaggregated data is one of the tools for identifying these unmet needs.

26. Essential health information for action contributes to national and global communication and reporting, especially to national health authorities, WHO Member States and donors.

**Target 3.2:** Progress towards or maintaining minimum levels of health service delivery according to agreed benchmarks in all level 3 emergencies and in at least 80% of level 2 emergencies.

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WHO commitments as lead agency of the Global Health Cluster

27. In mid-2011 WHO undertook an internal and external consultative process as a basis for enhancing its work in humanitarian response, particularly given the acute financing gap for WHO’s core functions in emergency risk management, including its role as Global Cluster Lead Agency. This consultative process is informing the development of a new, cross-organizational approach to improve the speed, consistency and predictability of the WHO response to both humanitarian and public health emergencies. Central to this approach is a new WHO Emergency Response Framework that serves as a common operational platform for the Organization's work in any emergency.

28. The major elements of this proposed Framework are (a) a clear statement of WHO Core Commitments in Emergencies for which the organization will be accountable, as well as the standards for measuring WHO's performance against each, (b) a process and criteria for WHO Grading of Emergencies to classify all acute emergencies within 12-24 hours in terms of the support that a Country Office would require from each level of the Organization, (c) the Management of WHO’s Major Functions in Emergencies which clarifies the roles and responsibilities of each level of the Organization to ensure that WHO's key leadership, information, technical and enabling functions in an acute emergency can be competently and rapidly performed at country level and, (d) WHO Emergency Policies in the areas of surge capacity, 'no-regrets' and 'health emergency leader' to help country offices ensure a more predictable response to major emergencies, building on the experience of other United Nations agencies and the evolving 2011 IASC humanitarian reforms.

29. These organisational changes ensure that the work of the new WHO's Emergency Risk Management and Humanitarian Response (ERM) department is better aligned to the strategic objectives of the GHC and the IASC reforms. Furthermore, a Global Emergency Management Team (GEMT) has been established and is composed of the Director ERM and the six Regional Advisers for emergency work. Close links between the GHC and the GEMT will be established. Among others, the GHC will align its bi-annual meetings with the bi-annual meetings of the GEMT to ensure full GEMT attendance. The GHC will tap the country cluster knowledge of the GEMT, as well as feedback received by partners from their country representatives. In addition, WHO will create stronger links between the GHC and the WHO technical departments.

Architecture and working methods of the GHC

30. The GHC will streamline its processes through the merger of the previous Working Group and the Policy and Strategy Group into one Core Group, supported by a Secretariat. The Core Group will follow developments in international humanitarian policies, and will propose strategic decisions and priorities to the GHC. Furthermore, the Core Group is responsible for managing the implementation of the GHC work plan. It will oversee the design and execution of the monitoring and evaluation exercises of the GHC and propose necessary action to respond to findings. The Core Group will have a rotational co-chair of one of the health cluster partners. The GEMT, through the WHO regional advisors and the director ERM, will be part of the Core Group.

31. The Core Group may at times establish time-bound technical working groups for specific tasks with clear deliverables and end dates. At least one of the annual GHC meetings will be combined with a debate or technical consultation on a specific topic, theme, or country.

32. The GHC communication will be clarified and simplified, with fewer but more informative email traffic and a more useful website. The GHC will meet twice per year. The Core Group will meet
six times per year. Each year there will be two face-to-face meetings, two teleconferences and two Core Group meetings during the GHC meetings. Each meeting will have a set agenda. Meeting minutes with clear actions for follow up will be distributed. During level 3 emergencies and when countries are at increased risk, there will be telephone conferences with GHC, GEMT and country cluster representatives (including the WR) to determine how best to provide support to the country cluster by solving issues that can only be addressed at the global and regional level.

33. The Global Health Cluster Secretariat supports and facilitates the work of the GHC and its Core Group, and serves as a conduit for information sharing. The GHC Secretariat is based in Geneva in ERM's Policy, Practice and Evaluation unit.

34. The role of the Secretariat will be to:
   - oversee the formulation of a Strategic Framework,
   - prepare annual work plans,
   - prepare Gantt charts with activities, milestones, deadlines, budget and responsible person,
   - improve and maintain the website,
   - produce monthly updates on issues of importance and progress on deliverables,
   - organize meetings, etc.

35. Furthermore, the GHC will strengthen its relation to other clusters, in particular the WASH and Nutrition and Food Security clusters. Building on the Survival Strategy that was developed after the recent Pakistan flooding, this inter-cluster coordination will seek clarification of technical roles between the Health, WASH and Nutrition and Food Security clusters.

**Communication between the GHC and the country health clusters**

36. At country level, the Health Cluster Coordinator reports directly to the country representative of the country cluster lead agency. The country representative of the country cluster lead agency reports directly to the country level Humanitarian Coordinator as well as to his/her agency supervisor on the responsibilities of the country cluster lead agency.

37. WHO, as global cluster lead agency, reports directly to the Emergency Relief Coordinator on its responsibilities as lead agency and keeps GHC partners informed on any related communications; country clusters have no direct reporting line to the GHC; Health Cluster Coordinators have no direct reporting line to the HC.

38. The links between the GHC and the country health clusters will be managed by the GEMT. As operational support to the countries is managed by the WHO regional offices, they will be responsible to keep WHO and the GHC regularly informed about any issues related to performance or requests for support from the country clusters.

**Linkages with regional and national partners**

39. The GHC will be aware of and involved in the preparation of any WHO regional initiatives relating to clusters. In several WHO regions that are mostly at risk of sudden onset natural disasters, the interest of regional and national partnerships is on strengthening Emergency Risk Management in countries. In such countries these partnerships will include a range of national and international stakeholders that are not currently members of the GHC, such as government's National Disaster management Units, and civil defense units. Developments in the IASC SWG on preparedness will be taken into account to see how the GHC engages with this priority within the humanitarian reform.
**Funding arrangements**

40. As Lead Agency of the Global Health Cluster, WHO is responsible for mobilizing resources to fulfill its related obligations through its regular funding channels.

41. As partners of the Global Health Cluster, each agency and organization is responsible for mobilizing resources to cover its contribution to the work of the GHC through its regular funding channels.

42. To cover the funding requirements of the collective activities of the GHC, WHO as cluster lead is responsible for ensuring that resources are mobilized in a coordinated and agreed way either through WHO funding channels or through partner funding channels. The option of multi-partner projects to specific donors is included in these possible funding channels.