The Global Health Cluster (GHC) meeting of partners was held in Geneva, Switzerland 22 to 23 March 2011. The meeting brought together participants from twenty-eight GHC partner organizations, five health cluster coordinators (HCCs) from countries in crisis, WHO regional and headquarters directors and technical staff.

The purpose of the meeting was to take stock of recommendations from the field and to build a common understanding among partners of GHC related issues and challenges in order to establish priority areas of work for 2011. These established priorities for the GHC in 2011 are essential for providing and improving support to the health response at country level in emergencies and crises in 2011. The initial focus is on the provision of specialized surge capacity for the core functions of the health cluster response to sudden emergencies. Related recommendations and agreed plan of action must reflect the IASC Principals’ new business model for humanitarian action and build upon the work and recommendations of the Cluster Approach Phase II Evaluation (CE2), 2010.

Tuesday 22 March 2011.

The morning sessions were chaired by Dr Daniel Lopez-Acuna, Director, Strategy, Policy and Resource Management, World Health organization (WHO/SPR)

Opening/Welcome

Eric Laroche - Assistant Director-General, World Health Organization, Health Action in Crises (WHO/HAC), opened the meeting, welcoming participants and thanking them for their commitment to the continuing improvement of the humanitarian health response at global, regional and country levels in order to save lives and reduce suffering. He noted that since the humanitarian reform in 2005 and the beginning of the cluster system, GHC partners have worked together in order to improve effectiveness of the response. For the second time, health cluster coordinators from all six WHO regions have been invited to participate in GHC meetings in order to ensure that the focus of the work of the GHC will be closely connected with the field level.
The Assistant Director-General continued that the Cluster Evaluation Phase 2 (CE2) was released in 2010 and highlighted that, although there are still areas for improvement, the cluster system is increasing coordination between partners. One area for further consideration is that, at country level, donors are often determining policy and influencing the response through earmarked funds. A more inclusive process should be agreed. The GHC must ensure partnerships go beyond consideration of disease control and reach out to those people who are often without a voice and who are not necessarily counted when making decisions and planning service delivery. The concerns of HCCs must be considered and the GHC must ensure its own impartiality and accountability as well as continuing to improve implementation and service delivery.

Report from the GHC Working Group

*Presenters:* Co-chairs of the GHC Working Group: Chris Lewis, Save the Children; Patricia Kormoss, World Health Organization

*Reference documents:* Annex 1-Report from the Working Group presentation; Annex 2-Template for a country health cluster strategy; Annex 3-Establishing a country strategy group

The GHC Working group presented its achievements, challenges and plan for 2011. The presentation included a breakdown of activities: capacity building; guidelines; inter-cluster / country support; health information tools. In order to address the many priorities, the Working Group established four sub technical task forces, each of which identified specific ways forward:

(i) A capacity building task team - to look at all aspects of the capacity building needs, from global to country level.
Areas identified for action included taking stock of training, noting that regarding HCC training, there is continual turnover of HCCs; a lack of HCCs fluent in some relevant language groups; a lack of non-WHO staff trained and a need to decentralise training and provide refresher training; a need to have a clear process for the HCC roster. This might be able to be linked to HCC workshops and re-activation of multi-cluster training. There is a clear need for information management training and country level training.

Other areas identified for action included development and guided management of **GHC roster and production of Standard Operating Procedures (SOPs)** for the health cluster.

(ii) A task team for Health Cluster guidelines to work on the specific areas of guidance requested by HCCs (working with large numbers of partners, sub-national and co-coordination with WHO/NGOs) as well as the first draft of the GHC Standard Operating Procedures for the implementation of the health cluster at country level. Once drafted, these documents would be passed to the Policy and Strategy Team for finalization and endorsement from all partners. This sub group would also need to establish the process (timelines, benchmarks) of the revision of the Health Cluster Guide.

(iii) A task team for Inter-cluster / country support, will include GHC country missions as required; continued roll out and adaptations of the Health Cluster Country Monitoring Tool and developing standard procedures for post deployment briefing for HCCs.
A Health Information Tools task team to refine and operationalize the assessment, monitoring and information management approach and its associated tools globally in order to better support field implementation.

All four task teams will report back periodically to the Working Group during monthly teleconferences. Partners are encouraged to join these task teams.

A number of issues were raised and/or reiterated in the discussion which followed. These included:

- The need for commitment from the partners to be involved in the work and activities of the health cluster.
- Financing of the global activities – since 2005, there have been special appeals for the establishment of the cluster and the tools at the global level. These funds have now been fully implemented and there is currently no dedicated budget for the GHC. Donors are not continuing to fund clusters at the global level through special appeals. The donors expect that global activities and staff costs to be part of the core budget of the agencies.
- The gap between the development of the tools at global level and capacity for use at country level.
- There is a need for increased and more effective training at country level.
  - It is important to prioritize countries more at risk, with a systematic plan for training at the country level.
  - GHC needs to know and support the adaptation in each country.
- As needs differ in each country, the GHC needs to work with the country office and health cluster to provide adequate guidance and support:
  - GHC support such as that provided to the HCC in Pakistan worked well especially as it was able to extend the focus (e.g., in assessments) and the adaptation of the tools was very useful - but required extensive human resources from the GHC.
- Implementation of existing tools remains a priority. Tools require a careful degree of adaptation and there is still no rapid assessment tool.
- There needs to be focus on building effective inter-cluster coordination and surge capacity.
- The HCCs lesson learned workshop held in June 2009 was seen as effective and should be repeated.

The overriding challenge for the Global Health Cluster is to ensure that support provided is in support and is useful towards meeting the needs of the country health response.

Specific priorities established for 2011 for the four task teams identified above:

- To take stock on training, especially on needs related to HCC training HCC/Lessons Learned/Workshop, refresher programmes, on need for country level training; to include information management and re-activating multi-cluster training.
- To build capacity on needs and capacity assessments and monitoring.
- To develop guidance on sub-national coordination and ways of dealing with large numbers of partners.
- To begin the revision process of the Global Health Cluster Guide.
- To support joint GHC mission to Southern Sudan.
- To undertake further GHC inter-cluster missions as required.
- To continue roll out of Monitoring Tool and develop an online version.
- To refine and operationalise assessment, monitoring and information management approach and tools, with periodic briefings from NATF.
– clarity on which tool the health cluster will use and how it will use it;
– developing an operational plan to implement at country level and for health information.

Report back from the Policy and Strategy Group

**Presenters:** Co-chairs of the GHC Policy and Strategy Team: Mary Pack, International Medical Corps; Nevio Zagaria, World Health Organization.

**Reference documents:**
- Annex 4-GHC position paper: removing user fees for primary health care services during humanitarian crises; 
- Annex 5-GHC position paper: civil-military coordination during humanitarian health action.

This session included a report back on the dissemination and use of two policy papers:
  - GHC position paper: removing user fees for primary health care services during humanitarian crises.
  - GHC position paper: civil-military coordination during humanitarian health action.

It also included priorities for 2011, which were: to revise Foreign Medical Teams concept paper and decide whether/not this should be taken on under the umbrella of the GHC; to re-visit Early Recovery for the Health Cluster; to develop strategy on human resource needs in emergencies; to develop a multi-sector response strategy / (survival strategy); to establish a mechanism to ensure that predictable surge capacity teams are deployed within 72 hours in response to sudden onset emergencies.

Specific priorities focused on the four task teams identified above:
- Develop position papers on
  - Deployment of foreign medical teams in emergencies
- Develop guidance on
  - Early Recovery for the health cluster
  - Inter-cluster coordination and programme synergy among clusters: towards an operational framework
- Develop Standard Operating Procedures of the GHC for sudden emergencies
  - Recommended human resource needs in emergencies
  - To define the core functions of the surge capacity team with a focus on coordination, assessment, information management
  - To establish a core team of senior, experienced personnel to manage the humanitarian response to all large scale emergencies involving the Cluster Lead Agency and GHC partners, deployable within 72 hours
  - To hold a workshop among this core group in 2011 to define roles, responsibilities and expected availability.
- To develop a GHC Strategy 2012-2014 – responsibility of Policy and Strategy group
- To ensure meetings of GHC (March and October, 2011) with a face to face meeting of Working Group and the Policy and Strategy Group (June/July, 2011)

Discussion elicited additional comment and concern which included (inter alia): the need to be sure that work is in line with IASC principles and promotes Inter-cluster synergy; the need to focus on accountability (including accountability to beneficiaries) and advocacy; tension arising from a sense of urgency to respond which could preclude a focus on preparedness. It was noted that there is pressure from donors to focus on large responses and pressure to decide if this is the way forward – to respond to them rapidly – to refocus on response.
Overall, there was a sense of the need to narrow the agenda but to develop clusters and increase strategies to ensure clusters can complement each other. GHC would continue to be involved in the work of the IASC.


Presenters: Alfred Dube, Health Cluster Coordinator Pakistan; Anne Golaz, UNICEF; Andre Griekspoor, World Health Organization.


The Overall objectives of the workshop Pakistan Health Cluster Lesson Learned Workshop were to:

1. To identify best practices and challenges faced during the health sector humanitarian response to flood affected population, August 2010 - January 2011
2. To identify what actions, systems, mechanisms and resources are needed in the next phase for health cluster partners in Pakistan in order to achieve a common strategic framework for health sector recovery in 2011

Participants of the workshop included: Pakistan Ministry of Health; Pakistan Health Cluster partners (national and provincial); the Pakistan Health Cluster Coordination team and Health cluster members; donors and WASH, Nutrition, CCCM and Logistic Cluster partners. Members of the Global Health Cluster assisted in the development of the concept and the running of the workshop. The workshop was designed to ensure maximum participation from humanitarian actors and government authorities from all provincial hubs along with the actors and Government authorities at the federal level.

While recognizing that there are areas that need to be improved, the participants at the workshop confirmed the need to continue to build on the coordination structures of the Health Cluster at district, provincial and national levels, moving towards complete integration with the Government and local structures and adapting to the changes.

The meeting then reviewed the contribution of GHC during the response, highlighting (inter alia)

• GHC’s positive role in defining the health cluster response strategy
• GHC support for resource mobilization for the cluster.
• The positive impact of messages from the country and the HQ being the same
• The usefulness of having a direct link GHC secretariat at WHO/HQ
• The heavy human resource investment provided by the GHC for the implementation of the Health Resource Availability Mapping System (HeRAMS) created a solid basis for continued monitoring and analysis.
• The meeting reviewed the involvement and contribution of GHC in the workshop development, highlighting (inter alia)
• The value of the holding a lesson learned within six months of the onset of the crisis and ensuring involvement of partners from all levels of the response.
• The added value of involving the members from the GHC at an early stage when preparing country lesson learnt exercises.
• The necessity to ensure that other countries receive the report from Pakistan to be able to learn and to adapt good practices where appropriate in their countries.
Update on the health cluster challenges in Cote d'Ivoire and Libya

Presenters: WHO/HAC Regional Advisers AFRO/EMRO/WPRO

Angela Benson, HAC Regional Adviser for the WHO Africa Regional Office, (AFRO). Osama Maher Emergency Health Adviser for the WHO Eastern Mediterranean Regional Office, presented current report on the situation in Northern Africa (attached).

IASC Updates and implications for the GHC - Implications of the IASC Principles' "new business model" discussion the future of the health cluster (Global and Country levels)


Reference documents: Internal use only: Draft thematic papers for the IASC Principals new business model for humanitarian response.

The IASC, in December 2010, had had a candid exchange among the Principals and the ERC came with a proposal of five areas that the Principals take on to discuss the new business model for humanitarian response.

Information concerning the United Nations Emergency Relief Coordinator's call to IASC Principles to work on a new Business Model for Humanitarian Response on 21 December was circulated to all Global Health Cluster (GHC) members early January. In response to these development, the GHC Policy and Strategy Team met via teleconference on the 19 and the 28 January to discuss and provide input, raise critical questions of concern to the Global Health Cluster on the five themes:

1. The evolving context for humanitarian action
2. Humanitarian leadership and coordination
3. Building national capacity for preparedness and early recovery
4. Accountability
5. Advocacy and Communications

While it is important to look individually at all of the five thematic areas outlined by the Principles in December 2011, it is important to recognize that they all have many components and cross-cutting issues that link them together. This is particularly evident between theme two 
*Humanitarian leadership* and coordination and theme four - *Accountability*. (see Annex XX for GHC note for the record).

The meeting of IASC Principals, held on 21-22 February 2011, highlighted the key transformative actions. The majority of these key points emerged because of the response to Haiti and Pakistan.

Discussion during the meeting on 21-22 February highlighted a number of issues, questions and comments:

- The need to consider and remember the role of member states, media and donors
- There was a focus at the meeting on togetherness.
- The need to use connections to ensure selection of effective staff
• People need to commit, to sign up to the strategy, to be monitored and evaluated.
• If OCHA is playing a greater role then they have to commit and be prepared to participate at all levels (especially at country level) in all clusters all the time, understanding the key issues of the cluster.
• A key action point from the meeting should be around the role of NGOs on the HCT to decide on accountability of representatives on the HCT to the overall response.
• The importance of inter-cluster coordination and the need to rationalise the work of many groups with focus on such aspects as HR, Accountability, Performance, National action.
• The need to identify the most effective and appropriate way for GHC to be involved in such work and the links with other issues such as SOPs.
• The importance of performance and monitoring of the humanitarian response.

In the next 4 weeks the GHC would need to position itself vis a vis the work of the IASC. All information received by the GHC secretariat will be shared with partners and the GHC workplans will be aligned to reflect any new developments as appropriate.

Report back from the Multi-Stakeholder-Cluster Meeting 1 February 2011

Presenters: Daniel Lopez-Acuna, World Health Organization; Chris Lewis, Save the Children; Mary Pack, International Medical Corps; Linda Doull, Merlin.

Reference documents: Annex 7-Draft Framework on Cluster Coordination Costs and Functions in Humanitarian Emergencies at the Country Level

The session included a power point presentation: Draft Framework on Cluster Coordination Costs and Functions in Humanitarian Emergencies at the Country Level which introduced key issues and stimulated discussion. The meeting considered these issues under seven areas of focus.

1. Effective coordination is integral to humanitarian action.
2. Cluster coordination should be tailored to scale.
3. Cluster coordination requires broad engagement.
4. The need to professionalize Cluster Coordination
5. Meeting coordination costs in unforeseeable acute emergencies.
6. Meeting coordination costs in foreseeable protracted emergencies.
7. Cross-Cutting Issue support at country level.

Overall, there were positive attitudes and results, with donors recognizing that the cluster approach is effective and important and that there are costs involved. The need for flexibility was recognized in responding to the differences in crises. There was still no agreement reached regarding the proposal to put the costs of coordination in the CAP. It was suggested that costing for coordination of foreseeable events should be mainstreamed. The view of representatives of the UN and NGOs was that this could not be done in the immediate term – a period of transition would be needed to enable adjustment of core budgets.

The GHC Secretariat will continue to follow this process and regularly feedback all developments to GHC Members.
Coordination and registration of Providers of foreign medical teams in the humanitarian response to sudden-onset disasters

Presenters: Anthony Redmond, University of Manchester; Nevio Zagaria, World Health Organization.


In December 2010, there had been a meeting in Cuba of key stakeholders. The meeting’s purpose was to address the issue of improving deployment of medical teams to countries facing sudden onset crisis. A summary of the outcomes were presented in power-point presentation. The summary included a review of general concerns: accountability, quality control, coordination, reporting. There were specific concerns: clinical competency, record keeping, follow up. Recommendations included the establishment of a Foreign Medical Teams Advisory Group (FoMeTAG), establishing draft Terms of Reference for FoMeTAG and that FoMeTAG oversee international registration of foreign medical teams.

It had been proposed that there be commitment to: adherence to a minimal set of professional and ethical standards and work in support of the national response; fostering onsite coordination with, and accountability to, local health service framework; operational coordination, cooperation and record keeping, data collection, data sharing and appropriate reporting; working only to the competencies for which they are recognised in their own country; supporting the development of a uniform reporting system to facilitate later analysis; securing an organised exit strategy agreed with local health providers.

Details regarding registration had been proposed. International registration of providers of FMTs would be inclusive and transparent and the Advisory Group when established would work through international agencies and associations, including WHO, IFRC/ICRC and major NGO’s, INGO’s, civil defence organisations and others. Providers of teams are formally registered internationally to promote accountability and a level of training, equipment and preparedness that meets an agreed international professional and ethical standard. Registration of FMTs would be seen as the first step on the road to quality assurance. To maintain quality, all countries would be encouraged to fund, support and deploy only those teams that were registered and therefore met internationally agreed standards. FoMeTAG and registration would each require funding and a secretariat, which could be housed together or separately and hosted by the same or separate agencies.

Draft terms of reference and suggested members were proposed with WHO Health Action in Crisis (as the host Agency)

- Representatives of the Global Health Cluster
- Representatives of selected main global providers of FMT
- Representatives of two NGOs to be designated, possibly on a rotation basis, for example by ICVA, SCHR and/or InterAction
- Representatives of bilateral agencies supporting actively this initiative
- Representatives of two countries having been affected by the most recent mass casualty sudden onset disasters
- Representatives of academic institutions engaged in this field
- The World Association on Disaster Emergency Medicine (WADEM)
• Individual experts from other organizations or institutions may be invited on a case by case basis

There was considerable discussion which entered into the details of the subject and provided suggestions and further thoughts for the revised concept note. It was decided that next steps should include revision of the concept paper. The Policy and Strategy Team was requested to finalise the paper through email, teleconferences and a final face-to-face meeting to reach consensus on the final version of the concept paper.
New Agenda item - Update on the IASC Needs Assessment Task Force (NATF)


Following the request of many of the GHC partners, a presentation on the work of the NATF was presented to the plenary. The presentation covered the various types of assessment tools that are being developed and an overview of the operational guidance.

Standard Operating Procedures for health cluster implementation

Facilitator: Linda Doull


Developing standard operating procedures for sudden emergencies was a key consideration at the meeting. Participants reviewed the recommendations which had come from the HCC Workshop in June 2010:

- Define the human resource needs of the HCC team.
- Ensure a sustainable funding for the HCC team.
- Visit countries in the early stages of major emergencies to ensure the effective implementation of the cluster; to highlight areas of concern and recommend action to be taken by the CLA.

The priorities suggested by the Working Group in 2011 were also considered:

- Deployment of surge capacity
- Template for Country Health Cluster Strategy (draft completed)
- Moving into strategic coordination mechanism (draft completed)
- Dealing with large numbers of partners – outline drafted
- Sub-national coordination, case studies – outline drafted

Additional areas for consideration included some particular IASC Key Transformative Actions

- Key Transformative Actions 7- Agreed to establish a system of inter-agency monitoring missions, led by OCHA, carried out periodically for all major emergencies, using the performance framework as a basis for assessment, and reporting to the ERC.
Discussion raised some concerns and comments regarding the need to ensure distinction between SOPs and guidelines and to note that SOPs refer to standard procedures and the clear stages and steps to be taken. SOPs are needed for setting up a cluster, for designation of the HCC and the team. SOPs need to be reliable and predictable and a standard way of doing business. SOPs relate to essential needs and capacity assessments, to what needs to be produced when in order to fill gaps. While information management is a separate area to assess, it is necessary for effective coordination. It is noticeable that in the field the HCCs often have no support, which can mean they are in a situation to fail. It was also noted that there should be alignment of these SOPs and those of HAC.

Predictable surge capacity for the health cluster

Facilitator: Muireann Brennan, Centers for Disease Control and Prevention.

The meeting reviewed relevant aspects of surge capacity, including the recommendations which emerged from the HCC Workshop in June 2010:

• Ensure deployment of HCC is from roster.
• Develop mechanisms with other clusters and partners (WASH, logistics) to use their surge capacity.
• Create surge capacity for assessments within GHC.

The GHC meeting had proposed:

• HCC and HCC team roster for surge capacity (including partners)
• Commitment from all partners

The IASC Key Transformative Actions included specific agreements:

• Agreed to despatch, within 72 hours, senior, experienced personnel to manage the humanitarian response to all large scale emergencies, with senior staff pre-trained for the task, and ideally trained together in teams to ensure understanding and cooperation from the outset of the response.
• Agreed that IASC organisations should boost their human resource capacity for humanitarian response by training existing staff on emergency management and by further developing rosters, especially for the deployment of senior staff, with recruitment agencies used as required to identify a wider pool of quality candidates.

Discussion elicited further comment and concerns including questions regarding how to actually establish predictable surge capacity. It was suggested that there was a need for teams available to be deployed – perhaps a core team which could be rapidly assembled, sometimes within a particular country. It was noted that the GHC had not yet reached this point because of standby costs so it may be more feasible to have a functional capacity in standby.. Concerns regarding training and identification of appropriate personnel were reiterated.

The meeting concluded that the first step was to:

• define the core functions of the surge capacity team with a focus on coordination, assessment, information management; and
• to establish a core team of senior, experienced personnel to manage the humanitarian response to all large scale emergencies involving the Cluster Lead Agency and GHC partners, deployable within 72 hours

Reflections from the Food Security Cluster Senior Adviser.

Presenter: Richard Trenchard, FAO, Food Security Cluster Senior Adviser
Richard Trenchard began with a reflection on lessons he had learned from the GHC and this meeting in particular, noting that it was useful for clusters to attend each other’s meetings. He commented on processes and the impressive degree of transparency and exchange of views and opinion. The preparation with policy papers and the efficient and effective management of the meeting itself (chairing, power points, time management, summaries etc) resulted in a productive and positive set of outcomes from a balanced mix of participants. The importance of having an efficient and effective secretariat was noted along with planning which approached the tasks with task teams for core areas. The importance of surge capacity was reiterated with reference too to WASH and its progress. The question was how to build on experiences in Pakistan to maintain minimal cluster functioning after the surge and how to measure impact. The issue of accreditation is important and the discussion here had been very specific and raised relevant issues. The meeting had been substantive and represented a conversation which should include principals, clusters and task teams to reflect the multiple dimensions of the work.

- The model of the GHC had been helpful for the establishment of the cluster on Food Security (FSC), which would be established formally on April 4 2011.
- There have been many consultations in preparation and FSC will have benefited by the best practices and best approaches they have been able to observe.
- FS is a complex and significant issue and touches on emergencies and recovery response. It touches on WASH, health and nutrition and what these others are doing affects what FSC needs to do. Therefore, FSC needs to look carefully at its role and will continue to reach out.
- Linkage between the groups contributes immensely to the overall humanitarian response, which, in turn, means the reduction of mortality and morbidity. Programmatic links must be explored. The Pakistan survival strategy has been the first time of looking at this from all levels of proceeding.
- Flexible approaches are key. It will be important to be careful in supporting multiple models for various responses. Many models/ approaches exist and it is useful that these are being mapped and brought together so each cluster does not have to look the same in each response.
- The cluster approach has some limits – especially at the community and district level. Maybe it is not necessary to replicate the national at the district level – but merge with others at the district (eg FSC/ WASH)
- Refugee situations are not always easy and require particular attention

Overall, FSC will begin by being clear about what they want to achieve will then focus on finding the best way to achieve it.

Inter-cluster coordination and programme synergy among clusters: towards an operational framework

Panel members: David Kaatrud, Director of Emergencies, World Food Programme; Jeff Tscharley, Food and Agriculture Organization, Dermot Carty, Deputy Director of Emergencies, UNICEF, Eric Laroche, Assistant Director General, World health Organization.

Moderator: Jorge Costilla, ECHO

A reference point for this panel was the ‘Informal Directions Paper: Strengthening inter-cluster coordination between Food Security, Health, Nutrition and WASH clusters’ of January 2011.

The purpose of this session was to bring together the Emergency Directors of the WASH, Food Security, Health and Nutrition Clusters to discuss key issues of programmatic synergy and inter-cluster coordination with members of the GHC.

The Moderator of the session noted a number of issues that specific to inter-cluster coordination which included (inter alia):

- The reference paper offers many salient points for consideration.
- From a field perspective, the aim is to reduce suffering.
- There is a battle between the risk factors and the interventions needed to reduce mortality.
- Health is a clear priority.
- Food must always be a consideration.
- While malnutrition only rarely kills people, during an emergency many people become malnourished – and malnourished people are more exposed to disease.
- WASH is important as higher levels of hygiene lower risk.
- By working together we can deliver better response and reduce mortality.

David Kaatrud – Director of Emergencies, WFP, began with the announcement that the Food Security Cluster (FSC) will formally open 4 April. Over 18 months consultations had taken place prior to the official launch of the Food Security Cluster to capture and benefit from the best practices and best approaches from other clusters. Two points were initially highlighted during introduction concerning inter-cluster coordination and programme synergy among clusters.

1. Food security is complex and touches needs in both emergencies and recovery response. The responses and approaches of WASH health and nutrition effects what FSC needs to do. Therefore we need to look at what we are doing and we want to continue to reach out. Linkage between the groups contributes immensely to the overall humanitarian response – the reduction of mortality and morbidity. Therefore we need to ensure strong programmatic links between the clusters. Pakistan survival strategy was the first time we looked at this at all levels.

2. We are very open to the links but also open to the flexible approach. We need to be careful to get the right model for the needs encountered – supporting multiple models for various responses. Many models and approaches exist. We need to map them and bring them together to be able to adapt to each unique situation.

The cluster approach has some limits, especially at the community and district level. The strength of joint programming among clusters may lead to being able to merge clusters at the district level and optimize coordination.

Dermot Carty, Deputy Director for Emergencies, UNICEF, highlighted some specific aspects of inter-cluster coordination building on his personal experience. These included (inter alia):

- Effective survival strategy is an important effort in inter-cluster.
• We thought we knew what to do after Ache and then came Myanmar then Haiti then Pakistan. Each situation was different.
• In Pakistan, the donors were driving the response for political reason more than humanitarian reasons. We had to do something but no-one knew how to tackle 10 million people in urgent need.
• FSC, WASH, NUT and Health came together, under enormous pressure to come up with a strategy. The result was the Survival strategy, outlining where we believed the most vulnerable existed and how to deal with that reality. Various HQs were not impressed, which added even more pressure, but ultimately it did not matter what HQ said: the train had already left the station.
• It was the first time we did something together and set up specific criteria. OCHA came on board and very quickly teams were established at the hub / district level. It worked better in some places than others – but overall was a success. Pak was a success and assistance was delivered in a multi-sector way in critical areas of need.
• This could be duplicated – and moved forward. We all know that is what we need to do.

The next speaker was Jeff Tschirley, FAO, who highlighted relevant aspects of this debate which included (inter alia):

• The Agriculture cluster is now is part of the FSC.
• The challenge as we saw it was to link food aid with food assistance with sustaining agriculture and then move into early recover and recovery.
• Food assistance is necessary early but then we move into sustainability. This is an historic partnership that leads to food security.
• Challenges include nutrition issues and health and WASH issues are all part of the challenge.
• We know that these clusters are key in order for the FSC to operate.
• We need to demonstrate synergy.
• The first step was to understand how the GHC fits into WHO
• FSC can really profit from the GHC and where we are and how we go about things.

Challenges for inter-cluster (and co-leads for FSC) were noted:
• Assessment – the need to pull out key information from WASH, HC, NUT
• Preparedness and transition – clusters have a strong role to facilitate the move to transition
• Accountability – we must all improve on this. We need to show how effectively we have used donor money, with a newly identified responsibility for beneficiary accountability.

Eric Laroche, Assistant Director-General, Health Action in Crises, WHO, added to the considerations, noting (inter alia) that because of the enormous size of humanitarian need in Pakistan, it was decided to focus on the vulnerable groups. This led to the WASH, Nutrition, Food Security and Health clusters joint collaboration which moved from attempting to provide blanket coverage to targeting vulnerable populations. Situations are different and demand different responses.

Some important issues of the overall response were highlighted:
• Planning is key - Unless a child is able to access essentials such as food and clean water, the results will be that the child will get sick.
• The Consolidated Appeals Process must be efficient and effective.
• Donors also need to be accountable. If the funds are not timely then the donors are responsible and should be added to the list of those to be held accountable.

Some additional points were raised by discussion in the plenary:
- We need to have high level of engagement from partners.
- Strong donor coordination is imperative.
- The development of the response strategy and the CAP needs to be well coordinated.
- There is a recognized need for improved analysis on sound information.
- More work is needed to identify who is accountable, to whom?
- It was noted that it is not so much that things are changing – it is that we know more and organizations have changed. There is a need to adapt to this reality.
- All of these clusters are aligned and aim ultimately to reduce mortality.

After input from these speakers, participants added opinion and concerns arising from the contributions. In general, there was consensus on key aspects and appreciation for the contributions.

**Priorities for 2011**

*Moderator: Daniel Lopez-Acuna, World Health Organization*


The second last session of the meeting was dedicated to identifying the priorities for 2011 as well as designating responsible entities and suggested timeline. The priorities for the Global Health Cluster proposed throughout the meeting were considered and reviewed.

**Policy and Strategy Team - Priorities for 2011**

It was agreed that there were three main priorities over the next three months.

1. **Revise Foreign Medical Teams concept paper** (*end April*)
   - Once revised, re-circulated to the Policy and Strategy Team. The Policy and Strategy team will make a proposal to the GHC on how to proceed.

2. **Surge Capacity** (*draft framework circulated to all prior to the July face-to-face meeting of the Policy and Strategy team*)
   - Define the core functions and various layers needed for the surge capacity team to respond to sudden onset emergencies
     - Coordination
     - Assessment
     - Information management
   - Establish / identify candidates for the core team of specialized / experienced personnel to manage the humanitarian response to all large scale emergencies. Core team to
     - be a mix of Global Lead Agency and A, and GHC partners
     - deployable within 72 hours
     - workshop to be held among this core group in 2011

3. **Multi-sector response strategy / building on the Pakistan survival strategy framework 2010** (*end June 2011*)
   - the Emergency Directors of WASH, Nutrition Health and Food Security Clusters will meet to discuss areas of joint programming and draft a framework.
   - Framework to be shared with GHC partners for input
The remaining priorities of the Policy and Strategy Team will be carried out in close collaboration with the Working Group.

4. **SOPs for the implementation of a health cluster at country level** (*end 2011*)
Develop strategy to ensure adequate human resource needs in emergencies. To include:
- SOP for information management
- SOP for health cluster coordination
- SOP for monitoring
Different models will be needed depending on the scale and projected duration of the crisis. Once drafted, partners then need to link their internal SOPs to the GHC SOPs.

5. **GHC Strategy 2012-2014** (*end September 2011*)
- Outline to be discussed at the face-to-face meeting in July
- Draft circulated for comments end August
- Final draft to be approved at the next GHC Meetings of Partners, October 2011.

6. **Re-visit Early Recovery for the health Cluster** (*end 2011*)

**Working Group Priorities for 2011**
In order to address the many priorities, the Working Group established four sub technical task forces, each of which identified specific ways forward.

1. **Capacity building task force**
   - Undertake a stock-take on training until now (*April 2011*)
   - Define and circulate process for the HCC Roster (*April 2011*)
   - Develop / circulate training strategy for 2011. (*April/May 2011*). Strategy to include:
     - HCC training HCC/LL/Workshop, refresher
     - Country level capacity building - how to move ahead
     - Information management - what is needed at what levels
     - Multi-cluster training for trained HCCs
   - Explore ways to build capacity of assessments, monitoring (*on-going 2011*)

2. **Guidelines** to work on the specific areas of guidance requested by HCCs as well as the process for the revision of the Health Cluster Guide.
   - Sub-national coordination - draft case-studies paper to be presented to the P&S Team by end June (*June 2011*)
   - Dealing with large number of partners - draft c paper to be presented to the P&S Team by end June (*June 2011*)
   - Start the f process of the Global Health Cluster Guide (to be discussed at the face-to-face meeting July (*July 2011*)

3. **Inter Cluster / Country Support**
• Support joint GHC mission to Southern Sudan - *(May 2011)*
  – WHO, Save the Children, UNICEF, IOM, Care, ECHO, USAID
• Further GHC inter-cluster missions as required
• Continued roll out of Monitoring Tool
  – On-line version developed

4. **Health Information Tools** to refine and operationalise assessment, monitoring and information management approach and tools *(on-going 2011)*
• Ensure periodic briefings from NATF
• clarity on which tool the HC will use and how.
• Capture GHC can input to the NAFT tools
• Operational plan to implement at country level
• Health information management

**Secretariat (on going 2011)**
• Support to the Working Group and Policy and Strategy Group.
• Ensure knowledge sharing and development of GHC website, develop and circulate GHC newsletter which includes updates on: Health Cluster Issues, IASC developments, information resources and publications, GHC work plan progress reports.
• Ensure regular GHC participation in IASC Task Teams and relevant Groups
• Organize back-to-back, face-to-face meeting of the Policy and Strategy Group and the Working group in July 2011.
• Organize back-to-back, face-to-face meeting of the Policy and Strategy Group and the Working group to be followed by Global Meeting of all Partners in October 2011.

The activities and work plan of the GHC 2011 will be as much as possible in line with IASC Principal's new humanitarian business model and the work of the IASC Task Team on the Cluster Approach while promoting inter-cluster synergy.

An updated work plan, taking into consideration the priorities agreed timelines will be circulated with the final report of the meeting.

**Closure**

The meeting closed with thanks and best wishes to Eric Laroche who is retiring at the end of March 2011.