18th Global Health Cluster Partner Meeting
Geneva, Switzerland
10 – 11 December 2014

Note for the record
Background

Building on discussions during the Global Health Cluster (GHC) partners meeting in February 2014 and subsequent GHC Core Group meeting in July 2014, the 18th Global Health Cluster meeting was convened in Geneva against the context of:

- Continued unprecedented global demand for humanitarian health action arising from five Level 3 crises and the Ebola outbreak response
- Recognised need for more focused support and innovative approaches for collective action to more effectively respond to current technical and operational capacity gaps which impede health cluster responses and to enhance readiness for future health crises
- Strengthening of GHC capacity through investment in the GHC Unit based in Geneva and wider revitalisation of the partnership to further strengthen global capacity for humanitarian health action
- Mid-term progress review of delivery against the GHC work-plan and 5 strategic priorities outlined in the Strategic Framework 2014-2015, namely:
  1. Strengthen and expand the global capacity for effective humanitarian health action
  2. Strengthen technical and operational support for country health clusters and coordinators
  3. Improve the standardization, quality, timeliness of humanitarian health information
  4. Address strategic and technical gaps
  5. Enhance the advocacy role of the GHC

The meeting was attended by 73 participants including representatives of GHC members and observers from NGOs, UN agencies, donors, international organisations, Health Cluster Coordinators, WHO Regional ERM Advisors and WHO HQ ERM staff. This was the first partner meeting for four new GHC members, whilst other members sent alternative representation due to country level Ebola response demands and conflicting meetings in Geneva. (See full participants list in Annex 1)

Meeting Objectives and Agenda

The meeting objectives and agenda were developed and agreed by the GHC Core Group. The emphasis was on having a working meeting setting out a realistic programme of work for the GHC in 2015, based on reflection on the challenges and realities in delivering on GHC activities during 2014. By the end of the meeting the GHC aimed to have:

1. **Agreed on priority gaps in health cluster response and identified potential solutions.** (which will enhance global capacity for humanitarian health)
2. **Understood and agreed how the GHC plans to improve its functioning.** (with an introduction to the GHC Unit, the revised governance structures and a draft of the new Standard Operating Procedures)
3. **Reviewed and re-affirmed the GHC strategic priorities.**
4. **Agreed the main GHC deliverables for 2015.**
   * Based on a review of GHC deliverables for 2014 and taking on board the implications
5. **Reviewed and agreed the planning process for the next multi-year GHC strategy.**

In addition, three overarching themes were agreed to channel thinking and discussion during the meeting:

- What one or two major changes should we make to more effectively improve the impact on the health outcomes of disaster-affected people we serve?
- What does this mean for the practical work of the GHC in the coming year in delivering these outcomes?
- How would this change my and my organisation’s role as a partner in the GHC?

Day 1 was devoted to plenary presentations and discussions on the successes and gaps in functioning and delivery of the Health Cluster. Short presentations focused on the business of the meeting were encouraged to allow sufficient time for discussion and to highlight the key issues for the working sessions on Day 2.

Day 2 was designed as a ‘sleeves rolled-up’ working day. Working groups took forward the key issues of concern for the GHC emerging from Day 1. For each topic, the working groups were asked to clarify
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the issue being addressed, and come up with solutions and practical deliverables in 2015 work-plan, with an indication of who can take this forward and how it is to be resourced. The list of working group topics reviewed and agreed during the meeting is outlined below with further details on the discussions in section 5.

1. Resourcing Country Clusters  
2. Health Cluster Professional Development  
3. Advocacy  
4. Gap Identification  
5. Ebola and Surge Capacity

*Full detailed presentations of the meeting are available on Dropbox at: [https://www.dropbox.com/sh/k2we3w8vlx5333r/AABG6tReeWzth4i4wb4TXasa?dl=0](https://www.dropbox.com/sh/k2we3w8vlx5333r/AABG6tReeWzth4i4wb4TXasa?dl=0)*

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Day 1: Wednesday 10 December 2014  
Chaired by Mary Pack, International Medical Corps

**Session 1: Opening Session and Health Cluster Response**

The GHC meeting was opened by Dr Bruce Aylward (WHO Assistant Director-General - Emergencies and Ebola Response Lead) who acknowledged that despite efforts to date, we are only partially meeting the humanitarian needs of affected populations. The Ebola outbreak response has further highlighted this global health capacity gap. The IASC Principles have led the humanitarian reform process. Mostly recently the Transformative Agenda has been useful but perhaps not bold enough to bring about the change needed to confront the ‘new normal’ of multiple Level-3 crises and emerging public health emergencies of international concern. All health actors and GHC members have a duty of participation to harness collective action for effective response. Within WHO, reform over the last 3 years has improved emergency response structures, governance and surge, but further adaptation is necessary. This will be addressed during an exceptional Executive Board meeting on 25 January 2015, which will discuss two key issues: 1) how WHO and partners will continue to implement the Ebola response and 2) the re-structuring of WHO’s emergency approach, including technical specialities, emergency operations, surge capacity, the role of partners and information management. Accountability lies at the heart of these discussions and the WHO Director-General is clear the GHC has a central role in strengthening field operational capacity, through improved governance and investment in the GHC Unit capacity. Dr Aylward expressed thanks to Dr Ahmed Zouiten for running the GHC Secretariat for the last 3 years.

Dr Rick Brennan (Director - WHO Emergency Risk Management and Humanitarian Response (ERM)) reiterated the need to identify the best strategies to more effectively respond to the increased level of need and address current gaps in humanitarian health capacity, recently amplified by the Ebola outbreak. In addition, these strategies must consider health system recovery to develop the resilience and readiness required to deal with future crises. Achieving this requires enhanced collective action, embodied by a strengthened Health Cluster. The GHC partners meeting must therefore focus on the future and how we can improve the functioning of the GHC.

**Health Cluster Response**  
Presenter: Linda Doull, GHC Coordinator

**Key presentation points (refer to presentation # 1)**

- Country Health Cluster (CHC) status - Currently there are 21 active country health clusters and 6 ‘cluster like’ structures across 6 WHO regions. 52% serve protracted (ungraded) emergencies. Only 30% have a dedicated health cluster coordinator. Cluster de-activation is rare which has major capacity implications, as the humanitarian response is already overstretched.

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1 This includes the presentation by Dr Nevio Zagaria on "Key findings of the survey to measure Functional Status, Disability & Health" at the end of Day 1.
• Common Gaps – A number of technical, human resource, operational and funding gaps are consistently identified by country health clusters and partners through health information management system (HIMS); cluster bulletins, reports and evaluations. However country specific and global gap-analysis is unsystematic resulting in a weak evidence base from which to effectively plan and deploy staff/service providers, identify lessons learned and advocate for resources.

• Cluster Performance Monitoring (CPM) – CPM remains unsystematic; only 12 country health clusters have undertaken the exercise in the last 2 years. Results indicate the need for improvement in needs assessment, accountability to affected populations, advocacy and addressing diversity (age, disability).

• GHC support to country clusters - Whilst this support is valued, it still remains inconsistent due to capacity and planning issues.

• Information management – Increased suite of tools/processes available online to facilitate standardised monitoring of cluster performance. Systematic uptake at country and global level is required to improve gap-analysis, support evidence based decision making and enhanced accountability.

Key discussion points

• Cluster activation is not always timely or responding to need (e.g. government resistance in Ebola-affected countries and Turkey). GHC should play a role in supporting alternative coordination mechanisms even if it is not formally recognised as a cluster (e.g. NGO coordination body in Gaziantep).

• Cluster de-activation rate is low compared to activation. Partners discussed whether clusters should continue in protracted crises. Whilst there should not necessarily be a quota on number of clusters, there needs to be a more systematic and rigorous review of coordination architecture in each context. Guidance on cluster deactivation does exist (IASC Cluster Coordination Reference Module) but anecdotal evidence suggests conversations about health cluster deactivation rarely occur. In addition, deactivation triggers for health sector need refinement; governments need to take a more central role in these discussions, particularly in protracted contexts, to identify the most appropriate coordination mechanism. Deactivation should align with the level of need and wider inter-cluster dialogue. Deactivation of a L3 cluster should not result in reduced funding for that country, while it often does.

• Funding clusters at country and global level whilst improving remains challenging. Funding CHC continues to be imbalanced (e.g. Central African Republic health cluster is only 47% funded). Despite the Central Emergency Relief Fund (CERF), partner agencies willing to respond still have problems accessing rapid funds, resulting in service delivery gaps. The Emergency Directors Group is aware of this but no immediate solution has been identified. Sustainable funding for CHC teams is problematic particularly in protracted crises.

• The GHC is currently funded by donor contributions to WHO/ERM and cluster partners. Current level of funding is substantially below that needed to fully implement GHC mandate. GHC partners should consider alternative contributions to the GHC (e.g. allocating staff to work on time limited projects; part funding GHC posts).

• At both levels, clusters should more effectively leverage existing resources (better identify/build partner capacity) and seek support from all cluster partners to secure funding.

• Country Health Cluster structure needs to be more consistent and appropriate to scale of crisis. Ideally there should be fully dedicated Health Country Coordinators (HCCs) with a coordination team (minimum being Information Management Officer and Public Health Officer). Increasing number of decentralised sub-national hubs requires additional focal points, mainly through international nongovernmental organizations partner appointments. More consideration should be given to appointment of national staff in cluster roles as they are immediately available and more sustainable, particularly in protracted contexts. Does having a dedicated HCC result improved cluster performance? Anecdotal evidence suggests yes, but this needs to be analysed more systematically. The effectiveness of CHC is also dependent upon the level of support HCCs receive from the CLA/GHC to ensure they have the necessary authority and capacity to fulfil their term of reference responsibilities. HCCs, WHO/ERM and the Global Health Cluster Unit (GHCU) agree there needs to be increased communication and support between them. Additional capacity within the GHC Unit (Coordinator, 2 Technical Officers, Secretariat Officer) and enhanced cross-team working between GHCU and ERM will facilitate stronger support to HCCs.

• Enhanced surge / deployment capacity at country and global level is recognised, albeit based on more detailed analysis of pre-existing partner capacity. The current ECHO funded NGO surge deployment project (Save the Children UK / International Medical Corps) has proved successful
supporting 9 surge staff for 6 positions; 15 deployments in 18 months) despite challenges of identifying suitable qualified staff. GHC surge capacity should be further strengthened based on this model involving other GHC partners and funders. In addition, GHC partners should assist in identifying and developing the capacity of national partners to respond in emergencies. Finally, based on the recent Ebola outbreak response, partners request that the GHC should have more acknowledged role in outbreak management, and work with other entities in Global Outbreak Alert and Response Network (GOARN). Senior level WHO managers should follow up on this immediately.

**Information management / evidence.** The GHC is currently unable to definitively answer two key questions, namely (1) What evidence do we have that things work? (2) How well have we performed over the years? The GHC Unit acknowledged the need to more effectively analyse available information to substantiate existing (largely anecdotal) reports on gaps (e.g. secondary health care: referral mechanism; needs of women and people with disabilities) and cluster performance, through a more systematic use of Information Management (IM) tools and meta-analysis to inform lessons learned. Additional GHC capacity required to assist with the back-log of information. GHC partners may wish to consider contributing to the Evidence & Advocacy Officer role which is currently unfunded.

**Key actions/recommendations**
- Encourage dialogue on cluster status – systematically review coordination structures as per Humanitarian Project Cycle guidance / annual Emergency Directors Group review.
- Systematic application of available IM tools and analysis of information to better demonstrate gaps, lessons learned and cluster performance.
- Need to monitor/support use of IM tools for planning and strategy development.
- Plan annual CPM exercises, including support needed.
- Develop and secure resources to enhance GHC surge deployment capacity.
- GHC to urgently undertake partner capacity mapping exercise.

**Session 2: GHC Functioning and Strategic Priorities**
Presenter: Linda Doull, GHC Coordinator

**Key presentation points (refer to presentation # 2*)**
- GHC work-plan currently framed by 5 Strategic Priorities outlined in the Strategic Framework 2014-2015. These priorities remain very relevant but the GHC must reaffirm its commitment to achieving them during 2015.
- The GHC has significantly under-performed in delivering the 2014 work-plan as evidenced by the red, amber, green (RAG) scored status update shared with participants – out of 22 planned activities, 3 (14%) are on track, 9 (41%) are in progress/at risk of not being achieved and 10 (45%) are off-track/no action taken – despite Core Group prioritisation exercise in July 2014.
- The new **GHC Structure and Standard Operating Procedures** (SOPs) must address the structural changes required to improve GHC performance in support of country health clusters, including:
  - **Strategic Advisory Group (SAG)** will replace the current Core Group as the governing body. Recent nomination process incomplete – only 5 of the 10 places filled.
  - **The GHC Unit:** investment moving from a Secretariat to a Coordination Team. This is an interim structure for 2015 whilst next GHC multi-year strategy and needs are more accurately defined.
  - Evidence & Advocacy Officer post not funded – request for GHC partner contribution.
  - **Diversifying GHC membership** through the introduction of **Associate status** to enhance collaboration with organisations with particular specialist capacities (e.g. technical expertise, training, research) and strengthen links with Foreign Medical Teams (FMTs) to address cluster gaps; establishing regular, joint country cluster engagement to discuss issues of mutual concern; further development of health cluster support teams to enhance surge capacity.
  - Resources: the current GHC funding is insufficient to deliver work-plan. Rough estimate of 2015 activity costs is US$ 902,472 (current biennial budget is US$ 150,000). Substantial fundraising effort required supported by all GHC partners.
  - **2015 work-plan:** Focus on ‘mission critical’ activities only – what will make greatest impact at country cluster level. The GHC must deliver to be accountable.
Key discussion points

- Government participation in the GHC SAG was proposed, whilst recognising this would be context dependant. SAG members to discuss further and decide on feasibility.
- Diversifying GHC governance and membership, including SAG and Associate status was welcomed. GHC members recognised the potential added value of FMTs, but raised some concerns about acceptance in particular contexts due to their often military origins. Ian Norton (FMT Coordinator) acknowledged concern and reassured that FMTs are subject to government approval and that some governments use them for logistic/transportation; not all FMTs have military origins.
- Timeline for WHO reform (post Ebola) and implications for GHC queried. Dr Rick Brennan confirmed that the Executive Board meeting on 25 January will start the process but big changes will take 12 months.
- GHC members requested greater clarity on the types of investments made by partners, to guide individual agency discussions on future contributions and promote new ideas.
- Whilst GHC Unit investment is welcomed, concerns raised about the capacity to provide technical support to HCCs. The GHCU coordinator confirmed that both GHCU Technical Officers will work in collaboration with ERM Technical Officers to ensure appropriate level of coverage. In addition, the GHCU coordinator explained that by adopting different ways of working with partners, WHO colleagues and country clusters and by securing additional funds, the GHC Unit can overcome some of the recent bottlenecks which have hindered support.

Key actions/recommendations

- GHCU to finalise SAG membership by 31 December. Core Group will stand down on 31 December. SAG will start on 1 January 2015. SAG to decide on government participation.
- Finalise SOPs by end January following review and comment by SAG.
- GHC and FMT Coordinators to meet to clarify relationship between both entities.
- ERM and GHC to clarify Technical Support portfolios and inform CHCs accordingly.
- GHCU to inform partners of outcomes of 25 January Executive Board meeting.

Session 3: Health Cluster Functioning – Case Studies

Four short country case studies were presented to highlight successes and challenges in cluster response to current L3 crises including the Ebola response in Liberia and Guinea and the conflicts in Syria and Central African Republic. Presentations were made respectively by the International Medical Corps (Director Health, Policy & Practice) and WHO Guinea (National Programme Officer); WHO Syria (WHO Representative) and WHO Central African Republic (HCC). Speakers were asked to consider issues around coordination and approaches used to scale-up access and service delivery. Full details can be found in the presentations. A summary of the main emerging themes is outlined below, including implications for the GHC in 2015.

Key presentation points (refer to presentations # 3-6)

Case study 1: Syria (Elizabeth Hoff – WHO Syria) (refer to presentation # 3)

- Highly politicized and restricted context has prevented cluster activation, severely limited humanitarian access, needs assessment and the number of health sector actors in Syria (only 13), whilst half the population now dependent on humanitarian assistance.
- Innovative approaches adopted by WHO to decentralise(scale-up health sector response include the development of strategic partnerships with targeted/specialist national nongovernmental organizations (56 to date); building partner capacity through collaboration with the private sector (17,000 healthcare providers trained in 2014); engaging academia/students to serve as key informants (e.g. 627 early warning and response system sentinel sites – 30% in opposition controlled areas surveillance) and tele-assessments; local procurement with private sector to overcome import restrictions.
- Addressing longer term recovery needs also essential (e.g. prosthetic services).
- Strong emphasis on due diligence and transparency to track performance has enhanced trust and dialogue with partners to facilitate access to affected populations.
Case study 2: Central African Republic (Richard Fotsing – HCC) (refer to presentation # 4)
- IASC L3 declaration in this protracted crisis has resulted in more focussed coordinated response as result of strategic response plan; increased number of implementing partners (now 40), dedicated health cluster staff and additional funding. However, sustaining this level of response remains challenging due to inadequate funding (WHO (CERF) 67% and Health cluster (CHF) 47% funded respectively) and human resources.
- Response scale-up beyond Bangui restricted due to insecurity, reduction of humanitarian access and limited local Ministry of Health and civil society capacity.
- WHO has stepped in as provider of last resort to address gaps including blood bank and ambulance services; national essential drug supply; negotiating free services.
- Suggestions to GHC: undertake strong advocacy to secure funding and humanitarian access. Assist in securing more technical and financial support to national health cluster.

Case study 3: Ebola Coordination (Ann Canavan – International Medical Corps) (refer to presentation # 5)
- Coordination weaknesses (inter-agency and with Ministry of Health / Government of Liberia at national and county level resulted in response gaps in all key areas. GHC and CHC should more effectively promote and communicate standardised coordination mechanism (and focal points) from the outset of the response.
- Early 4-W mapping and continual updating key to effective gap analysis and resource allocation.
- Health clusters to identify gaps in support to national and sub-national coordination which NGOs can co-lead.
- Preparedness for major communicable diseases (surveillance and outbreak management) must be prioritised and will have lasting benefits beyond Ebola.
- Multi-Agency Training Collaborative enables other agencies to acquire competencies to run Ebola Treatment Centres.
- NGO partners also needed to provide operational guidance to support specialist services (e.g. mental health and psychological services, child protection, social behaviour change).

Case Study 4: Ebola Response in Guinea (Diallo Amadou Mouctar - WHO Guinea) (refer to presentation # 6)
- Outbreak control was hampered by high mobility of sick and their contacts, high number of health staff being infected, rumours and stigmatisation around Ebola.
- Surge capacity to support response constrained due to language, short contracts and insufficient technical and operational expertise.
- Lesson learned are that effective involvement of community and regular contacts with hotspots are crucial.
- GHC support on advocacy, resource mobilisation and strengthening technical and operational expertise is needed.

Key discussion points
- Whilst an L3 declaration is useful in mobilising resources, limited partner capacity remains a significant constraint. Syria offers good examples of how engaging with non-traditional actors can enhance delivery and access. Partners discussed whether these lessons are transferable to other contexts where national capacity and private sector are much less developed.
- GHC should play a stronger internal and external advocacy role on behalf of country clusters like Syria and Central African Republic to secure resources and address issues which impede access to affected populations.
- Role of the Health Cluster in the Ebola response at global and country level and its links with other coordination mechanisms introduced via UNMEER/national governments has been unclear. Clarity needed on role and accountability of cluster in contexts where there is no-official activation but ‘cluster-like’ approach adopted.
- 66% of primary health care services closed in Liberia. What role does/should the health cluster have in maintaining non-Ebola health services during the crises and supporting wider recovery of the primary health care system?
- The IASC Cluster Coordination Reference Module clarifies the role of the cluster in preparedness. However this guidance has yet to be systematically addressed by the GHC and CHCs.
Key actions/recommendations
- GHC to support documentation of Syria approach and lessons learned.
- GHC to undertake partner capacity mapping exercise.
- GHC and Advocacy Task Team to develop an advocacy strategy and work-plan.
- GHC to clarify role in ongoing Ebola response and recovery process.
- GHC to map minimum preparedness actions undertaken by CHCs.

Session 4: Health Cluster Functioning (continued) – Lessons Learned

Lessons learned and preliminary findings were presented from an internal review and joint external evaluation respectively from two ECHO funded projects aimed at increasing health cluster capacity and performance. The projects are:

1. “Strategic NGO Partner Support for Health Cluster Strengthening” implemented by the SCUK and International Medical Corps NGO Consortium.
2. “Strengthening health sector performance in acute emergencies” implemented by WHO/ERM

Both projects focused on strengthening global surge capacity to enhance country cluster coordination and service delivery. In addition, the NGO Consortium assessed human resource capacity development needs to improve the performance of health cluster staff. The joint evaluation undertaken by WHO and the NGO Consortium also reviewed how the synergies between both projects could further enhance partnership. Findings are presented in summary below. Specifics for each project can be found in the presentations.

Key presentation points (refer to presentation # 7)
Presenters: Anna Oosterlink and Simone Van Dijk (Save the Children/NGO Consortium), Andre Griekspoor (WHO), Anne Golaz (WHO Consultant)

- Surge capacity deployed from both projects provided much needed added value to country health clusters particularly in the role of Cluster Coordinator at sub national level and Information Management Officer.
- Recruiting suitably qualified staff needs to improve mechanisms to identify suitable candidates, train, support and retain staff (see below Health Cluster Professional Development).
- Deployment process often complex and protracted. Greater clarity needed on the selection process. There is no ‘one size fits all’ surge deployment mechanism - a mix of deployment arrangements necessary to accommodate different organisational regulations.
- In situations where WHO cannot have a presence, NGOs staff can play a vital coordination role e.g. Health Sector Working Group in Gaziantep.
- Partnership working can be enhanced through greater clarity on management roles & responsibilities (including duty of care), system alignment, communication, resource allocation.

Key discussion points
- Challenges related to surge deployments experienced by other clusters – GHC should therefore learn about their solutions.
- Need to increase the capacity of health cluster deployed staff through re-vitalised Health Cluster training as part of wider professional development process.
- Alternative coordination solutions (at national and sub-national level) supported by the GHC and WHO should be more formally considered, not just where WHO presence is restricted.

Key actions/recommendations
- Based on lessons learned, a partnership approach should be expanded to strengthen health cluster coordination.
- NGO Consortium and GHCU to collaborate on developing continuation funding proposal for submission to ECHO.
- GHCU to explore additional approaches and funding to strengthen health cluster capacity.
Health Cluster Professional Development: Initial Findings and Recommendations

Key presentation points (refer to presentation # 7)
Presenter: Perry Seymour, NGO Consortium Consultant

- There is a lack of competent and deployable staff to fulfil key positions within the health cluster coordination team. They receive inadequate support and performance management is given insufficient attention.
- A comprehensive health cluster professional development strategy is recommended to address number of important, interlinked issues to improve recruitment, training, support and retention of health cluster coordination team staff.
- Key recommendations from the report to the GHC include:
  1. Provide guidance on minimum standard core health cluster team structure, terms of reference (TOR) for positions; development of health cluster competency framework; link recruitment of suitable candidates to HCC Induction programme and pathways framework.
  3. Development of a learning management and performance management systems.
  4. Retention and career development – review short term contracts, rotation system.

Key discussion points
- Partners discussed on whether developing local capacity for health cluster staffing is more sustainable and available.
- Job security is problematic as inadequate funding discourages suitable candidates from applying for positions.
- Complex and delayed administrative support services caused frustration among surge deployees (e.g. delayed transfer of salaries, contracts signed only after deployee is already in new duty station).
- There is a considerable disconnect between the level of professional development proposed and available resources. To have a well-functioning health cluster, requires the appropriate level of resources. Intention is to continue with the Save the Children UK /International Medical Corps Consortium initiative to support health cluster professional development and there are ongoing discussions with ECHO regarding follow-on funding. But also need to pursue funding from other sources. GHC partners agreed that partners should contribute to capacity building efforts more pro-actively (e.g. providing technical support).
- There are different opinions on whether being health cluster staff is a ‘career path’ due to the short term, emergency focus of their roles. However, the consensus was that professional development of cluster staff must be taken seriously – staff should be competent, well briefed, better supported and coached in their respective roles.

Key actions/recommendations
- Deliver updated Health Cluster training in 2015. GHCU to secure funding.
- GHC to address the 4 key recommendations outlined above, via the development of a Health Cluster Professional Development Strategy.
- Create a GHC Task Team to support strategy development, planning, implementation and necessary resource mobilisation.

Day 2 – Thursday 11 December 2014

Session 5: Working Group Discussions
Facilitated by Bobby Lambert

Below is a summary of the key points emerging from the working group discussions held on the 5 topics identified on Day 1 along with priorities identified for the 2015 work-plan, highlighted in italics.
Working Group 1 – Resourcing Country Clusters

What is needed from the GHC in 2015?
- Cluster building – embedded into health response
- Develop Health Information Management manuals and training tools
- Develop SOPs with guidance on funding for country clusters (e.g. tips on donor priorities)
- Guidelines for advocacy
- GHC to provide accountability guidance for partners
- Technical support for country cluster teams
- Standby resources (money and people) – for emergency response
- Training for clusters
- Transparency in recruitment – on website
- Better communications between GHC and country clusters, both formal and ad hoc

Working Group 2 – Health Cluster Professional Development

What is needed from GHC in 2015?
- Refine and agree what is required from HCCs (e.g. job descriptions, skills required, training needs)
- Every HCC to be offered training on annual basis – not a one size fits all training
- Health Cluster Guide – to include HC development
- Map and follow up on existing staff
- Promote pre/post mission briefing/debriefing
- Develop ‘community of practice’ – e.g. meetings just for HCCs, online, portal

Working Group 3 - Advocacy

What is needed from GHC in 2015?
1. An active Advocacy Working Group (AWG). Draft TOR existed from 2014. People in the breakout group on advocacy have agreed to be part of advocacy WG – anyone else welcome to join. (GHC Unit)
   - Action: Revise TOR for AWG
   - Action: AWG to produce guidance note and SOPs
2. Develop process and advocacy triggers for global action country office. HC at country level/partners identify an issue e.g. a rapid onset/ outbreak, reviewing strategic plans, anniversary events, launch of a humanitarian appeal. (AWG)
   - Action: Develop triggers and pathways for advocacy initiative
   - Action: Gain support, endorsement, buy-in for advocacy initiatives from GHC partners
3. GHC coordination and amplification of messages with other clusters. (GHC Unit)
   - Action: Develop advocacy strategy (AWG): Internal to promote the needs within the GHC and country clusters; External to engage external stakeholders to support health cluster activities
   - Action: Develop advocacy strategy and work-plan for GHC
4. Advocate for more ‘advocates’ (AWG)
   - Action: Create AWG response group email
   - Action: Create/support a ‘surge team’ for advocacy

Working Group 4 – Identifying Gaps

What is needed from the GHC in 2015?
1. Lack of understanding of country health clusters at regional/global level. Establishing a focal cluster points at regional level may also be a possibility.
   - Action: Communicate clearly within WHO what the GHC is. Develop clear TORs of who does what where.
2. Human resource capacity gap
   - Action: Global partner mapping – identify strengths of partners (e.g. MSF has Ebola training).
3. Response gap - When a crisis happens, identify the response gaps in each domain.
   • Action: Finalise tools for HC to identify gaps. Train HCCs/IMOs/NGO partners on tools.

**Working Group 5 – Ebola/Surge Capacity**

**What is needed from GHC in 2015?**
1. GHC has to have a more acknowledged role in outbreak management working with other entities (GOARN) in WHO.
   • Action: Senior level WHO Directors and managers need to take this up with most senior level management to ensure this takes place.
   • Action: The role of GHC is to follow up and ensure this happens, get feedback on the outcome of this meeting and updates on the process.

2. GHC needs to map the predictable response capacity and expertise that NGO partners have.
   • Action: Undertake response capacity mapping among operational partners, need to bring the partners and donors together to discuss this. (How to do we incentivise this?)
   • Action: Identify gaps, develop plans to address; build capacity among those who are willing to respond but lack expertise/training – this includes MOH/Govt.
   • Action: Develop performance expectations/criteria among GHC partners, develop ethical foundation/develop code of conduct for GHC membership i.e. must adhere to international standards and best practice around medical interventions.

3. GHC can convene and precipitate a call for assistance when it is needed whether the cluster is activated or not.
   • Action: Elaborate coordination protocol when host country government does not want to activate a cluster.
   • Action: Acknowledge role of GHC to identify most appropriate coordination solution.

4. Develop Ebola standards of care/best practice
   • Actions: Currently no consensus of treatment – GHC should convene and play a role as part of the technical discussion on developing different models of care which are documented and shared so we have a range of working models that work in different circumstances.

5. GHC needs to assist with transition and recovery of health systems in Ebola affected countries

**Session 6: Developing the GHC Work-plan for 2015**
Presenter: Linda Doull, GHC Coordinator

**Key presentation points**
- During this interactive session, participants were requested to identify the priority activities for inclusion in the 2015 GHC work-plan, aligned to the existing strategic priorities.
- Activities could be selected from those undelivered in 2014, those identified during working group discussions and completely new activities where appropriate.
- Prioritization of activities should focus on those which will make the most immediate impact on country health cluster ability to effectively deliver their mandate in 2015.

**Key discussion points**
- Top priorities identified by participants were: developing advocacy strategy and guidance; developing health information manuals and training to guide implementation of tools; implementing recommendations of health cluster professional development report; improving accountability through clarification of cluster roles and responsibilities, developing a framework for monitoring, evaluation, accountability and learning; strengthening surge capacity; partner mapping and gap analysis; clarifying the GHC role in outbreak management; increased support to Ebola response (technical guidance; health system recovery); develop a GHC communication strategy.
- Need to look at easiest ways to have more “green” rather than “amber/red” action points.
- Reiteration that delivery of the GHC work-plan is a shared responsibility by all GHC members.
- The 2015 work-plan must have realistic costs identified.
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Key actions/recommendations
- Task Teams will be established to deliver a number of 2015 activities. Guidance on the formation and oversight of Task Teams is outlined in the draft SOPs. Each Task Team will have an agreed TOR and will regularly report to the SAG to ensure accountability. Task Teams will need to be supported to finish tasks and Task Team members need to be accountable and committed to achieve tasks and respect timelines.
- All GHC members will be requested to identify which activity (or more) they commit to support during 2015. This could include leading or participating on particular initiatives (including Task Teams, allocating staff to work with the GHCU and/or making a financial contribution).
- Outcomes from Task Teams must be rolled-out to country clusters with the support of GHC partners.

Session 7: Developing the next GHC Multi-year Strategy
Presenter: Linda Doull, GHC Coordinator

Key presentation points (refer to presentations # 8)
The GHC Coordinator presented the rationale for developing a multi-year, multi-donor funded strategy including effectively positioning the GHC within the global humanitarian context; providing strategic direction, measuring progress and the difference made and mobilising resources more effectively. Key components of the strategy and a roadmap for development were suggested.

Key discussion points
- Health Cluster Coordinators should be included in the initial SAG/GHCU brainstorming session in Q1, particularly as there is only one limited HCC position on the SAG.
- Participants questioned whether strategy development had to wait for potential changes in WHO as CLA resulting from the 25 January Executive Board meeting. The GHC Coordinator reminded participants of ERM Director’s earlier comment that the GHC partnership should continue to move ahead with development plans, recognising that GHC strategy discussions can inform future WHO/CLA engagement, whilst also being prepared to adapt itself to new approaches.

Key actions/recommendations
- GHCU to agree the strategy development timetable with the SAG by the end of January 2015.

Session 8: Closing Remarks

Dr Rick Brennan reiterated his earlier comments on the need for the GHC to be fit for purpose to more effectively support country health clusters deliver the mandate through strengthened partnership. He re-affirmed that this meeting signalled WHO’s commitment as cluster lead agency to invest in this process and the new ways of working required to deliver the GHC strategy and be held accountable. He thanked partners for their significant contribution to current L3s and Ebola response and their future commitment to the GHC. Thanks were extended to Mary Pack, IMC for her many years as Co-Chair of the GHC Core Group.
Evaluation of the Meeting

Evaluation of achievement of meeting objectives

Each participant was requested to complete a simple evaluation form rating the achievement of the meeting objectives. A total of 32 forms were received. Aggregated results outlined below, indicate that the meeting delivered satisfactorily on its objectives, with a mean of just over 3.5 for all objectives.

An additional group feedback exercise was undertaken to garner participant suggestions for future meetings, the main recommendations being to:

Keep: the diversity of participants including the participation of the HCCs; the revision of the work-plan and the organisation, the duration of the meeting.

Change: incorporate more NGO perspectives on cluster experience; discussions to be more strategic rather than information sharing; offer more background material on case-studies prior to the meeting and for the case studies to focus more on coordination issues. Other top suggestions included having more time for networking at the end of Day 1 and for a more in-depth lessons-learned session on country cluster experience.
### Annex 1: List of Participants

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<th>Focal Point Email</th>
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### Annex 2: List of Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>CHC</td>
<td>Country Health Cluster</td>
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<td>CERF</td>
<td>Central Emergency Response Fund</td>
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<td>CLA</td>
<td>Cluster Lead Agency</td>
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<td>CPM</td>
<td>Cluster Performance Monitoring</td>
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<td>ECHO</td>
<td>EU Humanitarian Aid and Civil Protection department</td>
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<tr>
<td>ERM</td>
<td>Emergency Risk Management and Humanitarian Response Department at WHO headquarters</td>
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<tr>
<td>FMT</td>
<td>Foreign Medical Team</td>
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<tr>
<td>GOARN</td>
<td>Global Outbreak Alert &amp; Response Network</td>
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<td>GHC</td>
<td>Global Health Cluster</td>
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<td>GHCU</td>
<td>Global Health Cluster Unit at WHO headquarters</td>
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<tr>
<td>HCC</td>
<td>Health Country Coordinators</td>
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<tr>
<td>HIMS</td>
<td>Health Information Management System</td>
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<td>IASC</td>
<td>International Agency Standing Committee</td>
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<td>IM</td>
<td>Information Management</td>
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<td>SAG</td>
<td>Strategic Advisory Group</td>
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<td>SOPs</td>
<td>Standard Operating Procedures</td>
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<td>TOR</td>
<td>Terms of Reference</td>
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<td>UNMEER</td>
<td>UN Mission for Ebola Emergency Response</td>
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