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Executive Summary
The Global Health Cluster (GHC) meeting, hosted by the International Federation of Red Cross and Red Crescent Societies (IFRC), was held 10-11 June 2010 in Geneva, Switzerland. The meeting brought together 70 participants and observers representing 20 out of 38 partner agencies in order to take stock of progress made and discuss the way forward for the Global Health Cluster in 2010-2011.

The GHC meeting followed a Health Cluster Coordinator Lessons learned workshop that was dedicated to collecting the lessons learned and recommendations from experienced health cluster coordinators in acute and protracted emergencies. These were from the cluster lead agency (WHO) as well as NGO partners. Seven HCCs participated in the GHC meeting to share their recommendations and to help guide the GHC in its strategic thinking.

The main objectives of the meeting were to:
1) Assess progress and provide direction for the Global Health Cluster's Working Group and Policy and Strategy Team;
2) Build common understanding of Global Cluster related issues and challenges;
3) Take stock of recommendations from the field (including Haiti discussion, HCC Lessons Learned Workshop and Cluster Phase II evaluation).

Recommendations from this workshop to the GHC included:
- Ensure further clarity and transparency in the allocation of funds
- Work together with cluster lead agency (CLA) to ensure institutionalisation of the cluster approach within CLA
- Develop Standard Operating Procedures (SOPs) for the implementation of the cluster
- Define the Human Resources needs of the HCC team (HCC and Information Management capacity) and ensure sustainable funding and deployment from the HCC roster
- Ensure mandatory pre-deployment briefing and post-deployment debriefing
- Increase focus on partners
- Define learning strategy including key participation of WRs, NGOs, partners and HCCs
- Continue with HCC trainings and ensure further capacity building and information sharing between experienced HCCs.

A complete list or recommendations is included as an annex to the report

The GHC meeting had a special focus on country level clusters, drawing from the experience of the response to the earthquake in Haiti, the outcomes of the Cluster Evaluation Phase II and the recommendations from the HCC Lessons Learned workshop. It is noteworthy that the outcomes from the three sessions echoed each other in calling for clearer linkages between the cluster and Humanitarian Coordinator; institutionalization of the cluster approach within Cluster Lead Agency and partners at Global, Regional and Country level; support from Global and Regional level to the implementation of the cluster approach at country level; the availability of a surge team in large scale emergencies.

OCHA shared the way forward for the support to the inter-cluster coordination at country level through inter-cluster diagnostic and support missions and encouraged the GHC to take an active part in these initiatives.

The participants were updated on the latest technical guidelines on Mental Health and Psychosocial Support (MHPSS) and Reproductive Health (RH). Both technical areas have recently produced and updated existing guidelines to be used by the health cluster in emergency situations.
The suggested areas of action and way forward for the GHC in 2010-2011 included:

- **Policy issues**
  - Increase the institutionalization within WHO and partner organizations (UN / NGOs / donors) addressing roles and responsibilities of HCC versus WR. Predicable funding mechanisms need to be established
  - Define ways of working with national authorities during different phases of an emergency. Identify how to ensure standards with partners/governments
  - What to do when national standards are not compatible with global standards
  - Increased support from WHO/HQ and WHO/Regional Offices for the initial Flash/CAP development for sudden onset crises.

- **Operational Issues**
  - Define methodology for engaging large number of partners: inclusions versus effectiveness; developing guidance on structure of cluster in major emergencies.
  - Develop SOP on cluster management
  - Deployment process of trained personnel

- **Management Issues**
  - Identify how to influence a process when it is obviously on the wrong path
  - In acute emergencies - GHC to automatically send in a review / support mission within one month and ensure follow-up of recommendations

- **Tools**
  - Develop SOP of the GHC for cluster assessment
  - Develop a framework for monitoring humanitarian health response

- **Guidance/technical support**
  - GHC to develop SOP for activation and accountability (including all stakeholders) to ensure that there is a HCC team established with enough support to adequately function within the scale of emergency response
  - GHC to contribute with in-country technical support (assessments, strategic planning)

- **Further research / evidence gathering**
  - Document what worked and what challenges were identified
  - Increase monitoring - information is key
    - monitor impact of training
  - Develop a framework of coordination and technical standards for initial phases of research and rescue, mass casualty management and field hospitals
  - GHC Mission to Haiti to review implementation of the Flash Appeal and Health Cluster work.

- **Recommendations of the HCC Workshop**
  - GHC 4 Co-chairs to develop a matrix and assign responsible entities and timelines for action and report.

Next Steps: The co-chairs of the GHC Working Group and the Policy and Strategy Team will review the workplan in the light of the recommendations from the HCC Lessons Learned workshop and the suggested areas of action brought up by the plenary. The workplan will be shared by all cluster members and will be finalised by end of July.
1. Introduction

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3) Take stock of recommendations from the field (including Haiti discussion, HCC Lessons Learned Workshop and Cluster Phase II evaluation).

The meeting was chaired by Johan Heffinck/ECHO and Linda Doull/Merlin on 10 June and Robin Nandy/UNICEF and Tammam Aloudat/IFRC on 11 June.

Opening plenary

The Global Health Cluster meeting opened with a welcome by Mr Matthias Schmale, Under-Secretary General of Development, International Federation of Red Cross and Red Crescent Societies (IFRC).

Mr Schmale reflected on the importance of coordination, good policies and guidance and the need for IFRC to be included in the coordination of health activities in emergency situations. The new position paper on civil/military coordination was welcomed as this area has become crucial with the increased presence of military forces in emergency settings.

Dr Eric Laroche, Assistant Director-General, Health Action in Crises, WHO gave opening remarks reflecting on the 5 years since the implementation of the humanitarian reform and the cluster approach since 2005. The health cluster is active in 26 country countries and there is a need to ensure that all partners at global, regional and country level understand the importance of the functions of the cluster. The Cluster Evaluation Phase II (CE2) concludes that the benefits of the cluster approach outweigh the costs and that there is potential for clusters to further strengthen coordination and improve effectiveness. The recent events in Haiti highlighted many issues on the cluster approach and raised the question, 'Should we always aim to coordinate all health actors in a major disaster or should we coordinate the major actors?' The Haiti earthquake underlined the need to further strengthen the link between global cluster and country clusters. Due to the massive destruction experienced, the coordination role was backstopped at the regional and global levels and the Global Health Cluster functioned as a key coordination point and source for information collation, sharing and analysis. This proved to be effective with partners cooperating and being part of the sharing of information – and with so many contributing to and implementing systems jointly agreed before the terrible situation arose. Dr Laroche expressed his wish for the GHC meeting to provide further clarity and guidance to improve policies and support for the country level implementation of the cluster approach.
2. Report back from the Global Health Cluster Working Group

GHC Working Group co-chairs' Ms Gillian O'Connell and Ms Patricia Kormoss reported back to the plenary on the progress made by the GHC Working Group since November 2009 and reported on outstanding issues.

Merlin presented findings from the ECHO funded project, ‘Effective NGO Participation in Humanitarian Reform Mechanisms; Maintaining Good Practices’, which aims at engaging more NGOs at country level in the cluster. A series of workshops were organized in 12 countries to provide an overview of the Humanitarian reform and the cluster approach and orientation of the GHC tools and resources to partners in the field. So far 245 individuals from 131 national and international NGOs have participated in nine country level workshops. One of the main findings from the Project is that even in long term cluster countries, there were large knowledge gaps on the understanding of the humanitarian reform and the cluster approach which can be readily addressed by holding information workshops for all partners. The Project also highlighted that due to issues of high turnover of staff at country level, workshops on the cluster approach need to be run regularly. The project report will be finalized by 13 September and then disseminated to the GHC partners.

An update was presented to the plenary on the planned Health Cluster training activities and the way forward for trainings. Three Health Cluster Coordinators trainings are planned in 2010. The Working Group (WG) proposed that the GHC organize a HCC training in Geneva for Geneva based partners, in addition to the HCC trainings that will be organized in the regions. The dates and venues for the trainings have been set: San Salvador, El Salvador 22-25 June; Geneva, Switzerland 20-24 September; Jakarta, Indonesia 18-22 October (the dates may be subject to change). The HCC training package has not been updated since the last training in Tunisia October 2009. The way forward is to move towards regional ownership of the HCC trainings to ensure that individuals with regional experience are trained. For further capacity building the trained HCCs will be encouraged to take part in management courses and trainings organized by WHO and partners to ensure more in-depth knowledge on crises management.

The WG has prepared a draft outline for an orientation package to be used in capacity building efforts at country, regional and global level. The outline will be circulated for comments and thereafter slides and speaking notes will be developed. The final package will be available for the public on the GHC website and all partners are encouraged to use the package.

The GHC WG will establish a task force to collect case studies on co-stewardship at national and sub-national level. The case studies will be used by the Policy and Strategy Team to develop guidance for cluster partners.

The IASC Sub-Working Group on Gender and Humanitarian Action has developed an e-training on core issues on gender and how it relates to aspects of humanitarian response, including the Cluster approach. The training provides the basic steps a humanitarian worker must take to ensure gender equality in humanitarian programming during an emergency. The Global Health Cluster agreed that the training should be recommended to all partners and be included in the standard curriculum.
The current status and next steps of the 'Tool for Monitoring the Implementation of the Health Cluster at country level' was discussed. SAVE UK, International Medical Corps, UNICEF, UNHCR and WHO formed a task force after the Nairobi meeting to ensure progress on the tool and its implementation. So far the tool has been piloted in Haiti, Yemen and Zimbabwe. The aim of the tool is to be a cluster management tool that provides a snapshot of the status of the implementation of the 10 functions. It was underlined that the functioning of the cluster and the response to an emergency are two different issues. The Tool in its current forms is not able to measure progress made. However, there was agreement that a cluster that is functioning well, increases the likelihood for a better response. The tool will be further refined during the next 6 months.

Key issues raised by the plenary:
Merlin was asked to share their participant lists from the NGO workshops with the partners' headquarters to ensure that the knowledge will be shared within the organization. Merlin was encouraged to prepare the report for publication to further share the outcomes from the workshops.

UNHRC requested that trainings and workshops provide consistent messages and explanations of the roles, responsibilities and mandate of all agencies.

In Nairobi, 2009, Ms Gillian O’Connell, Merlin announced that she would not continue to Co-Chair the Working Group as of June 2010. In April 2010, a call went to partners for expression of interest to take on the Co-Chair Role. Dr Chris Lewis from Save the Children answered this call and was nominated by the Working group to take over the role of Co-Chair. This was confirmed by the plenary and Dr Chris Lewis was welcomed to the position.

The Chair thanked Ms Gillian O’Connell for her engagement in the GHC and specifically to all of her work as co-chair of the GHC Working Group.


The co-chairs of the GHC Policy and Strategy Team, Ms Mary Pack, International Medical Corps and Dr Nevio Zagaria, WHO, reported back to the plenary on the progress made and the remaining challenges for the team.

An overview on the development of a strategy for the funding of the country cluster was presented. The Policy and Strategy team has developed a costing matrix for three main scenarios by scale of crises. This will serve as the basis for the strategy that will be developed during the latter half of 2010. The developed cost-matrix is in line with the IASC Task team’s work on resource mobilization estimations for the cost of a country cluster. Dr Heffinck underlined that the funding for the global clusters is finished. However, the donors might be willing to fund specific activities on the GHC workplan.

An update on the status of GHC position papers was presented to the plenary. The first position paper on user fees was finalized earlier this year and is available on the GHC website in English and French. The paper will be further disseminated and all HCCs will be asked to discuss the paper in their cluster meetings. For the position paper on Civil military, the team has defined the scope and the consultant is working on finalising the paper. The next paper will deal with Human
Resources for health humanitarian response - an outline is being finalized. The Policy and Strategy team revised Strategic Priority 3 to include the work of the Policy & Strategy team. The new strategic priority is 'Identify specific humanitarian health priorities, based on shared analysis, and coordinate global actions to address them (GHC position papers, aide memoires, strategic guidance), recommending related action'. The work on the aide memoires has not yet begun. The matrix of roles and responsibilities will be further developed after the Terms of Reference for the inter-cluster coordination group have been finalised. The Team is fully engaged in the PDNA/PCNA process, and will conduct a revision of Draft GHC Health Recovery Guidance Note of November 2008.

The draft position paper on civil-military coordination in humanitarian health action was presented for further discussion among plenary participants. The objective of the paper is to provide guidance to Health Cluster members on civil-military coordination between the health partners and military and civil defense partners in humanitarian aid. A research mission is planned to Afghanistan and Haiti to look at the health services and civil-military coordination and civil-military relation in acute emergencies. The draft paper will be further revised based on the feedback received from the Policy and Strategy Team meeting and the plenary and the next draft shared with the GHC by end of June.

Key issues raised by the plenary:

- The need for and the possibility of creating a rapid pool fund for establishing the cluster in acute emergency onsets.
- The low cost estimation for sub-national clusters due to expectations of NGOs to take on this responsibility.
- The funding scenarios are generic and there needs to be room for exceptional countries, like DRC where the cluster approach is considerably more expensive due to the number of sub clusters and the situation in country.
- Need to hire international P3 information manager or rely on national resources.
- Need for a surge team at the initial stage of an emergency and the cost for such.
- How the link between the Health Cluster Coordinator and the humanitarian coordinator/resident coordinator can be strengthened.

4. Assessing the health cluster performance in the humanitarian health response for Haiti 2010: from UNDAC to PNDA - the 10 functions of the cluster

Panel members: Anshu Banerjee, WHO; Muireann Brennan, CDC; Andre Griekspoor, WHO; Chris Lewis, Save the Children; Robin Nandy, UNICEF; Xavier de Radigues, HNTS

Dr Daniel López-Acuña presented the objective of the session and its panel members. The panel members all have experience from working in Haiti in the aftermath of the 9 January earthquake, either directly with the health cluster at national or sub-national level or to support assessments. The session's discussion on Haiti centered on the ten functions of the cluster and the aim was to share experience on ‘What worked? What did not work? and What is the way forward?’ in order to further learn from the crisis and ensure support to the country clusters in future emergencies.

Function 1 - Coordination mechanisms and inclusion of all actors within the Health Cluster and inter-cluster
The Haiti experience showed the need for a new approach to the coordination of health actors in a major emergency. The Health Cluster had more than 400 partners.

Some of the key challenges included:

- **Large numbers of agencies**
  - Many agencies have no experience of emergencies let alone the cluster system and often were only in-country for short time periods. This took too much time/focus of the HC coordination at the expense of the other partners.
  - Continuity of staff was a major issue
  - There was little time/ability to work on strategic issues initially until the establishment of the forum for strategic discussion.
  - Initial coordination was focused in PaP – communication with the sub-national was difficult
  - The agencies did not meet to discuss strategic issues of the response, which led to confusion within Port-au-Prince even after 4 weeks.
  - A solution was found using umbrella coordination - groups of NGO coordinated among themselves then sent one representative to the HC meetings
  - Information dissemination was problematic, which hindered the functioning and planning of the response.

Chris Lewis, Save the Children who was active as co-steward in the sub-national cluster in Jacmel, referred to the inexperience of organizations - many were lacking emergency and cluster experience. Due to the large number of organizations and the high turn-over of people, the Cluster had difficulties in moving away from basic information sharing to the development of guidance and strategies for health actors. When the sub-cluster system was implemented the large humanitarian health actors divided the town between themselves to ensure coordination and health coverage.

Dr Robin Nandy mentioned the problem with the high turn over of staff and the consequences for the functioning of the cluster. Many health workers who only came to Haiti for a few days attended the Health Cluster meetings which led to very high attendance of new arrivals at the Health Cluster meetings. This had the effect of turning the Health Cluster meeting into briefings for new comers rather than focussed strategic planning and gap filling meetings. The high turn over of staff had negative consequences for the functioning of the health cluster.

**Function 2 - Coordination with national authorities & other local actors**

- The coordination cell in the Government was handed over to WHO initially and later handed back to Ministry of Health
- Ministry of Health co-chaired all technical groups
- There was little if no Ministry of Health coordination, which resulted in duplication with other agencies
- DFID attended some clusters and found some were better than others. One of the problems was the need for assessments
  - Feedback was that initial clusters were information sharing not dealing with strategies.
  - DFID felt that having close and direct communication lines with Health Cluster from the beginning, increased their confidence in the information they were receiving.
• It was recognised that the HCC was NOT given the resources to do the job adequately.

• Dr Anshu Banerjee provided a snapshot of the Health Cluster's coordination with national authorities and highlighted the close link that WHO has with the Ministry of Health. The coordination of the response is under the President's office and the Minister of Health is co-chairing the health cluster.

Ms Deborah Baglole shared her experience as a donor being in contact with all clusters and noted that the information received from the different clusters varied in quality and in quantity. DFID received feedback on the clusters' performances 10 days after the earthquake and many clusters lacked the necessary leadership and the ability to convey information - with the result that donors' decision making was delayed.

**Function 3 - Needs assessment & analysis: including identifying gaps**

CDC felt that overall, the assessments failed. This was due partly because ACAPs implemented the assessment, using people with no emergency experience. The IRA was used but it was not adapted, as it was too long and no one was skilled enough to abbreviate it. The process was too convoluted and the final results of the IRA (which emerged too late) were used as a survey not as an assessment.

There was a major delay in sending teams for assessment support because the teams were blocked. If they had been allowed to go initially, they could have influenced the process and outcome and the speed of getting the results. The IRA should be focused on setting priorities not getting numbers.

PDNA attempted to build on humanitarian assessments in order to plan for recovery. There is a need to try to encourage partners to consider the short, mid and long term consequence of their actions (e.g. free care leading to bankruptcy of hospitals if not). The PDNA relies on the national systems. Prior to the earthquake this was weak – after the earthquake it was worse.

The interagency MISP assessment was carried out in 3 locations. This assessment highlighted that there were 5 different coordinators of the RH working group in the first month and there was weak coordination between the RH working group and the HCC. Although sub-national RH working groups are now functioning, this should have happened earlier. On the positive side, the Flash Appeal recognised the RH needs which helped ensure adequate funds for the response.

USAID expressed their frustration that the tools that had been developed (e.g. the IRA) were not used and within the health cluster, especially as there were many gaps in information (e.g. 4Ws), which made it unclear as to what was happening. There was no time dedicated for sampling and the IRA guidelines were not followed. The Health Cluster did not receive the resources needed to carry out the coordination work. Dr Muireann Brennan and Dr Xavier de Radigues called for a discussion on the process of using the IRA.

The Health Cluster provided information for the Post-Disaster Needs Assessment (PDNA). All agencies should be encouraged to integrate recovery into the humanitarian response. The Haiti experiences showed that the humanitarian stage was too long and the availability of free health care undermined the pre-existing private sector.

**Function 4 - Strategy development & planning, including: Community based approaches; attention to priority cross cutting issues; filling gaps**

• In spite of the challenges faced, addressing the strategic needs could have occurred more quickly. The GHC needs to look at this, find solutions and offer guidelines on how to bring together the Cluster, keeping the important role of information sharing as well as developing strategy.

• The increase in numbers of working groups resulted in increased number of meetings. If a strategy had been in place earlier, this could have obviated poor interventions (e.g.
immunization campaign). This highlighted the need for strong strategy as well as the application of standards.

- Success was achieved with the creation of a smaller group (week 3-4) with 5-6 organizations to work on the strategy development. This was a reaction. Maybe GHC needs to be proactive and advocate for this through guidance.

- After action on Haiti is warranted. There is a need indicated for looking at inclusiveness versus effectiveness. Appropriate modalities should be put in place.

The Flash appeal included reproductive health but it should have been better integrated in the health cluster. Reproductive health meetings and a working group on gender based violence began after a few weeks but there was little communications between this group and the overall Health Cluster meetings.

Further discussion by the GHC on the need for working groups in large scale emergencies is needed. The major challenge in large scale emergencies is inclusiveness versus effectiveness, the HCC involvement of key actors for strategies in Haiti evolved out of necessity and this approach needs to be taken into consideration for the future.

**Function 5 - Contingency planning (and preparation)**

- ICC process initiated contingency planning and preparedness and CLA were asked to work on this with line ministries

- The HC went back the 2009 plan and updated it. HC went through all areas and identified lead agencies for each to take it forward.

Dr Anshu Banerjee underlined that contingency planning is important before entering the rainy season.

**Function 6 - Application of standards**

- **Injury management**

  The number of amputations depended on the type of agency responding. The short term agencies had much higher numbers of amputations. This could be due to the lack of experience and training in injury response in emergencies. We need standards and protocols for injury management in emergencies including earthquakes. It was noted that the number of amputations has depended on the surgery teams - those with more humanitarian experience and staff that stayed for longer periods had considerably lower numbers of amputations. Questions have been raised around code of conducts and application of standards in emergencies.

- **HIV**

  There are no standards within all clusters. Therefore it is unclear as to who is responsible for what. We need to work to ensure that roles are clarified and integrated in all clusters. The question was raised regarding the lack of standardization of HIV/Aids interventions. The division of work is not clear among the clusters and the creation of a sub-cluster should be avoided.

- **Mental Health**

  - Only two agencies were providing mental health care

  - Very difficult to work and to achieve the SPHERE standards due to the constraints faced in Haiti.
Function 7 - Training and capacity building

- Inter-agency collaboration between Health and Nutrition was strong.
- Training aspect in general was not strong.
- MHPSS offered a good induction session. This was linked with other countries and focussed on priority areas. It could have been extended for other areas.
- The Haiti Red Cross did much community based capacity building. They focussed on the national volunteers who were very quickly trained as well as Training of Trainings including work on health promotion, immunization.
- Some agencies, such as IRC did some training though more is needed. The degree of training should be improved in order to work towards higher adherence to standards.

IFRC’s capacity building efforts started early on, working with partners to train people on epidemic control, organize training of trainers and using mass SMS for massive public health campaigns.

Function 8 - Monitoring and reporting,

- There was very little consistent monitoring, which can be directly linked to the lack of support for the HCC.
- MOH was using a paper based system for reporting, which resulted in a loss of data.
- Two reporting formats were offered (one word and one excel file) on the one response, resulting in confusion.
- Too many people were trying to monitor – all on different formats for different audiences.

Monitoring and reporting has been unsatisfactory as the HCC and the health cluster had limited resources and did not get the necessary support.

There is a need for a standardized reporting system. The pre-earthquake system used by the MoH was paper based and was destroyed. The Health Cluster circulated forms for the partners to complete to track who was doing what, where, but the compiled information was never shared with the partners.

Function 9 - Advocacy and resource mobilization, including reporting

- Assistance offered by Health Cluster from HQ and PAHO initially was extremely helpful / useful for partners on the ground that.
- Having the Global Level Coordination initially was very helpful until the systems got set up within country.

Function 10. Provider of last resort

WHO had excellent opportunities to play provider of last resort due to its close relation with the Ministry of Health.

5. Haiti Real Time Evaluation - summary of findings

Dr François Grunewald presented a summary of the findings from the Haiti real time evaluation.
• The experience from Haiti calls for a paradigm shift in camp management as an urban crisis of this magnitude is different from previous experiences. The hurricane season will destroy the temporary settlements and it is crucial that the UN agencies take their responsibility and provide shelter for the population. The urban-context of the catastrophe urges us to rethink aid.
• The Haitian economy relied on micro finance systems and it needs to be restored in order to have a functioning economy.
• Organizations are giving food aid and free health care but it is crucial to consider the economic sector so there will be a functioning market when the organizations are pulling out. Due to the provision of free health care after the humanitarian phase of the emergency, pre-existing health facilities are facing severe financial difficulties, so there is an urgent need to deploy health economists to assess the situation. In addition, numerous Haitian health workers are leaving the country and this brain-drain needs to be discouraged.
• Organizations have sent highly qualified staff members but they have not considered the language requirements. The cluster meetings have been held in English which have excluded the national counterparts from participating.
• Staff have been sent in on short missions, working and living in very difficult conditions and they have received little or no support when returning to their duty stations.
• Guidelines for donating medical equipment and medicines were not followed, with the result that WHO and partners had to make considerable efforts to ensure safe disposals of large quantities of unwanted donations.
• Many clusters and sub-clusters had problems working with the national authorities. This was not the case for the Health Cluster, since the Cluster lead agency had close connection with MoH and involved the MoH actively in the cluster. WHO supported national authorities by providing them office spaces.
• There is a need for first-aid training courses for Haitians. Many died the first night of bleeding since people had no basic first-aid skills.
• Need to set up a surveillance system.
• The biggest post-emergency disaster was the absence of post operational care.
• The security situation made many agencies risk-aware and imposed curfews for their staff members at 5 pm, with the result that work was shut down early in the evening.
• Daily meetings at the peak of the crisis and thereafter, weekly, are key for a functioning cluster.

Dr Grunewald encouraged everyone to reflect on why the Health Cluster did not have the adequate resources and what should have been done to help the cluster.

**Key issues raised by the plenary:**

Better management of post operation care, the gaps in the referral system and the lack of post-operation care, all need to be tackled by several clusters. In Haiti the lack of post-operation care resulted in patients needing additional interventions.

The responsibility of triage of patients should not be left to one person in an emergency.

There was a lack of institutionalization and not enough acceptance and knowledge of the cluster approach at country and regional level.

There is a need to ensure that UNDAC and global clusters have an ongoing dialogue in the humanitarian phase.
The IRA failed because the cluster was overwhelmed and lacked technical expertise. The personnel who did use the IRA were not trained and did not have the Public Health background that is necessary to get adequate results. Cluster partners need to be ready to send technical expertise to support the process.

More guidance is needed on coordinating large acute emergencies. There is a need for change of direction of responses to large scale, sudden onset emergencies. It is essential to have a package of tools, guidelines for coordination of massive casualties and clear processes established. These exist in theory but have not been fully accepted and institutionalized. We need to abandon thoughts of a perfect assessment tool for the first period and have a more rapid tool. The lack of coordination was not due to the lack of money but to lack of processes and management. The question of why it was impossible for the HCC to work and to carry out its tasks needs to be asked and answered.

It is important to acknowledge what went well in the Health Cluster response and examine the successful case studies. There is a need for clear standards and benchmarks to evaluate the performance of the response and see from an academic point of view what can be improved.

It is important to prepare the ground by training and capacity building and mapping of partners before an emergency strikes – as well as to prepare the population for emergencies.

The right processes were identified but the Health Cluster and partners were not ready to implement them. Processes, acceptance and increased institutionalization need to be in place so that experts can travel to an emergency.

The UNDAC assessment that was done in the first week after the earthquake provided good information. Support from the global level was positive in the revision of the flash appeal.

6. Report back from HCC Lesson Learned Workshop - Implications of the findings and recommendations for the Global Health Cluster

The session was facilitated by Dr Chris Lewis, Save the Children UK; Dr Anshu Banarjee, WHO Albania; Dr Kosi Ayigan, WHO DRC; Dr Ahmed El Ganainy, WHO EMRO; Dr Ribka Amsalu, Save the Children USA, Hyo Jeong Kim, WHO Nepal. They reported back on the outcome and recommendations from the Health Cluster Coordinator Lessons Learned workshop 7-8 June in Geneva.

The objective of the workshop was through peer sharing, to collect lessons learned and good practices from experienced Health Cluster Coordinators and include these in the HCC training curriculum and country level workshops and missions.

The GHC Working Group, Health Action in Crises and WHO's Regional offices put forward candidates for the workshop and 26 past and present HCCs participated from WHO's six regions and partner NGOs. These represented a pool of experienced coordinators. The facilitator interviewed the majority of the participants prior to the workshop to better inform the basis of discussion.
**Recommendations to the GHC and lessons learned from the HCCs included:**

**Lessons learned and good practices**
- Transparency in the allocation and decision making process of pooled funds is essential
- Cluster Coordination requires a **HCC team** including IM capacity
- Health Cluster Guide is useful in some contexts. It is used and appreciated by both HCCs and partners
- Country health clusters need to define the task before choosing the tool
- HCC training has been valuable and should be part of broader learning strategy with increased involvement of partners and be a pre-requisite for pre-deployment
- Partners are providing briefing and debriefing with value for the deployed individual, the organisation and the cluster. The CLA appears to be weaker in this regard

**Bottle necks and constraints**
- The cluster approach is **not yet fully institutionalised** within the CLA and its partners in the GHC
- **Slow release of funds** channelled through the CLA and **inadequate funding for cluster coordination** both undermine the cluster approach

**Recommendations - strategic**
- GHC to work with the Cluster Lead Agency (CLA) to **ensure the institutionalization of the cluster approach** within CLA,
- Recognize the **key role of WR (HWCO)** in supporting the Health Cluster Coordinator;
- Develop **SOPs** for the implementation and management of the cluster
- Decide on the **level of decision making** depending on the scale of emergency
- Ensure all GHC members (including donors) encourage **country offices to strongly support the cluster approach**

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

**Funding**
GHC to:
- Establish generic TORs for the roll out of country health cluster steering committees for allocation of funds

CLA to:
- Ensure an agreed, transparent, rapid and “light” system for the channelling of funds (e.g. CERF) to partners.
Preparedness, briefing and debriefing

CL regional and country offices to:
- Produce country awareness raising programme on the role of the health cluster (for CLA, partners, government)

CLA Regional and country offices to:
- Prepare pre-deployment briefing packages & mechanisms for the HCC team members

GHC to:
- Develop standard procedures for post deployment debriefing of the HCC team members

Other recommendations:
- There needs to be an increase of focus on partners, with a specific suggestion to add all the GHC partners' logos on the health cluster guide to show inclusiveness and accountability.
- The request for the GHC developed tools should come from the country and not be imposed by the headquarters or the regional office.
- Donors are requesting different data against different indicators and there should, ideally, be one standardised reporting form
- Lessons learned workshops to be organized annually.
- Ensure information sharing between cluster coordinators at country level and also between cluster coordinators and headquarters.
- The Workshop participants stated that the HCC should be reporting directly to the Humanitarian coordinator and that the linkages should be strengthened.
- The Global Health cluster should visit the cluster when large scale emergencies happen, use the monitoring tool or a checklist to see with the WR what support can be given and ensure involvement of all levels of the organization to make sure recommendations are enforced.

Key issues raised by the plenary:
- The plenary suggested that the recommendations made during the workshop should be put in a matrix and brought forward by the GHC.
- The headquarters and regional offices need to work more closely together to support the cluster.
- The use of the suggested Health Cluster core indicators should be advised to ensure standardised reporting.
- It is noteworthy that the outcome of the Lessons Learned workshop and the session on Haiti (10 June) echo each other.
- Recommendations made are for both the cluster lead agency and the cluster partners to consider and/or implement.
- DFID welcomed the feedback on the CERF, bottle necks and constraints.
- USAID and DFID expressed their interest in bringing donors together to develop and support a standardised reporting for the organizations working in the cluster.
- Suggestion to do an evaluation of the functionality of the cluster one month into the response.
- The GHC meetings should always have a component of lessons learned from the field.
- The GHC should create alumni to enable HCCs to share experience.
- More training is needed for WRs and MoH on the Humanitarian reform.

Dr Grunewald presented the main findings and recommendations from the Cluster Phase II Evaluation and the issues of relevance for the health cluster. The evaluation was carried out by eight people with different expertise and experience. The team evaluated the 11 clusters at global and country level and made six country case studies. The findings show that the cluster system has managed to avoid duplications in the response - however it is a work intensive exercise. In countries where the clusters are functioning badly, the larger non-UN stakeholders have withdrawn from participating in the cluster since they do not want to loose time. The country clusters have a focus on large international organizations and use English as the communication language and the internet to share information. This has implications for the participation of smaller national NGOs in the cluster. When implementing the cluster at country level, the existing coordination mechanisms should be identified and the cluster should link with these. The cluster should refrain from creating costly layers. Each time the clusters have tried to apply external standards, it has failed. The national standards and strategies need to be taken into account. Where there are no national standards the cluster can help develop these. The health cluster has an advantage since it is working closely with the national authorities.

Mr Grunewald suggested that the cluster should alternate the cluster meetings on strategy with capacity building exercises and trainings since many organizations are lacking expertise in key areas of work. The clusters are often thinking vertically but they need to take into consideration the cross-cutting issues too.

Since health is a life saving intervention and therefore receives CERF grants, the health cluster has often the capacity to play the provider of last resort. Experience shows that many Resident Coordinators are not interested in the humanitarian action and this is a challenge in some countries.

The danger for the cluster is to focus mainly on funding and access to funds. It should instead focus on strategy, technical expertise and standards.

The key for the future of the cluster system is a strong OCHA which takes on its responsibilities.

Different clusters should encourage the funding agencies to give more time to evaluations on the field. The first cluster evaluation showed that the humanitarian reform clearly was a UN lead reform and even though the non-UN organizations have become more involved, this remains a perception.

Key issues raised by the plenary:

Concern was raised regarding the recommendation number six (Resolve outstanding policy issues at global level: links to peacekeeping and political missions and humanitarian space; institutional issues) and the simplification of the description of the relationship between UN and cluster. The integrated mission has not been mentioned in the cluster evaluation.

Concern was raised that the recommendations are not looking at any positive aspects. All recommendations are negative but there should be some focus on the positives and progress made.
The time given for the evaluation was very short. The report that was circulated was too closely linked to funding. Before carrying out health activities you have to deal with national standards.

8. Inter-cluster coordination

Ms Rachel Quick, OCHA, opened the presentation by expressing her delight at the recommendation for a stronger OCHA as the recommendation is a support to OCHA's mandate. The inter-cluster support missions started in an ad-hoc manner to support the inter-cluster coordination at country level and have now evolved to strengthening the ties between the clusters and the Humanitarian Country Team (HCT). So far, missions to Sudan and Pakistan have been conducted. The up-coming missions to Nepal and Colombia have been requested by the Humanitarian Coordinators in respective country. Requests for missions have also been made to Afghanistan, Niger, occupied Palestinian Territory, Yemen and Zimbabwe.

Specific Terms of Reference for each mission should be agreed in advance, in consultation between the HC, HCT, OCHA, Cluster Coordinators and other relevant stakeholders at the country level and with Global Cluster Lead Agencies and OCHA at the global level. The people coming on the missions are representing the mission not its lead agency.

Suggested action points/recommendations from the mission should ideally be produced before the mission leaves the country and in consultation with the requesting HCT. Suggested action points/recommendations should be practical and realistic, taking account of the funding situation in country. They should be addressed to particular stakeholders with suggested time-frames for action and with an indication of how results might be monitored and measured at the global and country level.

Key issues raised by the plenary:
WHO reaffirmed their support for the inter-cluster processes and missions.

It is important that the suggested recommendations be acted upon as the support missions tend to become information sharing and no real action is generated after the team has left the country - because the CLA on the ground do not see the added value of being part of an inter-cluster coordination mechanism.

9. Technical focus: Reproductive Health

Ms Wilma Doedens, UNFPA, introduced the new Inter-agency Field Manual on Reproductive Health in Humanitarian Settings. The purpose of the tool is to:

- serve as a tool to facilitate discussion and decision-making in the planning, implementation, monitoring and evaluation of RH interventions;
- guide field staff in introducing and/or strengthening RH interventions in refugee situations, based on refugee needs and demands and with full respect for their beliefs and values
- Advocate for a multi-sectoral approach to meeting the RH needs of refugees and to foster coordination among all partners.

What is new?
- Significant technical updates
The tool is available online electronically and in a hard copy version.

10. Technical focus: Mental Health in crises

Dr Mark van Ommeren, WHO, presented a new product by the IASC Reference Group on Mental Health and Psychosocial Support (MHPSS), titled, 'What should humanitarian health actors know?'. He stated that mental health is on the agenda in many large crises and that there are both inter-sector policies (IASC 2007) and health sector policies (IASC Reference Group, 2010) regarding the inclusion of mental health and psychosocial support in an emergency response. MHPSS is also integrated in Global Health Cluster products. Agreement has been reached on coordination:

- To have ad-hoc inter-cluster coordinating/working groups on MHPSS in emergencies with numerous MHPSS actors;
- There are to be no separate MHPSS Cluster and no separate MHPSS chapters in Appeals;
- There is Health Cluster accountability for mental health care in health sector activities.

In Haiti the MHPSS is a cross-cutting working group under health, protection and education clusters. Dr Ommeren presented the different tools and guides that have been developed or are under development:

- WHO toolkit on MHPSS assessment and situation analysis by humanitarian health actors
- Development of a guide on basic psychological support (psychological first aid) to replace “debriefing” (WHO, WVI & WTF, forthcoming)
- Inclusion of necessary psychological topics in Inter-agency Emergency Health Kit (2010) (Amytriptyline, haloperidol (in tablet), benzodiazepines (in tablet), phenobarb.)
- Evidence-based guidelines on management of mental, neurological and substance use disorders in development settings, approved by WHO Guidelines Review Committee (2009)
- Package on integrated management of mental, neurological and substance use disorders in development settings (cf IMCI) with modules on: psychosis, moderate/severe depression (handout), epilepsy, behavioral disorders (children). (forthcoming in 2010)
- Guide on M & E (to be conceptualized/developed)

Suggestion was made to include more information in the GHC guide on all cross cutting issues, including MHPSS, and to do more advocacy for MHPSS.

11. Summary of Priority Activities of the GHC 2010

Dr Daniel López-Acuña gave an overview of the funding situation and the activities and staff that are mainstreamed within the cluster lead agency's workplan and budget. He pointed out that very little of the ECHO donation to the GHC remains and that the priority activities need to be identified and funded by partners and WHO in a joint effort.

The suggested areas of action included:

- Policy issues
Increase the institutionalization within WHO and partner organizations (UN / NGOs / donors) addressing roles and responsibilities of HCC versus WR - predictable funding mechanisms need to be established
Define ways of working with national authorities during the different phases of an emergency. Find ways to ensure standards with partners/ governments
Identify what needs to be done when national standards are not compatible with global standards
Initial Flash/CAP development could be done via Global Health Cluster with input from WHO/HQ and WHO/Regional support while the country cluster is established

• Operational
  - Define methodology for engaging large number of partners – consider implications of inclusions versus effectiveness – develop guidance on structure of cluster in major emergencies.
  - Develop SOP on cluster management
  - Establish a deployment process of trained personnel

• Management
  - Ensure effective decision making processes
  - Determine how to influence a process when it is obviously on the wrong path
  - In acute emergencies - GHC to automatically send in a review / support mission within one month and ensure follow-up of recommendations

• Tools
  - SOP of the GHC for assessment
  - Framework for monitoring humanitarian health response needs to be developed

• Guidance/ technical support
  - GHC to develop SOP for activation and accountability (including that of partners) to ensure that there is a HCC team established with enough support to adequately function within the scale of emergency response
  - Ensure consistency of information
  - GHC to contribute with in-country technical support (assessments, strategic planning)

• Further research / evidence gathering
  - Document what worked and what challenges emerged
  - Increase monitoring - information is key
    • monitor impact of training
  - Develop a framework of coordination and technical standards for initial phase of research and rescue, mass casualty management and field hospitals
  - GHC Mission to Haiti for mid-term review of the Flash Appeal and Health Cluster work.

• Recommendations of the HCC Workshop
  - GHC 4 Co-chairs to develop a matrix and assign responsible entities and timelines for action and report.

Next Steps: The co-chair of the GHC Working Group and the Policy and Strategy team will review the workplan in the light of the recommendations from the HCC Lessons Learned workshop and the suggested areas of action brought up by the plenary. The workplan will be shared by all cluster members and will be finalised by end of July.

12. Next meeting

Due to financial constraints it had been decided at the GHC meeting in November 2009 to move from biannual to yearly meetings. This decision was revisited and suggestions were made to
either have nine-monthly meetings with the implication that the next GHC meeting take place in February 2011 or keep to the decision with annual meetings - the next in June 2011 - and have the GHC WG and Policy and Strategy Team meet in November. Suggestion was also made to hold the next meeting in conjunction with the World Congress of WADEM in Beijing May 2011. GHC will look into the practicalities and the financial situation and a final decision will be circulated to all partners.

13. Meeting Closure

Dr Daniel López-Acuña closed the meeting, thanking all the colleagues for their participation and the considerable work that everyone contributed during the meeting and pre-meetings. He gave a special thanks to all the Health Cluster Coordinators who attended and shared their experiences. The GHC is trying to be a learning mechanism that wants to review, take stock and learn and it is important to continue with this objective. He encouraged everyone to continue to think more collectively.
Annexes

Meeting Agenda
Participant list
Map of Health Cluster Coverage

Report back from the GHC Working Group

*Background documents:*
GHC workplan

Tool for Monitoring the Implementation of the Health Cluster

Different needs - Equal opportunities - Increasing Effectiveness of Humanitarian Action for Women, Girls, Boys and Men. An E-Learning Course

*Power point presentations:*
ECHO Effective NGO Participation in Humanitarian Reform Mechanisms: *Maintaining Good Practice for Cluster Partners*

Report back from the Policy and Strategy Team

*Background documents:*
GHC workplan

GHC Position Paper on User Fees for primary health care services during Emergency/ Humanitarian Crises

Draft Position paper on Civil-Military coordination

GHC Strategic Framework

*Power point presentations:*
Policy & Strategy Team Presentation

Civil-military coordination in humanitarian health action - Position Paper

Assessing the health cluster performance in the humanitarian health response for Haiti 2010: from UNDAC to PNDA - the 10 functions of the cluster

*Background documents:*
Matrix of Roles and Responsibilities

Haiti Real Time Evaluation - summary of findings
Background documents: The Health Response in Haiti after the earthquake - some food for thought


Report back from HCC Lesson Learned Workshop

Power point presentations: Health Cluster Coordinator Lessons Learned Workshop 7th & 8th June 2010

Cluster Phase II Evaluation: Findings and Recommendations for the Health Cluster

Lessons Learnt of the Cluster 2 Evaluation Process
The Health Cluster in Retrospect
Suggested reading: Phase Two Cluster Evaluation Framework http://tinyurl.com/2vl4hnm

Inter-cluster coordination

Background documents: Suggested Action Points arising from workshops and interviews during inter-cluster support mission to Pakistan
Proposed matrix with mission recommendations, accountabilities for follow up and timeline for activities - Joint Global Health Cluster Mission, Yemen April - May

Technical focus: Reproductive Health

Background documents:
Inter-agency Field Manual on Reproductive Health in Humanitarian Settings (to be downloaded from http://www.iawg.net/IAFM%202010.pdf)

Power point presentation:
The Inter-agency Field Manual on Reproductive Health in Humanitarian Settings

Technical focus: Mental Health in crises

Background documents:
MHPSS - What should humanitarian health actors know? http://tinyurl.com/2uft5hm

Priority Activities of the GHC 2010

Background documents: GHC workplan 2010, GHC Strategic Framework