Health Cluster Co-ordinator
Lessons learned workshop

Workshop Report

Geneva, Switzerland
Monday 7\textsuperscript{th} & Tuesday 8\textsuperscript{th}
June 2010

Timothy Foster
Co-facilitator
1. Executive summary

2. Workshop outputs
   - Summary of issues identified by participants in pre-workshop interviews
   - Participant expectations
   - Lessons learned and good practices, bottlenecks and constraints
   - Recommendations presented to Global Health Cluster meeting
   - Participants presenting to Global Health Cluster

3. Evaluation and recommendations for future workshops
   - Day 1 – the workshop so far
   - Day 2 – the workshop as a whole
   - Co-facilitator’s recommendations for future HCC lessons learned workshops
1. Executive summary

A two-day lessons learned workshop was held for Health Cluster Coordinators (HCCs) on 7th and 8th June in Geneva. 26 past and present HCCs participated, 22 from WHO’s six regions and four from two NGO members of the Global Health Cluster.

Prior to the workshop, the workshop facilitators contacted the participants by email and phone to identify key issues to consider during the workshop, see Summary of issues identified by participants in pre-workshop interviews.

At the start of the workshop, participants were asked to share one expectation of the workshop, see Participant expectations.

In subsequent sessions on Day 1, participants considered the different phases of an emergency response focusing on: pre-deployment issues, establishing the cluster, managing the cluster and post-deployment issues; where time permitted exit/handover of the cluster was also be considered.

The participants:
- Identified the lessons learned and good practices on the one hand, and bottlenecks and constraints on the other, see Lessons learned and good practices, bottlenecks and constraints.
- Formulated recommendations to imbed the former and overcome the latter.

On Day 2, the participants considered the relevance and pertinence of the:
- Health Cluster Guide
- Global Health Cluster tools
- Health Cluster Coordinator training courses and in-country workshops and missions

The sessions were organised in such a way that a proactive interaction from the participants was encouraged. Resource persons informed participant discussions rather than delivering formal presentations.

The participants presented their recommendations and findings to a panel comprising the co-chairs of the GHC working groups and other selected resource person at the end of the first day and before finalising their recommendations on the second day.

In the final session of the workshop, participants:
- Reviewed and finalised their recommendations which were regrouped and edited the next day by the workshop facilitators and participants attending the Global Health Cluster, see Recommendations presented to Global Health Cluster meeting.
- Agreed how to present their recommendations to the Global Health Cluster meeting later in the week, see Participants presenting to Global Health Cluster.

The participants would welcome feedback from the GHC on their recommendations and look forward to action on key issues.

The workshop was evaluated at the end of both days, see Evaluation and for the lead facilitator’s suggestions how to organise future HCC lessons learned workshops, see Co- facilitator’s recommendations for future HCC lessons learned workshops.

Further details of the workshop can be found in the as run version of the Workshop Team Pack.
2. Workshop outputs

**Summary of issues identified by participants in pre-workshop interviews**

The workshop facilitators:
- Contacted 33 experienced HCC to identify key issues
- Interviewed 12 by phone and received written comments from 4 more - 50% response rate! Very encouraging!

**Cluster approach**

**General**

Good pillar of humanitarian reform! But…..
- Designed for acute emergencies only?
- Can not achieve everything
- How can we make it sustainable?
- Whose agenda? UN or INGO?
- Internal politics of WHO!
- GHC lacks direct link with field
- “Provider of last resort” remains unclear

**What happens before and after the cluster?**

Cluster does not exist in a vacuum! But needs to relate to:
- Preparedness and contingency planning
- Pre-existing emergency and development coordinating structures

More work required on exit and handover

**Establishing the cluster**

**Government and ministries**

Relationship Cluster – Government important, but:
- Lack of understanding, coordination skills suspicion of cluster or vice-versa
- Need to highlight the three models, and who chooses which one to apply?
- Pre-existing WHO – Government relationship key
- Danger of cluster being pulled into internal MOH politics

**The battle of the organograms!**

The most number of comments by far!

Issues raised:
- HCC – WR relationship is key!
- Closely followed by relationship HCC, HC, RO etc.
- Emergency response requires speed and flexibility! Compatible with WHO’s “regular” structure?
- HCC is accountable to WR or Health Cluster?
- HCC represents Health Cluster or WHO?
- Double-hatting – difficult or impossible?

**Partners (first bite)**

International partners expect coordination! But:
- Field staff can lack understanding of cluster
- NGO viewpoint not always taken into account
- Need to communicate and demonstrate accountability to bring in wide range of partners
- Challenge of motivating partners

**Team & support**

Many comments!
• HCC needs a team, resources and support especially for IM
• Possibility to share workload with partners?

Managing the cluster

Meetings
• Coordination meetings are for strategy and policy or information sharing?
• Challenge of feeding partner information into defining priorities
• Need for working groups but can raise concerns about transparency
• Transparency essential in organising meetings and sharing responsibilities

Partners
HCC as “tough mother”, as “project builder”
Partners:
• Enormous range in terms of size, experience and length of involvement
• Military speak a different language
• Participation depends on service
• Need to adapt to prevent participation dropping off over time

Finance
(Raised here but will be discussed in greater detail on Wednesday)
How funds are channelled and managed is important, but:
• Pooled funds only used for UN!
• Inflexible and complicated financial systems can cause dangerous delays
• Transparency essential!

Pre and post-deployment
Major difference between WHO and NGOs
• Generally NGOs briefing and debriefing were rated highly
• Generally WHO’s performance was not so highly rated
• Need for SOPs for briefing and debriefing
• Importance of debrief for individual and lessons learned

Health Cluster Guide
Big thumbs up from HCCs and partners: especially for TOR, checklists, main functions, responsibilities etc!
To improve even further:
• Shorten by editing out duplication and redundancy
• Written for acute emergencies – but what about chronic emergencies?
• Ensure enough hard copies in the field – internet can be too slow!
• Not enough on monitoring
• Need to know and understand the guide before assignment as no time once there!
• How to ensure feedback reflected into future editions?

Health Cluster Tools
Tools need to be:
• simple and quick to use
• adapted to situation and time frame
• widely understood and accepted
• plug gaps not duplicate existing tools
• known and understood in advance
Health Cluster Coordinator training courses and in-country workshops

HCCT – positive feedback – especially in helping to understand cluster approach and funding and establish informal network

To improve further:
- Acute and chronic emergencies need different attitudes
- Importance of involving NGOs also possibly government and IM staff
- Target people who will be deployable
- RO and CO to adapt, run and follow up rather than HQ
- HCCs important audience but also WRs
- Less theoretical – more hands on
- More on IM tools

Other issues

Inter-cluster coordination and cross-cutting issues
- OCHA has key role in inter-cluster coordination but can lack capacity and resources
- Choice of country lead agency for each cluster has to be well done and promptly
- Inter-cluster coordination and cross-cutting issues need to be addressed in HCCT

Co-chairing/leading
Can work well, but needs further work:
- Very dependent on personalities
- Challenge can be political
- Can a non-UN agency lead the cluster and who can be an HCC?

Funding
Big issues – more discussion on Wednesday!
- Pool funding can work well where funds matched to capacity
- But how can coordination costs be covered?

Sub cluster
Needed from start in major emergencies – challenges:
- Maintaining good communication
- Understanding how they work and reporting lines
- Heavy workload and need for influence with the Government – NGO or WHO better suited?

Participant expectations
The top four headline expectations were:
- Understanding the Health Cluster at the global, regional, country, sub-cluster level
- Learning from, sharing and discussing with fellow participants
- Funding for coordination and partners
- Understanding WHO’s role as Cluster Lead Agency
## Lessons learned and good practices, bottlenecks and constraints

<table>
<thead>
<tr>
<th>Establishing the cluster</th>
<th>Managing the cluster</th>
<th>Pre and post deployment issues, exit/handover of cluster</th>
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<tbody>
<tr>
<td><strong>Lesson learned – Good Practice</strong></td>
<td><strong>Establishment of a Steering Committee to deal with procedures, prioritization, and fund allocation that reports back to the Health Cluster – improves transparency and managements of the cluster - help avoid perception of bias.</strong></td>
<td><strong>Pre-Deployment PHPD</strong></td>
</tr>
</tbody>
</table>
| **New 1e Step** | The more informed and supportive the WR – the better the cluster works. | • Training <cred> networks (HCC Coordination)  
  • Comdis Doc risk assessment  
  • Making most of in country resources ± know government structures  
  • WR trained  
  • Having worked in cluster  
  • Pre-briefing (R.O.) □ admin issues  
  • Hand-over notes overlap (Haiti)  
  • HCC - THA roles  
  • Lack of balance, understanding by WR. Line manager, "not my mandate"  
  • WHO country management  
  • NGO capacity (local)  
  • Howe to get help after  
  • Need commitment  
  • Donation  
  • Donor preferences |
| • Have meeting with WR + HCC + CO to ensure they understand what the cluster is and what is expected of everyone  
  • Have similar discussion with MoH | **Establishing Contact** | **Post-Deployment**  |
| **Establishing Contact** | **Contingency Plan - tapping it** | • Debrief at network (RO, NGO, stress) |
| • Pre-established relations + structures (protracted) / inside for coordination  
  • Willingness to be contacted + meet (acute) / outside  
  • Don't concentrate on friends / colleagues you know - reach out  
  • Establish link to OCHA  
  • Encourage CO to keep 4W before | • Keep updated / exist/ realistic / tested  
  • Instructions for implementing | |
| **Situational Analysis** | **Reach CCS (all newcomers)**  
  • Make sure CO + MoH fully involved in CCS development  
  • Get EHA highly involved in CCS - especially in protracted  
  • Watch media  
  • See baseline data | **In cases of large acute emergencies, the establishment of working groups with clear TORS that are time bound with specific tasks.**  
  • Co-ordination WHO-NGO strengthens the cluster – help avoid perception of bias – encourages further involvement of other NGOs.  
  • NGO leading the sub-groups and WHO the national cluster worked well. |
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<th>Talk to colleagues - all sectors</th>
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<tbody>
<tr>
<td></td>
<td>Usually info is available easily</td>
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<td></td>
<td>Use WR to make contacts (MoH, Disaster Management Authority)</td>
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<td>Start monitoring indicators</td>
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**First Meeting + 4W**

- WR chair + introduce HCC
- Clear agenda + time frame
- Invite all partners - national + international
- Objective: result oriented / program not process
- Don't explain the cluster, just get to work
- Do first meeting fast / immediately
- Establish info sharing system
- Prove added value of cluster lead agency (give info)
- Get contact details of all IRA / Lead Assessment

- Build consensus around process not tool
- Assign geographic areas
- Agree to small # of questions
- Focus on life-saving details

**EWARSNS**

- Review what surveillance system exists (including language + staff)
- Make sure MoH is on board
- If it doesn't exist, then define priorities for disease surveillance

**Logistics Support**

- First priority is lodging etc for personnel

Varying the location of the Cluster Meetings – co-chairing can help highlight that the cluster is about all partners – not just WHO.

The more involved the MOH – the stronger the cluster.

Joint advocacy and highlighting – giving credit to partners for work and gaps filled, strengthens the cluster.

Regular 1 to 1 meeting with partners increases the likelihood of involvement.
### Bottle necks and constraints

| **Lack of clarity on division of roles + responsibilities** (including between WR + HCC + MoH / government) |
| **MoH not accepting concept of cluster approach** |
| **Cluster approach not known in country or with Ministries** |
| **Clarity on objective of cluster meetings** |
| **Organizations who won't be involved in "cluster" (allergy to the word)** |
| **Small organizations who don't join cluster (many like in Haiti)** |
| **Refusal to share info** |
| **Struggling for government + others to accept cluster boundaries / or for cluster to fit into existing structures** |
| **Obsession with cluster label - (instead adapt + improve what exists)** |
| **Lack of dedicated IM staff** |
| **Dilemma of representing WHO or cluster** |
| **Government involvement when government perceived as perpetrators** |
| **Weak government** |
| **Humanitarian space (role of Ministry of Defence)** |
| **Institutional approach lacking (need WHO as 1 approach) - corporate response?** |
| **Process overshadowing community focus** |
| **Lack of clarity on accountability + reporting lines** |
| **Performance of WR (too weak or too strong (blocking)) - like on IM** |
| **No specific cluster budget (positive example in Pak)** |
| **Clarify accountabilities of HCC in cluster (A recommendation put in TOR reporting lines)** |

| Limited knowledge of the Humanitarian reform among partners (including MOH and head of agencies). |
| The close association of WHO with MOH |
| Difficulties with dealing with non-state actors. Scope of response and how to deal with non-state actors not always clear. |
| Conflict of interest of the HCC working for WHO – answerable to WR |
| Number of partners in the cluster – hard to manage – have strategic discussions |
| Keeping donor interest in protracted emergencies |
| RC-HC – not having full understanding of the humanitarian roles – and or not always giving enough focus to humanitarian issues. |
| No established link of communication between country, regional and Global cluster |
| The role of the Global Health Cluster is unclear |
| Lack of enough resources to build a team for the implementation of the 10 functions |
| Hard to always ensure the full involvement of partners such as ICRC, MSF. |
| No specified person to carry out assessments. |
| Lack of knowledge – training of how to use the tools. – no time for the HCCs to do it themselves. |
| Assessments are often carried out by individual agencies – with no coherence, ending with may small and different assessments not giving overall picture. Agencies do not discuss in health cluster |
| When rational policies and guidelines are not up to global norms or do not exist – how to bridge the conflict? |
| Development of emergencies needs compared to development – early recovery not always clear. |
| Strategic issues are not always adequately address in the cluster. |
| can be hard to address the different areas of |

### Pre-deployment

| **Timing deployment** |
| **Briefing package** |
| **Contract admin** |
| **No team** |
| **Support operational** |
| **Lack of training** |
| **Lack of funds** |
| **Confusion of roles WR - HCC - not knowledge** |
| **Profile - recruitment mismatch** |
| **Reporting to? WR - OCHA - HC** |
| **Beureaucracy** |
| **No deployment fund** |
| **Accountability** |
| **HCC - CLA - HC link. Level of decision making.** |

### Recommendations

| **Country offices should be briefed / trained on the cluster approach** |
| **Clear documentations of roles and responsibilities at all levels of the organizations WR - HCC (Revising the guide)** |
| **Institutionalisation of cluster approach from the DG / RD (MEMO)** |
| **Resources to ensure HCC + IM for at least 2 years (ADG)** |
| **Agreement on common package of tools for all country (RD)** |
| Mechanisms for acct. | interest/focus of the partners – (NGOs vs Donors vs UN Agencies vs MOH) versus the actual needs of the population. |
| WRs allegiance to MoH? | Monitoring of the cluster implementation not done |
| On Assessment: no clear agreed process for adaptation (2 hour meeting for example) - venue for discussions | No standard tool for monitoring. |
| Don't impose tools | Lack of resources – lack of resource mobilization specialist – (limited culture within WHO for resource mobilization). |
| Gathering + validating data | WHO capacity to implement (especially sudden on-set) not always there. |
| IRA too long (5 questions only!) | Target population (population in need versus donor constraints |
| Central focus - forgetting sub-national |  |
|  | • Technically we know what needs to be done – IDPs- host communities gaps but often restricted to smaller groups. |
|  | HCC not always having equal access to resources/ support with in WHO (drivers etc) can hinder work and role of HCC. |
|  | Partners working out of the cluster can be difficult. |
|  | Lack of humanitarian access can impede response |
|  | Dominance of other clusters (e.g. WFP) can reduce funds and focus of health needs |
|  | Lack of clear and agreed mechanism to handle cluster implementation especially with growing trend for pooled funding |
|  | • Lack of transparency in the distribution of funds, process prioritization, evaluation |
|  | Hard to provide funds to national NGOS – that do no meet international criteria |
|  | Lack of clarity between Cluster lead agency and OCHA |
|  | Slowness of project delivery due to slow distribution of funds |
|  | HCC reports back to WR and the working relationship depends on personalities not on process. |
Recommendations presented to Global Health Cluster meeting

Slide 1

Health Cluster Coordinator
Lessons Learned Workshop
7th & 8th June 2010

• First workshop of its type
• Held on the initiative of the Global Health Cluster
• 26 past and present HCCs from all six WHO Regions and two NGO partners
• Focusing on:
  – Lessons learned and good practice
  – Constraints and bottlenecks
  – Recommendations how to embed the former and overcome the latter

Slide 2

Lessons learned and good practice

• 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
Bottlenecks 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, in particular:
- 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 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

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Health Cluster Guide

GHC to:
• Increase the *focus on partners* including government in the guide and brand the guide accordingly
• *Involve partners* in the distribution and planned revision of the guide
• Ensure that the guide deals with both *acute and chronic emergencies*
• Work with other clusters to develop *common core content* for all cluster guides
Health Cluster Tools

Country Cluster to
- Review indicators and agree on what to measure, ways to collect data and which tools to use

GHC to
- Review the use of the GHC tools in countries where they have been used
- Define the process and resource needs to implement the GHC tools
- Identify and build links between the GHC tools and other tools developed by partners and other clusters
- Work with donors towards adoption of standard reporting format (with core indicators) for country implementation/reporting

Learning (1)

GHC to define a Learning Strategy which:
- Includes key participants: WRs, NGO and partners, HCCs, etc.
- Defines and develops competencies;
- Expands learning approaches and methodology;
- Enhances the sustainability of learning through follow-up, refresher training, coaching etc;
- Measures the impact of learning programmes and activities
Learning (2)

GHC & CLA to continue HCC training:
- RO to provide HCC Training as a prerequisite for deployment;
- **Refresher training** for active HCCs including focus on inter-cluster issues
- Hold regular HCC Lessons Learned workshops (yearly) with increased participation of NGOs and donors

GHC to develop an e-learning platform including:
- **A forum** for HCCs for information sharing;
- GHC led discussions on technical issues;
- **Alumni networks** to facilitate virtual sharing experience and “just-in-time” learning

GHC to make full use of:
- Learning opportunities provided by other UN, NGO and donor organisations
- Partners as resource persons in events they organise

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Feedback
Action
Impact
**Participants presenting to Global Health Cluster**

The six participants below attended the Global Health Cluster meeting. The workshop participants asked all six to be on the panel presenting their recommendations to that meeting, with Ms Hyo Jeong Kim, EHA/HCC Nepal and Dr Ribka Amsalu, Emergency Health Advisor, Save the Children actually delivering the recommendations.

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<thead>
<tr>
<th>Region</th>
<th>Participant and current function</th>
<th>Duty Station</th>
<th>Email</th>
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<tbody>
<tr>
<td>AFRO</td>
<td>1. Dr Kosi Ayigan, HCC DRC Kinshasa</td>
<td><a href="mailto:ayigank@cd.afro.who.int">ayigank@cd.afro.who.int</a></td>
<td></td>
</tr>
<tr>
<td>EMRO</td>
<td>2. Dr Ahmed El Ganainy, Emergency Operation Manager, EHA, EMRO Cairo</td>
<td><a href="mailto:elganainya@emro.who.int">elganainya@emro.who.int</a></td>
<td></td>
</tr>
<tr>
<td>EURO</td>
<td>3. Dr Anshu Banarjee, WR Tirana</td>
<td><a href="mailto:ban@euro.who.int">ban@euro.who.int</a></td>
<td></td>
</tr>
<tr>
<td>SEARO</td>
<td>4. Ms Hyo Jeong Kim, EHA/HCC Nepal Kathmandu</td>
<td><a href="mailto:kimhy@searo.who.int">kimhy@searo.who.int</a></td>
<td></td>
</tr>
<tr>
<td>NGO</td>
<td>5. Dr Chris Lewis, Emergency Health Advisor, Save the Children London</td>
<td><a href="mailto:c.lewis@savethechildren.org.uk">c.lewis@savethechildren.org.uk</a></td>
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<tr>
<td>NGO</td>
<td>6. Dr Ribka Amsalu, Emergency Health Advisor, Save the Children Washington D.C.</td>
<td><a href="mailto:ramsalu@savechildren.org">ramsalu@savechildren.org</a></td>
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3. Evaluation and recommendations for future workshops

The workshop was evaluated at the end of each day.

**Day 1 – the workshop so far**

Keep points and action taken:

- Participants appreciated the time management but felt there was insufficient time for discussion amongst themselves and with the panel - the panel discussion of the second day was extended accordingly
- They still wanted to have more on funding – participants referred to half day session on strategy and resource mobilisation on the day after the lessons learned workshop
- Subjects which needed further discussion
  - Exit strategy/phase out – suggested that this should be dealt with in future HCC learning events and editions of the Health Cluster Guide
  - Chronic emergencies – as above
  - HCC rotation by country – outside scope of this workshop
- Process
  - They appreciated the “café” and panel discussions on Day 1
  - They hoped that the outputs would be documented – see this report
  - They had some concerns about the facilitation of the workshop – these were discussed in detail and changes made accordingly for Day 2

**Day 2 – the workshop as a whole**

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<tr>
<th>Proposition</th>
<th>1 = disagree completely, 5 = agree completely</th>
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<td>Number of ticks and % of ticks</td>
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<tr>
<td></td>
<td>1</td>
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<td>The workshop met my expectations</td>
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<td>The workshop met its objectives</td>
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Co-facilitator’s recommendations for future HCC lessons learned workshops

These recommendations are from Tim Foster, co-facilitator of the workshop, and should be read in conjunction with those from the other members of the workshop delivery team and feedback from participants and others.

Objectives

The Global Health Cluster set the objectives for this workshop which was designed accordingly. The key issues arising during the interviews with participants informed the discussions at the workshop but came too late in the process to impact the workshop design.

Recommendation for future workshops

Both Global Health Cluster and participants identify key issues before the workshop is designed – this will inevitably mean that the design is carried out immediately before the workshop and require a workshop team which works very well together in a flexible manner.

Duration

Two days proved very short for the wide range of issues needing to be discussed and analysed let alone the formulation of clear recommendations.

Recommendation for future workshops

Either extend the workshop to three days or reduce the number of issues.

Participants

All the participants were or had been HCCs or acted in a similar role – this ensured open and frank discussion among peers.

Recommendation for future workshops

Retain the HCCs only rule for participants but include as many non-WHO participants as possible such as co-leads or sub-cluster coordinators – be flexible to be inclusive.

Process

The process of identifying what worked well (good practice and lessons learned) and what was not working so well (bottlenecks and constraints), and then moving to recommendations on how to embed the former and overcome the later was sound.

It was also useful to have a clear focus for what the next step would be, namely presenting the recommendations to the Global Health Cluster meeting later in the week.

Recommendation for future workshops

Retain the process but ensure that participants take ownership of it from the start – this may mean spending half a session on process and making significant changes to the programme on the spot.

If at all possible have the next workshop immediately before an important meeting such as the Global Health Cluster where the recommendations can be presented to people who should be able to take many of the recommendations forward.

Follow up

The participants contributed a great deal of thought and energy to coming up with key positive and actionable recommendations to be presented to the Global Health Cluster. The same commitment to future workshops may well depend on how the Global Health Cluster takes their recommendations forward.

Many of the issues identified by the participants could usefully be considered when preparing learning events, revising the Health Cluster Guide and the GHC tools.

Recommendation for future workshops

Ensure that there is initial feedback on the recommendations themselves from the Global Health Cluster is shared with the participants and that action actually taken is shared with them before the next workshop.

Make full use of the issues raised in future learning events, and revisions of the Health Cluster Guide and tools.
Workshop team
The workshop team was excellent and worked well together. The three “café” anchors made a substantial contribution.

Recommendation for future workshops
Retain the same team size but consider whether necessary to add rapporteurs for group work.

Panel
Feedback from the panel was useful and demonstrated where action was already being taken on a number of issues. The panel members however may have seen less value as the presentations from participants were necessarily prepared under pressure.

Recommendation for future workshops
Retain the same model but ensure that more time is available to prepare the presentations to the panel – see Duration above.

Documentation
The workshop generated a lot of output which needed to be recorded even if it was later boiled down into key issues and recommendations. Documenting this mass of output was challenging.

Recommendation for future workshops
Ensure so far as possible that output is typed up as it is generated – Emma Fitzpatrick for instance typed the draft recommendations straight into a Word document which was displayed on a screen for the participants to review – this was excellent.