CLUSTER COORDINATION PERFORMANCE MONITORING REPORT 2015
The World Health Organization is the Cluster Lead Agency and provides secretariat support.
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I. EXECUTIVE SUMMARY

Monitoring humanitarian coordination is necessary to ensure that clusters are efficient and effective coordination mechanisms meeting the needs of constituent members, and supporting delivery to affected people through the fulfilment of the core cluster functions. Between 2011-2012, the Global Health Cluster (GHC) worked with OCHA and other clusters to develop a Cluster Coordination Performance Monitoring Tool (CCPM) to provide cluster partners, Cluster Lead Agencies (CLA) and the Humanitarian Coordinator (HC), a detailed view of the structure of each cluster, an overview of cluster performance on core areas of operation and an assessment by partners of the performance of each cluster. Additionally, the CCPM aims to indicate how coordination could be improved and demonstrate added value as a basis for justifying the cost of coordination.

In 2015, of the 221 active country health clusters 14 (63 %) completed the CCPM at the national level: Afghanistan, Chad, Colombia, Iraq, Liberia, Mali, Myanmar, occupied Palestinian territory, Somalia, South Sudan, Sudan, Syrian Arab Republic, Turkey–Gaziantep, Ukraine.

Results indicated that each cluster had unique strengths and needs when working with partners at the national level. However, a global comparison identified some common needs and gaps requiring cooperative support from partners, CLAs, donors and other stakeholders at global, regional and national level.

There is an overall need to ensure availability of adequate staff of the health cluster teams, in order to ensure effective responses and coordinated efforts in crises and inform evidence-based decision making in the health sector. All of the participating health clusters reported a lack of adequate staffing within their cluster teams. The Global Health Cluster recommends that clusters should receive trained, dedicated national and sub-national coordinators and Information Management Officers (IMOs) with appropriate contract terms. This should include building capacity in use of appropriate sector-specific and cross-sectoral needs assessment tools and remote support systems.

Needs assessment provides the evidence base for strategic planning, as well as the baseline information upon which situational and response monitoring systems rely. The results from the CCPM indicated that there was a need to provide targeted direct support to clusters during county Humanitarian Needs

1 Afghanistan; Central African Republic; Chad; Colombia; Democratic Republic of Congo; Iraq; Liberia; Mali; Mauritania; Myanmar; Nepal; Niger; Occupied Palestinian territory, Pacific Region; Pakistan; Somalia; South Sudan; Sudan; Syrian Arab Republic; Turkey–Gaziantep; Ukraine; Yemen.
Overview (HNO) processes, particularly for protracted emergencies in order to strengthen needs assessment and gap analysis functions.

The need to continuously encourage Ministry of Health to strengthen their active participation, representation and leadership in clusters was another common concern highlighted by many clusters. This requires specific attention, encouragement and continued capacity building at national levels.

It was reported in many country clusters that the health sector was less prioritized in funding, resource mobilisation and project prioritisation compared with sectors such as food security and WASH. It was therefore recommended that Cluster Coordinators be offered advanced training on communication and resource mobilisation.

Delays or lack of partners’ commitment for sharing data resulted in sub-standard monitoring and reporting work in most countries. There was a recognised need to implement a tool that meets different monitoring and reporting needs of the implementing partners, as well as strengthening commitment of partners to share information in a timely manner.

Challenges in actively seeking greater engagement of affected populations in the design and implementation of health interventions remained. There was a reported need to provide strong guidance on accountability to affected population (AAP) for country health clusters to engage with affected populations in the design and implementation of health interventions. This would involve fostering effective communication between health cluster partners and affected communities for meaningful dialogue and identification of evidence-based needs, concerns and healthcare priorities to improve the quality of the strategic process and responses.

Results also highlighted areas of strength and good practices within each country. All clusters performed well with regard to partners supporting service delivery and advocacy against agreed strategic priorities. However, there was a recognition that there was still a need for more effective information and gap analysis to reduce duplication in response.

Overall there is no doubt that the CCPM exercise is of value in determining progress, strengths, gaps and ongoing challenges in the coordination of health clusters at national level. The comparative analysis highlights where the clusters are operating successfully and where intervention and support is needed at global and national levels.

This report provides an overview of the combined results from the 14 reporting health clusters as well as a summary of common challenges and recommendations. Details of the CCPM process are elaborated in Annex 1.
II. CCPM HEALTH CLUSTER IMPLEMENTATION

The OCHA Global Overview of Coordination Arrangements in 2015\(^2\) showed that the Health Cluster conducted the CCMP at a higher rate than any other cluster. However, despite increased emphasis on the need to assess performance and demonstrate accountability, systematic monitoring was still not being prioritised in all cluster countries.

During the annual Health Cluster Forum held in Hammamet, Tunisia, March 2015, Health Cluster Coordinators (HCCs) together with the Global Health Cluster unit (GHCU), agreed to a target of 75% CCPM implementation rate for 2015. All clusters were encouraged to confirm their plans with the GHCU and the Information Management team in the WHO Emergency Risk Management and Humanitarian Response Department (WHO IM team), so that necessary direct or indirect support could be organised.

As of the first week of December 2015, 14 health clusters had undertaken Cluster Coordination Performance Monitoring, representing 63% of the 22 active health clusters.

Thirteen of the 14 health clusters used the Public Health Risk Information Marketplace in Emergencies (PRIME) common online platform providing controlled access to online questionnaires as well as automated analysis and reporting services. The Health Cluster/Sector in occupied Palestinian territory used a different technical platform and slightly adapted the tool ensuring that the three core elements (demonstrated deliverables, consultation and joint review) were completed\(^3\). While there were some comparable results in the written responses that are reflected in the overall analysis in Palestine, not all of the data from the Palestine survey could feature in the overall quantitative analysis of this report. The Pakistan Health Cluster CCPM process was activated then stalled, as the HCC and Public Health Officer were deployed to support the Yemen and Iraq response which led to a delay in holding the joint workshop and some variances in the quantitative and qualitative reports results.

Implementation of the CCMP per WHO regions

In 2015, Colombia, the only active health cluster in the WHO Region of the Americas (PAHO), and Ukraine the only active health cluster in the WHO Region of Europe (EURO) implemented the CCMP, each country representing 8% of number of countries that completed the CCMP. Of the seven active health clusters in the Eastern Mediterranean Region (EMRO) six counties implemented the CCMP: Afghanistan, Iraq, Somalia, Sudan, Syrian Arab

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\(^2\)OCHA, Global Overview of Coordination Arrangements in 2015, OCHA 2016.

\(^3\)Please see Annex 1 for full description of the CCPM principals.
Republic, and Turkey-Gaziantep, representing 46% of the total countries. Myanmar represents 8% of all countries that implemented the CCPM and is one of two active health clusters in the WHO South-East Asia Region (SEARO). Four countries – Chad, Liberia, Mali, and South Sudan - out of the ten active health clusters in the WHO African Region (AFRO), implemented the CCPM totalling 31% of all countries that completed the CCPM in 2015. There were no active health clusters in the WHO Western Pacific Region (WPRO) during the reporting period in 2015.

**Composition of the Health Cluster Partnership**
All the Cluster Coordinators undertook a membership review before launching the CCPM survey to ensure the list of partners was up-to-date. The median number of health cluster partners per reporting country was 46, ranging from 11 in Colombia to 88 in Somalia.
International and national nongovernmental organizations (NGOs) represented the highest proportion of partners, followed by UN organizations, while the representation of national authorities and donors was similar across many countries, with the exception of South Sudan where 10 donors are represented in the Health Cluster. The proportion of the different constituencies is shown in the graph.

It is interesting to note that the Syrian Arab Republic Health Sector, that is working using a cluster-like approach, is comprised of only international NGOs and UN Agencies with no national NGOs or donors.

**Overall response rate**

Among the health clusters implementing the CCPM, the median response rate of partners was 51%. The highest partner response rate was recorded in Colombia and Syrian Arab Republic with 91% (10 from 11) and 87% (20 of 23) respondents respectively. The lowest rates were recorded in Ukraine and Liberia with 21% (13 of 63) and 27% (21 of 78) respectively.
III. HEALTH CLUSTER PERFORMANCE AGAINST THE SIX CORE FUNCTIONS + ACCOUNTABILITY TO AFFECTED POPULATIONS

Overview of the performance scores
This section combines the results from each health cluster, scored according to the six core functions, related sub-functions and accountability to affected populations (AAP). During the face to face workshops involving all stakeholders, each result was discussed in detail amongst partners and recommendations for future actions agreed (please see Annex 1 for full details of the CCPM process).

It is important to remember that the CCPM is not a process to evaluate individuals, nor does it measure results achieved in terms of the delivering objectives of the strategic response plan. The CCPM is a self-assessment tool that allows country cluster partners to self-evaluate the coordination functions of the cluster as a whole.

![Overall performance scores by country Health Cluster](chart.png)
1. Core function: Supporting service delivery

1.1 Provide a platform to ensure that service delivery is driven by the agreed strategic priorities

This function represents one of the main motives behind the cluster approach. It was noted that the clusters that scored “satisfactory” (Colombia, Myanmar, and Somalia) on this sub-function consist of one person cluster coordination team. Addressing the shortages of qualified human resources to support the Cluster Coordinator would help achieve better outcomes on this sub-function in 2016.

1.2 Develop mechanisms to eliminate duplication of service delivery

Investing in the implementation of different Information Management (IM) tools (e.g. Who’s doing What, Where? [3Ws] and the WHO Health Resources and Services Availability Mapping System [HeRAMS]) can help cluster teams to identify needs and gaps and improve analysis and planning. Ensuring availability of IM capacity, preferably with full time dedicated staff, or at a minimum part-time support, would contribute to the improvement of performance in this sub-function.

It was suggested that Health Cluster participation in the joint IM working group (often managed by OCHA) at country level represents an opportunity for cross-fertilization with other sectors’ IM work and can also provide a capacity building opportunity.
2. Core function: Informing strategic decision-making of the HC/HCT

2.1 Needs assessment and gap analysis (across sectors and within the sector)

Needs assessments provide the evidence base for humanitarian response. At the outset of an emergency, they provide the information needed to define the strategic objectives, and later for operational planning, staffing and resource requirements.

Taking good and satisfactory as acceptable performance levels, it is notable that 31% of clusters did not perform at the required level. As Cluster Lead Agency, WHO is responsible for taking appropriate action to address this inadequate staffing of cluster teams including high performing IMOs. A capacity building exercise is needed to ensure that the IMOs use the most appropriate sector-specific and cross-sectoral needs assessment tools. Direct support to clusters when the country undertakes the HNO should be organized to strengthen the overall health cluster performance in the needs assessment and gap analysis functions.

2.2 Analysis to identify and address (emerging) gaps, obstacles, duplication, and cross-cutting issues

Gap analysis identifies the difference between the desired/expected humanitarian response and the reality witnessed at a given time. It can be applied to multiple aspects of humanitarian response including: cluster/sector specific needs assessments; identification of priority interventions; development of guidance for the cluster to plan, train, and prepare for the provision of humanitarian assistance in a given context; operational capacity, activity or response; strategic and funding requirements. Each of these can then be further broken down based on criteria such as number of staff, response planning and required resources.

The health clusters’ performance on gap analysis, avoiding duplication and attention to cross-cutting issues, was rated almost identical to the needs assessment sub-function as the two sub-functions are closely linked.
To appropriately address the issues related to gap analysis, cluster partners recognised the need to systematically apply the needs assessment and gap analysis tools endorsed by the GHC. These tools include the HeRAMS and the 3W matrix, which had proven to be the tools of choice in terms of evidence-based decision making in the health sector. Although during the Health Cluster Forum in March 2015, participants agreed to implement HeRAMS not all countries have done so. The results from the CCPM noted that all of the countries that have implemented HeRAMS scored satisfactory and good in this sub-function.

2.3 Prioritization, grounded in response analysis

The results from this sub-function clearly indicated the need for remedial action in all clusters and were linked to the needs assessment and gap analysis. To score satisfactory or good on this sub-function HCCs needed to engage in a discussion with members and constituencies to determine priorities based on the needs assessment and gap analysis.

Setting up a Technical Working Group or a Task Team within the health cluster, to advise on the prioritization of the activities and services to be funded and implemented at field level, has proven to be an effective way to address the weakness registered in this sub-function, especially if combined with special attention to scaling up IM capacity in all active health clusters.
3. Core function: Planning and strategy development

3.1 Develop sectoral plans, objectives and indicators directly support realization of the HC/HCT strategic priorities

All health clusters undertaking the CCPM process, scored good or satisfactory in this sub-function. There were no weak or unsatisfactory ratings.

The positive results from this sub-function were highlighted in survey results as being due to the fact that the planning process led by the HCT with support from OCHA had become a routine exercise that all clusters undertook as part of the annual Humanitarian Program Cycle.

However, during the CCPM workshops, there was less consensus on the performance of clusters on this sub-function. In a few countries, partners were unhappy with their involvement in the process which seemed to be driven by the HCC with very little consultation with partners. Health cluster teams needed to be more inclusive during the planning process, either through direct involvement of partners with the coordination team, or through election of technical working groups that would support the process in close collaboration with partners. Partners in Chad, Sudan and Ukraine commended the cluster coordination teams’ work on this sub-function.
3.2 Application and adherence to existing standards and guidelines

It is important for all health cluster partners to continue to pay attention to quality assurance mechanisms ensuring that services provided to affected populations are evidence-based and follow acceptable national and international standards.

Health cluster teams should ensure that standards, norms and guidelines are shared with all cluster partners for adaptation or adoption when national standards do not exist. Adherence to the established standards by all cluster partners should be continually monitored.

3.3 Clarify funding requirements, prioritization and cluster contributions to health cluster’s overall humanitarian funding considerations

The only health cluster that scored unsatisfactory for this sub-function was Liberia. The CCPM Liberia report explained that the underlying reason for this result was the fact that the Liberian Health Cluster did not operate as an operational cluster but rather as an information sharing forum. The operational decision-making body (therefore the body with responsibility for this sub-task) was coordinated by a national task force and technical expert committee.

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4 The Liberian Health Cluster was established as a compliment to the National Ebola Coordination task team and the Ebola Technical Expert Committee. The core functions of the Liberian Health Cluster were reduced to include only the information sharing functions.
4. Core function: Advocacy

4.1 Identify advocacy concerns to contribute to HC/HCT messaging and action
Results from Somalia and South Sudan, which both scored satisfactorily in these sub-functions, highlighted that both clusters have expanded the scope of the coordination of the humanitarian response to include the overall country health sector response. Reports documented that this expanded coordination role created a higher expectation for stronger advocacy in a wider area of response needs.

During the CCPM workshops, it was clear that all clusters partners, while satisfied with performance in terms of advocacy, would appreciate stronger and more sustainable efforts from the coordination teams to elevate the importance of health within the overall humanitarian response in their respective countries. Encouraging a health cluster team member to join the CLA in the HCT was suggested as a first step towards supporting a stronger understanding of the needs of the health sector in the overall humanitarian response.

4.2 Undertaking advocacy activities on behalf of cluster participants and the affected population
The overall results of undertaking advocacy activities on behalf of the affected population were mainly satisfactory which was less favourable than the results the work achieved when advocating within the international humanitarian response plans in the sub-function. This result suggests a need to plan for strengthened advocacy activities outside of the humanitarian response plan, with a stronger focus on the affected populations.
5. Core function: Monitoring and reporting the implementation of the cluster strategy; recommending corrective action where necessary

Monitoring and reporting is a continuous process that records the assistance delivered to people in need, identifying shortcomings in the delivery of humanitarian aid and examines what was delivered versus the resources allocated.

Humanitarian response monitoring and reporting is essential in helping clusters examine whether sufficient progress is being made in reaching strategic objectives by providing an evidence base for taking decisions about future directions of the response.

The three clusters that scored unsatisfactory in this function (Somalia, Sudan and Gaziantep) reported having Joint Monitoring Framework in place, but delays or lack of partners’ commitment for sharing data resulted in sub-standard monitoring and reporting work.

6. Core function: Contingency planning/preparedness

A contingency plan is essential to bring all relevant actors to an advanced level of readiness whenever monitoring suggests an imminent emergency - or in the case of a very specific risk with potentially catastrophic impact. In an emergency, the contingency plan informs the Flash Appeal.

During the CCPM workshops supported by the GHCU, it became apparent that “Contingency Planning” did not mean the same thing for all the partners responding to the CCPM questionnaire. Some partners were not aware
of contingency planning as a core function of the health clusters. Other partners attributed the contingency planning responsibility to the CLA and the line ministries.

This led to imprecise appraisal of cluster performance in this function as some clusters which had not developed or contributed to a contingency planning process still scored good (e.g. Mali) or satisfactory (e.g. Liberia, Somalia and Colombia). Therefore, these results should only be viewed as an approximate rather than an accurate measure of cluster performance.

Efforts should be made to ensure that the contingency planning process is clearly defined within the cluster teams. Adequate attention must be paid to ensure that clusters contribute to the common national contingency planning process as well as having a written, agreed and shared cluster specific contingency plan.

7. Accountability to Affected Populations (AAP)

Accountability to Affected Populations (AAP) is defined as “an active commitment by humanitarian actors and organizations to use power responsibly by taking account of, giving account to and being held to account by the people they seek to assist”.

The challenges of actively seeking greater engagement of affected populations in the design and implementation of health interventions remained. In Iraq and Sudan, multi sector initiatives were implemented to strengthen feedback mechanisms. In Iraq, reports collating feedback from the affected populations were regularly shared and discussed within the HCT and actioned by the Inter-Cluster Coordination Group and Clusters. In Sudan, OCHA piloted a hotline for collecting feedback and complaints in Darfur for all clusters which the Health Cluster partners supported. However, none of the health clusters reported implementing full mainstreaming of AAP through all phases of the programme cycle. There is a need to promote more effective dialogue, creating an enabling environment that moves away from assumptions of understanding needs, priorities, risks and opportunities and making sure there are effective feedback and complaints mechanisms.

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5 IASC, AAP Operational Framework Final Revision: https://interagencystandingcommittee.org/file/511
IV. COMMON CHALLENGES FACING COUNTRY HEALTH CLUSTERS AND SUGGESTED RECOMMENDATIONS

The comparative analysis of cluster performance was useful in identifying common areas still requiring attention across all or most clusters. Relevant recommendations were formulated to respond to gaps and weaknesses.

Cluster teams’ staffing levels and HR issues

Common challenges

- The lack of predictable, longer-term contracted, well trained and high performing cluster personnel has greatly affected health cluster performance. 43% of health clusters globally and 61% of the health clusters under review had dedicated HCCs in 2015. This meant that 39% of the reporting HCCs had to divide their time amongst their cluster duties and other emergency responsibilities often referred to as ‘double-hatting’.
- 39% of health clusters globally had a dedicated IMO against 38% for the clusters under review.
- 70% of clusters had part-time or dedicated IM capacity, while 30% of clusters lacked any capacity in the IM field.
- None of the health clusters under review had sufficient sub-national coordination staffing. 50% of the reporting clusters had temporary measures to cover sub-national coordination needs through standby partners and other short-term arrangements.
- 62.5% of clusters had no communication personnel capacity, while 37.5% of clusters had access to part-time communication capacity, shared with the WHO office.
- None of the cluster teams had the complete staffing scheme as per the GHC minimum capacity guidance, and none of the cluster coordinators or any members of their teams had a longer-term contract.
- Many health cluster partners were limited in their capacity to provide direct support to health cluster coordination teams as the majority of partner human resources were deployed to focus on their own operations or they did not have funds for additional dedicated staff.

Common recommendations

- WHO as CLA, supported by the GHC, should ensure that all health clusters are adequately staffed with dedicated national and sub-national coordinators (as appropriate) as well as IMOs. Feedback from the CCPM process also highlighted a need in many clusters for greater
communication and monitoring and evaluation capacity on either a full or part-time basis as appropriate to context.

- Cluster team members should have adequate contracting arrangements to ensure predictability, efficiency and effectiveness in the longer term.
- Double-hatting should only be tolerated in limited contexts.
- All cluster teams should be required to undertake the Health Cluster Coordination Training following the new curriculum launched in September 2015.
- Vacancies at national or sub-national level should be filled by experienced short-term capacity (either through surge missions or Standby Partner deployments). At the same time, longer-term recruitment with adequate pre-deployment briefing by the GHCU, the WHO Regional and Country offices should be initiated. Appropriate hand-over periods should be respected for the transition of surge staff to the longer assignment.

**Partner engagement**

**Common challenges**

A number of common challenges emerged regarding partner engagement.

- 38% of clusters under review were co-led by the host country Ministry of Health (MoH) compared with 47% globally. Most partners who participated in the CCPM process would like to see stronger MOH engagement and leadership in national clusters. This was reinforced by the overall limited or absent participation in CCPM workshops. Some exceptions were Mali, Sudan and Somalia.
- 38% of clusters under review were co-led by a NGO compared with 47% globally.
- Partners in most clusters under review admitted that at times their engagement with health cluster work was sub-optimal. In each of the validation workshops, partners resolved to increase their participation in cluster activities and in representation.
- Partners themselves raised the need for increased and timely sharing of health information. The need for more regular reporting against cluster indicators was raised in most of the validation workshops. Partners also asked for further simplification of reporting tools and standardization of data collection matrices and frameworks.

**Common recommendations**

- Guidance on minimum commitment of partners in health cluster activities (as per IASC Cluster Coordination Reference Module, 2015) should be made more readily promoted at country level, and partners
held to account on their commitment to and participation in health cluster work.
- Greater advocacy efforts should be made at GHC and in country health clusters, to increase partner engagement for collective action and collective results.
- There should be advocacy at global and country levels to engage partner support for health cluster coordination teams and cover for coordination gaps at sub-national or national level.
- WHO, as CLA, should advocate with host governments for greater engagement of the MOH in the work of health clusters.
- The GHC should familiarize MOH representatives with WHO’s role in emergency coordination and the working modalities of country health clusters.
- The GHC could consider inviting selected MOH representatives to participate in selected global partner meetings as observers to increase government understanding of the role of clusters.

**Informing evidence-based decision making in the health sector**

**Common challenges**

Comparative analysis of participating clusters indicated challenges in the area of providing evidence for decision-making.

- Performance on needs assessment was rated satisfactory in about two thirds of the health clusters under review as was performance on gap analysis, avoiding duplication and attention to cross-cutting issues. However, prioritization grounded in response analysis was deemed mostly unsatisfactory or even weak in a few instances resulting largely from a lack of skilled and dedicated capacity in IM.
- 3W matrixes were seldom used as tools for gap analysis and strategic decision-making.
- HNOs in most cases were rushed and written as a requirement of the Inter-Cluster Coordination Group, with limited partner inputs, thus adding very little value to the strategic response planning exercise.
- HeRAMS was quoted by all clusters as a reference tool for improving the quality of in-depth health needs assessments. However, the automatic analysis and reporting version of HeRAMS was only recently available to health clusters and at the time of this report, with only the Gaziantep health cluster partially implementing the automatic tool.

**Common recommendations**

- Establishing Technical Working Groups or a Task Team within the health cluster to advise on the prioritization of the activities and services to be funded and implemented at field level can be an
effective way to address the weakness registered in this sub-function, especially if combined with special attention to scaling up IM capacity in all active health clusters.
- WHO, as CLA, should address poor IM by ensuring more predictable availability of high performing IMOs and supporting urgently needed capacity building in the use of the most appropriate sector-specific and cross-sectoral needs assessment tools.
- Providing direct support to clusters during country HNO processes should be organized to strengthen overall health cluster performance in needs assessment and gap analysis functions.
- Providing support for the introduction of the automated HeRAMS platform may encourage more clusters to implement and use the tool.
- The GHC Information Management Task Team should accelerate efforts to establish a support-desk to ensure country based IMOs can produce timely quality health information and evidence as the basis for decision making.

Funding requirements, resource mobilisation and project prioritization

Common challenges
More attention is needed to ensure funding and resources for health as a priority area.
- On average, 42% of health cluster funding requirements were covered in 2015. While health was less prioritized compared with sectors such as Food Security and WASH in many countries, clusters with high performing coordination teams were among the highest funded clusters in countries such as Sudan, Syrian Arab Republic and Turkey-Gaziantep.
- During the validation workshops, many partners called upon the Cluster Coordinator and Cluster Lead Agency to scale up resource mobilisation efforts to secure adequate funding for the health sector.

Common recommendations
- Strengthen health cluster performance throughout the Humanitarian Program Cycle to improve funding for health in humanitarian emergencies.
- HCCs should be offered advanced training on communication, resource mobilisation and donor relations.
- HCCs should invest in strengthening relationships with the donor community and bilateral cooperation agencies active in their respective countries.
- Donor conferences and sharing high quality cluster deliverables (strategic plans, bulletins, donor alerts...) with a wide network of funders was needed to enlarge the basis of health cluster funding.
- The CLA representative should engage in stronger advocacy on behalf of health clusters at all levels including with the HC/HCT to ensure better prioritization of health issues within humanitarian funding.

**Advocacy**

**Common challenges**

A challenge remains to advocate for health delivery.

- Most clusters had an acceptable record of advocacy on HC/HCT messaging and action, but CCPM workshops highlighted the need for stronger and more systematic advocacy efforts from coordination teams to increase the visibility of health in overall humanitarian response.
- In contrast most clusters performed poorly on advocacy for affected populations.

**Common recommendation**

- There is a recognised need for strong and systematic advocacy efforts to increase the visibility of health in overall humanitarian response.
- Stronger advocacy efforts were needed to ensure populations can access essential services to improve health outcomes.

**Monitoring and reporting implementation of the cluster strategy**

**Common challenges**

Monitoring and reporting implementation still demand attention.

- The importance of continued monitoring of cluster activities was recognised by all participating country in order to support cluster teams to examine progress in reaching strategic and cluster objectives.

**Common recommendations**

- The GHC Information Management Task Team should work on standardizing the indicator monitoring framework and data collection tools and support dissemination to all country health clusters.
- The country health clusters need a tool that meets the different monitoring and reporting needs of partners. A standard that has been developed by the GHCU in collaboration with the WHO IM team is scheduled to be piloted by end 2016.
- The GHC website should serve as a repository for country health cluster bulletins. The GHCU should more closely monitor production and quality of cluster deliverables (e.g. bulletins, monitoring reports, joint evaluation reports...).
Accountability to Affected Populations
This remains a key challenge for clusters and is the core of humanitarian response.

Common challenges
- Health cluster partners are expected to listen to, involve and communicate with affected populations throughout the humanitarian programme cycle, establishing a direct, responsible and respectful relationship with aid recipients. Affected people need to be enabled to participate and provide feedback into planning, implementation and monitoring of healthcare services, including through the establishment of complaints mechanisms. Where their needs cannot be met or planned for, constraints and regular programmatic updates should be shared with them.
- No reviewed clusters performed at the required level with regard to AAP. Challenges of actively seeking greater engagement of affected people in the design and implementation of health interventions remain.
- There was no systematic guidance or mechanism approach in place for collection of views and complaints of stakeholders, or for providing timely feedback and access to information concerning programs and services provided by cluster partners.

Common recommendations
- As the AAP starts from evidence-based programing, health cluster coordination teams should strengthen their performance throughout the Humanitarian Program Cycle - from the onset of emergency initiating a process of gathering, consolidating and analysing information on needs, to the gap analysis and prioritization exercise, to strategic planning, to resource mobilization and implementation.
- The HCC should foster effective communication between health cluster partners and affected communities for meaningful dialogue and identification of evidence-based needs concerns and healthcare priorities. This would improve the quality of the strategic process and related actions.
- The GHC should develop guidance on AAP to help country health clusters move towards more meaningful engagement with affected populations in the design and implementation of health interventions.
ANNEX 1 CCPM PROCESS FOR THE HEALTH CLUSTER

The Cluster Coordination Performance Monitoring (CCPM) process is a self-assessment of cluster performance by health cluster partners and coordinator against the six core cluster functions set out against:

1) The IASC Reference Module for Cluster Coordination at Country Level, 2015:
   i. Supporting service delivery;
   ii. Informing strategic decision-making of the HC/HCT for the humanitarian response;
   iii. Planning and strategy development;
   iv. Advocacy;
   v. Monitoring and reporting the implementation of the cluster strategy and results; recommending corrective action where necessary;
   vi. Contingency planning/preparedness activities in situations where there is a high risk of recurring or significant new disaster and where sufficient capacity exists within the cluster.

2) Accountability to affected populations.

The CCPM is a country-led process, which is supported by the Global Health Cluster and the WHO Regional Offices. It is ideally conducted jointly with all clusters (and sectors) at the same time, though it can be implemented by the health cluster or together with a group of clusters. The CCPM also includes a “Cluster Description” document that describes the clusters’ architecture, working modalities and outputs.

1. Cluster Description: An online questionnaire, completed by the cluster coordinator, that asks about cluster structure, membership and processes. It refers to a strategic advisory group and technical working groups, and availability of key deliverables with web-links. Information is summarized in a “Cluster Description” report.

2. Cluster Coordination Performance report: Online questionnaires are completed by the Health Cluster Coordinator and partners, recording partners’ and cluster coordinators’ views regarding cluster fulfilment of core functions.

Completed questionnaires are automatically analysed\(^7\). An overall score is calculated for each sub-function then results are aggregated by calculating a median score for each sub-function classified in terms of performance:

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\(^6\) IASC, Reference Module for Cluster Coordination at Country Level 2015
\(^7\) WHO, Coordination Performance Report Explanatory Note on Questionnaire and Analysis, 2012
Green  Good, Strong (>0.75)
Yellow Satisfactory, needs minor improvements (0.51 - 0.75)
Orange Unsatisfactory, needs major improvements (0.26 - 0.50)
Red Weak (<0.25)

After preliminary reports, a review meeting (validation workshop) is held for partners to consider survey results and follow-up actions with needs for additional support identified. A final report includes performance scoring and outcome of the validation workshop.

Monitoring coordination performance at national and sub-national level in both sudden onset and protracted crises ensures cluster efficiency and effective coordination mechanisms to fulfil core functions, to meet the needs of constituent members and to support the delivery of health services to affected populations. It can provide accountability, demonstrate added value and justify the cost of coordination.

It is recognized that some clusters have already developed performance tools based on peer review. While health clusters are encouraged to move towards using the CCPM, it is the joint collaborative outcome not the process which is most important.

The CCPM does not negate that earlier investment, but there are three core elements that must be completed:
1. There has to be demonstration of the verifiable deliverables, making available what has been done.
2. The opinions of the cluster coordinator and cluster partners/cross-cutting issues representatives should be separately documented.
3. A cluster meeting should take place to discuss the findings of the two elements above, with follow up action mapped out and requests for further assistance noted as needed.

A CCPM exercise should ideally take place three to six months after the onset of an emergency and then annually in protracted crises at times decided by the clusters. It is mandatory at national level but may at times occur at sub-national level. If several core functions are of concern, they will require a more frequent CCPM process to monitor and follow up.
HCCs should ensure the broadest possible participation of partners, including UN agencies, national and international NGOs, national governments and authorities, and focal points on cross-cutting issues.

The health CCPM process is supported through PRIME (Public Health Risk Information Marketplace in Emergencies), an online platform providing controlled access to online questionnaires, automated analysis and reporting services. Global clusters and OCHA may offer additional support. Outcomes include performance reports and recommendations regarding areas for additional support and improvement.

The CPM process for the Health Cluster is supported by the WHO IM team. A full CCPM process generally takes between 2 to 4 weeks and involves: planning, CCPM survey, cluster analysis and action planning, follow-up and monitoring. Figure 1 describes the process.

Figure 1: 10 Steps to Health Cluster Performance Monitoring

1. Preparation
   - Register/login to Prime (*) and get familiar with the C2 and CPM processes and tools.
   - Present the approach during the cluster meeting.
   - National level Coordinator to submit C2/CPM Request Form (***) for both national and subnational levels.

2. Transfer of partners’ invitation email to all partners.
3. Fill in both Cluster Description Form (CD) and Coordinators’ Cluster Performance questionnaire (CPQ) (***)
4. Monitor the evolution of the process through Prime’s CD and CPM dashboards.
5. Integrate the conclusions of the biannual workshop into the intermediate report on Prime.
6. Publish the final report through Prime’s Marketplace.

* Prime is accessible at: https://prime.interactwork.ch/
** Cluster Description and Cluster Coordination Performance Monitoring are the 2-pillars of Cluster Performance Monitoring.
*** The Activation Request Form triggers the process from the technical side. It is accessible on Prime.*