



## Global Health Cluster

### Meeting Summary

**7- 8 May 2008**  
**John Knox Center**  
**Geneva**

Participating agencies: CDC, ECHO, ICN, IFRC, IMC, IRC, Merlin, STC UK, STC USA, UNFPA, UNHCR, UNICEF, Women's Commission, WADEM, WVI and WHO [Click here for full list of Meeting Participants](#)

Click here for [Meeting Agenda](#)

#### **Wednesday 7 May 2008**

Morning Chairperson: Linda Doull, Merlin

#### **1. Opening remarks- Robin Nandy UNICEF**

Robin Nandy welcomed everybody to the ninth Global Health Cluster (GHC) meeting. He mentioned that Dr Eric Laroche, the Assistant Director General for Health Action in Crises, had requested a welcome address from a partner organization and that he felt honoured to be the one opening the GHC meeting.

The GHC had a slow start but there has been a lot of progress in the past 12 months. Among the highlights is the completion of the first tri-cluster training for cluster coordinators, the progress on the health cluster guide and on the Initial Rapid Assessment (IRA) tool. The GHC also began the Joint Country Missions with a first trip to the Ivory Coast.

This meeting will start with an update on progress on the GHC 2008 Work Plan, then explore how the GHC can better support country clusters, and then look towards the role of the GHC in 2009 and beyond.

Robin emphasized that the GHC is a valuable forum and that all partners have a responsibility to make it useful and worthwhile. He asked the chairs to ensure that at the end of each session we have concrete action points to move things forward.

#### **2. Review of agenda, meeting objectives, introduce chairpersons- Erin Kenney**

Administrative details were covered. The agenda and meeting objectives were reviewed for comments. Two new members were welcomed to the Global Health Cluster: the Women's Commission represented by Sandra Krause and The World Association for Disaster and Emergency Medicine (WADEM) represented by Marvin Birnbaum.

### 3. Progress on the GHC 2008 Work Plan- presented by members of various WGs

#### Capacity building of National Stakeholders - Altaf Musani (WG chair)

- The Working Group had a difficult start but now the guidance and strategy document is progressing well. The WG will ensure linkages and consistency with the guidance from the IASC concerning contingency planning. The WG will review the first draft in the next couple of weeks. The document should be complete as planned by July 2008.

#### Health Cluster Guide - Ron Ockwell (consultant)

- See power point presentation on [Health Cluster Guide](#)
- The Health Cluster Guide Steering Committee has had several teleconferences and has finished a first working draft.
- The chapters were presented and an updated version was circulated. Ron needs more help on specific chapters from the relevant GHC working groups by end May at the latest.
- Chapters requiring significant input from the GHC WGs are:
  - Assessment and monitoring
  - Analysis, strategy development and planning
  - Mobilizing, sharing and managing resources
  - Reporting, performance monitoring and evaluation
  - Managing and disseminating information **\*significant input required**
  - Standards and protocols **\*significant input required**
  - Promoting early recovery; rebuilding national systems **\*significant input required**
- The plan is to have a draft by mid-June and start field testing from July to September. The targeted users are senior staff members, Health Cluster Coordinators, medical directors working in the field and the donor community.

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| <p><b>ACTION:</b> WG chairs to ensure that input is provided to Ron as required by end May so that the guide can be complete as planned by mid-June.</p> |
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#### Health Recovery Paper- Egbert Sondorp (consultant for WG C&M)

- See power point presentation on [Health Sector Recovery](#)
- The development of this guidance has proven to be a complex undertaking and issues are still maturing.
- A sub-working group of the WG C&M has been formed to work with the consultant to finalize this guidance. So far three drafts have been produced after rounds of discussion.
- This guidance is aimed at persons in a position to influence the recovery process.
- The aim is to establish a common understanding of the meaning of health recovery.
- We need to move from the distinction between acute vs. chronic to disaster vs. conflict.
- The paper will focus on chronic conflicts and give an intro to health systems.
- It will provide an update on burning issues like service provision, basic packages, contracting, human resources, training certification, information management, assessment tools, health finances and user fees. The guidance will provide options not answers.
- This guidance is not aimed at being a comprehensive tool; instead aims to fill knowledge gaps.
- A first draft for wider circulation is expected by end July 2008.

#### Stakeholder Mapping -Nevio Zagaria (co-chair WG C&M)

- See power point presentation on [4W](#)
- Measure who is doing what where and when by health sub-sector and also by service provision within the sub-sectors
- The draft tool has been tested in Darfur; the tool and case study will be circulated to partners.
- The tool should be finished and available by this fall 2008.

### Gap Analysis Materials- Linda Doull (manager of this product of the WG C&M)

- Consultant Nadine Ezard is going on missions to field test the Gap Analysis Materials at the sub-national levels in Uganda and DRC.
- Gap Analysis Materials will be finalized by September.
- The questions surrounding this product are: how can this be used to augment existing tools (the IRA for example). How and when should country clusters use these materials? Should a specific tool be developed based on these materials? Would it be suitable to both chronic and acute situations?

### Mental Health Guidance - Mark van Ommeren

- See power point presentation on [Mental Health Task Force Update to GHC](#)
- Thanks to the GHC, 11,000 copies were printed of the Mental Health Guidelines.
- An inter-sectoral reference group is working to promote the implementation of the guidelines, and looking to do this by specific sectors/clusters.
- They are proposing to the GHC to consider a guidance note and checklist specific to the health cluster, drafted by the reference group, that could be promoted by the GHC. A draft should be available for review by the GHC by end June.
- Mark emphasized that there needs to be increased dialogue and coordination between the GHC and the global protection cluster.

**ACTION:** Mark to circulate draft health guide and checklist to GHC for review by end June.

### Products of the WG on IM - Jonny Polonsky (WG IM)

#### **Initial Rapid Assessment Tool**

- The IRA tool and guidance are nearly finalized. Both the GHC and the Nutrition Cluster have agreed on the tool, and are awaiting the approval by WASH.
- The IRA tool has been used in Kenya in the aftermath of the election violence. The tool was most successful when tested by multi-sectoral groups. The goal is to use the IRA tool in the assessment of the situation in Myanmar. When testing in Kenya the acute phase had already passed. The hope is that the Myanmar crisis will show if the tool works in acute onset situations. Country level officers in Myanmar have asked for the IRA and the GHC has shared it with partner organizations.
- Countries are expected to adapt the tool to their specific context.
- The 3 cluster WG is considering seeking endorsement from the IASC.
- The focus for the moment is on developing a dissemination plan.
- The electronic version and electronic aids, like database, reporting template will be developed. The goal is to try to obtain the \$100 computer for children as a platform for the electronic version.
- Much more work is needed to move from the tool to analysis, intelligence, and an evidence based work plan. Analysis capability and guidance is lacking.
- Many voiced the opinion that the tool was too long. There is some agreement. The country specific tools will probably be much shorter as they adapt the tool to their time frame and needs.

#### **Comprehensive tool**

- Work is now beginning on this. This might be a collection of specialty tools since the health sector has so many sub sectors. Unlike WASH who is creating just one comprehensive tool due to the specific and limited subject matter, health will require many tools.

#### **Benchmarks**

- Work is just beginning on this now. Start with a review and compilation of existing benchmarks from Sphere and other sources.
- GHC needs to define a few key benchmarks by which country clusters will be measured in the Phase 2 evaluation sometime in early 2009.

### Health and Nutrition Tracking Services (HNTS) - Richard Garfield

- The HNTS is in the process of hiring one epidemiologist and one nutritionist. The two jobs have been advertised and the nutritionist position will be filled shortly. The other position will need to be re-advertised due to a lack of qualified candidates.
- The work on the HNTS is progressing in Uganda, thanks to the cluster coordinator who is bringing the work forward. Chad will be the next country of focus.
- HNTS will create better data when more assessments are complete.
- The HNTS plans to move quicker and be more present in the field.
- A main goal is to ensure the quality of the data coming out of the HNTS.

### Joint Assessment Missions - Anne Golaz (partner in first JCM to Ivory Coast)

- See power point presentation on [Joint Country Missions: lessons learned](#)
- A concept note for the Joint Country Missions was shared in March and the first mission to Cote d'Ivoire, took place the same month. 12 country missions are planned for 2008.
- The first mission allowed GHC partners to test the mission concept and propose changes/improvements for future missions.
- The mission proposed dates have to be shared with partners well in advance to ensure a broad participation in the missions.
- The Côte d'Ivoire mission included three WHO and one UNICEF, global and regional participants, it didn't include any NGOs or donors. The inclusion of NGOs and/or donor in the mission team is essential to represent the partnership. The meetings should include all key in-country partners
- The joint mission should be divided in two parts: the assessment and the country support. The mission assesses gaps and weaknesses in performing cluster functions, and also provides country support in producing a plan of action based on the mission recommendations that should be discussed during a workshop at the end of the mission. The country support is the most important part, but unfortunately didn't happen with the Côte d'Ivoire mission. The follow-up of the agreed plan of action is essential.
- Joint missions are opportunities to present the CA and GHC tools to country partners.

**ACTION:** HAC to set firm dates asap for 11 remaining missions to get commitment from partners to be part of the team; all partners to inform their country offices that visits will take place and encourage their participation.

### Training and Roster - Robin Nandy (co-chair WG T&R)

- The first tri-cluster (Health, Nutrition and WASH clusters) training for future cluster coordinators finished 3 May. A total of 29 participants from the three-clusters got training including nine participants from the Health Cluster. The training was successful and the participant feedback was very positive. The training focused on building skills and learning about the cluster approach.
- Agreement that 3-cluster format was positive; it is difficult to organize but rewarding for the participants since it is key they meet and get a common understanding of the cluster and the different needs before meeting on an acute onset. The concept is to be considered for future trainings.
- WG must review and improve selection process for training; Need to solicit new CVs and nominate more candidates for the future training.
- WG must redraft TOR of HCC given feedback at training and given that the TOR was drafted in fall 2006 before even the guidance note was finalized.
- Aim to finish three more trainings during 2008 (two in English and one in French); decision needs to be made by the WG if these will be 3-cluster or only health cluster
- WG must consider if the training is suitable to both acute and chronic situation HCC
- WG must develop process for identifying HCC for long term chronic posts

### Inclusion of Cross Cutting Issues- Erin Kenney

- Contact has been made by the Support Hub to IASC focal points for age, gender, environment, AIDs, protection, mental health.
- The focal points for age, protection and mental health have already reviewed some near final products (IRA, gap analysis). Gender is willing and ready to begin review. We await the name of the person who will do the review. HIV/AIDS has not yet provided a response about their willingness to review GHC products. Environment (UNEP) is unable to spare the resources to review GHC products. WHO will therefore ask its environment department to review the GHC products until UNEP has secured the necessary resources.
- No budget has been allotted for this task.

### Integration of the cluster approach- Erin Kenney

- A group of 6 partners has had two teleconference to advance on this work plan item
- The group has determined that the priority is to conduct 2-3 regional workshops in 2008 with a focus on country level implementation
- The aim is to get maximum impact on current and future implementation of the cluster approach using the limited funds available by targeting partners' emergency response field staff (both international and national) that would be mobilized to work in or support other emergencies
- The aim would be to seek participation from many different organizations; both international and national staff
- The group suggests that the TOR of the JCMs be revised to include a one day workshop in country for all stakeholders on the cluster approach and GHC products
- Partners in this group plan to explore where existing inter-agency emergency groups might be able to support these workshops
- Priority locations Nairobi and Dakar; one English and one French
- IMC to circulate a draft concept note for comments by those on the teleconference
- Proposal for combining this work into a new WG to be proposed in the next session
- No funds spent so far. Total available \$150,000

### Public Private partnerships- Erin Kenney

- Recognition that private sector is increasingly important in humanitarian work.
- WHO and 4 partners attended meeting in NYC in January with WEF and their Health Care Industries Group. Opened communication; encouraged bilateral discussions and agreements; suggested secondment at regional or country level to explore options but WEF only interested in global level
- So far no concrete multilateral activities have been identified to take forward, but the contacts have opened the door for some bilateral discussions. Exploration on going.
- No chair has ever come forward to take this work forward.
- Budget of 20,000, remaining \$15,857

### Advocacy- Erin Kenney

- Aim has been to develop a paper that explains costs of cluster leadership and participation at country level and that encourages donors to fund country appeals.
- One suggestion was to use in part feedback from the Joint Country Missions, even though this is not in TOR of the JCMs
- No chair has ever come forward to take this work forward.
- Next session, determining way forward to complete these tasks in 2008. Proposal of WG to take on this and other advocacy issues.
- None of \$34,000 funds used so far. Planned to bring in partners to WHO fund raisers, conduct donor visits, or attend other donor events together.

### GHC meetings- Erin Kenney

- \$40,000 allocated; \$4,800 spent; remaining \$33,400

### Wrap Up - Linda Doull (morning chair)

- All products are getting closer to be finalized. However, there are question marks regarding the dissemination. We need to consider if training is required or if guidance is sufficient.
- We need to ensure coherency and linkages between the products and the WGs.
- WG should share lessons learned with other WGs.
- We need to keep momentum going and stick to our timeframes and deadlines. This will mean participation from everyone.

### Special Session on Myanmar-Alessandro Loretto

- See power point presentation [Cyclone Nargis](#)
- Update on situation
- We need to look into who is doing what where
- Challenges, constraints, opportunities, synergies
- Most probably we will send in an HCC, but not yet determined
- GHC partners need to encourage their staff in Myanmar to work with WHO as cluster lead and communicate and attend coordination meetings
- A communicable disease assessment document will be issued in the coming days

Afternoon Chairperson: Paul Spiegel, UNHCR

### 4. Commitment to work plan, participation, working arrangements- Erin Kenney

- See power point presentation on [GHC working arrangements and structure](#)
- Aim of this session is to agree to any changes to our working arrangements to facilitate the participation of partners and the completion of the 2008 work plan
- Currently we have 4 WGs, 2 Task Forces, 1 Steering Committee; Active participation in GHC plenary meetings but limited participation in working groups; WHO chairing or co-chairing all working groups; lots of email traffic and teleconference schedules; Work not mainstreamed into all organizations (many have not included GHC in job descriptions of staff)
- Proposal of the following actions: Merge working groups to bring together related products while keeping focus on priority areas of work; Reduce number of working groups; Ask each partner to participate in only one working group to concentrate our efforts; Establish WG co-chairs (one UN and one non-UN); Reduce email traffic by using website; Establish regular teleconference schedule; Circulate internal monthly update on progress (to avoid partners joining WGs simply as observers)
- Agreement was reached to merge existing structure into 3 working groups: Guidance and Tools, Country Support, and a third group to look at the unresolved issues
- WG Guidance and Tools to include: IRA, comprehensive tool, benchmarks, 4W, early recovery paper, gap analysis, health cluster guide, monitoring and evaluation tools
- WG on Country Support to include: Health Cluster Coordinator roster and training, integration of cluster approach and related capacity building, promotion of capacity building of national stakeholders
- The third group would take on advocacy, public/private partnership, attracting southern partners, endorsement/obligations issues, membership, health cluster branding, and evaluation of achievements and impact of the GHC so far
- Agreement that partners would split into one of the three groups during the afternoon session to discuss the role of the group, its TORs, and the way forward. Feedback to be provided by each of the three new groups the next day. See meeting summary, session 9 below for outcomes and final decisions based on group work.

## **5. Remarks by Dr Eric Laroche, Assistant Director General for HAC**

- The ADG noted that this was his first Global Health Cluster meeting and that he was very pleased to attend and to meet everyone.
- We need to ensure that what we are doing really makes the humanitarian health response more predictable, accountable and effective.
- We have to work for the affected populations.
- We have to be accountable to deliver at the field level.
- We need to get partners sitting at the same table; different responsibilities and competencies but the same level of engagement.
- The cluster was meant to make a difference to the people in the field. The cluster means equal partnership but not equal responsibility. The one who is ultimately accountable is the Humanitarian Coordinator (HC).
- We have to ask ourselves what we are working for. What we are discussing here needs to be relevant for the field and whatever happens here needs to have a connection to the field.
- The cluster lead in country must have the right to decide who they want to hire as health cluster coordinator. We at the global level need to have the mechanism and rosters in place to be able to deploy the right people.
- We have to think about how we can involve and include NGOs in the field. Working together takes a lot of time but is crucial. We cannot work in a vacuum; we all need to work together.
- Myanmar offers an immediate example of the challenges: how to get government on board, how to avoid stove piping between sectors, how to make inter cluster linkages, how to move from normal coordination mechanisms to more active cluster mechanisms, how to link in GHC products, how to integrate early recovery from the start?
- How can we get the message of the cluster approach to the field level? Should the global clusters be involved in the circuit from risk reduction to preparedness to response to recovery to risk reduction, or only in response?
- We have to look at ways to measure the effectiveness of the response and the benefits of our work. HNTS should be one measure. We need to get and present baseline data. WHO should be able to provide that: a health landscape.
- The role of the GHC should be to give parameters within which health actors should work.
- There is an increasing professionalization of the work we do. We have to consider issues such as access and humanitarian space.
- There is an important role for this group and we need to use this opportunity.

## **6. Streamlined working groups meet separately to determine chairs, TOR, and next steps**

- Three newly formed Working Groups met separately to determine the way forward to ensure coherency between products and prepare to report back on Thursday.

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| <b>Thursday 8 May 2008</b> |
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Morning Chairperson: Muireann Brennan

## **7. Open second day of meeting; review objectives of the day- Muireann Brennan**

## **8. Report on issues from IASC and their implications on global and country cluster work - Jamie McGoldrick, Head of Humanitarian Reform Support Unit/OCHA**

- It has been two years since the humanitarian reform was adopted and the response in the ongoing crises in Myanmar will show if it made a difference.

- With the cluster approach we started using a new 'vocabulary' that has been confusing for the field. We have learned our lessons about imposing this on the countries. We need to de-mystify what the cluster is and show that it is a field driven response. We need more help on this from global clusters and leads.
- Leaders within the United Nations are supportive of partnerships and the cluster approach.
- OCHA should not be operational; we should be the facilitators and give guidance and support to the clusters.
- We have started to bring in southern countries in our discussions with the G8. We have to show that the cluster approach will be an improvement and lead to positive change.
- Where we are now: The Rome statement confirmed support for the cluster approach and the continuation of the humanitarian reform.
- All three areas of the reform are mutually reinforcing.
- We have three types of countries: countries that have introduced the cluster approach, countries that are on their way to adopting the approach and countries that are resisting the cluster approach. OCHA is supporting the countries in the process.
- We have to feel that what we do here at HQ has an impact at field level. So far the field is not feeling the impact of the global clusters.
- Contingency planning needs to be an ongoing project and we need to have a pre-determined leader and stockpiles for a crisis.
- The cluster is the first step in delivering as one.
- There is a coming together of the various levels and players: ERC, HC, Cluster Leads.
- The donors have not closed the door for future funding to the global clusters. We are sure that the stand alone cost will go down the longer we continue.
- We want to create a general monitoring tool that shows the effectiveness. We have to track the effects and the benefits and show to the donors and G7.
- And there are many other issues we need to be looking at now: economic meltdown, climate change, food insecurity and prices.
- We have to keep an eye on the beneficiaries and the reasons why we are all in this work.
- We need to work more on preparedness and operational predictability.
- And we have to show impact through monitoring and evaluations.
- Issues raised by GHC plenary include: leadership in cluster approach still unclear; lots of responsibility without the authority; cluster won't work well until Delivery as one works well; the partnership reflex does not exist yet; government support does not exist yet; IM support not yet there; collective thinking should lead to better answers; there is no performance evaluation for HCs yet; culture change takes time; donors need to be pressured to really take on the good humanitarian donorship

## **9. Report back from Streamlined Working Groups**

### **Working Group on Guidance and Tools**

- See power point presentation: [WG Guidance and Tools report back](#)
- Co-Chairs: Nevio Zagaria (WHO) and Nichola Cadge (Save UK)
- Plan to work and have monthly updates through teleconferences.
- WHO will organize the translations that need to be done.
- Co-chairs will ensure work is finished and that there is coherence between products.
- Co-chairs to look for ways of linking guidance and tools to Joint Country Missions
- Products and their focal points:
  1. Health Cluster Guide - Nevio Zagaria
  2. Reference document for identifying and addressing gaps-Linda Doull
  3. Reference document on health recovery and transition-Nevio and Samuel Petragallo
  4. Development of software for the IRA and HNTS-Jonny Polonsky, Richard Garfield
  5. Benchmarks-Jonny Polonsky and Richard Garfield.
  6. Development of generic tool for monitoring implementation-?

### **Working Group on Country Support**

- See power point presentation: [WG Country Support report back](#)
- Co-Chairs: Gillian O'Connell of Merlin and not yet determined
- Products: Health cluster coordinators training (Robin), Joint Country Missions, Roster process (Edith), building national capacity of stakeholders (Jonathon), regional and country training and integration of cluster approach (Elizabeth)
- Propose to reduce from 12 JCMs to 6 JCMs; revise JCM TORs; add one day workshop curriculum; identify WHO focal point on this

### **Working Group 3**

- See power point presentation: [GHC Steering Committee report back](#)
- Proposal that WG 3 should become the GHC Steering Committee to determine direction for the GHC, the strategy for realizing it, and the conceptual framework for addressing the various issues that have not yet been fully taken on: advocacy, membership, partnerships (including with the private sector and with southern based actors), endorsement obligations, marketing and branding, and evaluation of achievements and impact of the GHC so far
- Chairs: Mary Pack of IMC and Eric Laroche of HAC/WHO
- Members: to be determined; suggested mix of UN and NGO and perhaps a donor representative (not more than 6)
- Products: paper describing the options for the GHC after 2008; depending on the option chosen, another paper is anticipated that would be a concept paper including a strategy that could be used as an advocacy and resource mobilization document describing the GHC achievements so far, plan of work for beyond 2008 and related required resources
- This proposal was fully supported by the plenary

### **10. Common current concerns, plans and operations- Alessandro Loretto**

- Contingency planning and joint appraisals are important
- GHC should consider Risk Analysis as a key function
- We need to move from information to intelligence to judgements to decisions
- We need to share information and make it useful
- Proposal to have periodic teleconferences to discuss issues of concern; proposal to do this either right before or right after the circulation of the IASC Early Warning Report; several partners expressed interest in being involved in this

**ACTION:** Alessandro Loretto to follow up to arrange next ER teleconference.

#### Afternoon Chair: Johan Heffinck, ECHO

Short presentation on the **Health in Fragile States Network** by Nichola Cadge of Save the Children UK. A steering committee that includes Linda Doull, Robin Nandy and Nichola meet via teleconferences two times per month to exchange information. Concentration on policy issues.

Short presentation on **WADEM** by Marv Birnbaum to explain the work of this new GHC partner organization. See [WADEM background document](#).

## **11. Field realities: implementing the cluster approach and improving the humanitarian health response**

This session included the following presentations as a basis to discuss support needed by country clusters:

(1) Perspectives from WHO: Daniel Lopez Acuna, Director, REC/HAC/WHO

(2) Perspectives from HCC: Videotaped interviews: Olu Olushayo (Uganda) and Ahmed El Ganainy (Sudan)

(3) Perspectives from Cote D'Ivoire JCM: Anne Golaz, UNICEF

(4) Perspectives from recently trained HCC. Elizabeth Berryman, Save UK

(1) Daniel Lopez Acuna reminded the plenary we should not be asking ourselves how we can respond to all country requests for help, but rather to consider particular process challenges, especially in the chronic countries. We need to look at supporting the country process of adopting the new working method. The decision has been made to use the cluster approach in all HC countries, but we need to monitor the process and look for impact. The JCM are an opportunity to take stock and identify gaps. We need to look at the most useful support from the GHC in each specific country case. Not all countries require the same support.

(2) See the [video of interviews by HCC](#). Support requested included:

- Direct communications with GHC for sharing information and for requesting support
- Efforts to build awareness and commitment within partner organizations
- Technical experts
- Development, dissemination and adaptation support of guidance and tools
- Clarification of functions within cluster lead country office
- Compile, document and disseminate lessons learned and best practices from cluster implementation in different settings
- Training and capacity building
- Inter-cluster linkages at global level
- Advocacy
- Regional stockpiles and related procedures
- Systems for monitoring and evaluation (of effectiveness of country and global activities)

(3) See the power point presentation on [JCM to Cote d'Ivoire](#)

- Main findings included; cluster approach adopted in February 08, a month before assessment mission; no HCC; limited WHO field presence weakening its ability to coordinate health at field level; MoH weak capacity; little knowledge of cluster approach; worry about who would handle and ensure follow up to the JCM; consider aligning JCMs with CAPs and CERF preparation; JCM need to include workshop to bring partners together and discuss plan of action based on mission recommendations, and learn about cluster approach and GHC products.

(4) Support requirements as seen from the recently trained HCC include:

- Train the WRs in the countries with cluster approach so they are aware of the HCC and that they can provide input in the selection of the HCC when a crisis happens
- Appoint clear focal points for communication in the HQ for funding and technical expertise
- Provide additional support for non-UN HCC to navigate in the UN system
- Direct communications system to HQ and regional offices
- Emphasize that in acute crises the EHA coordinator and HCC are two separate people
- Establish fund to enable HCC to get started

- Improve future HCC trainings:
  - Provide the participants with key bullet points instead of exercises
  - More emphasis on tools; make training more technical on tools
  - More emphasis on health systems
  - A third of the participants were from non-UN organizations, at future trainings, this group should be larger
  - Médecins Sans Frontières (MSF) should be invited to take part in the training. They are not part in the GHC, but they have been coming as observers, they are key health providers in emergencies
  - Train on best practices, especially on coordination (check list more helpful than an exercise)

## **12. Options for the Global Health Cluster 2009 and beyond**

The newly formed GHC Steering Committee that met the previous day and reported back in point number 9 above, proposed five possible options for the future of the GHC after 2008 (when the current global appeal funding ends):

1. Close up shop
2. Continue to meet for global level consultations but without activities and without any funding requirement
3. Continue country support activities with help from the Hub
4. Continue country support activities, plus the possibility of developing other products, with help from the Hub
5. Continue country support activities, plus the possibility of developing other products, with the help of a reinforced Hub that includes full time technical experts preferably seconded from partner organizations

### Discussion:

- A paper should be written describing these options by mid June, so that the GHC can make an informed decision on the way forward.
- Agreement from all partners that option 1 was unacceptable. The GHC is a valuable forum to continue.
- The option we choose should be aligned with the thinking of donors.
- Some partners voiced support for options 3 and 4, while others thought that option 5 lent the most potential support from the GHC to a more effective humanitarian response.
- Within 2008, the work of the WG on Guidance and Tools will be complete. But more time will be required to complete the work of the WG on Country Support including training, workshops and tool dissemination. This will require a coherent approach that is expected from WG on Country Support (strategic paper required).
- Any resulting GHC work plan for 2009 and beyond should focus on country implementation and country support.
- We should set goals for the next five years instead of just annual goals. Look at medium and long term goals. State vision, mission, objective (working better together to improve humanitarian health action)
- During acute emergencies, a reinforced Hub should provide technical support and ensure that the HCC has been put in place by Cluster Lead Agency using the roster.
- Some partners wanted to see the Hub remain neutral and inter-agency, and not as a part of HAC. The Hub needs to be perceived as GHC staff and not HAC staff.
- The question was raised about who should be supporting the roll out of the cluster approach: Is it the Hub or is it HAC as cluster lead?
- If the GHC decides to continue to exist in the form of options 3-5, then funding will be required. This should be part of the concept paper from the GHC Steering Committee.

**ACTION:**

The GHC Steering Committee must complete an options paper by mid June, a concept paper by mid September, and arrange a GHC meeting with donors in October.

Strategic paper by WG on Country Support to describe a coherent plan for the various activities (HCC training, partner training, JCM, etc)

**AOB**

Next meeting will take place in November in North America. Suggestion was made to have the meeting in the field. However that means much higher costs for participants. Erin to make the next meeting arrangements.

**13. The meeting was closed by Dr. Eric Laroche, Assistant Director General, HAC/WHO**

---End of record---