Meeting Summary

Hosted by UNICEF, NYC, 12-13 November 2008

Participating agencies: Africa Humanitarian Action(AHA), American Refugee Committee International, CARE, Catholic Relief Services, Center for Disease Control, Columbia University, ECHO, Harvard Humanitarian Initiative, International Medical Corps, International Rescue Committee, Johns Hopkins University, Merlin, Save the Children UK, Save the Children USA, UNFPA, UNHCR, UNICEF, Women's Commission, World Association of Disaster Emergency Medicine, World Vision International, WHO

Click here for full list of Meeting Participants

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Wednesday 12 November 2008

Day's Objectives: Gain common understanding of progress on GHC work plan 2008, related challenges and solutions; impact on field operations; gain insight for determining the way forward

Chair: Linda Doull, Merlin

1. Opening Remarks by Eric Laroche, Assistant Director General, HAC/WHO

Welcome to everyone. Great to see the ongoing commitment to the health cluster and to working together to improve humanitarian action in health. Happy to welcome first time participants who have asked to join our efforts from Catholic Relief Service, CARE and the American Refugee Committee International. Thank you to our colleagues at UNICEF for hosting us this week and for all the preparatory work, particularly by Robin Nandy and Andrea Thomas.

There has been a great deal of hard work that has been done since our meeting in May in Geneva. However, success at the global level is only relevant if it is improving health action at the country level. We cannot put more resources (time, staff, funds) into global level action, or ask for additional funding, if we cannot demonstrate our effectiveness.

We have to look at accountability. The architecture of humanitarian reform makes clear the lines of accountability of the cluster lead agencies at global and country levels. But what about the obligations and accountability of you the partners. Should participation in such forums continue to be voluntary, or should each of us have specific obligations to fulfil. This is part of the evolving process of the humanitarian reforms, and we must have this discussion as we move forward. Gap filling is everyone's responsibility. We have committed as cluster lead to serve as provider of last resort, but what is the commitment of partners to ensuring that gaps are filled and health action is effective? We need to be frank and look honestly at the challenges we face. If we share our views we need also to commit to the outcomes of the discussions. We need to work together.

Finally, we need to look beyond health action and consider how to move forward on technical collaboration on inter-sectoral issues. Who is responsible for making this dialogue and planning happen? For monitoring the results? What is the role of OCHA? We need to encourage OCHA to clarify its role and the services it will provide to the international humanitarian community.

At the donor/cluster lead meeting that took place on 22 October, donors voiced their appreciation and satisfaction with the results of the cluster approach. We have moved past counting how many countries have activated the cluster approach to HOW they implement the cluster approach…from

quantity to quality. We too at the global level must increasingly focus our attention to how we can best improve the quality of country level planning, response and recovery and achieve our ultimate goal of a systematically more effective and predictable and accountable humanitarian health action.

2. Update on cluster implementation at country level

(Daniel Lopez Acuna, Director, REC/HAC/WHO)

See Presentation on Cluster Implementation at Country Level

With 26 countries implementing the cluster approach by the end of this year, we have to make sure that they are ready and that the necessary resources are in place. We have to be clear on where the resources will come from. It is our role as the GHC to advocate for clusters at country level and for the funding of cluster functions through CAPs and Flash Appeals. We also need to look at having some seed money at the global level for immediate deployment and support to country clusters. Some partners agreed with this approach including the idea of establishing an emergency health cluster fund. Mainstreaming means that we all have to include elements of cluster work in our appeals and in our budgets at global and country levels. Partners stated that they are committed to mainstreaming cluster within their organizations but that the financial commitment was significant and difficult, especially given the current financial crisis that will seriously affect private contributions.

See Table Overview of Cluster Functioning in the Current 19 Countries. The table shows varying levels of engagement by partners. The majority of countries have conducted single agency assessments instead of joint needs assessments. There is very little joint contingency planning and little joint strategic planning.

The Joint Country Missions have taught us a great deal. See Table of Main Findings of the JCM. The members of the country clusters need to be briefed about the cluster approach. We need to reach out to the RO to get their support. We should include donors on these missions to give them an understanding of the complexities at country level. We need to better market and disseminate GHC tools at the country level. Particularly about joint needs assessments.

Partners voiced disappointment that there have only been three dedicated HCC appointed out of the 26 cluster countries. There was agreement that the GHC and WHO as cluster lead needs to focus on making country clusters work and that requires dedicated HCC and much more awareness building among partners at country level.

3. Discussion on strategic issues related to the work of the WG on Country Support

(Robin Nandy (UNICEF) and Gillian O'Connell (Merlin), WG Co-Chairs)

See Plenary Presentation of WG on Country Support

Progress in 2008: Important progress has been made: 4 Joint Country Missions (JCM), two tri-cluster trainings, one HCC training in December; total of 40 HCC trained since establishment of GHC. To do this, the WG has reviewed the concept note of the HCC and improved the training over time, reviewed the TOR of the HCC, reviewed and adapted the training objectives for HCC training, revised the curriculum to emphasize processes, approaches and skills and the GHC tools to facilitate these processes, established an inter- agency mechanism for selecting HCC candidates, agreed to promote the guidance note recommendations on capacity building of national stakeholders, and will conduct a health and nutrition cluster workshop for the Horn of Africa in November 2008 in Djibouti and a NGO partnership integration workshop in January 2009 aiming at getting the NGO participants to take their learning back to their country clusters. All trained HCC have been accepted onto the roster, but with qualifications about where they are ready to serve (chronic or acute, national or sub-national) and their availability (short term or longer term).

Issues and challenges: Country level support and acceptance of cluster approach is still weak; suboptimal country level leadership; roster candidates were from global level and were too experienced and therefore unable to be released to take a HCC post; need to focus more on those WHO staff currently wearing two hats (EHA and HCC) and promote the best of them to dedicated HCC; need guidance on how to use the roster; need regional buy-in of roster and its candidates, therefore trainings will now be regionally focused with representatives from the WHO regional offices

as resource persons and assessors; need to include training on early recovery, protracted emergencies, emergency preparedness; need to find innovative ways to build awareness and buy in among partners at country level; should we continue with JCM since they are limited in their impact and there has so far been no way to ensure that the recommendations are acted upon; length is too short to do a fair job, but too long to get GHC partners involved; if we continue, we need new TOR, much larger portion of the JCM should be a workshop, shorter time frame, more awareness building; we need to find a way to measure how clusters are doing: example of Haiti where feedback varies significantly and we do not have objective measures.

The following issues were raised during discussion: HCC need to be able to work in a team; we cannot underestimate the importance of their skill set; JCM should continue as a source of feedback for the GHC; recent WHO/ECHO evaluation to Myanmar was very useful and revealing; we need a better way to help the country clusters fill gaps and that is not happening with the JCM; WHO needs to work with its RO to get the recommendations implemented; WHO needs to commit to appointing a set number of dedicated HCC by the end of 2009; we need practical measurable goals to see how we do by end of 2009; we need 6-10 criteria to measure health cluster level of functioning; we need to be sure that the JCM allow those in country to voice their views openly; WHO and partners need to react to mission recommendations (so far mission participants have received no feedback on any report); we could oblige WRs to make written response to recommendations within a certain timeframe; need a WR workshop to get them on board; we might want to consider setting up rapid response team to go into any cluster country to help with its set up.

Priorities 2009: Train all sitting HCC (including EHA with 2 hats); create a demand for designated cluster coordinators by marketing to WR and RO; WHO must hire the roster coordinator and have that person manage the roster and keep in constant contact with candidates; continue HCC training; hold annual workshop of HCC for lessons learning and sharing; ensure the quality and utilization of the acute and chronic roster; developing capacity at country level in the cluster approach, processes and GHC tools; encourage all partners to work on building awareness and to brief staff; need to clarify to all WR and HCC and country clusters the point of contact for cluster questions/support (a specific post either in RO or in HAC; develop training module to be integrated in any partner deployment briefing or training; develop operational guidance checklist of action and make all partners responsible for making those cluster actions happen at country level.

4. Discussion on strategic issues related to the work of the WG on Guidance and Tools

(Nichola Cadge (Save UK) and Nevio Zagaria (WHO), WG Co-Chairs)

See Plenary Presentation of WG on Guidance and Tools

Progress in 2008: Guidance and tools nearing final drafts; already field tested and used in the field; ongoing work with Nutrition and WASH on the IRA; IRA endorsed in latest draft version by the three clusters; OCHA modified its 3W to include the GHC fields; HeRAMS tested in Darfur and Afghanistan; draft indicators proposed; near a final draft version of Health Cluster Guide for field use in 2009 that was reorganized to reflect revised HCC TOR; semi structured questionnaire developed for peer review of Guide.

Issues and Challenges: IRA needs to be introduced within contingency planning; IRA guide needs to be much simpler; how to get IRA accepted at field level; challenge of indicators is to agree on small number that all partners agree to use in acute and chronic emergencies; how these GHC tools link to the larger picture of the IASC and OCHA platform of information management. Important that GHC tools are used as a package and are tied to training and contingency planning at country level; ensure work at country level on tools involves national stakeholders and capacities.

The following points were raised during discussion: need to add health promotion and community outreach to HeRAMS; consider using Google or mobile phones; focus should be on building skills and buy-in; all partners must take responsibility for marketing tools at all levels

Priorities 2009: Develop tool dissemination plan; investigate synergies and common languages with Nutrition and WASH; focus on dissemination and roll-out of the tools at field level; appoint full time

focal point to drive the process and to advocate and be responsible for this work; systematic testing of tools to gather lessons learned for later adaptation and finalization in end 2009.

5. Health Cluster Functions and Responsibilities and HCC TOR

(Nevio Zagaria, REC/HAC/WHO)

See Table of Health Cluster Roles and Responsibilities

When the cluster approach was introduced, the HCC TOR was a mirror of the responsibilities of the Cluster Lead Agency. Our thinking has evolved and the HCC cannot do everything. Responsibilities can be shared between the HCC, the CLA and partners. One of the outcomes of our meeting in London at Merlin was a revision of the HCC TOR, the other was a table differentiating between the various roles and responsibilities of these three actors.

The following points were raised in discussion: the GHC needs to discuss the difference between being a participant and being a partner; partnership is critical; the title is not the issue, but rather the responsibilities that go along with the relationship and commitment; true partnership is very important. Networks can be very loose, we need to know who is responsible for what and who is doing what; perhaps HCC should report to HC and not to WR; how does the GHC fit in? should the HCC not consult the GHC?; perhaps the national authorities should be another column in the Table; there is still a lot of work to be done by the IASC on accountability; this was discussed also at the 22 October donor/CLA meeting; the GHC can feed into this discussion; we need to make the Humanitarian Country Teams see their responsibility as well; we need to consider the Humanitarian Accountability Project; we need a similar Table for the GHC to understand what our roles and responsibilities are to the GHC; GHC representatives support the GHC but have to continually justify it to their supervisors and agencies so the idea of committing to more is difficult for some; if the HCC and the CLA function well then partners will come (it is best to entice rather than force); table doesn't reflect work of partners in implementation at country level.

Agreement: Partners need more time to consider this issue internally and determine what they are willing to take on and commit to; but we should not divide the GHC into partners and non-partners; we have to find solutions/definitions reached by consensus.

Action:
WG G&T to develop a draft Table of GHC roles and responsibilities as a first step in this process, to add note to top of this Table that this is all in support of national authorities priorities and to add a row called "Programmatic Implementation" to show the work that partners are doing in executing humanitarian health action.
Partners to provide feedback on table by end December 2008 to Nevio (zagarian@who.int)

6. Discussion on the GHC Strategic Framework by WG on Policy and Strategy

(Mary Pack (IMC), Heather Papowitz (OFDA), Johan Heffinck (ECHO)

See Plenary Presentation of WG on Policy and Strategy

Progress in 2008: Options paper feedback led to Strategic Framework 2009-2011; the SF was presented and explained. See Draft GHC Strategic Framework 2009-2011. The final draft will be completed and placed on the website by end December 2008.

The following points were raised in discussion: This WG should make recommendations on how the GHC should position itself to get funding for country clusters; this WG should work on defining GHC and CLA accountability and work with Sir John Holmes on this question; the M&E must clearly separate country cluster processes from health outcomes.

Action:
WG P&S to complete Strategic Framework by end December 2008, circulate widely, put on website.

7. Update and discussion on HNTS by Pierre Salignon, Interim Manager, HNTS

Pierre introduced himself and explained that he has spent the last month getting up to speed and meeting with experts and stakeholders to see the way forward; in the coming weeks he will define an action plan for the coming 6 months; he asked agencies and the GHC to specify what they wanted from the HNTS and whether they were looking for normative or operational services from HNTS; Pierre asked for opinions and input from all concerned; HNTS aims to make information lead to action; success depends on the partner organizations; he expects partners to be pro-active and to help steer the way forward. There is currently an HNTS staff member in Kivu to look at possible HNTS support to the crisis. Pierre encouraged partners and the GHC to contact him and to make recommendations. If HNTS don't succeed in the next months it will be a collective failure. Still work ahead to organize the steering committee.

The following points were raised in discussion: strong support for the idea of opening a field office; we need to establish a process to measure mortality, malnutrition etc in a crisis situation; partners need to give a clear mandate to HNTS so they can move forward; we need HNTS to compile and make sense of data and validate data; we need to link HNTS to the Sphere standards and the revision of Sphere; we need more clarity on what HNTS can offer; we need to know and understand the core functions of the HNTS; we need a TOR of HNTS; we need to be able to respond to the finding of HNTS; we need to be ready to respond if HNTS tells us that mortality is increasing; we need to build understanding about what HNTS is and its core functions.

Daily Wrap Up: We need to make sure that the work plan developed tomorrow (13 November) includes the issues highlighted and discussed today and the lessons learned from cluster implementation about how the GHC might be most effective and useful; build guidance notes as discussed (on roster, on accountability, on roles and responsibilities at global and country levels); find solutions to sustainable funding for cluster work; ensure wide scale information and awareness and buy-in, share lessons between HCC; appoint dedicated HCC; provide feedback to HNTS to steer its way forward.

Thursday 13 November 2008

Day's objective: Gain common understanding of issues related to cluster implementation; gain understanding of WHO's programme of work and funding for 2009 and beyond and how it relates to the work of the GHC; reach agreement on GHC work plan for 2009 with aim for increased impact on field operations, related funding channels and the way forward

Chair: Johan Heffinck, ECHO

8. Update/discussion on inter-cluster work, cluster implementation, donor/cluster meeting 22 October, phase 2 cluster evaluation, Humanitarian Health Appeal

(Daniel Lopez Acuna, Director REC/HAC/WHO and Johan Heffinck of ECHO)

Humanitarian Tracking Tool. We must move now from the number of cluster countries to the quality of implementation; shift to operational and strategic focus, rather than a focus on coordination; still much work to be done on global awareness and the acceptance of the cluster approach; Humanitarian Tracking Tool from OCHA provides some insight into the level of cluster implementation at country level: 16 countries responded of which only 7 countries have a compact between the HC and the ERC, only 11 have a common humanitarian platform, only 12 countries report that they are having inter-cluster meetings, only 3 have early recovery networks.

Donor/CLA meeting of 22 October. The meeting was positive; donors want cluster work mainstreamed within CLA and partner agency programs and budgets and funding mechanisms; and the field level costs need to be included in CAPs and Flash Appeals; the GHC is one of the only clusters with a strategic framework.

ECHO cluster survey. See Presentation on ECHO informal survey on cluster implementation. ECHO asked seven open questions of its field staff; feedback from 21 out of 26 countries; results were a

general appreciation for the cluster approach; added value recognized; but with much variation between countries; significantly more inclusiveness of NGO; cluster leadership key to success; disconnect between global and country and between national and sub-national clusters; meetingitis; weakness of inter-cluster coordination and humanitarian country teams.

Action:
ECHO to circulate informal survey questions

Cluster Evaluation, Phase 2: Aim to assess the operational effectiveness of the cluster approach; whether clusters are identifying and filling the gaps; this is a move from the Phase 1 Evaluation that focused on cluster processes, meetings and participation. Consultant will meet with lead agencies to discuss indicators; outcome should be practical recommendations; set to begin in January; pending issues include selection of the countries (4 chronic and 2 sudden onset emergencies)

Agreement of GHC to move away from processes and towards outputs and outcomes.

Humanitarian Health Appeal: The proposal is one appeal that captures the funding needs of all health actors; something to consider for 2010.

9. Update on the WHO 5 Year Institutional Strengthening Program and mainstreaming of health cluster activities

(Daniel Lopez Acuna, Director REC/HAC/WHO)

See Presentation on WHO 5 Year Program and Mainstreaming of Cluster Activities

The WHO 5 Year Institutional Strengthening Program includes work in preparedness and emergency response and recovery. It is a follow up to the WHO 3 Year Plan but now with the cluster approach as a main area of work throughout. It is based on the WHO institutional framework of SO5; Pillar 1 of this program concerns the implementation of the cluster approach in all priority countries; the GHC work plan is a fundamental part of this work; cluster lead agencies has been asked to mainstream the cluster in their work plans and the result is this 5 year plan; it is about capacity building which has a major component being the health cluster work at global and country levels; WHO needs the GHC behind this way of thinking and way of including GHC activities in this funding proposal; we need to define the GHC work plan for 2009 and insert it line for line in the WHO funding proposal related to its 5 Year Program; we can highlight the activities within the 5 Year Program that are GHC activities to be completely transparent to donors and to partners.

The following points were raised in discussion: the 5Year Program should reflect the expected restructuring of HAC, the activities of the GHC within the 5 Year Program should be clearly labelled as such, mainstreaming can be seen as negative to the partners if all the funds will go only to WHO?; this is a good way to move forward for funding of GHC collective activities and the WHO inputs to those activities, but many NGO partners do not have similar funding mechanisms to raise funds for their own inputs into the cluster at global and country levels; the secretariat should remain within the plan; it would be helpful if partners documented their contributions to the cluster activities at global and country levels, to combine as a full package (maximum 5 pages).

Agreement for WHO to proceed in this way, to mainstream GHC work, to mobilize resources on its own behalf and on behalf of the collective activities of the GHC; more thinking required to see how partners can raise funding for their own inputs to cluster work (staff, travel, time, etc)

Action:
Partners invited to document their contributions to the cluster activities at global and country levels, to combine as a full package (maximum 5 pages each).
Partners invited to send comments to Daniel on the WHO 5 Year Program by end December.

10. Update on guidance by IASC Task Force on Safe Access to Firewood and alternative Energy in Humanitarian Settings (IASC Task Force SAFE) by Erin Patrick, Women's Commission

This is one of a series of presentations to the GHC over time to update partners on the work of the IASC Task Forces and Working Groups. The GHC has had similar presentations from the IASC Sub-Working Group on Gender and Sexually Based Violence, the IASC Sub-Working Group on Mental Health and Psychosocial Support and the IASC Task Force on Age-ing.

The IASC Task Force SAFE is co-chaired by the Women's Commission (working under the authority of InterAction), UNHCR and WFP. It is looking at humanitarian issues related to fuel and firewood collection, supply and use. It has developed a matrix of roles and responsibilities and a decision tree diagram to guide appropriate fuel strategies within the various sectors and in various settings. The guidance is expected to be endorsed by the IASC and circulated in 2009. The Task Force considers this a cross-cutting area of work; the Task Force has created a technical network and a website (www.fuelnetwork.org); various sectors have contributed concerning indoor air pollution, shelter design for optimal ventilation, related sexual violence, etc.

The issue was raised by the GHC as to whether this responsibility should be within an existing cluster such as shelter or protection or any cluster that then takes on the responsibility of ensuring any areas of strategic and operational overlap with other clusters. However, the Task Force defines this as a non-sector specific cross-cutting issue.

11. The GHC in 2009: finalizing the work plan in accordance with GHC Strategic Framework

Prior to this session, the WGs prepared their elements of the GHC work plan for 2009, arranged by Strategic Priority and Goals within the Strategic Framework, based on the issues raised during this two day meeting and the lessons learned over the past two years. During this session, the WG elements were consolidated into one draft GHC work plan for 2009. It was agreed that funding for this work plan would come from WHO resource mobilization efforts, supported by partners, towards its 5 Year Institutional Strengthening Program in which the specific GHC line items would be highlighted.

See Draft GHC Work Plan 2009 as developed during this session

Action:
WG Co-Chairs to submit track changes on draft work plan by 10 December to Erin for finalization by end of 2008.

12. GHC Meetings in 2009

Agreement to have two GHC meetings in 2009 in May and November. One should be in Geneva with the 6 WHO regional advisors; one should be in Nairobi with representatives of the regional health clusters. The GHC might try to arrange back-to-back the HCC workshop and the November GHC meeting to benefit from as much HCC participation as possible.

Action:
Secretariat to circulate options for dates (and locations) and to confirm in early 2009.

13. Brainstorming on GHC priority issues in humanitarian health in 2009

Priority areas of humanitarian health that should be considered by the WG on Policy and Strategy include the following so far. The WG will choose a few areas on which to concentrate its work in 2009 and will keep the GHC informed on progress. (listed in order recorded)

1. User fees
2. Funding during transition and recovery (example of Cote D'Ivoire)
3. Advocacy-what is the role of the GHC
4. Cross cutting issues-what should the GHC be doing

5. Gaining government support for cluster approach
6. Strategy for resource mobilization at country level (emergency fund? seed money?)
7. Governance
8. How to increase local involvement-southern based NGOs
9. Accountability
10. Linking training to most vulnerable areas (learning by doing)
11. Co-leadership
12. Private sector
13. Military and military assets
14. Non-medical, non-clinical areas such as social mobilization
15. Health promotion
16. Core Areas
17. Definition of Humanitarian Health Action
18. Marketing the health cluster
19. Attracting non-traditional donors (Gates Foundation?)
20. Supply chain
21. Health Sector under-funding
22. Do no harm, understanding root causes
23. Institutional relations with regional bodies
24. Primary health care-developing an understanding and prioritization
25. Environmental health as a gap area

14. Closing Remarks by Eric Laroche, Assistant Director General, WHO/HAC

First a thanks to Rick Brennan, who is leaving his post at IRC, for his dedication and valuable participation in the work of the GHC. This meeting has demonstrated how we can work as a team. Very positive interactions. We need to keep this going. Continue this way of working with openness and frankness and putting the elephants on the table to find ways to address the problems. Positive discussion and progress on funding and mainstreaming. Needs further discussion on developing a framework for planning the funding for each of us to meet our efforts in cluster work both at the global and country levels. The GHC Strategic Framework document as well as the WHO 5 Year Institutional Strengthening Program document have put us on a very good path. It has been important to link the GHC work to the wider process on the IASC, Humanitarian Coordinators, donors, inter-cluster work, etc. The issue of accountability has to be addressed. We have to work more on this among ourselves, but also with the ERC and IASC. WHO takes up the challenge and commits to having a minimum of 10 dedicated HCC in place by end 2009. Thanks to partners for their active participation. Thanks again to UNICEF for hosting. Looking forward to working together in 2009.