

Report on the

# First regional health cluster meeting

Cairo, Egypt  
5–7 November 2018



World Health  
Organization

Regional Office for the Eastern Mediterranean

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## 1. INTRODUCTION

The First regional health cluster meeting was held from 5 to 7 November 2018 in Cairo, Egypt. The meeting was organized by the Operational Partnerships team of the World Health Organization (WHO) Regional Office for the Eastern Mediterranean, in coordination with the Global Health Cluster (GHC) of WHO headquarters. Participants included health cluster coordinators (HCCs) and information management officers from nine Member States of the Region, who are working to drive the emergency operational response on the ground and fulfil WHO's mandate as Cluster Lead Agency for coordinating health emergency response.

The overall purpose of the First regional health cluster meeting was to strengthen capacity of HCCs, co-coordinators and information management officers in countries. The specific objectives of the meeting were to:

- strengthen understanding of how health clusters align with WHO at the regional and country level;
- operationalize health cluster guidelines and documents, including implementation of cash-based programming, taking an integrated approach with other clusters/sectors and guidelines based on the context of each cluster;
- improve information management through identifying gaps, suggesting solutions and sharing experience and resources, as available;
- improve quality of health care provided by health partners through improved cluster capacity and monitoring of services.

The programme for the three-day meeting was developed to address issues and challenges faced during emergency operations, and to determine how the Regional Office for the Eastern Mediterranean and GHC can support HCCs in overcoming the challenges. WHO headquarters and the Regional Office presented information to expand HCCs' understanding of various interventions and health service delivery strategies to be considered in an emergency, and strengthen coordination mechanisms.

## 2. SUMMARY OF SESSIONS AND DISCUSSIONS

### 2.1 Information management for health clusters

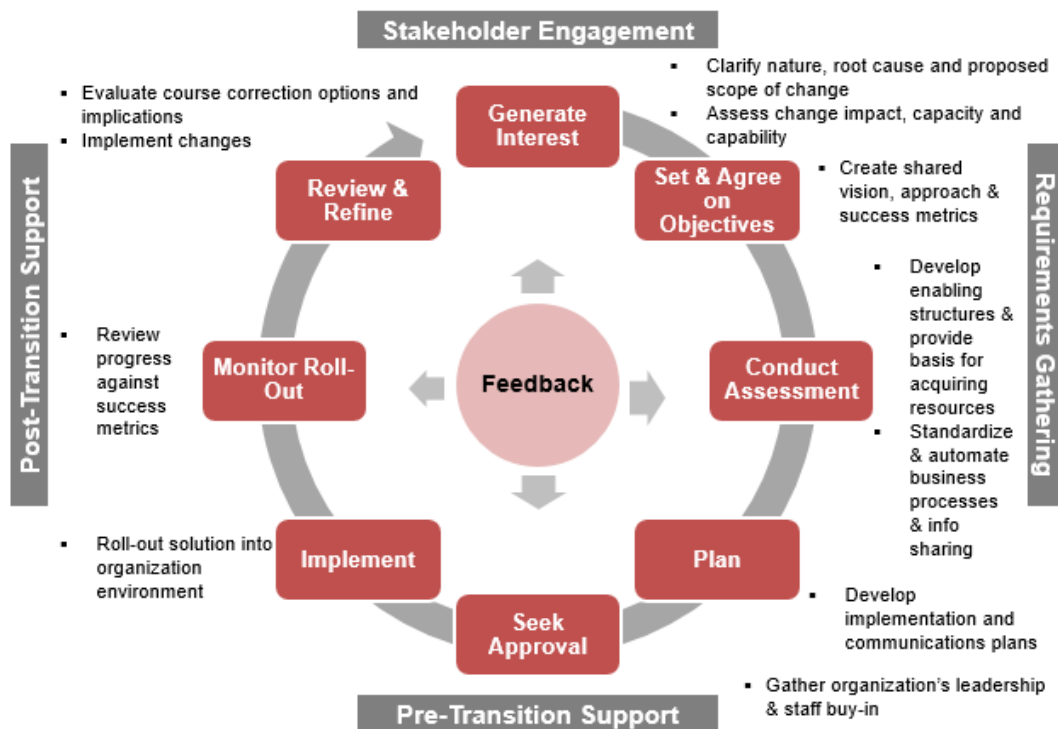
*Health Emergency Information and Risk Assessment (HIM): plans and support to health clusters*

The specific objectives and functions of the WHO Health Emergencies Programme (WHE)/HIM were presented. Ways to support countries to adopt and roll out the Standards for Public Health Information Services (PHIS), which is a priority for WHE, were explored. There is a need to standardize resources and introduce information technology solutions that build on current operating systems for harmonization. Information management is a critical function of humanitarian coordination mechanisms because it creates coherence, diffuses disputes and enables inter-cluster interventions. Information management is invaluable in emergencies to provide timely,

reliable and robust information to allow decision-makers to plan evidence-based response, monitor health status and mitigate risks faced by affected populations.

The PHIS Standards encompass a range of activities and products related to effective humanitarian coordination mechanisms, and aim to mitigate the challenges arising from multiple and conflicting health information priorities of different stakeholders. The Standards are designed to simultaneously standardize and support public health information at national and subnational levels, and include tools and resources to support the management functions of health clusters or equivalent coordination mechanisms. Discussions highlighted that implementation of PHIS Standards is a strategic priority for WHE, and HCCs and information management officers were advised to adopt the Standards to their own context to meet the different public health information needs consistently.

iMMAP is an international nongovernmental organization that provides information management services to humanitarian partners. A representative of iMMAP informed participants on the functions, activities and type of support the organization can provide to WHO country teams in relation to information, capacity-building/training and human resources. A Standby Partnership agreement exists between iMMAP and WHO that aims to foster good practices and new solutions to improve humanitarian preparedness and response, in terms of both capacity and capability. Through this partnership, iMMAP provide cost-efficient and effective services based on informed decision-making. iMMAP's cost-saving approach enables humanitarian aid and development organizations to reach more people and provide high-quality assistance that impacts the wider population. Figure 1 below summarizes iMMAP's information management process review, and the kind of stakeholder engagement that the organization adopts throughout the whole cycle of their intervention and the support they provide. The process involves data collection, data verification, data storage, information synthesis, and information visualisation. Furthermore, iMMAP confirmed that data received and collected from WHO and/or health cluster partners are never disclosed to any third party; such data belong to whichever partner iMMAP is working with; and the organization does not ask for raw data.



**Fig. 1. Information management process review**

### Action points

- HIM to set up data collection and data management systems and harmonize initiatives across the Region:
  - HIM has prioritized tasks and services requested by WHO country offices for 2019;
  - HIM has mapped existing tools and platforms in the Region and is developing a road map for 2019.
- HCCs and information management officers to adopt and implement PHIS Standards, as one of WHE's strategic priorities.
- iMMAP to provide data management support to countries in need. Pakistan, Palestine, Somalia, Sudan, the Syrian Arab Republic and Yemen to send their specific requests/needs for support to the Regional Office/GHC for coordination with iMMAP.

*Harmonizing indicators: discussion on core indicators for health cluster in emergencies*

WHO headquarters and the Health Operations Monitoring and Data Collection team within HIM are currently developing a monitoring and evaluation framework for emergency response, including indicators, in partnership with the Johns Hopkins University (JHU) Center for Humanitarian Health (CHH) and other stakeholders/agencies. The involvement of academia will provide an objective, evidence-based assessment of existing indicators, using a sound and standardized approach coupled with operational understanding. The main objectives of the partnership are to: define public

health indicators; agree a slimmed-down set of core indicators for emergency settings; and, measure the adequacy or effectiveness of these indicators in relation to humanitarian action needed, according to each emergency context. The exercise helps to address the growing demand for transparency and accountability, by providing context-appropriate core indicators that can be used across emergency settings to measure the strength of the health response.

Presentations by WHO headquarters and JHU detailed the ongoing partnership with regards to the need for coordination between WHO and other stakeholders, challenges identified, and which challenges are being addressed through the exercise. Prototypes of the project output were presented, and an open discussion took place on how JHU work aligns with and compliments the health clusters' vision and action plans.

During groupwork, participants were asked to work with a classification of indicators, as presented by WHO headquarters/Health Operations Monitoring and Data Collection: core versus specific indicators; mandatory versus optional indicators. Group 1 identified relevant indicators for global reporting (core indicators), while three other groups discussed HCCs' information needs for decision-making in three different emergency contexts – conflicts, natural disasters and epidemics. The purpose of the exercise was to inform both WHO headquarters/Health Operations Monitoring and Data Collection and JHU/CHH in their respective work, and to ensure HCCs' needs are addressed. The results of groupwork are shown in Table 1.

**Table 1. Classification of core and specific indicators**

<b>CORE</b>	<b>Specific indicator – epidemics</b>	<b>Specific indicator – conflicts</b>	<b>Specific indicator – natural disasters</b>
Resources	Affected population/ geographic area	Population access to health care	Type of disaster (acute onset)
Staffing: dedicated health cluster team in place (HCC, information management officer, communications officer)	Number of new cases in selected period (attack rate)	If HeRAMS available: functioning and human resources of a few critical services	Affected population
Funding: dedicated budget line for coordination	Underlying EPI data	EWAR reporting from health facility as a proxy for functioning	Affected infrastructure: health facilities
Coordination	Accessibility of population	Quality, resources, mass casualty incident trauma care	Affected supplies
Health cluster meeting taking place, with matrix of action points/follow-up shared	Resources available for response and assessment: financial, human, material	Surge national capacity	Affected personnel
Attendance (%)	EWARS/surveillance system in place	Referral pathways and change	Access to health facilities



CORE	Specific indicator – epidemics	Specific indicator – conflicts	Specific indicator – natural disasters
Ratio of technical/ management staff attendance	EPI data (coverage)	Population	Number/proportion of population affected (displaced/killed/insured)
Partners reporting to cluster (%)		Physical/geographic versus social barriers (coping/alternatives)	Number/proportion of health facilities affected (by level)
Strategic Advisory Group in place		Surveillance system of attacks	Number/proportion of health supplies
Humanitarian response plan in place (requires strategic response plan and humanitarian needs overview)		Conflict incidents	Number/proportion of health personnel (by cadre)
Existing database		Road closures	Access
Health cluster products available (4Ws, health cluster mailing list, health cluster bulletin, HeRAMS, EWARS/EWARN)		Active conflict	Displaced persons

HeRAMS = Health Resources Availability Monitoring System; EPI = Expanded Programme on Immunization; 4Ws = Who is Where, When, doing What; EWARS = Early Warning, Alert and Response System; EWARN = Early Warning, Alert and Response Network

### Action points

- HCCs to send current/2019 humanitarian data collection tools used to HIM for assessment for standardization.
- HCCs to send HIM a list of core indicators/type of data collected that are applicable to their specific context.
- WHO headquarters to finalize the monitoring framework project with JHU before health clusters establish a final list of core indicators for use in country contexts.
- Revise utilization of the word “core”, because core and specific indicators differ according to each context.

### *Harmonizing online systems and dashboards*

A questionnaire was distributed among HCCs, representing active health clusters across nine countries of the Region, to identify online data collection platforms used and analyse their strengths and weaknesses. Based on HCCs' collective responses, a guided group discussion, led by WHE/HIM, focused on identifying action points to ensure availability of a harmonized system, and building a regional dashboard for health clusters. Findings from the questionnaire and discussion, including capacity needs, gaps and required actions, are listed below.

- Three of nine countries (Pakistan, Somalia and Sudan) do not have structured data collections tools.
- Six of nine countries have online platforms; however, different tools are used throughout the Region.
- A decision will soon be made on which standardized platform to use in countries that lack an online system, based on advice issued by WHE/HIM.
- Once 2019 data collection tools are sent by countries lacking an online system, an online platform/system will be set accordingly, in collaboration with WHO headquarters, and information management officers will be trained on its use.
- There will not be “one platform” for data collection for all clusters: whatever is currently working in countries will be retained. The purpose is not to have a common platform, but to establish a regional dashboard to showcase health clusters’ work at the country level.
- GHC’s information management officer will liaise with all WHO regional offices to collate health cluster data, to collectively demonstrate cluster effectiveness and impact through a global dashboard.
- Somalia and Yemen are in need of iMMAP capacity for support in information management, and will send requests for support to be coordinated with iMMAP.
- Turnover of information management staff is very high; therefore, the information management function will be reviewed to see how it can be strengthened.

## **2.2 Health cluster internal organization**

Participants were divided into groups to consider some questions on health cluster performance monitoring. The results of the groupwork are given below.

*What potential challenges might adversely affect delivery of health cluster outputs?*

- Lack of (experienced) staff and high staff turnover (HCCs, information managers, etc.).
- Poor coordination between health cluster leads and partners, due to lack of understanding on HCCs’ role and WHO’s role as Cluster Lead Agency.
- Lack of access, limiting assessment capacity.
- Political friction.
- Available data not being used to drive the response, due to limited information sharing and issues around confidentiality.
- Inadequate planning and insufficient financial resources.
- Lack of standard operating procedures/proper handover.
- Lack of information management capacity, including inadequate data entry/reporting and insufficient capacity-building.
- Conflicting priorities between partners and donors.
- Engaging government entities (both a challenge and an opportunity).

*How frequently should the cluster self-monitoring tool be filled? How could the use and output of the tool be improved? What is expected from the analysis of data?*

- The current tool, endorsed by regional health clusters, to be used and filled once every four months by all clusters.
- Regional Office to put the form online allowing data entry to all clusters.
- Access to data will be restricted to each health cluster's own data and the Regional Office.
- HCC in Pakistan to receive comments/feedback on the self-monitoring tool so it can be further developed for other in-depth monitoring purposes.
- A new more detailed tool (linked to indicators) might later be developed, based on suggestions received.

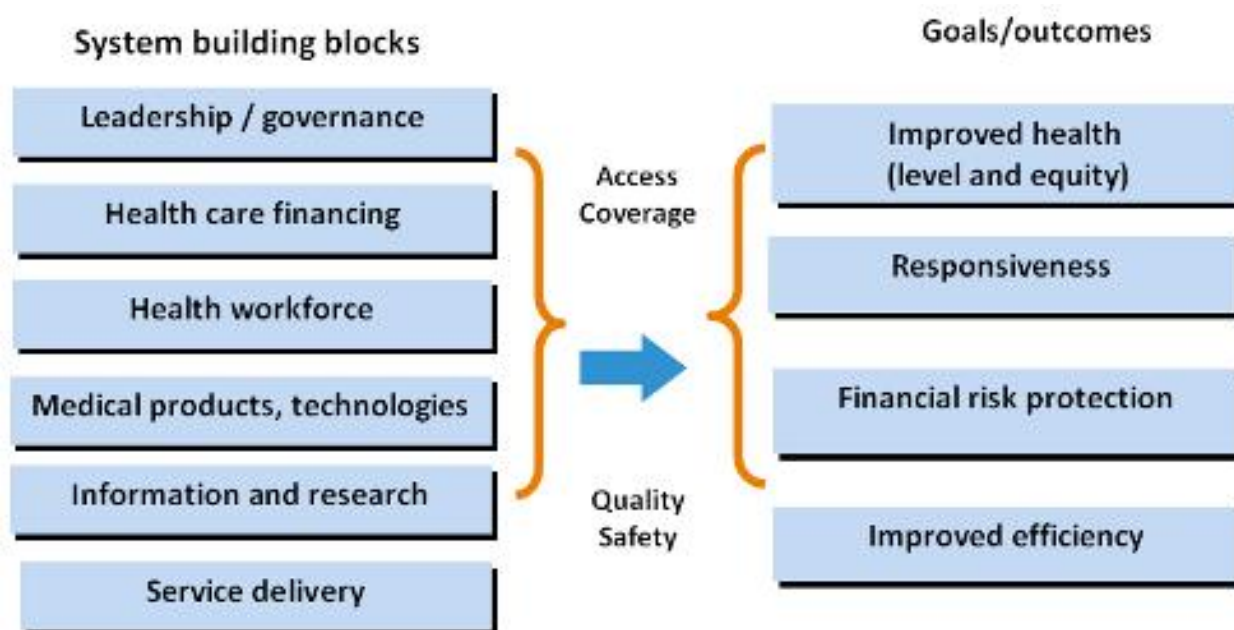
It is important to note that the regional self-monitoring tool does not replace existing Inter-Agency Standing Committee (IASC) cluster coordination performance monitoring and reporting requirements.

### **2.3 Technical documents, guidelines and standards for health care provision in emergencies**

WHO Health Systems Development (HSD)/Health Systems in Emergencies Lab (HSEL) presented on initiatives to support Member States of the Region in building health systems resilience. The programmes encourage WHO country offices to establish a team covering the three key functions – emergency management, health systems strengthening and cluster coordination – to work on strengthening the health system elements required for effective humanitarian response and successful implementation of national action plans for health security, in collaboration with all health clusters/sectors.

HSEL has a specific focus on health systems strengthening for universal health coverage adapted to fragile and conflict-affected countries to serve the most vulnerable populations (including migrants and displaced persons), and on preparedness for the International Health Regulations (2005) and all hazards. Figure 2 below summarizes the WHO Health Systems Framework which has been developed to ensure building health systems resilience and safeguard against health crises in Member States. There is a need to develop an integrated approach to identify and prioritize health systems strengthening interventions, and to adopt innovative ways of working and more appropriate coordination solutions to address challenges. The programmes are currently being tested in Afghanistan, Somalia and Sudan, under the Japan-funded UHC Project, to evaluate their effectiveness.

The majority of HCCs expressed interest in undertaking discussions on specific collaborations and activities that can be jointly implemented, with clear defined responsibilities for each entity. HCCs, together with other stakeholders, need better understanding of the process and where can it work, considering the political context and synergies between emergency and development actors.

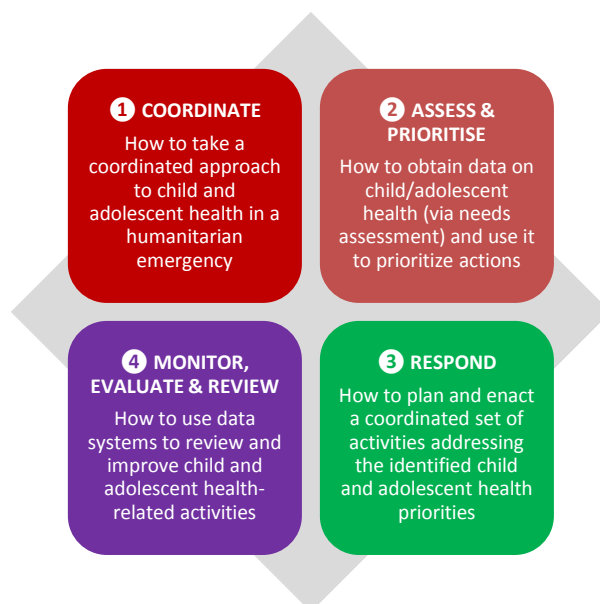


**Fig. 2. WHO health systems framework**

The Division of Health Promotion/Child and Adolescent Health informed participants on the recently developed regional operational field guide for child and adolescent health in humanitarian settings. The operational guide is based on a rapid review to identify (i) the gaps in current approaches adopted for responding to child and adolescent health during humanitarian emergencies, and (ii) the most relevant documents and resources for future programming.

The operational guide is a synthesis of existing standards and guidance documents, presented as a simple systematic approach, together with links to tools and resources to support action. The guide complements existing humanitarian frameworks and child and adolescent health strategies. It is a companion to existing guidelines on child and adolescent health and sexual and reproductive health in humanitarian emergencies, and has been developed to be used by programme managers and leaders in health (and related fields) at every stage of an emergency. The operational guide is being introduced in Sudan for testing and early implementation, as well as in Libya and the Syrian Arab Republic. Outcomes of early implementation in Sudan will be shared with all HCCs and participants. A copy of the operational guide document was distributed to HCCs for their feedback on how to move forward and implement the guidance within their specific emergency context. Figure 3 below refers to the Operational Guide, which is a step-by-step practical field programmatic guide that provides a clear approach to child and adolescent health in emergencies.

Participants were divided into groups to answer questions on needs related to technical standards and guidelines.



**Fig. 3. Step-by step approach for operational guide**

*What essential technical standards and guidelines are needed (both existing and not yet created) to guide health partners to provide quality health care services?*

The groups listed the following needs for standards/guidelines to improve quality of health care services:

- relevant country-specific guidelines/standards (e.g. essential health service package);
- IASC guidelines;
- health systems strengthening in emergencies;
- reproductive, maternal, newborn, child and adolescent health guidelines;
- the Sphere Handbook;
- cholera management;
- GHC: section on benchmarks (10 topics);
- minimum initial services package (all topics);
- gender-based violence IASC – health chapter.

*What kind of support is expected from WHO headquarters and Regional Office to apply technical standards and guidelines?*

WHO headquarters/GHC and the Regional Office are expected to communicate health cluster needs for standards and guidelines at both global and regional level. The groups raised the following needs:

- identifying priority thematic issues at regional level;
- identifying main focal person(s) for each technical guideline – one focal “desk officer” per country;

- training at country/cluster level on how to implement guidelines/standards (partners to be trained by local team);
- coordination/support of roll out at global/regional levels, and ensuring guidelines are operational;
- ensuring buy-in/ownership of all stakeholders (including health ministry) through the WHO country representative;
- monitoring and evaluation online platform: use/utility; implementation; bottlenecks; need for updates/revisions (what is not working, lessons learned/good practice, core indicators);
- global resources: funding and technical expertise;
- technical support/capacity-building;
- an online platform for sharing feedback/experiences and disseminating information;
- collaboration between WHE, HSD/HSEL and health cluster at country level.

## 2.4 Cash-based health interventions

Cash transfer programming (CTP) initiatives are growing in scale and scope following commitment on the use of cash transfers as part of the “Grand Bargain” to address the humanitarian financing gap. CTP is not well known among Member States of the Eastern Mediterranean Region. Therefore, overview and guidance was provided to HCCs on the nature of CTP, how to approach CTP systematically in the health response (including options analysis), and the kind of support needed to build HCC capacity in this area. Sector-specific CTP is expected to be coordinated under each sector/cluster and reflected in humanitarian response plans.

The presentation proposed a set of questions for considering a CTP initiative.

*What could be the added value of CTP to improve access to and utilization of health services?*

*Why should we be concerned about multi-purpose cash transfers if we do not do these kinds of programmes?*

*What can we do more of with regards to purchasing health services (through contracts with providers) in support of universal health coverage within humanitarian programmes?*

Key messages from the session are given below.

- CTP refers to programmes where cash or vouchers for goods or services are directly provided to beneficiaries (individuals, households, communities) and not to government or other state actors.
- CTP can be useful to improve access to and utilization of health services in humanitarian settings by reducing direct and indirect financial barriers and/or by incentivizing the use of free preventive services.

- Evidence on use of CTP for health from development contexts cannot always be extrapolated to humanitarian contexts. As there is little evidence on use of CTP in humanitarian settings, HCCs need to start promoting the importance of including health expenditures in the minimum expenditure surveys.
- CTP has to be linked to an existing health problem, and how to overcome that problem. HCCs can start by identifying direct and indirect financial barriers in each context, and possible options to address the barriers.
- Health systems that rely on direct out-of-pocket payments by patients as a main source of funding tend to be inequitable and ineffective due to various market failure issues. The optimal response to address household health expenditures (when health services are available with adequate capacity and quality, but user fees are applied) is through provider payment mechanisms. CTP for health should always be considered complementary to such supply-side health financing strategies, and not a replacement.
- As health needs are mostly unpredictable, health expenditures are not average. CTP to purchase health services should in principle be targeted to patients that need to use a priority service. The cash transfer amount should cover the direct and indirect costs of seeking treatment, and health services and medicines should only be obtained from pre-selected providers that meet minimum quality standards.

Three countries of the Region (Iraq, Sudan and the Syrian Arab Republic) have some experience in CTP. Therefore, in the group exercise, participants with experience were distributed across three groups to share country-specific solutions, and answer the following questions.

*Are there direct or indirect financial barriers to accessing services in your emergency context? (For example, linked to consultation, diagnostics, treatment/medication, referral and admission to hospital including surgical/obstetric interventions)*

*What options exist through cash and vouchers or contracting providers to reduce these barriers?*

*Are there preventive programmes or chronic treatments with low coverage and/or high default rates? Can conditional cash transfers improve coverage and adherence?*

Iraq, Sudan and the Syrian Arab Republic shared examples of CTP interventions used in their settings. Participants had an open discussion on the suitability of options for replication in other contexts. It was concluded that all countries should consider the financial barriers specific to each context, together with available options, and start talking logically about cash or vouchers transfers, and how such interventions can reduce financial barriers for improvement in health. CTP should be included in humanitarian strategies and planning for 2019, as most donors are urging their partners to adopt CTP approaches.

**Action points**

- Palestine, Somalia and Yemen to invite the technical officer for CTP in GHC/WHO headquarters, to support and guide in introducing CTP in 2019.
- Participants should read the Working paper for considering cash transfer programming for health in humanitarian contexts (March 2018), developed by GHC and WHO's Cash-based Intervention Task Team ([www.who.int/health-cluster/about/work/task-teams/working-paper-cash-health-humanitarian-contexts.pdf](http://www.who.int/health-cluster/about/work/task-teams/working-paper-cash-health-humanitarian-contexts.pdf)), in addition to other cash-related documents in the GHC Knowledge Bank, to learn about how CTP can be used to improve access to and utilization of health services in humanitarian settings through different mechanisms.
- HCCs should reach out to HSD to better understand the context of how CTP initiatives work, and determine how cash-based programming can be introduced in their countries.
- HSD and WHE to discuss whether health financing training is needed for HCCs that show interest in cash-based programming.

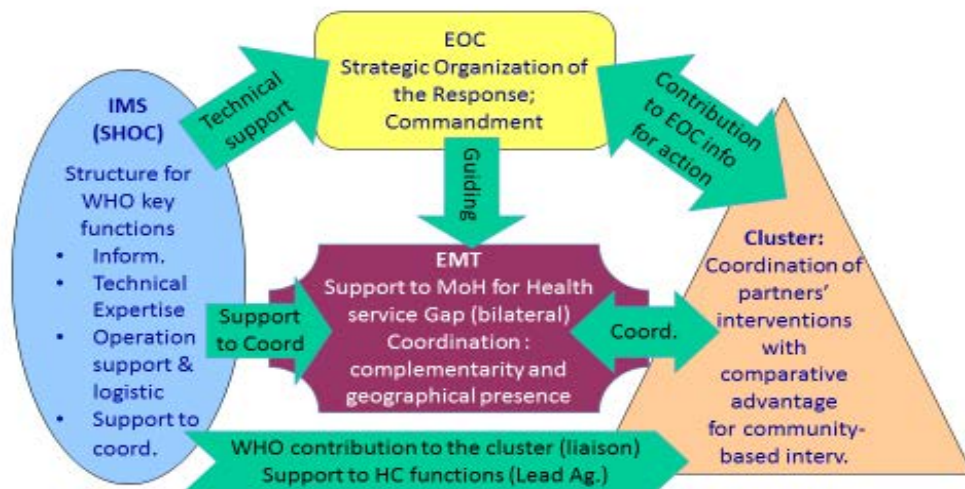
**2.5 Exploring alternative coordination mechanisms**

Presentations by WHO Emergency Operations Department aimed to stimulate ideas on how to improve coordination mechanisms at the regional level, while taking into consideration the political context of each humanitarian setting (as politics are a main driver of response operations). Issues included: coordination systems/mechanisms in emergencies; respective roles of incident managers, HCCs and WHO representatives; and proposed terms of reference for health clusters in the emergency operations centre (EOC).

The roles and respective functions of the EOC and the incident management system (IMS) were presented (Figure 4). A clear distinction needs to be made between partner coordination as a function of the IMS, within the WHO Emergency Response Framework, and the role of health clusters as a forum to coordinate partners. Further consideration was given to the type of EOC, either for WHO response or for national health ministry response. The plenary discussion highlighted the important role that health clusters can play in coordinating and effecting national implementation plans, as well as the need to identify common ways forward for EOC and health cluster operations. The EOC acts as a forum for people to come together, and functions through the different operational levels with procedural plans that dictate operations at each level. A WHO/EOC is a reflection of the WHO Emergency Response Framework and how WHE internally works through the IMS.

Participants broke into groups to brainstorm mechanisms for effective interaction between the IMS, EOC and HCCs. An example of an effective coordination mechanism and levels of coordination between partners is shown below in Figure 4.





**Fig. 4. Typical interaction between IMS, EOC, health cluster and emergency medical team**

#### Action points

- EOC to be viewed as the government's decision-making body and IMS as WHO's (as the lead agency for the health cluster/sector) internal response mechanism.
- HCCs to use the EOC (where available and appropriate) as a platform to operationalize partner functions, in close coordination with government/health ministry (if available), to ensure that humanitarian principles are respected.
- Incident managers should represent WHO as a partner agency in the health cluster.
- HCCs to re-acquaint themselves with WHO's Emergency Response Framework, as clarity is lacking among coordinators.
- Emergency medical teams to continue to be seen as a parallel/independently-acting entity; however, greater interaction between emergency medical teams and the health cluster is recommended.
- Emergency medical teams should be part of the health cluster emergency management/trauma working group.
- Further guidance is needed on EOC, IMS and health cluster interaction; roles and responsibilities need to be clarified with regards to partners' reporting line and to decision-making in low-governance or no-governance situations.
- At the end of an emergency event, clarification is needed to specify to whom handover passes and how handover is done.

#### 2.6 Working through an integrated approach

GHC and HCC/Yemen presented strategies for a more systematic, integrated and coordinated public health response. GHC has been intensifying its efforts to achieve better health outcomes through more effective joint action with clusters that have the

most direct impact on morbidity and mortality, namely: water, sanitation and health (WASH); nutrition; protection; and food security. An exercise has been done to survey key health and WASH stakeholders' knowledge and perceptions of cholera preparedness and response, and to review cholera preparedness and response plans from 15 clusters, in order to identify bottlenecks/factors that are weakening inter-cluster coordination mechanisms. The exercise indicated there was confusion among key stakeholders on leadership responsibilities and accountabilities. The survey also identified information-sharing issues – particularly within WHO – as a major constraint, while respondents showed confusion relating to the right channels for showcasing information. As agreed between GHC and WASH clusters, the findings of the exercise will inform development of a joint operational framework for cholera preparedness and response. The draft framework will be shared with HCCs for their review and feedback.

HCC/Yemen presented on adopting a global integrated approach in Yemen. Integrated programming for famine risk reduction (IFRR) started in April 2017, jointly with the nutrition, WASH and food security clusters. Many rounds of discussions took place to refine the approach, and piloting was initiated in 30 districts (out of 107) in June 2018. Despite a lack of quality data, selection of districts was based upon a set of agreed criteria by all partners. The IFRR package was introduced at three levels of intervention: household, community and health facility. Improvements in famine rates have been reported in targeted districts, and progress is being continuously monitored by all partners. Gaps are being identified, and will be addressed when requested funds are received. Detailed information on the approach is available from HCC/Yemen, to be shared with other countries.

Iraq, Sudan and the Syrian Arab Republic shared their successful experiences of inter-cluster coordination, albeit on a smaller scale than Yemen. The majority of countries expressed interest in enhancing multisectoral approaches and effective coordination mechanisms. GHC stressed that HCCs must take the initiative, and proactively reach out to other clusters/sectors to convince them to collaborate, as their responsibilities include collaborating through multisectoral interventions and demonstrating leadership. The concept of clusters working together is unnegotiable, and is already being done to varying degrees in different countries. The successful initiative in Yemen was the result of four HCCs collaborating together to address the huge problem of the famine through adopting an integrated approach.

### **Action point**

- WHE to ask the Regional Director for the Eastern Mediterranean to communicate with lead agencies of other clusters to issue a statement on strengthening inter-cluster coordination at the regional level; and to reinforce that WHO, as the health cluster lead, welcomes collaboration through integrated approaches.

## 2.7 Research under health clusters

JHU gave a presentation on operational research in the humanitarian context, and how clusters can use routine data to produce research papers in collaboration with JHU/CHH. The presentation highlighted the importance of operational research as a means to better understand how programmes work, aiming to improve quality and performance by learning from others' experiences. Operational research is mainly based on routine data collected, and contributes to finding solutions and overcoming challenges. Operational research is crucial to improve outcomes, assess feasibility and effectiveness of interventions, and advocate for policy change. JHU/CHH can contribute to the operational research cycle, and have a proactive role in ensuring that all cycle levels are covered. They have extensive experience in the Eastern Mediterranean Region, and support ongoing operational research in Afghanistan, Iraq, Somalia, the Syrian Arab Republic and Yemen with national research teams.

A concern was raised about processing and, in particular, sharing of information and data (even with donors). It was made clear that operational research would be based on current data collected, and not on data classified as confidential. Any raw data requested by donors or partners has to be approved by the WHO representative in each country, and shared after their permission has been obtained. Often it is necessary to negotiate with donors to convince them that a specific approach is good or bad, based on valid evidence. Focus is on operational research that guides with evidence and aims to improve health cluster outcomes. It was noted that research papers provide much stronger evidence than reports, because papers are scrutinized before they are published.

A number of countries are in need of operational research. Yemen lacks a referral system; therefore, operational research is required to ascertain the best practice in the country context. The northern region of the Syrian Arab Republic has a large number of nongovernmental organizations working in one health facility: therefore, research could assess whether this contributes to better quality of care, or instead results in fragmentation and waste of resources. Many research questions can come out of the countries themselves, based on actual operations and data regularly collected. Countries can start on a small scale by filling data in the PHIS matrix sent by WHO country offices, as proposed by JHU in the presentation.

JHU is a GHC partner and designated WHO Collaborating Centre for Research and Policy Guidance in Humanitarian Health Assistance, with a role to support research and capacity in different areas to complement the role of the health cluster. Research questions will be jointly defined by HCCs and JHU, be of mutual interest and will respond to the health clusters' needs. WHO funds allocated to cover salaries for operations, monitoring and evaluation and so on, would facilitate the initiation of research during 2019. JHU and WHO will have to jointly seek funding to implement identified research projects. JHU will explore donors' interests once concrete research ideas are available.

**Action points**

- JHU to review the existing agreement with WHO (and as an active WHO collaborating centre) to identify thematic areas for research and propose ideas.
- JHU and HCCs to explore availability of funding for newly generated ideas specific to the Eastern Mediterranean Region.
- WHE and JHU to discuss and agree on one or two research ideas, based on available data from clusters, to be shared for HCCs' feedback; country-specific ideas are welcomed from HCCs.
- The Protocol on Information and Data Sensitivity Classification designed for the Whole of Syria (WoS) response (based on existing global guidance) to be shared with HCCs.

**2.8 Success stories that can be replicated***Essential quality of care: experience from Iraq*

HCC/Iraq informed on an assessment of the quality of standard health services at primary health care centres in 59 existing camps for internally displaced persons in Iraq, which aimed to identify factors impeding achievement of basic minimum standards. The process started in 2017, using a data collection tool designed for health care providers trained to collect data through two different approaches. Real-time data were collected, which facilitated subsequent patient follow-up. The assessment was supported by the Iraqi Red Crescent Society, and data are owned by the Ministry of Health of Iraq. Partners were informed about the four-phased process, which was carried out by the health cluster – a factor that contributed to gaining the confidence of all stakeholders. The quality of care assessment proved a success due to availability of technical capacity and an active information management team that undertook the analysis work with the HCC. HCC/Iraq shared all materials related to the process, and is willing to support any country to replicate the Iraq example to improve quality of care.

Countries were advised to focus on improving quality of care and build on the process that has been developed for Iraq. WHO headquarters confirmed the process is replicable; however, a standardized monitoring tool needs to be developed, based on feedback received, that can be adapted in the field. The same process is being done in other countries using different approaches. It is proposed to include the quality of care assessment tool as a monitoring component in District Health Information System (DHIS) tools. Therefore, it is important to try out different approaches in different countries, to gather feedback that can be used to improve the outcome.

**Action points**

- The Gaziantep Hub of WoS and Sudan expressed interest to replicate the Iraq example; HCCs to communicate with HCC/Iraq to coordinate the needed support.
- WHO headquarters/GHC is establishing a quality assurance task team to collect and analyse approaches being implemented by WHO country offices/health

clusters to standardize the overall approach and tools for improvement of quality of care.

- JHU to share relevant study on improving quality of care in Ethiopia and Ghana as guidance for countries who wish to replicate.

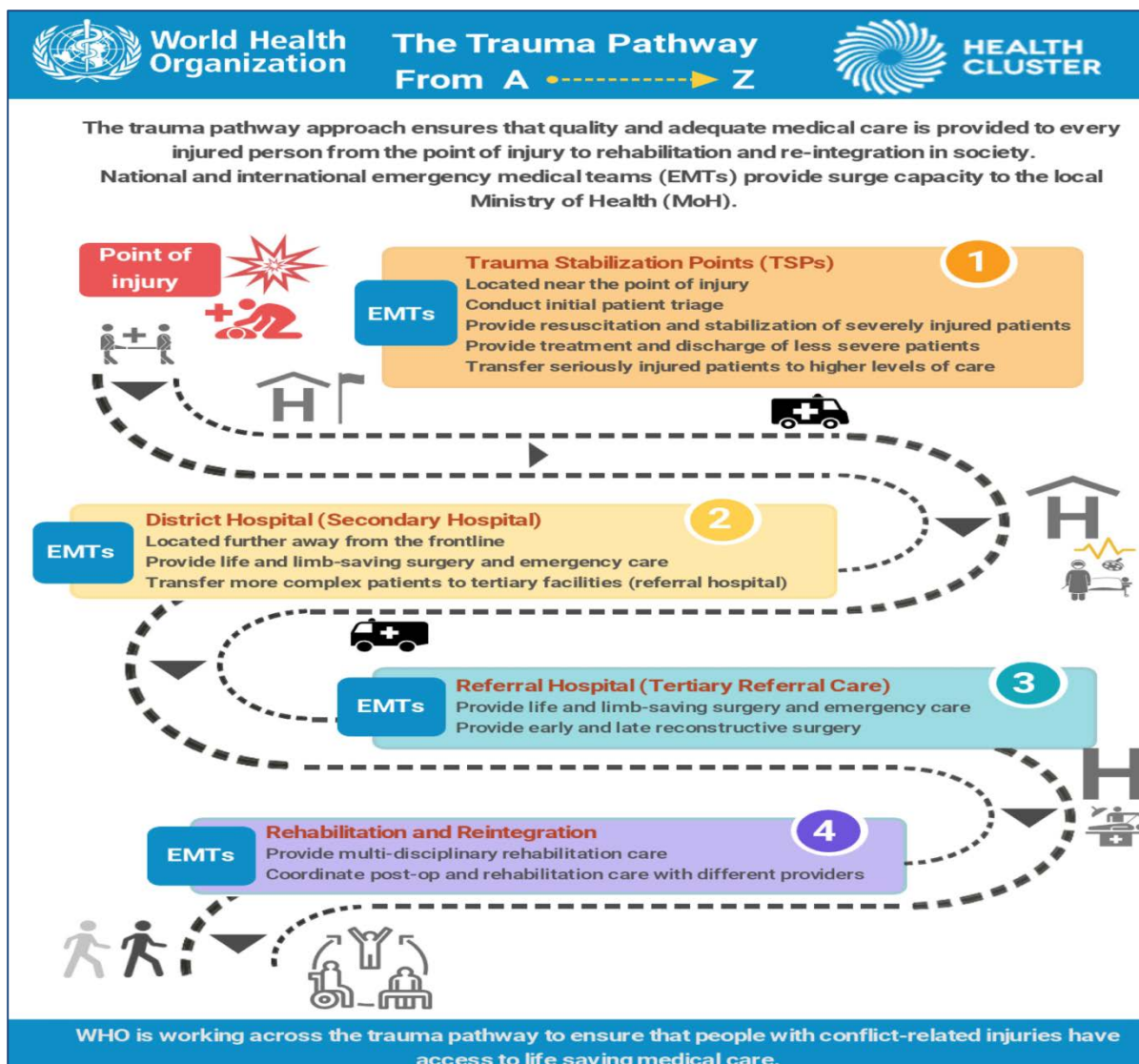
*Trauma management: experience from Palestine*

Ten countries of the Eastern Mediterranean Region have trauma care needs. Issues under discussion included: the role of health clusters; how WHO country offices can support the process; and the role of Regional Office in supporting HCCs. Countries exchanged their approaches on trauma management. Each country has a programme; however, different approaches are being used, and sometimes trauma management is done by non-reporting partners (for example, in the Syrian Arab Republic). WHO has a larger role than just trauma care: to coordinate and technically guide standards of care for injured persons. It is important to understand and define trauma management to enable HCCs to place WHO where it should be, and to define the role of the health cluster.

Trauma management is fragmented in the West Bank and Gaza Strip, and limited to surgical care and (occasionally) rehabilitation for patients. The health cluster in Palestine shared an infographic showing the trauma pathway, an approach designed to ensure that adequate and quality medical care are provided to every injured person, from the point of injury to rehabilitation and reintegration in society (Fig. 5). National and international emergency medical teams provide surge capacity to the local health ministry. Since WHO cannot directly provide services, it coordinates this pathway and ensures that any contributor in the pathway meets regularly; thus, the cluster is uniquely positioned to be able to include trauma management as part of its work. Indicators have been developed with WHO headquarters, to measure the trauma response in line with emergency medical team minimum data sets. In addition, a trauma checklist for stabilization units, adapted from WHO's *Classification and minimum standards for foreign medical teams in sudden onset disasters* (the "blue book"), has been cleared by WHO headquarters.

This approach can vary between different countries where trauma management is not a part of the health cluster. The Regional Office should support all HCCs to have a standardized trauma care/management system, harmonized and responsive to country needs, instead of each country taking a different approach.

WHO has developed a policy paper (awaiting final approval) on provision of trauma care in conflict situations, which covers issues including humanitarian space, international humanitarian law, codes of conduct, and so on. It also sets out when and how WHO should engage, and highlights WHO's and partners' responsibilities. The paper aims to guide WHO in working with partners that provide trauma services to ensure an effective approach is being adopted.



**Fig. 5. Trauma pathway, developed by HCC/Palestine**

## 2.9 Funding opportunities to health partners

*The Humanitarian Grand Challenge project: funding opportunities to deliver aid to hard-to-reach population in conflict zones*

The Humanitarian Grand Challenge project is funded by the United States Agency for International Development (USAID), the United Kingdom Department for International Development (DFID) and the Ministry of Foreign Affairs of the Netherlands, with support from Grand Challenges Canada. The project funds new ideas for local solutions that engage the private sector, and draws from the experiences of affected communities, in order to significantly improve and, in many cases, save the lives of vulnerable people affected by conflict. The project targets solutions that support communities to be prepared to respond to complex emergencies and take steps to create better lives for themselves. The key focus areas are: safe water and sanitation; energy; life-saving information; and, health products and services.

The project is funding ideas from local nongovernmental organizations and, with HCCs of nine countries in humanitarian settings, is the perfect forum to advocate for new and innovative solutions that can be implemented on the ground. Ideas that have been implemented on a small scale and can be expanded will also be supported, as long as people in hard-to-reach conflict zones are the target. The window for ideas is open and covers actions, systems and products.

### **3. CONCLUSION**

During the introductory session of the meeting, participants were requested to state expected outcomes, and what the meeting should achieve. Participants' feedback was compiled in a list and presented during the final session to ensure that all topics had been covered or that, at least, discussion had been initiated on specific issues. An evaluation form was distributed among participants. Feedback related to the need for more thorough discussions on harmonizing indicators and on exploring successful coordination mechanisms. Greater clarity was still needed in relation to the EOC/IMS/emergency medical team/HCC interface.

- Action points from the first regional health cluster meeting will be compiled for follow-up.
- Although there is no regional health cluster website, there is a global Knowledge Bank on the WHO/GHC site (<https://www.who.int/health-cluster/resources/publications/en/>). GHC will try to create a space on their website to include all available tools for countries of the Eastern Mediterranean Region.
- A proactive research agenda is not currently in place for WHE. However, WHO collaborating centres are undertaking research, and specific research ideas can be proposed in the agenda of the regional meeting for WHO Health Cluster Coordination in 2019.
- GHC noted issues raised during the health cluster meeting, and will provide feedback on support that can be extended to countries, within in the context of GHC's 2019 workplan.

**Annex 1****PROGRAMME****Monday, 5 November 2018**

08:30–09:00	Registration	
09:00–09:30	<b>Session 1.1: Welcoming and introduction to participants and facilitators</b>	<i>Michel Thieren, Alaa AbouZeid, Linda Doull</i>
	Guided group discussion on expectations from the meeting	
09:30–15:00	<b>Session 1.2: Information management for health clusters</b>	<i>Alaa AbouZeid</i>
09:30–10:00	HIM unit plans and support to health cluster	<i>Pierre Nabeth</i>
10:00–10:15	iMMAP: Surge capacity	<i>Craig Von Hagen</i>
10:45–11:15	Harmonizing indicators: Discussion on core indicators for health cluster in emergencies	<i>Emanuele Bruni, Chiara Altare</i>
11:15–12:00	Open discussion	
12:00–13:00	Breakout groups	
	- Harmonizing indicators: selecting the most important indicators for health in emergencies	
	- Report back to plenary and discussions	
14:00–14:30	Harmonizing online systems and dashboards	
14:30–15:00	Capacity, needs and gaps Group discussion	
15:30–17:00	<b>Session 1.3: Health cluster internal organization</b>	<i>Michael Lukwiya</i>
15:30–16:15	Monitoring of health cluster performance Breakout groups	
	- Challenges to deliver cluster outputs	
	- Minimum accepted deliverables from health clusters	
	- Methods for monitoring	
16:15–17:00	Report back to plenary and discussions	
17:00–17:30	<b>Session 1.4: Wrap up of day 1</b>	<i>Linda Doull</i>



**Tuesday, 6 November 2018**

09:00–11:15	<b>Session 2.1: Technical documents, guidelines and standards for health care provision in emergencies</b>	<i>Annemarie Ter Veen</i>
09:00–09:30	Introduction to regional operational field guide for child and adolescent health in humanitarian settings	<i>Jamela Alraiby</i>
09:30–10:00	Health systems in emergencies laboratory: Role of health clusters	<i>Ali Ardalan</i>
09:30–10:15	Breakout groups <ul style="list-style-type: none"> <li>- What are the essential technical standards and guidelines needed to guide health partners to provide quality health care services?</li> <li>- What kind of support is expected from the regional and global WHO technical units to apply technical standards and guidelines?</li> </ul>	
10:45–11:15	Report back to plenary	
11:15–13:00	<b>Session 2.2: Cash-based health interventions</b>	<i>Arun Kumar Malik</i>
11:15–11:45	Cash-based programming in health	<i>Andre Griekspoor</i>
11:45–12:15	Breakout groups <ul style="list-style-type: none"> <li>- Selection of interventions for cash-based programming</li> <li>- Challenges (country specific)</li> <li>- Countries to implement cash-based interventions: which, why?</li> </ul>	
12:15–13:00	Report back to plenary	
14:00–17:00	<b>Session 2.3: Exploring alternative coordination mechanisms</b>	<i>Jorge Martinez</i>
14:00–14:30	Cholera experience: Coordination structures in Eastern Mediterranean Region countries	<i>Osama Maher</i>
14:30–15:00	Coordination of health interventions between health cluster and Emergency Operations Centre	<i>John Haskew</i>
15:00–15:30	Breakout groups <ul style="list-style-type: none"> <li>- Suggesting a coordination system in emergencies</li> <li>- Proposed terms of references for health cluster in Emergency Operations Centre</li> <li>- Role of incident managers, Health Cluster Coordinators and WHO Representatives</li> </ul>	
16:00–17:00	Report to plenary	
16:45–17:00	<b>Session 2.4: Wrap up of day 2</b>	<i>Alaa AbouZeid</i>

**Wednesday, 7 November 2018**

09:00–11:15	<b>Session 3.1: Working through an integrated approach</b>	<i>Jamshed Tanoli</i>
09:00–09:30	GHC efforts to boost integrated approach and available guidelines	<i>Linda Doull</i>
09:30–10:00	Yemen experience with integrated 4 clusters approach	<i>Jamshed Tanoli</i>
10:00–10:45	Open discussion on other experiences in the Region	
11:15–12:30	<b>Session 3.2: Research under health cluster</b>	<i>Christina Bethke</i>
11:15–11:45	Research and operational research using available health cluster data	<i>Chiara Altere</i>
11:45–12:30	Open discussion to explore research ideas and way forward	
14:00–15:30	<b>Session 3.3: Success stories that can be replicated</b>	<i>Azret Kalmykov</i>
14:00–14:30	Essential quality of care: How experience from Iraq can be replicated	<i>Fawad Khan</i>
14:30–15:00	Trauma management: How experience from occupied Palestinian territory and Afghanistan be replicated	<i>Sara Halimah, David Lai</i>
15:00–15:30	Open discussion on other activities to replicate, how to pair health clusters and exchange resources	
16:00–17:00	<b>Session 3.4: Funding opportunities to health partners</b>	
16:00–16:30	The Humanitarian Grand Challenge project: funding opportunities to deliver aid to hard-to-reach population in conflict zones	<i>Chris Houston</i>
16:30–17:00	Final recommendations and commitments and plenary discussion	<i>Alaa AbouZeid, Linda Doull</i>

**Annex 2**

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The image features a large abstract composition of geometric blocks. A teal block occupies the top right and bottom right portions. A light grey block is in the top left. A horizontal grey band spans the middle. A dark grey block is in the bottom left. The bottom of the image is a solid grey bar containing contact information.

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