

# Health Cluster Guide

A practical guide for country-level  
implementation of the Health Cluster

# IASC

Inter-Agency Standing Committee

# Global Health Cluster



**World Health  
Organization**

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# ROLE AND FUNCTIONING OF A HEALTH CLUSTER

## **Key points:**

- ✓ The cluster serves as a mechanism for coordinated assessments, joint analyses, the development of agreed overall priorities, objectives and a health crisis response strategy, and the monitoring and evaluation of the implementation and impact of that strategy.
- ✓ The cluster should enable participating organizations to work together and with local health authorities, harmonize efforts, effectively integrate cross-cutting issues, and use available resources efficiently within the framework of agreed objectives, priorities and strategies.
- ✓ Participating organizations are expected to be proactive partners in assessing needs, developing strategies and plans for the overall health sector response, implementing agreed priority activities, ensuring attention to priority cross cutting issues and adhering to agreed standards, to the maximum extent possible.
- ✓ The cluster lead agency (CLA) is responsible to the Humanitarian Coordinator for ensuring the satisfactory functioning of the cluster and must be proactive in ensuring this.
- ✓ The CLA assigns a health cluster coordinator (HCC) and is responsible to provide the administrative and other support services required for the coordinator and the cluster to function effectively. In general, the HCC should be a full-time position without any responsibility for the lead agency's own programmes or activities.
- ✓ The HCC facilitates and leads the work of the cluster, and ensures coordination with other clusters in relation to activities relevant to public health as well as the cross-cutting issues.
- ✓ The organization of the cluster, and relationships with national authorities, depend on the context.
- ✓ The HCC takes into account all health related issues to avoid the establishment of stand alone groups in sub-areas of health cluster work such as reproductive health or mental health.

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The mission of the Global Health Cluster (GHC), led by WHO, is to build consensus on humanitarian health priorities and related best practices, and strengthen system-wide capacities to ensure an effective and predictable response. It is mandated to build global capacity in humanitarian response in three ways: (1) providing guidance and tools and standards and policies, (2) establishing systems and procedures for rapid deployment of the experts and supplies, and (3) building global partnerships to implement and promote this work.

The GHC does not provide direct support to country-level clusters, which should come from the regional and international headquarters of the designated CLA, but the GHC secretariat may help to put the CLA/HCC in contact with relevant sources of technical support, if/when needed.

For information about the role, activities and products of the GHC, see:  <http://www.humanitarianreform.org/humanitarianreform/>



## 1.1 THE CLUSTER APPROACH

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### The basics

#### *Why a cluster approach?*

An independent review commissioned by the UN Emergency Relief Coordinator in 2005 found significant gaps in humanitarian response. The cluster approach was adopted by the IASC the same year to improve the efficiency and effectiveness of the humanitarian response in crises; to increase predictability and accountability in all the main sectors of the international humanitarian response; and to ensure that gaps in response do not go unaddressed.

The cluster approach is one of the three pillars of the humanitarian reform the other two being strengthening the Humanitarian Coordinator system and strengthening humanitarian financing through, among other things, improved appeals and the Central Emergency Response Fund (CERF). OCHA has established a Humanitarian Coordination Support Section (HCSS) based in Geneva, to support HCs and IASC partners in implementing the reform and to monitor progress.

### ***What is the cluster approach?***

The cluster approach is a way of organizing coordination and cooperation among humanitarian actors to facilitate joint strategic planning. At country level, it:

- (i) establishes a clear system of leadership and accountability for international response in each sector, under the overall leadership of the humanitarian coordinator; and
- (ii) provides a framework for effective partnerships among international and national humanitarian actors in each sector.

It strengthens, rather than replaces, existing sector coordination mechanisms.

The aim is to ensure that international responses are appropriately aligned with national structures and to facilitate strong linkages among international organizations, national authorities, national civil society and other stakeholders.

### ***When should it be used?***

It is used in countries where a Humanitarian Coordinator has been appointed and should be used in any country faced with a sudden major new emergency requiring a multi-sectoral response with the participation of a wide range of international humanitarian actors. Where a cluster exists, it should also be used for inter-agency contingency planning for potential major new emergencies.

Clusters build on widely-accepted humanitarian principles and the principles of partnership agreed by the Global Humanitarian Platform<sup>3</sup> – see the paragraphs below.

<sup>3</sup> The Global Humanitarian Platform (GHP) is a forum launched in July 2006 to bring together on an equal footing the three main families of the wider humanitarian community: non governmental organizations, the Red Cross and Red Crescent Movement, and the United Nations and related international organizations in order to enhance the effectiveness of humanitarian action.

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## Humanitarian principles

As per UN General Assembly Resolution 46/182 (19 December 1991), humanitarian assistance must be provided in accordance with the principles of humanity, neutrality and impartiality. Adherence to these principles reflects a measure of accountability of the humanitarian community.

- ✓ **Humanity:** Human suffering must be addressed wherever it is found, with particular attention to the most vulnerable in the population, such as children, women and the elderly. The dignity and rights of all victims must be respected and protected.
- ✓ **Neutrality:** Humanitarian assistance must be provided without engaging in hostilities or taking sides in controversies of a political, religious or ideological nature.
- ✓ **Impartiality:** Humanitarian assistance must be provided without discriminating as to ethnic origin, gender, nationality, political opinions, race or religion. Relief of the suffering must be guided solely by needs and priority must be given to the most urgent cases of distress. (OCHA)

## Principles of partnership

- ✓ **Equality:** Equality requires mutual respect between members of the partnership irrespective of size and power. The partners must respect each other's mandates, obligations and independence and recognize each other's constraints and commitments. Mutual respect must not preclude organizations from engaging in constructive dissent.
- ✓ **Transparency:** Transparency is achieved through dialogue between all partners on an equal footing, with an emphasis on early consultations and early sharing of information. Communication and transparency, including financial transparency, increase the level of trust among organizations.
- ✓ **Result-oriented approach:** Effective humanitarian action must be reality-based and action-oriented. This requires result-oriented coordination based on effective capabilities and concrete operational capacities.
- ✓ **Responsibility:** Humanitarian organizations have an ethical obligation to each other to accomplish their tasks responsibly, with integrity and in a relevant and appropriate way. They must make sure they commit to activities only when they have the means, competencies, skills, and capacity to deliver on their commitments. Decisive and robust

prevention of abuses committed by humanitarians must also be a constant effort.

- ✓ **Complementarity:** The diversity of the humanitarian community is an asset if we build on our comparative advantages and complement each other's contributions. Local capacity is one of the main assets to enhance and on which to build. Whenever possible, humanitarian organizations should strive to make it an integral part in emergency response. Language and cultural barriers must be overcome.

[Global Humanitarian Platform, *A statement of commitment*, July 2007, <http://www.icva.ch/ghp.html> and on the CD-ROM attached]

### Decisions at country level

Decisions on the *clusters required* at country level are made on a case-by-case basis by the Humanitarian Coordinator in close consultation with the IASC agencies present and following consultations with national authorities. They are approved by the UN Emergency Relief Coordinator in consultation with the IASC principles.

*Cluster lead agencies* are designated taking account of the capacities of the different agencies in country to fulfil the required functions. They may, or may not, coincide with cluster leadership at the global level.

Where a number of humanitarian “hubs” are established for planning and managing the overall humanitarian response in different zones of a large geographic area, corresponding “zonal” clusters may be established with focal points designated by the respective cluster lead agencies.

Where zonal/sub-national-level clusters are established, the national level cluster normally focuses on policy issues and strategic planning while the zonal clusters focus on local planning and implementation issues.

While clusters are established on a sector basis it is recognized that there are cross-cutting issues that are important for all sectors. Typically these include gender, age, HIV/AIDS and the environment. Coordination among clusters on these and other issues is assured by an *Inter-Cluster Coordination Group*, convened by the OCHA team leader, that brings together the coordinators of all clusters.

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## Additional guidance

The key document on the cluster approach, developed after extensive consultation among agencies at the international level and endorsed by the IASC principals is:

 IASC. *Guidance note on using the cluster approach to strengthen humanitarian response*. Inter-Agency Standing Committee, 24 November 2006. Annex I presents the generic terms of reference for sector/cluster leads at the country level.

For additional information, see:

 IASC. *Operational guidance for cluster lead agencies on working with national authorities*. Inter-Agency Standing Committee, December 2008 (draft).

 IASC. *Operational guidance on designating sector/cluster leads in major new emergencies*. Inter-Agency Standing Committee, 23 May 2007.

 IASC. *Operational guidance on designating sector/cluster leads in ongoing emergencies*. Inter-Agency Standing Committee, 23 May 2007.

 IASC. *Rome statement on cluster roll-out*. Inter-Agency Standing Committee Working Group, 5-7 November 2007.

 IASC. *Strengthening NGOs participation in the IASC, a discussion paper*. Inter-Agency Standing Committee, 24 April 2006.

 *Principles of partnership, a statement of commitment*, approved by the Global Humanitarian Platform, 12 July 2007.

For information about the humanitarian reform, see:

 <http://www.humanitarianreform.org/>



## 1.2 ROLE OF A HEALTH CLUSTER

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### The purpose of the Health Cluster

The country-level Health Cluster (or existing sector coordination group adopting the cluster approach) should serve as a mechanism for participating organizations to work together in partnership to *harmonize efforts and use available resources efficiently* within the framework of agreed objectives, priorities and strategies, for the benefit of the affected population(s). This includes avoiding gaps and/or overlap in the international humanitarian health response and resources (human and financial).

The cluster should provide a framework for effective partnerships among international and national humanitarian health actors, civil society and other stakeholders, and ensure that international health responses are appropriately aligned with national structures.

The specific outputs usually expected from a Health Cluster are listed on page 9.

## Membership of the Health Cluster

The Health Cluster at *national* level should normally include:

- organizations providing or supporting health services in the affected areas – UN agencies (WHO, UNICEF, UNFPA), other international organizations (e.g. IOM, IFRC), the national Red Cross/Red Crescent society, international and national NGOs, and representatives of key private-sector health service providers; and
- the main health-sector donors and other important stakeholders.

Clusters at *zonal* (sub-national) level should normally include the health agencies active in the zone and any donor representatives or other health stakeholders present at that level.

## The Health Cluster, national health authorities and existing coordination mechanisms

The Health Cluster lead agency (CLA) serves as a bridge between the national and local health authorities and international and NGO humanitarian health actors. A key responsibility of the CLA is to ensure that international humanitarian actors build on local capacities and that they develop and maintain appropriate links with relevant government and local authorities (notably the ministry of health – MoH) and local civil society organizations involved in health-related activities.

The nature of those links will depend on the situation in the country and on the willingness and capacity of each of these organizations to lead or participate in humanitarian activities:

- Where the MoH is in a strong position to lead the overall humanitarian health response, the cluster should organize the international humanitarian response in support of the host government's efforts. This would typically be the case following a natural disaster.

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- In other cases, particularly in a situation of ongoing conflict, the willingness or capacity of the Government or State institutions – including the MoH – to lead or contribute to humanitarian activities may be compromised, and this will clearly influence the nature of the relationships which it establishes with international humanitarian actors. [IASC. *Guidance note on using the cluster approach to strengthen humanitarian response*, 24 November 2006]

Practical arrangements may vary accordingly. It has often been found appropriate for a MoH representative and the CLA to co-chair meetings at both national and sub-national levels. Some useful ideas are provided in:

 IASC. *Advocating with national authorities*. Cluster-Sector Leadership Training Tip Sheet, Inter-Agency Standing Committee, 6 July 2007.

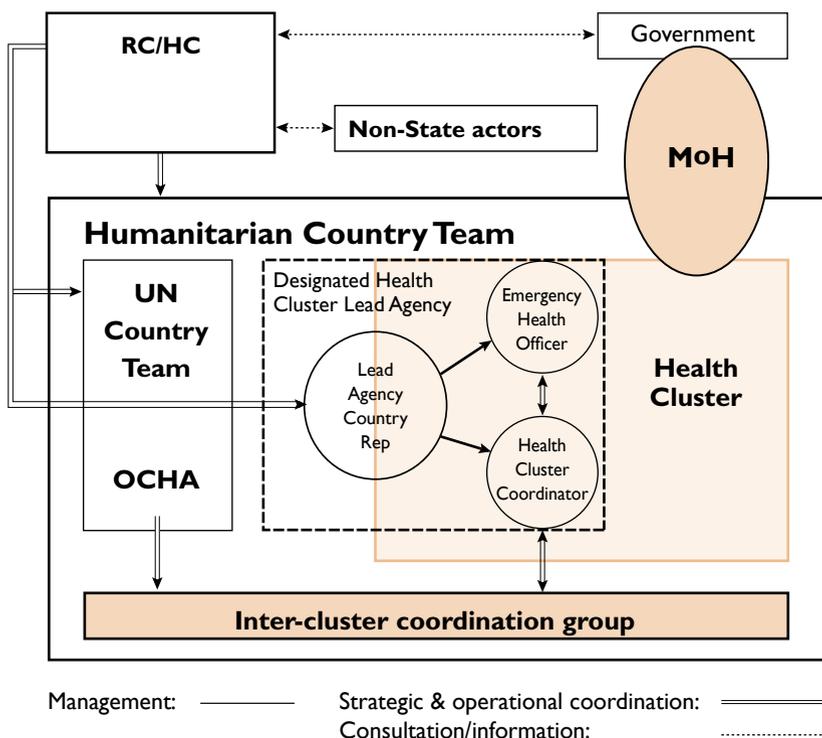
The relationships among the Cluster Lead Agency Representative (CLAREP), the HCC, the cluster, the RC/HC and the government/MoH are shown in Figure 1a. Note that:

- The CLA Representative is accountable to the RC/HC for the satisfactory fulfilment of the overall CLA function.
- The HCC is a staff member of the CLA who reports to the CLA Representative and represent of the cluster as a whole.
- As one of the health partners with programme activities that contribute to the overall health response, the CLA should normally be represented in the health cluster by the CLA Emergency Health Officer.
- Inter-cluster coordination is assured at two levels, namely:
  - At the policy level, the country representatives/directors of the designated CLAs meet together under the chairmanship of the RC/HC in the context of the humanitarian country team or in separate meetings, when needed.
  - At the strategic and operational levels, the coordinators of all clusters meet regularly together under the chairmanship of the OCHA team leader in the context of an inter-cluster coordination group.

The Inter Cluster Coordination Group (ICCG) is a key mechanism for the clusters to work together, identify humanitarian needs that require a multi-sectoral response, and strategize and plan accordingly. This is the body where the cluster coordinators have to report and discuss how the different cross-cutting issues and other humanitarian needs have been mainstreamed and where and how concerted action with other clusters is

needed. This is particularly relevant for the response to HIV, sexual violence, disabilities and MHPSS.

**Figure 1a The Health Cluster and the wider architecture in countries affected by a humanitarian crisis**



### 1.3 ROLES OF THE CLUSTER LEAD AGENCY, OF THE COORDINATOR AND OF PARTNERS

#### Responsibilities of the Health Cluster lead agency

The CLA has to ensure the establishment of an adequate coordination mechanism for the health sector. This includes: adapting the generic TOR for and appointing a country-level health cluster coordinator (HCC); ensuring appropriate relations with the MoH and avoiding duplication with any existing health sector coordination

mechanisms; assuring information management and other support services necessary for the satisfactory functioning of the cluster; designating health cluster focal points at sub-national (zonal) level where needed; and advocating for resources for all humanitarian health partners. The CLA also serves as “provider of last resort” – see the box below.

The generic responsibilities of cluster leads at the country level are spelt out in:

 IASC. *Guidance note on using the cluster approach to strengthen humanitarian response*. Inter-Agency Standing Committee, 24 November 2006. Annex I presents the generic terms of reference for sector/cluster leads at the country level.

The CLA country representative is accountable to the Humanitarian Coordinator (HC) for fulfilling these responsibilities.

The specific responsibilities of the health CLA are shown in the first two columns of the Figure 1b and 1c.

At the same time, the CLA is a partner in the cluster and should be represented in cluster meetings by its own emergency health programme manager.

### PROVISION OF LAST RESORT

Where necessary, and depending on access, security and availability of funding, the cluster lead, as provider of last resort, must be ready to ensure the provision of services required to fill critical gaps identified by the cluster. This includes gaps in relation to early recovery needs within the health sector.

Where critical gaps persist in spite of concerted efforts to address them, the cluster lead is responsible for working with the national authorities, the Humanitarian Coordinator and donors to advocate for appropriate action to be taken by the relevant parties and to mobilize the necessary resources for an adequate and appropriate response.

The Health Cluster lead agency’s responsibility for “Provision of Last Resort” should be activated when all three of the conditions below are met:

1. the Health Cluster agrees that there is an important life-threatening gap in the Health sector response, and
2. one or more of the agreed benchmarks for the health sector response as a whole is not being met, and
3. evidence suggests that a significant proportion of the target population is at risk of avoidable death if the gap is not filled urgently.

## What is expected of the Health Cluster Coordinator (HCC)

The generic ToR for a HCC is reproduced in the second column of the Figure 1e below. In summary, the coordinator is expected to:

- ☑ Enable cluster partners to be more effective by working together, in coalition, than they could individually, and to maximize the benefit for the target population of the cluster partners' individual inputs and efforts.
- ☑ Provide leadership to and work on behalf of the Cluster as a whole, facilitating all cluster activities and maintaining a strategic vision.
- ☑ Ensure that needs, risks, capacities and opportunities are assessed and understood as best possible at all stages of the humanitarian response, and that information is shared.
- ☑ Generate the widest possible consensus on priorities and a health response strategy to the crisis that addresses the priority needs and risks in the sector, incorporates appropriate strategies, and promotes appropriate standards.
- ☑ Work with cluster members collectively and individually to identify gaps in response and try to ensure that available resources are directed to addressing priority problems and that assistance and services are provided equitably and impartially to different areas population groups on the basis of need.
- ☑ Ensure the effective integration of cross-cutting issues into the cluster's activities and strategies.
- ☑ Ensure coordination with other clusters in all activities relevant to public health.

The role is to “facilitate” and “lead”, not to direct. The HCC should not be the emergency health programme manager of the CLA.

## What is expected of cluster partners

Health Cluster partners are expected to subscribe to the overall aim of the cluster (see page 9) and to:

- ✓ be proactive in exchanging information, highlighting needs and gaps and reporting progress, mobilizing resources, and building local capacity;

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- ✓ share responsibility for Health Cluster activities including assessing needs, developing plans and guidelines, and organizing joint training; and
- ✓ respect and adhere to agreed principles, policies and standards, and implement activities in line with agreed priorities and objectives.

However, it is up to individual organizations to determine their levels of participation. The cluster approach does not require that humanitarian actors be held accountable to the HCC or CLA. Individual organizations can only be held accountable to the CLA when they have made specific commitments.

The roles and responsibilities of the CLA Representative, the HCC and cluster partners are summarized in the Figures 1b and 1c below.

### Additional guidance

-  IASC. *Guidance note on using the cluster approach to strengthen humanitarian response*. Inter-Agency Standing Committee, 24 November 2006. Annex I presents the generic terms of reference for sector/cluster leads at the country level.
-  IASC. *Operational guidance on the concept of “provider of last resort”*. Inter-Agency Standing Committee, May 2008 (draft).

### Accountability framework for the Health Cluster at country level: definitions of the RASCI diagram

<b>RESPONSIBLE</b>	Those who do the work to achieve the task. There can be multiple resources responsible.
<b>ACCOUNTABLE</b>	The person/people ultimately answerable for the correct and thorough completion of the task.
<b>SUPPORT</b>	Those who may help in the task.
<b>CONSULTED</b>	Those whose opinions are sought. Two-way communication.
<b>INFORMED</b>	Those who are kept up to date on progress. One-way communication.

Figure 1b presents an example of the attribution of accountability, responsibility and other roles as defined by the RASCI diagram to the main health cluster constituencies. Country-specific context may need different attributions of roles and responsibilities to the health cluster main actors. This should be part of the discussions among partners that have to take place at the beginning of the work of the health cluster and periodically discussed thereafter.

**Figure 1b RASCI diagram for the Health Cluster functions at country level**

Functions	CLA Rep.	Health Cluster Coordinator	Cluster Partners
1. Coordination mechanisms and inclusion of key actors within the Health Cluster and inter-cluster	<b>A</b>	<b>R</b>	<b>R, S</b>
2. Relations with other key stakeholders	<b>A, R</b>	<b>R</b>	<b>S, C, I</b>
3. Needs assessment, situation monitoring & analysis, including identifying gaps in health response	<b>A</b>	<b>R</b>	<b>R, S, C</b>
4. Strategy development and gap filling	<b>A</b>	<b>R</b>	<b>R, S</b>
5. Contingency planning	<b>A, R</b>	<b>R</b>	<b>R</b>
6. Application of standards	<b>R, S</b>	<b>R, S</b>	<b>A, R</b>
7. Training and capacity building, including emergency preparedness	<b>A</b>	<b>S</b>	<b>R, S, C</b>
8. Monitoring and reporting	<b>A, R</b>	<b>R</b>	<b>R, S</b>
9. Advocacy and resource mobilization	<b>A, R</b>	<b>S, C</b>	<b>S, C</b>
10. Provider of last resort	<b>A, R</b>	<b>S</b>	<b>S, C</b>



### Figure 1c Roles within a country-level Health Cluster

Functions <sup>1</sup>	Cluster Lead Agency (CLA)		Cluster Partners <sup>4</sup>
	Cluster Lead Agency Representative (CLA Rep.) <sup>3</sup>	Health Cluster Coordinator (HCC) <sup>2</sup>	
<p>1. Coordination mechanisms and inclusion of all health actors within the Health Cluster and inter-cluster (1+2) See chapters 1 &amp; 2</p>	<p>Appoint an HCC and assure the support services necessary for the effective functioning of the cluster. [CLA Rep.]</p> <p>Use the CLA's existing working relations with national health authorities and with national and international organizations, civil society and non-State actors that are active in the health sector to facilitate their participation in the Cluster and relationships with the HCC, as needed. [CLA Rep./EHO]</p> <p>Ensure that sectoral coordination mechanisms are adapted over time to reflect the evolution of the crisis and the capacities of local actors and the engagement of development partners. [CLA Rep.]</p> <p>Work within the Country Humanitarian Team to help ensure appropriate understanding and prioritization of health concerns and appropriate inter-sectoral/inter-cluster action, when required. [CLA Rep.]</p>	<p>1a. Identify and make contact with health sector stakeholders and existing coordination mechanism, including international organizations.</p> <p>2. Hold regular coordination meetings with country health cluster partners, building when possible on existing health sector coordination fora.</p> <p>3. Collect information from all partners on Who's Where, since and until When, doing What, and regularly feed the database managed by OCHA (4W). Provide consolidated feedback to all partners and the other clusters.</p> <p>10. Represent the Health Cluster in inter-cluster coordination mechanisms at country/field level, contribute to jointly identifying critical issues that require multi-sectoral responses, and plan the relevant synergistic interventions with the other clusters concerned.</p>	<p>Participate actively in Cluster meetings and activities at national and local levels.</p> <p>Coordinate with local authorities and local health actors in the areas where working.</p> <p>Share information on the situation and own organization's activities.</p> <p>Encourage local health actors to participate in relevant peripheral health coordination mechanisms, where such exist.</p> <p>Propose ways by which the Cluster can be more effective in supporting the delivery of, and equitable access to, health services in the field.</p>
<p>2. Coordination with national authorities &amp; other local actors (3) See chapter 1</p>	<p>In coordination with the Humanitarian Coordinator, maintain appropriate links and dialogue with other national and local authorities, State institutions, local civil society and other relevant actors (e.g. local, national and international military forces, peacekeeping forces and non-State actors) whose activities affect humanitarian space and health-related programmes. [CLA Rep.]</p>	<p>1b. Identify and make contact with national authorities, national NGO and civil society.</p>	<p>Consult with the HCC/CLA concerning their own relations with key stakeholders in the field.</p>
<p>3. Needs assessment &amp; analysis including identifying gaps (6) See chapters 3 and 4</p>	<p>Make CLA technical expertise and other resources available for cluster and inter-sectoral assessments, as required. [CLA Rep.]</p> <p>Participate actively in the analysis of available information on health status and risks, health resources, and health service performance, and the ongoing monitoring of these key aspects. [EHO]</p> <p>Ensure the rapid establishment of an appropriate early warning and response system (EWARS) in coordination with national health authorities. [CLA Rep./WHO]</p>	<p>4. Assess and monitor the availability of health resources and services in the crisis areas provided by all health actors using GHC tool: Health Resources Availability Mapping System (HeRAMS).</p> <p>5. Ensure that humanitarian health needs are identified by planning and coordinating joint, inter-cluster, initial rapid assessments adapting to the local context the IRA tool, as well as follow-on more in-depth health sub-sector assessments, as needed.</p> <p>6. Mobilize Health Cluster Partners to contribute to establishing and maintaining an appropriate Early Warning and Response System, and regularly report on health services delivered to the affected population and the situation in the areas where they work.</p>	<p>Participate in joint assessments and data analysis making staff and other resources available as required and possible.</p> <p>Provide regular monthly activity reports on the health services supported at all levels of care</p> <p>Collaborate in assuring prompt EVAR sentinel site reporting from the selected health facilities.</p>

Functions <sup>1</sup>	Cluster Lead Agency (CLA)		Cluster Partners <sup>4</sup>
	Cluster Lead Agency Representative (CLA Rep.) <sup>3</sup>	Health Cluster Coordinator (HCC) <sup>2</sup>	
<p>4. Strategy development &amp; planning (8), including: Community based approaches (4), attention to priority cross cutting issues (5), and filling gaps See chapter 5</p>	<p>Participate actively in gap analysis, priority setting and the development of a health crisis response strategy and cluster action plan. Ensure that humanitarian responses build on local capacities and that the needs, contributions and capacities of vulnerable groups are addressed. [EHO]</p> <p>Ensure that Cluster/sector plans take appropriate account of national health policies and strategies and lessons learned, and incorporate appropriate exit, or transition, strategies. [CLA Rep./EHO]</p> <p>Ensure that opportunities to promote recovery and appropriate re-building of the health system are identified and exploited from the earliest possible moment, and that risk reduction measures are incorporated in Cluster strategies and plans. [CLA Rep./EHO]</p>	<p>7. Lead and contribute to the joint health cluster analysis of health-sector information and data (see points 3, 4, 5 and 6) leading to joint identification of gaps in the health sector response and agreement on priorities to inform the development (or adaptation) of a health crisis response strategy.</p> <p>12a. Provide leadership and strategic direction to the Health Cluster in agreeing on priorities and strategies, and planning coordinated action to address critical un-covered gaps.</p> <p>15. In a protracted crisis or health sector recovery context, ensure appropriate links among humanitarian actions and longer-term health sector plans, incorporating the concept of 'building back better' and specific risk reduction measures.</p>	<p>Participate in gap analysis, priority setting and the elaboration of a health crisis response strategy and cluster action plan.</p> <p>Ensure that own organization's project activities contribute to the agreed health crisis response strategy and take appropriate account of priority cross-cutting issues.</p> <p>Plan/adapt own activities to contribute to filling identified gaps.</p> <p>Ensure that own organization's project activities promote recovery from the earliest possible moment, and contribute to risk reduction, where possible</p>
<p>5. Contingency planning (7) See section 5.5</p>	<p>Participate actively in cluster/inter-agency contingency planning and preparedness for new events or set-backs. [EHO]</p>	<p>11. Lead joint Health Cluster contingency planning for potential new events or set-backs, when required.</p>	<p>Conduct the joint contingency planning for possible future events/ set-backs in the areas of operations with the other partners</p>
<p>6. Application of standards (9) See chapter 6</p>	<p>Ensure that all Cluster partners are aware of relevant national policy guidelines and technical standards, and internationally-recognized best practices. [CLA Rep./EHO]</p> <p>Where national standards are not in line with international standards and best practices, negotiate the adoption of the latter in the crisis areas. [CLA Rep.]</p>	<p>13. Promote adherence of standards and best practices by all health cluster partners taking into account the need for local adaptation. Promote use of the Health Cluster Guide to ensure the application of common approaches, tools and standards.</p>	<p>Adhere to agreed standards and protocols and promote their adoption in the delivering of health services whenever possible</p>
<p>7. Training and capacity building (12) See chapter 6</p>	<p>Promote/support training of staff and capacity building of humanitarian partners, and support efforts to strengthen the capacities of the national authorities and civil society to assure appropriate, sustainable health services. [CLA Rep./EHO]</p>	<p>14. Identify urgent training needs in relation to technical standards and protocols for the delivery of key health services to ensure their adoption and uniform application by all Health Cluster partners. Coordinate the dissemination of key technical materials and the organization of essential workshops or in-service training.</p>	<p>Ensure that own staff are adequately trained for the activities undertaken</p> <p>Identify own training needs, make these known, and assign staff to attend trainings as and when opportunities are made available</p> <p>Collaborate in organizing training for staff of local health actors and other partners, making trainers and other resources available when possible</p>



Functions <sup>1</sup>	Cluster Lead Agency (CLA)		Cluster Partners <sup>4</sup>
	Cluster Lead Agency Representative (CLA Rep.) <sup>3</sup>	Health Cluster Coordinator (HCC) <sup>2</sup>	
8. Monitoring and reporting (10) See chapter 8	Produce and disseminate Cluster sitreps and regular Health Bulletins using HCC input. [EHMP/Communications Officer]	9. Ensure partners' active contribution to and involvement in joint monitoring of individual and common plans of action for health interventions; collate and disseminate this and other information related to the health sector in Cluster sit-reps and/or regular Health Bulletins.	Participate in defining and agreeing on any information and reports that Cluster partners should provide to the HCC, and provide such information and reports a timely manner.
9. Advocacy and resource mobilization (11) See chapter 7	Provide information regularly to the news-media and, where consensus points are agreed with cluster partners, represent the Cluster in press conferences, interviews, etc. [CLA Rep./ Communications Officer]  Advocate for donors to fund priority health activities of all Cluster partners. [CLA Rep.]  Represent the interests of the health sector in discussions with the Humanitarian Coordinator and other stakeholders on priorities, resource mobilization and advocacy. [CLA Rep.]	12b. Provide leadership and strategic direction to the Health Cluster in developing the health sector components of FLASH Appeal, CHAP, CAP and CERF proposals and other interagency planning and funding documents.	Contribute to overall Cluster efforts to advocate for appropriate attention to all public health needs (and humanitarian principles in general).  Present own activities in the context of the overall health sector effort whenever possible and appropriate  Emphasize the importance of – and own commitment to – coordination and collaboration
10. Provider of last resort (13)	Act as the provider of last resort (subject to access, security and availability of funding) to meet agreed priority needs. Inform the Humanitarian Coordinator and CLA's own headquarters of resource needs and work with them to secure the necessary resources. [CLA Rep./EHO]	8. Inform the CLA Representative of priority gaps that can not be covered by any health cluster partner and require CLA action as provider of last resort.	Call attention to the need for activation of the POLR function, when needed.
<b>Notes:</b>			
<sup>1</sup> In this first column, [#] = corresponding points in the generic ToR for CLAs			
<sup>2</sup> Once the Cluster Approach is activated and a country CLA designated, the CLA country representative and country office are responsible for fulfilling HCC functions to the maximum extent possible pending the designation and arrival of an assigned HCC.			
<sup>3</sup> The CLA Representative (CLA Rep.) is responsible for assuring that all these functions are satisfactorily fulfilled. Certain functions may be delegated to the CLA Emergency Health Programme Manager (EHO) and other CLA staff, as indicated, but those marked [CLA Rep.] should be fulfilled by the CLA Representative personally or be delegated to the HCC.			
<sup>4</sup> Cluster partners would normally be represented in Cluster meetings by their country directors or emergency health programme managers. The CLA would normally be represented by its EHO as one of the cluster partners.			

## 1.4 CLUSTER ACTIVITIES DURING THE DIFFERENT PHASES OF THE HEALTH RESPONSE

Figure 1d lists the main actions to be taken during four distinct phases of response. The time frame and the focus of response during each phase depend on the nature of the disaster/crisis. Note that:

- Phase 1 needs to be completed very quickly in case of a sudden-onset disaster. A little more time may be taken in case of a slow-onset crisis but the activities are similar.
- For some emergencies, there may be an early warning phase in advance of the onset of the crisis.
- In some cases, particularly in case of a complex (conflict) emergency, the situation may evolve differently in different parts of the country; the acute phase may last longer in some areas than others, and certain areas may regress.

Figure 1e outlines the programme planning and management processes that Cluster partners need to keep in mind and that the coordinator must facilitate. Note that:

- Assessment, analysis, the development of agreed objectives, priorities and strategies, and monitoring the implementation of the health crisis response strategy is the responsibility of the *Cluster as a whole, led by the HCC*.
- The detailed planning, implementation, monitoring and evaluation of individual projects are the responsibility of the *individual organization concerned*. However, where the cluster approach is fully adopted and organizations work in partnership, the HCC and Cluster partners *may* organize joint monitoring and jointly-sponsored, independent evaluations of projects including real-time evaluations under the leadership of the HCC.
- The process of assessment, analysis, and planning is *iterative*: refinements and adjustments are made as up-dated information becomes available – see chapter 3, especially Figure 3b.

Note that Figure 1e reflects an *ideal* process of agreeing a health crisis response strategy (step 2) and individual organizations then producing their own action plans in the context of that response

1  
ROLE AND  
FUNCTIONING  
OF A HEALTH  
CLUSTER

2  
EFFECTIVE  
COORDINATION

3  
ASSESSMENT  
AND  
HEALTH  
SITUATION  
MONITORING

4  
ANALYSIS AND  
PRIORITIZA-  
TION

5  
STRATEGY  
DEVELOPMENT  
AND  
PLANNING

6  
STANDARDS

7  
ADVOCACY  
AND  
RESOURCES  
MOBILIZATION

8  
CLUSTER  
PERFORMANCE  
MONITORING  
AND LESSONS  
LEARNED

9  
STANDARD  
SERVICES AND  
INDICATOR  
LISTS

ANNEXES

strategy (step 3). This should be feasible from the outset in two situations: (i) in case of a slow-onset crisis; (ii) when an inter-agency contingency plan had been prepared in advance.

In other cases, steps 2 and 3 will be undertaken in parallel during the initial stages:

- the HCC will have to work to bring together as many as possible of the main health actors to share information and progressively develop a shared analysis of the situation and needs, agree on overall goals, response strategies and, eventually, an overall health crisis response strategic plan; while, at the same time,
- individual organizations draw up their own initial action plans taking account the overall health cluster's agreed strategic plan, and of what is known about the response plans of other actors, while remaining flexible to adjust their plans if/when needed to better address priority needs.

In each situation, health cluster partners (led by the HCC) should agree on the overall joint, or collaborative, process of assessment, analysis, strategy development and planning to be followed.

**Figure 1d Principal cluster activities during the different phases of emergency response**

<p><b>Phase 1</b></p> <p><i>Sudden-onset crisis:</i> First 24 to 72 hours</p> <p><i>Slow-onset crisis:</i> First 1-2 weeks</p>	<ul style="list-style-type: none"> <li>☑ Preliminary contacts, activation of the inter-agency contingency plan (if any)</li> <li>☑ Preliminary enquiries and consolidation of information</li> <li>☑ First health cluster coordination meeting(s) – national and sub-national levels               <ul style="list-style-type: none"> <li>↳ preliminary working scenario (anticipated health needs and risks)</li> <li>↳ preliminary “who-where -when-what” (4W) resource inventory and gap analyses</li> <li>↳ identification of initial, gender-sensitive response priorities and actions</li> </ul> </li> <li>☑ Establishment of a health coordination office and database</li> <li>☑ Preparation and dissemination of first health cluster/sector bulletin</li> <li>☑ Participation in initial inter-cluster/inter-sectoral coordination meetings; contribution to initial inter-cluster/sectoral analysis and planning</li> <li>☑ Collection of pre-crisis information</li> <li>☑ Planning the initial rapid assessment (IRA)</li> <li>☑ Initiate the EWARS</li> </ul>
<p>↓</p>	
<p><b>Phase 2</b></p> <p><i>Sudden-onset crisis:</i> First 4 to 10 days</p> <p><i>Slow-onset crisis:</i> First month</p>	<ul style="list-style-type: none"> <li>☑ Implementation of <i>iHerAMS</i></li> <li>☑ Launching the initial rapid assessment (IRA)</li> <li>☑ Fully implement the EWARS</li> <li>☑ Establishment of emergency health information system (field reporting)</li> <li>☑ Definition of standards and protocols</li> <li>☑ Regular health coordination meetings – national and sub-national levels               <ul style="list-style-type: none"> <li>↳ up-dated working scenario, resource inventory and gap analyses</li> <li>↳ agreement on up-dated, gender-sensitive response priorities and actions</li> </ul> </li> <li>☑ Formulation of initial health sector strategic plan</li> <li>☑ Preparation of health component of the UN-OCHA flash appeal (if any)</li> <li>☑ Preparation of proposals for CERF funding (if any)</li> <li>☑ Preparation and dissemination of regular health-sector bulletins</li> <li>☑ Continuing participation in inter-cluster/inter-sectoral coordination meetings; contribution to inter-cluster/sectoral analysis and planning and effective integration of cross-cutting issues including gender equality.</li> </ul>



<p><b>Phase 3</b></p> <p><i>Sudden-onset crisis:</i> ≈ 4 to 6 weeks (disaster) to up to 3 months (conflict)</p> <p><i>Slow-onset crisis:</i> ≈ 2–3 months</p>	<ul style="list-style-type: none"> <li>☑ Establishment of full HeRAMS and emergency health information system (HIS)</li> <li>☑ Coordination of contributions to surveillance and early warning and response</li> <li>☑ Continuation of regular health coordination meetings (e.g. weekly)</li> <li>☑ Development of health crisis response strategy</li> <li>☑ Planning scenario (identified health problems and risks)</li> <li>☑ Overall objectives, strategies, health cluster action plan</li> <li>☑ Implementation and monitoring of initial response (with gender-sensitive indicators)</li> <li>☑ Preparation of CHAP and consolidated appeal</li> <li>☑ Resource mobilization</li> <li>☑ Frequent up-dating of resource inventory and gap analyses</li> <li>☑ Establishment of technical working groups, as/when needed</li> <li>☑ Organization of joint training, as/when needed</li> <li>☑ Coordination of logistics support for health activities</li> <li>☑ Monitoring implementation of the health crisis response strategy &amp; cluster action plan</li> </ul>
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<p><b>Phase 4</b></p> <p>(continuing humanitarian response &amp; progressive recovery)</p>	<ul style="list-style-type: none"> <li>☑ Continuation of regular health coordination meetings (e.g. bi-weekly)</li> <li>☑ Periodic up-dating of the planning scenario, HeRAMS, and gap analyses</li> <li>☑ Coordination of the replacement of departing international teams</li> <li>☑ Establishment/suspension of technical working groups, as needed</li> <li>☑ Maintenance of HIS, surveillance and EWARS</li> <li>☑ Real-time or interim/mid-term evaluation of sector response</li> <li>☑ Comprehensive assessment/in-depth sub-sector assessments, as needed</li> <li>☑ Updating of strategic/action plan with increasing focus on recovery</li> <li>☑ Contingency planning for possible changes in the situation</li> </ul>
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<p><b>Phasing out</b></p>	<ul style="list-style-type: none"> <li>☑ Phase-out plan for emergency programmes as recovery programmes increase</li> <li>☑ Final (ex-post) evaluation and lessons-learned exercise</li> </ul>
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**Figure 1e Process of planning and implementing a health sector humanitarian response**

