

Health Cluster Coordination Guidance for Heads of WHO Country Offices as Cluster Lead Agency



Health Cluster coordination guidance for heads of WHO country offices as cluster lead agency

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Abbreviations

For definitions, see references (1) and (2).

AAP	accountability to affected populations
CAAP	Commitments on Accountability to Affected People
CERF	Central Emergency Response Fund
CHF	Common Humanitarian Fund
CHS	Core Humanitarian Standard on Quality and Accountability
CLA	Cluster Lead Agency
EMT	emergency medical team
ERC	Emergency Relief Coordinator
ERF	Emergency Response Fund
FAO	Food and Agriculture Organization of the United Nations
GCLA	Global Cluster Lead Agency
GOARN	Global Outbreak Alert and Response Network
HC	Humanitarian Coordinator
HCC	Health Cluster Coordinator
HCT	Humanitarian Country Team
HPC	humanitarian programme cycle
HRM	humanitarian response monitoring
HRP	Humanitarian Response Plan
HWCO	Head of WHO Country Office
IASC	Inter-Agency Standing Committee
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OIE	World Organisation for Animal Health
OPR	Operational Peer Review
PoLR	provider of last resort
PSEA	protection from sexual exploitation and abuse
RC	Resident Coordinator
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WFP	World Food Programme

1. Purpose and scope of this guidance

The purpose of this document is to provide Heads of WHO Country Offices (HWCOs) with a clear understanding of their **responsibilities and accountabilities** in WHO's role as **country-level Cluster Lead Agency (CLA)** for health within the Inter-Agency Standing Committee (IASC), with particular reference to the implementation

of the IASC Transformative Agenda and the commitments of the World Humanitarian Summit (Istanbul, Turkey, 23–24 May 2016) at country level. HWCOs are **responsible** and **accountable** for the activities of the Health Cluster at the country level, when WHO is designated as the CLA for health in a specified country.



Responsible

the responsible agency does the work required to achieve the task. Multiple agents may share this responsibility.



Accountable

the accountable agency is ultimately answerable for the correct and thorough completion of the task.

As CLA for health, the HWCO has a dual role, representing both WHO and all the other partners of the Health Cluster.

As the head of the CLA, the HWCO is ultimately accountable to the Resident/ Humanitarian Coordinator (RC/HC) for carrying out the CLA responsibilities and securing appropriate dedicated resources to ensure the establishment of strong Health Cluster coordination mechanisms to implement the six core functions of a cluster at country level defined by the IASC, as well as ensuring accountability to affected populations (AAP).

This paper is divided into three main sections.

1. Introduction to the IASC, the cluster approach, the New Way of Working and the Humanitarian Development Nexus and WHO's 13th General Programme of Work.
2. Strategic leadership and key areas of engagement for the health CLA. This section provides an overview of WHO's leadership responsibilities as the Health Cluster /Health Sector lead agency and as a member of the Humanitarian Country Team (HCT).
3. Cluster core functions. This outlines the responsibilities of the cluster and ways in which WHO leadership assists partners in delivering these functions.

The hyperlinks below will help you to navigate the five main sections of the guidance, as well as the list of abbreviations, the Annex and the Table of Contents.

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The Inter-Agency Standing Committee and the cluster approach

The Inter-Agency Standing Committee (IASC) is the primary mechanism for interagency coordination of humanitarian assistance.

It is a unique forum involving key humanitarian partners, both within and outside the United Nations system.

Inter-Agency Standing Committee

The IASC was established in June 1992 in response to United Nations General Assembly resolution 46/182 on the strengthening of humanitarian assistance. Under the leadership of the United Nations Emergency Relief Coordinator (ERC), IASC develops humanitarian policies, agrees on a clear division of responsibility for the various aspects of humanitarian assistance, identifies and addresses gaps in response, and advocates for effective application of humanitarian principles. See <https://interagencystandingcommittee.org/>.

The IASC Principals are the executive heads of the 18 United Nations and non-United Nations organizations that form the IASC (3). They work together to ensure coherence of preparedness and response efforts, formulate policy and agree on priorities for strengthened humanitarian action.

The cluster approach (4) was adopted by IASC in 2005 to address gaps and increase the effectiveness of the humanitarian response by building partnerships and improving coordination to support national authorities (Fig. 1).

Clusters are groups of humanitarian organizations, both within and outside the United Nations system, working in the main

sectors of humanitarian action, e.g. health, water, sanitation and hygiene (WASH), logistics. They are designated by IASC and have clear responsibilities for coordination.

The cluster approach ensures that international responses to humanitarian emergencies are predictable and accountable and have defined leadership, by making clearer the division of labour between organizations and their roles and responsibilities in different areas.

The IASC has designated WHO as the Global Cluster Lead Agency (GCLA) for health. For the official designation of all Cluster Lead Agencies at the global level, see Fig. 1.

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Fig. 1 Cluster approach



Source: (4).

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The **Global Cluster Lead Agency (GCLA)** in a specified sector provides the following types of support to strengthen field response:

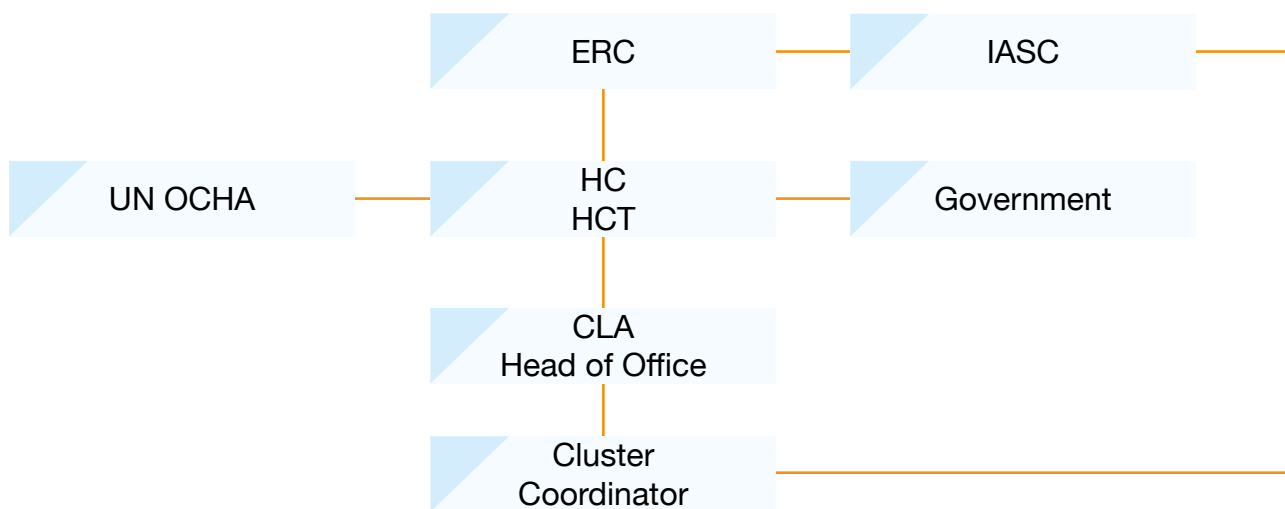
- technical surge capacity;
- trained experts to lead cluster coordination at the field level;
- increased stockpiles, some pre-positioned within regions;
- standardized technical tools, including tools for information management;
- agreement on common methods and formats for needs assessments, monitoring and benchmarking;

- best practices and lessons learned from field-tests.

At country level, it is the HC or RC who will recommend the activation of clusters when there is an identified gap in the enabling environment warranting their activation, selecting country CLAs based on the agencies' respective coordination and response capacity, operational presence and capacity to scale up.

When WHO is designated country level CLA for health, WHO leads and manages the Health Cluster. Where possible, it does so in co-leadership with government bodies.

Fig. 2 Relationships in the cluster approach



Source: (1).

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Health Cluster roles and responsibilities at the country level

As stated in United Nations General Assembly resolution 46/182 of 1991 (paras 4–6), **national authorities** have the primary responsibility for taking care of the victims of natural disasters and other emergencies occurring in their territory (5).

The designated **Cluster Lead Agency (CLA)** leads and manages the cluster. Where possible, it does so in co-leadership with government bodies and nongovernmental organizations.

At the level of the IASC infrastructure architecture (Fig. 2), the **Head of the WHO Country Office (HWCO)** is ultimately accountable to the RC/HC for carrying out the CLA responsibilities (6,7).

The **Health Cluster Coordinator (HCC)** is the neutral representative of the cluster as a whole and is responsible for the day-to-day coordination and facilitation of the work of the cluster. The Cluster Coordinator will ensure the accountability and transparency of the decisions and work of the cluster. Co-coordinators, subnational coordinators, information managers and other Health Cluster team members report to the national Cluster Coordinator. At the operational level, the Health Cluster is often chaired by a representative of the Ministry of Health, where appropriate, with the support of the cluster team.

Cluster partners drawn from national and international agencies (United Nations, nongovernmental organizations, government, representatives of the International Federation of Red Cross and Red Crescent Societies, donors and other stakeholders) commit themselves to the minimum participation in clusters, as defined by the IASC reference module for cluster coordination at country level (4). Provision is also made in the cluster for those humanitarian actors that may wish to participate as observers, including donors, mainly for information-sharing purposes.

Health sector or Health Cluster?

“Sector” refers to a distinct technical area of humanitarian action.

The cluster approach seeks to formalize the accountabilities and responsibilities of lead agencies.

At the country level, the representative of the CLA is accountable to the HC. This line of accountability is the primary difference between a sector and a cluster.

In countries where the government has the responsibility for coordination, WHO is often referred to as the Sector Lead rather than Cluster Lead.

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Transformative Agenda

In December 2011, the IASC Principals agreed to a set of reforms under the “Transformative Agenda” (8) to improve humanitarian response, and committed the organization to the ultimate objective of AAP.

Among the measures adopted in the Transformative Agenda is enhanced accountability for the HC and members of the HCT for the achievement of **collective results** and streamlined

coordination mechanisms. At the global level, the aim is to strengthen **preparedness and technical capacity** to respond to humanitarian emergencies. At the country level, the aim is to strengthen response through predictability, accountability and partnership by ensuring **better prioritization and definition of the roles and responsibilities of humanitarian organizations**. Information management and analysis are key in this regard.

The New Way of Working: the Humanitarian Development Nexus

During the World Humanitarian Summit in 2016, the New Way of Working, or Humanitarian Development Nexus, and the link with peace-building (9) were introduced to acknowledge that the international community’s responsibilities towards populations affected by crisis require complementary interventions from humanitarian, development and peace-building actors. This includes actions to reinforce and strengthen the capacities that already exist at national and local levels based on the comparative advantage of the various actors, including those outside the United Nations system, to achieve the collective outcomes.

The New Way of Working is based on joint analysis and joint planning between governments and development partners

for collective outcomes (Fig. 3). The HWCO should promote humanitarian interventions that apply early recovery approaches in the response and seek integration with existing health services and transition of governance responsibilities to local authorities, while development work streams should target fragile and conflict-affected areas in a more operational manner, addressing key bottlenecks in health systems performance that also contribute to constraints in the humanitarian response, with more flexibility in contracts and adapted management of risks. Recognizing the interdependence of health systems performance and capacities for emergency preparedness and response, the convergence of humanitarian and longer-term development approaches for improving health

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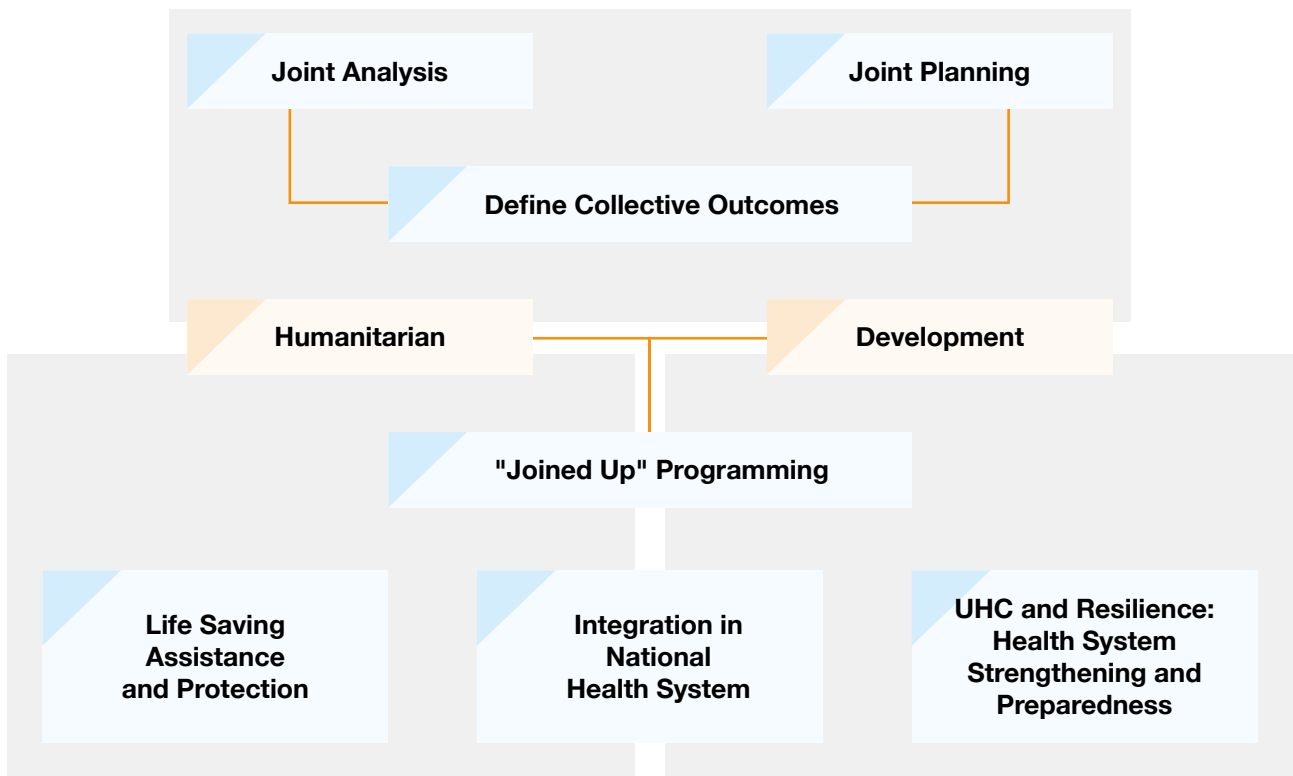
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service coverage is vital in order to implement, mainstream and expand access to essential and high-quality health services based on primary health care principles for those affected by protracted emergencies. This is done by

fostering the interface between humanitarian and development through connections in analysis, planning and coordination. In conflict-affected settings, health programming should be conflict-sensitive.

Fig. 3 The New Way of Working



UHC: universal health coverage.

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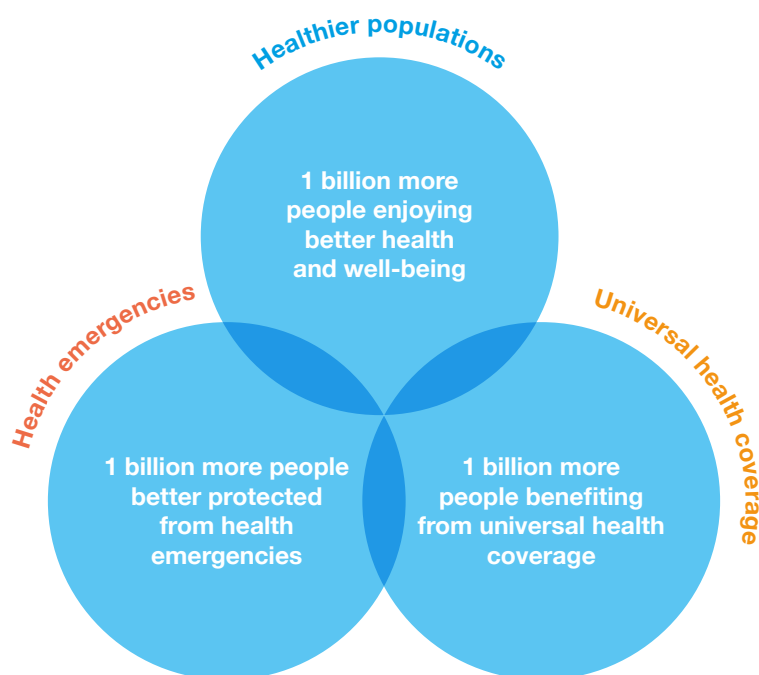
The WHO 13th General Programme of Work was adopted by Member States in May 2018 (10). It has three interconnected strategic priorities to ensure healthy lives and well-being for all ages, expressed in the “triple billion” goals (Fig. 4):

- 1 billion more people benefiting from universal health coverage
- 1 billion more people better protected from health emergencies
- 1 billion more people enjoying better health and well-being.

The 13th General Programme of Work was developed in support of the United Nations Sustainable Development Goals, in particular Goal 3, “Ensure healthy lives and promote well-being for all at all ages”.

The goal of having 1 billion people better protected from health emergencies is associated with three major outcomes: (a) countries are prepared for health emergencies; (b) epidemics and pandemics are prevented; (c) there is rapid detection of and response to health emergencies (10). The Health Cluster directly supports this goal, as well as contributing to achieving universal health coverage and healthier populations.

Fig. 4 The triple billion goals



Source: (10).

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2. Strategic leadership and key areas of engagement

Key message

WHO, as Cluster Lead Agency (CLA) for health, should demonstrate leadership in humanitarian health response, ensuring accountability to affected populations, prioritization of health concerns and appropriate intersectoral/intercluster action, while maintaining established bilateral relations with the Ministry of Health and other governmental entities.

WHO has specific responsibilities and accountabilities for emergency operations under a World Health Assembly resolution (WHA65.20 of 2012) (11), the International Health Regulations (2005) (12) and within the global humanitarian system as the IASC CLA for health. The full cycle of management must be tackled in all phases of the humanitarian programme cycle (HPC) – prevention, preparedness, response and recovery.

WHO's operational response to emergencies is managed through application of the

Incident Management System, as described in the Emergency Response Framework, 2nd edition (13). To deliver an effective operational response, WHO has six critical functions that it must fulfil at country level – each with one or more subfunctions. WHO's critical functions for emergency response under the Incident Management System are leadership, partner coordination, information and planning, health operations and technical expertise, operations support and logistics, and finance and administration.

This section provides details of WHO's obligations in the leadership and coordination functions, as the IASC-designated country level Cluster Lead Agency for health.

Principles of WHO's work as Cluster Lead Agency for health

As stated in United Nations General Assembly resolution 46/182 of 19 December 1991, humanitarian assistance “must be provided in accordance with the principles of humanity, neutrality and impartiality” (5).

- Accountability to affected populations
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- IASC protocols related to the classification and management of large-scale humanitarian operations
- Cluster deactivation

- **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.

The Health Cluster is also founded on the principles of partnership between and among affected populations, national governments, the United Nations, international organizations, nongovernmental organizations, the Red Cross and Red Crescent societies, academia and the private sector (14).

- **Equality** requires mutual respect between members of the partnership irrespective of size and power. The participants 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** is achieved through dialogue (on equal footing), with an emphasis on early consultations and early sharing of information. Communications and transparency, including financial transparency, increase the level of trust among organizations.
- **Results-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.

These principles are guided by the right to health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (15) by international humanitarian law and by international human rights law.

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Accountability to affected populations

Accountability to affected populations (AAP) puts the affected persons and their needs at the heart of the emergency response, often referred to as the **people-centred approach**. Rather than seeing the community as a homogeneous entity, AAP takes into account the needs and capacities of different groups in the community:

women, men, girls, boys, elderly people, people with disabilities, people with mental health problems, etc. The different needs and capacities of all these groups are considered in shaping the response plan and the way cluster partners and affected populations interact through all the phases of the HPC.

Accountability to affected populations is divided into three dimensions of accountability:

- **taking account**, meaning that actors should go to the community to solicit opinions and thoughts from a broad spectrum of women, girls, boys and men;
- **giving account**, meaning that humanitarian actors will provide information to the community throughout the HPC, outlining what the plans and commitments are, how and why decisions were made and what the process was;
- **being held to account**, allowing affected people an opportunity to assess the quality of the response of an agency and the relevance of the activities conducted, to assess the way the activities have been implemented and to provide feedback on how well the activities have been addressing their needs.

To support this approach, and building on the IASC AAP Commitments and Guidance, the Global Health Cluster developed the Health Cluster Operational Guidance on Accountability to Affected Populations (16, 17). This guidance is designed to assist, with

cluster partners, in leading emergency responses with strong and robust accountability systems, through which affected populations can increasingly influence the type, delivery and quality of assistance they receive.

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A critical element of AAP is the provision of mechanisms to implement **protection from sexual exploitation and abuse (PSEA)**. Upholding and promoting policies on PSEA is critical in all operations in all countries. It is of particular relevance in emergencies, since the relationship between humanitarian workers and beneficiaries is inherently unequal in terms of power and level of authority. Therefore, staff must be vigilant and rigorously refrain from any action that may suggest or imply that a sexual act may be demanded as a condition for protection, material assistance or service.

The WHO Policy on the Prevention of Harassment provides mechanisms to prevent, from the outset, sexual exploitation and abuse by defining the conduct expected from WHO staff and collaborators. The policy demands reaction and sanction at any point (18,19).

The HWCO is accountable for:

1. clarifying WHO commitments on AAP and putting these into practice, including incorporating them in staff inductions and agreements with operational partners;
2. incorporating the Commitments on Accountability to Affected People (CAAP)

(20) into all relevant statements, policies, response plans (e.g. humanitarian response plans – HRPs) and operational guidelines and promoting them with operational partners, within the HCT and among cluster members;

3. systematically including AAP in all needs assessments and monitoring, review and evaluation processes (including interagency-real-time evaluation);
4. facilitating the provision of feedback from affected people on the services and protection offered by their agencies, including ensuring a complaints mechanism;
5. providing information for affected people about health services and support available in local languages, and ensuring that information on the emergency situation, on availability and on the nature of humanitarian responses is systematically communicated to affected populations using relevant communication mechanisms;
6. designating a senior focal point on PSEA, developing a PSEA workplan and reporting back on progress to the HC.

During the World Humanitarian Summit in 2016, many organizations, including governments, donors and nongovernmental organizations, committed themselves to the nine elements of the Core Humanitarian Standard on Quality and Accountability (CHS) that set out guidelines showing how organizations and individual humanitarian workers can improve humanitarian services and make them more effective and efficient (21).

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Core humanitarian standard	Quality criterion
CHS1 Communities and people affected by crisis receive assistance appropriate and relevant to their needs.	Humanitarian response is appropriate and relevant.
CHS2 Communities and people affected by crisis have access to the humanitarian assistance they need at the right time.	Humanitarian response is effective and timely.
CHS3 Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.	Humanitarian response strengthens local capacities and avoids negative effects.
CHS4 Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them.	Humanitarian response is based on communication, participation and feedback.
CHS5 Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.	Complaints are welcomed and addressed.
CHS6 Communities and people affected by crisis receive coordinated, complementary assistance.	Humanitarian response is coordinated and complementary.
CHS7 Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection.	Humanitarian actors continuously learn and improve.
CHS8 Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers.	Staff are supported to do their job effectively, and are treated fairly and equitably.
CHS9 Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically.	Resources are managed and used responsibly for their intended purpose.

Protection mainstreaming

Protection mainstreaming (22) is the process of incorporating protection principles and promoting meaningful access, safety and dignity in humanitarian aid. The following elements must be taken into account in all humanitarian activities:

- **prioritization of safety and dignity and avoidance of causing harm** – prevent and minimize as much as possible any unintended negative effects of intervention which can increase people’s vulnerability to both physical and psychosocial risks;
- **meaningful access** – arrange for people’s access to assistance and services, in proportion to needs and without any barriers (e.g. discrimination); pay special attention to individuals and groups who may be particularly vulnerable or have difficulty accessing assistance and services;

- **accountability** – set up appropriate mechanisms through which affected populations can measure the adequacy of interventions and address concerns and complaints;
- **participation and empowerment** – support the development of self-protection capacities and assist people to claim their rights, including, not exclusively, the rights to shelter, food, water and sanitation, health and education.

The HWCO is accountable for:

1. ensuring that protection is mainstreamed and that health programmes are designed and implemented so that protection risks and potential violations are taken into consideration.

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The HWCO and the Humanitarian Country Team

The HCT is the top interagency humanitarian leadership body in a country. It is led and chaired by the HC. The HCT's primary purpose is to provide the strategic direction for collective interagency humanitarian response. The HCT is ultimately accountable to the people in need.

As stated in United Nations General Assembly resolution 46/182 (5), the affected State retains the primary role in the implementation of humanitarian assistance within its territory. Whenever possible, the HCT operates in support of and in coordination with national and local authorities, while ensuring adherence to humanitarian principles.

WHO, as CLA for health, works within the HCT to ensure appropriate understanding and prioritization of health concerns and appropriate intersectoral/intercluster action, while maintaining established bilateral relations with governments.

Working in support of the HC, the HCT has the following responsibilities (23):

1. to provide a shared strategic vision for collective humanitarian action in-country, set out in a common strategic plan (the HRP);
2. to oversee the Inter-Cluster Coordination Group, cluster lead agencies and subnational coordination bodies, as well as other interagency bodies;
3. to support efforts led by the WHO HC to obtain free, timely, safe and unimpeded access by humanitarian organizations to populations in need;
4. to ensure that preparedness and response efforts are inclusive and coordinated;
5. to link emergency operations with rehabilitation and peace-building activities.

The HWCO is accountable for:

1. the dual role of representing WHO and the Health Cluster/Sector consistently and effectively within the HCT; this includes regular participation in all HCT meetings and activities; when the HWCO is not available, s/he sends a designate to represent both WHO and the Health Cluster/Sector;
2. ensuring WHO's adherence to humanitarian principles, Principles of Partnership (14) and policies/strategies adopted by the HCT;
3. participating actively in HCT strategy development, planning and policy development and subsequent implementation;
4. ensuring that coordination mechanisms are fit for purpose and evolve and adapt to the operational context, including at subnational level.

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Coordination with national authorities and other local actors

The term “national authorities” refers to the internationally recognized or de facto national government of a country in which a humanitarian operation is taking place (24).

The RC or HC, all CLAs and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) are responsible for consulting national authorities regarding existing capacity and coordination mechanisms for humanitarian

response. WHO as the CLA for health should work closely with national authorities in jointly developing priorities and strategies for the sector and in monitoring and following up to ensure that programmes and initiatives continue to meet changing needs. WHO should also, where necessary, explain what the government can expect from the CLA (including the principle of the **provider of last resort (PoLR)**) and cluster partners.

“In addition to the six core functions of the Cluster the designated CLA is the **provider of last resort (PoLR)**. This means that, where necessary and depending on access, security and availability of funding, the Cluster Lead, as PoLR, must be ready to ensure the provision of services required to fulfil crucial gaps identified by the Cluster and reflected in the Humanitarian Response Plan” (4, 13).

Cluster Lead Agencies and the HCT should be part of any preparedness planning activities carried out in the region or country, including the development of a contingency plan for likely emergency scenarios. As soon as practicable, they should also develop strategies and plans for transition as the situation moves from emergency to recovery, in keeping with the principles and guidance of the Humanitarian Development Nexus (9).

In cases where the national authorities are unwilling or unable to lead the humanitarian response, or in cases where the national authorities are taking the lead but there are significant discrepancies between national

authorities and the humanitarian actors in terms of principles and objectives, the RC/HC and WHO as the CLA for health should continue to advocate for humanitarian space and a humanitarian response that covers the needs of the entire affected population.

The HWCO is accountable for:

1. maintaining, in coordination with the RC or HC, appropriate links and dialogue with other national and local authorities, local civil society and other relevant actors (e.g. military forces, peacekeeping forces and non-State actors) whose activities affect humanitarian space and health-related programmes;

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2. facilitating the participation of national health authorities, national and international nongovernmental organizations, civil society and non-State actors in the Health Cluster;
3. promoting capacity-building initiatives, including technical assistance, training, material support and support for national authorities to meet their obligations under international and national law.

Ensuring appropriate coordination of all health actors

In its engagement with others, WHO needs to recognize that it is **one partner** alongside other local, national, regional and international actors for health.

WHO is expected to lead and assist other actors for health by providing strategic direction, common operational planning, reliable information, coordination and technical guidance. At the same time, these other actors have their own responsibilities, strengths, comparative advantages and expertise in different aspects of the work in emergencies and outbreaks. They need to be given the space and the support to perform their roles effectively. WHO should not duplicate the operational capacity already present in other actors for health, but rather enable and contribute to the collective response.

Because the cluster coordination function requires a degree of independence from the CLA, HWCO should ensure that the Health Cluster Coordinator (HCC) is dedicated to this function only. WHO technical staff and/or the WHO

Incident Manager (or his/her designate) should represent WHO as a technical partner cluster. As the HWCO represents both WHO generally and the CLA on the HCT, it is recommended that the HCC reports to the person mandated to represent WHO as CLA on the Humanitarian Coordination Team. The Health Cluster functions should always be conducted in close collaboration with all Incident Management System functions.

The HWCO is responsible for:

1. ensuring protection and early recovery are mainstreamed and integrated; overseeing the implementation of the HRP and endorsing collective HCT positions;
2. as a collective and key component of the HCT, committing to the operational leadership, responsibilities and performance of the country-level cluster response;
3. contributing to the implementation of the Health Cluster Strategic Objectives, policies and guidance.

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The HWCO is accountable for:

1. securing adequate structure and resources (financial and human) to ensure that the Health Cluster can fulfil its core functions, including ensuring that the Health Cluster is represented in

intercluster coordination mechanisms at country/field level, contributing to jointly identifying critical issues that require multisectoral responses, and planning the relevant synergistic interventions with the other clusters concerned.

Cluster activation

The RC/HC and CLAs consult national authorities to identify the humanitarian coordination mechanisms that exist and their respective capacities. When adequate coordination mechanisms do not already exist, clusters may be activated. WHO is then accountable to the ERC, through the RC or HC, for leadership/co-leadership in delivering an efficient and cost-effective humanitarian response. WHO also has accountabilities to other HCT members, to Health Cluster partners, to other activated clusters, to governments, to donors, to affected populations (as noted earlier) and to other stakeholders.

A formally IASC-activated cluster has specific characteristics and accountabilities. It is **accountable** to the HC through the CLA as well as to national authorities and to people affected by the crisis.

Cluster Lead Agencies are encouraged to consider developing clearly defined, agreed and supported sharing of cluster leadership with nongovernmental organizations wherever feasible.

Once the Health Cluster is established and fully functional, a variety of alternative budget mechanisms can be considered for cluster activities. These may include the Central Emergency Response Fund (CERF), country-level

pooled funds such as the Emergency Response Fund (ERF) and Common Humanitarian Fund (CHF) (25), and directed donor funds.

The HWCO is responsible for:

1. ensuring protection and early recovery are mainstreamed and integrated; overseeing the implementation of the strategic plan and endorsing collective HCT positions;
2. as a collective and key component of the HCT, committing to operational leadership, responsibilities and conduct of the country level cluster response;
3. contributing to the implementation of the Health Cluster strategic objectives, policies and guidance.

The HWCO is accountable for:

1. agreeing with the Ministry of Health and the HCT on the most appropriate coordination structure, management approach and plan for the Health Cluster at field level; the Health Cluster plan should involve a management structure with clearly established functions, reporting lines and resourcing/ expenditure mechanisms;

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2. supporting initial staffing, assessment and identification of the scope of work for a new cluster architecture; key staff – in particular a dedicated HCC and a dedicated information management officer – should be deployed to provide minimum coordination capacity, drawing wherever possible from trained and experienced personnel and standby partnerships; when decentralized coordination is recommended, key subnational coordination and information management staff should be recruited;
 - additional cluster support staff may be requested, depending on the scope and context of the event, e.g. a Health Cluster support officer, communication officer and/or a public health officer;
3. acting as the Fund Manager for Health Cluster budgets and taking responsibility for financial and administration oversight pertaining to cluster functions and activities, unless such responsibilities have been formally reassigned under WHO emergency response protocols.

IASC protocols related to the classification and management of large-scale humanitarian operations

In 2018, the IASC established protocols related to the classification and management of large-scale humanitarian operations.

IASC Protocol 1. Humanitarian system-wide scale-up activation

The IASC system-wide scale-up activation is a system-wide mobilization in response to a sudden-onset and/or rapidly deteriorating humanitarian situation in a given country, including the subnational level, where the capacity to lead, coordinate and deliver humanitarian assistance does not match the scale, complexity or urgency of the crisis. It can only be applied for a limited period of six months, unless one additional three-month extension is warranted. It is a short-term

injection of additional capacity to meet urgent humanitarian needs.

The decision regarding scale-up activation will be based on an analysis of five key criteria: scale, complexity, urgency, capacity and risk of failure to deliver effectively and at scale to affected populations. National authorities must always be informed of a scale-up activation; it is not contingent on an assessment of national capacity, nor is it a measure of the severity of the crisis, so should not result in an exacerbation of any inequities in funding between crises.

Details of the division of responsibilities, the activation and deactivation procedure and steps for decision-making and monitoring are included in the Protocol (26).

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IASC Protocol 2. “Empowered leadership” in a humanitarian system-wide scale-up activation

During a humanitarian crisis, it is possible that the roles and responsibilities of the HC could be revised for an initial limited period of six months. These revised roles and responsibilities are outlined in the Empowered Leadership Protocol (27). They apply only for the period of scale-up activation, and so may only be extended if the scale-up activation is also extended. Contribution to collective results should be considered a key component of the responsibilities and performance of country-level operational leadership of each HCT member agency.

The HWCO is accountable for:

1. ensuring strong leadership and engagement with the government and the HCT representing both WHO and health partners, since the scale-up will rely on inputs from all health stakeholders;
2. securing adequate resources (financial and human) to ensure that the WHO Health Cluster can fulfil its core functions in a timely manner; in the case of a newly activated cluster and if additional staff are required, the HWCO must include these positions in the surge support request;

3. maintaining ongoing and constant communication with the HC;
4. while engaging actively with the HCT and the national government and donors, ensuring appropriate oversight and management of health sector assets and resources.

Humanitarian System-wide Scale-up Activation Protocol for the Control of Infectious Disease Events

In addition to major humanitarian crises triggered by natural disasters or conflicts, infectious disease events, including outbreaks, can result in a humanitarian system-wide scale-up activation to ensure a more effective response (28). Under the International Health Regulations (IHR) 2005, WHO assesses the risks associated with infectious disease events on an ongoing basis, consulting as necessary with the relevant governments, WHO country offices, the United Nations Children’s Fund (UNICEF) and partner agencies, including the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE). The WHO Director-General informs the United Nations Secretary-General and the ERC of all public health events assessed as high or very high risk at regional or global levels, and/or when WHO declares an internal Grade 3 emergency.

“The designation of a Scale-Up response to an infectious disease event will be issued by the Emergency Relief Coordinator (ERC), in close collaboration with the Director-General of WHO, and in consultation with IASC Principals and, potentially, Principals of other relevant entities [...]. For infectious disease events, the designation of a Scale-Up activation should be based on both an analysis of the IASC’s five criteria [scale, urgency, complexity, capacity and risk of failure to deliver effectively and at scale to affected population] adapted to meet International Health Regulations (IHR) (2005) criteria [see Protocol Annex 1] and WHO’s formal risk assessment of the event” (28).

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The HWCO is accountable for:

1. supporting the WHO Director-General in assessing the risks associated with infectious disease events in-country;
2. consulting with ministries of health, relevant governmental institutions,

UNICEF and partner agencies from the Global Outbreak Alert and Response Network (GOARN), including FAO and OIE;

3. providing technical inputs for the deliberations of the IASC Emergency Directors Group.

Cluster deactivation

The IASC Principals have agreed that an annual coordination architecture review should be conducted by each HCC/HCT to recommend continuing, deactivating, scaling down and/or handing over clusters, as appropriate. To ensure that clusters continue to operate only while they are strictly needed, deactivation plans and transitional coordination mechanisms should be prepared as soon as possible after activation.

During the transition process, the line of accountability for core cluster functions and responsibilities (such as PoLR) must be clear. Transition plans should show in detail how accountabilities will shift to government or to other crisis coordination mechanisms.

The HWCO is accountable for:

1. participating in the annual coordination architecture review and implementing

its recommendations; this may include preparing transition or deactivation plans in collaboration with cluster partners and national counterparts; in the event that the HCT does not undertake an annual review, the HWCO should regularly review the appropriateness of the health coordination mechanism;

2. for sudden-onset events, developing an outline of a transition or deactivation strategy at 90 days after activation;
3. establishing strong links between humanitarian and development coordination bodies, consistent with the principles and spirit of the Humanitarian Development Nexus; where possible, this should include alignment of recovery approaches with national transition/development plans and objectives.

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STRATEGIC LEADERSHIP AND KEY AREAS OF ENGAGEMENT

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- Accountability to affected populations
- Protection mainstreaming
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3. Cluster core functions

Key message

The **Head of the WHO Country Office**, as the representative of the CLA for health, is ultimately accountable to the RC/HC for carrying out CLA responsibilities and ensuring appropriate resources to implement the six IASC core functions of a cluster at country level, as well as ensuring accountability to affected populations.

Under the IASC Transformative Agenda, the IASC Principals agreed to refocus the application of the cluster approach on **strategic and operational** gaps analysis, planning, assessment and results. The six core functions of a cluster at country level are:

1. to inform strategic decision-making by the HC/HCT
2. to plan and implement cluster strategies
3. to support service delivery
4. to monitor and evaluate performance
5. to build national capacity in preparedness and contingency planning
6. to support robust advocacy and resource mobilization.

Information management for strategic decision-making

A key prerequisite for any effective humanitarian response is the availability of timely, reliable and robust information. In order to make sound decisions in a public health emergency and humanitarian health response, decision-makers need public health information to assess and monitor the health status of, and risks faced by, the affected population,

the availability and actual functionality of health resources, morbidity and mortality trends and the performance of the health system. Managing the requisite information includes planning, collection, processing, storage, analysis, dissemination and evaluation consistent with the principles of humanitarian information management in emergencies (29).

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- Information management for strategic decision-making
- Planning and strategy development
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- Advocacy and resource mobilization

Coordinating assessments and needs analysis is a responsibility shared among all humanitarian actors. To the extent feasible, all assessment activities should be undertaken jointly with partners. All actors are responsible for ensuring engagement with and feedback to affected populations through the coordinated needs assessment process.

The HCT sets the overall requirements for humanitarian information management services, products and tools in consultation with clusters and agencies with information management capacity, so that systems can be tailored to context and resources.

While the responsibility for ensuring appropriate information management for an effective and coordinated intercluster response rests with OCHA, the responsibility for ensuring appropriate information management for an effective and coordinated cluster response rests with the CLA.

WHO, as the CLA for health, will make available technical expertise and other resources for cluster and intersectoral assessments, as required. The Global Health Cluster Unit has developed the Standards for Public Health Information Services in Activated Health Clusters and other Humanitarian Health Coordination Mechanisms (30), which provide a framework for the development and monitoring of information management actions.

The HWCO is accountable for:

1. ensuring Health Cluster/Sector risk and needs assessments are coordinated and contribute to multicluster/multisector initial rapid assessment and interagency assessments;
2. ensuring that reliable flows of information between the HCT and the Health Cluster are evidence-based for strategic decision-making and planning purposes;
3. participating in the development of appropriate in-country humanitarian and Health Cluster/Sector information management systems, including the establishment/reactivation of Early Warning, Alert and Response System reporting and ensuring regular reporting on surveillance;
4. ensuring that key information products, such as Health Cluster/Sector situation reports, epidemiological bulletins, dashboards, etc. are produced and disseminated regularly;
5. ensuring that vital information about the humanitarian response is provided to affected communities;
6. ensuring the provision of the latest updated information on health status and public health risks for the affected population.

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Planning and strategy development

Strategic planning within the HPC refers specifically to the delivery of a strategic response plan by the HCT.

The HWCO, representing the CLA for health, ensures that Health Cluster/Sector plans take appropriate account of national health policies and strategies and internationally recognized best practices and incorporate appropriate exit, or transition, strategies.

The HWCO, representing the CLA for health, ensures that opportunities to promote recovery and appropriate rebuilding of the health system are identified and exploited from the earliest possible moment, and that risk reduction measures are incorporated into strategies and plans.

Where national standards are not in line with international standards and best practices, the HWCO should negotiate the adoption of the appropriate international standards.

The HWCO is accountable for:

1. as a member of the HCT, establishing strategic objectives for the collective humanitarian response and regularly reviewing objectives, priority activities and plans;
2. representing the interests of the Health Cluster and partners in discussions with the HC and other stakeholders;
3. in consultation with the HCC, providing leadership and strategic direction for the WHO Health Cluster in agreeing priorities and strategies, and planning coordinated action to address critical gaps;
4. ensuring that WHO and the Cluster Partnership deliver on their commitments to achieve the results prioritized in the HRP;
5. ensuring that humanitarian responses build on local capacities and that the needs, contributions and capacities of vulnerable groups are addressed;
6. promoting adherence to standards and best practices by all Health Cluster partners, taking into account the need for local adaptation;
7. promoting use of the Global Health Cluster Guide (31), the Sphere humanitarian standards (32), the Global Health Cluster policy and tools (33) and other relevant technical guidance to ensure the application of common approaches, tools and standards.

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Supporting service delivery

WHO, as the CLA for health, provides a platform that ensures service delivery is driven by the HRP and strategic priorities and that adaptations of the plan and priorities are evidence-based and informed by monitoring of health needs and risks and by Health Cluster/ Sector performance. All steps must be taken to ensure that priority gaps are filled and that duplication is avoided.

WHO, as the CLA for health, identifies and develops clear recommendations, disseminates guidance and provides technical assistance to the Ministry of Health and partners on the most relevant actions to respond to health needs and to prevent and/or control public health risks.

The CLA is the **PoLR** (34). Where necessary, and depending on access, security and availability of funding, the CLA, as the PoLR, must be ready to ensure the provision of services required to fulfil crucial gaps identified by the Health Cluster and reflected in the Health-Cluster-led HRP.

The HWCO is accountable for:

1. coordinating and collaborating with the Ministry of Health and partners, including through the Health Cluster, GOARN, emergency medical teams (EMTs) and standby partners, to ensure the delivery of essential high-quality health services; this involves clarifying standards and defining an essential package of health services that covers community, primary and referral levels;
2. developing mechanisms to eliminate duplication of service delivery;
3. collaborating with ministries of health and partners such as UNICEF to frame the event and risk through risk communication and community engagement, and provide authoritative information using all relevant communication platforms;
4. ensuring that essential high-quality services required to fulfil critical gaps identified by the Health Cluster are provided.

Monitoring and reporting

Humanitarian response monitoring (HRM) (35) is a continuous process that records the aid delivered to an affected population, as well as the achieved results against

the objectives set out in the HRP. It tracks the inputs, outputs, outcomes and, where possible, the impact of the interventions on the affected populations.

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HRM can demonstrate how the combination of resources (inputs and activities) produces results, the delivery of goods or services (outputs), which over time leads to short or medium-term effects (outcomes), and ultimately could effect a change in the humanitarian situation (impact). In humanitarian settings, the main impacts in the Health Cluster/Sector are prevention of, or smaller increases in, morbidity and mortality.

Monitoring and evaluation should be an integral part of the response strategy (see Global Health Cluster guide) (31) and should be gender-sensitive, be participatory as far as possible and take account of other locally relevant cross-cutting concerns. Health Cluster partners should collectively monitor the implementation of the overall health response strategy and ensure evaluation of the overall Health Cluster/Sector response.

The Humanitarian Response Plan Mid-term Review (36), Periodic Monitoring Review (PMR) (37) and Operational Peer Review (OPR) (38) are different monitoring tools that are or could be used at different stages of response; the Health Cluster should be ready to organize or participate in these processes.

Monitoring cluster coordination at national and subnational level is necessary to ensure that clusters act as efficient and effective coordination mechanisms, fulfil the core cluster functions, support efficient delivery of relevant services, meet the needs of cluster members and demonstrate AAP.

Cluster coordination performance

monitoring is a self-assessment exercise. Clusters assess their performances against the six core cluster functions and AAP. Performance monitoring enables all cluster partners and coordinators to identify strengths and weaknesses of performance and paths to improvement.

A cluster coordination architecture

review is initiated and led by the HC/HCT, supported by OCHA. It assesses whether cluster coordination structures continue to be appropriate in light of changes in the humanitarian context and determines whether they should (a) continue as they are; (b) be expanded; (c) be streamlined; or (d) transition, with a plan and benchmarks for deactivation.

The HWCO is accountable for:

1. monitoring the performance of mandated areas and raising any implementation issues with the HC/HCT, involving the relevant WHO regional office and headquarters as appropriate;
2. participating in any interagency operational reviews and formal evaluations;
3. leading periodic reviews of the Health Cluster functions, performance, structure and funding, and adapting resources and structures as appropriate.

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Contingency planning and preparedness

The Transformative Agenda introduced two approaches to preparedness:

- the emergency response preparedness approach (39); and
- a common framework for the development of national and local preparedness capacity (40).

The emergency response preparedness approach is part of the **humanitarian programme cycle (HPC)**. The approach gives country teams the opportunity to analyse and monitor risks that should be part of the interagency needs assessments and related response plans. It provides tools for United Nations country teams and/or HCTs to (a) understand risks and establish a system to monitor them; (b) establish a minimum level of preparedness; and (c) take additional action, including developing contingency plans, to ensure readiness to respond to identified risks.

Cluster Lead Agencies have to operationalize the emergency response preparedness plan, which provides a systematic and coherent multihazard approach to emergency preparedness that enables humanitarian actors to prepare for rapid, effective and efficient action. It has three key components:

- hazard identification, risk management and risk monitoring
- minimum preparedness actions
- contingency planning and advanced preparedness actions.

The emergency response preparedness approach provides a group of minimum preparedness actions. These measures serve as the basic building blocks of emergency preparedness and include:

- risk monitoring (risks should be evaluated based on their likelihood and potential impact);
- establishment of coordination and management arrangements;
- preparations for joint needs assessments;
- response monitoring;
- information management;
- establishment of operational capacity and arrangements to deliver critical relief assistance and protection.

Wherever possible, these actions should be implemented at the same time as strategies to mitigate risk and prevent escalation of needs.

The HWCO is accountable for:

1. ensuring a thorough risk analysis that draws on a wide range of expertise from cluster partners, national institutions and organizations and independent experts;
2. operationalizing and monitoring the quality and comprehensiveness of the emergency response preparedness plan;
3. establishing effective WHO engagement in all aspects of the emergency

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response preparedness approach and ensuring that WHO and Health Cluster engagement is consistent with the HCT level;

4. maintaining coherent involvement in national capacity development (of government, national nongovernmental

organizations and communities) for preparedness and, after consultation with the RC and the United Nations Development Programme, taking a leadership role as required;

5. ensuring that WHO country office(s) have clear repurposing plans in place.

Advocacy and resource mobilization

Advocacy is required to ensure that the two main pillars of humanitarian action – protection and assistance – are adequately resourced and addressed.

The IASC’s protection policy stresses that protection is a shared, humanitarian system-wide responsibility (41). **Protection** (42) is about advocating for, supporting or undertaking activities that aim to obtain full respect for the rights of all individuals in accordance with international humanitarian, human rights and refugee law (40). Protection is enshrined in the principle of humanity and is an objective of humanitarian action. It is an issue that must inform all aspects of humanitarian response.

Full and unimpeded **humanitarian access** is a fundamental prerequisite for effective humanitarian action. In its resolution 1894 (S/RES/1894) (43), the United Nations Security Council underscored the importance of upholding the humanitarian principles of humanity, neutrality, impartiality and independence. Humanitarian access, mandated by General Assembly resolution 46/182, refers to a two-pronged concept, comprising humanitarian actors’ ability to reach

populations in need and affected populations’ access to assistance and services.

An HCT protection strategy, which needs to inform and be informed by the HRP, should aim to save lives and ensure the safety and dignity of affected persons, while at the same time alleviating their suffering. The Health Cluster/ Sector must contribute to that strategy and ensure that cluster/sector-specific issues – such as attacks on health care, access to an essential package of health care and clinical management of rape – are adequately addressed.

WHO, as the CLA for health, and Health Cluster partners should understand and know “who” is at risk, from “what” or from “whom”, as well as “why”. They should also regularly assess and address any unintended consequences of their actions, e.g. recruiting primarily male health care providers and thereby limiting access by women to health care in some settings.

Attacks on health care (44) and health workers means any act of verbal or physical violence or obstruction or threat of violence that interferes with the availability, access and delivery of curative and/or preventive health services

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during emergencies. Attacks on health care can include deliberate damage/destruction of health facilities, looting, forced closure of facilities, violent search of facilities, use of military force, chemical attack, killing or abduction of health care workers and/or patients, denial or delay of health services, forcing staff to act against their ethics, etc. Such attacks not only endanger health care providers and patients, they also deprive people of care when they need it most.

Advocacy includes communicating the right messages to the right people at the right time. This can mean involving humanitarian agencies, nongovernmental organizations, community-based organizations, national governments, local and international media, parties to conflict, companies, donors, regional bodies, communities affected by emergencies and the general public.

The HC, in consultation with the HCT and ERC and in accordance with the collective strategic plan, may initiate interagency fundraising, including flash appeals and strategic/humanitarian response plans.

WHO, as the CLA for health, represents the interests of the Health Cluster/Sector in discussions with the HC and other stakeholders on priorities, resource mobilization and advocacy.

WHO, as the CLA for health, should request the HC to activate CERF rapid response window when indicators show that the health situation is deteriorating and there is a need for emergency intervention. It should also consolidate WHO Health Cluster inputs for applications to the CERF underfunded emergencies window when critical gaps exist and no other resources can be mobilized quickly.

Where critical gaps persist in spite of concerted efforts to address them, WHO, as the CLA for

health, is responsible for working with the national authorities, the HC 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 HWCO is accountable for:

1. ensuring people have access to impartial assistance – in proportion to need and without discrimination;
2. gathering and consolidating data and establishing national registries on **attacks on health care** as well as documenting the consequences of attacks for health care delivery and public health;
3. engaging with donors to raise funds in line with the strategic objectives of the Sector/ Cluster response plan, in concert with relevant WHO regional offices and headquarters;
4. representing and advocating for resources for Health Cluster priorities and perspectives fully, fairly and impartially to the HC/HCT, donors, governments and other external interlocutors;
5. assisting the HCT in designing modalities for the allocation of in-country pooled funds, including the ERF, CHF and CERF submissions;
6. supporting the prioritizing of health in funding through in-country pooled funds, CERF and inclusion in the flash appeal and/or strategic/humanitarian response plan;
7. constantly monitoring budget requirements and funding forecasts for the Health Cluster to manage the risk that funding shortfalls will affect the provision of services.

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4. Conclusion

This guide has reviewed key overarching frameworks, such as the IASC; the establishment of a Health Cluster and mandated roles and responsibilities; the Transformative Agenda; key outcomes of the World Humanitarian Summit and the subsequent Humanitarian Development Nexus; and WHO's 13th General Programme of Work.

It has focused on areas for strategic leadership and key areas of engagements for WHO as CLA for health. Throughout the document, there are clear guidelines for the role of HWCOs, who have designated accountabilities and responsibilities when they represent WHO and donor partners while engaging with local governments and actors.

5. References

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Annex

Health Cluster Coordination: Specific accountabilities and responsibilities for the Heads of WHO Country Offices as Cluster Lead Agency

1. Key areas of engagement

- Accountability to affected populations
- Protection mainstreaming
- The HWCO and the Humanitarian Country Team
- Coordination with national authorities and other local actors
- Ensuring appropriate coordination of all health actors
- Cluster activation
- IASC Protocol 1. Humanitarian system-wide scale-up activation and Protocol 2. “Empowered leadership” in a humanitarian system-wide scale-up activation
- Humanitarian System-wide Scale-up Activation Protocol for the Control of Infectious Disease Events
- Cluster deactivation

2. Cluster core functions

- Information management for strategic decision-making
- Planning and strategy development
- Supporting service delivery
- Monitoring and reporting
- Contingency planning and preparedness
- Advocacy and resource mobilization

1. Key areas of engagement

Heads of WHO Country Offices (HWCOs) have specific accountabilities and responsibilities when WHO acts as Cluster Lead Agency (CLA) representing WHO and donor agencies while working with governments to deliver ethical,

practical and effective responses to health needs in crisis situations. This document aims to guide that process. Throughout the document there are clear guidelines on the accountabilities and responsibilities of HWCOs.

Accountability to affected populations

The HWCO is accountable for:

1. clarifying WHO commitments on accountability to affected populations (AAP) and putting these into practice, including incorporating them in staff inductions and agreements with operational partners;
2. incorporating the Commitments on Accountability to Affected People (CAAP) into all relevant statements, policies, response plans (e.g. humanitarian response plans – HRPs) and operational guidelines and promoting them with operational partners, within the Humanitarian Country Team (HCT) and among cluster members;
3. systematically including AAP in all needs assessments and monitoring, review and evaluation processes (including interagency real-time evaluation);
4. facilitating the provision of feedback from affected people on the services and protection offered by their agencies, including ensuring a complaints mechanism;
5. providing information for affected people about health services and support available in local languages, and ensuring that information on the emergency situation, on availability and on the nature of humanitarian responses is systematically communicated to affected populations using relevant communication mechanisms;
6. designating a senior focal point on protection from sexual exploitation and abuse (PSEA), developing a PSEA workplan and reporting back on progress to the Humanitarian Coordinator.

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KEY AREAS OF ENGAGEMENT

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Protection mainstreaming

The HWCO is accountable for:

1. ensuring that protection is mainstreamed and that health

programmes are designed and implemented so that protection risks and potential violations are taken into consideration.

The HWCO and the Humanitarian Country Team

The HWCO is accountable for:

1. the dual role of representing WHO and the Health Cluster/Sector consistently and effectively within the HCT; this includes regular participation in all HCT meetings and activities; when the HWCO is not available, s/he sends a designate to represent both WHO and the Health Cluster/Sector;
2. ensuring WHO's adherence to humanitarian principles, Principles of

Partnership and policies/strategies adopted by the HCT;

3. participating actively in HCT strategy development, planning and policy development, and subsequent implementation;
4. ensuring that coordination mechanisms are fit for purpose and evolve and adapt to the operational context, including at subnational level.

Coordination with national authorities and other local actors

The HWCO is accountable for:

1. maintaining, in coordination with the Resident or Humanitarian Coordinator (RC/HC), appropriate links and dialogue with other national and local authorities, local civil society and other relevant actors (e.g. military forces, peacekeeping forces and non-State actors) whose activities affect humanitarian space and health-related programmes;

2. facilitating the participation of national health authorities, national and international nongovernmental organizations, civil society and non-State actors in the Health Cluster;
3. promoting capacity-building initiatives, including technical assistance, training, material support and support for national authorities to meet their obligations under international and national law.

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Ensuring appropriate coordination of all health actors

The HWCO is responsible for:

1. ensuring **protection and early recovery** are mainstreamed and integrated; overseeing the implementation of the HRP and endorsing collective HCT positions;
2. as a collective and key component of the HCT, committing to the operational leadership, responsibilities and performance of the country-level cluster response;
3. contributing to the implementation of the Health Cluster strategic objectives, policies and guidance.

The HWCO is accountable for:

1. securing adequate structure and resources (financial and human) to ensure that the Health Cluster can fulfil its core functions, including ensuring that the Health Cluster is represented in intercluster coordination mechanisms at country/field level, contributing to jointly identifying critical issues that require multisectoral responses, and planning the relevant synergistic interventions with the other clusters concerned.

Cluster activation

The HWCO is responsible for:

1. ensuring protection and early recovery are mainstreamed and integrated; overseeing the implementation of the strategic plan and endorsing collective HCT positions;
2. as a collective and key component of the HCT, committing to operational leadership, responsibilities and conduct of the country-level cluster response;
3. contributing to the implementation of the Health Cluster strategic objectives, policies and guidance.

The HWCO is accountable for:

1. agreeing with the Ministry of Health and the HCT on the most appropriate coordination structure, management approach and plan for the Health Cluster at field level; the Health Cluster plan should involve a management structure with clearly established functions, reporting lines and resourcing/expenditure mechanisms;
2. supporting initial staffing, assessment and identification of the scope of work for a new cluster architecture; key staff – in particular a WHO Health Cluster Coordinator (HCC)

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KEY AREAS OF ENGAGEMENT

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and an information management officer – should be deployed to provide minimum coordination capacity, drawing wherever possible from trained and experienced personnel and standby partnerships; when decentralized coordination is recommended, key subnational coordination and information management staff should be recruited; additional cluster support staff may be requested, depending on the scope and context of the event,

e.g. a Health Cluster support officer, communication officer and/or a public health officer;

3. acting as the Fund Manager for Health Cluster budgets and taking responsibility for financial and administration oversight pertaining to cluster functions and activities, unless such responsibilities have been formally reassigned under WHO emergency response protocols.

IASC Protocol 1. Humanitarian system-wide scale-up activation and Protocol 2. “Empowered leadership” in a humanitarian system-wide scale-up activation

The HWCO is accountable for:

1. ensuring strong leadership and engagement with the government and the HCT representing both WHO and health partners, since the scale-up will rely on inputs from all health stakeholders;
2. securing adequate resources (financial and human) to ensure that the WHO Health Cluster can fulfil its core functions in a timely

manner (see Section 2); in the case of a newly activated cluster and if additional staff are required, the HWCO must include these positions in the surge support request;

3. maintaining ongoing and constant communication with the HC while engaging actively with the HCT and the national government and donors; the HWCO also maintains oversight and management of assets and resources.

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- Cluster deactivation

Humanitarian System-wide Scale-up Activation Protocol for the Control of Infectious Disease Events

The HWCO is accountable for:

1. supporting the WHO Director-General in assessing the risks associated with infectious disease events in-country;
2. consulting with ministries of health, relevant governmental institutions, the United Nations Children's Fund (UNICEF) and partner agencies from the Global Outbreak Alert and Response Network (GOARN), including the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE);
3. providing technical inputs for the deliberations of the Inter-Agency Standing Committee (IASC) Emergency Directors Group.

Cluster deactivation

The HWCO is accountable for:

1. participating in the annual coordination architecture review and implementing its recommendations; this may include preparing transition or deactivation plans in collaboration with cluster partners and national counterparts; in the event that the HCT does not undertake an annual review, the HWCO should regularly review the appropriateness of the health coordination mechanism;
2. for sudden-onset events, developing an outline of a transition or deactivation strategy at 90 days after activation;
3. establishing strong links between humanitarian and development coordination bodies, consistent with the principles and spirit of the Humanitarian Development Nexus; where possible, this should include alignment of recovery approaches with national transition/development plans and objectives.

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- Cluster deactivation

2. Cluster core functions

Information management for strategic decision-making

The HWCO is accountable for:

1. ensuring Health Cluster/Sector risk and needs assessments are coordinated and contribute to multicluster/multisector initial rapid assessment and interagency assessments;
2. ensuring that reliable flows of information between the HCT and the Health Cluster are evidence-based for strategic decision-making and planning purposes;
3. participating in the development of appropriate in-country humanitarian and Health Cluster/Sector information management systems, including the establishment/reactivation of Early Warning, Alert and Response System reporting and ensuring regular reporting on surveillance;
4. ensuring that key information products, such as Health Cluster/Sector situation reports, epidemiological bulletins, dashboards, etc. are produced and disseminated regularly;
5. ensuring that vital information about the humanitarian response is provided to affected communities;
6. ensuring the provision of the latest updated information on health status and public health risks for the affected population.

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CLUSTER CORE FUNCTIONS

CONTENTS

- Information management for strategic decision-making
- Planning and strategy development
- Supporting service delivery
- Monitoring and reporting

- Contingency planning and preparedness
- Advocacy and resource mobilization

Planning and strategy development

The HWCO is accountable for:

1. as a member of the HCT, establishing strategic objectives for the collective humanitarian response and regularly reviewing objectives, priority activities and plans;
2. representing the interests of the Health Cluster and partners in discussions with the Humanitarian Coordinator (HC) and other stakeholders;
3. in consultation with the Health Cluster Coordinator, providing leadership and strategic direction for the WHO Health Cluster in agreeing priorities and strategies and planning coordinated action to address critical gaps;
4. ensuring that WHO and the Cluster Partnership deliver on their commitments to achieve the results prioritized in the Strategic Plan;
5. ensuring that humanitarian responses build on local capacities and that the needs, contributions and capacities of vulnerable groups are addressed;
6. promoting adherence to standards and best practices by all WHO Health Cluster partners, taking into account the need for local adaptation;
7. promoting use of the Global Health Cluster Guide, the Sphere humanitarian standards, the Global Health Cluster policy and tools and other relevant technical guidance to ensure the application of common approaches, tools and standards.

Supporting service delivery

The HWCO is accountable for:

1. coordinating and collaborating with the Ministry of Health and partners, including through the Health Cluster, GOARN, emergency medical teams (EMTs) and standby partners, to ensure the delivery of essential high-quality health services; this involves clarifying standards and defining an essential package of health services that covers community, primary and referral levels;
2. developing mechanisms to eliminate duplication of service delivery;
3. collaborating with ministries of health and partners such as UNICEF to frame the event and risk through risk communication and community engagement, and provide authoritative information using all relevant communication platforms;
4. ensuring that essential high-quality services required to fulfil critical gaps identified by the Health Cluster are provided.

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CLUSTER CORE FUNCTIONS

CONTENTS

- Information management for strategic decision-making
- Planning and strategy development
- Supporting service delivery
- Monitoring and reporting

- Contingency planning and preparedness
- Advocacy and resource mobilization

Monitoring and reporting

The HWCO is accountable for:

1. monitoring the performance of mandated areas and raising any implementation issues with the HC/HCT, involving the relevant WHO regional office and headquarters as appropriate;
2. participating in any interagency operational reviews and formal evaluations;
3. leading periodic reviews of the Health Cluster functions, performance, structure and funding, and adapting resources and structures as appropriate.

Contingency planning and preparedness

The HWCO is accountable for:

1. ensuring a thorough risk analysis that draws on a wide range of expertise from cluster partners, national institutions and organizations and independent experts;
2. operationalizing and monitoring the quality and comprehensiveness of the emergency response preparedness plan;
3. establishing effective WHO engagement in all aspects of the emergency response preparedness approach and ensuring that WHO and Health Cluster engagement is consistent with the HCT level;
4. maintaining coherent involvement in national capacity development (of government, national nongovernmental organizations and communities) for preparedness and, after consultation with the RC and the United Nations Development Programme, taking a leadership role as required;
5. ensuring that WHO country office(s) have clear repurposing plans in place.

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CLUSTER CORE FUNCTIONS

CONTENTS

- Information management for strategic decision-making
- Planning and strategy development
- Supporting service delivery
- Monitoring and reporting

- Contingency planning and preparedness
- Advocacy and resource mobilization

Advocacy and resource mobilization

The HWCO is accountable for:

1. ensuring people have access to impartial assistance – in proportion to need and without discrimination;
2. gathering and consolidating data and establishing national registries on **attacks on health care** as well as documenting the consequences of attacks for health care delivery and public health;
3. engaging with donors to raise funds in line with the strategic objectives of the Sector/Cluster response plan, in concert with relevant WHO regional offices and headquarters;
4. representing and advocating for resources for Health Cluster priorities and perspectives fully, fairly and impartially to the HC/HCT, donors, governments and other external interlocutors;
5. assisting the HCT in designing modalities for the allocation of in-country pooled funds, including the Emergency Response Fund (ERF), Common Humanitarian Fund (CHF) and Central Emergency Response Fund (CERF) submissions;
6. supporting the prioritizing of health in funding through in-country pooled funds, CERF and inclusion in the flash appeal and/or strategic/humanitarian response plan;
7. constantly monitoring budget requirements and funding forecasts for the Health Cluster to manage the risk that funding shortfalls will affect the provision of services.

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CLUSTER CORE FUNCTIONS

CONTENTS

- Information management for strategic decision-making
- Planning and strategy development
- Supporting service delivery
- Monitoring and reporting

- Contingency planning and preparedness
- Advocacy and resource mobilization

