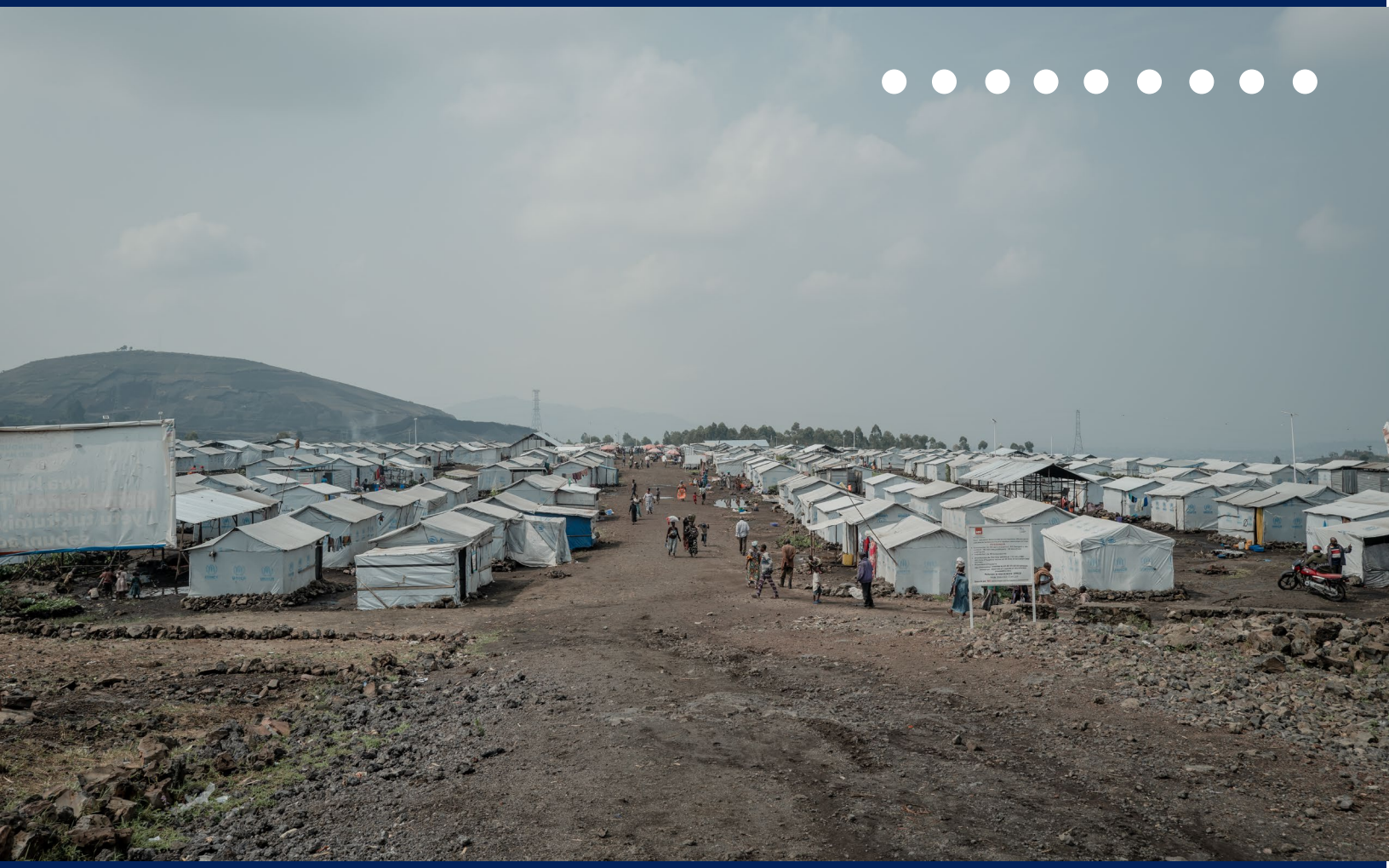
Formative evaluation of the Global Health Cluster

Web annexes



HEALTH CLUSTER

World Health Organization

WHO/DGO/EVL/2025.86

Cover photo: General view of Bushagara internally displaced persons (IDP) camp, north of Goma in the Democratic Republic of the Congo. August 2024

Credit: WHO / Guerchom Ndebo

Contents

Terms of Reference

TITLE	*Formative Evaluation of the Global Health Cluster (Revised July2024)*
RECRUITING OFFICER	*Chief Evaluation Officer, WHO Evaluation Office and Global Health Cluster Coordinator*
CONTRACT MODALITY	*LTA*
LOCATION OF ASSIGNMENT	*Home based; travel to various regional offices and countries offices and WHO Geneva*
LANGUAGE(S) REQUIRED	*English*
DURATION OF CONTRACT	*September 2024 – April 2025*

Background

The Cluster approach was introduced in 2005 within the wider context of humanitarian reform by the Inter-Agency Standing Committee (IASC). Its weaknesses identified in the interagency real time evaluation of the 2010 Haiti earthquake and 2010 Pakistan floods response were a key factor in stimulating the Transformative Agenda reforms that followed. It was in recognition that a lack of adequate coordination had previously hampered the relevance, timeliness, effectiveness and efficiency of humanitarian response. Defined as the designated responsibility for multi-actor sectoral coordination, the approach was introduced to strengthen predictability, response capacity, coordination and accountability, by strengthening partnerships in key sectors of humanitarian response, and by formalizing the lead role of agencies/organizations in each of these sectors. The Cluster approach includes nine areas of sectoral coordination and two common service Clusters that enable the other sectors.

The IASC Reference Module for Cluster Coordination stipulates **six core functions** of a country-level cluster, alongside the strengthening of partnerships and the predictability and accountability of international humanitarian action *(1)*:

1. **Support service delivery** by providing a platform that ensures service delivery is driven by the Humanitarian Response Plan and strategic priorities; and developing mechanisms to eliminate duplication of service delivery.
2. **Inform the HC/HCT's strategic decision-making** by preparing needs assessments and analysis of gaps (across and within clusters, using information management tools as needed) to inform the setting of priorities: identifying and finding solutions for (emerging) gaps, obstacles, duplication and cross-cutting issues; and formulating priorities based on analysis.
3. **Plan and implement cluster strategies** by developing sectoral plans, objectives and indicators that directly support realization of the overall response's strategic objectives; applying and adhering to common standards and guidelines; clarifying funding requirements, helping to set priorities, and agreeing on cluster contributions to the HC's overall humanitarian funding proposals.
4. **Monitor and evaluate performance** by monitoring and reporting on activities and needs; measuring progress against the cluster strategy and agreed results; and recommending corrective action where necessary.
5. **Contingency planning/preparedness/national capacity building** where needed and where capacity exists within the cluster.
6. **Support robust advocacy** by identifying concerns and contributing key information and messages to HC and HCT messaging and action; and undertaking advocacy on behalf of the cluster, cluster members, and affected people.

WHO's Leadership and Coordination Responsibilities at Country level

WHO has been IASC designated Cluster Lead Agency (CLA) for Health since 2005. In 2012 WHA Resolution 65/20 cited the need to invest in WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies. The was reiterated in 2015 during the reform of WHO's work in outbreaks and emergencies with health and humanitarian consequences, and subsequent WHA Resolution 68/27. Its' cluster coordination accountabilities are enshrined in the Organization's Emergency Relief Framework *(2)*, and the Protect Pillar of WHO's Global Programme of Work *(3)*. WHO's wider role in emergency coordination is further articulated in the HEPR framework *(4)* for strengthening the global architecture for health emergency prevention, preparedness, response and resilience. WHO implements its CLA mandate through the Global Health Cluster (GHC) unit hosted within the Humanitarian Department of the WHO Emergencies Program. The GHC program of work and its support to country health clusters is guided by the GHC Strategy 2020-2025 *(5)* and annual workplans.

At country office level, WHO Heads of Country Offices (HWCO) are responsible and accountable for the activities of the Health Cluster when WHO is designated as CLA in a specific country, as articulated in HWCO Guidance *(6)*. Terms of reference of health cluster coordinators and other county cluster coordination teams functions have been defined and align with the IASC core cluster functions *(7)* and related policies including AAP, Localization, Humanitarian Development Peace Nexus and Centrality of Protection. Some WHO regions have designated Operational Partnership positions to enable their country health clusters and other emergency networks.

Relevant findings from recent reviews

The IASC Cluster Approach continues to be the predominant humanitarian coordination mechanism which continually strives to adapt and foster more context appropriate coordination, based lessons learned from multiple reviews and evaluations of past humanitarian crises. Additionally, the current intense pressures faced by the global humanitarian and health sectors are also accelerating implementation of several initiatives and reviews (WHO-HEPR; IHR/INB negotiations; OCHA-ERC Flagship Initiative) which will drive changes in coordination architecture at country, regional and global level. Of particular note are the UNICEF CLARE II evaluation (2023), Global Protection Cluster review on Centrality of Protection in Humanitarian Action (2019), external review of the global GBV Area of Responsibility (2023) and the IASC independent review of the humanitarian response to internal displacement (2024 *(8)*)

In addition, GHC commissioned reviews and evaluations include the Evaluation of the Health Cluster and WHO Coordination Architecture in Northeast Nigeria and Mozambique (2020), Evaluation of the Global Health Cluster and WHO sexual reproductive health project in Bangladesh (Cox's Bazaar), Yemen, and Democratic Republic of Congo (Kasai) (2021), Health Cluster Capacity Development Strategy Mid-Term Review (April 2022), and a series of four COVID19 related studies to examine coordination, multisectoral collaboration, vaccination in humanitarian settings and its impact on humanitarian health response (2023-2024).

Each one offers a range of recommendations to Cluster Lead Agencies to improve their ways working. The Global Health Cluster (GHC) must similarly adapt to remain relevant and agile in its support to country health clusters to provide quality health assistance and be accountable to the crisis-affected people it serves. The evaluation team will be expected to review these findings and recommendations as part of the desk review.

Rationale for the Evaluation

Health emergencies threaten lives, disrupt societies, and devastate economies. Their frequency and intensity are increasing. COVID-19 exposed critical gaps in preparedness at every level, leading to staggering losses: millions of deaths, trillions in economic damage, and setbacks in education and poverty reduction. Beyond pandemics, high-threat epidemics, humanitarian crises, and climate-related disasters claim tens of thousands of lives and inflict billions of dollars in economic harm annually. WHO's goal is to better protect 7 billion people from health emergencies by 2028, with specific targets across prevention, preparedness, detection, response, and system strengthening. The work of the Health Emergencies Programme is captured under the "Protect" Pillar of GPW14

and broken into two main strategic objectives: (1) Prevent, mitigate and prepare for emerging risks to health from all hazards, (2) Rapidly detect and sustain an effective response to all health emergencies.

Global humanitarian & health needs are high **and have increased** in scale and complexity and the correlation between the risks and drivers of health emergencies, including pandemics, with those of humanitarian emergencies has never been more evident. The global increase in the number of active conflicts, internal population displacement, refugee crises, food and water scarcity, climate change, and rising communicable disease outbreaks, complicated by severely strained humanitarian resource capacity, is driving millions of people into devastating situations in many countries. Their situation is further compounded by the increasingly blatant disregard of international humanitarian law and systematic attacks on health care and other critical social infrastructure such as water, sanitation, and energy.

At the launch of the Global Humanitarian Overview in December 2023, over 299 million people were expected to need humanitarian assistance in 2024. By May 2024, this number has risen to 308 million people living in 32 countries directly affected by humanitarian emergencies, with spillovers to 39 additional countries.

WHO, in its capacity as Health Cluster Lead Agency, is currently supporting 30 Health Clusters (28 country; 2 regional) providing humanitarian health assistance for 89.1 million people targeted by 2024 Humanitarian Response Plans, through the operational support of 900 local and international partners. Whilst the target population for health cluster assistance is less than in 2023 (103M) this does not reflect reduced humanitarian health need; on the contrary, it reflects the fiscal crisis forcing the prioritization of core humanitarian assistance to people with the most severe needs and often hardest to reach. As a result, crisis-affected people previously supported by the health cluster are being left behind. Reinforcing community and health service/system resilience is therefore essential to meet current demand and mitigate future shocks.

The target population currently supported by health cluster has increased by 37% since 2020; current funding requirements have increased by USD 1.2billion over the same timeframe. Despite increased needs, many health clusters are severely underfunded through the humanitarian response plans.

In this operating context, WHO in its capacity as Cluster Lead Agency for Health has been enabling cluster partners to deliver results and achieve better health outcome for crises affected people. In 2023 the Health Cluster reached 68 million out of the 107 million target population - including 87,109,073 PHC/OPD consultations; 2,017,683 trauma consultations; 7,553,544 maternal health consultations, 2,666,686 MPHSS related consultations; 22,525,220 vaccinations and 451,225 disability related consultations.

As noted above, various thematic reviews and project evaluations have indicated that positive progress have been made in GHC roles and responsibilities, yet challenges remain, and gaps and bottlenecks have been specifically highlighted in certain clusters and countries. IASC guidance, requests cluster leads to regularly draw lessons from past activities and revise strategies accordingly, however unlike other Cluster Lead Agencies (UNICEF, WFP, UNHCR; UNFPA), WHO has never evaluated the GHC to consider whether it has/can effectively deliver its mandate. The Global Health Cluster Strategic Advisory Group (SAG) has therefore requested WHO, as cluster lead to conduct such evaluation so that its recommendations can inform the development and implementation of the new GHC strategy (2026-2030). Given the recent completion of IASC reviews and evaluations directly relevant to clusters, coupled with the transition of OCHAs Emergency Relief Coordinator and their vision for humanitarian coordination, conducting an external evaluation now will generate valuable insights into GHC performance and lessons learned to inform its future direction and provide recommendations to WHO as CLA to enable the GHC deliver its mandate.

Purpose and Objectives

Overall, the evaluation purpose is to determine whether the Global Health Cluster is fit for purpose, make recommendations for improvements, and inform strategic direction. As such, this evaluation will have a **dual purpose**, focusing on **learning** while also supporting **accountability** of WHO's cluster leadership responsibilities towards its partners including donors and communities affected by humanitarian crises. The evaluation will ***formatively* draw lessons** for WHO to be better equipped to exercise systematic, high-quality GHC leadership in both its technical and coordination aspects. The forward-looking aspect, which will more broadly contribute to strengthening the ways in which agencies define and strive for more effective coordination, is particularly relevant in the context of **escalating humanitarian needs**, the opportunities and added requirements of the various ongoing or **recent reform processes** and the legacy of the COVID-19 pandemic. These events represent an opportunity for this evaluation to reflect further on the ways in which the GHC can operationalize AAP, implement the localization agenda and apply the humanitarian development peace nexus in an emergency response, among others.

Alongside the prospective component, the evaluation will also ***summatively* assess** the progress achieved, or not achieved, by GHC, including whether or not it is fit for purpose and adapted to the reforms and changing circumstances and improved the ways it executes its role and meets cluster core functions and effectively deliver its mandate in the evolving global humanitarian and health landscape. Furthermore, it will also assess to what extent has the GHC performed against its strategic priorities.

Toward this end, the ***evaluation's objective*** will be to assess, as systematically and objectively as possible, the relevance, effectiveness, efficiency, connectedness, coordination and coverage of GHC role to date, at both the global and country levels.

The evaluation should foster peer learning among cluster members and generate **actionable recommendations** for WHO informing its new multi-year GHC strategy 2026-2030 and will contribute to the agency's engagement in the wider humanitarian reform processes.

Evaluation Scope

The **temporal scope** of the evaluation will span from Sept 2014 when a dedicated GHC Coordinator was appointed, to date, yet it should primarily concentrate on the last five years. The evaluation will **focus on how WHO's CLA mandate is implemented through the GHC and will have** both a **global and country-level focus**. While the questions that will drive the evaluation will be fine-tuned during the inception stage, the broad areas of inquiry which will determine the exercise's scope are outlined in the section below.

The evaluation will *not* seek to assess *impact*, understood as long-term changes in the conditions of the affected population as a direct consequence of WHO's CLA role but, rather, will strive to examine WHO's *effectiveness in facilitating sectoral coordination.*

At the **global level**, assessing effectiveness will cover the Global Health Cluster performance in consolidating policies, setting standards and guidelines, building response capacity by training coordination teams, partners and national counterparts, establishing and maintaining surge capacity and standby rosters, and when necessary, stockpiling, and providing operational support, including needs assessment/information management, emergency preparedness, advocacy and resource mobilization. At the **country level**, this will include the country-level Cluster performance in enhancing the relevance and appropriateness, timeliness, effectiveness and efficiency of the health sector. At both levels, this will also entail an examination of WHO's performance as a partner in fulfilling its CLA role.

At the country level, the team will propose a mix of countries to be visited reflecting acute and protracted crises including where IASC system wide scale up occurred *(9)*. While the majority of health clusters have been activated in the WHO AFRO and EMRO regions, other activated clusters in EURO, SEARO and PAHO could also be considered to capture lesson from contextual adaptation.

Furthermore, the evaluation will examine alignment/complementarity with other initiatives such as the WHO hosted partnerships including the Emergency Medical Team (EMTs) , the Global Outbreak Alert and Response Network (GOARN) and the Global Health Emergency Corps (GHEC).

Evaluation Users

The main client for this evaluation will be the WHO Executive Director for Emergencies. Other key intended users of this evaluation include the following:

- Director of WHE Humanitarian Department and teams
- GHC Team
- GHC Strategic Advisory Group (SAG); GHC Partners and donors
- WHO Representatives in Country Offices (COs), Health Cluster Coordinators, and other relevant colleagues in COs where Health Cluster has been activated
- WHO Regional Emergency Directors; Program Area Managers and Operational Partnership Team Leads
- Other relevant WHE departments/teams including ARC/GOARN, SHO/OSL, Preparedness/EMTs, Human Resources; Resource Mobilization; Strategic Planning and Partnerships/GHEC
- WHO Executive Board and IOAC
- OCHA and Global Cluster Coordinators Group

As part of the inception phase of this evaluation, a more detailed **stakeholder analysis** will be conducted to help identify key stakeholders' stakes. Stakeholders will be involved in the evaluation from the initial stages of the evaluation process. Also, the evaluation will be made available publicly, and donors, member states, academic institutions and the public will have access to the final publication.

Guiding Evaluation Questions

The following evaluation questions are indicative. During the inception phase, the selected Evaluation Team will discuss with WHO Evaluation Office, WHE Humanitarian Department and Reference Group members, use their insights from the desk review of WHO documents and propose a "definitive set" of questions. Prioritization of questions, additional sub-questions, and any new areas of enquiry will also be developed and discussed during the inception phase.

This will be further supported by the development of a **theory of change** and the definition of **specific indicators** which the evaluation will use as a reference to draw its findings on (to be formalized in the evaluation matrix).

Criteria	Suggested Questions/sub questions
Relevance/Appropriateness	• To what extent is the management of WHO's CLA responsibilities aligned with the principles and standards prescribed by the Cluster approach? • To what extent did the Health Cluster meet the needs of affected people, including the most vulnerable and hard to reach groups? • To what extent do the affected communities and local actors participate in the cluster and have decision-making power in the planning and delivery of humanitarian assistance?
Effectiveness	• To what extent and how has the Health Cluster contributed to improved emergency response through greater predictability, accountability, and strengthened partnership at the country and global levels? • To what extent has WHO effectively delivered on the six core functions of the Health Cluster? • What factors are contributing to/or hindering humanitarian actors to deliver more effective and efficient assistance through the health cluster? • How can the health cluster be strengthened at the global and country level? What further inputs are required? • In what ways has WHO fulfilled its "provider of last resort" role when identified gaps have not been addressed?
Efficiency	• How well has WHO mobilized resources at its disposal to fulfil its CLA responsibilities at country and global levels?
Coherence/Coordination/Connectedness	**Coherence** How and to what extent did the Health Cluster contribute to strengthen inter-cluster and multi-sector collaboration to achieve better health outcomes? **Coordination** To what extent did Health Cluster action strengthen coordination for local, national, regional and global action to prevent, prepare for, respond and recover from public health and humanitarian emergencies? • Did it avoiding duplication and maximize coverage? • How effective and inclusive were coordination mechanisms given political, operational and other constraints (i.e., with other national/international coordination mechanisms)?

	• To what extent has adequate and timely leadership for the response been put in place? **Connectedness** How equipped is WHO to ensure that its CLA responsibilities will result in long-term, enduring sectoral coordination for enhanced response capacity (including decision-making and capacity strengthening of national/local stakeholders)? And how well was the response linked to the efforts of development and peace actors? • To what extent is WHO using its position as a cluster lead agency to strengthen the link between humanitarian and development planning and programming?
Coverage	• Has the Health Cluster proven to be a sufficiently flexible to respond to the needs of most vulnerable populations in acute, protracted and slow onset crises? • What were the main reasons that the Health Cluster interventions provided or failed to provide major population groups with assistance and protection, proportionate to their needs? • When did it manage to improve the response (geographically and programmatically to humanitarian needs?

Evaluation Design, approaches and Methods

Design and approaches

The methodology described in this section is indicative, and the independent external Evaluation Team hired to conduct this evaluation is expected to adapt the approach and propose adjustments needed to undertake the assignment. These can include additions to the evaluation design; approaches to be adopted; appropriate sampling strategy; data collection and analysis methods; and an evaluation framework. The proposals should also refer to methodological limitations and mitigation measures. The design of the evaluation will be non-experimental and combine a theory based with a utilization focused approach in assessing the GHC.

With a strong focus on utilization, the approach of the evaluation will concentrate on engaging with the principal users of the evaluation process and report, focusing on utilization and use of the findings and recommendations

by all key stakeholders. Primary users are WHE leadership, the GHC team and GHC SAG at the global level while secondary users will be at country level, and focal points at regional level and, as far as possible, key stakeholders including implementing partners and civil society. The evaluation process and recommendations are intended to trigger ownership both at headquarters, regional and country level. The evaluators should suggest how they will engage with each user group and specify the purpose. It is strongly recommended they use iterative feedback loops throughout the evaluation. Mixed data collection methods will be used as far as possible. Discussions with stakeholders will provide qualitative evidence. To answer the overarching and specific evaluation questions the evaluation team will draw from the available data from the GHC reviews, progress reports and databases; relevant IASC reports, OCHA information portals (Humanitarian Action, Reliefweb, Financial Tracking Services) and cluster products at country and regional level.

The methodology is expected to be innovative, gender responsive and enable rigorous and systematic data collection and rigorous analysis, identified emerging good practices which could be replicated in other countries. The evaluators will assess the options and describe in detail the suitable methods to meet the purpose, scope, and objectives of this evaluation. The methodology will be further refined in the inception phase. Overall, the evaluation requires an analysis at the national, regional and global levels.

Considering the strategic focus of this multi-stakeholder partnership it is expected that evidence will be collected primarily through an extensive/comprehensive desk review, including Cluster policies and strategies, complemented by key informant interviews, focus group discussions and online surveys of key internal and external stakeholders. Other data or information, which is deemed to be necessary to answer evaluation questions, can also be gathered from a review of secondary sources, such as program documents, annual progress reports, or monitoring records available with GHC and implementing partners.

Methods:

The evaluation will employ a **mixed-methods** approach including qualitative and quantitative data collection. Data will be triangulated to the extent possible to ensure soundness of findings. Given the **number of volatile contexts** and related travel challenges, primary data collection options will be carefully assessed and **alternative, creative approaches to data collection** sought where necessary. Virtual data collection including online surveys and remote interviews seem pursuable and will be explored and fine-tuned during the inception phase.

A minimum of **three country cluster case studies** will be considered and discussed with WHE, and the evaluation Reference Group. Countries could be selected as representative cases of their specific CLA profile on a **range of criteria**, which are likely to include, among others: emergency profile (type and level), stages of CLA implementation (e.g., early activation, implementation, phasing out), number of Cluster members at both the national and sub-national level, funding available, etc.). Selection will also seek to capture maximum regional

diversity, while avoiding duplication (and "evaluation fatigue") in COs that have participated in other recent WHO/GHC/IASC evaluations.

The inception report will provide a complete list of data sources to use to answer each evaluation question; an initial list is included below:

Key Informant Interviews (KIIs) and **Focus Group Discussions (FGDs)** with key stakeholders. Key stakeholders will include but will not be limited to: WHO staff at HQ (Geneva), Regional Office (RO) and Country Office (CO) levels, Cluster members at HQ and CO level, Cluster Co-coordinators, HC/RC at CO level, national and sub-national authorities, donors, and directly affected populations (to the extent possible).

Structured document review of key documents — such as strategic policy documents related to the CLA, plans, project proposals, reports, meeting materials, lessons learned, and previous WHO/GHC-led and interagency evaluative exercises, at both global and country level – in pursuit of specific data points or facts.

Survey - Conducting an online survey across all currently activated health cluster settings will be considered to capture key information primary stakeholders including Health Cluster Coordination teams; their Strategic Advisory and Technical Working Groups on cluster governance, partnership and support from the GHC and CLA. A similar survey may be considered to capture insights from all GHC partners.

Comparative/Benchmarking analysis, exploring what other **Clusters** have done differently in the past few years to enhance their CLA responsibilities and what **other organizations** have done in undertaking coordination effectively in complex settings that might inform how the GHC exercises its role. This comparative/benchmarking analysis will be framed in such a way as to account for a variety of future scenarios as they related to WHO/GHC's latitude for change.

Triangulation

Considering evaluation findings, conclusions and recommendations are to be used for organizational learning, informed decision-making, and accountability; findings should be based on triangulated evidence, and conclusions and recommendations should derive from the findings. Multiple sources should be used to ensure that the findings can be generalized to the response and were not the results of bias or the views of a single agency or type of actor. Three types of triangulation methods are envisaged: 1) cross reference of different data sources (interviews and documentation) from country, regional and global levels, 2) triangulation through the different stakeholder consultation, and 3) review by GHC staff and consultation with implementing partners key respondents during the report drafting process and at the validation meeting. Triangulation should allow the team to determine how much weight to put on diverse sources of information The triangulation efforts will be

tested for consistency of results, noting the inconsistencies do not necessarily weaken the credibility of results, but may reflect the sensitivity of different types of data collection methods. This is to ensure validity, establish common threads and trends, and identify divergent views.

Norms and Standards

The guidance documents mentioned below are those that the Evaluation Team is expected to comply with:

- United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System 2016[1]; (including impartiality, independence, quality, transparency, consultative process)
- Ethical Guidelines for UN Evaluations will guide the overall process[2]
- WHO Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis.
- The evaluation should incorporate the human rights-based approaches and gender perspectives.

Evaluation Management

The WHO Evaluation Office will manage the evaluation **together and the WHE** Humanitarian Department. The Evaluation Office and WHE will be advised by a **Reference Group** comprising relevant WHO staff from across the organization; representatives of the GHC SAG and wider membership; and at least two Health Cluster Coordinators. Please see the TOR for the Reference Group for specific roles and responsibilities of the group.

Evaluation management

The external evaluation team will operate under the guidance and supervision of an evaluation management team comprised of the Chief Evaluation Officer and designated member of the Global Health Cluster team. The evaluation management team will be responsible for the contractual aspects, day-to-day oversight, and management of the evaluation, as well as evaluation budget. They will facilitate communications with the WHO country offices, health clusters, and other relevant stakeholders. They will also be responsible for the quality of the evaluation and provide the first round of comments to the evaluation team before submission of the revised

[1] UNEG Norms and Standards for Evaluation, 2016. Available at: http://www.unevaluation.org/document/detail/1914

[2] UNEG Ethical Guidelines, 2008. Available at: http://www.unevaluation.org/document/detail/102

draft to WHO's response staff. They will check whether the findings and conclusions from the evaluation are relevant, and recommendations are implementable, and propose improvements to the recommendations. They will approve all deliverables and payments. In addition, the team will contribute for dissemination of the evaluation findings and to follow-up on the evaluation recommendations with a management response.

Support/facilitation will be provided by WHO EVL and GHC to the evaluation team at the global level, and for country-level work, by the respective country office, Health Cluster Coordinators and focal points.

The role of WHO country offices, Cluster Coordinators, and M&E focal points will be the following:

- Provide the evaluation team with all information, resource documents and contacts necessary for the evaluation,
- Facilitate the communication and coordination between the evaluation team and WHO's implementing partners in-country
- Organize/facilitate logistics, security, virtual meetings and workshops, any related costs will be part of the regional evaluation and not from country office budgets
- Provide comments on the key deliverables to minimize factual errors, misinterpretations, and omissions.

The **Evaluation Reference Group** will be composed of a designated member from the GHC team relevant WHO staff from across the organization; representatives of the GHC SAG and wider membership; and at least two Health Cluster Coordinators. Comments by the Reference group will be submitted according to a deadline respecting the agreed chronogram. The evaluation technical proposal should include a minimum of 2 weeks for any comments of validation by the Reference group. The evaluation team must address all comments made by the Reference group and integrate or make reference to them in a reviewed version of the inception and final report.

The Reference group will have the following roles:

- Generally, advise the evaluation team on various aspects of the evaluation and help this team make decisions.
- Contribute to the preparation and design of the evaluation.
- Provide feedback and comments on the second draft of the inception report and on the technical quality of the work of the consultants.
- Assist in identifying internal and external stakeholders to be consulted during the evaluation process.
- Participate in review meetings organized by the evaluation team.
- Provide comments and substantive feedback from a technical point of view to ensure the quality of the second draft and final evaluation reports.
- Propose improvements/inputs to the preliminary recommendations.
- Play a key role in learning and knowledge sharing from the evaluation results.
- Contribute to disseminate the findings of the evaluation.
- Advise on the management response to the evaluation, and follow-up when appropriate.

Each report delivered will be reviewed by WHO and the reference group (10 working days should be allocated for this for each deliverable). The evaluation team should integrate and respond to comments received and submit a revised version of each report. All comments must be addressed in the matrix but how or if they are incorporated into the report will remain a decision of the evaluation group to respect their independence. Payment will only be made according to the deliverables table above and no longer than 15 days after said deliverable are approved.

Team Composition and Required Qualifications

Profile of the Evaluation Team: Role and Qualifications/Experience

For this evaluation WHO will contract an institution (consulting firm, research institute or a vendor with similar capacities), which will offer a core team of qualified evaluation professionals. Based on their understanding of the task, the team may choose to enlist additional expertise as they see fit, including subcontracting with national evaluation partners for field-based activities; however, in the interest of time it is envisioned that the team will include one team leader and 2 or 3 team members to allow for field missions to take place in parallel. The Evaluation team should be composed of a gender-balanced team of researchers and technical experts with strong expertise in qualitative methods of data collection, comprising the following qualifications:

TEAM LEADER PROFILE

The team leader should have proven experience in past evaluations. References are required. S/he will be responsible for managing and leading the evaluation team, undertaking the data collection and analysis, as well as report drafting, presentation to stakeholders and dissemination.:

Required skills Team Lead:

- Post-graduate University degree in Evaluation, Social sciences or another relevant field
- Proven experience minimum ten years in conducting evaluations and research
- Excellent and proven knowledge of evaluation designs and approaches in humanitarian settings
- Proven experience leading a multi-country evaluation team
- Extensive experience and knowledge of IASC and cluster coordination work
- Knowledge of latest methods and approaches in evaluation, especially participatory methods and accountability to affected populations
- Experience facilitating and collecting information, with affected populations
- Knowledge of the equity and gender approaches and their application
- Fluency in spoken and written English; French (see team requirements)
- Good ability to draft reports clearly and concisely.
- Excellent interpersonal skills with ability to work in a multi-cultural environment

- Desirable:
- Previous experience with multi-country evaluations and humanitarian evaluations within the UN system is an asset
- Previous experience working with the UN and familiarity with WHO's emergency responses and/or WHO programmes is an asset

Previous common experience between proposed team members is a plus

Required skills for the team:

- All team members should have a degree in the social sciences, economics, international development or other relevant disciplines with at least a bachelor's degree and 5-7 years relevant experience
- The evaluation team must count with the support of at least one local evaluator for each of the countries where missions will take place.
- The Team will need to include expertise in the following areas:
- Experience with coordination in humanitarian settings
- Proven experience minimum five years in conducting evaluations and research
- Proven experience in facilitating and collecting information with vulnerable groups,
- Knowledge of human-rights and gender-based approach to development. It is expected that at least one of the team members has a strong track record of evaluating gender equality.
- Experience assessing humanitarian response
- Strong analytical skills to compile and consolidate a variety of inputs and produce concise and easy-to-understand documents
- Good understanding of UNEG norms and standards for Evaluation and other international evaluation standards.
- Experience working in the at least the WHO Africa and Eastern Mediterranean regions
- Desirable:
- Experience undertaking multi-country evaluations
- Familiarity with the cluster system and/or GHC is an asset
- Previous experience with multi-country evaluations and evaluations within the UN system is an asset

The technical proposal should highlight which member(s) of the Evaluation team possesses each required or desired competencies above. Sample of previous evaluations in English is required for the team lead. All team members should provide references.

The evaluation team is responsible for its own travel arrangements, own travel insurance, including medical evacuation, and for its own security arrangements. Under a corporate contract for services, the company does not fall under UN security management arrangements. All costs should be included in the financial proposal. It is recommended that a description of the role and responsibilities of each team member and an explanation of his or her competencies (i.e., matching the required skills) be provided.

Phases, Timeframe and Deliverables:

The evaluation is expected to have three defined phases with specific deliverables attached to each phase which the independent evaluation team contracted is expected to complete:

Phase1. Inception report, to clarify objectives and ensure good mutual understanding of the evaluation and its objectives, and adaptation of evaluation questions if needed. To finalize the inception report, a validation and consultative process is expected before the end of phase 1 involving country offices and the HQ offices as well as the reference group.

Phase 2. Data collection and analysis, includes two clear separate stages: (a) the in-depth desk review including program countries monitoring reports, to include country level information, and key informant interviews, online surveys, and GHC draft country case study reports for primary data collection; and (b) data analysis and triangulation of data to arrive at findings and conclusions. Validation of initial findings will be done through an in-country workshop that will take place with key stakeholders to ensure recommendations are viable, aligned with any developments, and forward looking.

Phase 3. Report drafting and dissemination, will include an initial draft to be shared with the Evaluation Reference Group for comments, and a final report which will incorporate comments to the draft report as well as discussion from the workshop. A comment matrix will ensure that all comments are addressed, although they will not necessarily be incorporated into the final document to guarantee independence of the evaluation team. The evaluation results will be shared with the primary and secondary users through the final evaluation report. Additionally, workshops with key partners will be held in each country at the end of the missions. During this virtual workshop, the evaluation team will present the key evaluation findings and results and discuss the operationalization of the recommendations towards ensuring that the findings are shared and understood. The results may also be shared with other organizations. Additionally, as an accountability exercise, it would be good for country offices to share the findings of the report with national partners. A documented presentation prepared by the evaluation team may be used for this purpose. A tentative time frame for the evaluation and expected deliverables is provided below (tentative schedule based on the duration and delivery dates). The evaluation must be completed within 33 working weeks over a 9-months period. This might be subject to change.

Timeframe

This evaluation will be undertaken from **September 2024**, with a final report expected by **early-April 2025**. The table below provides an overview of the tentative timeframe and key deliverables.

Deliverables	Date	Responsible party
TOR finalized	12 July 2024	EVL + GHC
Deadline RFP	29 July 2024	LTA holders
Selection and contracting of evaluation team	Mid-August 2024	EVL + GHC
Kick off meeting	3 September, 2024	EVL + GHC + selected team
Draft inception report (IR)	30 September 2024	Independent evaluation team
Presentation of IR to EMG/ERG	4 October 2024	Independent evaluation team
Final IR	11 October 2024	Independent evaluation team
Data collection	October-December 2024	Independent evaluation team
Data Processing, Analysis, and Validation	Jan -Feb 2025	Independent evaluation team
Draft synthesis report	March 3rd 2025	
Quality assurance	2 weeks in total	EVL+GHC and reference group
Presentation of key findings and recommendations to EMG/ERG/Member State's missions in Geneva	March 17th, 2025	Independent evaluation team
Presentation of Final Evaluation Results and Recommendations to the SAG	March 24th, 2025	EVL + GHC + independent evaluation team
Final report and policy brief	April 3rd 2025	Independent evaluation team

Dissemination	April to June 2025	EVL + WHE

Inception Report Proposed Structure (maximum 15000 words excluding annexes):

I. Presentation of the Context and Object of Evaluation

II. Purpose, Objectives and Scope of the Evaluation

III. Reconstruction of the Theory of Change (if absent)

IV. Evaluation Framework (evaluation criteria and questions), with an evaluation matrix (disaggregating each evaluation criterion, with evaluation questions, indicators, information sources and methods of gathering information).

V. A complete Methodology section, including:

- an explanation and rationale of the methodological design; - sample and list of people to interview and sites to visit; - data collection tools (questionnaire, interview guidelines, etc.); - limitations and mitigation measures; - ethical considerations; - data analysis (how the data will be analyzed, what technique will be used, software, etc.); - dissemination of the evaluation

VI. A Work Plan and description of the role and responsibilities of each team member.

VII. Deliverables and Quality Assurance.

Final Evaluation Report Proposed Structure (maximum 20.000 words excluding annexes):

I. Executive Summary (max. 5 pages)

II. Background and Context and object of the evaluation

III. Purpose, objectives and scope of the Evaluation

IV. Evaluation criteria and questions

V. Detailed Methodological Framework

VI. Limitations of the Evaluation

VII. Ethical considerations

VIII. Findings: analysis of data according to the evaluation questions and evaluation criteria

IX. Conclusions: should be firmly based on evidence and analysis, be relevant and realistic, with priorities for action made clear.

X. Suggestions for improving the M&E framework

XI. Recommendations: action-oriented recommendations that can inform potential alternative ways of implementation for improved results,

Global Health Cluster Strategic priorities and priority objectives

Strategic priorities and priority objectives (2020 – 2025)	
Strategic priority 1: Strengthen coordination for local, national, regional and global actors to prevent, prepare for, respond to and recover from public health and humanitarian emergencies.	
1.1	Enhance understanding and interface amongst all coordination mechanisms.
1.2	Strengthen coordination preparedness at the country level.
1.3	Ensure capacity to fulfil coordination functions for national and sub-national coordination platforms in acute and protracted emergencies.
Strategic priority 2: Strengthen inter-cluster and multi-sector collaboration to achieve better health outcomes.	
2.1	Strengthen global commitment for inter-cluster and multi-sector action
2.2	Provide support to Country health clusters/Sectors on inter-cluster and multi-sector action
Strategic priority 3: Strengthen our collective and respective health information management use	
3.1	Improve the standardisation, quality, timeliness of and access to public health and humanitarian information.
3.2	Improve the use of information for operational decision-making and evidence-based advocacy.
3.3	Demonstrate the effectiveness and impact of the Health Cluster at country and global levels.
Strategic priority 4: Improve the quality of Health Cluster action	
4.1	Promote and strengthen partners' technical and operational capacity to deliver health services.
4.2	Identify, develop and mainstream guidance on key humanitarian and public health strategic issues.
4.3	Systematically capture and disseminate knowledge.
Strategic priority 5: Strengthen Health Cluster advocacy at local, country, regional and global levels.	
5.1	Improve protection of health care providers and users.
5.2	Increase safe access to and equity of health service across crisis-affected contexts.
5.3	Enhance capacity, visibility and effectiveness of the Health Cluster to support advocacy in crisis-affected contexts.

Source: GHC, 2024. Global Health Cluster Strategy 2020-2025

Core functions of the country-level cluster

	Core functions of the country-level clusters	Description
1	Support service delivery by providing a platform that ensures service delivery is driven by the Humanitarian Response Plan and strategic priorities; and developing mechanisms to eliminate duplication of service delivery.	Providing a platform that ensures service delivery is driven by the identified needs of affected populations • Securing commitments from humanitarian partners in responding to needs and filling gaps • Developing protocols for information sharing and operational coordination which ensures confidentiality where needed • Ensuring comprehensive joint analysis of needs, response and gaps to support operational decision-making and advocacy • Establishing operational connections with health development partner coordination structures for supporting activities related to implementation of the humanitarian–development nexus
2	Inform the HC/HCT's strategic decision-making by preparing needs assessments and analysis of gaps (across and within clusters, using information management tools as needed) to inform the setting of priorities: identifying and finding solutions for (emerging) gaps, obstacles, duplication and cross-cutting issues; and formulating priorities based on analysis.	Ensuring effective and harmonised joint needs assessment and analysis, involving all relevant sectors and partners • Ensuring health cluster partners agree on assessment tools and approaches • Ensuring integration of agreed priority cross-cutting issues in sector and intersector needs assessments • Ensuring protection mainstreaming and gender-sensitive programming • Providing regular health situation analysis reports • Representing the interests of the cluster and cluster partners in discussions with the humanitarian coordinator and other stakeholders
3	Plan and implement cluster strategies by developing sectoral plans, objectives and indicators that directly support the realisation of the overall response's strategic objectives; applying and adhering to common standards and guidelines; clarifying funding requirements, helping to set priorities, and agreeing on cluster contributions to the HC's overall humanitarian funding proposals.	• Developing or updating agreed response strategies and workplans for the cluster and ensuring that these are adequately reflected in overall humanitarian country team strategies; and ensuring that response plans are in line with existing policy guidance and technical standards • Ensuring adoption of a people-centred approach in development of the health cluster strategy • Ensuring effective links with the ICCG and other clusters in order to improve the humanitarian integrated response through joint planning

		• Promoting emergency response actions while at the same time considering the need for early recovery and resilience planning as well as prevention and risk reduction concerns • Clarifying funding requirements, helping to set priorities, and agreeing cluster contributions to the overall humanitarian funding proposals
4	Monitor and evaluate performance by monitoring and reporting on activities and needs; measuring progress against the cluster strategy and agreed results; and recommending corrective action where necessary.	Ensuring adequate monitoring mechanisms are in place to review the impact of cluster activities and progress against the strategic health cluster objectives • Periodically assessing performance through CCPM and ensuring that the information generated is shared with partners • Ensuring that cluster coordination mechanisms are adapted over time to reflect the capacities of local actors and the engagement of development partners • Ensuring adequate data-sharing mechanisms are in place to review the impact of cluster activities and progress against implementation plans • Ensuring adequate reporting and effective information sharing
5	Build national capacity in preparedness and contingency planning Contingency planning/preparedness/national capacity building where needed and where capacity exists within the cluster.	Build national capacity in preparedness and contingency planning Investing in the institutional capacities of local and national partners, including preparedness, response and coordination capacities • Developing mechanisms to enhance capacity building through in-country trainings • Drawing lessons learned from past activities and revising strategies accordingly • Serving as a forum for strengthening operational coordination and problem solving • Ensuring adequate contingency planning and preparedness for new emergencies and seasonal adaptation of responses • Providing contingency planning scenarios for the health cluster response
6	Support robust advocacy by identifying concerns and contributing key information and messages to HC and HCT messaging and action; and undertaking advocacy on behalf of the cluster, cluster members, and affected people.	• Identifying core advocacy concerns, including resource requirements, and contributing key messages to the broader advocacy initiatives of other actors • Encouraging donors to fund humanitarian actors while at the same time encouraging cluster partners to mobilise resources for their activities • Developing and implementing a communications and advocacy strategy on behalf of all cluster partners to ensure that key decision

makers, including government and donors, are aware of needs, priorities, and gaps, and the importance of providing support

• Representing the interests of the cluster in discussions with national, regional and global stakeholders on prioritisation, resource mobilisation and advocacy

Source : Health Cluster, World Health Organization (6)

Interview guides

Global stakeholder key informant interviews

Background

HealthGen Limited has been commissioned by the World Health Organization (WHO) to conduct an independent evaluation of the health cluster at global and country levels. WHO has been the Inter-Agency Standing Committee (IASC) designated Cluster Lead Agency (CLA) for Health since 2005. WHO implements its CLA mandate through the Global Health Cluster (GHC) unit hosted within the Humanitarian Department of the WHO Emergencies Programme. The GHC programme of work and its support to country health clusters is guided by the GHC Strategy 2020-2025 and annual work plans. At country office level, WHO Heads of Country Offices (HWCO) are responsible and accountable for the activities of the Health Cluster when WHO is designated as CLA in a specific country.

The purpose of the evaluation is to assess the extent to which the GHC is fit for purpose, with a view to making recommendations that feed into the preparation of the Cluster's next Strategic Plan. The evaluation has a summative component, which will focus on progress achieved towards the Strategic Priorities in the current GHC Strategic Plan and the core functions of country-level clusters, and a formative component which will focus on learning to inform forward-looking recommendations. At country level, the evaluation will seek to understand the key priorities of WHO and its partners, recognising the importance of locally driven humanitarian assistance, accountability to affect populations, preparedness and the Humanitarian Development Peace (HDP) nexus. The evaluation will cover the GHC's work since September 2014, but with a particular focus on last five years.

Thank you for your willingness to talk to us. We anticipate that the interview will take one hour. May we have your permission to record the interview? All information provided to the evaluation team during interviews will be kept confidential and comments and opinions will not be attributed to specific people interviewed.

Introduction

1. Please explain your current role.
2. Please explain your knowledge of and involvement with the Health Cluster (including coordination) at global, regional or national levels.

Core KII questions

Role and relevance

3. Are you familiar with the objectives and strategic priorities of the GHC? Do you think the objectives of the Health Cluster are still aligned to needs at global/regional/country levels?
4. Are the Strategic Priorities in the current GHC Strategic Plan the right ones? Are there other issues that should be given more priority in future?

5. To what extent is WHO's management of its CLA responsibilities aligned with the principles and standards of the cluster approach (see Annex 1)?
6. What strengths does WHO bring to its role as CLA for the GHC? What are its weaknesses in relation to this role? Are there areas where WHO could improve implementation of its CLA mandate?
7. To what extent has WHO been a successful coordinator of the GHC? [3]
8. To what extent has the GHC supported appropriate prioritisation of health interventions within coordinated responses? How are Health Cluster strategies and interventions aligned to meet the needs of affected people? How are clusters accountable to affected populations?

Effectiveness and efficiency

9. How well has WHO performed its CLA role in relation to
    a. Policies, setting standards and developing guidelines humanitarian crises and public health emergency response?
    b. Providing support to country health clusters, (improved predictability and adequate and timely leadership for the response at national and sub-national levels, especially surge support)?
    c. Providing support to country health clusters, through quality and timely public health information for use in operational decision making?
    d. Providing support to country health clusters, through evidence-based advocacy at global and country levels?
10. In what ways has WHO fulfilled its "provider of last resort" [4] role when identified gaps have not been addressed?
11. What role do WHO regional offices play? How have they contributed to fulfilling WHO's CLA responsibilities at country level? Have they played a role in strengthening a regional response to cross-border issues? [5]
12. Has there been progress towards achieving the Strategic Priorities given in the GHC Strategic Plan (see Annex 2)? Which areas of activity have made the most progress/least progress? Which areas of activity have been the most challenging?

[3] primary role of the CLA, and improving coordination was the main rationale for establishing the cluster approach

[4] Where there are critical gaps in humanitarian response, it is the responsibility of cluster leads to call on all relevant humanitarian partners to address these. If this fails, then depending on the urgency, the cluster lead as 'provider of last resort' may need to commit itself to filling the gap. If, however, funds are not forthcoming for these activities, the cluster lead cannot be expected to implement these activities but should continue to work with the Humanitarian Coordinator and donors to mobilize the necessary resources.

[5] i.e. if there is an mpox outbreak in DRC, are they ramping up preparedness in South Sudan?

13. How well has WHO mobilised resources to fulfil its CLA responsibilities at global and country levels? Are there any critical resource gaps? How does this compare with other clusters and CLAs?
14. How well have the GHC and health clusters reduced duplication, maximised the use of available resources and contributed to efficiency gains?

Coherence and coordination

15. To what extent has the GHC improved external coherence, including through engagement in inter-cluster and multi-sector collaboration (at global, regional and country levels) and coordination with other international and national coordination mechanisms?
16. To what extent has there been joint working within WHO at global, regional and country levels to deliver Health Cluster actions?
17. How well has the GHC coordinated with other WHO partner networks e.g. EMTS and GOARN? How well have these other partner networks coordinated with the GHC?
18. To what extent have Health Cluster actions improved local partner participation in decision making and supported the operational need of implementing partners?
19. To what extent have Health Cluster actions strengthened coordination for local, national, regional and global action to prevent, prepare for, respond and recover from public health and humanitarian emergencies?
20. At global and country levels, how well is WHO using its position as CLA to strengthen the link between humanitarian responses and national health systems, and between the humanitarian and development/peace nexus?
21. To what extent has the GHC supported cluster transition and deactivation?

Coverage and equity

22. To what extent and how do the GHC and country health clusters consider issues of health equity, gender equality, disability and human rights in their functioning?

    a. Lessons and recommendations

23. What are the key lessons that have been learned from the experience of the GHC and WHO's role as CLA? Can you suggest any examples of countries that offer useful lessons?
24. What have been the main challenges for the GHC? How well has the GHC been able to adapt to emerging global health challenges (e.g., reduced funding for humanitarian responses, increased IDPs, protracted crises, climate change? What steps has WHO taken to ensure that the cluster approach remains fit for purpose in a rapidly evolving environment? What steps should it take in future?
25. How well do you think the GHC has performed compared to other clusters (why and please provide examples)?

26. What are likely to be the main opportunities and challenges for the GHC going forward?
27. What else could WHO, as CLA, do to strengthen the Health Cluster at the global, regional and country levels?
28. Do you have any other recommendations for WHO and the GHC?

Country stakeholder key informant interviews

Background

HealthGen Limited has been commissioned by the World Health Organization (WHO) to conduct an independent evaluation of the health cluster at global and country levels. WHO has been the Inter-Agency Standing Committee (IASC) designated Cluster Lead Agency (CLA) for Health since 2005. WHO implements its CLA mandate through the Global Health Cluster (GHC) unit hosted within the Humanitarian Department of the WHO Emergencies Programme. The GHC programme of work and its support to health clusters is guided by the GHC Strategy 2020-2025 and annual work plans. At country office level, WHO Heads of Country Offices (HWCO) are responsible and accountable for the activities of the Health Cluster when WHO is designated as CLA in a specific country.

The overall purpose of the evaluation is to assess the extent to which the GHC is fit for purpose, with a view to making recommendations that feed into the preparation of the Cluster's next Strategic Plan. At country level, the evaluation will seek to understand the key priorities of WHO and its partners, recognising the importance of locally driven humanitarian assistance, accountability to affect populations, preparedness and the Humanitarian Development Peace (HDP) nexus. The evaluation will cover the GHC's work since September 2014, but with a particular focus on last five years.

Thank you for your willingness to participate in this evaluation. We anticipate that the interview will take one 45 minutes. All information provided to the evaluation team during the interview will be kept confidential and used for the purpose of preparing the evaluation. All participants will remain anonymous

Introduction

1. Please explain your current role
2. What is your understanding of the GHC and WHO's role as cluster lead agency?
3. How are you involved with the country health clusters?
4. What are the most critical issues for the health sector in the ongoing humanitarian response and public health emergencies?

5. What is the main focus of the Health Cluster, nationally or at any sub-national level?

Core KII questions

Role and relevance

6. To what extent has WHO been a successful coordinator of the GHC and country health clusters? [6]
7. How well has WHO performed its CLA role at country level in relation to the core cluster functions and specifically: formulating policies, setting standards and developing guidelines; building response capacity, maintaining surge capacity and stockpiling; and providing support for service delivery?
8. What strengths does WHO bring to its role as CLA? What are its weaknesses in relation to this role? Are their areas where WHO could improve implementation of its CLA mandate?
9. To what extent have WHO as CLA at country level supported[7] prioritisation of the health sector, or of other sectors where appropriate, in the coordinated response?
10. To what extent has the GHC supported appropriate prioritisation of health interventions within a coordinated response?
11. How are Health Cluster strategies and interventions aligned to meet the needs of affected people? Has the Health Cluster been sufficiently flexible to respond to the needs of the most vulnerable populations in acute, protracted and slow onset crises? How is the cluster accountable to affected populations?
12. How and to what extent is WHO using its position as CLA to strengthen the link between the humanitarian and development/peace nexus?
13. What role do WHO regional offices play? How have they contributed to fulfilling WHO's CLA responsibilities at country level? Have they played a role in strengthening a regional response to cross-border issues? [8]

Effectiveness and efficiency

14. To what extent have WHO as CLA and the Health Cluster contributed to an improved humanitarian responses and public health emergencies at country level?

14.8Through improved predictability?

[6] primary role of the CLA, and improving coordination was the main rationale for establishing the cluster approach

[7] Under some circumstances, the HC needs to prioritise between sectors (if funding is very low). For a CERF allocation for example. It would be inappropriate for the WR to push the health sector if food / nutrition was obviously the biggest challenge.

[8] i.e. if there is an M-POX outbreak in DRC, are they ramping up preparedness in South Sudan?

14.9 Through evidence-based advocacy?

14.10 Through adequate and timely leadership for the response at national and sub-national levels?

14.11 Through quality and timely public health information and its use for operational decision-making?

14.12 Through strengthening the capacity of national and local partners?

14.13 Through monitoring health worker safety?

15. In what ways has WHO fulfilled its "provider of last resort" [9] role when identified gaps have not been addressed?

16. Which areas of activity have made the most progress/least progress? Which areas of activity have been the most challenging?

17. What factors have contributed to the Health Cluster's success in delivering a strong response in humanitarian and public health emergencies? What factors have hindered its success?

18. How well has WHO mobilised resources to fulfil its CLA responsibilities at country level? [10] Are there any critical resource gaps? How does this compare with other clusters and CLAs?

19. To what extent has the Health Cluster reduced duplication and maximised use of available resources?

20. Have Health Cluster efforts to strengthen disease prevention and/or emergency preparedness brought efficiency gains in meeting/mitigating health needs during humanitarian and public health emergencies?

Coherence and coordination

21. How well is the Health Cluster engaged in collaboration with other clusters and with other sectors? How well is it coordinated with other national coordination mechanisms (e.g. within the UN system or the MOH)?

22. To what extent has the Health Cluster strengthened coordination for national and local action to prevent, prepare for, respond and recover from public health and humanitarian emergencies? How well is the Health Cluster supporting localization?

23. What role has the Health Cluster played in supporting government leadership and coordination of humanitarian and public health emergencies?

[9] Where there are critical gaps in humanitarian response, it is the responsibility of cluster leads to call on all relevant humanitarian partners to address these. If this fails, then depending on the urgency, the cluster lead as 'provider of last resort' may need to commit itself to filling the gap. If, however, funds are not forthcoming for these activities, the cluster lead cannot be expected to implement these activities but should continue to work with the Humanitarian Coordinator and donors to mobilize the necessary resources.

[10] GHC mobilise resources at both levels, but my understanding is that WHO as CLA is responsible for mobilising resources at country level to support the functioning of the Health Cluster,

24. Do local partners participate in the Health Cluster and if so, how are they involved in decisions about the planning and delivery of humanitarian health emergency assistance?
25. How well does the Health Cluster support implementing partners, including through strengthening capacity?
26. Is there a transition plan? How and how well has WHO supported cluster transition and deactivation (if relevant)? Any examples of successes and challenges?
27. What is the country health clusters doing to ensure long-term, sustainable sector coordination and capacity for delivering a strong health response in humanitarian and public health emergencies?
28. To what extent is WHO using its position as the CLA to strengthen the link between coordination of humanitarian responses and development/peace planning and programming?

Equity

29. How does the country health clusters consider issues of health equity, gender equality, disability and human rights in planning, implementation and monitoring and evaluation?

29.8Lessons and recommendations

30. What are the key lessons that have been learned from the experience of the country Health Cluster and WHO's role as CLA? What have been the main challenges?
31. How well has the Health Cluster and WHO performed (been successful) compared with other clusters?
32. What are likely to be the main opportunities and challenges for the country Health Cluster going forward? What could WHO do to strengthen the Health Cluster at the country level? Do you have any other recommendations for WHO and the GHC going forward?

Country focus group discussion with Health Cluster NGO partners[11]

Background

HealthGen Limited has been commissioned by the World Health Organization (WHO) to conduct an independent evaluation of the Health Cluster at global and country levels. WHO has been the Inter-Agency Standing Committee (IASC) designated Cluster Lead Agency (CLA) for Health since 2005. WHO implements its CLA mandate through the Global Health Cluster (GHC) unit hosted within the Humanitarian Department of the WHO Emergencies Programme. The GHC programme of work and its support to country health clusters is guided by the GHC Strategy 2020-2025 and annual work plans. At country office level, WHO Heads of Country Offices (HWCO) are responsible and accountable for the activities of the Health Cluster when WHO is designated as CLA in a specific country.

The overall purpose of the evaluation is to assess the extent to which the GHC is fit for purpose, with a view to making recommendations that feed into the preparation of the Cluster's next Strategic Plan. The evaluation has a summative component, which will focus on progress achieved towards the Strategic Priorities in the current GHC Strategic Plan and the core functions of country-level clusters, and a formative component which will focus on learning to inform forward-looking recommendations. At country level, the evaluation will seek to understand the key priorities of WHO and its partners, recognising the importance of locally driven humanitarian assistance, accountability to affect populations, preparedness and the Humanitarian Development Peace (HDP) collaboration. The evaluation will cover the GHC's work since September 2014, but with a particular focus on last five years.

Thank you for your willingness to participate in this group discussion. We anticipate that it will take around one and a half hours. All information provided to the evaluation team will be kept confidential and comments and opinions will not be attributed to specific people.

Introductions

1. Please explain your current role.

FGD questions

[11] International, national and local

2. What do you know about the GHC and WHO's role as Health Cluster lead agency?
3. Are you involved with the country Health Cluster (national and/or sub-national) and, if so, how?
4. How well has WHO performed its CLA role in Health Cluster coordination and in relation to the core cluster functions? [12]
5. To what extent have WHO as cluster lead and the Health Cluster contributed to an improved response in humanitarian and public health emergencies at national and sub-national levels?
    - Through improved predictability and accountability?
    - Through evidence-based advocacy?
    - Through adequate and timely leadership for the response at national and sub-national levels?
    - Through quality and timely public health information and its use for operational decision-making?
    - Through strengthening the capacity of national and local partners?
    - Through monitoring health worker safety?
    - Through strengthening accountability to affected populations?
6. What factors have contributed to the Health Cluster's success in delivering a strong response in humanitarian and public health emergencies? What factors have hindered its success?
7. Has the Health Cluster been sufficiently flexible to respond to the needs of the most vulnerable populations in acute, protracted and slow onset crises (and how)?
8. Does the country Health Cluster have a localisation strategy? If so, what progress has been made with this? What actions have been taken to implement it/ what have been the challenges?
9. To what extent is there meaningful participation of local partners in the Health Cluster?
10. How are local partners involved in decisions about the planning, funding and delivery of humanitarian health assistance?
11. To what extent and how does the Health Cluster support the needs of local implementing partners, including through strengthening capacity and financial support?

[12] Supporting service delivery by providing a platform for agreement on approaches; informing strategic decision making for the response through coordination of needs assessment, gap analysis and prioritisation; planning and strategy development; advocacy on behalf of cluster participants and affected populations; monitoring and reporting on the cluster strategy and results; contingency planning, preparedness, capacity building where needed; accountability to affected populations.

12. What role has the Health Cluster played in supporting government leadership and coordination in humanitarian and public health emergencies? How well has it played this role and what challenges have been encountered?
13. What does GHC do better / worse than other clusters)?
14. What are likely to be the main opportunities and challenges for the country health clusters going forward?
15. What could WHO do to strengthen the Health Cluster at the country level?
16. Do you have any other recommendations for WHO and the Health Cluster going forward?

Interview guides – Cluster lead agency responsibilities and principles and standards of the Cluster approach

From the Global Health Cluster Interim Terms of Reference – 11 March 2015

WHO responsibilities as Cluster Lead Agency

Subject to the availability of funds and application of WHO rules, policies and procedures, WHO is ultimately responsible for ensuring the fulfilment of the Cluster Lead Agency role in the Health Cluster to the Emergency Relief Coordinator. These responsibilities include:

- Mainstreaming of the Cluster Approach and the Transformative Agenda within WHO and promoting their understanding within WHO departments and offices at global, regional and country level.
- Negotiating with other UN agencies around Cluster issues that need to be reflected in global level documentation.
- Advocating at the highest level of the IASC, Emergency Directors Group, donors and other concerned bodies the needs and position of the GHC.
- Ensuring that adequate human and financial resources and administrative structures are availed at global, regional and country level.

Guiding Principles

As a multi-agency platform, the overall approach and work of the GHC will be underpinned by the following principles to promote collaborative action.

- **Commitment and voluntary cooperation:** Effective coordination can only be voluntary, based on each partner's willingness to join others in agreeing on priorities and overall response strategies and to adjust its actions to the particular humanitarian context as well as to other partners' capacities. The cluster approach demands commitment and an openness to collaborate and adapt on the part of all agencies and individuals concerned.
- **Partnership:** Collaborative and complementary partnerships at all levels, based on transparency, mutual understanding and the tapping of comparative advantages and competencies, are essential to improving humanitarian action.
- **Community participation and accountability to affected populations:** Community based programming is essential to successful cluster implementation and humanitarian health action. Affected populations must be involved in the actions of the country cluster, and the Health Cluster will actively seek ways to be accountable to the affected population.
- **Support national authorities' coordination efforts, priorities and building capacities:** Clusters should support and/or complement existing national coordination mechanisms for response, preparedness and recovery. Where appropriate, appropriate national health counterparts should be actively encouraged to co-chair cluster meetings from as early as possible.
- **Adherence to humanitarian principles and the right to health:** Health interventions will be based on humanitarian principles and on human rights, which state that humanitarian interventions should be provided based on needs alone, be accessible without discrimination, and be affordable for all. Universal access to primary health care is a fundamental element of any humanitarian health response for populations affected by crises.

Strategic priorities in the Global Health Cluster strategy plan 2020-2025

Strategic Priority 1: **Strengthen coordination for local, national, regional and global actors to prevent, prepare for, respond to and recover from public health and humanitarian emergencies**

- Enhance understanding and interface amongst all coordination mechanisms
- Strengthen coordination preparedness at country level

- Ensure capacity to fulfil coordination functions for national and sub-national coordination platforms in acute and protracted humanitarian and public health emergencies

Strategic Priority 2: Strengthen inter-cluster and multi-sector collaboration to achieve better health outcomes

- Strengthen global commitment for inter-cluster and multi-sector action
- Provide support to country health clusters/sectors on inter-cluster and multi-sector action

Strategic Priority 3: Strengthen our collective and respective health information management use

- Improve the standardisation, quality, timeliness of and access to public health and humanitarian information
- Improve the use of information for operational decision-making and evidence-based advocacy
- Demonstrate the effectiveness and impact of the Health Cluster at country and global levels

Strategic Priority 4: Improve the quality of Health Cluster action

- Promote and strengthen partners' technical and operational capacity to deliver health services
- Identify, develop and mainstream guidance on key humanitarian and public health strategic issues
- Systematically capture and disseminate knowledge

Strategic Priority 5: Strengthen Health Cluster advocacy at local, country, regional and global levels

- Improve protection of heath care providers and users
- Increase safe access to and equity of health services across crisis-affected contexts
- Enhance capacity, visibility and effectiveness of the Health Cluster to support advocacy in crisis-affected contexts

Complete survey analysis

Purpose of the online survey

The online survey was designed to capture the general perception of the stakeholders about the Health Cluster as it currently stands, including it being 'fit for purpose,' relevant, effective, coherent and efficient as well as to explore new and complementary areas to inform its future directions.

The survey was administered to **315 individuals** at a country, regional and global level, including representatives from the Health Cluster, at all three levels as well as other stakeholders as noted below in details. Of the **proposed sample of 984 respondents in total, 315** were considered complete, resulting in a response rate of approximately **32 percent**. The survey was anonymous and administered using the Survey Monkey platform.

The perception survey sought respondents' insights on several key areas regarding Health Cluster's activities:

1. **Relevance:** Respondents were asked about their view regarding the relevance of the Health Cluster's engagements on several aspects such as response to the needs of the most vulnerable groups, provision of coordination platform, prioritisation of health interventions, accountability to affected population, partnerships.
2. **Effectiveness:** View were gathered on the effectiveness of the Health Cluster's activities, specifically its contribution to improvement of humanitarian crisis and public health emergency responses.
3. **Enabling Factors:** Participants were invited to identify what they consider top three factors enabling the Health Cluster's contribution to an improved response to a humanitarian crisis or public health emergency.
4. **Hindering Factors:** Participants were invited to identify what they consider top three factors hindering the Health Cluster's contribution to an improved response to a humanitarian crisis or public health emergency.
5. **Efficiency:** Respondents expressed their opinion on the Health Cluster's availability, maximization and avoidance of duplication of resources.
6. **Coherence and Coordination:** Respondents rated Health Cluster's internal and external coherence and coordination.
7. **Connectedness:** Respondents rated Health Cluster's contribution to sectoral coordination, humanitarian, development and peace nexus and cluster transition and deactivation.
8. **Areas for Improvement:** Participants identified areas where WHO could improve its engagement to strengthen the Health Cluster.
9. **Top Successes:** Respondents shared their perception on the key successes of the Health Cluster.
10. **Recommendations:** Respondents were encouraged to share specific recommendations for the WHO and Health Cluster to consider for future activities.

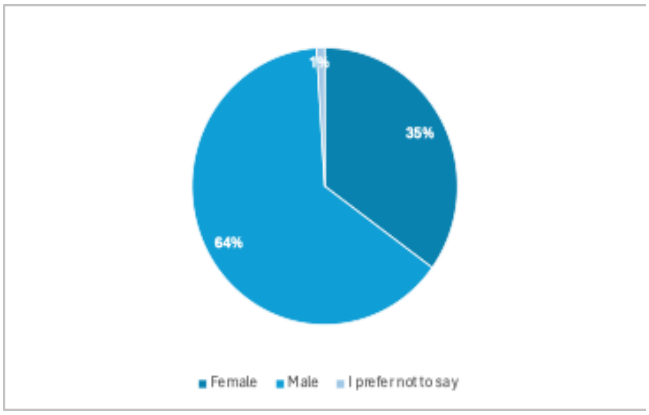
Methodology of the perception survey

The survey with a limited number (23) of closed-ended questions was designed and administered using Survey Monkey (see Inception report for data collection instruments). The survey was pretested, revised and administered in four languages, English, French and Arabic, and Spanish. The estimated time to complete the survey was 15 minutes. It was administered throughout the data collection phase ensuring enough flexibility for the stakeholders to respond. The response rate varied across the levels, with the highest rate at the country level with 279 responses and the response rate of **34 percent**, followed by global level with **26 percent**, while the lowest response rate was achieved at the regional level, with **16 percent** response rate. Specifically for the country level data analysis, due to significant difference in participation rates among countries, which may introduce bias, Inverse Probability Weighting (IPW) analysis method was applied.

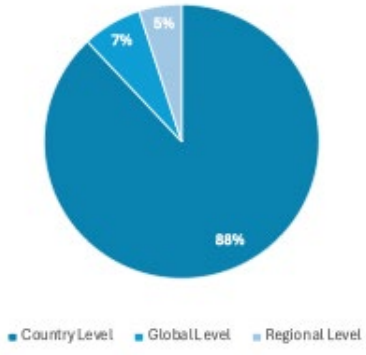
Stakeholder group	Survey requests	Survey responses	Response rate
Total	984	315	32%
Global level	80	21	26%
Regional level	94	15	16%
Country level (total)	810	279	34%
Country level (individual)			
Afghanistan	390	46	12%
Ukraine	134	24	18%
Burkina Faso		18	
Myanmar		20	
Colombia		11	
Ethiopia	69	14	20%
South Sudan	95	13	14%
Syria	2	13	650%
Lebanon		8	
République Centrafricaine	70	15	21%
Madagascar	23	6	26%
Tchad		5	
Nigeria	25	5	20%
Niger	130	5	4%
Palestine	300	6	2%
Somalia		5	
Yemen		5	
Bangladesh		7	
Gaza		1	
USA		1	
Honduras		1	
Sudan		1	
Türkiye		1	
Venezuela		4	
Other		46	

Survey's response data

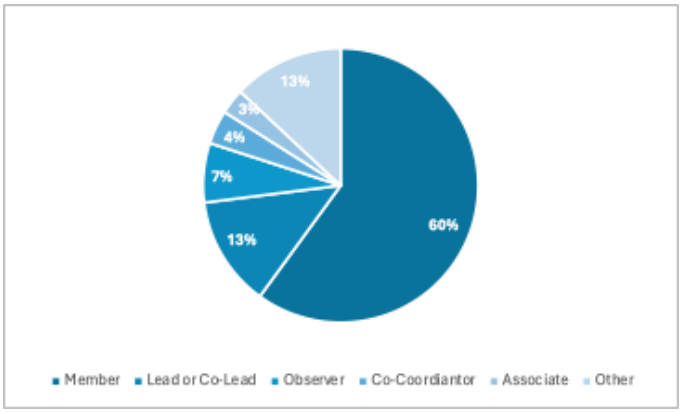
Total number of respondents amount to 315, whereas 64% were male and 35% female while 1% decided not to share this information.



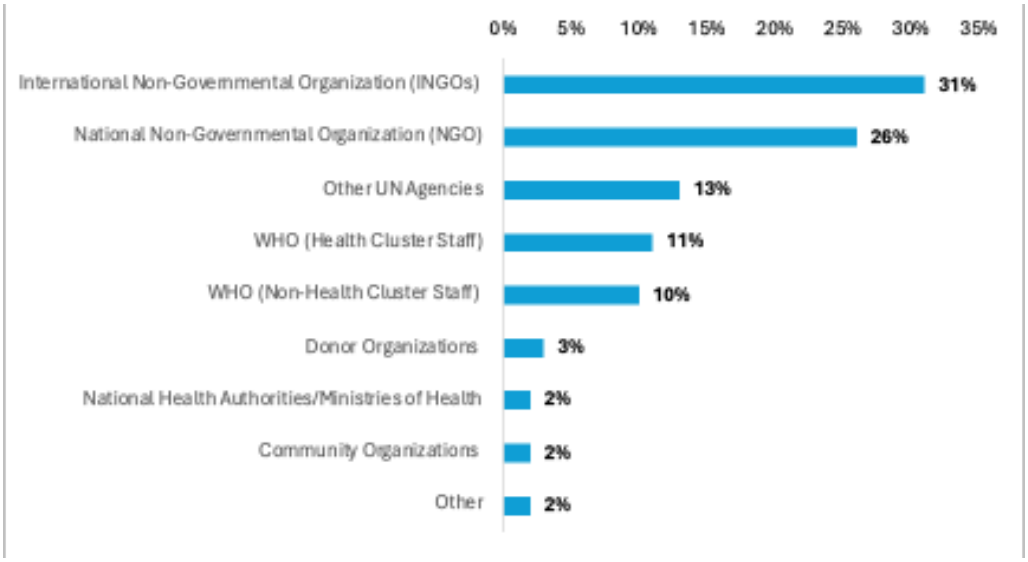
Majority of survey participants work at country level (88%), followed by global level (7%) and regional level (5%).



Most survey participants are associated with the Cluster through the role of Member (60%), followed by Lead or Co-Lead (13%), Observer (7%), Co-coordinator (4%), Associate (3%), while 13% occupy other roles.

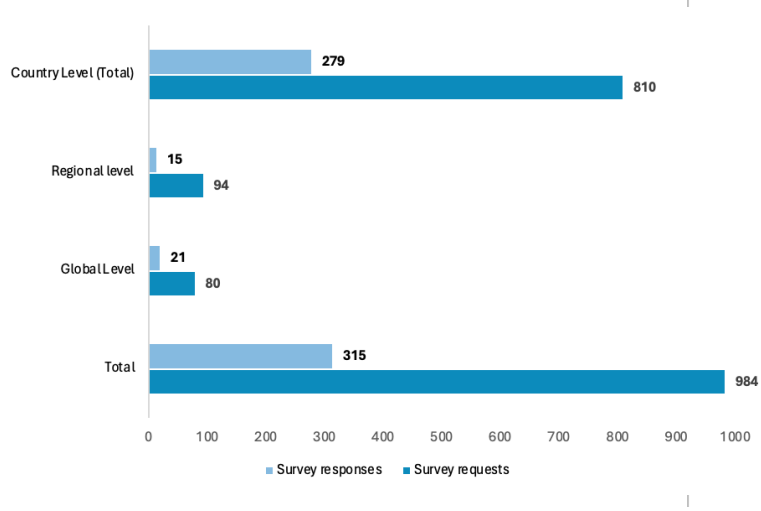


The highest number of respondents came from International NGOs (31%), followed by National NGOs (26%), and Other UN Agencies (13%). WHO (Health Cluster Staff) (11%) had a slightly higher number of respondents than WHO (Non-Health Cluster Staff) (10%). A smaller proportion of respondents came from Donor Organizations (3%), followed by National Health Authorities/Ministries of Health (2%). Community Organizations (2%) and Other (2%) had very few respondents. Academic Institutions had only one respondent. No respondents came from Other Government Bodies (0%) or the Private Sector (0%).

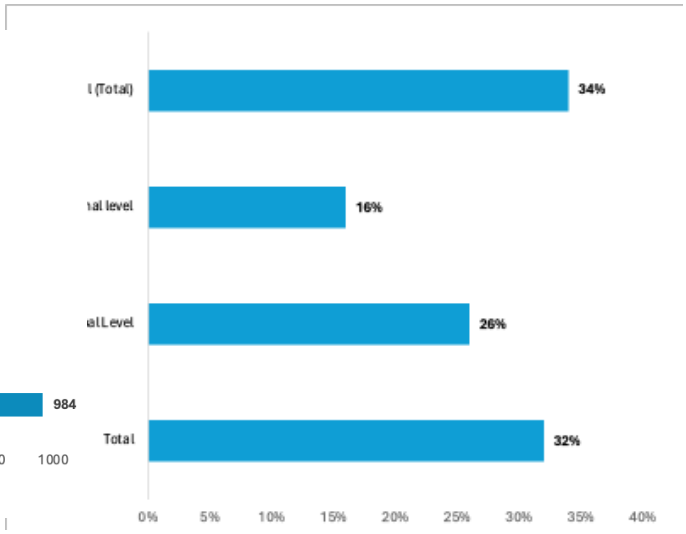


Stakeholder group	Survey requests	Survey responses	Response rate
Total	984	315	32%
Global level	80	21	26%
Regional level	94	15	16%
Country level (total)	810	279	34%

Survey requests vs. Survey responses



Response rate



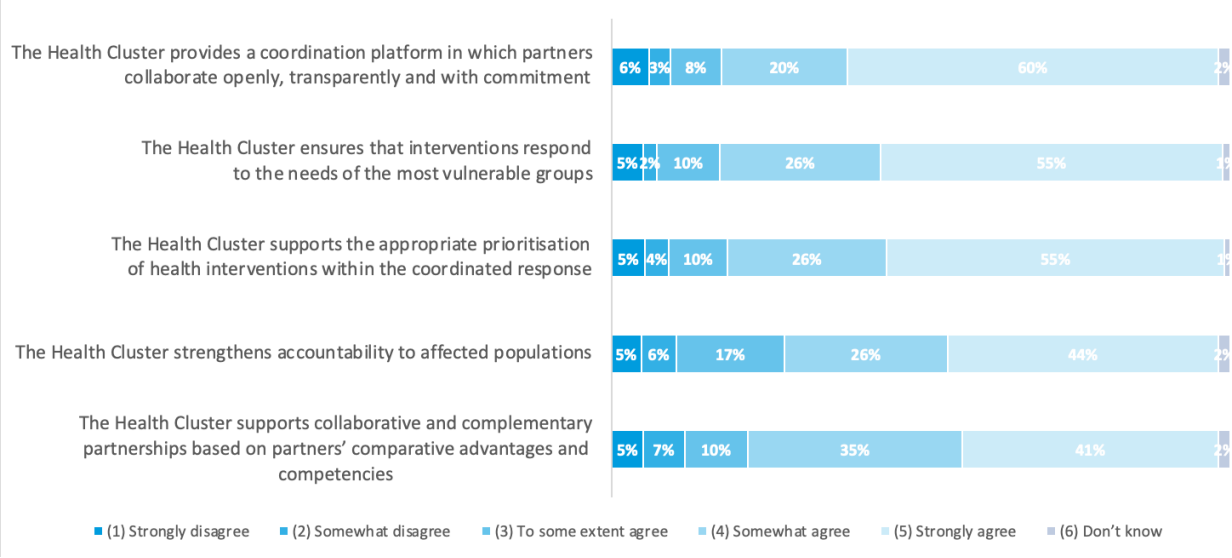
Responses to the perception survey questions

The following sections provide responses to individual survey questions.

Total number of respondents amount to 315, whereas 64% were male and 35% female while 1% decided not to share this information. Majority of survey participants work at country level (89%), followed by global level (7%) and regional level (5%). Most survey participants are associated with the Cluster through the role of Member (60%), followed by Lead or Co-Lead (13%), Observer (7%), Co-coordinator (5%), Associate (3%), while 13% occupy other roles.

The highest number of respondents came from International NGOs (31%), followed by National NGOs (26%), and Other UN Agencies (13%). WHO (Health Cluster Staff) (11%) had a slightly higher number of respondents than WHO (Non-Health Cluster Staff) (10%). A smaller proportion of respondents came from Donor Organizations (3%), followed by National Health Authorities/Ministries of Health (2%). Community Organizations (2%) and Other (2%) had very few respondents. Academic Institutions had only one respondent. No respondents came from Other Government Bodies (0.00%) or the Private Sector (0.00%).

Survey Question 7: Please indicate your level of agreement with the following statements.



Overall, the responses show a strong endorsement of the Health Cluster's work, with a majority of respondents "strongly agreeing" with most of the statements. The highest approval is seen in the following areas - *providing a coordination platform for collaboration* (60% "strongly agree" and 20% "somewhat agree"); *ensuring that interventions respond to the needs of the most vulnerable* (55% "strongly agree" and 26% "somewhat agree"") and *supporting the appropriate prioritization of health interventions* (55% "strongly agree" and 26% "somewhat agree"). The slightly lower strong agreement rate (41% "strongly agree", 35% "somewhat agree") was noted for the statement on the Health Cluster *support for collaborative and complementary partnerships based on partners' comparative advantages and competencies* and somewhat less agreement was expressed for the Health Cluster's role in *strengthening accountability to affected populations* with 44% of respondents agreeing strongly and 26% "somewhat agreeing". 2% of respondents reported "don't know" in most areas.

At the **global level**, out of 21 respondents, the highest-rated function of the *Health Cluster is providing a coordination platform where partners collaborate openly, transparently, and with commitment*, with 67% of respondents "strongly agreeing" and 14% "somewhat agreeing", however, 14% of respondents somewhat disagreed, and another 5% strongly disagreed. The second-highest rated function is the Health Cluster's ability to *support the appropriate prioritization of health interventions within the coordinated response*, with 43% of respondents "strongly agreeing" and 33% "somewhat agreeing". Only 10% of respondents disagreed (either somewhat or strongly). The Health Cluster's role *in ensuring that interventions respond to the needs of the most vulnerable groups* received 71% total positive responses, with 48% of respondents "strongly agreeing" and 24% "somewhat agreeing". Only 5% of respondents disagreed. Somewhat lower rated were the Health Cluster's efforts in *supporting collaborative and complementary partnerships based on partners' comparative advantages* with 62% total positive responses, with 33% "somewhat agreeing" and 29% "strongly agreeing". However, this statement also had the highest negative feedback with 29% total disagreement. Finally, the lowest rated statement is referring to Health Cluster's ability to *strengthen accountability to affected populations*, with only 33% of respondents "strongly agreeing" and 14% "somewhat agreeing" and 38% agree to "some extent". Another 14% of respondents somewhat disagreed.

At the **regional level**, out of 15 respondents, the highest-rated function of the Health Cluster is its role in *providing a coordination platform where partners collaborate openly, transparently, and with commitment*, with 53% of respondents "strongly agreeing" and 33% "somewhat agreeing". The second-highest rated statement is the *Health Cluster's ability to ensure that interventions respond to the needs of the most vulnerable groups*, with 40% "strongly agreeing" and 40% "somewhat agreeing", followed by the Health Cluster's role in *supporting collaborative and complementary partnerships based on partners' comparative advantages* also received 80% positive responses. However, unlike the previous two statements, it records 14% of disagreement. Slightly lower level of positive feedback is observed in the Health Cluster's ability to support the appropriate prioritization of health interventions, with 53% "strongly agreeing" but only 20% "somewhat agreeing" and additional 20% agreeing to some extent. The lowest rated area of Health Cluster's work refers to its role in *strengthening accountability to affected populations*, with only 33% "strongly agreeing" and 40% "somewhat agreeing" and 14% of respondents disagreeing.

Out of the **279 country level respondents**, stakeholders generally perceive the actions as effective, with a particularly strong endorsement by the WHO and UN Agencies which note the highest overall positive response at 92%, followed by Donors/INGOs at 88%, while National Health Agencies and NGOs have the lowest positive response at 85%. The three highest rated statements include the GHC's role in *responding to the needs of vulnerable populations* with 62% of respondents "strongly agreeing" and 24% "somewhat agreeing" and only 6% disagreeing, followed by the statement on *prioritisation of health interventions* with 85% of total positive response (62% "strongly agree" and 23% "somewhat agree") and 8% disagreeing and finally the statement the *Health Cluster provides a coordination platform in which partners collaborate openly, transparently and with commitment* with 85% of total positive and 8% total negative perception (5% "strongly disagree" and 3% "somewhat disagree"). This is true across the stakeholder groups. Slightly lower response rate was noted for the statement the Health Cluster supports collaborative and complementary partnerships based on partners' comparative advantages and competencies with 81% of total positive response and 8% of total negative response. The lowest ranked statement was the Health Cluster *strengthens accountability to affected populations* with 70% of positive and 9% of total negative responses. The same is notable across the stakeholder groups, with a slightly lower positive perception among both Donors and INGOs and National Health Agencies and NGOs (67%), compared to WHO staff (71%).

Commonalities: Across total, global, regional, and country levels, the three highest-rated functions of the Health Cluster are:

- Providing a coordination platform where partners collaborate openly, transparently, and with commitment.
- Ensuring that interventions respond to the needs of the most vulnerable populations.
- Supporting the appropriate prioritization of health interventions.

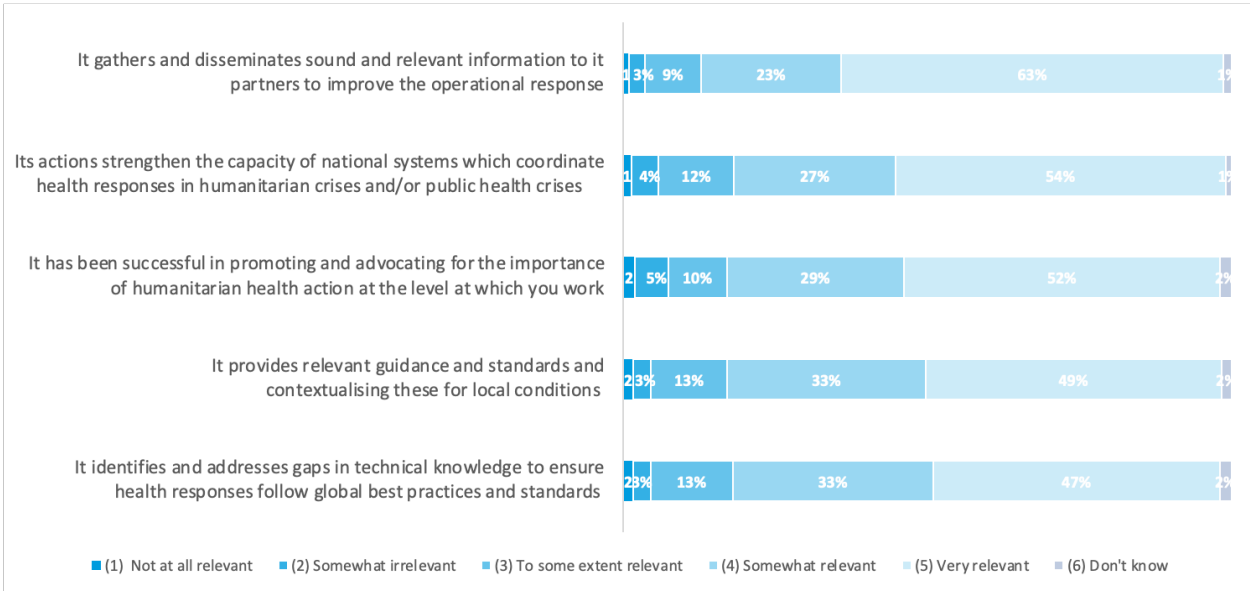
Similarly, across all levels, the lowest-rated function is the Health Cluster's role in strengthening accountability to affected populations, indicating a widespread perception that accountability mechanisms need improvement regardless of the operational level

Differences: While the overall trends remain consistent, there are notable differences in the degree of agreement and ranking between global, regional, and country respondents.

- Country-level respondents are the most positive, showing the highest levels of strong agreement across all functions, including prioritization and accountability.

- Global-level respondents are the most critical, with higher rates of disagreement and more mixed responses across multiple functions.
- Regional-level respondents tend to fall in between, showing moderate agreement levels and less polarization than global respondents.
- Accountability is the lowest-rated function at all levels, but global respondents rate it the lowest, while country respondents perceive it slightly more favourably.

Survey Question 8: Please indicate your level of agreement with the following statements:



Overall, a significant proportion of respondents consider the organization's role highly relevant, particularly in *gathering and disseminating information* (63% "very relevant", 23% "somewhat relevant"), followed by *strengthening national systems* (54% "very relevant", 27% "somewhat relevant"). While still rated highly relevant, areas related to technical knowledge (with 47% considering it "very relevant", 33% "somewhat relevant") and *contextualized guidance* (49% "very relevant", 33% "somewhat relevant") show a slightly lower level of strong agreement.

At the **global level,** out of 21 respondents, the highest-rated functions of the Health Cluster are *gathering and disseminating relevant information to partners and providing relevant guidance and standards contextualized for local conditions*, both receiving 81% total positive responses, with the first one noting 14% opinion on being "somewhat irrelevant". Just a slightly lower total positive response was noted was noted the *Health Cluster's role in advocating for humanitarian health action* receiving 76% with 43% of respondents "strongly agreeing" and 33% "somewhat agreeing", however, with 19% of respondents rating this function as somewhat irrelevant. The Health Cluster's role in *identifying and addressing gaps in technical knowledge* received 67% total positive responses, with

43% somewhat relevant and 24% very relevant, while the lowest-rated statement was *strengthening the capacity of national systems which coordinate health responses*, with only 43% total positive responses (38% "very relevant", 5% "somewhat relevant"). Additionally, 14% found it "somewhat irrelevant", and 5% found it "not at all relevant".

At the **regional level**, out of 15 respondents, the most highly rated function of the Health Cluster is its role in *strengthening the capacity of national systems that coordinate health responses in humanitarian and public health crises*, with 47% of respondents rating this as "somewhat relevant" and 47% as "very relevant", followed by its role in *gathering and disseminating relevant information* to its partners to improve operational responses, with 67% of respondents rating this function as "very relevant" and 20% as "somewhat relevant". 80% of total positive response was noted for both, the Health Cluster's role in *identifying and addressing gaps in technical knowledge* to ensure best practices and its role in providing relevant guidance and contextualizing standards for local conditions. The lowest-rated function is the Health Cluster's role in *promoting and advocating for the importance of humanitarian health action*, with only 27% of respondents rating this function as "very relevant" and 40% as "somewhat relevant". Notably, this category has the highest level of disagreement with 13% of respondents finding it "somewhat irrelevant" and 7% selecting "don't know".

Out of the 279 country level respondents, stakeholders generally perceive the actions as effective, with a particularly strong endorsement from Donors/INGOs and slightly highest negative ranking among the National Health Agencies and NGOs. The three highest-rated statements regarding the relevance of the Health Cluster's actions include its role in *gathering and disseminating sound and relevant information to partners*, with 62% of respondents "strongly agreeing" and 26% "somewhat agreeing", totalling 88% positive responses, and only 4% disagreeing. This is true across the stakeholder groups. This is followed by the statement on strengthening the capacity of national systems coordinating health responses, which received 85% total positive responses (61% "strongly agree" and 24% "somewhat agree") and 6% negative responses. The third highest-rated statement was *identifying and addressing gaps in technical knowledge to ensure best practices*, with 81% positive responses (53% "strongly agree" and 28% "somewhat agree") and 4% negative responses. This is highly positively rated statement across the stakeholders' groups, with the WHO staff and other UN Agencies rating it slightly higher than other stakeholders, namely 87%, compared to Donors and INGOs (79%) and NGOs and National Health Authorities (73%).

Slightly lower response rates were noted for the statement on *promoting and advocating for the importance of humanitarian health action*, which received 80% positive responses (56% "strongly agree" and 24% "somewhat agree"), though 7% of respondents expressed uncertainty ("don't know"). Especially Donors and INGOs as well as WHO and UN Agencies strongly support the success of advocacy efforts, while this is lower for the National Health Authorities/NGOs with 16% considering it "not at all relevant" or "somewhat irrelevant". The lowest-ranked statement was *providing relevant guidance and standards contextualized for local conditions*, with 79% positive responses (49% "strongly agree" and 30% "somewhat agree") and 5% negative responses, along with a 6% of "don't know". Across the stakeholder groups, this remains one of the most divisive statements with the high level of positive responses for the Donors and INGOs (83%), but higher negative ranking by the National Health Authorities and NGOs (22%) compared to all other stakeholders.

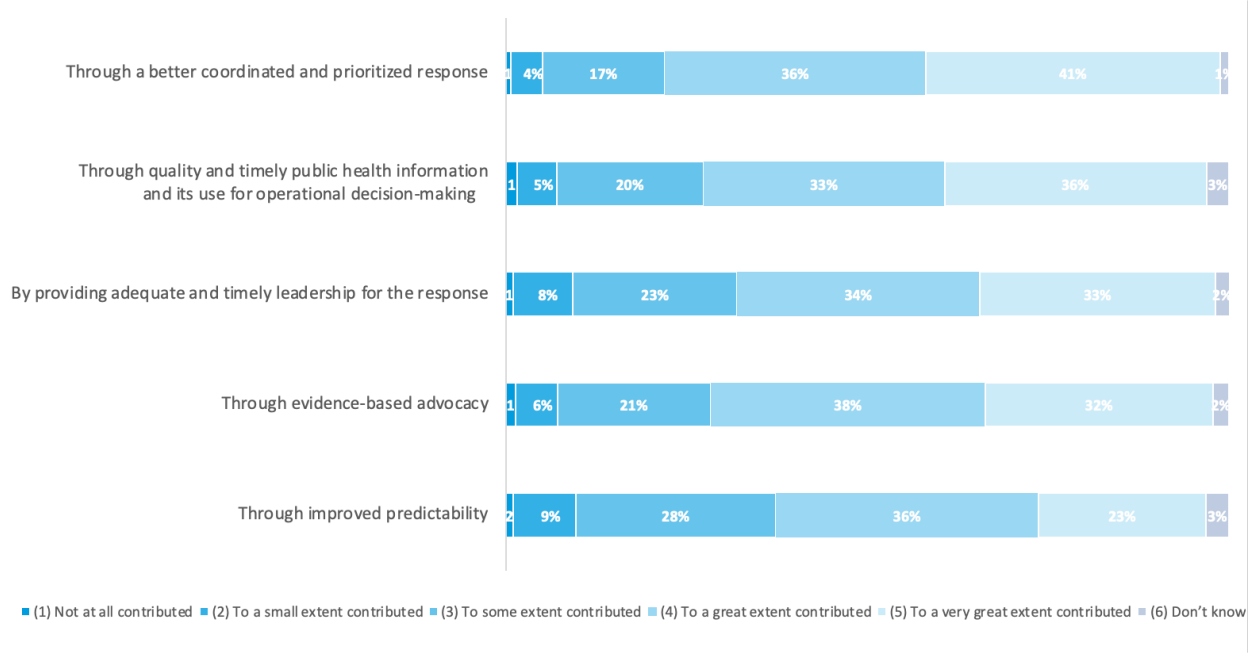
Commonalities:

- Across total, global, regional, and country levels, the highest-rated function of the Health Cluster is its role in gathering and disseminating relevant information to partners, consistently ranking as the most valued aspect of its work.
- The second most frequently endorsed function is the strengthening of national systems that coordinate health responses, particularly at the total and country levels, where it receives strong agreement.
- Identifying and addressing gaps in technical knowledge also emerges as a highly relevant function across levels, although slightly lower positive ratings appear at the global level, where it ranks lower compared to other functions.
- While still receiving majority positive responses, advocacy for humanitarian health action and contextualizing guidance for local conditions are consistently rated lower than other functions across all levels, indicating that these areas are perceived as weaker aspects of the Health Cluster's role.

Differences:

- Country-level respondents provide the most favourable assessments, showing higher strong agreement rates across nearly all functions, particularly for strengthening national health system capacity and disseminating information.
- At the global level, there is more variation in agreement, with the strongest approval given to information-sharing but lower ratings for technical knowledge and national health system strengthening. The Health Cluster's role in strengthening national health systems is rated significantly lower (only 43% positive response) at the global level, compared to 85% at the country level.
- At the regional level, strengthening national health systems ranks as the highest-rated function (94% total positive response), whereas advocacy for humanitarian health action is the lowest-rated function, with the highest level of disagreement and uncertainty compared to other levels.
- While gathering and disseminating information is rated highly at all levels, it is strongest at the country level (88%) and slightly lower at the regional level (67%).
- Technical knowledge is more highly rated at the regional and country levels than at the global level, where it has a lower percentage of strong agreement and higher disagreement.

Survey Question 9: To what extent has the Health Cluster contributed to an improved response using the following?



The survey results, **overall**, indicate that the Health Cluster's strongest contributions are in ensuring *better coordination and prioritization* (41% to a "very great extent" and 36% "to a great extent"), *providing quality and timely public health information* (33% to a "very great extent" and 36% "to a great extent"), and *adequate and timely leadership* (33% to a "very great extent" and 34% "to a great extent"), followed by *supporting evidence-based advocacy* (32% to a "very great extent" and 38% "to a great extent"). Stakeholders expressed notably less confidence in *predictability improvements* (only 23% to a "very great extent" and 36% "to a great extent").

At the **global level**, out of 21 respondents the highest-rated contribution of the Health Cluster is its ability to ensure a *better coordinated and prioritized response*, with 38% of respondents rating this as contributed "to a very great extent" and another 38% "to a great extent". Only 10% of respondents believed that the contribution was "to a small extent". The second-highest rated function is the *provision of quality and timely public health information for operational decision-making*, with 19% rating it as contributed "to a very great extent" and 43% to a great extent. Only 5% of respondents believe there was no contribution at all. The Health Cluster's role in *evidence-based advocacy* received 60% total positive responses, with 15% of respondents rating the contribution as "to a very great extent" and 45% of respondents as "to a great extent". However, 10% of respondents believed the contribution was "to a small extent".

Somewhat lower perception of the Health Cluster's contribution to an improved response was notable in reference to its ability to *provide adequate and timely leadership* with 52% total positive responses, inclusive of 5% of "to a very great extent" contributed" and 48% "to a great extent" contributed. A notable 19% of respondents believed the

contribution was minimal (5% "not at all contributed" and 14% "to a small extent" contributed"). The lowest-rated function was *improving predictability*, with only 48% of respondents rating the contribution as "to a very great extent", 29% and "to a great extent" 19%.

At the **regional level**, out of 15 respondents, the most highly rated contribution of the Health Cluster is its role in *providing quality and timely public health information* to support operational decision-making, with 47% of respondents rating this as contributing "to a great extent" and 33% "to a very great extent". The second-highest rated contribution is the Health Cluster's efforts in *evidence-based advocacy*, with 40% of respondents agreeing that it contributed "to a great extent" and 33% "to a very great extent", while 13% of respondents believed the contribution was only "to a small extent". The Health Cluster's role in ensuring a *better coordinated and prioritized* response received 67% positive feedback, with 40% of respondents rating the contribution as very great and 27% as great. A slightly lower level of positive feedback is observed in the *Health Cluster's efforts to improve predictability*, with 36% agreeing it contributed "to a great extent" and 29% "to a very great extent", while 29% of respondents only rated it as contributing to some extent. The lowest-rated area is the Health Cluster's ability to provide *adequate and timely leadership for the response*, with only 29% rating the contribution as great and 36% as very great. While the strong agreement percentage is relatively high, the fact that 21% of respondents rated the contribution as minimal (7% "not at all" and 14% "to a small extent").

Out of the **279 country-level**, stakeholders generally perceive the actions as effective, with highest positive responses from WHO and UN Agencies staff (93%) and the lowest overall positive responses (76%) from Donors and INGOs. The survey results indicate strong positive perceptions of the Health Cluster's contributions across multiple areas. The highest-rated statement was ensuring a *better coordinated and prioritized response*, with 78% of respondents rating it positively (42% "to a very great extent" and 36% "to a great extent") and only 4% negative responses. Similarly, *providing quality and timely public health information for operational decision-making* received 73% positive responses (40% "to a very great extent" and 33% "to a great extent"), with 6% negative responses and 4% "don't know".

Evidence-based advocacy and providing adequate and timely leadership for the response were also highly rated, each receiving 72% positive responses. For evidence-based advocacy, 33% rated it "to a very great extent" and 39% "to a great extent", while for *leadership*, 38% rated it "to a very great extent" and 34% "to a great extent". Both statements had 6% negative responses, with 3% "don't know" for leadership and 3% for advocacy. High positive confidence in these two statements was especially noted by the WHO staff, while it's somewhat lower for other stakeholders. The lowest-rated statement was *improving predictability*, with 63% positive responses (24% "to a very great extent" and 39% "to a great extent"), 8% negative responses, and 5% "don't know".

Commonalities:

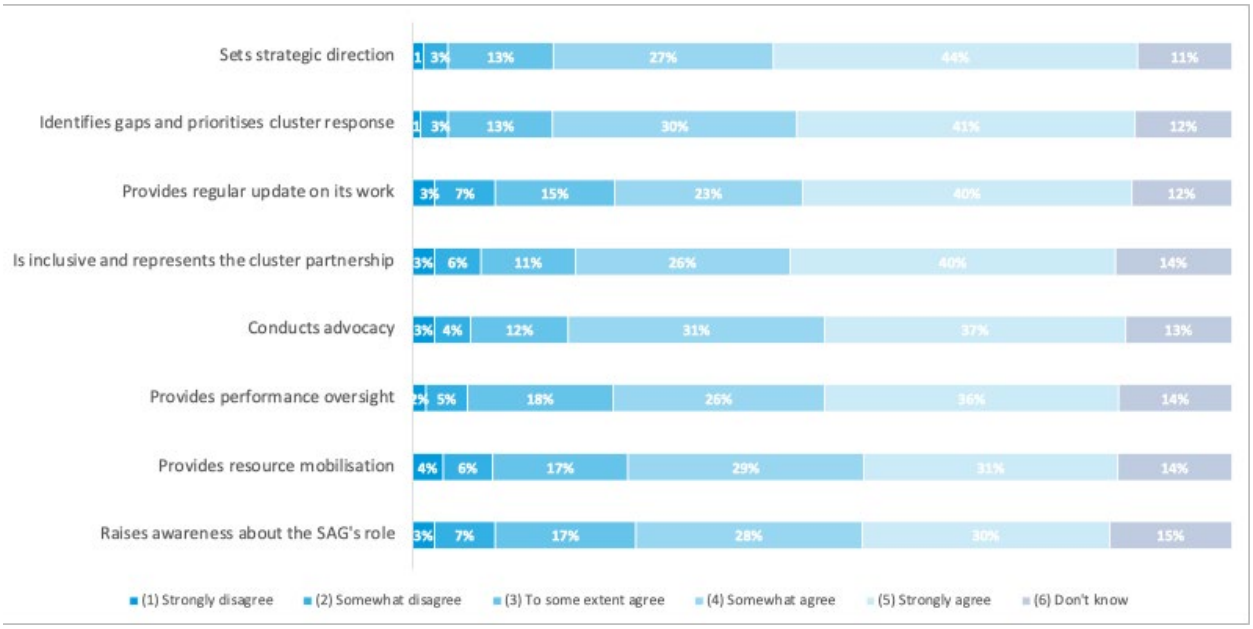
- Across total, global, regional, and country levels, the highest-rated contribution of the Health Cluster is its role in ensuring a better coordinated and prioritized response. This function consistently receives the strongest approval, with country-level respondents showing the highest positive ratings (78% total positive response), followed by global (76%), regional (67%), and total level (77%). The strong ratings across all levels reaffirm the Health Cluster's effectiveness in facilitating structured and well-organized responses.

- The provision of quality and timely public health information is also widely recognized as a key contribution. It ranks among the top two or three functions at all levels, reflecting broad agreement on its value for operational decision-making.
- Evidence-based advocacy and providing adequate and timely leadership are also consistently well-rated. While these functions do not always take the top spot, they receive strong positive responses across all levels, indicating that the Health Cluster's role in advocacy and leadership is appreciated, though slightly less than coordination and information-sharing.
- One clear trend across all levels is that the lowest-rated function is improving predictability. This function receives lower positive responses compared to other contributions, with respondents at all levels expressing some uncertainty or disagreement about its effectiveness.

Differences:

- Country-level respondents express the highest levels of satisfaction across all functions, particularly in coordination and public health information-sharing, where positive ratings exceed 70%.
- At the global level, responses are more varied, with higher disagreement rates than at the country level, particularly for leadership (19% negative) and predictability (29% negative), indicating a more cautious or critical perspective from global respondents.
- At the regional level, public health information-sharing ranks the highest, while leadership is rated the lowest, with 21% of respondents believing the Health Cluster's leadership contribution was
- The perception of predictability improvement varies across levels, but it is consistently the weakest-rated function, with global-level respondents being the most critical (only 48% total positive response), while country-level respondents are slightly more favourable (63% positive).

Survey Question 10: To what extent do you agree with the following statements regarding GHC Strategic Advisory Group's (SAG) role?



Overall, the survey results indicate that the GHC Strategic Advisory Group (SAG) is generally perceived as effective, particularly in *setting strategic direction and identifying gaps and prioritizing cluster responses* with a strong agreement rate of respectively 44% and 41% and agreement rate of respectively 27% and 30%. A slightly lower but still strong level of agreement is observed in the *GHC's 's advocacy efforts and inclusivity in representing the cluster partnership* with 37% and 40% of respondents, respectively, "strongly agreeing" with these statements and 31% and 26%, respectively, agreeing. *Performance oversight and resource mobilization* appear to be less strongly recognized aspects of the SAG's work, with only 36% and 31% of respondents, respectively, "strongly agreeing" that the SAG fulfils these roles effectively and 26% and 29% agreeing with it. A notable 18% of respondents agree to some extent that GHC provides performance oversight and 17% that it provides resource mobilization, with 14% respondents for each statement answering that they don't know. *Raising awareness about the SAG's role and the provision of regular updates* received moderate endorsement, with 30% and 40% of respondents "strongly agreeing", respectively and 28% and 23% agreeing, respectively. Moreover, these categories had some of the highest levels of uncertainty, with 15% and 12% of respondents selecting "don't know".

At the **global level**, the highest-rated functions of the GHC's SAG role are *setting the strategic direction and identifying gaps and prioritizing cluster response,* both receiving 52% total positive responses as well as 24% negative responses ("strongly disagree" and "somewhat disagree"). These are followed by the GHC's ability to *conduct advocacy and ensure inclusivity and represents the cluster partnership* which both received 38% total positive responses each, but also 33% negative responses each.

Somewhat lower rated was the SAG's *performance oversight* function which received 29% total positive responses, with 14% "strongly agree" and 14% "somewhat agree". Although negative responses, 29% are equal to positive ones, a notable additional 29% of respondents only agreed to some extent. The lowest-rated functions are "*provides*

regular update on its work" with 23% of total positive response, "*provides resource mobilization"* with 19% and "*raising awareness"* about the SAG's 14% total positive responses. While the first and the latter statement both received 38% of total negative responses ("strongly disagree", "somewhat disagree"), provides resource mobilization statement is notable the one with the highest total negative responses, with 48%.

At the **regional level**, out of 15 respondents, the two highest-rated functions of the SAG are its role in *setting strategic direction and identifying gaps and prioritizing the cluster response*, both receiving 69% total positive responses. With 38% of respondents "strongly agreeing" and 31% "somewhat agreeing". The SAG's role in *providing resource mobilization* ranked third, with 36% of respondents "somewhat agreeing" and 29% "strongly agreeing", totalling 65% positive responses. However, 29% of respondents selected "don't know". Further, the SAG's advocacy role received 60% total positive responses, with 33% "strongly agreeing" and 27% "somewhat agreeing" but also 27% of respondents selecting "don't know".

A lower level of confidence is observed in the following statements - *providing regular updates on its work,* with only 53% total positive responses and 27% of respondents selecting "don't know", while 7% somewhat disagreed; *is inclusive and represents the cluster partnership* with 50% total positive answers; *provides performance oversight* with 47% of total positive perception and 7% of somewhat disagree. A lowest rated area is the GHC's ability to *raise awareness* about its role, with only 47% of respondents expressing positive agreement and the highest percentage, 13%, of respondents who somewhat disagreed. 27% answered "don't know".

At the **country level** the survey results indicate strong positive perceptions of the GHC's Strategic Advisory Group (SAG) role across various areas, with the WHO and UN Agencies staff marking the most positive responses and Donors and INGOs most negative ones. The highest-rated function was *identifying gaps and prioritizing the cluster response*, with 71% of respondents rating it positively (39% "strongly agree" and 32% "somewhat agree") and only 3% negative responses. A notable 17% of respondents selected "don't know". Notable differences across stakeholder groups where WHO and UN Agencies staff mark 73% positive responses, Donors and INGOs 65%, while National Health Agencies/NGOs mark only 46%. Similarly, *setting strategic direction* received 70% positive responses (44% "strongly agree" and 26% "somewhat agree"), with only 2% disagreement. However, a high level, 17%, of "don't know" was noted. As above, WHO and other UN Agencies staff mark the highest positive perception values (73%), followed by Donors/NGOs (60%) and National Health Agencies/NGOs (59%). *Conducting advocacy* (64% positive, 5% negative) and is *inclusive and represents the cluster partnership* (63% positive, 5% negative) also received strong approval, though both statements had relatively higher levels of "don't know" responses (22% and 25%, respectively). *Providing resource mobilization and provides regular update on its work* both received a lower total positive rating, 60% total positive, and 5% and 7% total negative responses, respectively. The first statement received 19% and the latter 21% of "don't know". Notably, *provides regular update on its work* receives the lowest rating from the WHO and other UN Agencies staff (57%), followed by Donors/INGO (60%) and with the most positive perception noted by National Health Agencies/NGOs (63%). The lowest rated statements are *"provides performance oversight and raises awareness about the SAG's role"* with 58% and 57% of total positive responses, respectively and 5% and 7% of total negative responses, respectively. The first statement received 23% and the latter 25% of "don't know" feedback.

Commonalities:

- Across total, global, regional, and country levels, the highest-rated functions of the GHC Strategic Advisory Group (SAG) are its role in setting strategic direction and identifying gaps and prioritizing the cluster response. These functions consistently receive the strongest positive responses, with country-

level respondents rating them the highest (71% and 70% total positive responses, respectively), followed by regional (69%), global (52%), and total level (44% and 41%). This reinforces broad recognition of the SAG's effectiveness in guiding strategic priorities and shaping response coordination.

- The SAG's role in advocacy and ensuring inclusivity within the cluster partnership is also widely acknowledged but with slightly lower ratings than strategic functions. Across levels, respondents express moderate confidence in its advocacy efforts, with country-level respondents rating it the highest (64% total positive response) and global respondents the lowest (38%).
- One notable trend across all levels is that the lowest-rated functions are raising awareness about the SAG's role, providing performance oversight, and resource mobilization. These functions consistently receive the lowest positive feedback and the highest "don't know" responses, indicating either limited awareness or uncertainty about the SAG's effectiveness in these areas.

Differences:

- Country-level respondents express the highest levels of satisfaction, particularly regarding the SAG's ability to identify gaps and prioritize responses (71%) and set strategic direction (70%).
- At the global level, responses are more polarized, with higher disagreement rates, particularly on resource mobilization (48% negative) and raising awareness about the SAG's role (38% negative). The SAG's ability to provide regular updates also received one of the lowest positive ratings (23%).
- At the regional level, strategic direction and response prioritization are the highest-rated functions, but respondents also express notable uncertainty, with 29% selecting "don't know" on resource mobilization and 27% on advocacy and regular updates.
- At all levels, the SAG's role in raising awareness, providing oversight, and mobilizing resources is the weakest-rated function, with global-level respondents expressing the most dissatisfaction and country and regional respondents indicating more uncertainty than outright disagreement.

Survey Question 11: In your opinion, what are the three main factors that have enhanced the Health Cluster's contribution to an improved response to a humanitarian crisis or public health emergency?

In total, survey shows a vast number of references pointing to three following strength areas of the Health Cluster's efforts ensuring its's improved response to humanitarian crisis and public health emergencies: **(i) coordination efforts, (ii) data-driven decision-making, and (iii) strengthened local capacities to ensure an effective response to humanitarian crises and public health emergencies.**

One of the most frequently highlighted strengths of the Health Cluster is its **strong coordination and collaboration** among diverse stakeholders. Respondents consistently recognized the Health Cluster as a vital platform that unites international organizations, national governments, NGOs, and local actors, ensuring a more efficient and streamlined response to health crises. Through well-established coordination mechanisms, the Health Cluster fosters inclusive partnerships and structured communication, enabling stakeholders to align their efforts, prevent duplication, and

maximize impact. Regular meetings and active engagement at both national and subnational levels ensure that responses are adapted to local needs, making interventions more effective. In contexts where engagement with local authorities was strong, such as in Ukraine, South Sudan (at times), and parts of the Sahel region, the Health Cluster was recognized for its ability to harmonize responses, facilitate collaboration, and provide a platform for collective decision-making. This collaborative approach strengthens the overall response capacity, allowing organizations to leverage their collective expertise and work toward sustainable health solutions.

Another critical factor contributing to the success of the Health Cluster is its commitment to **data-driven decision-making and effective information management.** Respondents emphasized the importance of reliable and timely data collection, which allows for real-time tracking of health crises and facilitates proactive, informed decision-making. By utilizing tools such as disease surveillance systems, mapping of healthcare actors, and regular assessments, the Health Cluster enables health responders to identify priority needs, detect emerging threats early, and optimize resource allocation. Additionally, transparent information sharing fosters trust and accountability, ensuring that all stakeholders have access to relevant and up-to-date data. This systematic approach to information management strengthens coordination efforts and enhances the overall effectiveness of emergency health interventions.

A third key strength repeatedly mentioned in the responses is the Health Cluster's role in **capacity building and a rapid resource mobilization.** Respondents highlighted the positive impact of skill development initiatives, including structured training programs, which empower healthcare workers and partners to manage crises more effectively. Additionally, resource mobilization efforts have successfully secured critical funding and logistical support, enabling the timely delivery of health services in emergency settings. The Health Cluster's ability to engage donors and advocate for sustained funding further reinforces the resilience of health interventions, ensuring that the necessary resources are available to strengthen emergency preparedness and response capacity.

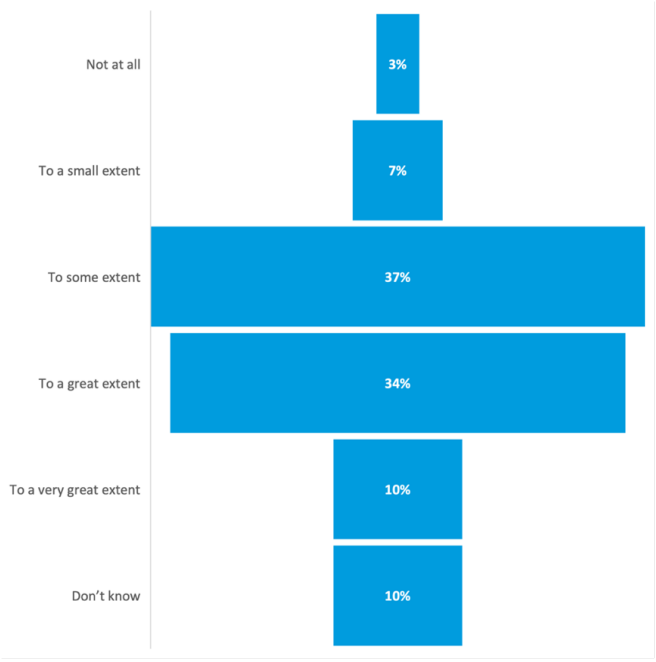
Survey Question 12: In your opinion, what are the three main factors that have limited the Health Cluster's contribution to an improved response to a humanitarian crisis or public health emergency?

The effectiveness of the Health Cluster in responding to humanitarian crises and public health emergencies is significantly impacted by three major challenges: **coordination difficulties, resource limitations, and political and security constraints.** These factors consistently emerge as the most significant barriers, undermining the efficiency and sustainability of health interventions.

Despite the above-mentioned praises for the GHC's role in coordination and collaboration, **coordination** also surfaced as one of the most frequently cited limitations, reiterating the complexity of coordination efforts as a part of the GHC's role. Survey shows that in some contexts, coordination mechanisms were fragmented, with various organizations, including UN agencies and INGOs, operating in silos rather than working towards a unified response. In several cases, local NGOs and government actors were either insufficiently engaged or sidelined altogether, leading to a lack of ownership and sustainability in interventions. Leadership challenges and a lack of strategic direction further weakened coordination structures in certain countries. The inability to harmonize health sector strategies with other humanitarian and development programs results in overlapping efforts, delays in response, and a failure to address critical gaps. Political barriers, government interference, and bureaucratic restrictions, particularly in

Myanmar, Afghanistan, and the Occupied Palestinian Territories, created additional obstacles, limiting the Health Cluster's ability to coordinate effectively and restricting humanitarian access.

Another major and complex obstacle is the **lack of sufficient financial resources and capacity constraints,** that hinder the full realization of its efforts. A lack of adequate financial resources, coupled with restricted donor interest as well as their coordination emerges a major challenge for effective work of the Global Health Cluster. This has further direct repercussions on the technical capacity where many respondents noted that short-term donor funding cycles make it difficult to establish sustainable training programs, and when funding priorities shift, critical capacity-building efforts are often disrupted. While some areas benefit from strong capacity-building initiatives, others—especially at the local level—receive inadequate training and funding. Moreover, even where training programs exist, retaining trained personnel remains a challenge.



The third critical challenge is the **sociopolitical and security constraints** that significantly impact health responses in conflict-affected and fragile settings. Political instability, governance challenges, and restrictive government policies often limit the cluster's ability to operate effectively. In many regions, national regulations create barriers to the importation of medical supplies and the deployment of emergency response teams. Additionally, access to affected populations is often hindered by security threats, including armed conflict, infrastructure destruction, and geographical inaccessibility. Logistical constraints, such as poor road conditions and bureaucratic restrictions on movement, further delay the delivery of essential health services. Political interference, including biased decision-making in funding allocation and restrictions on humanitarian engagement, also compromises the neutrality and effectiveness of the cluster.

Survey Question 13. To what extent has the Health Cluster reduced the duplication of available resources?

Overall, the survey results indicate a mixed perception of the Health Cluster's effectiveness in reducing resource duplication. The largest proportion of respondents, 37%, believe duplication has been reduced only to some extent, followed by 34% of respondents that consider it reduced "to a great extent". Only 10% perceive that Health Cluster reduced the duplication of available resources. Additionally, 3% believe duplication has not been reduced at all, and 7% think it has only been minimized "to a small extent". "Don't know", was selected by 10% of respondents.

At the **global level,** out of 21 respondents 38% of respondents responded with "to a great extent", while an equal 38% rated Health Cluster's reduction of the duplication of available resources as "to some extent". Only 5% rated it as "not at all", additionally, 10% of respondents selected "don't know".

At the **regional level**, out of 15 respondents, **20% of respondents rated it as "to a very great extent", another 7% perceive it as "to a great extent" and the largest proportion of respondents, 33% believe that GHC has been successful in resource duplication only "to some extent". Conversely, 20% of respondents believe that the GHC has been successful on this aspect "to a small extent" and further 20% selected "don't know".**

At the **country level**, the survey results indicate that 75% of respondents provided a positive rating, with 40% stating "to a great extent" and 7% "to a very great extent," while 35% selected "to some extent". Conversely, negative responses remain minimal, with only 3% selecting "not at all" and 4% "to a small extent", totalling just 7% negative perception. 11% of respondents selected "don't know". Across the stakeholders, WHO and UN Agencies staff reports the highest level of agreement (48% "to some extent agree" and only 6% "to a very great extent"), followed by National Health Agencies and NGO with 44% of total positive responses and Donors and INGO with 43%.

Commonalities:

- Across total, global, regional, and country levels, there is a mixed perception regarding the Health Cluster's effectiveness in reducing resource duplication. While positive ratings outweigh negative ones at all levels, the most frequently selected response across total, global, and regional levels is that duplication has been reduced "only to some extent".
- At all levels, a smaller proportion of respondents believe duplication has been significantly reduced, with few selecting "to a very great extent" as their response. Additionally, across levels, there is a consistent level of uncertainty, with a notable portion of respondents selecting "don't know" (ranging from 10% at the total level to 20% at the regional level).
- Negative responses remain relatively low at all levels.

Differences:

- Country-level respondents express the highest levels of confidence in the Health Cluster's efforts to reduce duplication, with 75% providing a positive rating (40% ""to a great extent"," 7% "to a very great extent"). This is significantly higher than at the global and regional levels, where the dominant response is "to some extent."
- At the global level, responses are evenly split between "to a great extent" and "to some extent" (both 38%).
- At the regional level, scepticism is higher, with only 7% selecting "to a great extent" and 20% believing the Health Cluster's success in reducing duplication is minimal ("to a small extent"). Additionally, 20% selected "don't know".
- At the total level, responses mirror the global trend, with the largest group (37%) selecting "to some extent" and only 10% believing duplication has been reduced "to a very great extent".

Survey Question 14: To what extent has the Health Cluster maximized the use of available resources?

Overall, stakeholders generally acknowledge the Health Cluster's efforts in maximizing the use of available resources, though perceptions are varied. The largest proportion of respondents, 37%, believe that resource utilization has been effective only to some extent, indicating that while some efficiencies have been achieved, there is still room for optimization. A significant 34% of respondents agree that resources have been used “to a great extent”, however, only 15% believe this has been maximized to a very great extent. Only 2% believe resources have not been maximized at all, and 5% think this has been done “to a small extent”. The 7% of respondents who answered, “don’t know”.

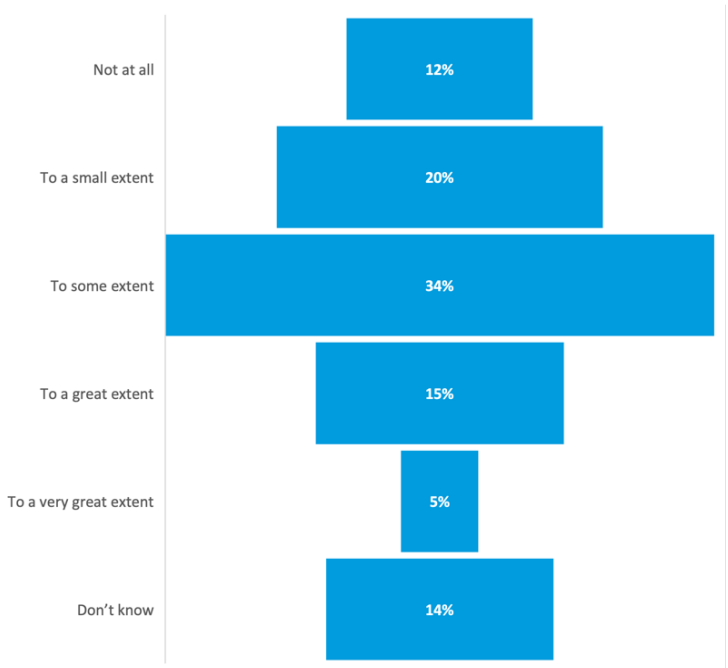
At the **global level**, out of 21 respondents, 43% rated the Health Cluster’s maximization of available resources as "to some extent" and 29% as “to a great extent”. However, 10% of respondents responded with “not at all“, and another 10% rated it as only “to a small extent”. Additionally, 10% of respondents answered, “don’t know”.

At the **regional level**, out of 15 respondents, 27% consider to a very great that the HC maximized the use of resources, followed by 13% who perceive it “to a great extent” and 40% to some extent. 7% of respondents responded with “to a small extent” and 13% with “don’t know”.

At the **country level**, the survey results indicate that 47% of respondents provided a positive rating, with 32% selecting “to a great extent”, 15% “to a very great extent”, while the majority of respondents opted for a “to some extent” 39%. Negative responses were minimal, with only 2% selecting "not at all" and 3% “to a small extent”, totalling just 5% negative perception. 9% of respondents selected “don’t know”. Across the stakeholders, WHO and other UN Agencies staff show notably higher positive perception with 54% of total positive responses, followed by Donors and INGOs with 47% and finally National Health Agencies and NGOs with only 37% and highest medium positive perception, “to some extent” 45%.

Commonalities:

- Across total, global, regional, and country levels, there is a mixed perception of the Health Cluster’s effectiveness in maximizing the use of available resources. While positive responses outweigh negative ones at all levels, the most frequently selected response across total, global, regional, and country levels is that resource utilization has been effective "only to some extent".
- At all levels, a smaller proportion of respondents believe that resource maximization has been achieved “to a very great extent”, with only 15% at both the total and country levels, 27% at the regional level, and no strong agreement at the global level.



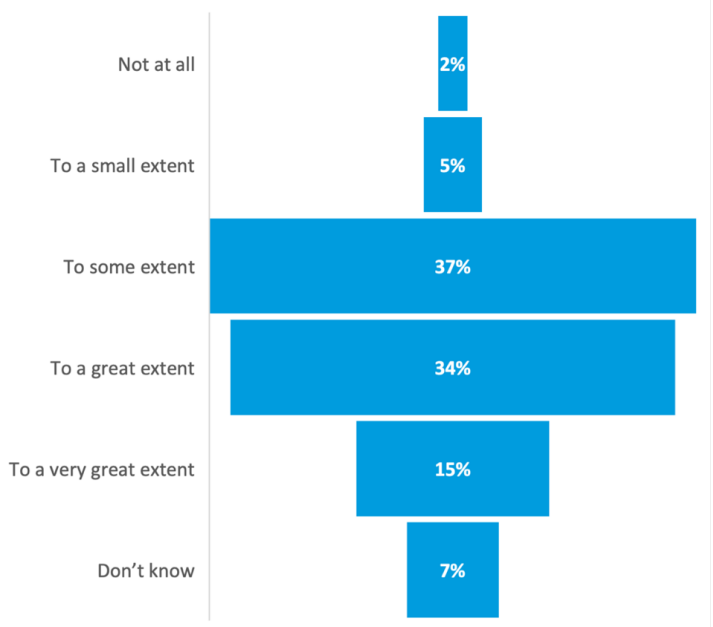
- Negative responses remain relatively low across all levels

Differences:

- Country-level respondents express the highest level of confidence in resource maximization, with 47% providing a positive rating (32% “to a great extent”, 15% “to a very great extent”), which is higher than global and total levels, where fewer respondents rated it as effective to a very great extent. However, 39% still selected “to some extent”.
- At the global level, responses are more critical, with 43% rating the effectiveness as “to some extent” and only 29% as “to a great extent”. Notably, 10% believe the Health Cluster has not maximized resources at all.
- At the regional level, positive ratings are slightly higher than at the global level, but responses remain cautious, with 40% selecting “to some extent”, 27% “to a very great extent”, and 13% responding with “don’t know”, indicating more uncertainty than at other levels.
- At the total level, responses closely align with the global and country perspectives, with 37% selecting “to some extent”,34% “to a great extent”, and 15% “to a very great extent”. This reinforces the general perception that while resource utilization is recognized, it is not yet fully optimized.

Survey Question 15: Does the Health Cluster have sufficient resources to fulfil its responsibilities?

Overall, the majority of respondents (34%) believe that resources are available only to some extent, with further 32% of respondents (12% not at all and 20% “to a small extent”) indicating that the Health Cluster has insufficient resources. Only 15% believe resources are available “to a great extent”, and a mere 5% state that resources are fully sufficient (“to a very great extent”).



At the **global level**, out of 21 respondents, 24% selected "not at all" and an additional 24% choosing “to a small extent”, totalling 48% negative responses. Meanwhile, 29% believe that Health Cluster has sufficient resources to fulfil its responsibilities “to some extent”, but only 5% rated it as “to a great extent” or ”to a very great extent”, each. Additionally, 14% of respondents selected “don’t know”.

At the **regional level,** out of 15 respondents, 26% responded positively ("to a very great extent" and "to a great extent"). The highest percentage of respondents, 40%, responded with "to some extent", while total of 33% tended to more negative perception, with 20% responding with "to a small extent" and 13% with "not at all".

Out of the **279 country level respondents**, only 13% of respondents provided a positive rating, 11% "to a great extent", and only 2% "to a very great extent", while the majority of respondents, 35%, selected "to some extent". Conversely, 37% of respondents expressed negative perceptions, with 10% selecting "not at all" and 27% "to a small extent". Additionally, 15% of respondents selected "don't know". Across the stakeholder groups, National Health Agencies and NGOs are the most divided group with the highest percentages of respondents claiming that Health Cluster has sufficient resources, 21%, but also high number, 40%, considering that they don't have enough resources. Only 9% of WHO and UN Agencies staff perceive their resources as sufficient while on contrary, 40% consider that they don't have enough resources. 28% of Donors and INGOs consider that the Health Clusters don't have enough resources and 11% are of the positive opinion.

Commonalities:

- Across total, global, regional, and country levels, there is a widespread perception that the Health Cluster lacks sufficient resources to effectively fulfil its responsibilities. The most frequently selected response at all levels is that resources are available "only to some extent".
- Negative perceptions about resource availability are strong at all levels, with a significant proportion of respondents selecting either "not at all" or "to a small extent". At both global and country levels, negative responses exceed 35%, reflecting a broad consensus that the Health Cluster faces resource constraints.
- At all levels, very few respondents believe resources are fully sufficient ("to a very great extent"), with only 5% at the global level, 2% at the country level, and 5% at the total level selecting this option. Additionally, there is a consistent level of "don't know" responses.

Differences:

- Country-level respondents express the most concern about resource shortages, with only 13% providing a positive rating, compared to 26% at the regional level and 15% at the total level. Additionally, 37% of country-level respondents express negative perceptions, the highest among all levels.
- At the global level, respondents are equally critical, with 48% negative responses (24% selecting "not at all" and 24% selecting "to a small extent"), the highest proportion of outright disagreement across all levels.
- Regional-level respondents are slightly more positive, with 26% agreeing that resources are sufficient "to a great extent" or "to a very great extent", a significantly higher percentage than at the global (10%) and country (13%) levels. However, 40% still selected "to some extent".

At the total level, responses align closely with the global trend, with 32% negative responses and only 15% believing resources are available "to a great extent".

Survey Question 16: To what extent has the Health Cluster improved coherence and co-ordination through:

Overall, stakeholders perceive the Health Cluster made significant improvements in co-ordination and collaboration efforts, particularly through *coordinating with other international and national mechanisms* where 46% of respondents reported that it improved "to a great extent", and 26% to a very great extent. Similarly, *joint working with Health Cluster partners* received a strong endorsement, with 41% agreeing that it has improved "to a great extent" and 31% to a very great extent. The survey reveals mixed perceptions regarding *engagement in inter-cluster and multi-sector collaboration*, with 28% agreeing to a very great extent, 37% agreeing that it has improved "to a great extent", but 24% only to some extent. A similar pattern is observed in *meaningful engagement of relevant stakeholders, particularly National/Local NGOs*, where 35% see very great improvement, 32% improvement "to a great extent", but 20% only to some extent. As for the statement on strengthening co-ordination for local, national, regional and global action to prevent, prepare for, respond and recover from public health and humanitarian emergencies, 23% of respondents agreed with it to a "very great extent" and 42% "to a great extent".

Shared leadership through the establishment of co-coordinators at national and sub-national levels shows a fairly strong endorsement with 29% "very great extent" and 34% great extent, however, 22% participants rated it as improving only to some extent. Similarly, *ensuring local partners' decision-making power* received mixed ratings, with and 22% of participants noting that it has improved to a very great extent, 32% "to a great extent" and 26% stating it has improved only to some extent. No significant difference in perception when it comes to Global Health Cluster's improvement of coherence and co-ordination through *supporting the operational needs of implementing partners, including capacity strengthening*, with 22% agreeing with the statement "to a very great extent", 39% "to great extent" but 21% only "to some extent".

The lowest total high improvement rate was noted for *ensuring local partners' decision-making power in the planning and delivery of humanitarian assistance*, with 22% rating it as improved to a "very great extent" and 32% as improved "to a great extent".

On a **global level,** the most positively rated statement was strengthening co-ordination across different levels of action, with 40% of respondents rating this as "to a very great extent" and 27% "to a great extent", while 14% rated it as "not at all improved" and "to a small extent" improved." Joint working with Health Cluster partners to deliver actions, received 10% responses as "to a very great extent" and 57% responses as improved "to a great extent". Only 10% rated this statement with "not at all" and ""to a small extent"". This statement was followed by coordination with international and national co-ordination mechanisms, with 14% rating this statement as "to a very great extent" and 48% as "to a great extent", while 10% rated it as "not at all" and "to a small extent"". Joint working within WHO received 48% total positive responses, while 10% of respondents rated it as "not at all improved," and another 5% rated it as "to a small extent" improved".

Ensuring local partners' decision-making power in planning and delivery and Shared leadership through co-coordinators at national and sub-national level received both 46% total positive responses, as well as notable 27% of total negative responses, inclusive of "not at all improved" and "to a small extent" improved". Further on the lower ranking end are the statements *Meaningful engagement of relevant stakeholders, including national and local actors, and Engagement in inter-cluster and multi-sector collaboration* which both received 43% of total positive perception

and 24% and only 10% of total negative opinions, respectively, while the statement *Supporting the operational needs of implementing partners, including capacity strengthening* also received 43% of total positive opinion and the highest total negative perception of 28%.

For a **regional level data**, out of 15 respondents, the **highest-rated function** of the Health Cluster is **its ability to meaningfully engage relevant stakeholders, including national and local actors, with 47% rating this as a tool to improve coherence and co-ordination "to a great extent" and 33% "to a very great extent".** The second-highest rated function is the Health Cluster's role in facilitating inter-cluster and multi-sector collaboration, with 40% of respondents rating it as improved "to a great extent" and 33% to a "very great extent" and 13% of respondents as "to a small extent", followed by the joint working within WHO to deliver Health Cluster actions, also with 73% total positive responses. Similar feedback was noted regarding the Health Cluster's coordination with other international and national mechanisms, with 43% agreeing it improved "to a great extent" and 29% "to a very great extent". Strengthening co-ordination for local, national, regional and global action to prevent, prepare for, respond and recover from public health and humanitarian emergencies received 67% positive perception as well as 14% of negative, "not at all improved" and "to a small extent" improved, followed by joint working with Health Cluster partners to deliver Health Cluster actions with 21% of "to a "very great extent" improved", 43% "to a great extent" improved and 36% "to some extent improved".

The lowest improvement rate was noted for *ensuring local partners' decision making power in the planning and delivery of humanitarian assistance, shared leadership through establishment of co-coordinators at national and sub-national level including by National/Local NGO, and supporting the operational needs of implementing partners, including capacity strengthening*, with respectively 46%, 46% and 43% of total positive answers ("to a very great extent" improved and "to a great extent" improved) and 27%, 27% and 28% of total negative answers ("not at all" improved and "to a small extent" improved).

On a **country level**, the survey results indicate a strong overall positive perception of Health Cluster's improvement of co-ordination and coherence through different strategies, with most areas receiving high approval ratings, whereas the highest positive sentiment is noted within WHO and other UN Agencies staff, followed by Donors and INGOs, and finally the National Health Authorities and NGOs with the lowest positive ranking. The highest-rated statement is joint working with Health Cluster partners to deliver Health Cluster actions with 66% positive responses, (29% "to a "very great extent" improved and 37% "to a very great extent" improved, followed by meaningful engagement of relevant stakeholders, including national and local actors, and support for the operational needs of implementing partners, including capacity strengthening, both receiving 66% positive responses. A strong 35% selected "to a very great extent," and 31% "to a great extent" for stakeholder engagement, 23% "to a very great extent," and 43% "to a great extent" for supporting the operational needs of implementing partners, including capacity strengthening. However, 12% of respondents rated the latter negatively, the highest negative response among the highly rated statements. Across all three statements, there is a slightly higher positive experience among the WHO and other UN Agencies staff, especially for the last statement with their total positive response 74% compared to 63% for Donors/INGO and 59% for National Health Authorities and NGOs. Strengthening coordination for local, national, regional, and global action to prevent, prepare for, and respond to emergencies followed closely with 65% positive responses. Within this, 42% rated it "to a great extent" and 23% "to a very great extent." Coordination with other international and national coordination mechanisms similarly received 65% positive responses, with 41% rating it "to a great extent" and 24% „to a very great extent" and only 7% giving negative feedback. Different than for other statements, the highest positive ranking is marked by Donors and INGOs (69%), followed by National Health

Authorities and NGOs (67%) and lastly WHO staff (63%). Engagement in inter-cluster and multi-sector collaboration was positively rated by 63% of respondents, with similar sentiment across the stakeholder groups, while joint working within WHO to deliver Health Cluster actions received 62% total positive responses (32% to a "very great extent" and 30% "to a great extent") and only 7% total negative responses. Within the stakeholders, WHO and other UN Agencies staff mark the highest positive notion (68%), while Donors and INGOs mark notably lower positive score (49%).

On the lower end of positive ranking, *ensuring local partners' decision-making power in humanitarian response* and *ensuring local partner's decision-making in humanitarian assistance* were both perceived positive with a total value of 57%, both with only 9% of total negative answers. Both statements mark somewhat higher positive notion by the WHO and other UN Agencies staff.

Commonalities:

Across total, global, regional, and country levels, the highest-rated areas of improvement in the Health Cluster's coordination and collaboration efforts include:

- Joint working with Health Cluster partners to deliver actions – This function consistently receives the highest levels of positive feedback, particularly at the country level (66% total positive), followed by total (72%), global (67%), and regional (64%). This suggests a strong perception that collaboration among Health Cluster partners has improved significantly.
- Coordination with international and national mechanisms – This function also receives strong approval across levels, reinforcing broad recognition of the Health Cluster's role in aligning efforts between national and global actors.
- Meaningful engagement of relevant stakeholders, including national and local actors – While positively rated across levels, this area also shows mixed perceptions, particularly regarding the depth of engagement and inclusivity.
- Inter-cluster and multi-sector collaboration – While viewed as an area of relative improvement, the feedback is more varied compared to direct Health Cluster coordination efforts, with a significant portion of respondents across levels stating that improvements have been achieved only "to some extent".

The lowest-rated areas across all levels include:

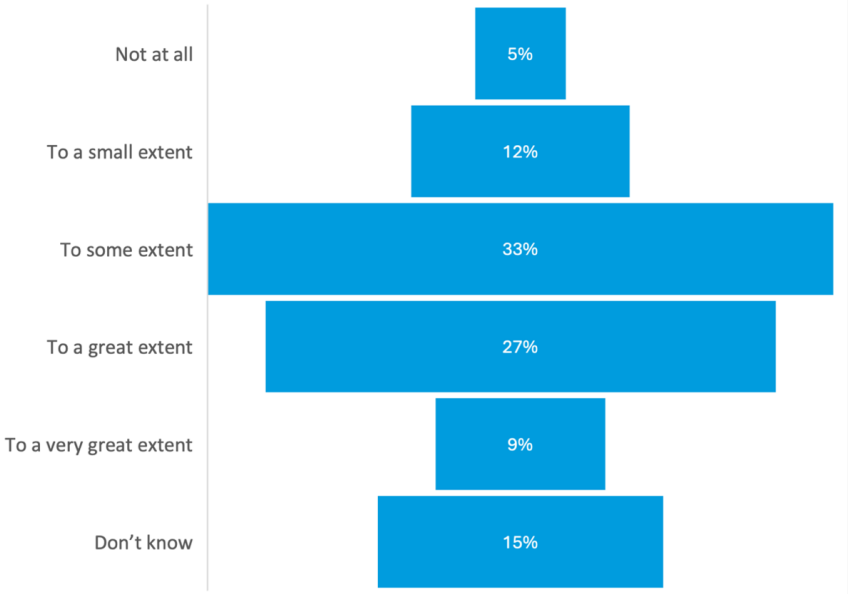
- Ensuring local partners' decision-making power – This function consistently receives the weakest ratings, with lower total positive responses and higher uncertainty or negative ratings. This suggests that despite efforts, full inclusion of local actors in decision-making remains a challenge.
- Shared leadership through co-coordinators at national and sub-national levels – While there is some recognition of progress, particularly at the regional and country levels, negative responses are relatively high across all levels, reflecting ongoing concerns about leadership structures and local partner involvement.
- Supporting the operational needs of implementing partners, including capacity strengthening – While receiving moderate positive feedback, this function also has a relatively high level of negative perception, particularly at the global and regional levels, suggesting that capacity-building efforts may not be reaching all partners effectively.

Differences:

- Country-level respondents express the strongest overall confidence in coordination improvements, with higher total positive ratings in most categories, particularly in joint working with partners (66%) and supporting the operational needs of implementing partners (66%).
- At the global level, perceptions are more mixed, with higher levels of negative responses (27%-28%) for local partner decision-making power, shared leadership, and operational support. Strengthening coordination across different levels of action is the highest-rated function at this level (67% positive response), reflecting a greater focus on system-wide integration rather than localized efforts.
- At the regional level, engagement of relevant stakeholders is the highest-rated function (80% total positive responses), while perceptions about leadership and decision-making power remain weaker.
- At the total level, responses closely align with country and regional perspectives, with higher endorsement for direct Health Cluster collaboration but mixed responses for inclusivity and leadership.

Survey Question 17: To what extent has WHO as CLA strengthened the link between the humanitarian response and development and peace planning and programming?

Overall, the survey results suggest that stakeholders have mixed perceptions about WHO's effectiveness as a Cluster Lead Agency (CLA) in strengthening the link between humanitarian response, development, and peace planning. The largest proportion of respondents, 33% believe progress has been made only to some extent, followed by 27% of respondents who responded with "to a great extent". Only 9% responded with "to a very great extent". Conversely, 17% of respondents (5% "not at all" and 12% "to a small extent") believe that WHO has made minimal progress in this area. Furthermore, 15% of respondents selected "don't know".



On a **global level**, the largest proportion of respondents, 29%, believe that WHO as CLA strengthened the link between the humanitarian response and development and peace planning and programming only “to a small extent” and further 19% of respondents stated, “not at all”. Only 10% rated it as “to a great extent”, and 5% as “to a very great extent”. A significant 24% selected "don’t know”.

On a **regional level**, out of 15 respondents, 20% rated that WHO, in its role as CLA strengthened the link between the humanitarian response and development and peace planning and programming “to a great extent” and 20% to a very great extent. The largest proportion, 33%, believe the improvement is only to some extent, while 13% of respondents selected “not at all”, and another 13% answered “don’t know”.

On a **country level**, majority of respondents, 36%, believe that WHO as CLA strengthened the link between the humanitarian response and development and peace planning and programming only to some extent, followed by 21% who indicated improvement “to a great extent”, while 10% felt that it was “to a very great extent”. On the other hand, 13% of respondents assessed the improvement as “to a small extent”, and only 2% reported “not at all”. Meanwhile, 17% selected “don’t know”. Among the stakeholders, National Health Authorities and NGOs hold the most positive opinion with 35% of total positive answers, followed by WHO and UN Agencies, 32%, and Donors and INGOs with the least positive perception, 25%.

Commonalities:

- Across total, global, regional, and country levels, there is a widely shared perception that WHO as the Cluster Lead Agency (CLA) has made only limited progress in strengthening the link between humanitarian response, development, and peace planning. The most frequently selected response across all levels is that progress has been made "only to some extent".
- Negative perceptions, while not dominant, are present at all levels, with global-level respondents expressing the highest level of dissatisfaction (48% total negative responses, including 29% "“to a small extent”" and 19% "not at all"). Meanwhile, country- and regional-level respondents report somewhat lower levels of negative feedback, but still indicate that progress has been minimal.
- Across all levels, only a small proportion of respondents believe that WHO has made significant progress (“to a very great extent”), with this response never exceeding 10% at the total and country levels and reaching only 5% at the global level.
- A notable trend across all levels is the high proportion of “don’t know” responses, ranging from 13% at the regional level to 24% at the global level.

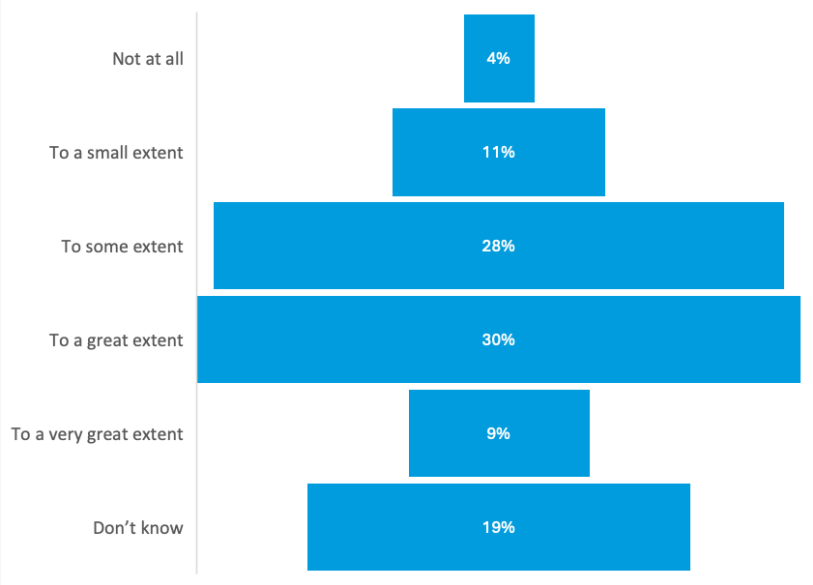
Differences:

- Country-level respondents express the most moderate view, with 36% stating that progress has been made "to some extent" and only 12% negative feedback (“to a small extent” or "not at all"), the lowest level of dissatisfaction among all groups. However, 17% opted for “don’t know”.
- At the global level, responses are the most critical, with 48% total negative responses and only 15% total positive responses (“to a great extent” or “to a very great extent”), the lowest approval rating across all levels. Additionally, 24% of respondents selected “don’t know”.

- At the regional level, responses are more balanced, with 40% total positive responses ("to a great extent" and "to a very great extent"), the highest among all levels. However, negative responses still account for 26% and 13% responded with “don’t know”.
- At the total level, responses closely align with the country-level trend, with 33% selecting "to some extent" and 27% "to a great extent”, but only 9% "to a very great extent." However, the total level has slightly more negative feedback (17%) than the country level (12%), indicating a more reserved view of WHO’s role in this area when looking at the overall picture.

Survey Question 18: To what extent has the Health Cluster supported cluster transition and deactivation?

Overall, the survey results suggest that stakeholders have mixed perceptions about the Health Cluster’s effectiveness in supporting cluster transition and deactivation. The largest proportion of respondents, 36%, selected “don’t know”. Among those with an opinion, 26% believe it has been made only to some extent, followed by 16% of respondents who rated it as “to a great extent”, while only 4% expressed strong confidence by selecting “to a very great extent”. Conversely, 18% of respondents (5% "not at all" and 13% “to a small extent” believe that the Health Cluster has made minimal progress in this area.



On a **global level**, the highest percentage, 30% selected “don’t know”, indicating that many respondents lack awareness or information on the issue. Responses were evenly split between “to a small extent” 25% and “to some extent”, 25%, while only 10% rated it as “to a great extent”. A notable 10% stated “not at all”.

On a **regional level**, out of 15 respondents only 13% rated the improvement as "to a very great extent," while another 13% selected “to a great extent” and 13% respondents believe that Health Cluster supported cluster transition and deactivation only to some extent. 20% of respondents responded with a “to a small extent”, while 33% of respondents selecting “don’t know”, the highest ratio of all answers.

On a **country level**, data shows that the largest proportion of respondents, 35%, selected “don’t know”. Positive perception was noted by 2% of respondents who responded with to a very great extent, 24% of respondents who rated the improvement” to a great extent”, while 26% believe that Health Cluster supported cluster transition and deactivation to some extent. Meanwhile, 10% of respondents responded with” to a small extent” and a small percentage (3%) reported not at all. While the trends are similar across the stakeholders, WHO and Other UN Agencies staff hold the most positive perception with 31%, followed by National Health Authorities and NGOS, 29% and Donors and INGOs with only 15% and high level of “don’t know”, 41%.

Similarities:

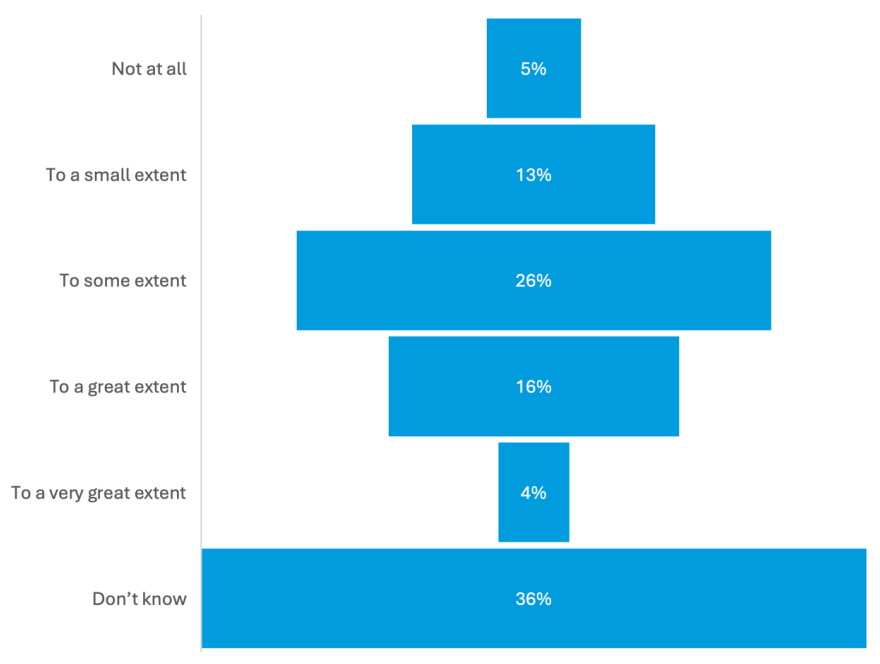
- Across total, global, regional, and country levels, stakeholders exhibit significant uncertainty regarding the Health Cluster’s effectiveness in supporting cluster transition and deactivation. This is reflected in the high proportion of “don’t know” responses, which range from 30% at the global level to 36% at the total level and 35% at the country level, with the regional level recording the highest uncertainty (33%).
- Among those with an opinion, the most frequently selected response across all levels is that progress has been made "only to some extent," reinforcing the perception that efforts in this area remain limited or unclear.
- Few respondents express strong confidence in the Health Cluster’s effectiveness in this area, with only 4% at the total level, 2% at the country level, 13% at the regional level, and 10% at the global level selecting “to a very great extent”.
- Negative perceptions, while not dominant, are present at all levels, with the highest levels of dissatisfaction observed at the global level (35% total negative responses: 25% “to a small extent” and 10% “not at all”) and the regional level (33% total negative responses: 20% “to a small extent” and 13% "not at all").

Differences:

- Country-level respondents exhibit the highest uncertainty, with 35% selecting “don’t know”, slightly lower than the total level (36%) but higher than the global (30%) and regional (33%) levels. Despite this uncertainty, 26% believe progress has been made “to some extent”, and 24% state that progress has been achieved “to a great extent”, the highest positive perception among all levels.
- Global-level respondents are the most critical, with only 10% providing a strong positive rating (“to a great extent”) and the highest level of negative responses (35%).
- At the regional level, responses are highly polarized, with the highest proportion of “to a very great extent” responses (13%) but also significant uncertainty (33%) and notable negative feedback (33%).
- At the total level, the trend mirrors country-level responses, with “don’t know” being the most frequently selected option (36%) and only 16% expressing confidence in progress (“to a great extent”).

Survey Question 19: How well equipped is WHO to ensure that its CLA responsibilities will result in long-term, sectoral co-ordination for enhanced response?

Overall, the survey results suggest that stakeholders have varied perceptions regarding WHO's ability to fulfil its Cluster Lead Agency (CLA) responsibilities for long-term sectoral coordination. The largest proportion of respondents, 30%, believe that WHO is equipped "to a great extent", followed closely by 28% who responded with to some extent. Only 9% of respondents expressed strong confidence in WHO's capabilities by selecting "to a very great extent".



Conversely, **14% of respondents ("4% not at all" and 11% "to a small extent") believe that WHO is minimally equipped for this role. Additionally, 19% of respondents selected "don't know".**

On a **global level**, the highest proportion of respondents, 43% rated it as "to some extent," followed by 19% selected "to a small extent". Only 10% rated it as "to a great extent" and 5% as "to a very great extent". A relatively low, 5%, selected "not at all" and 20% responded "don't know.

On a **regional level**, 20% of respondents selected "to a very great extent" and 13% ""to a great extent",", while the largest proportion, 33%, consider that WHO is equipped only to some extent to ensure that its CLA responsibilities result in long-term, sectoral co-ordination for enhanced response. 13% selected "not at all" and another 13% "don't know".

On a **country level**, 10% of respondents believe that WHO is equipped to a "very great extent" to ensure that its CLA responsibilities will result in long-term, sectoral co-ordination for enhanced response, another 28% rated it "to a great extent" and 31% selecting to some extent. 9% of respondents responded with "to a small extent" and only 2% reported not at all. However, a notable 19% of respondents selected "don't know". Notable differences across the stakeholders, with WHO and other UN Agencies staff noting 44% of total positive responses, compared to Donors and INGOs and National Health Authorities and NGOs, both groups with 34%.

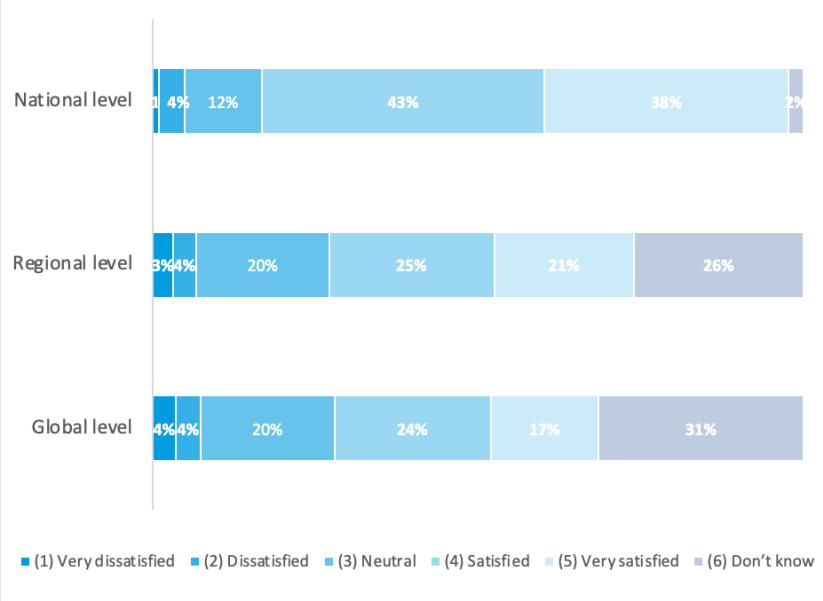
Commonalities:

- Across **total, global, regional, and country levels, stakeholders have mixed perceptions regarding WHO's ability to fulfil its Cluster Lead Agency (CLA) responsibilities for long-term sectoral coordination.** The most frequently selected response at all levels is "to some extent," suggesting that while WHO is seen as making efforts in this area, **many stakeholders believe there is room for improvement.**
- **Few respondents express strong confidence in WHO's capacity to fulfil its CLA responsibilities** for long-term coordination. Only **9% at the total level, 10% at the country level, 10% at the global level, and 20% at the regional level rated WHO as being fully equipped "to a very great extent".**
- Negative perceptions exist **at all levels but remain relatively low, with total negative responses (sum of "not at all" and ""to a small extent"") ranging from 14% at the total level to 24% at the global level**. The **highest level of dissatisfaction is observed at the global level (24%),** while **country-level responses show the least negative feedback (11%).**
- A **notable trend across all levels** is the **high proportion of "don't know" responses**, ranging from **13% at the regional level to 20% at the global level.**

Differences:

- Country-level respondents express moderate confidence, with 38% total positive responses ("to a great extent" and "to a very great extent"), but 31% still selecting "to some extent".
- Global-level respondents are the most critical, with only 15% providing strong positive feedback ("to a great extent" or "to a very great extent"), the lowest across all levels. Additionally, the global level has the highest total negative responses (24%) and the highest "don't know" percentage (20%).
- Regional-level respondents show the most optimism, with 33% total positive feedback (20% "to a very great extent" and 13% "to a great extent"), but also a relatively high level of disagreement (13% "not at all") and 13% "don't know".
- At the total level, responses align closely with the country-level perspective, with a nearly equal split between moderate and strong agreement (30% "to a great extent" and 28% "to some extent"), but also a significant proportion of respondents who remain uncertain (19% "don't know").

Survey Question 20: What is your overall satisfaction with the work of the Health Cluster at different levels?



Overall, the survey results suggest varying levels of satisfaction with the Health Cluster's work across national, regional, and global levels. The highest level of satisfaction is observed at the national level, where 43% of respondents reported being "satisfied" and 38% "very satisfied", totalling 81% positive responses. At the regional level, satisfaction is lower, with only 25% indicating they are "satisfied" and 21% "very satisfied", bringing total satisfaction to 46%. Additionally, 20% of respondents selected "neutral", while 26% selected "don't know". The lowest satisfaction is recorded at the global level, with only 24% "satisfied" and 17% "very satisfied" (41% total satisfaction). Meanwhile, 20% remain "neutral", and 31% selected "don't know", which is the highest uncertainty rate among the three levels.

On a **global level**, the highest Satisfaction is with the national level, for which 48% of respondents are "satisfied" and 24% are "very satisfied", while only 14% expressed dissatisfaction. There is a moderate satisfaction with the global level where 38% of respondents are "satisfied "and 14% "very satisfied" while 19% are dissatisfied. A lowest satisfaction is noted with the regional level, where only 19% are "satisfied" and 5% are "very satisfied", while 15% are "dissatisfied". Regional level shows the highest rate of "don't know" answers, where 43% of respondents opted for this answer.

On a **regional level**, the highest satisfaction is noted with the Health Cluster at national level, with 33% of respondents being "very satisfied" and 20% "satisfied" and only 7% of "dissatisfied". High percentage remained neutral, 27% and 13% opted for "don't know" answer. There is a moderate satisfaction with the HC at regional level, with 27% of respondents being "very satisfied", and 27% "satisfied", and dissatisfaction at 13%. Neutral responses are high, 33%. The lowest satisfaction as noted regarding the HC at global level with 13% of respondents being "very satisfied" and 20% "satisfied", although the percentage of "dissatisfied" remained low, 7%. A significant 33% of respondents selected "don't know" and 27% remained neutral.

On a **country level,** the highest satisfaction was noted with the Health Cluster at national level, with 82% of respondents expressing satisfaction (49% "satisfied" and 33% "very satisfied") and only 4% indicating dissatisfaction (0% "very dissatisfied" and 4% "dissatisfied"). 9% were neutral, and 5% responded "don't know". Highest satisfaction among the WHO and other UN Agencies staff (86%), followed by National Health Authorities and NGOs (82%) and notably lower positive perception by Donors and INGOs with 75%. In general, there is a moderate satisfaction with the HC at regional level, with 41% positive responses (27% "satisfied" and 14% "very satisfied") but also dissatisfaction is noted to be minimal (2% "very dissatisfied", 2% "dissatisfied"). There is a high level of "don't know" responses, 36%, while 19% remained neutral. No differences in reflection across the stakeholder groups. The lowest satisfaction was noted with HC's work at global level, with only 38% positive responses (18% "satisfied", 20% "very satisfied"), although dissatisfaction remains low (2% "very dissatisfied", 2% "dissatisfied").Neutral responses are at 17%, but the "don't know" response is the highest at 41%. Notably lower positive perception by Donors and INGOs (30%) compared to WHO and other UN Agencies staff and National Health Authorities and NGOs, both with 40% of total positive responses.

Commonalities:

- Across total, global, regional, and country levels, the highest satisfaction is consistently recorded at the national level, where stakeholders express strong approval of the Health Cluster's work. The lowest satisfaction is consistently recorded at the global level, while regional-level satisfaction varies but remains moderate to low across all groups.
- Across all levels, satisfaction at the national level is significantly higher than at other levels, with total satisfaction ranging from 81% at the total level to 82% at the country level. In contrast, satisfaction with the global and regional levels is consistently lower, with total satisfaction not exceeding 50% in any group.
- Another common trend is the high proportion of "don't know" responses at the regional and global levels, with uncertainty reaching as high as 43% at the regional level and 41% at the global level in country-level responses. This suggests that stakeholders at all levels may have less visibility into the operations and impact of the Health Cluster at these levels.
- Dissatisfaction is relatively low across all levels, with most responses falling into neutral rather than negative categories. Even at the global level, where satisfaction is lowest, dissatisfaction remains under 20% in all cases.

Differences:

- Country-level respondents express the highest satisfaction overall, particularly at the national level (82% satisfaction, the highest across all levels). However, satisfaction with the regional and global levels is significantly lower, with high "don't know" responses (36% and 41%, respectively), indicating less familiarity with Health Cluster operations beyond the national level.
- Global-level respondents' rate national-level coordination as the most effective, with 72% satisfaction, the highest of any category at the global level. However, satisfaction with regional coordination is the lowest (24%), reflecting greater concerns at this level compared to country-level respondents.
- Regional respondents provide mixed views, with 60% satisfaction with national-level coordination but only 40% satisfaction with regional-level coordination. The high percentage of neutral (33%) and "don't know"

(33%) responses regarding the Health Cluster's global-level performance suggests limited awareness or engagement with Health Cluster activities at the global level.

- At the total level, the satisfaction trend mirrors the country-level pattern, with the national level receiving the highest ratings (81%) and the global level the lowest (41%).

Survey Question 21: What are the key successes of the Health Cluster?

The Health Cluster has emerged as a vital mechanism in humanitarian health response, facilitating coordination, rapid emergency interventions, health system strengthening, advocacy, and expanded healthcare access in crisis-affected regions. Stakeholder feedback highlights several recurring themes that demonstrate its impact in ensuring life-saving interventions and improving health outcomes in challenging humanitarian contexts.

Strengthening Coordination and Collaboration

One of the most consistently recognized successes of the Health Cluster is its ability to coordinate diverse actors effectively. By bringing together UN agencies, international NGOs, local organizations, and government bodies, the Cluster ensures that resources are used efficiently, duplication of efforts is minimized, and response strategies are aligned. Its structured coordination mechanisms, regular meetings, and information-sharing platforms have played a critical role in maintaining an organized and predictable humanitarian response. Moreover, the Health Cluster has been instrumental in fostering inter-sectoral collaboration, particularly with the WASH, Nutrition, and Protection clusters, to ensure a comprehensive approach to health crises. In the context of disease outbreaks, for example, coordination with the WASH Cluster has been crucial in preventing the spread of cholera by ensuring access to clean water and sanitation alongside medical treatment. Similarly, in complex emergencies such as in Gaza and Sudan, the Cluster has been at the forefront of advocating for medical supplies and ensuring a unified response among humanitarian actors.

Rapid and Effective Emergency Response

Another key success of the Health Cluster is its ability to mobilize rapid and effective emergency responses to disease outbreaks, natural disasters, and armed conflicts. By coordinating emergency medical teams, ensuring the provision of critical health supplies, and deploying mobile clinics, the Cluster has ensured that healthcare reaches affected populations in a timely manner. This capability has been particularly evident in public health emergencies, including cholera, hepatitis C, and scabies outbreaks, where coordinated efforts have contained disease transmission and mitigated fatalities. In war-torn areas and refugee settings, the Cluster has facilitated continuity of essential health services, ensuring that displaced populations receive medical care despite the challenges posed by insecurity. For example, in the Rohingya refugee crisis, the Health Cluster played a crucial role in providing hepatitis C treatment and strengthening disease surveillance. In Yemen, over 3,000 health facilities have received Health Cluster support, allowing them to deliver life-saving services despite ongoing conflict and infrastructural challenges.

Health System Strengthening and Capacity Building

Beyond emergency response, the Health Cluster has made significant strides in strengthening health systems and building the capacity of national health institutions. This includes training healthcare workers, providing technical support to ministries of health, and developing emergency health strategies that improve crisis preparedness. By investing in local capacity building, the Health Cluster ensures that national and local health systems become more resilient and less dependent on external actors. This approach has enabled sustainable interventions that continue even after international humanitarian support decreases. In Myanmar and Yemen, for example, the Cluster has implemented mass casualty management training and emergency preparedness programs, equipping local healthcare providers with the skills needed to respond effectively to crises. These initiatives have strengthened national health systems and improved long-term health resilience.

Advocacy and Resource Mobilization

A major strength of the Health Cluster has been its ability to advocate for increased funding, influence policy decisions, and secure critical support for health interventions. It has successfully lobbied for greater investment in emergency health programs, facilitated funding for national NGOs, and pushed for policy changes that enhance healthcare access in crisis-affected regions. In addition to securing financial resources, the Health Cluster has played a vital role in promoting internationally recognized health standards and ensuring that humanitarian responses align with best practices in global health governance. For example, in Ethiopia and Sudan, the Health Cluster has been instrumental in securing funding for emergency medical supplies and advocating for expanded healthcare services.

Expanding Access to Healthcare for Vulnerable Populations

A consistent theme in stakeholder feedback is the Health Cluster's success in expanding healthcare access to vulnerable and hard-to-reach populations, particularly in conflict zones, remote rural areas, and displacement settings. Through mobile clinics, outreach programs, and partnerships with local health facilities, the Cluster has ensured that essential healthcare services remain available even in the most inaccessible or high-risk areas. These efforts have been crucial in addressing maternal and child health needs, controlling communicable diseases, and delivering emergency medical care. For example, in Yemen, the Health Cluster has supported over 3,000 health facilities, allowing them to continue providing basic healthcare services despite the ongoing war. Similarly, in Latin America, the Cluster has worked with local health authorities to improve cross-border health responses, ensuring that displaced populations receive uninterrupted care.

Survey Question 22: What else could WHO, as CLA, do to strengthen the Health Cluster? & Survey Question 23: Do you have any other recommendations for WHO and the Health Clusters?

Survey analysis indicates that several structural and operational improvements are necessary for the Global Health Cluster (GHC) to enhance its role as the Cluster Lead Agency (CLA) in strengthening the Health Cluster. At the same

time, these identified areas for improvement align closely with the recommendations provided by respondents for both WHO and Health Clusters more broadly. The feedback underscores recurring challenges in coordination, data management, advocacy, funding, and emergency preparedness, demonstrating that many of the gaps affecting the GHC's leadership role are also reflected in the overall functioning of Health Clusters at national and sub-national levels.

Enhancing Coordination and Leadership

The most frequently mentioned area for improvement is strengthening coordination and leadership within the Health Cluster. Several respondents emphasized the need for better organization and stronger leadership structures, particularly at the national and sub-national levels. Stakeholders pointed out that coordination gaps and inefficiencies have led to challenges in managing the cluster effectively, and they called for more structured decision-making processes and clearer responsibilities for leadership roles.

A repeated concern was the lack of dedicated personnel for coordination tasks, with some respondents specifically stating that staffing gaps and the absence of long-term cluster roles negatively impact leadership stability. Others pointed out that the cluster would benefit from appointing more regional focal points and deputy coordinators from other agencies to ensure broader representation and avoid an over-reliance on WHO personnel alone. Additionally, some respondents noted that the Health Cluster should engage more meaningfully with all stakeholders, including local partners and national health authorities. This would increase inclusivity in decision-making and strengthen collaboration between humanitarian organizations and governments.

Improving Data and Information Management

Another frequently mentioned concern was the need to strengthen data systems and information-sharing mechanisms. Several stakeholders highlighted gaps in data collection, monitoring, and analysis, which limit the cluster's ability to make evidence-based decisions. Some responses pointed to inconsistencies in reporting and a lack of standardized tools for tracking partner activities and health interventions. One recurring issue was the inefficiency of humanitarian operations due to poor data management. Some respondents specifically mentioned that multiple teams were providing the same training or services to the same populations because of a lack of coordination in data tracking. Improving data harmonization and monitoring systems was seen as essential for ensuring more effective resource allocation and reducing duplication. Additionally, there were calls for enhanced real-time data sharing to improve situational awareness and response planning. Some stakeholders suggested that WHO should take the lead in ensuring that all partners follow standardized reporting mechanisms and use unified data platforms.

Expanding Capacity Building and Training

Many respondents called for more training and capacity-building efforts, particularly for national and local partners. There was strong emphasis on strengthening the skills of local NGOs, health authorities, and cluster coordinators to ensure they can manage health interventions more effectively. Stakeholders also highlighted the need for continuous training rather than one-time workshops, ensuring that knowledge and expertise are retained within national institutions. Some specifically mentioned that WHO should invest in long-term training programs, mentorship opportunities, and workshops that focus on emergency response coordination, health data analysis, and overall

cluster management. Additionally, some responses emphasized that capacity-building efforts should be decentralized, ensuring that regional and sub-national clusters receive the same level of support as national structures.

Strengthening Advocacy and Policy Influence

Another area of concern frequently raised in the responses was the need for stronger advocacy and more predictable funding mechanisms. Several respondents pointed out that the Health Cluster has been operating for extended periods without sufficient funding, limiting its effectiveness. Many stakeholders urged WHO to increase efforts in advocating for sustained financial support for Health Cluster operations. Some also suggested that WHO should work directly with donors to ensure more flexible funding streams that can be adjusted according to emerging needs. Additionally, some responses highlighted the need for WHO to advocate for the inclusion of national and local health actors in decision-making processes. By ensuring that governments and local organizations have a stronger voice in the cluster system, WHO could help bridge the gap between humanitarian interventions and national health policies.

Improving Emergency Preparedness and Response

Several stakeholders emphasized the importance of strengthening emergency preparedness mechanisms to enhance the cluster's response capabilities. Some noted that contingency planning for emergencies needs to be more robust, with pre-positioned resources and dedicated response funds to enable rapid mobilization. Additionally, some respondents called for improving surge capacity, ensuring that trained personnel are readily available for deployment in emergencies. There were also calls for WHO to ensure better transition strategies from humanitarian emergency response to long-term development efforts, ensuring that health interventions contribute to national health system resilience

Key Informant Data

Table 1. Key Informant Interview Completion by Levels, Focus Countries, and Methods

Category	Type	Conducted	Contacted	Completion Rate
By level				
	Subnational	**27**	**29**	**93.1%**
	National	**59**	**80**	**73.75%**
	Regional	**6**	**14**	**42.86%**
	Global	**14**	**18**	**77.78%**
By country				
	Chad	**4**	**4**	**100%**
	DRC	**17**	**17**	**100%**
	Colombia	**24**	**28**	**85.71%**
	Sudan	**11**	**16**	**68.75%**
	Yemen	**11**	**17**	**64.71%**
	Myanmar	**19**	**27**	**70.37%**
By method				
	FGD	**19 (157 people)**	**19**	**100%**
	KII	**106**	**141**	**75.18%**

Table 2. Key Informant Interview Completion by Stakeholder Category

Main Category	Subcategory	Completed	Target	Completion Rate
Country level				
	Government; National Health Authority	4	4	100%
	National/Local Health Partners	8	12	66.67%
International level				

	Donor Organization	9	10	90%
United Nations				
	WHO (Health Cluster Staff)	24	29	82.75%
	WHO (Non-Cluster Staff)	9	11	81.82%
	WHO Senior Staff	8	17	47.06%
	Other UN Agencies	18	21	85.71%
Health Cluster				
	Health Cluster Observer	4	5	80%
	Health Cluster Member	11	16	68.75%
	GHC Global Partners	3	6	50%
	GHC Management	0	1	0%
Others				
	Other Clusters	4	5	80%
	Health Cluster Territorial Tables	3	3	100%
	Governance Bodies	1	1	100%

Theory of Change Workshop

Objectives of the workshop

- Present a draft Theory of Change (ToC) of the Global Health Custer for discussion and inputs
- Using inputs received further develop the Theory of Change for use as a framework for the evaluation

Expected outputs

- An agreed upon and enhanced version of the ToC, which will:
    - Be presented at the HCC forum
    - Forms the basis for the version that will be included in the Inception Report.
- Note of unresolved issues from the discussion/ToC which may be explored in any further KIIs and/or further data collection

Format

- Online workshop of up to two hours and recorded (with group work and plenary)

Participants

Proposed category of participants for the ToC workshop

Category of participants
Health Cluster Coordinators and others participating in the Health Cluster Forum (16-18 October 2024, Istanbul)

Session plan

Time (Istanbul)- 17th October 2024	Session	Responsibility
16:30 – 16:40	Introduction to the workshop	Linda/Ricardo
16:40 – 17:00	Presentation of the Theory of Change (ToC) Why a Theory of Change Overarching structure	Glyn Taylor (Evaluation Team Leader)

	Inputs to outcomes Global level Inputs to outcomes Country Level Enabling factors/risks	
17:00 – 17:30	Facilitated group exercise	Group facilitators and note takers
17:30 – 17:50	Reconvene into plenary and feedback from each group	Evaluation Team
17:50 – 18:00	Wrap up and next steps (for the evaluation)	Linda/Ricardo

List of activated Country Health Clusters

Table 3. List of activated clusters studied focus countries

Region	Country	Emergency Profile (type, level, scale, IASC System-Wide Scale-up)	Cluster Implementation Stage (early activation, implementation, phasing out)	Cluster Funding Level (>75%; medium 40>75%); underfunded (<40%, extremely underfunded <20%)	Pooled Funding Mechanism (national/regional humanitarian pooled funding mechanism)	Migration/Refugee Coordination (Present/Not present)	Flagship Initiative (Present/Not present)	Regional/Context Diversity	Francophone Country	Remote / in country data collection
Africa (AFR)	Chad	Conflict, High, National, IASC System-wide	Early Activation (2007)	Extremely underfunded (<20%)	Yes (CERF)	Yes	No	Central Africa	Yes	In-country
Americas (AMR)	Colombia	Migration/Refugee crisis, Medium, Regional	Early Implementation (2010)	Underfunded (<40%)	Yes (CERF)	Yes	Yes (Regional Refugee and Migrant Response Plan (RMRP)	Latin America	No	In-country
AFRO	Democratic Republic of the Congo	Conflict, High, National, IASC System-wide	Early Activation (2006)	Extremely underfunded (<20%)	Yes (CERF, CBPF)	Yes	No	Central Africa	Yes	In-country
Southeast Asia (SEAR)	Myanmar	Conflict, High, National, IASC System-wide	Early Activation (2012)	Underfunded (<40%)	Yes (CERF, CBPF - The Myanmar Humanitarian Fund)	Yes (Country Based Pooled Fund)	No	Southeast Asia	No	Remote
EMRO	Sudan	Conflict, High, National, IASC System-wide scale up crisis	Early Activation (2009)	Underfunded (<40%)	Yes (CERF)	Yes	No	East Africa	No	Remote
Eastern Mediterranean (EMR)	Yemen	Conflict, High, National, IASC System-wide	Early Activation (2015)	Extremely underfunded (<20%)	Yes, (CERF, CBPF)	Yes	No	Middle East	No	Remote

Health Cluster Country data

Number of Health Cluster and Staffing

Year	HCCs	HC Co-coordinator	IMOs	PH Officers	Comms Officers	Health Clusters	Sectors	Sub-national hubs
2019	30	30	27	17	6	25	2	83
2020	23	25	26	8	5	25	2	102
2021	30	26	30	13	5	27	2	143
2022	33	26	39	12	9	28	2	151
2023	29	23	44	11	6	25	2	157
2024	28	24	41	12	4	26	2	132
2025	26	25	25	8	2	26	2	119

Partners

Year	Donors	National authorities	UN agencies	NNGOs	INGOs	Other and observers	Total
2019	137	74	162	576	581	126	1656
2020	126	72	163	604	576	118	1659
2021	162	70	166	638	649	119	1642
2022	163	58	163	725	715	155	1816
2023	145	54	155	760	687	153	1954
2024	173	56	163	852	689	234	2167
2025	186	54	146	744	690	222	2042

Funding and People in Need/Targeted

Year	Funding requested	Funded	% of requested funding received	People in need	Targeted people	% of targeted population
2019	2,273,400,000	130,169,700	6%	91,492,951	66,078,451	72%
2020	2,052,800,000	95,638,400	5%	93,711,600	66,181,400	71%
2021	2,537,400,000	52,452,000	2%	128,673,000	83,178,658	65%
2022	3,065,000,000	116,941,000	4%	156,838,303	96,612,651	62%
2023	3,502,200,000	393,513,000	11%	166,736,238	102,047,210	61%
2024	3,222,800,000	354,599,000	11%	178,300,000	89,285,597	50%
2025	3,155,709,000	236,585,000	8%	165,772,900	79,898,343	48%
Total	19,809,309,000	1,379,898,100	7%	981,524,992	583,282,310	59%

Global Health Cluster headquarters level staffing changes (2024-2025)

Position	2024	2025
GHC Coordinator P5 staff	✓	✓
G5 Admin Assistant staff	✓	✓
GHC Secretariat P3 staff	✓	✓
Technical Officer P4 staff	✓	Contract ended (12 April 2025- vacant)
Technical Officer P4 staff	✓	✓
Technical Officer P5 staff	✓	✓
Localisation Advisor P4 Standby Partner Deployee	✓	NORCAP Contract Ended 31 March (vacant)
IMO P4 Consultant	✓	WHO Consultant until 18 Feb (US funding terminated) CANADEM SBP from 19 Feb
IMO P3 Consultant	✓	WHO Consultant until 18 Feb (US funding terminated) CANADEM SBP from 19 Feb
TO GBV in Emergencies staff non-WHE	✓	Contract ended 28 Feb 2025. (US funding terminated) Position Vacant

Focus countries and reason for selection

The case study country selection criteria included:

- Emergency profile (type, level, scale, IASC System-Wide Scale-up)
- Stages of cluster implementation (e.g., early activation, implementation, phasing out)
- One country with the presence of a national or regional humanitarian pooled funding mechanism
- The presence of an additional migration/refugee focused coordination platform or outbreak coordination platform
- One flagship initiative country
- Diversity across regions and across contexts (which can also support uptake of recommendations through including more country and regional offices)
- Francophone country in AFRO – based on a perception of bias toward Anglophone contexts
- Size of country-level partnership, number of country health clusters partners

Additional considerations

Need to avoid evaluation fatigue – ruled out Somalia and Syria

- Preclude other countries in Whole of Syria approach e.g. cross border operations from Turkey
- While regional diversity/coverage is considered important, there is no support for inclusion of the Western Pacific Region
- Ease of access (including visas)

The selected countries proposed here (see Table below) have been validated during the ERG meeting which was held on 14th November.

Table 4. Proposed case study focus countries

WHO Region	Selected country	Criteria	Mode of data collection
AFRO	Chad	Francophone country Refugee coordination platform Long-standing cluster activation Additional issues considered: • underfunded crisis • cross border issues with Sudan • universal support in interviews	In-country
Americas/PAHO region	Colombia	Flagship country Migration coordination platform Relatively recent activation Additional issues/aspects considered: • Government support for clusters.	In-country

		• Universal support in interviews	
AFRO	DRC	Activated since 2006 Underfunded Will need more time in country (2 weeks)	In-country
AFRO	Mozambique	Activated since 2019 Underfunded The government doesn't want clusters, and were activated for the cyclone, but they remain because of conflict in the north and mix displacement	Reserve (in-country)
EMRO	Sudan	Current, IASC Scale up crisis Country Based Pooled Fund	Remote
SEARO	Myanmar	Country Based Pooled Fund Additional considerations: • Universal support in interviews	Remote
EMRO	Yemen	Pooled Fund Additional considerations: Universal support in interviews	Remote
EURO	Ukraine	EURO region Current, highly funded crisis Challenges: • Resource intense, • Possible challenges for budget as a result.	Remote

Chad Health Cluster short analysis

Key country data

Humanitarian and health context

Chad is experiencing a complex humanitarian crisis, aggravated by climatic shocks, conflicts and health emergencies. Almost 40% of the population, or 7 million people, need humanitarian assistance.

- East: The Sudanese crisis has forced more than 700,000 refugees and 200,000 Chadian migrants to take refuge in the east of the country, where living conditions are precarious.
- Lac: The Lac province, affected by internal displacement and armed attacks, counts more than 220,000 displaced persons and 41,000 returnees.
- Southern Chad, affected by inter-community conflicts and flooding, is facing growing food insecurity, with 3.7 million people in a critical situation, and 1.8 million children suffering from malnutrition.

In 2025, the humanitarian response will target 5.5 million people, concentrating on priority provinces where 58% of the most vulnerable populations are located. Interventions will include emergency aid, access to basic services and resilience programmes, with priority given to cash transfers to preserve the dignity of beneficiaries. Health sector component below.

People in need of support to meet priority health needs (timeframe; data from range of sources): 3.6 million, according to the HNRP2025 (reprioritized)

Priority health sector issues (e.g. access to essential health care; disease outbreaks; health care infrastructure; security): access to health facilities and quality care in provinces experiencing humanitarian crises, epidemic risk and likely to contract diseases under surveillance (measles, cholera, yellow fever, dengue, chikungunya, leishmaniasis, and malaria); Access and care of returnees, internally displaced persons, former IDPs; children and women of reproductive age; vaccination and sexual and reproductive health (SRH). (HNRP 2024)

Sector Objective[13]*:* Provide emergency medical assistance enabling equitable, rapid access and a continuum of health services to 1.1 million people living in areas heavily affected by various shocks

Activities: Provision of emergency primary health care, including community health care and promotion and awareness activities as well as vaccination while strengthening the health system menu CLHEA

[13] All quoted directly from the HRNP

- Support for referral and secondary health services including strengthening the health system
- Implementation of the DMU in SSR including strengthening the provision of services and information in SRMNIA-NUT with the provision of medicines and essential SR products, emergency obstetric care and blood transfusions, access to family planning services and information as well as clinical management of rape victims
- Provision of essential medicines and emergency medical equipment to health facilities including repairs to existing sanitation facilities
- Provision of psychological first aid to survivors of violence and persons with severe mental disorders in communities and institutions
- Collection, processing, analysis and dissemination of essential health information, including access to and availability of vital health services, prevention, detection and response to epidemics

Health cluster

People in need covered by the health cluster (timeframe): 1.1 million (HRP 2024)

Funding required (timeframe): For 2025 - $41.3 million for 2025

Funding received (timeframe): For 2024 - Total incoming funding US$787.1 million against an original requirement of US$1.2 billion *(10)*

Number and category of health cluster staff: Cluster coordination is in place in 3 regions - the Lakes (Lac) region, the South and the East (the largest crisis response for refugees from Sudan (new and old).[14]

Health cluster national and sub-national Coordinators and Co-Coordinators:

N'Djamena (National cluster): 4 cluster positions - HCC, IMO, Public Health Officer and Communications Officer. Only the HCC and IMO are filled - both are dedicated posts and filled by consultants. The Public Health Officer and Communications posts are currently vacant and have never been filled for years.

- East: Coordination is spread over multiple locations, run partly by OCHA and partly under the UNHCR's Refugee Coordination Model.
- Abeche: the coordination 'hub' for the Eastern response. Abeche hosts a sub-national cluster with an HCC. This post is currently filled by a national consultant - who is double-hatting[15] -. Three other coordinators report to the HCC in Abeche
- Farshana: OCHA is based in Farshana, WHO has a cluster IMO post here. At the time of the research visit, this post was temporarily vacant, having been filled until January 2025.
- Adre: There is no cluster in Adre (Assunga Health District), but a health and nutrition sector working group, led by WHO and the MoH.

Additionally in Lake and South cluster coordination is in place, but WHO has no coordination/cluster posts. Clusters are run by partners (one INGO (IRC for Lake) and UNFPA for South).

Health cluster Technical Working Groups: Mental health and sexual and reproductive health at the national level and in Adre. There is also a data working group in national level.

[14] There is a complexity in the set-up in Chad due to the mix-situation. There are lot of disputes around terminology. Thus, nationally, it's called cluster in the lake and at national level, but in the south and in the east sub-group.

[15] Dr Raoul is also WHO's incident manager for the east

Key findings

Role and relevance:

- [Extent to which WHO has been a successful coordinator of the health cluster; Key strengths and weaknesses of WHO in its role as CLA at country level (including in relation to core cluster functions); Whether WHO as CLA has been able to distinguish the cluster response as independent from WHO's technical response in support of government]

Notwithstanding the longevity of cluster coordination in Chad[16], the Health Cluster at national and sub-national levels is in a state of flux. At national level, following a vacancy in the HCC position until one year ago, staff described themselves as 're-establishing' basic cluster functions of the cluster over the last year.

In the East, following the outcomes of a P2P mission[17] WHO was been charged (in December of 2024) of with taking over the coordination of emergency health from UNHCR. This means that WHO has taken the coordination role, in support of Government, in the majority of health districts in the East, including those with refugee camps. In one single health district, however, Asunga, which covers Adre and the largest refugee transit camp in the East of Chad, the coordination is slated to remain under the Refugee Coordination Model i.e. WHO shares data not only with the Ministry of Health but to UNHCR's public health lead and data platform in Abeche (see effectiveness below). Country wide, the cluster function is significantly under-staffed against the model. Sub-nationally, all staff are national consultants and double-hatting.

Although COUPS is technically the co-lead of the cluster at national level, they have chaired the meeting infrequently, citing capacity constraints for their inconsistent presence.

Strengths:

Overall, WHO's CLA role is well integrated into its overall technical support function. In Adre, partners describe sector meetings as covering:

- Information sharing, basic prioritisation, deconfliction, and gap filling.
- Support to rapid response in the event of an outbreak or newly displaced population (not necessarily through stockpiling.)
- Strong integration with Government at local, subnational; alignment with national plan - albeit under centralised control.

[16] The health cluster was established in 2007

[17] The Peer-2-Peer (P2P) Support Project is a tool of the Inter-agency Standing Committee (IASC). It aims to 'provide senior level inter-agency peer support to Humanitarian Coordinators (HCs) and Humanitarian Country Teams (HCTs)' and 'to strengthen the delivery of collective humanitarian assistance and protection in country operations' through targeted support missions.

- WHO in its CLA and Government support functions improves the participation of partners in disease surveillance
- Provision of tools
- Harmonization of work between organizations and community relays
- Creation of ad hoc groups to work in the event of a crisis

While there are some gaps in the application of the core cluster functions at all levels, WHO is successfully implementing basic coordination functions seen as priorities by most partners, including the Government.

Weaknesses:

- WHO staff, government and donor representatives, and NGO partners each listed a range of challenges with information management, such as lack of quality and data consistency. Partners complained that information management was inadequate and stated that information needs to be better centralised. From the perspective of partners in Adre, information flows out via the 3Ws and is shared in meetings but does not return in a meaningful or usable form.[18]
- Insufficient inter-cluster collaboration (i.e., UNHCR notes that there are inter-cluster meetings), but these are not specific to health and disease outbreaks such as cholera.
- Inconsistency in human resources over time.

Health in the country level response

- [Extent to which the health cluster response as part of the HRP is genuinely needs driven and free of political influence; Relevance and alignment of strategic priorities and activities to country needs; How well are global and country-level health cluster strategies and interventions aligned to meeting the evolving needs of affected people, including the most vulnerable and hard to reach groups in acute, protracted and slow onset crises; [Does health receive an appropriate level of support from donors and government? Is this affected by perceptions of the health cluster's independence and effectiveness? Is the cluster functioning at the operational level i.e. has it ensured that highly affected geographical areas or specific populations have been addressed by the response?] Health cluster accountability to affected populations (how and to what extent).

[18] Partners noted that the meetings were information oriented rather than action oriented. However, worth noting that Adre meetings cover only one health district (Assunga) – i.e. it is sub-sub national (under the health cluster in Abeche and under the refugee response model). Many decisions, whether to respond in the event of an outbreak or crisis, for example, need to be passed up the chain to more senior staff (sometimes in Abeche – sometimes in N'Djamena). This applies to the Government (where the MCD need to pass decisions up the PDS, and or the MoH in N'Djamena.

Partners and WHO frequently referred to the health cluster strategy as fully aligned with the national health plan, with consistent objectives.

These questions are especially relevant in the East. As noted above, WHO has very recently (since December 2024) been tasked with coordinating the health response in the East, albeit partly under UNHCR's Refugee Coordination Model. Previously, health coordination for camped refugee populations—and to a limited extent—had been managed separately.

In Adre especially, the relationship between the health sector working group and the District Health Chief was very close and positive. In discussions, partners, including government representatives, discussed the challenges of expanding the capacity of the primary healthcare system to meet the needs of Adre's population (which had increased by an estimated 230,000 people—requiring an additional 11–12 health posts).

Effectiveness and efficiency

Cluster contribution to an improved response

- Extent to which the health cluster has supported progress towards strategic priorities and with planned activities.
- Quality and timely public health information to inform operational decision making

The national and sub-national clusters/health working groups are regularly described as forums for information sharing, and this is supported by ample evidence in interviews and documents produced by clusters at various levels. Interviewees described much of this information sharing as useful but relatively 'passive,' coming in the form of 'programme updates' or 'key achievements' per partner. Meeting minutes and sitreps confirm this.

Cluster guidance[19] lists six purposes of the clusters' IM function. These include "ensuring that reliable flows of information between the HCT and the Health Cluster are evidence-based for strategic decision-making and planning purposes," and "...contribut[ing] to multi-cluster/multi-sector initial rapid assessment and interagency assessments."

The national-level health cluster in Chad has played a significant role in multi-sectoral needs assessments-both ad hoc and through an annual set of assessments that include workshops with affected communities in crisis-affected areas (see AAP below). These were described as forming the basis of the HNO and, as such, playing a role in the development of the overall health sector response strategy. However, partners described the overall capacity for needs assessments in Chad as lacking.

There is little evidence, however, of strategic, higher-level decisions being made in cluster or sector meetings, or resulting from them. Rather, partners frequently cited their inability to make strategic decisions based on the

[19] Health Cluster coordination guidance for heads of WHO country offices as cluster lead agency. WHO 2019

information available. WHO staff and partners noted the lack of a comprehensive set of health data and an updated assessment of health needs at the country level.

As detailed below (see efficiency), both donors and government representatives are frustrated by the lack of a detailed and constantly updated set of data on the services being provided in the health sector. One significant donor representative stated that they needed a sufficiently disaggregated and detailed dataset, specifically to support decisions on resource allocation. Government representatives at the national level were also clear that they required the same level of detail in order to engage in resource allocation. This level and frequency of data go beyond the specified information management function required of the cluster (and OCHA's 3/5Ws), and yet there is an expectation that the cluster should be able to deliver it.

In some countries, including parts of DRC, some donors require clusters to 'approve' funding decisions-i.e., to verify that new programmes are priorities and not duplicative. Pooled funding decisions are also typically managed through cluster structures-i.e., allocation decisions (if not ultimate partner choice) are managed in cluster groups. In Chad, however, partners reported that it was common for partners to register with authorities in N'Djamena and to set up pre-determined programmes without checking with local partners and coordination structures, resulting in duplication.

Cluster/sector meetings, however, do support operational decision-making for geographically and/or thematically specific issues. Bulletins and sitreps detail discussions on specific public health risks, communicable disease trends, priorities, needs, and gaps in specific areas-especially those newly affected or showing an increase in needs. Partners listed occasions when meetings used this type of information for 'tactical' decision-making-i.e., relatively small-scale, targeted, but rapid/responsive decision-making. This includes immediate gap filling or operational deconfliction.

While not all partners are active in the clusters, all partners listed significant challenges with data and sharing-each from their own unique perspective. Data sharing with/reporting to the cluster is inconsistent. Some partners do not share data with the cluster; some report inconsistently and/or infrequently. All partners report internally, and there is a general perception that partners prioritise internal and donor reporting.

There are multiple data platforms with multiple data format requirements. In Chad, there is a specific challenge between the cluster IM structure and that of UNHCR. This challenge extends beyond information management, but IM is a significant component. As noted above, WHO had taken over coordination of the health response in the east of Chad only a few weeks prior to the research visit.

- Information management for camped refugees and some host communities is managed through UNHCR's 'Ajala' platform. Information is organised around 'welcome town', refugee sites (camps), returnee sites and transit sites. The system interface *(11)* allows inquirers to click on any settlement with refugees or returnees and receive an overview of data.
- WHO, on the other, hand, organises data according to the system of the Chadian Government, at the health district level i.e. WHO/Government data has not, thus far, been disaggregated to camp level. The new arrangement, however, information from partners in Adre (Asunga Health District) remains under UNHCR's RCM.

Government representatives at local level, were satisfied with the existing arrangement. Arguably, having had UNHCR previously responsible for camps, were more focused on the Government run system, and less on camps.

Local, non-governmental partners clearly stated that coordination was relatively strong in Asunga, where the sector working group was active, but significantly less strong in other health districts with camps.

It appears that a step change in capacity would be required to fulfil the full cluster coordination function in such a way that camped refuges were brought under WHO's coordination umbrella - and this would also require a seamless, proactive arrangement with UNHCR and/or those with camp management responsibilities.

A few additional facets of the health cluster in Chad also undermined its ability to play a strategic function:

- Interviewees frequently raised the centralised nature of decision making. Significant decisions typically needed to be referred up the chain: to Abeche from Adre and to N'Djamena from Abeche and other regional hubs across the country. Overall, there was acknowledgement of a lack of capacity in Government overall. Leading to a disconnect between Government and the national cluster.
- The make-up of the cluster at national level is typical. Cluster partners include UN agencies and international actors, and a range of national NGOs. This is a mixture of thematically and geographically diverse actors, some actors focus on specific areas, and others on specific technical subjects (such as mental or sexual and reproductive health).

Monitoring health worker safety

The cluster has no activities for monitoring health worker safety. This is only considered to be an issue in the 'Lac' area in Chad, where there had been a small number of security issues with non-state actors.

Accountability to Affected Populations (AAP)

There was no evidence of active strategies for AAP being discussed in Health Cluster meetings or planning. AAP was one focus of a health cluster workshop in N'Djamena in 2024[20], in the form of a presentation reminding partners that strengthening AAP is a core cluster function. A number of partners referred to an OCHA focal point for AAP, and their desire to centralise AAP mechanisms, (the inference being that these were complaints mechanisms.)

As above, there is an element of community participation in the workshops which form the basis of the assessments behind the HNO. In all three humanitarian hubs, Lakes, South and East, OCHA leads a multi-sectoral assessment, including a questionnaire. This concludes with a workshop including community participation, which forms the basis of the HNO.

Health cluster contribution to efficiency in the health response (for example, through reducing duplication and/or maximising use of available resources)

[20] Health Cluster Chad, 2024. Atelier National Cluster Sante. N'Djamena

As above, cluster partners at national and sub-national level described localised processes among active/present partners aimed at gap filling and prioritisation. Efficiency gains could be inferred in some cases, but the scale would be relatively small.

A Government representative stated that in some areas, NGO operations appeared over-resourced in relation to Government run facilities. A lack of clear, updated and consistent data means that conversations about resource allocation and efficiency, notably in camps, could not be had.

> *"Now, if one partner opens a nutritional treatment unit with a capacity of 10 beds, another opens one that also has a capacity of 10 beds. But every month, we only have 5 people. Why open a second one? So, let's have a look at these duplicates. If we had data, we could take action. But we don't have reliable data to enable us to take action, that's the problem."*

Health cluster contribution to cluster transition and deactivation.

Given the challenges with capacity in Government, there is no significant, serious discussion of cluster transition, nor any exit strategy.

WHO regional office support to the country health cluster in strengthening the response

Some engagement with AFRO regional office was mentioned, given the need for cross border collaboration with Sudan.

Coherence and coordination

External coherence

- [Health cluster contribution to external coherence and coordination (inter-cluster and multi-sector collaboration; coordination with national coordination mechanisms); Joint working within WHO and coordination with other WHO partner networks (e.g. EMTS, GOARN)]

Inter-cluster meetings take place in N'Djamena every two weeks, but partners and cluster staff noted that attendance and consistency was challenging because of the heavy schedule of meetings and the range of emergencies in Chad. Typically, partners and coordination staff refer to 'inter-cluster coordination' in reference to a general meeting covering updates from all clusters. Minutes and reports do refer to expectations of "collaboration and synergy" between the health cluster and Nutrition, CCCM, Shelters, WASH, Child Protection, Protection and Education.

There is ample evidence of inter-cluster meetings in smaller/ad-hoc groups around individual themes/communicable diseases. For example:

- Hepatitis-E, for which meetings included WASH partners; and upcoming (at the time of the research visit) meetings for diphtheria. These meetings, as was the case in DRC, were co-chaired with the Government, who typically assign an incident manager for each outbreak.

- Collaboration between the health cluster and child protection and GBV working groups, including the mapping of services to facilitate referrals and capacity strengthening for healthcare professionals (capacity strengthening below).

Internal Coherence

WHO management in Chad is supportive of the cluster function. As noted above, none of the cluster posts in WHO are 'core' posts. While the cluster function is respected within WHO and many roles are double-hatted, all staff in cluster posts (whether single- or double-hatted) are consultants-i.e., hired on a series of short-term contracts. This series of short contracts has led to gaps resulting from contract breaks. The key IM post in the east was vacant at the time of the visit. The incumbent had left approximately two weeks prior to the research visit. Staff and partners recognised the importance of the role and were hopeful that the post would be renewed. The HCC was also on a contract break during the evaluation visit. The consultant status was also a source of contention for most of the WHO staff interviewed, who noted a perception that consultants are considered to have a 'lesser' status within WHO.

Localisation and Nexus Programming

- [Health cluster contribution to localisation and improved local partner participation in decision making; Health cluster contribution to strengthening and ensuring sustainable national and sub-national coordination for prevention, preparedness and response to public health and humanitarian emergencies; Health cluster contribution to strengthening the link between humanitarian responses and national health systems, and between the humanitarian and development/peace nexus]

Directly following the global localisation strategy, and with support from Geneva, the cluster in N'Djamena held a localisation workshop in 2024. This resulted in an agreement to localisation advisor who is working with national NGOs on the development of a plan to allow local organisations internal clearance process. Almost all UN agencies select partners after posting opportunities on a centralised online system, the UN Partnership Portal (UNPP). WHO is not yet part of the UNPP, and partner selection and the contracting process was described as a "minimum 6-month process," which was still ongoing.

At the national level, the cluster offered support to local partners seeking assistance in accessing funding. One or two partners had requested assistance, but there was not much for WHO to offer beyond CERF funding (USD 2 million from UFE, USD 1 million for RRW in Wadi Fira, and USD 500K for anticipatory action). The cluster in N'Djamena had planned to run a "marketplace" for local partners (with BHA, Swiss, and Swedish funding).

As in other contexts, OCHA has a localisation advisor who is working with national NGOs on the development of a plan to allow local organisations to access monetary investments. OCHA in Chad does not have an AAP advisor but does have a focal point within the coordination unit. This individual attends national-level health cluster meetings and sub-working groups under the Ministry of Health.

Provider of last resort

WHO staff noted that there had been an internal discussion about the legitimacy of WHO stepping in the response of the East. In the early stages of the response, WHO Had provided medicines and supplies, the response and coordination were understood as being under UNHCRs mandate.

Data sources

Key informants interviewed

Name	*Number of people reached*
Eric Didier	1
Partners focus group N'Djamena	12
COUPS	2
Dr Raoul Abeche	1
ECHO Tchad	1
Groupe de travail santé Adre	7
IMO Cluster N'Djamena	1
MCD Adre	2
OCHA Adre	3
OCHA N'Djamena	3
Résident OMS	2
Santé mentale ADRE	2

Key documents and data reviewed

Dr. Jean-Bosco NDIHOKUBWAYO, 2023. Analysis of the humanitarian and health crisis in eastern Chad linked to the influx of refugees and returnees following the armed conflict in Sudan.

Health Cluster Chad, 2023. Health Cluster Bulletin - October 2023 (No. 04).

Health Cluster Chad, 2024. Atelier National Cluster Santé. N'Djamena - Chad.

Health Cluster Chad, 2023. Weekly situation report for the health sector (No. 003).

Health Cluster Chad, 2023. Weekly situation report for the health sector (No. 004).

OCHA, 2024. Bilan de la Réponse Humanitaire janvier - septembre 2024.

OCHA, 2024. Analyse Financements Humanitaires 2021 - 2024.

OMS Chad, Ministère de la santé publique de la République du Chad, Santé Chad, 2024. Weekly report on the humanitarian and health crisis in eastern Chad linked to the influx of refugees and returnees following the Sudanese conflict.

World Health Organization, 2023. Public Health Situation Analysis Chad.

World Health Organization, 2024. Chad: Sudan Crisis Health Situation Dashboard.

Colombia Health Cluster short analysis

Key country data

Humanitarian context

Colombia faces persistent humanitarian challenges, especially in areas where the presence and capacity of the state are more limited. These challenges arise from the expanding geographical impact of the internal armed conflict, its intensification in certain areas, and ongoing disasters. In 2024, approximately 8.3 million people are facing urgent humanitarian needs.

The Humanitarian Country Team (HCT) estimates that 517 municipalities—equivalent to 46% of the country—concentrate 5.3 million people with humanitarian needs at severity levels 3, 4, and 5. Colombia hosts 2.9 million Venezuelan refugees and migrants, of whom 503,682 are in an irregular migratory situation.

The Community Priorities Response Plan (HRPCP), which proposes a biennial strategy for 2024-2025, prioritizes 1.7 million USD of the most vulnerable people, including children, adolescents, women, and ethnic communities. The HCT has identified a financial requirement of USD 332 million for the coming 2025.

Colombia is a pilot for the Flagship initiative, which aims to transform humanitarian action by placing affected populations at the centre of all efforts. This involves adapting response strategies and coordination mechanisms to reduce the dependence of affected people on humanitarian aid and promote durable solutions.

Health context

- **People in need (health sector):**
    - 6,1 million in 2025, according to HRCP
    - 10,54 million in 2025, according to the Health Cluster Strategic Priorities 2025[21]
- **People in need prioritized by the health cluster**: 784,000 people in 2025
- **Funding required (timeframe):** US$ 48,666,743
- **Funding received (timeframe):** US$ 13,414,284. 26% Coverage of 27,6%[22]

[21] This number includes people in need of humanitarian and development attention.

[22] Retrieved from FTS UNOCHA https://fts.unocha.org/plans/1181/summary

- **Number and category of health cluster staff:** Three people at the national team. One international staff, who is also the Health Emergency International advisor. One national consultant (nominally as the public health officer), who plays the role of operative coordinator and links the national cluster with the territorial tables. One national consultant for the public information officer position. Five other people are double hatted for co-leading the subnational hubs while providing health technical advice.
- **Subnational hubs (represented in territorial tables):** 22
- **Number and category of health cluster partners:**
    - 95 according to the Health Cluster
    - 75 according to the HRPCP 2024-2025

Cluster Structure

To coordinate the health emergency response, the Health Cluster was activated in Colombia in 2010. Since the Pan American Health Organization (PAHO) serves as the regional office of the World Health Organization (WHO) in the Americas, PAHO is responsible for acting as the Lead Agency of the Cluster in the region.

The Health Cluster in Colombia is co-led by the National Health Ministry of Colombia who develops the coordination spaces, PAHO, and the Colombian Red Cross. The third co-leader is elected by the cluster partners.

- **Strategic Group:** Along with the three co-leaders of the cluster, the participants of the strategic group will jointly agree on the cluster's agenda. The group has 8 members from international and national organizations, UN agencies and the Ministry of Health.
- **Technical Health Groups:** In practice, the Mental Health technical group and the Reproductive and Sexual technical group are operating in the national level.
- **Territorial and Regional Health Tables** (subnational hubs): The Territorial Health Tables are proposed as a platform for coordination, dialogue, and articulation between the State, cooperation organizations civil society and academics. Their goal is to strengthen local governance to address the humanitarian gaps and health priorities identified during and after emergencies. The tables are co-led by the Departmental Health Institute or the Regional Health Secretariats (governmental bodies in the regions of Colombia) and by a PAHO consultant, who also fulfils the role of institutional technical strengthening. Not all the territorial tables have a dedicated PAHO person in their territory, but all have a governmental person leading the discussions.

Health Cluster Activities are focused on[23]:

1. Supporting access to and delivery of services.
2. Inform strategic decision-making
3. Response strategy
4. Strengthen the capacity for preparedness, anticipatory action, response, and recovery of the different actors
5. Monitoring and evaluation
6. Advocacy

Key findings

Role and relevance

WHO in its CLA role

- Extent to which WHO has been a successful coordinator of the health cluster:

PAHO holds legitimacy as a health authority among the actors involved. There are no concerns regarding PAHO's role as the cluster coordinator, and the overall perception is positive. The health cluster is better consolidated than most of the other clusters, which can be attributed, on one hand, to the governmental resolution that established the health cluster as a mandatory mechanism to coordinate the health response between the Ministry of Health and international cooperation. On the other hand, this success is also credited to the strong personality of the PAHO national consultant, who works proactively.

At the national level, the leadership role is shared with the Ministry of Health and the Colombian Red Cross. Although the Ministry of Health is one of the co-leads of the cluster at the national level, the person in charge is frequently changed, and the significance of this position is not fully understood by the rest of the Ministry's structure. The third co-leadership was established at the request of a counterpart to better represent the interests of international cooperation within the cluster, where the Ministry also participates in agenda setting. The Colombian Red Cross, as the third co-lead, has expressed a lack of understanding of its role in the cluster. As a result, its participation functions more as a partner rather than a leader in practice.

[23] According to the Country Health Cluster's Terms of Reference.

At the subnational level, the cluster's functions are carried out by the territorial tables (mesas territoriales in Spanish), where the departmental health authority co-leads along with PAHO, adopting a more operational approach to coordination. However, this level is significantly understaffed compared to the intended model/design, with all staff members being national consultants who hold dual roles, and in some cases, cover more than one territorial table. This situation makes personal capabilities a critical factor in determining whether PAHO's strength is more prominent on the technical advisory side or the coordination side, with both profiles being observed during the visits. In contrast, at the national level, a dedicated national consultant is assigned for the cluster coordination role.

- Key strengths and weaknesses of WHO in its role as CLA at country level (including in relation to core cluster functions):

Strengths:

- Information sharing, and strong data production, including the use of health information coming from the government.
- Strong integration with Government at local, subnational; alignment with national institutions and plans.
- Well defined cooperation and co-leadership with the government: The role of the Ministry of Health as co-leader of the cluster is generally well perceived, particularly for its contributions to capacity strengthening, fast information sharing, and effective coordination of actions between the government, as the first responder, and international cooperation in its complementary role. However, the leadership dynamic between PAHO and national institutions can be disrupted by frequent changes in the person in charge, as well as by the bureaucracy and slow procedures within the Ministry, which impede timely decisions for responses to health emergencies.

Weaknesses:

- Lack of strategic approach, and difficulty to communicate key information from the national to the subnational level and vice versa.
- The lack of high-level discussions, with decision-makers often absent from coordination meetings, further weakens the alignment of actions and priorities. The absence of strong or strategic discussions limits the ability to harmonize efforts across different actors and levels.
- Partners frequently approach the national cluster with agendas and activities already set and promised to donors, making action plans more of an effort to coordinate pre-determined actions rather than a strategic tool to align priorities effectively.
- Contracts that undermine the legitimacy of the person, and lack of consistency on the information management person which gives more responsibilities to only one person.

- Whether WHO as CLA has been able to distinguish the cluster response as independent from WHO's technical response in support of government:

The difference is clear at the national level, where the cluster has a dedicated consultant for the coordination role, and at the subnational level, where the same person is double-hatted for both technical strengthening and cluster coordination (see role and relevance above). In general, this arrangement is perceived as a good optimization of resources, with no significant difficulties in representing both roles. However, there is a caveat in cases where the subnational PAHO representative is someone who previously worked with the government and continues to follow the state's logic, which can undermine the balance needed to effectively represent international cooperation within coordination spaces. At the same time, the overload of work due to the double functions ends up affective the effectiveness of the coordination role.

Health in the country level response

- Extent to which the health cluster response as part of the HRP is genuinely needs driven and free of political influence:
- Relevance and alignment of strategic priorities and activities to country needs:
- [How well are global and country-level health cluster strategies and interventions aligned to meeting the evolving needs of affected people, including the most vulnerable and hard to reach groups in acute, protracted and slow onset crises?]
- Extent to which the health cluster has supported appropriate prioritisation of health interventions within a coordinated response [Does health receive an appropriate level of support from donors and government? Is this affected by perceptions of the health cluster's independence and effectiveness? Is the cluster functioning at the operational level i.e. has it ensured that highly affected geographical areas or specific populations have been addressed by the response?]:

Due to the solid structure of the cluster, the health response is able to navigate the Colombian dual architecture effectively. This is partly possible because of the strong and well-consolidated information system that the national government has in Colombia for health purposes, which enables the cluster to gather its own data and estimate needs to respond to. Nonetheless, there are clear difficulties in information management and alignment between the cluster and the two coordination architectures .

PAHO, as the co-leader of the Health Cluster, has emphasized the tension surrounding the official numbers of People in Need (PiN) for the health response, particularly between their own estimates-mainly based on government data and the Migrants and Refugees Response Plan -and the estimates provided by the Humanitarian Response Plan (HRPCP). This discrepancy creates challenges in measuring the reach and progress of the planned health interventions, and do not maximize the prioritization efforts of vulnerable populations. However, the HRPCP health strategy and the cluster activities, there is a good level of coherence (see annex 2)

There were no general concerns about the quality of data provided by the government or about its interference in making health estimations. However, there were specific concerns regarding the broader agenda of the government, which seems to prioritize certain areas of response-mainly leaving the needs of migrants to be addressed by international cooperation.

Accountability for affected populations

- Health cluster accountability to affected populations (how and to what extent):

There was no evidence of active strategies for Accountability to Affected Populations (AAP) being discussed in Health Cluster meetings or planning. Nonetheless, under the Flagship Initiative, communities are invited to participate in territorial table meetings to express their needs and perceptions of the response. These invitations are extended when the co-leads deem it pertinent and appropriate based on the subjects to be discussed.

Effectiveness and efficiency

Cluster contribution to an improved response

- Extent to which the health cluster has supported progress towards strategic priorities and with planned activities:

The strategic priorities of the health cluster are broad enough to address the particularities of Colombia. However, this also means that they do not necessarily provide a clear guideline for making strategic decisions or provide a strategic direction that the Global Health Cluster (GHC) intends to pursue.

There is a consistent perception of a lack of strategic vision from the higher levels of coordination. At the subnational level, where coordination is more operational, there are frequent complaints about the insufficient strategic perspective provided by the national level. Discussions often reflect this gap in guidance.

Simultaneously, the national level expresses concern about the lack of sufficient support from the regional office, from which they expect clearer strategies and guidelines to align national and subnational activities effectively (see coherence and coordination below). This challenge is further compounded by the language barrier, which represents a significant obstacle in translating the global vision into actionable strategies at the national and subnational levels.

- How well WHO as CLA and the health cluster have contributed to an improved response through:

Policies, setting standards and developing guidelines:

Although the cluster was created in 2010, its Terms of Reference were only consolidated about five years ago, marking a significant milestone for establishing clear guidelines on the cluster's functioning.

The document “Strategic Priorities for 2025 from the Cluster Perspective and the Territorial Tables” places a strong emphasis on the specificities of each department that hosts a territorial table. This strategic document also makes its own estimations of People in Need (PiN), which differ from the data provided by the Humanitarian Response Plan (HRPCP) (see above).

The methodology for assessing needs, response, and gaps, developed by PAHO and promoted for use by the government during the territorial tables, has improved the understanding of international cooperation as a complementary aspect of the government response. This approach has also facilitated better resource optimization.

Improved predictability and adequate and timely leadership for the response at national and sub-national levels:

At the national level, there are mixed opinions about the effectiveness of coordination. While everyone acknowledges its importance and the need for it, coordination efforts are often perceived as slower than the evolving needs and hindered by bureaucratic obstacles coming from government procedures.

At the subnational level, leadership is seen as timelier and more effective, particularly when it comes to operational coordination. The support provided to the territorial tables from the national cluster leadership is regarded as essential for improving processes, enhancing the ability to interact effectively with governmental counterparts at the subnational level that recognize the legitimacy and coordination expertise of the national level.

Quality and timely public health information to inform operational decision making:

Colombia has strong public health information systems that are generally perceived as credible and unbiased by humanitarian actors, despite the potential for political biases in needs assessments and in the prioritization of actions. The country also has a reliable culture of information exchange, with information flowing effectively from the government to the international sector. However, some actors—particularly international ones—have raised concerns that the extremely open information sharing between PAHO, and the government could compromise the neutrality of the cluster response.

Despite a constant flow of information from the subnational level to the national cluster, the strategic intention behind this information is not evident. As a result, the cluster’s agenda often ends up being a rapid information-checking exercise across multiple territories with diverse needs rather than a focused strategic discussion. At the same time, national decisions do not always lead to effective local actions due to challenges in practical implementation.

While the core purpose of the cluster is to enhance efficiency and coordination, in practice, it often functions more as an information-sharing platform than as an operational mechanism. Despite the abundance of information available, there is a perception that it is not sufficiently focused on strategic decision-making.

Evidence-based advocacy:

PAHO's leadership is vital for maintaining a balance between the government and humanitarian actors, but its close ties to the government may limit its ability to advocate independently for humanitarian action. Advocacy within the health cluster is not particularly strong; however, PAHO's mediation efforts are recognized as essential to ensuring that the state remains the first responder, and that the cluster's response truly complements governmental actions.

Some organizations perceive the Ministry of Health's role as primarily focused on surveillance and control of the emergency response, frequently requesting additional information and, in some cases, potentially violating confidentiality agreements by sharing this information with the government. One of the most frequent requests from organizations is for PAHO to advocate for differential regulations from the government to facilitate operations, considering that delays in import processes and excessive controls on health services during emergencies hinder the ability to provide timely and adequate responses.

Support for capacity development and operational needs of national and local partners:

Capacity development efforts are particularly visible through the strengthening processes PAHO conducts with governmental counterparts at both national and subnational levels. At the subnational level, for example, coordination spaces previously tended to be highly technical, focusing mostly on epidemiological events rather than on facilitating effective and coordinated responses. The introduction of the methodology for assessing needs, responses, and gaps has notably improved the capacity of local health authorities to coordinate and effectively incorporate complementary actions from humanitarian organizations.

Another specific example was observed during the evaluation visit to a territorial table that was actively responding to a massive displacement crisis. In this case, the national level provided a succinct discussion on Sphere Standards during the coordination meeting, clearly reflecting efforts toward practical and timely capacity strengthening.

Nonetheless, there is an ongoing concern about the frequent rotation of health personnel among national and local partners operating health services. Donors specifically pointed out that they have not observed innovative strategies ensuring that funds invested in capacity development achieve lasting impacts, given the continuous need for repeated training sessions. The establishment of clearer protocols and guidelines was highlighted as essential to guarantee the sustainability and effectiveness of capacity-development initiatives.

Resource mobilisation:

There is no evidence of cluster’s activities for resource mobilisation.

Monitoring health worker safety:

There is no evidence of cluster’s activities for monitoring health worker safety.

- Health cluster contribution to efficiency in the health response (for example, through reducing duplication and/or maximising use of available resources):

As mentioned before, commitments already established at the national level are a consequence of a lack of strategic clarity and slow processes, leading some organizations to prefer acting independently to ensure that the response reaches affected populations promptly, even if this means opting out of coordination efforts. Moreover, the absence of strategic discussions at the national level results in decision-makers rarely participating in cluster meetings, and not all partners engage in these discussions.

Technical working groups tend to find more common ground due to the clear relationship between their specific subjects and mandates. Organizations participating in these spaces consider that coordination efforts are more effective there, with genuine resource maximization occurring through focused collaboration. However, these organizations are discouraged of participating on the national cluster spaces where they don't find a place for the specificities of their discussions.

Similarly, the territorial tables have proven effective for coordinating operational decisions, reducing duplication, and maximizing available capacities. Information sharing within these spaces strengthens the needs, response, and gaps structure, ultimately enhancing the effectiveness of the operational response.

A good practice identified is the work of the bi-national tables, whose potential lies in addressing similar challenges and the need for complementary actions on both sides of the borders. Additionally, the ability to exchange information at the territorial level provides the flexibility needed for rapid coordination without the delays associated with navigating the national levels of two different countries.

- Health cluster contribution to cluster transition and deactivation:

There is no clear intention of planning for a cluster deactivation, despite the cluster having a solid structure to support the nexus approach in a country where the government is present.

However, one of the territorial tables has acknowledged the potential absence of PAHO in their coordination body and has begun to plan measures to ensure the sustainability of the table. This could be interpreted as an organic outcome of efforts to make coordination spaces more sustainable in the long term.

- Factors that have supported and limited success in delivering/supporting a strong response:

The obligation to hold cluster meetings under Colombian law grants these spaces greater legitimacy and compels governmental institutions to participate as part of their official duties. This legal framework reinforces the coordination efforts and ensures that key stakeholders are consistently involved.

Colombia's strong health system is another factor that supports response efforts, as it theoretically ensures access to emergency care for everyone. However, this also places considerable emphasis on affiliation efforts, which can complicate the operational aspects of emergency responses.

A significant limitation is the lack of resources and dedicated personnel from PAHO, highlighting the need for better resource coordination and specific funding to improve planning and support logistics for activities. This resource gap makes it challenging to maintain effective and timely responses to emergencies.

Additionally, the absence of monitoring or evaluation of actions, coupled with weak follow-up and accountability mechanisms, significantly limits the effectiveness of response efforts. The lack of structured mechanisms to track progress and measure impact undermines the continuity and overall success of the response.

- WHO regional office support to the country health cluster in strengthening the response:

Guidance from Washington has significantly shaped pandemic preparedness strategies, with regional expertise positively influencing national and local levels. However, beyond that specific context, there is little evidence of substantial guidance coming from the regional level. Moreover, it is challenging to assess the effectiveness of the tools and methodologies provided by WHO and PAHO, as language barriers significantly limit their accessibility and implementation at both national and subnational levels.

There is a clear gap in the articulation of the national coordinator's role, as it is formally held by one person who receives global and regional guidelines, while a national consultant leads cluster meetings and manages overall coordination at both national and subnational levels. Although both individuals maintain good communication, this division creates an additional layer of communication and complicates the application of global policies and guidelines.

Coherence and coordination

External coherence

- Health cluster contribution to external coherence and coordination (inter-cluster and multi-sector collaboration; coordination with national coordination mechanisms):

From the perspective of some organisations participating in different clusters, and even from broader coordination architectures, the Health Cluster is considered one of the most solid and functional. However, at the inter-cluster level, while there is some contact with other clusters, it is limited and does not necessarily reflect an established coherence between sectors.

As mentioned before, there is no common agreement on the People in Need (PiN) estimations, and different datasets from one architecture or another are used to establish priorities and activities across the sector. Even if the Country Health Cluster follows the JIAF methodology for its PiN estimations, the HRP and the cluster’s numbers are still far from each other. This lack of consensus complicates the coherence of the coordination efforts and the strategic planning of the response.

Localisation and Nexus Programming

- Health cluster contribution to localisation and improved local partner participation in decision making:

- Health cluster contribution to strengthening and ensuring sustainable national and sub-national coordination for prevention, preparedness and response to public health and humanitarian emergencies:
- Health cluster contribution to strengthening the link between humanitarian responses and national health systems, and between the humanitarian and development/peace nexus:

The main localisation and nexus strategy used in Colombia is implemented through governmental involvement in the cluster structure. This not only facilitates the humanitarian sector's complementarity with the existing Colombian government health response but also strengthens institutional coordination capacity at all levels, empowering territorial authorities to take ownership of coordination spaces and identify their needs, capacities, and gaps.

At the subnational level, the co-leadership of territorial tables is used by local authorities as a way to legitimise their voice and advocate for their requests at the national level. In this sense, the cluster contributes to strengthening the relationship between the Ministry of Health and the Departmental Health Institutes.

However, this process faces challenges every time elections take place at both the national and subnational levels. PAHO representatives note that it typically takes around a year to consolidate relationships with the government so that they fully understand the purpose of the cluster spaces, the scope of the cluster's contributions, and how meetings and processes should be conducted. As a result, there is a constant drain on time and resources to ensure its sustainability, beyond having a legislative resolution that provides long-term institutionalisation for the territorial tables and the cluster.

Additionally, under the Flagship Initiative, communities are invited to participate in territorial table meetings to express their needs and perspectives on the response. These invitations are extended when the co-leads consider them relevant and appropriate based on the topics to be discussed.

Coverage and equity

- Extent to which the country health cluster considers issues of health equity, gender equality, disability and human rights in planning, implementation and M&E:

Equity and differential approaches are introduced into cluster discussions through two main channels. First, among organizations with mandates that advocate for these approaches, focusing on specific populations such as people with disabilities or women, children and youth.

In parallel, the territorial tables demonstrate a clear understanding of the need for a diverse focus in their responses, adapting to the characteristics of each territory. For instance, territories with a significant presence of ethnic minorities show a better understanding of and response to their differential needs.

Both channels are valuable for the purpose of mainstreaming equity objectives; however, they do not replace the need for an overarching approach, which is not clearly visible from the perspective of the cluster's leaders.

Key challenges and lessons learned

The co-leadership of PAHO and the Ministry of Health is generally perceived as a good practice for facilitating better information exchange and ensuring the capacity strengthening of the government, not only in technical health matters but also in leading health emergency responses at both national and subnational levels. The lesson learned here is that, where feasible, collaborating closely with governments is not only desirable but also practical. This approach promotes a nexus strategy, maximizes resources, and ensures a coordinated response not only among partners but also with the government as the first responder.

In this context, the leadership of local governments is essential for effective health coordination, with the involvement of community leaders identified as a best practice that should be further developed. The ultimate objective is to fully transition leadership to the government. However, challenges such as frequent government turnover and capacity gaps hinder this process, especially in sectors like health.

The model of needs, response, and gaps has been instrumental in structuring the humanitarian response as a complementary effort in Colombia and in strengthening coordination spaces at the subnational level. Despite the absence of a PAHO staff member dedicated exclusively to coordination—and even when one person must cover multiple territorial tables—the co-leadership and capacity-strengthening efforts aimed at health authorities at the territorial level have enabled the territorial tables to function as effective coordination mechanisms. In this regard, the effectiveness and efficiency of the cluster are more evident when it comes to operational coordination.

On the other hand, from the perspective of strategic priorities, there is a persistent challenge in determining whether the priorities set by the Global Health Cluster are genuinely aligned with the needs and context of national clusters or if they are merely broad enough to serve as an umbrella covering diverse contexts without adequately addressing the specific coordination characteristics required.

At the national level, the biggest challenge lies in evolving from a model focused primarily on information sharing and operational coordination to one that serves as a platform for clear strategic guidance. Such a shift is essential to ensure that emergency responses are both relevant and effective for the territories.

Lastly, in the Colombian context, a critical question is when to phase out the provision of complementary responses to crises that continuously strain the public health system, without undermining the state-building process. This challenge is particularly significant considering that Colombia faces extensive and widespread development challenges with direct impacts on health issues. Moreover, the country is constantly dealing with emergencies, often involving a combination of armed conflict, migration flows, epidemics and natural hazards that exceed the State's response capacity.

Key documents and data reviewed

Clúster Salud Colombia, Organización Panamericana de la Salud, Organización Mundial de la Salud, 2024. Respondiendo en salud a las emergencias de manera conjunta.

Clúster Salud Colombia, 2024. Plan de Trabajo Clúster Salud.

Clúster Salud Colombia, 2024. Plan de fortalecimiento de capacidades nacionales y locales socios clúster salud y mesas territoriales de salud.

Clúster Salud Colombia, Organización Panamericana de la Salud, Canada, USAID, 2024. Prioridades estratégicas 2025 desde la perspectiva del clúster y las mesas territoriales de salud.

Clúster Salud Colombia, Organización Panamericana de la Salud, 2024. Alertas de emergencias y su implicación en salud - Resumen de las emergencias humanitarias en julio 2024.

Clúster Salud Colombia, Organización Panamericana de la Salud, 2024. Panorama de seguimiento de El Fenómeno de El Niño y sus implicaciones en salud 2023-2024.

Health Cluster Colombia, 2024. Supporting locally led action Area Based Coordination in Colombia.

Inter-Agency Coordination Platform for Refugees and Migrants from Venezuela (R4V), 2024. Refugee and Migrant Response Plan 2025-2026.

Oficina de Coordinación de Asuntos Humanitarios (OCHA), 2024. Plan de Respuesta a Prioridades Comunitarias 2024-2025.

Oficina de Coordinación de Asuntos Humanitarios (OCHA), 2024. Actualización PRPC Colombia 2025.

Comparative chart of the global strategic priorities, the national health response strategy and the national cluster activities in Colombia

GHC Strategic Priorities 2020-2025[24]	National cluster activities *(12)*	HRPCP 2024-2025 Health response strategy[25]
Strategic Priority 1: Strengthen coordination for local, national, regional and global actors to prevent, prepare for, respond to	Strengthening community and institutional capacities.	Strengthening institutional and community capacities to facilitate effective access to health services that guarantee durable solutions; this requires the enhancement of

[24] Directly quoted from the Global Health Cluster Strategy Plan 2020-2025

[25] Directly quoted from the HRPCP 2024-2025

and recover from public health and humanitarian emergencies		available health services and the processes of referral and counter-referral at different levels of care, aimed at ensuring comprehensive and safe care for the population.
Strategic Priority 2: Strengthen inter-cluster and multi-sector collaboration to achieve better health outcomes	-	-
Strategic Priority 3: Strengthen our collective and respective health information management use	Epidemiological surveillance.	-
Strategic Priority 4: Improve the quality of Health Cluster action	Supporting access to and delivery of services Providing primary healthcare actions, including sexual and reproductive health, mental health and psychosocial support, care for prevalent childhood diseases, chronic diseases, and communicable and non-communicable diseases.	To promote the provision of health services based on quality standards that are effective and complementary; this requires the design of a set of appropriate and intersectoral interventions that respond to the risks and structural determinants of health, which stem from the specific profiles of people affected by emergencies. These interventions must take into account the intersections of gender, age, disability, ethnicity, race, and/or health conditions, among other factors or situations. To contribute to effective access to physical and mental health services for the most vulnerable people affected by emergencies, aligned with the mechanisms and public policies established or to be established by the country, as well as the needs and capacities identified at the community level. This approach aims to facilitate the development of durable solutions with a territorial and intersectoral focus.
Strategic Priority 5: Strengthen Health Cluster advocacy at local, country, regional and global levels	-	At the community level, it is considered necessary to increase participation and strengthen capacities based on local knowledge to facilitate prevention and promotion processes related to health. This includes primary health care, epidemiological surveillance, and first response.

Democratic Republic of Congo Health Cluster short analysis

Key country data

Humanitarian and health context

With an estimated population of 118 million in 2024[26], the Democratic Republic of Congo (DRC) is facing a humanitarian crisis rooted in decades of armed conflict, political instability and structural fragility. While forced population displacement is the most visible manifestation, this crisis is the result of complex, interconnected issues and underlying causes that have yet to be addressed in a structural and decisive manner.

The east of the Democratic Republic of Congo remains the scene of a complex conflict, marked by confrontation between, on the one hand, the Armed Forces of the DRC (FARDC) and their allies and, on the other, a myriad of non-state armed groups (GANE). The latter, sometimes temporarily allied with the national forces, are also at odds with each other, fuelling a cycle of violence targeting civilians and certain communities. The fragile security situation has led to the deployment of foreign forces and regional military operations, with limited results. In North Kivu and Ituri, this situation has also led to the establishment of a state of siege since May 2021, restricting the operation of courts, administrations and civil authorities. (direct quote) [27]

WHO reports that at least 3,082 injured people were admitted to Goma's health facilities between 26 January and 7 February. Both health facilities and morgues are overwhelmed. As of 5 February, the DRC Red Cross had buried over 2,000 bodies, with 900 still awaiting burial in overcrowded morgues.

The WHO has also raised concerns about a worrying increase in rape and other gender-based violence (GBV) perpetrated by armed men during clashes. Protection actors have recorded 45 cases of rape among displaced persons, including 21 survivors of gang rape who have been admitted to two hospitals in Goma.

The cholera situation in Goma and surrounding areas remains alarming. Between 3 and 9 February, a spike in cases was reported in the Buhimba health area, with over 70 cases reported near the Bulengo displacement site. At least 80 per cent of cholera cases in North Kivu are reported on the displacement sites, according to the Health Cluster. The dismantling of many sites has complicated the situation due to the dispersal of displaced people and the suspension of epidemiological surveillance activities following recent fighting. (Direct quote) *(13)*.

- **People in need of support to meet priority health needs** (timeframe; data from range of sources): 19.6 million people affected.

[26] HRP 2025
[27] HRP 2025

- **Priority health sector issues** (e.g. access to essential health care; disease outbreaks; health care infrastructure; security): Access to essential health care conflict related displacement, MPOX, cholera, measles, COVID-19 and Marburg Virus.

Health Cluster

- **People in need covered by the health cluster (timeframe): 8.7 million**
- **Funding required (timeframe):** $264 million *(14)*
- **Funding received (timeframe):** 34% funded
- **Number and category of health cluster staff:**
  - National team: 2
  - Health Cluster Co-ordinator: 1 FT
  - Information management officer: 1 FT
  - Public health officer: 0
  - Communications officer: 0
  - Subnational hubs: 5
- **Number and category of health cluster partners: UN; INGO; NNGO; donors; technical partners; other**
  - Partners: 117
  - International NGOs : 40
  - National NGOs : 60
  - UN agencies : 4
  - National authorities: 5
  - Donors: 5
  - Observers: 3
- **Health cluster Technical Working Groups:** Mental health and sexual and reproductive health at the national level and in Adre. There is also a data working group in national level.

Key findings

Role and relevance

- To what extent has WHO has been a successful coordinator of the health cluster:

On balance - 'yes'. There are some gaps in the application of the core cluster functions (below), but overall, WHO is successfully implementing the functions seen as priorities by most partners, under very challenging circumstances.

Nonetheless, capacity has fluctuated over time. The cluster is currently well-staffed, in part because of the influx of resources that has come with the Mpox response - a pattern that has been repeated over time for other emergencies.

Overall, WHO's CLA role is well integrated into its overall technical support function. This includes solid interconnectivity between the Mpox response and the cluster function - although some partners saw the cluster as being overly focused on the Mpox response, to the detriment of other response elements.

The clusters are actively undertaking coordination (national, international NGOs, government, and observers), prioritisation, deconfliction, basic information management, and interface with the government (with some caveats, see below).

Key strengths and weaknesses of WHO in its role as CLA at country level (including in relation to core cluster functions):

Overall, WHO's CLA role is well integrated into its overall technical support function. There have been some challenges with overlapping functions between Mpox response, WHO's Emergency Management system and cluster, but evidence that WHO has been working through these challenges.

Strengths

- Prioritisation, deconfliction, gap filling - this includes the provider of last resort function which was highlighted by WHO in North and South Kivu and in Kinshasa. This includes rapid response in the event of an outbreak - not necessarily through stockpiling.
- Info-management as 3Ws, 5Ws. This is one of the basic information products, but it is important in the context of presenting an overview of the summary, gap filling and the basis for an understanding of deconfliction (see also weaknesses)
- Good knowledge of the terrain
- Some elements of capacity strengthening, but this is a complex issue (below)
- Joint analysis with other clusters
- Fundraising support
- Provision of tools
- Harmonization of work between organizations and community relays
- Inclusive work approach
- Ongoing communication with partners
- Creation of ad-hoc groups to work in the event of a crisis

Weaknesses

- Irregular update of the stakeholder mapping
- In the minds of partners, the cluster (see capacity strengthening below) should play a role in monitoring the capacity of partners. Monitoring of cluster members' interventions
- Insufficient investment in localization (see further explanation below) Insufficient administrative support to partners
- A focus on epidemics to the detriment of other cluster functions
- Insufficient inter-cluster collaboration
- Inconsistency in human resources over time

WHO in its CLA role

- [Extent to which WHO has been a successful coordinator of the health cluster; Key strengths and weaknesses of WHO in its role as CLA at country level (including in relation to core cluster functions); Whether WHO as CLA has been able to distinguish the cluster response as independent from WHO's technical response in support of government]

WHO managers and HCCs are very clear about this distinction and aware of the nuances involved. One senior manager stated that, beyond understanding the distinction, the most important facet of the role is the diplomacy required to carry it out effectively. The same manager noted that he was a convert to the value of the cluster function within WHO. Originally, he had been sceptical and stated that he had not understood the value of the cluster function to WHO's role as a technical agency. He described himself as a convert, having come to appreciate the value of the connection with health partners in the humanitarian response.

The relationship between the Government and humanitarian health partners is complex in North and South Kivu. In focus group discussions, partners consistently stated that they recognised the need to work more closely with the Government and to be better integrated into Government systems and structures. From the perspective of the Government, while largely satisfied with their partnership with the health cluster, they also sought a greater level of understanding of the collective, non-governmental response and wanted more information from partners who do not report. Some of these actors are operating, in the eyes of the Government, without proper authorisation.

In DRC, there is no fundamental or principled issue with cooperating with the Government. Some response activities are taking place in contested areas or areas held by non-government actors. In both North and South Kivu, the respective technical representatives sit on the mental health task team. Representatives of the DPS participated in the focus group discussions in South Kivu. In South Kivu, the DPS has occasionally chaired health cluster meetings and has also chaired partner meetings on specific issues. However, the DPS does not have the capacity, or ultimately the desire, to take a key position as co-lead of the HCC. The lack of a financial incentive was raised as a significant issue.

In essence, the cluster is an effective but limited conduit for technical coordination and communication with the Government, and between international and national non-governmental partners. Arguably, however, weaknesses on the part of the cluster mechanism and limited Government capacity mean that further progress is unlikely, and the status quo is likely to be maintained. The cluster is unable to make a significantly greater contribution to integration with Government systems, to the extent that the principled approach allows this to be desirable.

From the point of view of non-governmental partners and stakeholders, there is some confusion between WHO's cluster and technical response, and WHO's technical support to the Government.

- To what extent are health cluster strategic priorities aligned to needs (including freedom from political influence, including the most vulnerable and hard to reach groups in acute, protracted and slow onset crises?)

From the perspective of the sub-national clusters, the national cluster has prioritized interventions on the three pillars of the National Health Strategy: Pillar I, IDPs (6 intervention packages), Pillar 2 epidemics, Pillar 3: nutrition. In the east of the country, in addition to national priorities, the cluster has prioritized interventions based on the HRP. The IDP pillar is active in both North and South Kivu and an essential part of the response in and around Goma (at the time of the interviews).

Effectiveness and efficiency

Cluster contribution to an improved response

- [Extent to which the health cluster response as part of the HRP is genuinely needs driven and free of political influence; Relevance and alignment of strategic priorities and activities to country needs; How well are global and country-level health cluster strategies and interventions aligned to meeting the evolving needs of affected people, including the most vulnerable and hard to reach groups in acute, protracted and slow onset crises; [Does health receive an appropriate level of support from donors and government? Is this affected by perceptions of the health cluster's independence and effectiveness? Is the cluster functioning at the operational level i.e. has it ensured that highly affected geographical areas or specific populations have been addressed by the response?] Health cluster accountability to affected populations (how and to what extent).

Quality and timely public health information to inform operational decision making:

The cluster has strengthened the capacity of partners to collect and report data into DHIS2, as well as trained partners to enter data into the 3/5Ws

The national and sub-national clusters/health working groups are regularly places for information sharing, and this is supported by ample evidence in interviews and documents produced by clusters at various levels. Interviewees described much of this information sharing as useful but relatively 'passive,' coming in the form of 'programme updates' or 'key achievements' per partner. This includes the health clusters' participation in rapid assessments, typically organised' IM function. These include "ensuring that reliable flows of information between the HCT and the Health Cluster are evidence-based for strategic decision-making and planning purposes," and "...contribut[ing] to multi-organised/multi-sector initial rapid assessment and interagency assessments."

There is little evidence of strategic, higher-level decisions being made in cluster or sector meetings, or resulting from them. Rather, partners frequently cited their inability to organise internal and donor reporting.

This includes the health clusters' IM function. These include "ensuring that reliable flows of information between the HCT and the Health Cluster are evidence-based for strategic decision-making and planning purposes," and "...contribut[ing] to organise the cluster; some report inconsistently and/or infrequently. All partners report internally, and there is a general perception that partners prioritise internal and donor reporting.

As detailed below (see efficiency), government representatives are frustrated by the lack of a detailed and constantly updated set of data on the services being provided in the health sector. One government representative stated that they needed a sufficiently disaggregated/detailed data set, specifically to support decisions on resource allocation. This level and frequency of data are beyond the specified information management function required of the cluster (and OCHA's 3/5Ws), and yet there is an expectation that the cluster should be able to deliver it.

When actively engaged in funding allocations, the clusters in both North and South Kivu play a role in verifying that new programmes are priorities and not duplicative. Pooled funding decisions are also typically managed through cluster structures—i.e., allocation decisions (if not ultimate partner choice) are managed in cluster groups.

Cluster/sector meetings, however, do support operational decision-making for geographically and/or thematically specific issues. Bulletins and sitreps describe discussions on specific public health risks, communicable disease trends, priorities, needs, and gaps in specific areas—especially those newly affected or showing an increase in needs. Partners listed occasions when meetings used this type of information for 'tactical' decision-making. In interviews, partners described numerous examples of targeted, rapid/responsive decision-making. This includes immediate gap-filling or operational deconfliction. While not all partners are active in the clusters, those who participate do come to the table at important junctures and make decisions. This includes the health clusters' participation in rapid assessments, typically organised as multi-cluster exercises by OCHA.

- Does the health cluster improve accountability to affected populations (AAP)

There was no evidence of specific interventions/systems at to aid cluster level. No specific standard approaches were raised at cluster level were raised during interviews or focus groups.[28] In Bukavu, in keeping with coordination in other structures, OCHA has a specific focal point for AAP, whose role includes sitting on all clusters, including in health and advocating for AAP.

Documents contained specific references to activities in support of AAP. WHO funded the NGO COSAMED in South Kivu via a CERF grant, with the aim of improving improved access to essential basic health care services for IDPs and host families (FAMAC), people living with disabilities, and returnees. The project, in collaboration with the local health authorities, organized a complaint management mission in the supported health facilities to gather feedback from beneficiaries and plan a recovery plan for future interventions.

Health cluster contribution to efficiency in the health response (for example, through reducing duplication and/or maximising use of available resources)

As above, cluster partners at national and sub-national level described critical discussions among active partners aimed at gap filling and prioritisation in specific response areas (geographical or thematic). Efficiency gains could be inferred in some cases, but at a relatively small scale.

As was the case in Chad, local Government officials, who were very positive about the relationship with WHO and the cluster in general, stated that they had neither the data nor the influence to make efficiencies in ongoing programming. Typical of conversations with Government representatives one stated:

> "(…) We find organizations that duplicate each other…. three or four organizations are all in the same health area and cover the same needs. When you tell them this, is there a way we can harmonize? They say, 'our donor requires this or that'".
>
> "(…) Even the reports some give us… they say, this is the donor's template…. these are the indicators expected by the donor, and we just fold our arms."

Policies, setting standards and developing guidelines:

Partners were asked in focus groups to describe the functions of the cluster which were of most value to them, and what they associated with the clusters and cluster meetings. This function was not brought up unprompted. When asked, however, partners brought up clear examples in which standards had been the focus of cluster meetings. In particular, WHO was recognised as having focused on the appropriate standards of treatment and care in response to new disease outbreaks and in maternal health more broadly.

[28] The one short field visit to an IDP site on the outskirts of Goma was cancelled as a result of the deterioration of the security situation.

In North Kivu, the lack of a standard approach to running mobile clinics was raised as a significant issue. In the context of mass displacement and poor security around Goma (at the time of the interviews), a mobile clinic strategy was a key part of the IDP response pillar, as a means of providing basic health care. Partners noted that the range of services varied greatly. Most operated only for short periods during the day; the extent to which they were able to facilitate referrals was variable and typically low; many were not able to support routine vaccinations. Cluster staff were unaware of whether or not there was a global standard for mobile clinics, they were already conscious of this issue, and it was already an action point for discussion with Kinshasa or Geneva.

Improved predictability and adequate and timely leadership for the response at national and sub-national levels:

At the subnational level, the partners, cluster coordinators and observers were acutely aware of how cluster coordination capacity had varied over time. Partners consistently noted that there had been periods in the past two years where that had been gaps which left the cluster coordinators significantly overstretched. These gaps were in the IMO position and in the co-cluster lead position.

In addition, in South Kivu, the HCC, until 3 months earlier had been 'double-hatting' - acting as the emergency focal point for WHO's response, as well as the cluster role. Partners noted challenges in capacity during this period. WHO staff, including HCCs noted the connection between funding and staffing levels. The MPOX outbreak, and the funding associated with it, was attributed with having increased staffing levels overall, leading to the filling of the IMO and WHO specific positions, allowing for HCCs to focus on that role.

Evidence-based advocacy:

Partners raised clear examples of advocacy undertaken on their behalf by the cluster. These principally included issues. Primarily, these included advocacy for funding, especially on behalf of local partners

Resource mobilisation:

Pooled funds (DRC humanitarian Fund and CERF) utilise the cluster system in some form in allocations. Some funds have been mobilized at the provincial level (Bukavu) and allocated to a handful of partners. Overall, the level of mobilization of funds is insufficient or low according to the partners.

Coherence and coordination

External coherence

- [Health cluster contribution to external coherence and coordination (inter-cluster and multi-sector collaboration; coordination with national coordination mechanisms); Joint working within WHO and coordination with other WHO partner networks (e.g. EMTS, GOARN)]

Inter-cluster coordination was consistently noted as a weakness in North and South Kivus. Key partners noted the extent to which the health clusters made significant improvements in internal coordination, but that overall, coordination remained overly vertical/internal i.e. there remains a lack of inter-cluster coordination.

Inter-sectoral coordination for specific disease outbreaks is held under the DPS, with the participation of OCHA, when epidemics such as cholera occur. The health cluster participates in meetings planned by the DPS but collaborates or involves the DPS little or not at all in the selection of partners, and in the operationalization of direct responses.

Overall, the Mpox response was consistently seen as very well integrated into health cluster coordination in North and South Kivu (see below). Standalone Mpox-focused meetings have been held with the necessary cluster partners, and updates have been consistently delivered in cluster meetings. This positive, however, was seen as having the unintended side effect of dominating the cluster meetings. This focus on Mpox was seen as limiting the space for the prioritisation of other key elements of the response. One partner referred to this as a "vertical response within the vertical." This issue was raised by partners in the sub-working groups on mental health and SRH. One partner, referring to the dominance of epidemic response in the cluster meetings, stated

> '(…) We have the three groups. We cannot say, however, that there has been a single meeting where we discussed all aspects of health'.

Localisation and Nexus Programming, coverage and equity

- [Health cluster contribution to localisation and improved local partner participation in decision making; Health cluster contribution to strengthening and ensuring sustainable national and sub-national coordination for prevention, preparedness and response to public health and humanitarian emergencies; Health cluster contribution to strengthening the link between humanitarian responses and national health systems, and between the humanitarian and development/peace nexus]

Partnerships and capacity strengthening of national partners:

Meeting minutes and bulletins contain numerous reports of training for national partners, including local health staff, on a range of issues. These include medication and care specific to Mpox and other diseases, as well as protection. In Bukavu, there is an ongoing programme of training for local partners on PSEA. This training was undertaken through focal points, to be followed by peer-to-peer training internally, and monitored by WHO's PSEA focal point.

Participation of local partners:

In terms of participation, in both the general and technical groups, local members are likely the majority cluster members, by some margin. Several partners, while small, are diaspora led or regional organisations that technically/legally have INGO status. The cluster has a clear formula to define active partners including 5Ws reporting and analysis. Beyond these, however, there are a still a significant volume of partners whose precise status and capacity are harder to define. (see also OCHA request for the national health cluster in Chad to 'verify 86 national partners').

Credibility/trust is key issue at the centre of conversations in the Kivus. As above, this applies to a range of partners both local and international. The notion of capacity strengthening builds on the assumption that cluster partners

have a genuine humanitarian mission i.e. their primary motivation is to deliver quality services in an impartial way, especially in the last mile. In DRC, as in other resource scarce environments, there are a number of deep-seated suspicions:

- Questions about the motivation of some partners: specifically, the idea that some are businesses, created to generate income rather than to deliver - 'briefcase NGOs'. From WHO's senior management, to Government, to international and other local partners expressed doubt about the fundamental motivation of some cluster members. These organisations, in the words of one WHO staff member, have the capacity to generate very credible proposals and equally convincing reports, without the capacity (and sometimes the intent) to deliver quality services on the ground.
- These partners are attracted, in part at least, because the clusters act as a conduit to funding. This conduit is direct in the sense that the clusters play a role in the allocation processes for OCHA led pooled funding mechanisms, as well as acting as a filter for prioritisation. In the DRC, the Humanitarian Coordinator recently stated that 60% of all funds from the DRC Humanitarian Fund should go directly to NNGOs.[29] Despite this being the case, the quantity of funding per allocation for health can be extremely small.[30]

There is an expectation among some partners that the cluster should, or could, play a quality control or even a 'policing' function. Recognising that the Government does not have the capacity to run checks on all partners, a number of partners recommended that the cluster take on the role of field monitoring-essentially, quality assurance for all cluster partners. Cluster staff also noted that they had been approached by donors to play the same role. Cluster staff stated that they did not have a budget or other resources to perform this function, but they did not question whether or not it was an appropriate role for the cluster. While this is not a credible expectation for WHO as CLA, it does highlight a very significant, systemic issue.

- What is the Health Cluster's contribution to strengthening and ensuring sustainable national and sub-national coordination for prevention, preparedness and response to public health and humanitarian emergencies?
- To what extent does the health cluster contribute to strengthening the link between humanitarian responses and national health systems, and between the humanitarian and development/peace programming?

The appropriate Government counterpart sits on the mental health task team. Despite having excellent relations with the cluster in North and South Kivu, however, the DPS does not co-lead (also noted above). Under the current conditions in the Kivus, and given the current capacity of the Government, there was no serious discussion of nexus programming-specifically as it relates to exit strategies and handovers (as opposed to joint working with health).

[29] An Interview with OCHA in Kinshasa remained pending due to the evacuation for security reasons that happened during the country visit.

[30] Cluster staff stated that sometimes they sometimes disagreed with the partner selections by OCHA, having participated in the allocation processes themselves. Essentially, parcels of funding are given to sub-national clusters, and cluster meetings decide on priorities to quite a precise level of detail. The pooled fund staff themselves, however, accept and process proposals.

Documents refer to one set of consultations with UNFPA and the Ministry of Health around ensuring coherence with an ongoing payment scheme, i.e., ensuring that humanitarian agencies comply with the copayment arrangements applied by UNFPA and the MoH for MCH drugs.

Data sources

Key informants interviewed

- Information Management Officer Bukavu
- North Kivu Medical Director OCP
- IMO (North Kivu)
- North Kivu HC Co Coordinator
- North Kivu HCC
- Head of Sub Office WHO Bukavu
- MPox Emergency Lead WHO
- PSEA focal point WHO
- Head of Provincial Division of Health (North Kivu)
- Bukavu (South Kivu) IMO
- North Kivu Head of Sub Office
- HCC Bukavu
- Bukavu Humanitarian affairs Officer
- Bukavu Head of Provincial Division of Health (DPS)
- AAP Focal Point
- MSF Spain
- MSF Holland

Other information sources

- FGD - General Health Cluster partners (North Kivu) (1)
- FGD - General Health Cluster partners (North Kivu) (2)
- FGD - General Health Cluster partners (North Kivu) (3)
- FGD - Mental Health Task Team (North Kivu)
- FGD - Sexual and Reproductive health task team (North Kivu)
- FGD - General Health Cluster Partners (Bukavu) (1)
- FGD - Bukavu General Health Cluster Partners (Bukavu) (2)
- FGD - Mental Health Task Team (Bukavu)
- FGD - Sexual and Reproductive Health task team (Bukavu)

Key documents and data reviewed

Cluster Santé République Démocratique du Congo, 2024. Bulletin Cluster Santé Sud-Kivu Mars (Bulletin No. 02). Sud Kivu.

Cluster Santé République Démocratique du Congo, 2024. Bulletin Mensuel Janvier et Février Nord Kivu (Bulletin). Sud Kivu.

Cluster Santé République Démocratique du Congo, 2024. Réunion Cluster santé Harmonisation entre les partenaires de développement et d'urgence (DPS Ituri).

Cluster Santé République Démocratique du Congo, 2024. Bulletin Mensuel Novembre Nord Kivu (Bulletin). Nord Kivu.

Cluster Santé République Démocratique du Congo, 2024. Plan d'action prioritaire reponses Minova, Fizi et Kalehe.

Cluster Santé République Démocratique du Congo, 2024. Réunion Cluster Santé Sud Kivu Maniema.

DRC Country Health Cluster, n.d. Note sur le calcul du cout unitaire de santé.

Health Cluster Nord Kivu, 2024. Compte rendu de la réunion ordinaire de coordination du cluster santé Nord-Kivu (Décembre).

Health Cluster Nord Kivu, 2024. Compte rendu de la réunion ordinaire de coordination du cluster santé Nord-Kivu.

Health Cluster Sud-Kivu & Maniema, 2024. Formulaire pour la contribution au SitRep du cluster santé.

Ethical considerations

The ET followed the UNEG ethical guidelines to fulfil obligations to respondents participating in this evaluation, in addition to the guidance given in the WHO evaluation policy, WHO Evaluation Practice Handbook and UNEG Norms and Standard. These were as follows:

Respect for dignity and diversity: The ET respected the differences in culture, local customs, religious beliefs, gender, disability, age and ethnicity and the potential implications of these when carrying out the evaluation. The ET minimised any risk of disruption to the respondents, provided ample notice and respected their privacy.

Rights: The ET ensured that participants were treated as 'autonomous agents' and were given the time and information to decide whether they wish to participate.

Redress: Participants were provided sufficient information on how to register a complaint.

Confidentiality: The ET respected respondents' right to provide information in confidence and made them aware of the scope and limits of confidentiality. Names and any other identifying information have been anonymised.

Data security: Data are stored systematically and securely and in line with data protection policy and are only accessible to the ET. If requested and following appropriate anonymisation, data can be shared with WHO. Data will be deleted two months after the evaluation has been completed.

Responsibility: Any dispute or difference of opinion among the ET or between the ET and the client in connection with the findings and/or recommendations were clearly explained.

Integrity and independence: The ET ensured that any emerging issues and potential deviations were clearly discussed and agreed with WHO. The ET has provided an independent judgement free from bias and takes full responsibility for the accuracy of information presented in the report.

Intellectual property: All materials produced during the conduct of this evaluation are WHO's property and can only be used by prior written permission.

Methodological risks and mitigations measures

RISK	LEVEL	MITIGATION
Data availability and quality		
Availability of reliable and complete secondary data and specifically disaggregated data	High	The ET informed WHO in advance about the documents/data required so they could source this. In the case that some documents/data were unavailable, the ET informed WHO of the implications for the ET's understanding and the methodology.
Availability of respondents		
Availability of personnel with institutional knowledge and experience and monitoring data	Medium	Other non-cluster actors involved in the sector contributed information for data triangulation.
Key stakeholders are not aware of the evaluation, its purpose and uses	Low	Each stakeholder was provided with background information before an interview or FGD.
Limited availability of high-level respondents, country coordinators, partners for interviews	Low	Sufficient respondents from each category were identified and contacted. On-site interviews were planned in advance according to availability. When difficulties arose, flexibility for re-scheduling was offered. In some cases, interviews were switched to virtual modality. The ToC consultation was planned to take place during an existing event. (Annex 5)
Low response rate from online surveys	Medium	The original response deadline was extended, and the link was shared multiple times to ensure engagement.
The survey results over-represent certain categories of respondents over others	High	Several survey reminders were sent, the response deadline was extended and, to reduce bias, IPW analysis was applied.

Participants may not participate due to confidentiality concerns or unavailability	Low	The ET sought consent (either verbal or written) from participants and ensured they were informed about ethical considerations, including anonymity. Participants had the chance to choose to allow recording or not. Interviews were only conducted when consent was given.
Potential evaluation fatigue from repeated data collection processes in priority countries	Medium	The team adapted KII questions to the type of participant to ensure relevance and reduce the demand on their time. The ET also conducted consultation on the ToC during the Health Cluster Coordinator Forum in Istanbul to minimise meetings.
Cultural sensitivities and biases		
Data collection instruments may not be culturally or linguistically sensitive	Medium	All data collection instruments were pre-tested before data was collected. Support from researchers helped to adapt the questions to the language and culture without changing the intent of the questions.
Some degree of bias in the identification of respondents for KIIs	Low	Lists provided by WHO were compared with other sources to broaden the respondents' profiles. Snowball sampling was used as well.
Evaluators bias	Low	Information was triangulated. Multiple ET discussions were conducted to identify potential biases and ensure consistency.
Technical limitations		
Use of Artificial Intelligence (AI)	Low	The ET is aware of AI tools limitation and best practices when used. All information generated using AI was double checked and cross-referenced.
Security and travel		
Unexpected events may hamper evaluation timelines and data volume and quality	Medium	An evacuation happened during the DRC visit, preventing the team from finishing interviews in Kinshasa. Some of these were subsequently conducted virtually.
Travel requirements for some priority countries may prevent the ET from accessing the countries in time for data collection	Medium	Country accessibility was a criterion for selection of countries for field visits.

Country level data analysis, due to the significant difference in responses between countries, may have introduced bias	Medium	Inverse Probability Weighting (IPW) analysis method was applied.

Bibliography

Chad Health Cluster (2025) Information Watch on Cluster Members' Activities, p. 7.

Cluster Salud Colombia, 2024. Plan de fortalecimiento de capacidades nacionales y locales socios clúster salud y mesas territoriales de salud.

Cluster Salud Colombia, 2024. Plan de Trabajo Clúster Salud.

Cluster Salud Colombia, Organización Panamericana de la Salud, Organización mondial de la salud, 2024. Respondiendo en salud a las emergencias de manera conjunta.

Cluster Santé République Démocratique du Congo, 2024. Bulletin Cluster Santé Sud-Kivu Mars (Bulletin No. 02). Sud Kivu.

Cluster Santé République Démocratique du Congo, 2024. Bulletin Mensuel Janvier et Février Nord Kivu (Bulletin). Sud Kivu.

Cluster Santé République Démocratique du Congo, 2024. Bulletin Mensuel Novembre Nord Kivu (Bulletin). Nord Kivu.

Cluster Santé République Démocratique du Congo, 2024. Plan d'action prioritaire reponses Minova, Fizi et Kalehe.

Cluster Santé République Démocratique du Congo, 2024. Réunion Cluster santé Harmonisation entre les partenaires de développement et d'urgence (DPS Ituri).

Cluster Santé République Démocratique du Congo, 2024. Réunion Cluster Santé Sud Kivu Maniema.

COSAMED, World Health Organization (2024). Rapport de la dernière mission de gestion des plaintes dans la ZS de Kahele (AS Nyamukubi, Bushushu, Muhongoza et Kahele) Mai au 10 Juillet 2024.

Dr. Jean-Bosco NDIHOKUBWAYO, 2023. Analysis of the humanitarian and health crisis in eastern Chad linked to the influx of refugees and returnees following the armed conflict in Sudan.

DRC Country Health Cluster, n.d. Note sur le calcul du cout unitaire de santé.

Egeland, J., Msuya, J., 2024. Proposal for a simplified and more efficient humanitarian system.

Global Health Cluster (2023) Cluster Coordination Performance Monitoring 2022, p. 41.

Global Health Cluster (2024) 'Supporting locally led action: Use of country based pooled funds to support locally led action'.

Global Health Cluster (2024). GHC Localization Strategy Results Monitoring Framework.

Global Health Cluster (2024). GHC Localization Strategy: Health Cluster Meeting, Feb 15th, 2024.

Global Health Cluster (2024). Localization in the Health Cluster Coordination: Gaziantep, Northwest Syria Case Study.

Global Health Cluster (2025). ERG extra documents evidence of good practice.

Global Health Cluster (2025). Health cluster localisation efforts countries tracking.

Global Health Cluster (GHC) (2007) Multi-Year Strategy 2017-2019 Survey. 10 January 2007. World Health Organization (WHO).

Global Health Cluster (GHC) (2017) Funding Report 2014-2016. 12-13 January 2017, Geneva. World Health Organization (WHO).

Global Health Cluster (GHC) (2018) Health Cluster Advocacy Strategy 2017-2019. Endorsed at GHC Partner Meeting, 17-18 April 2018, Brussels, Belgium.

Global Health Cluster (GHC) (2023) Accountability to Affected Populations: Operational Guidance. August 2023. World Health Organization (WHO).

Global Health Cluster (GHC) (2023) Minimum Standards: Accountability to Affected Populations (AAP). August 2023. World Health Organization (WHO).

Global Health Cluster (GHC) (2023) Terms of Reference for Members: Global Health Cluster Steering Group on Localization. 20 October 2023. World Health Organization (WHO).

Global Health Cluster (GHC) (2024) Cluster Transition: Transition Session. 18 October 2024. Available at: https://washcluster.net/

Global Health Cluster (GHC) (2024) GHC and Regional Office Collaboration on Health Cluster Response. World Health Organization (WHO)

Global Health Cluster (GHC) (2024) GHC Localization Strategy: Towards a Meaningful Engagement of Local and National Actors in the Health Cluster. 20 June 2024. World Health Organization (WHO)

Global Health Cluster (GHC) (2024) Health Cluster Forum: GHC Update – 16 October 2024. Geneva: World Health Organization.

Global Health Cluster (GHC) (2024) Results of Survey: Leadership, Representation, and Engagement of Local and National Actors. 24 January 2024. World Health Organization (WHO)

Global Health Cluster, 2017. Advocacy strategy - Key activities and timelines for action.

Global Health Cluster, 2017. Advocacy strategy - strategic objectives and key approaches/activities.

Global Health Cluster, 2017. Engagement with other networks, GHC Multi-Year Strategy 2017-2019.

Global Health Cluster, 2017. GHC Multi-Year Strategy 2017-1029 Survey, Summary Results.

Global Health Cluster, 2020. Global Health Cluster Strategic Advisory Group, Terms of Reference.

Global Health Cluster, 2020. Global Health Cluster Strategic Advisory Group, Terms of Reference.

Global Health Cluster, 2024. Notes – Group Exercise – Health Cluster Localization Commitments Session "Operationalizing the GHC Localization Strategy."

Global Health Cluster, 2024. Operationalizing the Health Cluster Localization Strategy.

Global Health Cluster, 2024. Supporting locally led action, Quality improvement and supporting partner performance especially in hard-to-reach areas.

Health Cluster (2024) 'Supporting locally led action: Funding sources in Sudan', October.

Health Cluster Chad, 2023. Health Cluster Bulletin - October 2023 (No. 04).

Health Cluster Chad, 2023. Weekly situation report for the health sector (No. 003).

Health Cluster Chad, 2023. Weekly situation report for the health sector (No. 004).

Health Cluster Chad, 2024. Atelier National Cluster Santé. N'Djamena - Chad.

Health Cluster Colombia, 2024. Supporting locally led action Area Based Coordination in Colombia.

Health Cluster Colombia, OPS, Canada, USAID, 2024. Prioridades estratégicas 2025 desde la perspectiva del cluster y las mesas territoriales de salud.

Health Cluster Myanmar, 2024. Advocacy paper Strengthening Myanmar health cluster coordination through an expanded and localized coordination in the four humanitarian areas.

Health Cluster Myanmar, 2024. Myanmar Operational Health Partners Group, Strategic Advisory Group, Terms of Reference.

Health Cluster Myanmar, 2024. WHO MMR Budget Lifeline Project, October.

Health Cluster Niger, 2024. Niger lessons learned Flagship Initiative.

Health Cluster Nord Kivu, 2024. Compte rendu de la réunion ordinaire de coordination du cluster santé Nord-Kivu (Décembre).

Health Cluster Nord Kivu, 2024. Compte rendu de la réunion ordinaire de coordination du cluster santé Nord-Kivu.

Health Cluster Sud-Kivu & Maniema, 2024. Formulaire pour la contribution au SitRep du cluster santé.

Health Cluster Sudan, 2024. 4Ws Dataset, January to November 2024.

Health Cluster Yemen, 2020. Yemen Health Cluster Annual Report 2020.

Health Cluster Yemen, 2021. Yemen Health Cluster Annual Report 2021.

Health Cluster Yemen, 2022. Yemen Health Cluster Annual Report 2022.

Health Cluster Yemen, 2024. Health Cluster Bulletin January and February 2024.

Health Cluster Yemen, 2024. Health Cluster Bulletin May and June 2024.

Health Cluster Yemen, 2024. Health Cluster Bulletin Yemen July & August

Health Cluster Yemen, 2024. Health Cluster Bulletin Yemen March & April 2024.

Health Cluster Yemen, May 2024. Yemen Health Cluster Achievement Dashboard.

IASC (2020). DR Congo: Ebola virus disease response - Operational Peer Review.

ICCG (2022) Information Sharing Protocol - National level. Guidelines.

Inter-Agency Standing Committee (IASC) (2020) IASC Cluster Transition Guidance. Geneva: Inter-Agency Standing Committee.

Myanmar Health Cluster (2024) '2024 Humanitarian Response', 21 August.

Myanmar Health Cluster (2024) 'Strategy 2025-2026 Draft'.

Myanmar Health Cluster (2024) Myanmar 2025 Humanitarian Needs and Response Plan: Health Cluster at a Glance. Humanitarian Needs and Response Plan (HNRP) – Health Sector. Myanmar Health Cluster, p. 1.

Myanmar Health Cluster (2024) Myanmar Health Cluster Bulletin - Quarter Two 2024. Bulletin, p. 2.

Myanmar Health Cluster (2024) Myanmar Health Cluster Bulletin: July-November 2024. Bulletin, p. 3.

OCHA, 2024. Analyse Financements Humanitaires 2021 - 2024.

OCHA, 2024. Bilan de la Réponse Humanitaire janvier - septembre 2024.

OCHA, 2025. Yemen Humanitarian Needs and Response Plan.

OMS Chad, Ministère de la santé publique de la République du Chad, Santé Chad, 2024. Weekly report on the humanitarian and health crisis in eastern Chad linked to the influx of refugees and returnees following the Sudanese conflict.

Organización Panamericana de la Salud, Cluster Salud Colombia, 2024. Alertas de emergencias y su implicación en salus - Resumen de las emergencias humanitarias en julio 2024.

Organización Panamericana de la Salud, Cluster Salud Colombia, 2024. Panorama de seguimiento de El Fenómeno de El Niño y sus implicaciones en salud 2023-2024.

Peer 2 Peer Support, IASC (2023). Syria Earthquake - Operational peer review, Mission report.

REACH (2024) 2024 Multisectoral Needs Assessment (MSNA) Key Findings Brief. Brief. Myanmar, p. 5.

Sudan Health Cluster (2023) Sudan Health Cluster Bulletin. Bulletin, p. 6.

Sudan Health Cluster (2024) '4Ws Indicators Dashboard'.

Sudan Health Cluster (2024) 'Health Cluster Partners Operational Presence'.

Sudan Health Cluster (2024) 'Meeting Minutes – HYBRID National Health Cluster Coordination Meeting'.

Sudan Health Cluster (2024) 'Sudan - Health Cluster Meeting'.

Sudan Health Cluster (2024) Sudan Health Cluster Bulletin. Bulletin, p. 10.

Sudan Health Cluster (2024) Sudan Health Cluster Bulletin. Bulletin, p. 7.

Sudan Health Cluster Strategic Advisory Group (SAG), 2024. Terms of Reference. Sudan Health Cluster. Available upon request.

Sudan Health Cluster, 2024. Draft Terms of Reference. WHO. Available upon request.

United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2024. Sudan Humanitarian Needs and Response Plan 2024. [online] Financial Tracking Service. Available at: https://fts.unocha.org/plans/1188/summary

WHO Health Cluster (2024). HCC Forum IM Session USB. Unpublished internal document.

WHO Health Cluster (2024). Introduction to Locally Led Action Sessions. Unpublished internal document.

World Health Organization (2012) 'WHA65.20 - WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies', in Tenth plenary meeting, Agenda item 13.15. Sixty-fifth World Health Assembly, p. 4.

World Health Organization (2017) Standards for Public Health Information Services in Activated Health Clusters and Other Humanitarian Health Coordination Mechanisms. Geneva: WHO

World Health Organization (2019) Health Cluster coordination guidance for heads of WHO country offices as cluster lead agency. Geneva: World Health Organization.

World Health Organization (2022). Health Cluster Capacity Development Strategy 2020–2023: Mid-Term Review, April 2022. WHO, Geneva.

World Health Organization (WHO) (2020) Health Cluster Capacity Development Strategy 2020-2023. Geneva: World Health Organization.

World Health Organization (WHO) (2024) Health Cluster Coordinator P5/P4 post description. Geneva: World Health Organization.

World Health Organization (WHO), 2024. Global Health Cluster Localization Strategy: Towards a Meaningful Engagement of Local and National Actors in the Health Cluster. Geneva: WHO

World Health Organization (WHO), year unknown. N - Health Cluster - HEPR alignment.

World Health Organization, 2023. Public Health Situation Analysis Chad.

World Health Organization, 2024. Chad: Sudan Crisis Health Situation Dashboard.

World Health Organization. (2014). Global Health Cluster Strategy 2014-2015. WHO.

World Health Organization. (2015). Global Health Cluster Interim Terms of Reference. WHO.

World Health Organization. (2017). Global Health Cluster Strategy 2017–2019. WHO.

World Health Organization. (2020). Global Health Cluster Strategy 2020-2025. WHO.

Yemen Health Cluster (2024) 'Health Cluster Coordination Meeting Minutes: Aden, Yemen 24th January 2024'.

Yemen Health Cluster (2024) 'National Health Cluster Coordination Meeting Minutes: Sana'a, Yemen, 18 December 2024'.

Yemen Health Cluster (2024) 'National Health Cluster Coordination Meeting Minutes: Sana'a, Yemen, 22 January 2024'.

Yemen Health Cluster (2024) 'National Health Cluster Coordination Meeting Minutes'.

Yemen Humanitarian Fund (2024) YHF Newsletter January-June 2024. Newsletter, p. 2.

References

1. ReliefWeb Response [website] About Us | ReliefWeb Response

2. Emergency Response Framework: internal WHO procedures. World Health Organization: Geneva; 2024 https://iris.who.int/bitstream/handle/10665/375964/9789240058064-eng.pdf?sequence=1

3. A Global Health Strategy for 2025-2028: Fourteenth General Programme of Work. World Health Organization: Geneva; 2025 9789240101012-eng.pdf

4. Strengthening health emergency prevention, preparedness, response and resilience. World Health Organization: Geneva; 2023 who_hepr_wha2023-21051248b.pdf

5. Global Health Cluster Strategy 2020-2025. Global Health Cluster, World Health Organization: Geneva; 2024 ghc-strategy-2020-2025-final-29-jan (1).pdf

6. Health Cluster coordination guidance for heads of country offices as cluster lead agency. Global Health Cluster, World Health Organization: Geneva; 2019 9789240000001-eng.pdf

7. Cluster coordination at country level: guidance. Inter-Agency Standing Committee; 2015 Reference Module for Cluster Coordination at Country Level (revised July 2015).pdf

8. Independent review of the humanitarian response to internal displacement. Humanitarian Policy Group; 2024 Independent review of the IASC_response to internal displacement_Summary reportIndependent review of the IASC_response to internal displacement_Summary report

9. WHO grading of public health events and emergencies. World Health Organization: Geneva [website] https://www.who.int/emergencies/grading

10. Tchad Besoins Humanitaires et Plan de Réponse 2024. OCHA Services [website]Tchad Besoins Humanitaires et Plan de Réponse 2024 | Financial Tracking Service

11. Ajala plateform de coordination. [website] Liste des sites | Plateforme de coordination de l'urgence

12. Colombia Plan de Respuesta a Prioridades Comunitarias Colombia 2024 – 2025. OCHA Services [website] Colombia Plan de Respuesta a Prioridades Comunitarias Colombia 2024 - 2025 | Financial Tracking Service

13. DR Congo: Intensification of violence in North Kivu and South Kivu provinces. OCHA; 2025 DR Congo - Intensification of Violence in North Kivu and South Kivu Provinces - Situation Report #2 (11 February 2025).pdf

14. Democrative Republic of the Congo. Global Health Cluster, World Health Organization [website] Democratic Republic of the Congo

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