Formative evaluation of the Global Health Cluster

Executive summary

World Health Organization

HEALTH CLUSTER

WHO/DGO/EVL/2025.87

Executive summary

Overview of the evaluation object

The World Health Organization was designated by the Inter-Agency Standing Committee (IASC) as the Cluster Lead Agency (CLA) for the Global Health Cluster (GHC) when the cluster approach was established in 2005. In 2012, World Health Assembly Resolution 65/20 *(1)* stated the need to invest in WHO's response and role as health CLA to meet the increasing health demands of humanitarian and public health emergencies. This mandate was reiterated in 2015 during the reform of WHO's work in outbreaks and emergencies with health and humanitarian consequences and in the subsequent World Health Assembly Resolution 68/27 *(2)*.

The GHC's primary role is to strengthen the coordination of health sector responses in humanitarian settings. Its vision is to save lives and promote dignity in humanitarian and public health emergencies, and its mission is to collectively prepare for and respond to humanitarian and public health emergencies to improve the health outcomes of affected populations. As the IASC-designated CLA, the WHO holds a permanent seat and co-chair role in the GHC's Strategic Advisory Group (SAG) and provides secretariat support through the Global Health Cluster Unit (GHCU) within the WHO Health Emergency Programme (WHE) *(3)*. WHO's accountability for GHC operations is formalized in its Emergency Relief Framework and the Protect Pillar of the WHO Global Programme of Work.[1]

WHO, as the CLA, is ultimately responsible to the Emergency Relief Coordinator for ensuring the fulfilment of its lead agency role in the GHC *(4)*. The GHC has five strategic priorities (SPs) and 14 corresponding objectives focusing on strengthening coordination, interagency collaboration, health information management, quality of health cluster action and advocacy. At the country level, the GHC is mandated to fulfil the six *(5)* plus one IASC-mandated core cluster functions (CFs): supporting service delivery; informing decision-making; strategic planning/implementation; monitoring/evaluating performance; building national preparedness capacity; advocacy; and accountability to affected populations (AAP). The additional core function aims to support and contribute towards ensuring AAP, which is a major initiative within IASC, requiring clusters and other actors to implement the IASC AAP Policy *(6)*.

As of March 2025, the Global Health Cluster (GHC) has been activated in 28 countries, encompassing 2 regional coordination mechanisms and 119 subnational health clusters, engaging a total of 2072 partners. The funding requested for project implementation by GHC partners amounts to US$ 3 155 709 000, with US$ 236 585 000 secured, targeting a population of 79 898 343 individuals, which represents 48% of those in need.

Evaluation purpose, objectives and intended audience

The evaluation serves a dual purpose of accountability and learning. While it is a formative evaluation, undertaken to generate forward-looking recommendations for improving WHO's humanitarian coordination and informing the next GHC Strategy (2026–2030), the summative component evaluates progress against the GHC's SPs, core country-level CFs and CLA responsibilities *(7)*. The evaluation's main objectives were to systematically and objectively assess the relevance, effectiveness, efficiency and coherence (connectedness

[1] WHO, Evaluation terms of reference, 2024.

and coordination) of the GHC. The evaluation scope was all work undertaken from September 2014 to 2025, with a particular focus on the last six years (2019–2025), at global, regional and country levels.

Primary stakeholders include WHO leadership (e.g. the Executive Director for Emergencies, health cluster teams), National Health Authorities and GHC partners *(8)*. Secondary stakeholders include international donors, other clusters, WHO departments, country health cluster partners (local NGOs, private sector, academia) and specialized agencies.

Evaluation methodology

WHO, at the request of the GHC SAG,[2] commissioned an independent and external evaluation of the GHC. The evaluation employed a non-experimental design combined with theory-based and utilization-focused approaches. It used mixed methods to collect both quantitative and qualitative data, enabling robust triangulation of findings. Data collection methods included desk review of 179 key documents and secondary data analysis focusing on the GHC public health information services (PHIS) dashboard, cluster coordination performance monitoring (CCPMs)[3] and health cluster dashboard *(9)*. It also included 106 key informant interviews (KIIs)[4] and 19 focus group discussions, reaching a total of 263 respondents. The KIIs were conducted with a diverse group of stakeholders, both internal to WHO *(10)* and external *(11)*, covering global, regional and country levels. At country level, KIIs and focus group discussions were conducted remotely for three countries (Myanmar, Sudan and Yemen), and face-to-face in-country for the three other focus countries (Chad, Colombia and the Democratic Republic of the Congo). There were 13 distinct categories of key informants and focus group discussion participants, of which the largest were national/local partners (35%) and health cluster members (28%). In addition, an online survey was administered to 984 respondents at global, regional and country levels with a 32% overall response rate. More than half of the survey respondents were male (64%) while 35% were female. The largest categories of respondents in the online survey were international (31%) and national (26%) nongovernmental organizations.

The evaluation is framed against five criteria (relevance, effectiveness, efficiency, coherence/coordination and connectedness) and addresses five overarching evaluation questions and specific thematic areas related to the GHC SPs, core cluster functions and CLA responsibilities, as outlined in the Theory of Change (ToC), which frame the analysis.

[2] The Strategic Advisory Group is the central body which guides the cluster with regards to its strategy and policy lines. Its members decide on priorities and actively shape the health cluster's orientation. In doing so, they benefit from their experience in the area of health emergency response.
[3] Cluster Coordination Performance Monitoring (CCPM) is an IASC-mandated self-assessment of cluster performance against the six core cluster functions plus accountability to affected populations. It is a country-led process, supported by Global Clusters and OCHA.
[4] 37 female, 41 male, 26 undisclosed.

Key findings and conclusions

Key findings (highlighted in bold) and the conclusions that emerge from these are presented below.

Relevance

The GHC is considered relevant as it has strengthened health management and coordination systems responding to the needs of the most vulnerable populations during major humanitarian crises and disease outbreaks in countries requiring support and continued doing so even when circumstances on the ground changed. The GHC and health clusters at the country level play a vital role in ensuring the appropriate prioritization of health interventions and target populations. This process has relied on robust needs assessments which, in turn, have depended on the availability and use of data and the active engagement of all key partners. Measures to align interventions with local realities and update plans based on real-time information are critical; the GHC is playing a vital role in this and needs to continue to do so. Community engagement and ownership are crucial, ensuring that affected populations participate in decision-making and that interventions align with their long-term health needs. Development of guidance by the GHC and provision of training on AAP is a start, but better understanding of AAP and its implementation by country health cluster partners is essential to strengthen accountability to affected populations.

Efficiency

Despite being underfunded, the GHC efficiently delivered results in an economic and timely way at both global and country levels. It has used its very limited financial and human resources[5] (compared to needs) extremely well, even at times in emergencies, where the health cluster has not been activated.[6] The GHC's global leadership has enabled it to fill gaps, ensuring health clusters have essential staff and other support through its surge capacity and partner network (such as SBP). While the GHC has done the best it can given the low level of resourcing, the current funding crisis brings new and unprecedented challenges. The uncertain situation, with further funding cuts remaining likely, calls for the GHC to prioritize and adjust to the humanitarian reset and hone in on core/essential functions, focusing on those that enable it to remain in place to provide the most essential level of support at both global and country levels whilst examining linkages with the regions.

Coherence

Overall, the GHC tends to be coherent and well coordinated with other interventions, both at the global and the country level. While it has strengthened and diversified partner engagement and collaboration with major humanitarian actors, it could be further mainstreamed within WHO and its role as CLA not be deprioritized compared to other WHO priorities.

[5] US$ 4.16 million for 2024–2025 and, as of April 2025, 6 core staff under WHE and 4 posts occupied by non-WHO, consultant or SBP.
[6] E.g. Lebanon, Malawi.

This could help to reduce the burden on the GHC and health clusters, especially given the current funding climate. At the global level, WHO's different roles – such as its normative, operational and coordinating functions – are clearly delineated. However, this clarity often does not translate to the national level, where roles and responsibilities tend to blur. This disconnect has resulted in ad hoc lines of communication and support that diverge from the health cluster's original design, requiring the GHC headquarters team to invest additional effort in supporting country-level clusters. It has also led to siloed operations and limited collaboration with other WHO emergency units.

The role of WHO regional offices in the cluster system remains limited, largely because the cluster approach was originally designed without a formal regional component. Nonetheless, regional offices provide varying levels of support and collaborate with country offices, offering valuable additional capacity despite the absence of a clearly defined role.

Coordination

The health cluster has engaged in efforts with other clusters to promote intersectoral and multisectoral collaboration, including the development of joint frameworks and projects. In some national contexts, this has led to more integrated and effective responses. Nonetheless, intercluster collaboration remains weak in certain countries, and intercluster planning does not necessarily translate into meaningful cooperation during response operations. There has been engagement to ensure coherence across coordination mechanisms – such as the GHC, EMT, GOARN and other emergency health networks – and further steps are now being taken to strengthen alignment through the Global Health Emergency Corps (GHEC) initiative. Although it is too early to assess its full impact, the GHEC has potential to enhance coherence across coordination platforms at global, regional and country levels.

Connectedness

The GHC has not made significant progress towards strengthening connectedness through transition planning, nor towards capacity-strengthening for national authorities for coordination in acute or protracted crises, despite organizing some workshops on cluster coordination with the participation of ministries of health.[7] Similarly, there is little evidence that health clusters have strengthened connectedness by strengthening linkages between humanitarian programming and health system strengthening.

The integration of local authorities and national partners into leadership roles is variable (but still remain limited), and decision-making processes have improved. INGOs are often included at the co-coordinator level. This gap at national and local levels weakens opportunities for building coordination capacity and preparing for sustainable transitions. While the GHC and health clusters are not solely responsible, given the varying reliability and capacities of local authorities in complex emergency settings, the limited engagement inhibits the incorporation of gains made during emergency responses into long-term health governance systems. This risks continuing the burden both on the GHC and on WHO as CLA and increasing dependency on the health

[7] Since August 2024, coordination workshops on cluster coordination with ministry of health participation have been held in Burkina Faso, Central African Republic, Chad, North-eastern Nigeria, Ukraine (GHC headquarters team, Personal communication).

clusters. Attempts were made by the GHC to include the nexus in its agenda, but these efforts were not sufficient to be translated into any strong action or collaboration across humanitarian and developmental areas. The GHC's efforts to promote preparedness and contingency-planning are showing results, although progress is slow and global-level monitoring remains relatively new. National clusters are incorporating preparedness activities, but the comprehensiveness and integration of these plans vary significantly across countries. This highlights the need for greater standardization to ensure consistent quality.

Effectiveness

The effectiveness of the GHC is considered to be mixed. At the global level, it met its strategic objectives and core CFs with differing degrees of success (strengthened health-related humanitarian management and coordination systems, diversified collaboration with humanitarian bodies, strengthened technical and operational capacity of national and local level health partners). This is likely to have resulted in improved response and health outcomes for affected populations in humanitarian and public health emergencies, including preventing high levels of morbidity and mortality. However, it is difficult to ascertain the extent to which these changes have been achieved across health clusters in the absence of baselines and monitoring and evaluation systems that enable assessment of performance at higher (outcome) levels.

GHC advocacy at global level is an area for improvement. While the GHC team has been effective in evidence-based advocacy for health within the cluster system, and more broadly for COVID-19, it could do more to highlight issues and use this to engage with donors to mobilize resources. Likely improvements could include defining its global advocacy role more clearly, developing specific strategies to engage donors, addressing resource and capacity constraints and leveraging data and success stories to strengthen its influence.

Whilst monitoring and reporting on cluster results at country level enables the GHC to track the collective achievement of country health clusters, the lack/absence of monitoring and evaluation at global level is an area for improvement and prevents the GHC from reporting progress against its objectives, identifying and rectifying gaps and showcasing its performance.

Key recommendations

The recommendations listed here are high level; specific recommendations are listed in the main body of the report.

Strategic-level recommendations

1. To remain fit for purpose and optimize operations-focused coordination in a simplified coordination model, where the health cluster is activated, the GHC should place emphasis on the specific strategic priorities. These include ensuring the capacity to fulfil coordination functions at national level in priority countries in line with the humanitarian reset, quality coverage and prioritization of health cluster action, diversifying donor funding and developing a monitoring and evaluation framework.

1.1 Coordination: Ensure the capacity to fulfil coordination functions at national level in priority countries in line with the humanitarian reset. (SP1.3)

- Retain a scaled-down, focused model for surge capacity, focusing on priority countries and providing HCCs and information management capacity.

1.2 Quality, coverage and prioritization of health cluster action (SP4.1 and SP4.2): Identify, develop, mainstream and contextualize guidance.

- Strengthen partners' capacity to deliver, taking into consideration the available capacity at global level and country levels, as well as changes in dynamics at country level after the reset and according to context.

1.3 Information management (SP3.1 and SP3.2): Ensure partners' access to standardized, quality and timely public health and humanitarian information and its use for operational decision-making (see operational recommendation 1.2 below).

1.4 Multisector coordination (SP2): In line with the prospective humanitarian reset, the GHC at global and country levels should engage in emerging models of intersector and multicluster collaboration.

- At subnational level, design a model which enables/supports partners' participation in area-based coordination.
- From national level, establish and maintain connections with health partners working under area-based coordination, which ensures that both WHO and health partners actively advocate for health within the coordinated response.

1.5 Linkages between humanitarian action and health-system-strengthening, including support for national ownership and leadership of health sector coordination (SP1.2) (see operational recommendation 1.3 below).

1.6 Support local led action, community engagement and accountability (SP4.1): Informed by the humanitarian reset, rework the GHC approach to localization, AAP and community engagement in decision-making and service delivery. This has to take into consideration a realistic assessment of WHO/GHC capacity going forward, in terms of both financial and human resources, as well as local capacity after the impact of the drastic funding cuts in the global humanitarian sector. Incorporate learning from other clusters/CLAs.

2. Diversify donor funding (CLA responsibility 4): Allow the GHC to advocate directly to donors for autonomously managed resources, to be better able to deliver a streamlined package of services outlined in these recommendations. This requires diversification of the donor base and a degree of autonomy for the GHC. While undertaking advocacy for this purpose, focus on the good news – what is working and what is essential, effective and efficient– in order to incentivize and retain a donor base.

3. To measure the GHC strategy and action plan performance, develop a robust monitoring and evaluation framework: it is essential that the GHC can track and measure progress. This requires a performance framework which has clear key performance indicators (KPIs) for global and country levels in line with these recommendations. Incorporate learning from other CLAs.

Operational level recommendations

1. Focus on the essential/successful core cluster functions at country level, in line with the size and role of the cluster after the reset, maintaining minimum levels of deployable capacity, including a realistic assessment of the ongoing capacity of health cluster and standby partners.

1.1 Provide a platform for collaboration. This would be as a support function to the IASC/humanitarian coordinator-led system at country level. This would be part of the broader architecture for responsive decision-making, operational deconfliction and gap filling, including engagement in common information management platforms (see below).

1.2 Provide a platform and the necessary tools for technical exchange (SP3, CF2 and CF3). This includes the essential interface between local health authorities, WHO and partners acting as a conduit for essential guidance and standards.

- Design/adapt the cluster coordination IMO function. Ensure that as part of any prospective common information platform in support of a reset cluster coordination model, health cluster staff at country level can engage with partners to produce and provide the required standard of information. This includes participation in needs assessment mechanisms in support of evidence-based decision-making.
- WHO and the GHC must maintain a coherent focus on data collection, analysis and reporting to guide priority-setting and response-planning, as well as maintenance of key public health data sets under the PHIS.
- In line with the focus on minimum standards above, review the PHIS toolkit and focus on essential tools which have proven their added value (CF2). Focus on the lighter version of PHSAs, thus reducing the use of more resource intensive tools.
- Retain an essential minimum capacity at global level and within these limits focus on information management through a streamlined version of the PHIS Toolkit (see operational recommendation below).
- In light of the humanitarian reset's prospective emphasis on pooled information management capacity, WHO must ensure this same minimum standard of technical health information is available in cluster and non-cluster settings. This will require widespread consultation with all actors with a stake in information within WHO.

1.3. Assert the temporary nature of clusters and ensure the transition to ownership to national and local entities as rapidly and ethically as possible.

Organizational level recommendations

1. Reinforce the response model. Ensure that while responding to humanitarian crisis and health emergencies, WHO emphasizes the linkage between emergency response/preparedness and health-system-strengthening work.
2. Concentrate on key elements of service delivery, including equipment, supplies and considering a joint approach to logistics.

References

1. Sixty-fifth World Health Assembly, 26 May 2012, Agenda item 13.15: WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies 2012 (WHA65.20 Microsoft Word - A65_R20-en.docx).
2. Sixty-eighth World Health Assembly, Provisional agenda item 16.1, 15 May 2015: Global health emergency workforce: Report by the Director-General. Geneva: World Health Organization (WHA68/27 EB Document Format).
3. Global Health Cluster interim terms of reference. Geneva: World Health Organization; 2015 [not published].
4. The emergency relief coordinator [website]. Inter-Agency Standing Committee; n.d. (The Emergency Relief Coordinator | IASC).
5. Health cluster coordination: guidance for heads of WHO country offices as cluster lead agency. Geneva: World Health Organization; 2023 (9789240000001-eng.pdf).
6. Task force on accountability to affected people [website]. Inter-Agency Standing Committee; 2023 (IASC Task Force 2 on Accountability to Affected People | IASC).
7. IASC reference module for cluster coordination at country level, revised July 2015. Inter-Agency Standing Committee; 2015 (IASC Reference Module for Cluster Coordination at Country Level, revised July 2015 | IASC).
8. Global Health Cluster partners [website]. World Health Organization; 2023 (Global Health Cluster Partners).
9. Health Cluster dashboard: Q1 March 2025 [website]. World Health Organization; 2025 (Health Cluster Dashboard -Q1 March 2025).
10. Metcalfe-Hough V, Fenton W, Manji F. The Grand Bargain in 2022: an independent review. London: ODI Global; 2023 (The Grand Bargain in 2022: an independent review | ODI: Think change)
11. Independent evaluation of WHO's whole of Syria response (2021): report. Geneva: World Health Organization; 2025 (Independent Evaluation of WHO's Whole of Syria Response (2021): Report).

Any enquiries about this evaluation should be addressed to:

Evaluation Office, World Health Organization

Email: evaluation@who.int

Website: Evaluation (who.int)