HEALTH CLUSTER

THE HEALTH CLUSTER CAPACITY DEVELOPMENT STRATEGY

2016 – 2019

Photo credit: WHO

TABLE OF CONTENTS

FOREWORD

The number, scale and severity of protracted humanitarian crisis shows an increasing trend in recent years while the humanitarian system has never been so challenged as of now. Effective leadership and good coordination in health plays a vital role in addressing these challenges. The Global Health Cluster has identified a number of crucial functions such as in coordination and health information management, which needs to be strengthened and further developed and will be part of the current WHO reform process under its 'one single program approach'.

The overall aim of the Health Cluster Capacity Development strategy is to reduce death and vulnerability by building effective leadership and coordination mechanisms to address future epidemics of large scale and continue to address chronic and protracted crisis and strengthen health systems in fragile and vulnerable countries, effectively and in a cost-efficient manner. This will be achieved by developing a cadre of high performing personnel to effectively lead and coordinate the cluster to deliver an effective response to achieve better health outcomes. Synergies will be built with other roles under the Global Health Emergency Workforce such as the Standby Partners, the Emergency Medical Teams and GOARN.

This requires financial commitment and support, human resources and technical expertise with a profound set up and structure. In order to address those, the Health Cluster Capacity Development Strategy 2016-2019 was developed to provide a clear framework and guidance.

The strategy and framework sums up the ideas and views which have been studied during the training needs analysis and the last training course and experiences by people in the field but it also provides the agenda for future work. There is still much to do. The strategy and the related competency framework will enable us to improve the health care for affected populations by identifying the right personnel and build up high level performers for the health clusters globally.

The Global Health Cluster Strategic Advisory Group are delighted that the WHO and its partners, under the Global Health Cluster has produced this collaborative work, and we look forward to following the impact of this strategy.

ACKNOWLEDGEMENTS

The Global Health Cluster would like to thank the members of the Global Health Cluster Capacity Development Task Team and Peer Reviewers who have contributed, by means of their feedback, reflections, ideas and conversations, to the thinking behind the development and writing of this Strategy

Between 2008 and 2015 nine Health Cluster Coordinator Trainings and three Tri Cluster Coordinator Trainings (Health, Nutrition and WASH) took place in: Tunisia, Tanzania, Ecuador, Egypt, Indonesia, Switzerland, El Salvador and France. The Global Health Cluster would also like to thank the Participants, Trainers, Facilitators and Donors who took part or supported these trainings; this Strategy is based on the learning and experience which came from all of these events.

EXECUTIVE SUMMARY

The Health Cluster Capacity Development Strategy 2016 – 2019 has been developed in order to ensure high quality and effective leadership and coordination in all heath responses to acute and protracted humanitarian crisis. The strategy provides the basis for strengthening the recruitment, learning and performance of current and potential health cluster personnel and for providing them with opportunities for continuous professional development.

The Strategy was developed by the Global Health Cluster Capacity Development Task Team with further input and feedback from Peer Reviewers drawn from Global Health Cluster partners.

The Learning Needs and GAPs which are addressed by the strategy were identified by means of two Learning Needs Analysis, which were conducted in 2014 and 2015 respectively. But needs change over time, so the strategy will ensure that these needs are refreshed and reprioritised at least once during the life of the strategy.

The Strategy will ensure that there is a blended and competency based approach to learning and development, in which a variety of learning and training activities and access to high quality learning resources will be provided, and it also recognises and supports the critical role played by Line Managers in ensuring that learning takes place in a timely manner, is acted upon and is part of a Health Cluster Professional Development Plan.

The strategy proposes nine strategic objectives and it will be implemented by means of the Log frame in Annex 4 which will be underpinned by an Annual Plan and budget for each year of the strategy.

1. The Vision - What will we have achieved four years from now?

A cadre of high performing health cluster coordination personnel will have been established in order to ensure that the leadership and coordination of all health responses to an acute or protracted humanitarian crisis is responsive, accountable, consistent, predictable, and efficient and provides Value for Money[1]. The coordination of the response will build national capacity, resilience and preparedness and be delivered in support of the response efforts of national authorities, and in collaboration with other partners and clusters, in order to meet the needs and the rights of the affected population and lay the foundations for recovery.

2. The Aim

To establish a systematic and structured approach to high quality, blended and impactful capacity development that responds to the increased need and expectation for health clusters to demonstrate effective health response leadership and coordination in all types of emergencies.

The Strategy addresses the need to identify and develop high-performing, dynamic and adaptable health cluster coordination personnel and teams that:

1. Have the required combination of skills, knowledge and attitudes needed to lead and coordinate an effective health response that meets the needs of the affected population.

2. Are ready to be deployed to crisis-affected countries

3. Are able to stay in their role for the time required

4. Are continuously supported at all levels (by the Global Health Cluster Unit, WHO HQ, ROs, WCOs, cluster partners and other stakeholders)

5. Are able to transfer knowledge and build the capacity of local counterparts

6. Have professional development incentives, career paths and job stability.

[1] Value for Money (VFM) is defined as ensuring that an input is provided at the right time, to the required quality standard and at the right cost.

3. The Scope

The specific target audience for this Capacity Development Strategy is all health cluster coordination personnel at both national and sub-national levels who have identified capacity gaps. This includes, but is not exclusive to, the roles of Health Cluster Coordinators, Information Management Officers, Public Health Officers and any other identified personnel.

Since personnel come to the health cluster through a variety of recruitment and management mechanisms, the strategy is not specific to any agency. Rather, it includes all health cluster personnel who come to their roles through the WHO's Division of Human Resources, surge mechanisms, partner organisations, globally-managed stand-by partner rosters or recruitment at country level. At present, this includes an estimated national level 24 Health Cluster Coordinators, 12 public health information officers, as well as co-leads, surge support and other public health officers working across the 71 sub-national hubs.

4. The Strategic Objectives

Over the four years of the Strategy the following Strategic Objectives will be achieved:

YEAR 1 - 2016

4.1. A modular and competency based blended learning programme[2], using a variety of knowledge and skills based learning and training activities for Health Cluster Coordination and Health Cluster Teams is developed and implementation commences, and is supported by the Health Cluster at global, regional and national levels.

The 2014/15 Learning Needs Analyses strongly suggests the following training programmes:

- Health Cluster Coordination Training: aimed at Health Cluster Teams and emphasising the strategic, coordination and information requirements of a health response, the core skills (such as leadership, communications, advocacy and partnership building) and the collective deliverables of the Humanitarian Programme Cycle.

[2] When fully developed the blended learning programme will consist of induction, direct training, on line learning, mentoring, coaching and a Community of Practice

- Public Health Information System Training, specifically emphasising the information requirements of a health response and the tools that support them.

  Existing and future relevant training courses and programmes will also be mapped out and personal placed on them if appropriate.

  4.2. The Health Cluster Capacity Development Task Team is fully operational and its' outputs are fully harmonised with other GHC Task Teams, and informed by the capacity development activities of other clusters.

  4.3. Access to high quality blended learning materials and the use of consistent and effective learning approaches/methodologies is established, by means of:

- An online learning resource bank containing contextualised learning resources and training materials, case studies, examples of best practice, work based assignments, detailed sessions plans and evaluation tools, feedback and impact assessment tools.

- A pool of high quality facilitators /trainers and resource people who meet the criteria established by the GHC Capacity Development Task Team identified from GHC Partners, appropriate regional and national agencies and authorities and other appropriate stakeholders.

- Ensuring that all learning and training events and activities are informed by best practice from other clusters, consortiums and partners

  4.4. The critical role of partner agencies and Line Managers in identifying and supporting individual learning and team performance is strengthened and supported, and all Health Cluster personnel regularly participate in performance management reviews that are aligned with the Health Cluster Capacity Development Strategy and Competency Framework and form part of a Health Cluster Professional Development Plan.

  4.5. All Health Cluster partner agencies have the policies and processes in place in order to be able to induct and train personnel on how they can actively contribute to Health Cluster activities during health emergencies.

YEAR 2 - 2017

4.6. Effective mechanisms are in place to facilitate the integration of feedback from Health Cluster and inter-Cluster lessons learned,

debriefs of personnel and end of mission reports into Health Cluster capacity development activities and the production and dissemination of follow up reports,.

4.7. A learning culture is firmly established throughout the Health Cluster in which all personnel, and their Line Managers, are jointly responsible and accountable for ensuring that they have the requisite competencies for their role in a response, and in which those personnel who have the potential for professional development in Health Cluster roles are identified, supported, mentored, coached and developed in preparation for taking up these roles.

YEAR 3 - 2018

4.8. A modular Health Cluster coordination programme provides a career pathway to a professional award through accreditation by an internationally recognised academic institution. This will include the accreditation of "on the job" and prior learning. [3]

YEAR 4 - 2019

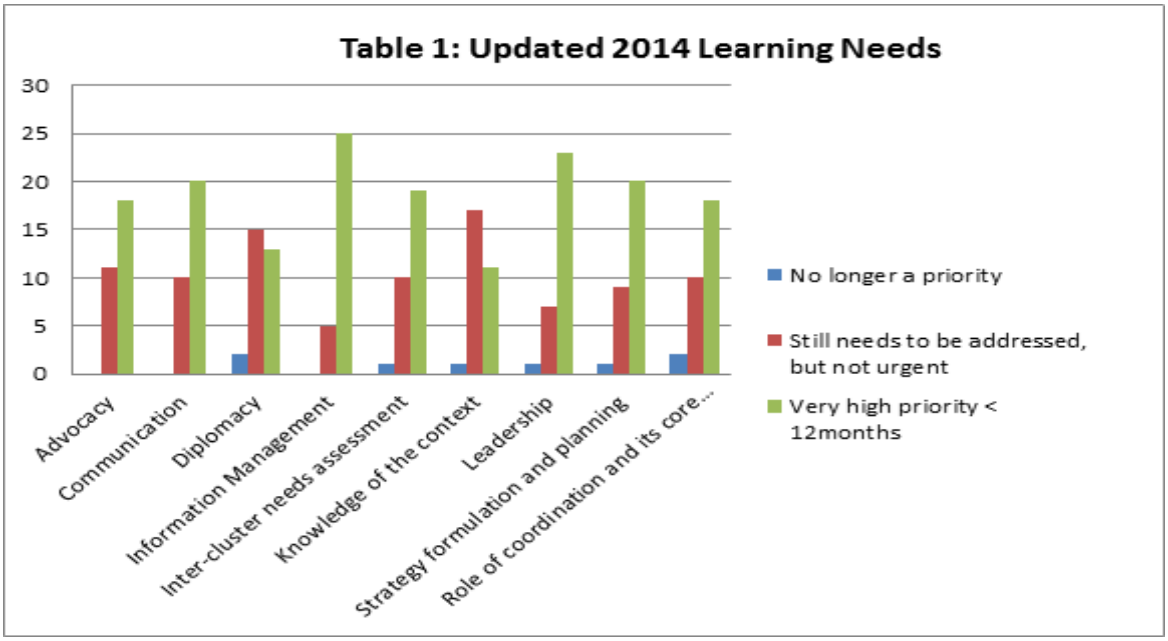
4.9. Effective capacity development forums, protocols and mechanisms for engaging with and working with national and sub-national health authorities and regional and national institutions are fully established and operational in order to ensure effective exit strategies and to build national response coordination capacity and community engagement.

5. Learning Needs, Gaps and Priorities

The learning needs which will be addressed by this strategy were identified by means of two learning needs analyses (LNA). The first LNA was completed in November 2014, and reported in the Health Cluster Professional Development Initial Findings and Recommendations (**Annex 1**).

A second LNA was conducted by the Capacity Development Task Team in November 2015. The findings of the combined LNAs are shown in **Table 1:**

[3] The institution will need to be scoped out



The combined LNAs showed that the following learning needs/gaps are a high and urgent priority and will be the focus of activities in 2016 and beyond. The learning needs/gaps are in priority order:

PRIORITY ORDER	LEARNING NEEDS/GAPS
1	Information Management
2	Leadership
3	Communication
3	Strategy Formulation and Planning
5	Inter Cluster Needs Assessment
6	Advocacy
6	Role of Coordination and its Core Functions

The following learning needs/gaps were also identified as priorities but are less urgent:

- Diplomacy
- Knowledge of the context

The LNA conducted in 2015 also identified role-specific learning needs/gaps which will be taken into account in the design and development of appropriate training and learning materials.

For a copy of the full Learning Needs Analysis (LNA) Report November 2015 see **Annex 2.**

At the Global Health Cluster Meeting in December 2015 the following needs were also identified as priorities by partners and participants:

- Working remotely in hard to reach and insecure contexts
- Prioritisation
- Negotiation

The learning needs and gaps on which this Strategy is based will be reviewed annually by the Health Cluster Capacity Development Task Team and incorporated into Annual Plans.

6. Capacity Development Activities

The learning activities which will be provided under the auspices of the Health Cluster Capacity Development Strategy will follow the 70-20-10 rule which is the foundation for blended learning. This rule suggests that successful capacity development takes place within three clusters of learning experience: challenging "on the job" assignments (70%), developmental relationships such as coaching, mentoring and peer exchange (20%), and direct/formal training (10%). Most organisations now acknowledge that reliance on formal training alone restricts the impact of learning on performance.

The approach to capacity development will also be innovative, based on best practice in the humanitarian sector and make effective use of current and future technology.

The Health Cluster Capacity Development Task Team will provide the guidance and stewardship needed to:

6.1. Ensure the effective implementation of the Strategic Objectives

6.2. Develop and implement a Health Cluster Coordination Competency Framework for Health Cluster Personnel. (See Annex 3 for the Final Draft).

6.3. Produce an annual Work Plan and budget with costed activities

6.4. Provide detailed guidance to individuals and their Line Managers on how to use the Competency framework in order to identify learning needs and link to agency performance review processes.

6.5. Develop the tools and guidance needed to incorporate Health Cluster coordination competencies into all Health Cluster partners' selection and recruitment processes

6.6. Produce annual training plans, based on the log frame and containing the planned programme of all training events, workshops and learning activities. The plan will also contain the eligibility criteria for participants and the process for accessing places

6.7. Provide the curriculum, training design, methodology and evaluation tools advice and guidelines for all Health Cluster Personnel training.

6.8. Provide an online learning portal with access to high quality learning materials and resources, information about planned capacity development events and links to eLearning, webinars and Communities of Practice and other online peer exchange platforms.

6.9. Identify a pool of high quality trainers and facilitators from Health Cluster partners and other Clusters, and provide them with pedagogical guidance and support.

6.10. Strengthen the induction and orientation for all personnel in health cluster coordination related roles.

6.11. Provide access to structured coaching, mentoring and shadowing based on learning needs which are linked to needs and priorities

6.12. Provide the tools and guidance to develop professional development pathways for all personnel in Health Cluster coordination related roles

6.13. Provide guidance for the minimum criteria for acceptance onto deployment rosters and deployment to a response

6.14. Identify and establish a link with appropriate academic institutions

6.15. Refresh and update the Learning Needs Analysis bi-annually

7. Implementing the Strategy

The implementation of the Strategy will be by means of the Log Frame in **Annex 4** and Annual Plans and budgets which will be reviewed bi-annually by the Health Cluster Capacity Development Task Team.

The strategy identifies in broad terms when the strategic objectives will be achieved. The Log Frame in **Annex 4** specifies further in which quarters certain activities should take place. These broad outlines serve as a framework to develop detailed annual plans, including associated detailed budget plans.

Milestones have been incorporated in the log frame so that progress towards strategic objectives can be measured. Progress reports will be presented during GHC partner meetings in which the partners can provide feedback and suggestions, where the strategy has to be adjusted on taking the strategy forward.

8. The Risks and Assumptions and How They Will Be Identified, Addressed and Mitigated

8.1. GHC members agree on the competency framework.
The competency framework will be shared with the partners for consultation, so they can provide input and get a sense of ownership of the framework.

8.2. Partners can be found to engage with the training
Partners with a comparative advantage will be approached with a concrete ask to provide support. For example, some organisations and institutions are specialised in information handling and could be approached to cover these specific sessions. The partner capacity survey mapping implemented in 2015 will also be used for this.

8.3. HC personnel can access learning materials in field locations
While the internet is generally improving, the platform through which e-learning material is being made available should be designed in such a way that small bandwidth can still be accessed.

8.4. The GHC is able to influence the performance review of WHO staff
The GHC should advocate with WHO HR, which manages the contracts of HC staff, for cluster coordination specific essentials to be included in the performance review formats, clearly stating the need for this.

8.5. All Line Managers conduct performance reviews periodically which are aligned to the *Health Cluster Competency Framework* and they accurately identify and capture Health Cluster learning needs. All Line Managers will receive a copy of the Competency Framework, and written guidelines will be provided on how to incorporate these in the performance reviews. Partner organisations who second/surge staff to the Health Cluster will also could receive a copy of these documents. .

8.6. All Line managers are willing to engage with learning needs
Results from Learning Needs Assessments and training reports of the HCC training and other learning activities will be widely distributed to relevant ROs, WCOs and all Health Cluster partners to provide information to Line Managers on the advantages of investing in Health Cluster staff development. .

8.7. Priority is not given to ensuring that the requisite legal frameworks that enable rapid deployment of partner staff are in place
The WHO and GHC partners must find appropriate legal solutions for deploying staff through partnership arrangements.

8.8. Partners are willing to make staff available for deployment
Results from pilot projects and various cluster research reports highlight the advantages of agencies making staff available to fill Health Cluster positions in acute and protracted humanitarian crises. These reports also provide guidance on good practice and policies developed within partners to address and resolve this challenge.

8.9. National health authorities are able to express concrete capacity building needs
Standardised tools and approaches for capacity needs identification will be developed and disseminated to enable national health authorities to identify concrete needs and gaps

9. Funding and Resourcing the Strategy

9.1. Donors will be approached to fund specific elements of the strategy, such as covering the costs of trainings, setting up and maintaining databases and underwriting posts

9.2. Partners will be expected to mainstream and embed Health Cluster activities and to contribute to the implementation of this strategy by supporting those parts of the strategy where they have a comparative advantage in a certain area, e.g. delivering training.

9.3. It is also expected that Health Cluster strategic partners will commit their own agencies funds to making personnel/human resources available to the cluster for a health response.

9.4. The WHO (as cluster lead agency) and cluster partners will ensure that appropriate learning and development expertise is available to support quality implementation of this strategy.

9.5. As the development of this strategy is taken forward and adjustments are made to the strategy based on the findings of monitoring and evaluation reports yearly budgets will be made to specify the associated costs.

10. Monitoring and Evaluating the Impact of the Strategy

10.1. The implementation of the strategy will be monitored by reporting on the milestones set in the log frame. Regular progress will be monitored through quarterly reports by the Capacity Development Task Team to the Global Health Cluster Coordinator, reporting on achievements made towards milestones and identifying lessons to take forward and make adjustments to the strategy where necessary.

10.2. After year two (2017) and year four (2019), external mid-term and final evaluations[4] respectively will establish the extent to which the goals and targets have been achieved. The findings from monitoring reports and evaluations will be shared with the Capacity Development Task Team and the SAG. At the end of each deployment, Health Cluster staff will be debriefed, and their collective feedback may be used to adapt the strategy.

[4] Funding will need to be identified for these evaluations

10.3. The ultimate goal of the strategy is to significantly improve the quality of health cluster coordination when responding to an acute or protracted humanitarian crisis.

The performance of the Health Cluster response will be monitored by means of:

- Health Cluster Progress Reports based on the HRP and KPIs and other specific standard deliverables
- Country Cluster Performance Monitoring
- Joint Health Sector Reviews
- Health Sector Evaluations

The lessons learned from these reviews will be evaluated by the Health Cluster Capacity Development Task Team and addressed in Health Cluster capacity development activities.

ANNEX 1:

Health Cluster Professional Development Initial Findings and Recommendations 2014 - By Perry Seymour and Sandro Colombo

TABLE OF CONTENTS:

1. INTRODUCTION

Since its establishment in 2005, the Global Health Cluster (GHC) partnership has had a solid history in humanitarian action. Member organisations and partners have collaborated in a many emergencies, striving together globally and at the country level to bring about more effective, efficient and predictable health interventions in emergencies.

Moreover, the WHO, as the Cluster Lead Agency, has instituted a number of recent measures that have moved the work of the GHC forward, including the adoption of the World Health Assembly resolution on humanitarian health (resolution 65.20 of May 2012) and the introduction of the Emergency Response Framework (ERF). These changes have come into place at the same time as other significant changes in the humanitarian system, particularly the reforms of the Inter-Agency Standing Committee and the Transformative Agenda (TA).

At the same time, the number, scale, and severity of humanitarian crises shows an increasing trend, due to a combination of factors. The humanitarian system has never been so challenged as now, with four L3 crises, the Ebola epidemic and several protracted emergencies with no end on sight. Moreover, the changing nature of humanitarian crises (such as overlapping of natural disasters and complex emergencies, trans-border crises like in the DRC/CAR region or currently in the Ebola crisis) and the shrinking humanitarian space (such as in Syria and Iraq) pose new challenges to health workers.

As the number and complexity of such emergencies has grown, the human and technical capacity to effectively coordinate the health response of diverse actors has not evolved proportionally: there is an overall shortage of skilled Health Cluster Coordinators (HCCs) with broad public health competence and the right mix of leadership and communication skills, supported by a competent coordination teams, able to mobilise additional technical expertise and financial resources, available to be deployed at short notice and to remain in position for extended periods. The *Health Cluster Coordination Performance 2013* report highlighted the fact that staffing of Health Cluster teams was sub-optimal in many countries.

There are currently around 24 countries with active clusters, some with sub-national hubs. Considering the staffing needs for coordination teams working in large-scale crises, the need for replacing Health Cluster staff on leave or R&R, natural attrition, etc. the number of staff required for health coordination ranges conservatively between 50-70 professionals. At the estimated cost of 10-15M $USD[5] per year, which represents a very small share of total humanitarian funding for health, the main constraints do not seem of financial nature. Arguably, it is the limited pool of potential Health Cluster staff, with the required requisites and motivation, job security and development opportunities, together with the needed technical support and administrative human resources and systems that represents the main bottlenecks.

2. OBJECTIVES AND SCOPE OF THE REPORT

In order to address these current human and technical issues, this document proposes a collection of strategic priorities to guide Health Cluster professional development activities over the short and medium term. It responds directly to the *WHO Corporate Framework for Learning and Development 2014 – 2020*, particularly:

- **Objective 1**: Equip staff to perform their functions at the level of excellence
- **Objective 2:** Support staff development, career path and learning pathways.

This document also builds upon the *Staff Development Plan for Emergency Health Staff* that originated in July 2014 from WHO's Department of Emergency Risk Management & Humanitarian Response. It is aligned with nearly all of its proposals, outlining in further detail how some of the same proposals could be operationalized for Health Cluster coordination teams.

This document also responds directly to *the Global Health Cluster Strategy 2014-2015*, particularly:

- **Strategic priority 1:** Strengthen and expand the global capacity for effective humanitarian health action;
- **Strategic priority 2:** Strengthen technical and operational support for country health clusters and coordinators

[5] This is a conservative, initial benchmark, calculated using average health cluster team sizes (2-3 staff per country x 24 clusters) and average unit staff costs (average P3/P4/P5) estimated at USD200k per year.

And finally, this document also builds on the ambitions of the current GHC Work Plan and lessons learned from cluster and inter-cluster evaluations, while responding to emerging issues facing Health Cluster teams in the current humanitarian context.

The document's **primary goal** is to put forward recommendations aimed at gradually strengthening the pool of **Health Cluster coordination teams** who have the right skills, knowledge and attitudes, ready to be deployed at short notice to crisis-affected countries, willing to stay in position for the time required, continuously supported by HQ, ROs, country offices, and partner agencies, and with adequate incentives for professional development, career and job stability.

The underlying **principles** of the strategy are:

- Its comprehensive scope: the need to encompass most of the interconnected phases of HR management where the bottlenecks exist; and
- A gradual pace and flexible approach: the capacity and resource constraints suggest proceeding incrementally, with an ambitious goal, but realistic, flexible plans.

Thus, these proposals are articulated across five linked and sequential themes that sequentially address main issues in the professional development of Health Cluster teams generally, and HCCs specifically, from their identification to their retention. This strategy puts forward recommendations for improvement through systematic and transparent processes and procedures for each of these phases.

These include:

A. Selecting candidates
B. Ongoing assessment of staff learning needs
C. Supporting Health Cluster teams
D. Performance assessment
E. Retention and career path.

The **assumptions** for these proposals to be successful include:

- Clear and strong political commitment to the capacity development from WHO ERM department and the GHC partnership at their highest managerial levels;

– A substantial investment of GHC partnership staff time and additional financial resources.

The recommendations herein are ambitious, particularly when one considers the capacity and financial constraints of the WHO, GHC and partners, and the competing needs of the humanitarian response. The strategy needs, therefore, to be **incremental and with a short/medium-term timeframe**. It needs to be translated into realistic plans, supported by a monitoring system that will allow for adjustments to address problems and new opportunities in its implementation.

This document also makes numerous planning suggestions for those components of the strategy that can be more easily translated into activities and outputs (see Annex A). Those components that are more policy-related, such as retention, incentives, career path, etc., will require more discussion and are less easily defined in terms of activities. Like the strategy proposals, the proposed planning elements are built on the underlying assumptions of strong commitment and additional resources. They will need to be scaled down if those assumptions are not fulfilled.

3. METHODOLOGY AND FINDINGS

The professional development proposals found herein are the result of a multi-pronged consultation process that occurred during August to October 2014.

The consultation process included:

– Consultation meetings with various WHO HQ staff, including Human Resources and Emergency Health
– Consultation meetings with the GHC Unit
– Reviews of reports and other documentation including Health Cluster evaluations, lessons learned reports and cluster performance monitoring reports
– A learning needs assessment (LNA) conducted globally through:

- A structured self-assessment questionnaire, directed to HCCs and former HCCs (28 respondents);
- An open-ended questionnaire, directed to members of the GHC Core Group, WHO ERM Regional Advisors; GHC secretariat, ERM senior staff and others (6 respondents).

- Consultation interviews (both face-to-face and by telephone) with key informants, including members of the GHC, WHO and member agencies' staff at HA, regional office and country level and partner/surge staff (27 respondents).

  The consultation pool was comprised of a targeted group of stakeholders, all of whom have strong field experience, but with varying experience working with the WHO or the Health Cluster. However, it should be noted that, due to the rather all-encompassing effects of the Ebola crisis on senior humanitarian health managers, the response rate for the consultation activities ranged from reasonable (49% for the structured self-assessment) to poor (15% for the open-ended questionnaire). Furthermore, the lack of availability of respondents in the consultation interview process resulted in the participant pool being largely skewed toward WHO personnel. Further detail regarding the findings can be found in Annex A of this report.

  Despite the constraints on the consultation process, the results were rather clear. Respondents were rather united in their messages, many of which were repeated systematically and unambiguously across the respondent pool. On the whole, there was a general agreement that there are a number of systemic and interrelated bottlenecks at the root of the shortage of a pool of effective Health Cluster teams. At the core of this is the need for **new, structured systems, policies and processes** for the selection, training, support, retention of Health Cluster staff, all which are likely to require substantial investment and resources from the WHO (as Cluster lead agency), the GHC Unit and GHC partners. More specifically, this report is responding to the following specific findings:

- The **lack of competent Health Cluster staff** who can be deployed at short notice, whether because of availability issues or because of skills/experience issues (or both).
- The importance of **reforming the selection process** of Health Cluster staff in order to ensure that competent and experienced staff are effectively recruited into post.
- **Significant capacity gaps in the HCC pool** in areas such as information management, strategy formulation and planning, agencies' mandate, role of coordination and its functions, knowledge of the context, soft skills (such as communication, advocacy, diplomacy, leadership) and managerial skills.

- The need for a radical **increase in the structure, type and amount of support provided to Health Cluster coordination teams.**
- The **absence of a performance assessment/management structure** that addresses the complexities of managing Health Cluster Coordinators and is built upon a clear competency framework and based upon a process of continual assessment and management engagement.
- **Ongoing retention issues** that centre on a lack of funding for longer-term contracts, lack of recognition of the work, and the general fatigue that comes from working in an isolated environment with very little support or effective tools.
- The need for **Health Cluster partners to more fully and confidently assume their roles responsibilities**, per the *GHC Strategic Framework* and the *Cluster Coordination Reference Model*, participating more proactively in the Cluster and working collectively to build cluster capacity in country and globally.
- The need for the **WHO to assume a different, more active role** in health coordination in emergencies, more fully institutionalising the Cluster approach within the Cluster Lead Agency itself.

The proposals in this document are, thus, built on the recommendations that emerged directly from the emergency health practitioners themselves and thus respond directly to their staffing concerns and needs. Health Cluster staff expressed a number of direct support needs that are critical to their successful performance and retention. However, these concerns are also mediated by the realities of the resource limitations that exist for professional and capacity development and are, thus, intended to be a collection of real options from which the Health Cluster partnership should decide upon based on a combination of Health Cluster imperatives and priorities regarding current and potential resource allocations.

4. HEALTH CLUSTER PROFESSIONAL DEVELOPMENT RECOMMENDATIONS

Part A. Selecting Candidates:

1. Health Cluster Coordination Team composition, Job Profiles and Person Specifications (likely in the short term)

The GHC should define a **minimum standard core for the composition of a Health Cluster coordination team.** This would be a minimum core that would be adapted according to the size, scope and grading of each individual emergency.

Such a core is likely to be comprised of the following roles:

- Health Cluster Coordinator
- Information Management Officer
- Technical Advisor
- Communications Officer
- Other options, depending on size and capacity, which may include roles such as Administrative Support personnel or a Logistician.

Each position should be accompanied by **clear Job Profiles (or TORs) and Person Specifications** in order to unambiguously frame:

- The Job Role Summary
- Essential roles and responsibilities
- Essential and desirable competencies, skills, education and experience
- Key performance targets or goals

These will serve as the basis for selection as candidates can then be assessed against the requirements of the positions and the requirements of the emergency, be it L1 - L3. This goal coincides with a similar action as outlined in the *WHO Staff Development Plan for Emergency Health Staff*.

2. Health Cluster Competency Framework (likely in the short term)

A **Health Cluster Competency Framework** should be developed that defines the knowledge, skills, capabilities and attitudes/behaviours that are directly related to successful performance of Health Cluster teams. In other words, to achieve excellent cluster coordination performance, Health Cluster teams should excel in the identified competencies.

The development and use of a Health Cluster Competency Framework would aid the Health Cluster in achieving several goals:

- Translation of the cluster coordination core functions into criteria for recruitment and selection.
- Establishment of standards of excellence that are shared across the Cluster and across the Cluster team functions.
- Focus learning and development actions on the achievement of core functions.
- Provide a basis for ongoing cluster coordination performance feedback and development.
- Accelerate development of a learning and development culture[6].

The *WHO Corporate Framework for Learning and Development 2014-2020* suggests that the WHO will define the required behavioural and technical competencies needed to perform different job functions, aligned to learning and development needs. It is suggested that the GHC integrate any such work with any competency development at the corporate level.

There is also significant work on Cluster coordination competencies happening across the Cluster Coordination system. There is currently an ongoing discourse that represents an important step towards informing induction-level training design and evaluation, supporting harmonisation efforts and contributing to the delivery of quality training across the global clusters. It is recommended that the GHC harmonise any Health Cluster Competency Framework with these efforts, building on recent work such as:

- The recent IASC Humanitarian Coordination competency framework
- The Surge Competencies Analysis work led by the Stand-by Partner Training Secretariat (which highly recommends a competency approach to induction training design)
- The UNICEF Cluster Coordination Competency Strategy work which outlines essential competencies for cluster coordination staff (there are a number of expected deliverables as part of this project that will be of interest to the GHC, including mapping exercises).

An initial Health Cluster framework is indicated below, which outlines desired competence (the knowledge, skills and attitudes) required for Health Cluster teams to effectively perform their key functions. It utilises the six cluster coordination functions as the basis for defining the competencies required of a

[6] UNICEF Cluster Coordination Competency Development Strategy, 2014

well-performing Health Cluster team. For each cluster function, there is an indication of the key competence and the underlying knowledge and skills required.

The framework could be used for the selection of new HCCs (or the assessment of existing HCCs), the choice of which type of crises they should be deployed to, the identification of their learning needs and capacity-building opportunities, and the assessment of their performance. Such a competency framework to be translated into specific components of knowledge and skills that can be assessed and linked to the HCCs' Job Profile and Person Specification, as well as ideally interrelate with the inter-cluster efforts mentioned above. Furthermore, it is suggested that the GHC enlist the assistance of a human resources expert who can support the development of indicators to measure the competencies against set targets.

Please find table on following page:

CLUSTER FUNCTION	COMPETENCE	KNOWLEDGE	SKILLS
Supporting service delivery	Technical leadership; field experience	Determinants of morbidity & mortality per type of emergency; effective PH interventions and programmes to address health and HS priorities	Communication skills; Negotiation with partners
Informing strategic decision making of the HCT	Focus on results	Basic epidemiology and IM; health and HS priorities in emergencies	Analytical capacity; team skills; cultural sensitivity to the context
Planning and strategy development	Direction setting; leadership	Health standards & guidelines; effective PH interventions; project / programme management; basic costing	Synthesis capacity; negotiation with partners; advocacy skills; writing skills
Advocacy	Understanding of the policy and funding environments, as well as donor priorities	Key components of strong advocacy messages	Communication & writing skills; developing and delivering short advocacy messages that are appropriate for varied targets.
Monitoring and reporting	Focus on results	IM; project / programme management	Writing skills; synthesis capacity
Contingency planning/preparedness / capacity building	Direction setting	Determinants of morbidity & mortality per type of emergency; effective PH interventions & programmes	Synthesis capacity; negotiation with partners; advocacy skills; team skills

Legend. PH: public health; HS: health system; HCT: Humanitarian Country Team; IM: information management

3. Health Cluster team candidate identification process, particularly for HCCs (potentially in the short to medium term)

A number of mechanisms are used by the various GHC members to provide human resources support to emergency responses: internal deployments from various programmes and offices, the use of standby partners or surge rosters and external recruitment. Yet, the variety of mechanisms does not result in consistent success in identification and recruitment of Health Cluster coordination staff. There remains an ongoing lack of availability of Health Cluster staff with the right skills for various contexts.

Yet, many respondents believe that the availability issues are primarily because the current pool is simply too small and too many agencies are dipping into it to meet their staff needs. Thus, there were a number of suggestions regarding ways to widen the pool itself. Many respondents mentioned how they see potential candidates for Health Cluster roles moving through a number of other pathways, such as other technical training programmes (both formal and informal education programmes), partner agency programmes and systems, various humanitarian initiatives/programmes, et.

Thus, it is proposed to create a **Health Cluster Pathways Framework**, through which the pool of candidates for Cluster positions, particularly HCCs, could be identified for further assessment. The Framework would be comprised of numerous pathways, each of which is imbued with particular criteria and clear actions meant to identify potential candidates for further assessment.

- Candidates could be identified through:
- Various training programmes such as:
    - Surge training
    - ICRC H.E.L.P. training
    - HCC training
- GHC advertisement, both internal to member agencies and external through media and networks
- Recommendations of supervisors of health emergency staff
- Voluntary application of GHC member agencies' individual staff

- Agency specific programmes or induction programmes
- Others?

The GHC would need to systematise criteria and communication links between the organisations and institutions who run the various programmes, integrating into a 'Health Cluster talent spotting' system of sorts. Potential candidates who meet the criteria and demonstrate the aptitude and competencies for coordination would be identified by the partner/agency/institutions and passed on to the GHC as a potential candidate.

Such candidates would then be invited to the next step, the **GHC HCC Programme**, a training programme whose content would be comprised largely of the updated HCC training materials, but with an added assessment mechanism. It is proposed to specifically select new HCCs (and possibly other members of the coordination teams) through this mechanism. Candidates would be accepted on the basis of pre-defined requirements (education[7] and relevant field experience). This goal coincides with a similar action as outlined in the *WHO Staff Development Plan for Emergency Health Staff*: only candidates who have received an initial training will be considered for key positions such as Health Cluster Coordinator.

The HCC Coordinator Programme would have several objectives:

- To provide participants with an updated overview of the humanitarian reform and its implications on the work of HCCs and with some tips on soft skills;
- To assess participants on their baseline knowledge, skills and behaviours (against the competency framework outlined above) for informing decisions on the type of deployments of those judged eligible for an HCC;
- To assess additional learning needs of HCC candidates and discuss with them tailored mentoring support, development opportunities and career paths.

The course should be compulsory for HCCs; current HCCs who have not been trained will be requested to attend the course (priority criteria to be determined). A decision is to be made if the courses would be organised at global and/or regional levels.

[7] An agreement needs to be reached on minimum education requirements: e.g. nursing diploma and/or medical degree or other background with a MPH).

During the course, participants could be assessed through an assortment of possibilities that would need to be agreed upon by the GHC. These could include a mixture of any of the following:

- A test on their knowledge of public health in emergencies;
- A psycho-attitudinal test[8] to determine if their personality is fit for the purpose
- Their performance during a simulation
- Structured observation by a training facilitator
- Candidacy interviews.

In line with the recommendations from the consultation and the conclusions of the HCC LNA, the former 'Health Cluster Coordinator training course' is currently being revised to reflect recent changes in humanitarian architecture (such as the TA and the Humanitarian Programme Cycle), changes in the WHO (such at the ERF), as well as to refocus the course on the *coordination* skills that are required for the position. Once the revision is complete (late 2014), the course will need further attention to ensure that it objectives are aligned with other elements of this strategy such as:

- Health Cluster Competency Framework
- The Health Cluster coordination team job descriptions and person specifications
- The collection of assessment processes that are outlined above, based on GHC decisions about final assessment requirements.

It is also recommended that the GHC review the **GHC HCC Programme** in light of current activity in the Global Cluster Coordination Group, OCHA (GCCG) who are working to improve cooperation on training and capacity building for cluster coordinators and inter-cluster coordinators, as well as to determine how best to coordinate/harmonise efforts between and across clusters though common approaches and events that will lead to economies of scale and the identification of best practice. The GCCG is also working to agree on a common framework to teach coordination competencies and the application of established policy (such as the Humanitarian Programme Cycle).

[8] Reportedly used by the ICRC

Part B. Supporting Health Cluster Teams:

Health Cluster teams are in dire need of clarity regarding a long list of frameworks, policies, tools, templates, checklists, etc. that serve to guide their work in many important ways. These needs could easily be met through a combination of the following:

1. Revision Of The Global Health Cluster Guide (Likely In The Short Term)

A revision of the Health Cluster Guide, based on the TA and ERF standards and procedures, as well as on recent technical guidelines, is in order. The revised Health Cluster Guide should provide the key policy and operational guidance to HCCs, as well as relevant supporting information to guide their role in facilitating a predictable, coordinated and effective response, one that highlights the overarching principles and standards applicable to health in emergencies and suggests how the coordinated and collaborative efforts of cluster partners, in partnership with government, can contribute to an effective and efficient education sector response.

2. An Online Global Health Cluster Portal (Likely In The Short Term)

In combination with the development of clear Health Cluster policies, templates, checklists, and tools, Health Cluster teams would benefit from an online portal where such documents (an online version of the 'Cluster in a Box' or a Cluster 'toolkit') could be referenced and easily found. This could be built on the Prime model, or could complement the Prime model in various ways, for instance by being integrated into it.

There are a number of good examples from other Clusters who use a 'Cluster' site to store such relevant items and make them easily and readily available to Cluster staff. UNICEF is working on a 'cluster in a box' that could prove to be a model for the GHC portal and should support the GHC as it launches on a similar project.[9]

[9] GHC is currently in the early stages of developing a cluster-in-a-box, being led by IMC and UNICEF.

3. Staff Capacity Building

Various other modalities of capacity building should be offered to the Health Cluster teams, particularly HCCs, based on the competency framework, the individual learning and professional development needs that emerge through performance assessment and the LMS. Possibilities include:

3.1 Direct support to Health Cluster staff (likely in the short to medium term)

Health Cluster staff consistently mentioned the need for some sort of institutionalised, formal, direct support system that would be available to them either:

- Continuously (ideally)
- At regular, planned intervals.

Mentoring was consistently mentioned in the consultations. The mentoring suggestions ranged from the idea of a full mentoring programme that is connected to professional development roles, to "I'd just like to know that there's somebody I could call!" But, regardless of the model should be something that is consistent and readily available, without requiring too much time.

This type of support is already carried out on an informal basis by various HQ and RO staff and supports the mentoring proposal as made in *Staff Development Plan for Emergency Health Staff*. Staff who receive informal mentoring report on the rather significant difference it makes to their work and thus demands to be more formally institutionalised. Mentoring support should be tailored to the needs of the Health Cluster coordinator teams and the context of the crisis-affected country of deployment. It should include a plan of regular contact with agreed upon objectives, deliverables and feedback that become part of the performance assessment (PMDS) by the official supervisor (which for many is currently the WR, but could also be their own agency line managers).

It is acknowledged that this type of support requires technical and financial resources that may not currently be available. However, this could be accomplished by making three senior staff in HQ and three in RO available to provide support mentoring for two to three HCCs or Health Cluster teams with a one-hour Skype/telephone call every 10 days. At this rate, that would work out to the equivalent of one working day, per month, per senior staff and would cover 12-18 HCCs.

A helpdesk could be another modality of support that could be explored. The Child Protection Working Group utilises such a model that could be examined and adapted.

3.2 Advanced trainings and E-learning (likely in the short to medium term)

Various suggestions emerged from the consultation regarding the focus, type and modalities of thematic or advanced training. It is acknowledged that developing such training modules for the Health Cluster would likely require a substantial, and possibly inhibitive, investment. Thus, feasibility considerations point to the opportunistic use of existing trainings, both face-to-face and electronic courses, instead of developing in house or through academic institutions. Furthermore, it is recommended that the Health Cluster build upon existing learning possibilities in order organisations.

The only exception might be **a course on Health Information Management in Emergencies** that should likely be considered for in-house development. It is an area that has been consistently pinpointed as being weak in multiple evaluations of health response, as well as by multiple respondents in the strategy consultations and the learning needs analysis. The *Health Cluster Coordination Performance 2013* report also highlights the fact that only half of the Clusters have information management support staff, thus requiring that other coordination team members fulfil this function. The report also highlighted that reinforcement and support is needed in needs assessment and gap analysis (which rely heavily on information management elements), which was also the only sub-function in which the Clusters scored 'weak'.

Please note that the Stand By Partnership Training Secretariat[10] is in the final stages of the design and delivery of joint information management training. It could be useful to make this training a starting point for any health-specific IM training.

A number of themes for further capacity development emerged from the strategy consultation, such as:

[10] In 2012, stand-by partners of UNICEF, UNHCR, UN OCHA and WFP decided to establish a dedicated capacity to harmonize on-going and future training and learning initiatives. In an effort to bring this collective effort to a higher level, a permanent Training Secretariat (TS) became operational in early 2013 and is hosted by UNICEF.

- Interventions that address the main causes of mortality, morbidity, disability & suffering per type of emergency
- Information management, including needs assessment, early warning/surveillance, basic elements of field epidemiology
- Strategy formulation and planning
- Health financing (how to cost services, overheads, etc.)
- Epidemiology
- Early warning systems/surveillance
- Mental health
- Reproductive Health
- Mobile clinics & referral
- Mapping, GIS.

In terms of current trainings, there are a number of possibilities that Cluster teams could tap into rather immediately, many of which already offer solid public health and emergency elements. For acute emergencies, the WHO's surge training represents the core curriculum, which, along with the ICRC's H.E.L.P[11] course, in partnership with several academic institutions, covers a wide range of public health topics relevant for humanitarian health response. For protracted emergencies, the ADHS[12] course, managed by the Royal Tropical Institute of Amsterdam and the Health Systems through Conflict and Recovery course, organised by the Scuola Sant'Anna of the Pisa University, offers a similar curriculum spread over two weeks and centred on the analysis of health systems in complex emergencies and the approaches for correcting some of their long-standing distortions.

Although an initial mapping of available and relevant training courses will be found in an annex of the final version of this report, it is suggest that GHC should conduct a global thematic training and e-learning mapping exercise that identifies the types and modalities of available trainings that staff and managers can use to fill capacity gaps identified through the recruitment/assessment process, through general performance management and through the LMS. Furthermore, it is suggested that the GHC work link with current GCCG and the UNICEF Cluster Unit efforts on the same and to investigate potential synergies with other Clusters and humanitarian actors. The final product should be a matrix of learning events, a mapping of synergies and an initial identification of gaps in the resources, along with a list of learning materials still needed to address the learning gaps that would be identified from the activities proposed in part C of this report below (Ongoing Assessment Of Staff L&D Needs).

[11] Health Emergencies in Large Populations
[12] Analysing Disrupted Health Sectors

The GHC would also need to determine the criteria for developing specific advanced or thematic training courses as well as for inviting Health Cluster coordination teams in. Such criteria may include:

- the learning needs of Health Cluster teams, as assessed against the Health Cluster Competency Framework
- the relevance of the course(s) to the crisis to which they have been (or will be) deployed
- the quality of the training
- career prospects
- equity of opportunities
- local arrangements for replacing the HCC during the training
- financial considerations.

3.3 Global Online Fora (likely in the medium term)

Several respondents mentioned the operational and educational value of moderated web discussions on various technical themes, possibly oriented to problem solving. It could also be an open web space (or could be linked to the GHC Online Portal mentioned above) with regular meetings involving various Health Cluster staff, moderated by an expert of some sort.

This approach seems to be a promising modality of peer-education and active participation of Health Cluster staff in technical discussions and should be tested in a cluster of countries or a region before being scaled up in all crisis-affected countries. It would require thorough preparation (availability of a competent moderator, agreement on topics to be discussed, distribution of relevant background material, assignment of tasks, etc.) and adequate IT platforms and connectivity requirements (in some countries, stable connectivity can be a problem).

While a number of consultation respondents suggested training solutions for various technical and thematic needs, there were also other indications that online fora could also serve as a substitute for some of them. For many Health Cluster staff, their technical development and support needs are rather specific and may not necessarily need to be met by dedicating the significant amount of human and financial resources that is often required to develop, deliver and attend face-to-face training. For many of them, their needs could likely be met by participating in a forum where they can present their various technical challenges, learn lessons from others dealing with similar field issues, receive some expert technical guidance and ask questions.

3.4 Ongoing Assessment Of Staff L&D Needs (likely in the longer term)

The GHC should work closely with the WHO and Regional Offices to **develop a Learning Management System** (LMS). An LMS is the infrastructure that would deliver and manage learning content, identify and assess individual and organisational learning or training goals, track the progress towards meeting those goals, and collect and present data for supervising the learning process of Health Cluster staff as a whole. It is envisioned that the LMS project would begin by using the Health Cluster Coordination Competency Framework to identify and describe the current competency gaps around which the LMS would be built.

It is recommended that the GHC build upon the synergies of the work that other Clusters are doing in this regard. UNHCR has a functional learning management system for its staff at present; the Camp Coordination and Camp Management Cluster and the UNICEF-coordinated Clusters are currently working to establish such systems as well.

Furthermore, the *WHO Corporate Framework for Learning and Development 2014-2020* suggests that the WHO will institute a system whereby staff will develop individual learning plans for staff to identify the knowledge, skills and competencies required to enhance their performance. The plans are meant to be a collaborative effort involving managers and staff, setting meaningful goals for performance and learning. The GHC should explore these plans further and identify possibilities to dovetail with GHC LMS elements.

The Learning Management System mentioned above would be the framework whereby such training is identified, managed and recorded. It would be comprised of a database of Health Cluster staff's attendance on various trainings and would ensure that learning opportunities are offered on an equitable basis and to record the assessment of individual participants.

3.5 Performance Assessment (Ongoing)

The strategy consultation process revealed a rather clear agreement on the need for a particularly rigorous selection process of Health Cluster Coordinators (HCCs), followed by a probationary period with a supervisor (likely HQ or RO for WHO staff; various line management possibilities for surge/partner staff) accountable for the HCC in the first period. And, as mentioned previously, suitability for the role should be assessed against a clear and current

competency framework and TOR before the deployment and then reviewed in the field.

However, Health Cluster Coordinators are subject to a particularly complex performance management structure. While a clear process exists in WHO that regulates performance assessment of its staff, HCCs, however, operate in a special environment: in addition to being WHO/surge/partner staff, they also represent the interests of, and assume responsibilities for, the wider constituency of cluster member agencies and often interact with the Humanitarian Coordinator.

In addition to this, it seems that very few members of Health Cluster teams generally, and HCC specifics, are actually subject to regular performance appraisals that are linked to other aspects of organisational human resources, such as professional development and improvement procedures. There are a couple of easy answers to this, such as the fact that existing systems need to be used and line managers need to fulfil their obligations in this regard.

Thus, in light of the complexities of the Health Cluster team's situations, and the imperative of ongoing lack of performance assessment, it is proposed that the GHC Unit, as the one with the global oversight on cluster performance conduct a performance management or assessment mapping/tracking in order to determine wether Health Cluster teams are having regular performance appraisals and by whom. It would also be important to understand the criteria against which they are being assessed, as well as what, if any, follow-up or action occurs as a result. ¨

4. RETENTION AND CAREER DEVELOPMENT

Given the increasing profile of health response in emergency interventions, it is becoming even more imperative that retaining technical staff with experience and expertise is essential. However, the Health Cluster has had ongoing difficulties retaining such experience and expertise. The message from the strategy consultation regarding ways to retain Health Cluster staff is rather clear. Retention issues centre on the uncertainty of short-term contracts, lack of recognition at work and the general fatigue that comes from working in an isolated environment with very little support or standardised tools.

4 Job Security (likely long term only)

There is a wide mix of contract arrangements across the Health Cluster. However, far too many Health Cluster staff are working on temporary contracts of

approximately six months. Thus, many of them are already starting their preparations to leave shortly after they arrive in the job. At the moment, there doesn't seem to be an immediate way to change the employment structure into one that addresses the inherent temporary nature of the work, thus making it a challenge for the Health Cluster to address such retention issues. However, despite the lack of a foreseeable solution, this report aims to raise attention to the matter in the hopes that such attention may serve as the beginning of institutional efforts across all Health Cluster partnership to contrive to develop contract arrangements that better serve the goals of the health response in disasters and emergencies.

5 Support and Development (ongoing)

For many of the interviewees, the problem isn't simply the short-term nature of the contracts. Rather, it is the general dearth of demonstrations of commitment from those who are institutionally tasked to support them (be that the ROs, GHC, line managers or partner agencies). Health Cluster staff would remain in the positions longer if they were offered **more support and developmental incentives** that are addressed in other areas of this strategy. Institutionalising some of the proposals herein would serve to make Health Cluster staff members feel like there is a sense of commitment from the GHC and WHO to their ability to do their jobs, to the development of their skills, and to alleviate the general isolation that many of them feel.

Health Cluster staff want clear:

- Clear TORs
- Demonstration of support from the GHC and their managers
- Periods of rest
- Training and professional development opportunities
- Access to good, standardised tools and support in using them.

6 Career Development Opportunities (likely in the medium term)

As part of the consultation process, interviewees were asked about their ideas for a Health Cluster career path. However, the consultation demonstrated that informants are rather divided on this topic:

- Some think that Health Cluster coordination is a defined, mid-career, "permanent" job, with HCCs in particular moving from one crisis to another.
- Others believe that it can be only a temporary assignment, because it can be too stressful if carried out for too long. In addition, a professional who works for too long in coordination can end up losing some technical and operational skills that are important for the job.

If the jury is still out on this subject, there seems to be a consensus on the fact that different career paths fit the profile and expectations of different HCCs and no universal solution is applicable. Many informants highlighted, for example that the profile of a HCC working in acute emergencies is different from that of a HCC deployed to countries affected by protracted crises. While the former should be operation-driven, dynamic and, preferably, with a charismatic personality, the latter should be more analytical and skilful in negotiation and diplomacy. While the former's deployment can be relatively short, the latter can last several years. Different career paths, therefore, may be envisaged for HCCs with different skills and personality and deployed to different crises. And for many, the question doesn't seem to be a question of 'career path', but one of 'what next?'

Nevertheless, for those who want to stay in the emergency experience, there is very little in place in terms of clear developmental opportunities and/or exposure to other contexts that might serve to further capacitate them. One clear message that emerged was that Health Cluster staff and those who work with them would like to see a **rotation system** instituted. This would involve moving Health Cluster staff across regions, often in lateral moves, to regional and HQ positions. If the GHC could provide further career opportunities in other areas of world, other emergencies, other contexts, then Health Cluster staff would see that as a 'path' of varied experiences that would attract many of them.

The Child Protection Working Group and the WASH Cluster successfully implemented a different model by integrating capacity development functions into the TORs for their Rapid Response Teams (RRT). The feedback indicates that where RRT members have been deployed in support of capacity building and preparedness (for example to conduct training), this is valued as highly as when RRT members have deployed to coordinate an ongoing or new response. A variation of this model could be integrated into the current surge staff model or could be offered as an incentive (or rotation) for Health Cluster staff who are moving off an emergency project and are awaiting their next assignment.

ANNEX A: LEARNING NEEDS ASSESSMENT AND CONSULTATION INTERVIEW FINDINGS

1. Findings from the HCC LNA:

The structured questionnaire was sent to 47 staff (HCCs, former HCCs and surge staff); the **response rate was 49%**. Respondents are **experienced HCC**s: they have worked an average of 46 months (range 6-168 months) in that role, in an average two countries each (range 1-4).

Main Findings:

- Almost two thirds of respondents (65%) had attended a **HCC training**; the respondents made a number of suggestions concerning critical thematic areas of this training that should be strengthened or added to the current curriculum[13];
- Nearly all (91%) respondents had attended **other relevant courses**[14], with surge training, pre-deployment and ADHS being the courses with highest attendance.
- Seventy four per cent of respondents think that HCCs working in **protracted emergencies** need additional training in the following areas: recovery; resilience-building, analysis of disrupted health sectors; links between relief and development; needs assessment, planning and monitoring of chronic needs and service gaps; emergency preparedness; national capacity building; transition mechanisms to existing development processes; advocacy; donor and media relationships.
- All respondents are familiar with the WHO **Emergency Relief Framework** and have used it for different purposes; overall they reported that it is a useful guidance document, but outlined some of its limitations.
- The three competency areas in which respondents feel **most confident** are:
    - management of cluster meetings (95%)
    - reporting (87%)
    - management of the coordination process in general (66%).
- The three competency areas in which the respondents feel **least confident or need assistance** are:

[13] Data collection and analysis (GIS, HeRAMS,); costing health services; contingency planning; early recovery; strategy development; personality requirements; advocacy; communication; review of cluster performance; links to UNDAC; large scale events

[14] 6 surge, 6 pre-deployment; 6 ADHS; management of emergencies; Public health (WHO); M Sc International humanitarian medicine; M sc in Disaster M edicine; PH in complex emergencies; 3-cluster training; health emergencies in large populations; communicable diseases.in emergencies; GHC training 2010; IDRR, Public Health Emergency Preparedness & Response; Transforming priorities into projects; PHPD, CERF, needs assessments for M IRA

- information management (77%)
- advocacy (50%)
- formulation of strategies and planning (46%).

– More specifically, functions for which that the respondents perceive their **skills** as the **weakest** are:
  - those related to information management
    - providing inputs to the website (100%)
    - data representation with maps and graphics (96%)
    - contact list management (61%)
– undertaking advocacy activities on behalf of cluster participants and the affected populations (14%)
– ensuring linkages between humanitarian interventions and longer-term sector recovery and development (61%)
– linkages with needs assessments of other clusters (55%).

– Overall, findings from this learning needs assessment seem to be **consistent** with recommendations from GHC meetings, cluster performance monitoring and evaluations of cluster response in recent crises.

2. Findings From The Consultation Interviews:

During October 2014, the consultants conducted 27 consultation interviews with Health Cluster stakeholders worldwide. The consultation pool was comprised of a targeted group of stakeholders, all of whom have strong field experience, although with varying experience working with the WHO or the HC. Overall, they are very knowledgeable informants regarding the functioning of the HC at its various levels. The consultation interviewees were from:

WHO region:
- PAHO: 2
- EMRO: 8
- AFRO: 4
- WPRO: 2
- SEARO: 2
- EURO: 1
- HQ: 5
- Other (partners and GMC members): 2

Agencies:
- WHO: 18
- EC: 1
- IMC: 1
- DFID: 1
- SCUK (surge): 3

Functions:
- Regional / inter-country advisor: 8
- Health Cluster Coordinators (HCCs): 6
- WR: 1
- GHC or WHO Emergency staff: 4
- Emergency officer: 1
- Technical advisor: 2
- WHO HR: 1
- Other: 2

Main Findings:

- Criticism of the WHO role in the HC was raised by numerous informants. It concerns:
    - its territoriality in health coordination and resistance towards other cluster members;
    - lack of HR policy (career, contracts, promotion, etc.);
    - lack of understanding of the importance of coordination and potential benefits for the organisation and the health response;
    - an overly bureaucratic approach that favours ticking checklists and following procedures, rather than focusing on the needs of beneficiaries;
    - sometimes resistance towards staff coming from other regions.

- One of the clear messages from these interviews is that **WHO** should reconsider its role in the HC, investing more resources while opening up to cluster member agencies. At the same time, **member agencies** should be more pro-active in their partnership. Based on these comments, it seems that without radical political and cultural changes in the WHO, and without operational changes in the GHC partnership, any strategy or plan would improve only improve the effectiveness of the Health Cluster at the margins.

- **Availability** of competent HCC to be deployed at short notice: there is a general consensus that they are too few. This situation becomes more acute when one considers the increasing number of crises and their geographical spread, each of which requires different coordination hubs with a dedicated HCC. Selection processes seem to favour staff more on a 'clientelistic', informal basis (staff known by the WR or the RO) than on a competence basis. There is not enough attention paid to the personality traits that play an important role in Health Cluster coordination. Since Health Clusters should be operationally driven, Cluster teams should come preferably from NGOs or even locally. Many highlighted the importance of Health Cluster teams to support the HCC in key functions (data manager, info manager, logistician, communications officers), which would require substantial additional funding.

- There was agreement on the need for a **more structured and rigorous selection process of HCCs** (e.g. using the model for the Humanitarian Coordinators), followed by a probationary period with a HQ or RO supervisor accountable for the HCC in the first period. Suitability to the role should be assessed against a clear and current competency framework and TOR before the deployment (through CV, exam and interview) and then reviewed in the field. The selection of competent HCC seems to be the weakest aspect of the HCC job cycle, which should be reformed and institutionalised. There seems to be a consensus that training cannot substitute for effective selection: it cannot address the most serious technical and communication weaknesses: staff without solid technical background, field experience, right personality and adequate communication skills should not be in the HCC position. There seem to be too many Health Cluster teams with staff that do not know enough about public health (determinants of morbidity and mortality in emergencies), IM and field epidemiology; acute □□chronic emergencies, etc.

- There are, however, a number of **capacity gaps** that could indeed be filled by appropriate training and support. Some of these include strategy formulation and planning, the role of coordination and its functions, knowledge of the context, soft skills (mainly communication); managerial skills. However, these capacity gaps would need to be identified at some point in the process and a professional development plan to fill them should be completed. A refreshed HCC training that focuses on these elements could be integrated as part of the solution, but the ability to implement the knowledge and skill gained on the HCC course needs to be accompanied by a support structure that facilitates this.

- **Training**: There were a number of suggestions regarding ways to address the capacity gaps of Health Cluster teams, such as training, on-the-job supervision and mentoring. However, it was mentioned that there are capacity constraints to sustain their implementation. The most ambitious proposal was to develop a training curriculum based on a master course structure, with an initial short course for all potential HCC followed by individually-tailored education paths covering the different functions of the HCC, different public health programs, etc. E-learning could be a delivery option, but cannot substitute completely for face-to-face training: writing skills, project proposal development could be e-learning modules. Moderated Web

discussions were also suggested. Some highlighted, however, that the GHC/WHO don't have the capacity to develop, implement and sustain such a programme, which should be commissioned to an academic/educational institution/consultancy.

- **Mentoring** was consistently mentioned in the consultations. The mentoring models ranged from the idea of a full mentoring programme that is connected to professional development roles, to "I'd just like to know that there's somebody I could call!" But, regardless of the model should be something that is consistent and readily available, without requiring too much time. A helpdesk could be a modality of support.

- **Retention issues** centre on lack of funding for longer-term contracts, lack of recognition of the work, and the general fatigue that comes from working in an isolated environment with very little support or effective tools. HCCs deployed in protracted emergencies are those with better prospects of remaining employed, with rotation to different countries and across different functions in health emergencies. Most informants agree that HCC should be a temporary job, with lateral move to other assignments (emergency preparedness, policy work etc.) after some years.

ANNEX B. PROPOSED WORKPLAN

COMPONENT OF THE STRATEGY	MAIN ACTIVITIES	OUTPUTS	TIMEFRAME	NOTES
Competency framework	Develop the framework outlined in the L&D strategy	Detailed list of essential and desirable skills, knowledge and attitudes for HCC; methods & tools for assessing them	Jan-Apr 2015	The framework needs to be made compatible with the WHO general competency model; education in health expert might be required
Health Cluster Team candidate identification process	Identify the core pathways of the Health Cluster Pathways Framework and selection criteria; institutionalise the links between Pathways and the induction programme.	The HCC Pathways Framework	Jan-May 2015	Refreshed HCC induction training materials are now available and ready for further revision. The selection and assessment tools probably require the technical advice of an education expert; Admin. / Secretarial
	Further revise HCC training materials in light of the Health Cluster competency framework and HCC job descriptions	Refreshed HCC induction training materials are now available		

Health Cluster Team candidate identification process	Develop / adapt knowledge and psycho-attitudinal tests for selecting HCCs + structured observation and interview guidance tools, harmonized with the competency framework + learning needs assessment	Tests available and integrated into the induction programme		support needed for organizing the inductions The expected output of 3 inductions is 35-45 HCC, both new or HCC not previously trained, by early 2016
	Identify trainers	Trainers in place; familiar with the curriculum and materials		
	Advertise induction	Course advertised (internally & externally)		
	Define selection criteria; select participants	Criteria agreed upon; 30 participants selected		
	Logistics (venue, admin, etc.)	All in place		
	Conduct **1st induction**	Around 20 HCC and HCC candidates inducted; **12-15 HCC selected for recruitment or re-assigned**	June 2015	
	Conduct 2nd induction	Around 20 HCC and HCC candidates inducted; **12-15 HCC selected for recruitment or re-assigned**	November 2015	

	Conduct 3rd induction	Around 20 HCC and HCC candidates inducted; **12-15 HCC selected for recruitment or re-assigned**	April 2016	
Ongoing Assessment of staff L&D needs	Work closely with WHO and RO to develop a Health Cluster Learning Management System that coordinates the competency framework with ongoing skills assessments processes and trainings and capacity building offerings.	Overview on participation of HCC in training for planning purposes	2016	The GHC Learning Management System would need to integrate various other pieces in this workplan, such as the competency framework, job descriptions, available trainings, the mentoring and performance management systems.
Supporting Health Cluster Teams	Revise **Health Cluster Guide** (TA, ERF)	Key reference for HCC	2015	
	Online Global Health Cluster portal: updated with relevant guidelines, policies, templates, checklists, and tools	Easy to use Global Health Cluster portal.	Ongoing	A focal point to be identified with the responsibility of identifying relevant documents and upload them into the web
	Institute a programme of **mentoring** HCCs through an institutionalised system ("help desk", regular contacts, field	6 mentors identified in WHO HQ and RO and GHC member agencies	Incrementally, from 2015	Mentoring work should be included in the ToR of mentors and mentored HCCs,

	visits, educational objectives with tasks assignments and review, regular performance assessment, etc.)	2-3 HCCs assigned to each mentor		including a system for informal performance assessment.
		Mentoring guide prepared		
		Around **15 HCCs receiving regular mentoring support**		
	Advanced training: 1. Conduct a global thematic training and e-learning mapping exercise in coordination with the mapping activities of GCCG and other Global Clusters	Training opportunities identified and prioritised	Jan-Apr 2015	This component requires the establishment of a GHC working group; Development of new training depends on GHC availability of capacity and financial resources; decision if in-house or externally commissioned
	2. Develop new trainings to cover learning needs not targeted by existing courses, particularly for **health information management in emergencies**.		2015	

	3. Mentors to match learning needs of their HCCs with training opportunities, financial resources and operational demands	**10 HCCs attend advanced training** relevant to their learning needs and emergency context of their assignment	2015-2016	
	GHC online fora for moderated web-discussions: Agree prioritised list of topics (either through the L&D needs assessment process, mentoring or agreeing with HCCs); set up IT platform and formats; identify moderators (who would likely select and distribute relevant materials).	3-4 moderated web-discussions involving an average 8 HCCs	Setup: summer 2015 Delivery: late 2015 through 2016	The chosen topic areas should also be integrated into the ongoing L&D needs assessment, the mentoring/performance assessment process and the LMS.

REFERENCES:

Health Cluster Coordinator Lessons Learned Workshop Report, Timothy Foster, 2010

Emergency Response Framework (ERF), World Health Organization, 2013

Corporate Framework for Learning and Development 2014-2020, World Health Organisation, 2014

UNICEF Cluster Coordination Competency Development Strategy, Avenir Analytics, 2014

Staff Development Plan for Emergency Health Staff, World Health Organisation, 2014

Health Cluster Coordination Performance Report, World Health Organization, 2013

Review of Evaluations, Country Mission Reports and Lessons Learned, Global Health Cluster, 2011

ANNEX 2:

Learning Needs Analysis (LNA) Report 16 November 2015

1. Aim of the Learning Needs Analysis

The aim of this LNA was to:

1.1. Update and build on the LNA carried out in 2014 and reported in the Health Cluster Professional Development Initial Findings and Recommendations November 2014.

1.2. Provide the baseline learning needs which will be addressed in the Health Cluster Capacity Development Strategy 2016 – 2019.

2. Methodology

An on-line survey consisting of 14 questions was developed by the GHC Learning and Development Consultant, Gillian O'Connell in collaboration with the NGO Consortium Learning and Development Consultant, Perry Seymour. A copy of the survey can be found here:
https://www.surveymonkey.com/r/7BHJX9C
Six (6) of the questions in this survey were about learning needs. The remaining questions were focused on the Health Cluster Capacity Development Strategy and Competency Framework.
The survey was sent out by the GHC Unit on the 2 November 2015 with a deadline of 9 November 2015. Two planned reminders were sent out and the survey deadline was extended to the 12 November 2015 in order to encourage more responses. This resulted in 8 more fully completed responses. The results of the survey were reviewed by Gillian O'Connell and Save the Children Health Cluster Support Expert and Capacity Development Task Team Member Gerbrand Alkema.

3. The Response to the Survey

The link to the on line survey was sent to **95** potential respondents who represented a wide range of stakeholders. For a full list of everyone who was invited to participate in the survey please see **Annex 1**.

– 52 of the 95 potential respondents responded to the survey by opening the link, giving an overall response rate of **55%,** and a non-response rate of **45%**

- 35 of the 95 potential respondents fully or partially completed the survey beyond Q3 - giving an overall completion or partial completion rate of **37%**

- 17 of the 95 potential respondents did not complete the survey beyond the first three questions, i.e. name, role and length of service, and therefore did not provide any usable feedback., i.e. a non-completion rate of 16%

Summary: Of the 52 people who responded to the survey by opening the link, 35 provided usable feedback beyond Q3 giving a net completion or partial completion rate of **67%** .

The response rates to this survey compare well with typical response rates for internal on line surveys which generally receive a response rate between 30 – 40%.

Possible reasons for non-completion:
The stakeholders were told that the survey would take no more than 20 minutes to complete, and most respondents completed or partially completed it within this time. Question 4, which was on areas to be covered by the strategy, was qualitative. Some respondents, when confronted with a question which required some reflection, may have decided to postpone answering this, and subsequent, questions until a later time but were then not able to do so. It is also possible that some respondents were curious about the survey, and wanted to review the questions in order to ensure reliability and validity.

4. Results

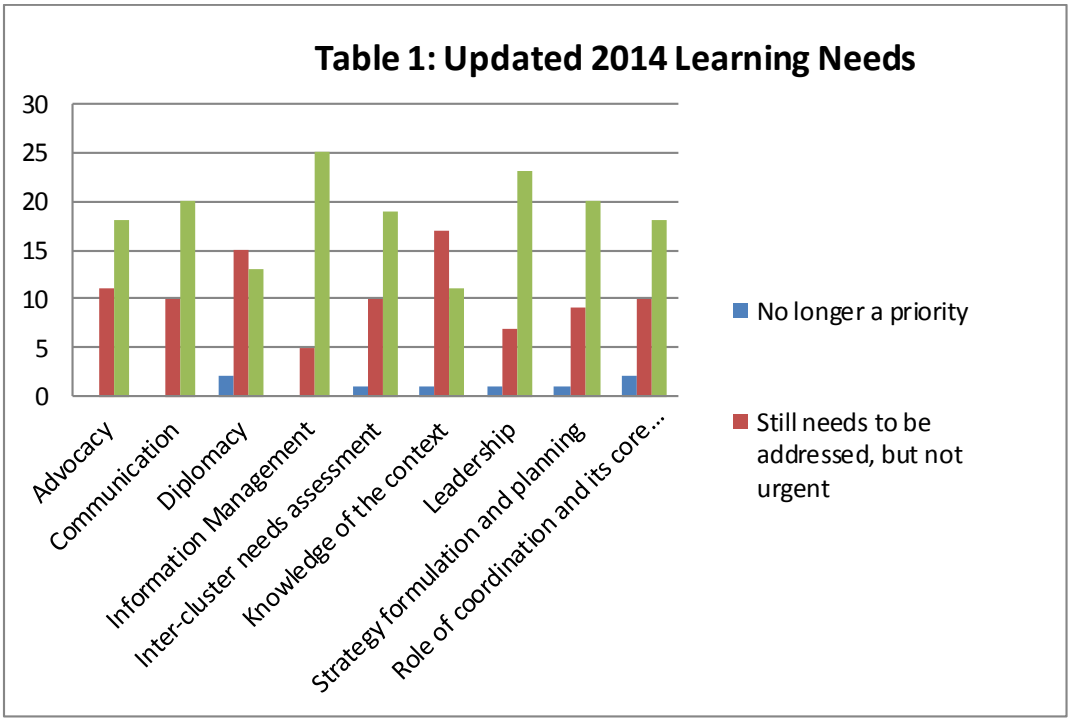
The analysis of the feedback from the questions which focused on the Learning Needs was carried out on 13 November 2015 by the GHC Learning and Development Consultant, Gillian O'Connell and the NGO Consortium/Save the Children Health Cluster Support Expert Gerbrand Alkema.

The full results of the survey can be found in **Annex 2.** This report focusses on the answers to questions: 9, 10, 11, 12, 13 and 14 which all focused on or included an element of learning needs. Other questions in the survey refer the Health Cluster Capacity Development Strategy and Competency Framework and will be analysed separately.

Questions 4 was also reviewed as, although this question was about areas the strategy should address, the question was possibly ambiguous and some respondents had answered it in terms of learning needs. For all Questions, apart from Question 14, if something has only been mentioned once it has not been included in this report.

Q9: The following priority learning needs were identified in the 2014 Health Cluster Professional Development Report. In your opinion are these still priorities for Health Cluster Personnel?

The results of the answers to this question are presented in **Table 1.**



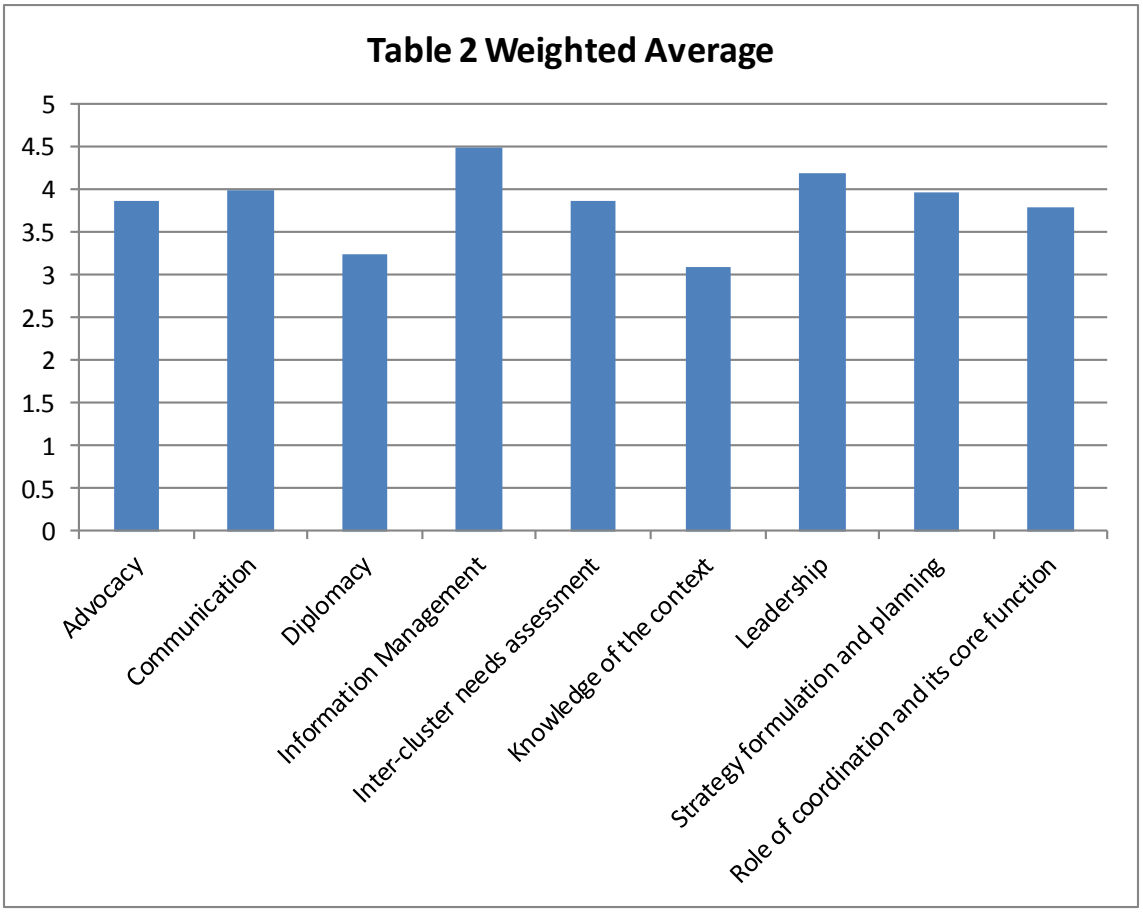
All the learning needs identified in 2014 are still seen as a priority, with the following needing to be addressed in the next twelve months:

PRIORITY ORDER	LEARNING NEEDS
1	Information Management
2	Leadership
3	Communication
3	Strategy Formulation and Planning
5	Inter Cluster Needs Assessment
6	Advocacy
6	Role of Coordination and its Core Functions

following learning needs still need to be adressed but are not urgent:

- Diplomacy
- Knowledge of the context

The results for each learning need are presented as a weighted average in **Table 2.**



Q9 also asked for any other comments which helped to explain the respondents assessment of the level of priority.

The full list of comments is below in **Table 3.**

A summary of some of the key issuses raised in the comments:

- Advocacy – no agreed framework within the Health Cluster, the priorties are becomimg more complex and there are differences across agencies
- IMO is a major priority and needs a consistent implementation of the tools and good data collection
- Inter-Cluster Coordination – too dependant on individuals, not systematic enough

– There is a disconnect between the theory and practice, for example the role of coordination and core functions may be known, but there needs to be a stronger focus on their application.

  It was also noted by the reviewers that there was no reference to technical knowledge or skills.

Table 3:
Q9: Please add any other comments which helps to explain your assessment of the level of priority

1	Advocacy: a very interesting concept when WHO in several occasions do not declare or backup HCC in highly sensitive issues (destruction of medical facilities by the state in power; cholera outbreaks, etc) not to "upset" the host government. The Role of Coordination and its core functions: WHO can't continue having HCC double hatting as WHO and HCC,
2	Theoretical knowledge on the role and function of a cluster coordinator are probably well known. What is needed are skills to be a better coordinator, able to analyse contexts and situation in a comprehensive way, taking into account the needs of the most vulnerable (such as older people) in the analysis and response planning. There are still huge gaps in the analysis and SRPs
3	The lower priority learning needs simply reflect those that are generally well developed among personnel. The higher priority areas show the areas that would have the largest impact on other areas. eg information management impacts on other areas of cluster, and there are some areas that are becoming more complex in the current humanitarian climate, such as advocacy
4	The issue with allocating priorities will depend on the person themselves, some will have a number of these skills, so building the others would be a priority.
5	It is very importance in the present scenario when there are many crisis happening around the work that require humanitarian response that health cluster have capacities ad capabilities re advocacy, effective communication and information management as priorities. These are the weak areas in the health cluster.
6	All these needs remain highly important to target for at least two main reasons: 1. to be coherent with the WHO Reform process and its transformation Agenda; 2. Many health clusters coordinator are new due to the high level of HCC turn over.
7	Inter-cluster needs assessments are in place, but different contexts use different formats, I think mainly at global level there is little consensus and

	agreement on which tools to use.
8	If the coordination team is not aware of its role and core functions, we have a real problem. Leadership and strategy development are critical for cluster coordinators and they need to know how to gain input from all actors and then formulate overall themes and plans and effectively lead partners in that direction. Often this also includes participation in needs assessments which need to work across clusters and not in a vacuum, especially WASH where so much of health is directly impacted by poor wash services.
9	Note: prioritization depends on the context. Just to give one example, the priorities are not the same in an acute emergency that in a protracted emergency
10	Creating productive interpersonal relationships; self-management
11	While advocacy is key to ensuring resource allocation and prioritization of interventions, there are agencies with this area of expertise who can support/input while also engaging relevant HQ backstopping. Diplomacy is integral with all areas and thereby cross cutting
12	It is important that Health Cluster personnel are well motivated and supported to do their job through appropriate communication channels and info management. The latter is also important in dealing with partners and ensuring concise analysis and info sharing. This builds into helping the personnel understand their roles etc. The others that are not urgent should be addressed in context of overall GHC strategy
13	Not sure why they wouldn't still be a priority, barely a year later. Are we not repeating work already done? Also, don't feel comfortable with structure of questions - everything seems equally urgent.
14	Understanding of advocacy and its increasing operationalization role (strategy, plans, activities, funds); use and availability of standardized tools and methodologies for information management; competent and trained health professionals in the field presenting the health cluster/sector; continuous update of knowledge and skills for strategy development and planning; comprehensive understanding of the role of coordination and its 6 core functions - are the areas of high priority permanently and also based on the fact that the health cluster has a very high turnover of staff (dedicated and double hatted) who may not have the necessary background.
15	Can't teach leadership
16	Role of coordination and core functions known, however application of them remains important. Cluster coordination is involved in advocacy only partly - the role of HCT and CLA more important. Communication/diplomacy/leadership should be seen as one. Adequate

information management and use of the health data is only possible and useful if the context of the crisis is known and understood. Confusion and exact understanding around objectives, strategy, input/output/outcomes/ and activities often remains an issue for a lot of coordinators

The additional Learning Needs identified in Q4 are as follow:

Learning Needs	Number of times mentioned
Resource mobilization, including Proposal Writing	11
Monitoring and Evaluation	7
Technical Skills	5
Conflict Management and negotiation	3
Budget Management and Monitoring	2
ERF	2

Q10: In addition to the learning needs in Q9, what other knowledge and skills gaps exist specifically for Health Cluster Coordinators?

	Knowledge Gaps	Skills Gaps
Technical Knowledge	3	
Innovation	1	2
Linking relief, recovery and development	2	

Q11: In addition to the learning needs in Q9, what other knowledge and skills gaps exist specifically for Information Management Officers?

	Knowledge Gaps	Skills Gaps
GIS/Mapping	3	9
Analysis	4	3
Data handling	5	
Tools	4	
Health Information Systems	2	

Q12: What knowledge and skills gaps exist specifically for sub-national Health Cluster Personnel?

	Knowledge Gaps	Skills Gaps
Health Cluster functions, system and approach	10	1
Technical knowledge	2	

Q13: Do you have any other comments about a Learning Needs Analysis for Health Cluster Coordination?

Comment	Number of times mentioned
Need for further training for national staff	2
(use) eLearning	2

Q14: Do you have any other comments, queries or suggestions regarding a Capacity Development Strategy, Competency Framework and/or Learning Needs Analysis for Health Cluster Coordination?

Comment	Number of times mentioned
Needs for technical Humanitarian Architecture Knowledge	1

Annex 1: Stakeholders invited to take part in the survey

WHO REGIONAL ADVISORS	CURRENT HCC	GHC STRATEGIC ADVISORY GROUP
Alexandra Simon-Taha	Iman SHANKITI	Andre GRIEKSPOOR
Ciro Ugarte	Richard FOTSING	Pascale FRITSCH
Dana Van Alphen	Arsene DAIZO	Mary PACK
Lucien Manga	Ernest DABIRE	Richard GARFIELD
Nevio Zagaria	Amadou DIALLO	Francesco Checchi
Nguessan Bla Francois	Daoud Mohammed ALTAF	Marian Schilperoord
Rodrico Ofrin	Jennyfer DULYX	Sonia Walia
Ute Enderlein	Dr Theodore YAO	Nevio Zagaria
OTHER HCCS	Gabriel Sierra NOVELO	Iman Shankiti
Abdihamid Warsame	Edwin C SALVADOR	Gabriel Sierra Novelo
Dereje	Innocent NZEYIMANA	**GHC CAPACITY BUILDING TASK TEAM**
Dr Naidu	Dr Mahmoud DAHER	Ahmed Zouiten
Alaa Abou Zeid	Dr Abdelnasser SOBOH	Panu Saaristo

Iliana Mourad	Rokho KIM	Amanda Mcclelland
Ina Bluemel	Sardar Hyat KHAN	Emily Blake - Turner
Julius Weseka	Geraldo MEDINA	Eva Elfenkamper
Khan Muhammad Fawad	Aggrey BATEGEREZA	Gerbrand Alkema
Liviu Vedrasco	Jamshed TANOLI	Linda Doull
Maria Louiza Galer	Alan Mpairwe	Marie There Benner
Mohammad Shafiq	Magadelne ARMA	Perry Seymour
Rosine Sama Kanembe	Azret KALMYKOV	Rudi Connix
Ruth Goehle	Camilo VALDERRAMA	**IM TASK TEAM**
Judith Harvie	Dorit NITZAN KALUSKI	Emma Diggle
Craig Hampton	Patrica KORMOSS	Francesco Checchi
Eba Pasha	Jorge MARTINEZ	Gabriel Novelo
Ibrhaim, Nageeb Hammad	Will CRAIGIN	Iman Shankiti
OTHER ERM OR WHO	Alfred DUBE	Marian Schilperoord
Adelheid Marschang		Pascale Fritsch
Andre Griekspoor	Rachel Pounds	Richard Garfield
Anne Ancia		Sonia Walia
Hyo-Jeong Kim		
Jon Carver		
Michelle Gayer		
Ngoy Nsenga		
Samuel Petragallo		
Xavier de Radigues		
Jorge Castilla-Echenique		

ANNEX 3:

Health Cluster Competency Framework

Purpose
The purpose of this competency framework is to provide a set of standards to:

- Facilitate staff recruitment into cluster roles on the basis of expected competencies
- Define the learning outcomes for a capacity development and professional development programme
- Provide the basis for appraising and managing staff performance

The competencies are designed to be:

- Primarily for Health Cluster staff in humanitarian contexts
- Complementary to other function specific or technical frameworks, such as the Core Humanitarian Competencies and the Public Health Information Services Technical (PHIS) Competency Framework
- Relevant to different professional levels
- Sufficiently flexible to be used as a recruitment, learning and development and performance management tool
- Concise, logical and easy to use
- Transferable globally across people, countries and cultures.

The framework, therefore, aims to be inclusive of priorities, approaches and structures of the different members and organisations who carry out Health Cluster activities in emergency situations. It identifies 11 functional competencies with specific examples of behaviours, each of which have been grouped into domains that are reflective of the stages of the Humanitarian Programme Cycle stages and the Cluster Functions at Country Level. These competencies are followed by ten competencies that are personal, rather than role-specific, in nature.

Each competency has the following components:

- Competency: a blend of the knowledge, skills and qualities needed to complete a task, deliver an input, achieve an output and to have an impact.
- Role-Specific Behaviours: examples of how Health Cluster staff can demonstrate the associated competency.

DOMAIN[15]	COMPETENCY[16]	ROLE SPECIFIC BEHAVIOURS HEALTH CLUSTER COORDINATION	ROLE SPECIFIC BEHAVIOURS PHIS OFFICERS
Needs Assessment & Analysis	1. Coordinate timely and effective needs assessment and response gap analysis (across sectors and within the sector).	A. Ensure that humanitarian health needs, gaps and risks are identified by planning and coordinating timely joint, inter-cluster, initial rapid assessments adapting to the local context the MIRA and/or HESPER methods, as well as instigating mortality estimation and surveillance of epidemic-prone diseases and attacks against health care, as per global GHC standards. B. Assesses and monitor the availability of health services provided by all health actors by instigating timely data collection as per global GHC standards (Health Resources Availability Mapping System [HeRAMS], 3/4W matrix). C. Advocates for assessments to be conducted jointly by local and	A. Locally adapts and executes (or, in the case of MIRA, supports) data collection, analysis and reporting so as to deliver public health information services relevant to needs and risks identification, including rapid assessment, HESPER, EWARS, population mortality estimation and monitoring of violence against health care, based on GHC global standards and applications, where appropriate training and supporting data collection by health partners. B. Locally adapts and executes HeRAMS and 3/4W matrix data collection, analysis and reporting, while maintaining an up-to-date list of health partners, based on GHC global standards and applications, training and supporting data collection by health partners.

[15] The GHC Competency Framework domains are taken from the stages of the Humanitarian Programme Cycle (HPC), a coordinated series of actions undertaken to help prepare for, manage and deliver humanitarian response. For more information, please see: www.humanitarianresponse.info/en/programme-cycle/space

[16] The GHC Competency Framework competencies are taken from the Reference Module for Cluster Coordination at Country Level, which outlines the basic elements of cluster coordination for field practitioners to help facilitate their work and improve humanitarian outcomes. For more information, please see: https://www.humanitarianresponse.info/en/coordination/clusters

		international health agencies.	
	2. Coordinate analysis to identify and address (emerging) risks, gaps, obstacles, duplication, and cross-cutting issues.	A. Leads and contributes to the joint interpretation of assessment data, set against pre-crisis baseline health data, leading to joint identification of priority risks and gaps in the health sector response and agreement on priorities to inform the development (or adaptation) of a health sector response strategy.	A. Compiles literature searches of pre- and in-crisis secondary health data, rapid assessment and other available primary data into a regularly updated public health situation analysis document, structured as per global GHC standards. B. Produces info-graphics, including graph, maps and dashboards, as required, so as to illustrate specific aspects of the health situation
Strategic Response Planning	3. Collaboratively develop sectoral plans, objectives and indicators that directly support realisation of the HC/HCT strategic priorities.	A. Works closely with the Ministry of Health and the SAG and other local and international cluster partners to establish clear strategic imperatives that support existing coordination mechanisms and the delivery of long-term strategic objectives. B. Produces purposeful, evidence-based plans that define life-saving and realistic priorities and gaps developed in a clear objective/results which are underlined with relevant indicators, A detailed funding plan is mandatory.	n/a

	4. Accurately identify response priorities grounded in response analysis and (emerging) public health information	A. Work with HC partners on an ongoing basis to interpret available information, identify new threats to public health, as well as emerging or outstanding gaps in service provision, and decide and follow through on actions to address these. B. Represents the Health Cluster in inter-cluster coordination mechanisms at country/sub-national level, contribute to jointly identifying critical issues and scenarios that require multi-sectoral responses, and plan the relevant synergistic interventions with the other clusters concerned. C. Informs the CLA Representative of priority gaps that cannot be covered by any health cluster partner and requires CLA action as provider of last resort.	A. Maintains EWARS and monitoring violence against health care data collection systems, producing regular analyses and bulletins.
	5. Ensure effective contingency planning, preparedness and capacity building	A. Leads joint Health Cluster contingency planning for potential new events or setbacks, when required. B. Continuously monitors the health	A. Maintains and updates the public health situation analysis, introducing secondary data as they arise, so as to support evidence-based contingency planning and preparedness.

		situation and inform partners regularly. C.. In a protracted crisis or health sector recovery context, ensures appropriate links among humanitarian actions and longer-term health sector plans, incorporating the concept of 'building back better' and specific risk reduction measures.	
Resource Mobilisation	6. Clarify funding requirements, priorities and cluster contributions for the HC's overall humanitarian funding considerations (e.g. Flash Appeal, CAP, CERF, Emergency Response Fund/Common Humanitarian Fund)	A. Provides leadership and strategic direction to Health Cluster Partners in the development of the health sector components of FLASH Appeal, CHAP, CAP and CERF proposals and other interagency planning, resource allocation and funding documents. B. Advocates for local health actors and joint operations of international and local agencies.	A. Produces ad-hoc info graphics as required to support planning, resource allocation and funding documents.
Implementation & Monitoring	7. Coordinate service delivery through the implementation of the cluster strategy and results, recommending corrective action where necessary	A. Holds regular coordination meetings with country health cluster partners, building when possible on existing health sector coordination forums. B. Develops and implements	A. Locally adapts and supports partner execution of a Health Management Information System (HMIS), as per GHC global standards and applications, producing regular reports, so as to support monitoring of health system

		mechanisms to fill gaps and eliminate duplication of service delivery C. Regularly checks implementation results against set targets	performance. B. Designs, executes and reports on administrative or survey-based estimation of vaccination coverage. C. Maintains and produces regular analysis or bulletins from key information systems (HeRAMS, 3/4W matrix) so as to support monitoring of health service availability.
	8. Promote and ensure application and adherence to the Core Humanitarian Standard and relevant technical standards and guidelines[17].	A. Promotes application of standards and best practice by all health cluster partners to the local context. B. Promotes the use of the Health Cluster Guide to ensure the application of common approaches, tools and standards. C Identifies urgent training needs in relation to technical standards and protocols for the delivery of key health services to ensure their adoption and uniform application by all Health Cluster partners.	n/a

[17] Any health response should be based on the Core Humanitarian Standard, thereby translating our commitment to improve the effectiveness of humanitarian response and to respect humanitarian standards and principles. For more information, see: www.corehumanitarianstandard.org

	9. Coordinate participation and engagement with standard monitoring and reporting mechanisms such as Cluster Performance Management procedures and other tools.	A. Ensures partners' active contribution to and involvement in joint monitoring of individual and common plans of action for health interventions; collate and disseminate this and other information related to the health sector in Cluster sit-reps and/or regular Health Bulletins. B. Links monitoring and reporting to programmatic responses.	A. Compiles data from multiple sources and supports the publication of a health cluster bulletin, as well as an EWARS epidemiological bulletin, as per GHC global standards and applications. B. Locally adapts and executes Operational Indicator Monitoring application of the GHC in order to collect, analyse and report on key health performance and service output indicators for the whole health cluster.
	10. Identify advocacy concerns and undertake effective advocacy activities on behalf of cluster participants and the affected population.	A. Collects information required to contribute to HC and HCT messaging and action. B. Includes health cluster partners in advocacy for priority health actions and changes.	A. Maintains and regularly updates analysis and reports on attacks against health care. B. Supports ongoing interpretation of data on health risks, service availability and performance in order to correctly identify advocacy issues and concerns.
Operational Review & Evaluation	11. Coordinate participation and engagement with Operational Peer Review (OPR)and Evaluation procedures and activities.	A. Ensures the Health Cluster's active contribution to relevant OPR assessment activities. B. Translates recommendations of the OPR into Cluster strategic plan for implementation.	A. Produces analyses from active data collection applications and systems, including ad hoc info-graphics, to support OPR and evaluations.

		C. Supports and facilitates possible evaluation missions	

PERSONAL COMPETENCIES	HCC	PHISO
1. Lead, guide and inspire partners, stakeholders and country CLA in order to deliver results and impact.	√	
2. Actively develop self, others and the Health Cluster as an integral part of building the Cluster's coordination capacity.	√	√
3. Effectively facilitate training events and workshops, acting as the trainer and/or resource person as necessary	√	√
4. Work collaboratively and build high performing teams within a particular context.	√	√
5. Build effective networks with partners and stakeholders in order to ensure service delivery.	√	√
6. Demonstrate effective meeting organisation, management and participation	√	√
7. Speak and write clearly, confidently, accurately, and with impact for different audiences.	√	√

8. Consistently influence decisions in best interests of affected populations.	√	
9. Ensure the full engagement and participation of current and new partners and stakeholders.	√	
10. Build consensus for effective decision making.	√	

ANNEX 4:
THE LOG FRAME

Principal Objective: A cadre of high performing health cluster coordination personnel is established in order to ensure that the leadership and coordination of all health responses to an acute or protracted humanitarian crisis is responsive, accountable, consistent, predictable, and efficient and provides Value for Money. The coordination of the response will build national capacity, resilience and preparedness and be delivered in support of the response efforts of national authorities, and in collaboration with other partners and clusters, in order to meet the needs and the rights of the affected population and lay the foundations for recovery.				
Specific Objective: To establish a systematic and structured approach to high quality, blended and impactful capacity development that responds to the increased need and expectation for health clusters to demonstrate effective health leadership and coordination in all types of emergencies.				
	INDICATOR	**MILESTONES (YEAR**	**SOURCE OF VERIFICATION**	**RISKS AND ASSUMPTIONS**
STRATEGIC OBJECTIVE 1				
A modular and competency-based blended learning training programme, using a variety of learning activities for Health Cluster Coordination and Health Cluster Teams w be developed and implementation/delive y will commence, and be supported at globa regional and national levels	Full training package ready by end of Q3 2016	Competency framework agreed (Q2 2016) A CDTT sub Working Group is established to develop training package (Q2 2016)	Training package Training reports Competency Framework	GHC members agree on competency framework Partners can be found to engage with the training
Activities: Engage with partners on expected competencies from HC teams and staff Finalise competency framework for HC staff Identify partners and other stakeholders who may contribute to the training Develop and finalise training package for HC staff based on competencies				Year Q1 2016 Q2 2016 Q2 2016 Q3 2016
STRATEGIC OBJECTIVE 2:				
The Health Cluster Capacity Development Task Team will be fully operational and its' outputs harmonised with other GHC Task Teams and informed by the capacity	Objectives and ToRs of task teams established and shared with all task teams by the end of Q1 2016.	Objectives and ToRs for task teams agreed (Q1 2016)	ToRs of task teams Reports and reviews from other clusters	Partners can be found to engage with different task teams

development activities of other clusters.				
Activities: Identify and establish relevant task teams in the GHC Develop objectives and ToRs for task teams and share with all task teams Approach partners to take part in task teams, based on comparative advantage				Year Q1 2016 Q2 2016 Q2 2016
STRATEGIC OBJECTIVE 3:				
Access to high quality blended learning/training materials and the use of consistent and effectiv learning approaches, methodologies established	Database with e-learning and high quality blended learning and training materials established by December 2016 Number of HC staff accessing e-learning materials	Priority Learning Needs for HC staff established (Q2 2016) Learning material assessed and agreed (Q3 2016) Online platform for e-learning materials established (Q4 2016)	CD TT meeting minutes Online platform with training materials Log on counts Training reports	HC staff can access learning materials in field locations
Activities: Collect and assess quality of existing learning and training material Develop necessary learning and training materials Establish database with learning and training material Create and launch an online learning portal as a part of the GHC website Provide guidance on how to access learning and training material for HC staff in the field				Year Q2 2016 Q2 2016 Q3 2016 Q4 2016 Q4 2016
STRATEGIC OBJECTIVE 4A:				
The critical role of Partner Agencies and Line Managers in identifying and supporting individual learning and team performance strengthened and supported	100% of personnel performance reviews have a health cluster learning plan by the end of 2016	Role of line managers in staff development established (Q2 2016) Expectations of line managers and guidance on how to address learning needs in performance reviews shared (Q2 2016)	Personnel performance reviews Survey among HCC staff	GHC is able to influence performance review of WHO staff Line managers are willing to engage with learning needs
Activities: Review current performance review practices for health cluster staff Establish role and responsibility of line manager in identifying learning needs Provide guidance to unified identification of learning needs and approaches to addressing learning needs Develop and roll out formats for HC performance review Use of new formats in performance reviews Survey learning needs of partner agency staff working related to their role in the health cluster				Year Q2 2016 Q2 2016 Q3 2016 Q3 2016 Q3 2016 Q4 2016
Strategic objective 4b All HC personnel regularly participate in performance management reviews that are aligned with the	100% of HC personnel had a performance review using the competency framework for Health Cluster staff	Establish competency framework (Q2 2016) Share competency framework with HC partner and stakeholder line	Performance reviews of HC staff Survey for HC staff	Partner agencies accept to incorporate competency framework in their evaluations and annual review procedures

Health Cluster Competency Framework and form part of a Health Cluster professional development plan/programme		managers and health cluster staff (Q2 2016)		
Activities: Develop competency framework for HC staff Train line managers and HC staff on competencies Provide format for HC performance reviews Use new formats for HC performance reviews				Q1 2016 Q2 2016 Q2 2016 Q3 2016
STRATEGIC OBJECTIVE 5:				
All HC Partner Agencies have the policies and processes in place in order to be able to make personnel available to lead or join a HC Coordination Team in a timely manner.	Number of HC staff available for rapid deployment Number of newly declared emergencies with critical coordination positions filled through surge within 7 days by the end of 2017	Identify potential candidates to join roster (Q2 2016) Train identified personnel Q2 & Q3 2016) Establish live roster synergised with the GHEW (Q3 2016)	Training reports Deployment roster	Legal framework in place in WHO to deploy partner staff rapidly Partners are willing to make staff available for rapid deployment
Activities Agree competencies for HC personnel Identify potential HC staff in HC members and other stakeholders Establish legal frameworks with partners for rapid deployment Establish live roster of deployable staff Train HC staff				Year Q1 2016 Q2 2016 Q2 2016 Q3 2016 Q2 & Q3 2016
STRATEGIC OBJECTIVE 6:				
Mechanisms are in place that integrate Health Cluster and inter-cluster lessons learnt from monitoring, evaluation and review processes and tools with HC capacity development activities.	Number of lessons learned identified, which have resulted in new actions and changes in way of working by end of 2017	Mechanisms and tools developed (Q1 2017) Database established capturing lessons learned (Q2 2017)	Final guidelines Database	
Activities Establish guidelines to capture lessons learned Establish database capturing lessons learned Analyse findings of the CCPM through Learning Needs lens Review operational peer reviews to identify training needs through thematic analysis				Year Q1 2017 Q2 2017 Yearly Q4 Yearly Q4

STRATEGIC OBJECTIVE 7:				
A learning culture is firmly established throughout the HC, in which all personnel and their Line Managers are jointly responsible and accountable for ensuring that they have the requisite competencies needed for their role in a response	Number of Performance Reviews for HC staff addressing relevant learning needs Number of HC staff requesting participation in relevant learning activities and training events	Integrate review of learning needs into 100% of performance reviews Q2 2017	Performance Reviews	Relevant learning materials and ongoing training programme is available Q1 2017
Activities: Organise and offer cluster coordination trainings for cluster staff (both comprehensive HCC training and specific training) Advocate with ROs and COs to incorporate learning needs in performance reviews Establish a core group of coachers and mentors at all levels for HC staff				Year Q3/4 2016 Q3 2016 Q4 2016
STRATEGIC OBJECTIVE 8:				
A modular Health Cluster coordination programme provides a pathway to a professional award through accreditation by an internationally recognised academic institution that includes accreditation of "on the job" and prior learning. (the institution would need to be scoped out)	Accreditation framework in place and agreed	Identify academic institution to manage accreditation project (Q3 2017) Accreditation plan in place (Q4 2017) Personnel enrolled in pilot accreditation process (Q1 2018) Accreditation and learning pathway to recognised award established and participants enrolled (Q2 2018)	Meeting minutes Plans and frameworks Enrolment figures	Institution to provide accreditation is identified Donor interest for this project can be found Accreditation plan agreeable to relevant stakeholders Partners willing to allow personnel to take part
Activities: Identify relevant academic institutions Develop a plan for accreditation process Enrol personnel in pilot accreditation process Enrol first students in academic pathway learning				Year Q3 2017 Q4 2017 Q1 2018 Q2 2018
STRATEGIC OBJECTIVE 9:				
Effective capacity development forums, protocols and mechanisms for engaging with and working with national and sub-national health authorities	Number of capacity building initiatives undertaken by the cluster for national health authorities by the end of 2019	Identify specific capacity building needs of national health authorities (Q1 2018) Develop HC	Capacity building needs report Handbook	National health authorities are able to express concrete capacity building needs

and regional and national institutions fully established and operational.		capacity building handbook for national authorities (Q2 2018) Participation and engagement with activities and events starts in Q3 2018		
Activities: Identify capacity building needs of national authorities Develop guidelines for capacity building Pilot training for HC personnel on capacity building with national authorities				Year Q1 2018 Q2 2018 Q3 2018