Clusters: Who, What, Where, How?

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A single conversation across the table with a wise man is better than ten years' study of books.

Longfellow
Hyperion
Chapter 7 (quoted from the Chinese)

Recent discussions have indicated that confusion and misinformation exist relative to the functions of the "Health Clusters" as an element of "Humanitarian Reform". Following the earthquake and tsunami that devastated parts of Southeast Asia, major problems with the coordination of activities became apparent. After gaps became apparent, UN agencies gradually initiated efforts to provide assistance with coordination. Although coordination gradually improved, instances of unnecessary duplication, failure to share information, and parochial competition still occurred. The discussion that follows is aimed at providing a basic understanding of the potential role(s) of the Clusters in the delivery of health care during crises.

One of the basic problems identified following the earthquake and tsunami was the failures of the responding organizations to communicate with each other. As a possible solution to this problem, the Interagency Standing Committee (IASC) of the UN-OCHA was charged to provide an ongoing forum at the national and international levels, whereby major stakeholders could communicate with each other. The resulting changes for coordination and control during disasters have been labeled "Humanitarian Reform". The objectives of the Humanitarian Reform movement are to enhance communication and coordination between all of the participants in disaster relief and recovery. A major component of Humanitarian Reform was the organization of operational areas into functional groups called "Clusters". A *cluster* is a group or bunch of similar things growing together.[1] The Clusters were formed at the global level and the current Clusters are listed in Table 1. Each Global Cluster is comprised of a designated lead UN agency and partners that play roles in disaster risk reduction and responses. These partners include UN agencies, non-governmental organizations, and donors. The Health Actions in Crisis (HAC) Department of the World Health Organization (WHO) was designated as the lead agency for the Global Health Cluster (GHC). The HAC/WHO provides the staff for the GHC. The current partners in the Global Health Cluster are listed in Table 2. All of the partners listed, excepting the World Association for Disaster and Emergency Medicine (WADEM) and the International Coalition of Nurses, are operational, i.e., they work in the field. The WADEM became the only non-operational, academic partner in the GHC in 2008.

Currently, there are two levels of Health Clusters: (1) Global; and (2) Country. The organizational structure of the clusters was designed such that the Country Health Clusters would bring all of the operational organizations together to share objectives and actions during disasters.

Importantly, it was mandated that during a disaster, the Country Clusters also should operate as functional coordinating entities at the national and sub-national levels. It is envisioned that during a disaster, the participating partners would join together in the local Clusters with the objective of sharing information and coordinating their activities. The Country Clusters have been operational following the earthquakes in Haiti and Chile, and more recently, during the floods in Pakistan. Reports by the Country Clusters regarding their efficacy in achieving their objectives have been varied. No performance evaluations are available.

The primary role of the GHC has been to foster communications between the global partners, to provide tools that should assist the Country Clusters in their activities, and to provide guidance through the development of position papers. Since its inception, the GHC has made substantial progress. It has made available several products for use by the Country Clusters. Products include but are not limited to: (1) a rapid assessment tool; (2) the Health Resources Availability Mapping System (HeRAMS); (3) a Cluster Guidebook; and (4) a position paper advocating against fees for the provision of primary and emergency health care during crises.[1] Members of the GHC have provided the WHO with guidance during crises in Pakistan, Somalia, Haiti, China, Myanmar, and the 2009 global H1N1 pandemic. Major issues under discussion include civil-military cooperation, violence to relief workers, gender issues, and accountability.

From my perspective as the WADEM representative in the GHC, several important issues remain:

1. *Exclusion of the WHO Regional Offices*—the WHO, together with the GHC essentially have circumvented the WHO Regional Offices and have gone directly to the countries with the formation of the Country and Sub-country Clusters. The value of the Regional Offices was exemplified in the public health responses to the earthquake and tsunami and following the earthquakes in Haiti and Chile;
2. *Mandate without authority and resources*—Unfortunately, the Clusters (including the GHC) have been charged with providing Coordination and Control, but have not been afforded either the authority or given adequate resources to implement necessary actions. Such an arrangement without authority and resources has doomed many projects/efforts in the past. The continued existence of the GHC may depend on identification of the resources necessary. Currently, there is no clear line of authority between the Country Clusters

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UN Clusters	UN Lead Agencies	Basic Societal Systems
Agriculture	Food and Agriculture Organization	Food and Nutrition
Camp Coordination/Management	UN High Commissioner for Refugees	Coordination and Control
Early Recovery	United Nations Development Program	
Emergency shelter	UN High Commissioner for Refugees	Shelter and Clothing
Health	World Health Organization	Medical Care and Public Health
Logistics	World Food Programme	Transport and Logistics
Nutrition	United Nations Children's Fund	Food and Nutrition
Protection	UN High Commissioner for Refugees	Security
Water/Sanitation/Hygiene	United Nations Children's Fund	Water and Sanitation
Education	United Nations Children's Fund	Education
Emergency telecommunications	Office for Coordination of Humanitarian Affairs/World Food Programme	Communications
		Economy
		Social structures

Table 1—Designated clusters of the IASC/UN-OCHA compared with the WADEM Basic Societal Systems

UN Partners: FAO, UNFPA, UNHCR, UNICEF, and WFP
Non-UN Partners: African Humanitarian Action; American Refugee Committee; CARE International; Catholic Relief Services; Centers for Disease Control and Prevention; Columbia University; Concern Worldwide; Emergency & Relief Agency; European Commission Humanitarian Office; Handicap International; Harvard Humanitarian Initiative; HelpAge International; International Centre for Migration and Health; International Council of Nurses; International Federation of the Red Cross and the Red Crescent Societies; International Medical Corps; International Organization on Migration; International Rescue Committee; International Council of Voluntary Agencies; Johns Hopkins University Center for Refugee & Disaster Response; Médecins du Monde; Merlin; Office of Foreign Disaster Assistance (USAID); Public Health Agency of Canada; Save the Children (UK); Save the Children (USA); Terre des Hommes; Women's Commission for Refugee Women and Children; World Association for Disaster and Emergency Medicine; and World Vision International
Observers to the Global Health Cluster: International Committee of the Red Cross; Interaction; Médecins Sans Frontières; and the Sphere Project

Table 2—Partners in the GHC (FAO = Food and Agriculture Organization; UNFPA = UN Populations Fund; UNHCR = UN High Commissioner for Refugees; WFP = World Food Programme; UNICEF = UN Children's Fund)

and the respective Ministries of Health or between the Country Clusters and the GHC;

3. *Country Clusters operate only during crises*—The Country Clusters have been activated only during or after an event. In order to be optimally effective, the Country Clusters must be operational, and must participate in planning, prevention, and mitigation activities. The provision of Coordination and Control must be continuous and participating staff must be experienced either by operations during prior crises, or through the use of drills and exercises. Country Clusters should be mandated, given the necessary authority to make things happen, and the resources required through national legislation and budgets;
4. *Lack of Inter-Cluster Coordination*—the actual operations of each of the clusters is heavily dependent upon the activities of the other clusters. However, for the most part, each of the Clusters has been operating isolated from the other Clusters. This problem currently is being addressed by the IASC;
5. *Absence of Performance Evaluation*—the performance of the activities of the Country Clusters has not been undertaken in a scientific manner. This largely has been due to the failure to designate a standardized set of indicators of function. The evaluations required not only must examine the outcomes but also the impacts of the provision of Coordination and Control by the Clusters.
6. *Inadequate Input from the Academic Community*—for the most part, operational organizations cannot undertake studies and develop standards from the studies.

The Cluster concept is relatively new and the Clusters have had to overcome long-standing independence of operations. Humanitarian Reform has great potential and the Clusters should facilitate much needed reform in the way response operations will be conducted in the future. Their efficacy must await evaluations of their operations, but we must not judge their efficacy until objective studies of their process, outcomes, and impacts have been conducted. The GHC must create a common set of performance standards that are essential before such evaluations and enhancements can become reality. Clusters are an excellent model, and we must not judge their efficacy until we can objectively evaluate and use the results of evaluations for continuous quality improvement.

We were so exceedingly genteel, that our scope was limited.
Dickens
David Copperfield
Chapter 25

References
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