

Health workforce coordination in emergencies with health consequences

Report by the Secretariat

1. This report describes the work that WHO is undertaking at global, regional and country levels to improve coordination of the response to emergencies with health consequences. Strong coordination both of all health actors in emergencies and of collaboration with actors in other sectors is vital to ensuring the predictability, coherence and effectiveness of emergency operations. Central to improved coordination is the concept of the Global Health Emergency Workforce, comprising national responders and international responders from networks and partnerships. These networks and partnerships include the Global Outbreak Alert and Response Network, the Global Health Cluster, emergency medical teams, standby partners and other members of the Inter-Agency Standing Committee.
2. The present report describes the steps that WHO has taken to strengthen internal coordination for emergency response across the three levels of the Organization and external coordination with partners working on emergencies with health consequences. An earlier version of this report was considered by the Executive Board at its 140th session in January 2017.¹
3. Recent history shows that the world is not fully prepared to prevent, detect and respond to large-scale health emergencies. WHO monitors over 160 public health events annually, and between January and October 2016 it responded to emergencies in 47 countries (see the complementary report by the Secretariat on the WHO response in severe, large-scale emergencies).² The past two decades have witnessed important major outbreaks due to emerging diseases³ as well as “traditional” outbreak-prone diseases.⁴ Worldwide, an estimated 130 million people are in need of humanitarian assistance, with over 200 million also affected annually by natural and technological disasters. The need for improved coordination among the various actors involved in health emergency preparedness and response has never been more pressing.

¹ Document EB140/10; see also the summary records of the Executive Board at its 140th session, second meeting, section 3 and fourth meeting.

² Document EB140/7.

³ Such as severe acute respiratory syndrome (SARS), infection with avian influenza A(H5N1), influenza A(H1N1) or Middle East respiratory syndrome coronavirus (MERS-CoV), Ebola virus disease and Zika virus disease.

⁴ Such as yellow fever, cholera, meningitis and measles.

COORDINATION ACROSS THREE LEVELS OF WHO

4. Further to the request of the Executive Board during its special session on the Ebola emergency in January 2015,¹ and reflecting many of the recommendations from the series of evaluations carried out during and after the Ebola crisis in West Africa, WHO has undertaken substantive reform of the way that it works in emergencies with health consequences. In May 2016, the Health Assembly welcomed the progress made in the development of the new Health Emergencies Programme.²

5. The Programme was established and designed to manage WHO's work in the prevention of, preparedness for, response to and early recovery from emergencies, regardless of the hazard, including infectious diseases, natural disasters and societal conflicts. Aligned across the three levels of WHO, the Programme now follows a common structure reflecting the major functions of WHO in emergency risk management: infectious hazard management; country preparedness (pursuant to the International Health Regulations (2005)); health emergency information and risk assessment; emergency operations; and management and administration. Over the next 12 to 18 months, all aspects of the Programme will be operationalized, optimizing partnerships and networks to leverage system-wide capacities for emergency work in health. Progress in this effort is already being seen.

6. Standard operating procedures are being developed to ensure coherent approaches to emergency health information, risk assessment, grading and emergency response across the Programme. WHO is strengthening the management of its emergency operations through the adoption and institutionalization of an incident management system – a best practice approach that is increasingly being taken up by public health and emergency agencies worldwide. Under this system, critical emergency management functions are established at country level, with support teams at regional and headquarters levels providing technical and operational backstopping and oversight.

7. Effective application of this new approach to multicountry, multiregional events was demonstrated in the response to the outbreak of Zika virus disease. Following the declaration of the outbreak as a Grade 2 emergency on 22 January 2016, WHO rapidly established an Organization-wide incident management system to support ongoing efforts by the Pan-American Health Organization/WHO Regional Office for the Americas and to coordinate the global response. A consistent structure for that system across the Organization allowed for improved communications, information-sharing and coherence of priorities. Within a week of the grading, US\$ 2.6 million was released from the WHO Contingency Fund for Emergencies, facilitating critical early response actions in the Region of the Americas. By mid-February 2016, WHO had published 16 Zika-related interim technical guidance documents. In close collaboration with partners in the Global Outbreak Alert and Response Network, the Inter-Agency Standing Committee and the United Nations Office for the Coordination of Humanitarian Affairs, the incident management planning team led the development of a global strategic response plan and joint operations plan, engaging partners at regional and global levels. Incident management teams were established in other regions to further coordinate response activities. Together with a proactive approach to communications, this has strengthened the operational response, improved the support provided to countries, and advanced WHO's global leadership role.

¹ See resolution EBSS3.R1 (2015).

² See decision WHA69(9) (2016) and documents A69/30 and A69/61.

8. A biennial results framework for the Programme has been developed to better align and integrate work planning, budgeting and implementation across the three levels of the Organization, as well as to establish clear lines of accountability. It will be used to monitor progress towards specific coordination objectives, with defined and measurable outcomes to be achieved with countries and partners. Furthermore, the Programme's human resource capacity is being strengthened with additional personnel across offices, and emergency response rosters of staff from within and outside the Programme, to address skills gaps and enhance interoperability.

COORDINATION AT GLOBAL LEVEL

Inter-Agency Standing Committee

9. The Inter-Agency Standing Committee is the primary mechanism for interagency coordination of humanitarian assistance; it is a forum that involves most of the key United Nations and non-United Nations humanitarian partners. WHO participates actively in the main bodies under the Committee, including: the Principals group, which oversees global priorities and strategies for collective humanitarian action and on which the Director-General represents the Organization; the Emergency Directors Group, which addresses operational priorities and issues at country level; and the Working Group, which oversees the development of interagency policy and guidance.

10. The Inter-Agency Standing Committee already has clear protocols and processes for a collective response to and coordination of large-scale natural disasters or conflicts that require system-wide mobilization (so-called "Level 3 (L3)" emergencies). Similar mechanisms and processes do not currently exist for large-scale outbreaks. In its decision WHA69(9), the Health Assembly encouraged WHO's "ongoing collaboration with the United Nations Office for the Coordination of Humanitarian Affairs to enhance humanitarian system-wide coordination of the response to large-scale infectious hazards in the future".

11. To this end, WHO worked closely with the Inter-Agency Standing Committee's Emergency Directors Group to develop new protocols for leadership and coordination in large-scale events due to infectious hazards, based on existing Committee mechanisms. For these events, the new protocols allow for interagency Level 3 activation, as well as temporary expansion of the Inter-Agency Standing Committee, on an as-needed basis, to include the Global Outbreak Alert and Response Network and major public health institutions involved in the response. This will be known as "IASC+".

12. The newly defined procedures include a time-bound situation assessment by WHO and the United Nations Office for the Coordination of Humanitarian Affairs; consultation and decision-making with the Emergency Directors Group (and other non-Inter-Agency Standing Committee stakeholders as appropriate, including the Global Outbreak Alert and Response Network for infectious disease risks and events); recommendations to the Principals of the Standing Committee; and explicit activation and deactivation triggers. The immediate communication of joint strategic response priorities and allocation from the United Nations' Central Emergency Response Fund to support these priorities will be initiated, as will a review of the coordination and leadership arrangements within 7–10 days.

13. These IASC+ activation procedures were endorsed by the IASC Principals in December 2016.

Global Health Cluster

14. The Inter-Agency Standing Committee's cluster approach is a vital mechanism for coordinating sectoral action in humanitarian emergencies. The health cluster is currently activated in 24 countries to support national authorities in meeting the health needs of 72.2 million crisis-affected people. The Global Health Cluster comprises 48 partners, including international organizations and United Nations agencies, non-State actors, national authorities, academic and training institutes and donor agencies. There are more than 300 partners at country level.

15. WHO is recruiting 24 health cluster coordinators on longer-term contracts to ensure more predictable, dedicated and skilled leadership at country level. To support countries with coordination of in-country operational partners and to build operational and technical capacity, additional surge roster capacity is being identified through mapping and gap analysis. A new multiyear development plan is being rolled out to build and sustain capacity within the cluster.

16. Strengthened collaboration and coordination are being sought with other clusters (for example, those for nutrition, water and sanitation, food aid and logistics) in order to improve the overall response to emergencies with health consequences. WHO plays an important role in the Inter-Cluster Coordination Group at global level and is working more closely with other clusters in settings such as the humanitarian response to the crisis in northern Nigeria and the cholera outbreak in Yemen. Inter-cluster collaboration is also a key element of the Inter-Agency Standing Committee's IASC+ protocol.

Global Outbreak Alert and Response Network

17. Enhancing and expanding the Global Outbreak Alert and Response Network, a system of over 200 multidisciplinary technical partners, is a priority for the WHO Health Emergencies Programme. This is being accomplished through strengthening the Network's oversight, policies and secretariat functions; identifying and engaging new partners and consolidating existing commitments; strengthening its ability to leverage functional experts of the health emergency workforce and provide operational support, specifically for staff health and safety; and implementing joint training with partners to improve field-level coordination.

18. The Network's 21-member Steering Committee meets every six months to provide strategic direction to the development and operations of the Network, and has agreed on priorities for the development and operations of "GOARN 2.0" in line with the above.

19. Since the beginning of 2016, Network partners have been more involved in alert, risk assessment, preparedness and response activities; they have been holding regular consultations by teleconference in support of early joint assessment of developing outbreaks, and to strengthen coordination and planning of international response and country support. The first European regional meeting of Network partners was held in St Petersburg, Russian Federation, in October 2016.

20. WHO is also exploring how to strengthen Network involvement in and support for national alert and response capacity through the Joint External Evaluation initiative (in the context of the International Health Regulations (2005)), including capability to deploy and receive international experts.

21. The Network's operational support team is working closely with the Global Health Cluster, emergency medical teams, and others to develop Network-driven international outbreak response training, coordination of partner contributions through a new global faculty, and delivery of new training materials and courses.

Emergency medical teams

22. The WHO emergency medical teams secretariat manages the training, capacity-building, standard-setting and quality assurance processes for this global initiative. The overall goals are to strengthen national capacity to respond to emergencies with health consequences, as part of the global health emergency workforce, and to create mechanisms for that capacity to be effectively leveraged and coordinated by national health emergency operations centres, including through calling on neighbour, regional and global teams to provide temporary surge capacity in times of need, consistent with the principles of the International Health Regulations (2005).

23. A peer-reviewed quality assurance and verification system has been developed allowing emergency medical teams to provide direct patient care in disasters, outbreaks and other emergencies with health consequences. Over 75 organizations have started the process of mentorship, training and quality improvement, with 30 visited in 2015, and seven teams verified as reaching the agreed international standard.¹

24. In coordination with the United Nations Office for the Coordination of Humanitarian Affairs, the WHO emergency medical teams secretariat has created a coordination platform for work with other forms of rapid response teams, particularly those engaged in search and rescue. This system, active within minutes of a disaster, uses the agreed virtual on-site operations coordination centre, recording team arrivals and referring them to the affected country's coordination mechanisms within the ministry of emergency management and ministry of health, with support from the United Nations Office for the Coordination of Humanitarian Affairs and WHO. The system, trialled for the first time in the Nepal earthquake in 2015, was shown to be fit for the purpose of coordinating the 149 teams responding to that disaster, with an estimated 3500 medical responders in the first seven days. That finding was confirmed in Ecuador in 2016.

25. A minimum data set has been agreed for emergency medical teams to report on to the affected Member State when working there. This ensures a standard flow of information that contributes to the early warning system for disease outbreaks, creating sentinel reporting sites that enable the affected health system to respond.

26. The emergency medical teams initiative has become more active in complex and protracted emergencies, with involvement in coordination and operational planning in Iraq, Nigeria and Yemen. In 2017, the WHO emergency medical teams secretariat is continuing to work on defining rapid, field-focused working groups to strengthen other aspects of team deployment, continuing to build the capacity of rapid response clinical and public health teams, and to strengthen coordination systems for national and international or bilateral response operations by bolstering health emergency operating centres in affected Member States.

¹ Australia, China, Israel, Japan, the Russian Federation (two teams) and the United Kingdom of Great Britain and Northern Ireland.

Standby partners

27. Launched in 2013, the WHO standby partners initiative is an increasingly central element of WHO's coordination in response to humanitarian emergencies, and a strong complement to WHO's other response partnerships. WHO holds global agreements with seven partners¹ and is able rapidly to access and deploy highly skilled personnel of the global health emergency workforce with a broad range of humanitarian and technical profiles to support field emergency work, including information and data management, mapping, water and sanitation, nutrition, public health, logistics, project management and social work.

28. Through the International Humanitarian Partnership, two further partnerships are under negotiation with government agencies to support individual deployments, as well as highly specialized service packages. Further expansion is planned, through the mapping of existing capacity gaps to identify opportunities for new partnerships. A training needs analysis is also planned and will be implemented in priority areas, to ensure greater harmonization across the partnerships.

Operational support and logistics

29. The WHO Health Emergencies Programme provides guidance and technical support to the Global Supply Chain initiative for pandemic preparedness and response. This initiative was launched at the World Economic Forum 2015, under the leadership of WFP, and includes UNICEF, the World Bank and several private-sector supply companies. The goal is to identify public–private supply chain options or preparedness solutions, to estimate needs and monitor global supply resources more accurately, and to develop better mechanisms to access supplies in times of public health emergencies of international concern and pandemics. The (informal) network is developing an information platform with support from the University of Minnesota (United States of America), to provide upstream and downstream supply chain visibility and coordination in operations.

REGIONAL COORDINATION

30. Targeted human resource capacity-building has been undertaken in priority regions, to ensure that the Programme is better able to support vulnerable countries. One country in which this approach has had a significant impact is the Syrian Arab Republic, now entering its sixth year of conflict with no sign of a decrease in intensity or the level of suffering of the population, where WHO has increased its investment in leadership and coordination of the health sector response for the Syrian Arab Republic.

31. In line with the reform of WHO's work in health emergency management, additional human resources have been deployed at regional and country levels to support the “whole of Syria” humanitarian health response. This has led to increased coordination through joint planning and response by hubs in Jordan, Syrian Arab Republic and Turkey for the delivery of emergency medical assistance, including immunization, to besieged and hard-to-reach areas. Improvements in standardized data collection across the country have also been seen.

¹ International Civilian Response Corps (CANADEM), the Information Management and Mine Action Program (iMMAP), the Netherlands Enterprise Agency, the NGO Consortium for the Global Health Cluster, the Norwegian Refugee Council, RedR Australia and the United Kingdom Department for International Development.

COORDINATION AT COUNTRY LEVEL

32. Coordination structures and mechanisms at country level vary according to the capacities of national and local authorities and the scale and type of emergency (for example, outbreak or sudden onset natural disaster). Ensuring strong, inclusive coordination structures involving local and international partners with clear roles and responsibilities at national and subnational levels is vital to optimizing the response. As far as possible, national leadership of health sector coordination is promoted and supported. A growing number of ministries of health are establishing emergency operations centres that can provide a focus for response coordination.

33. In acute public health events, rapid engagement of the appropriate partners of the global health emergency workforce with technical and operational capacities may be sufficient to stop an outbreak. Global Outbreak Alert and Response Network partners are often key to this. When an outbreak amplifies, additional coordination mechanisms may be required to draw on capacities from technical and intersectoral partners, as was the case with the response to the Ebola outbreak in West Africa. For events and outbreaks due to zoonoses, such as the Rift Valley fever outbreak in Niger, coordination with the animal health sector is vital. In this context, joint training events with the World Organisation for Animal Health have already proved to be of great value in the recent outbreak of highly pathogenic avian influenza virus infection in Cameroon and Togo.

34. For conflict-related and sudden onset disasters, a larger array of responders from the global health emergency workforce may be present, including non-State actors, emergency medical teams and technical agencies. In these settings, one overarching coordination mechanism for the health sector is needed, often with related task teams to address specific issues, such as surgical care or reproductive health, in more detail. There may also be a need for a specific coordination cell for emergency medical teams.

35. Depending on the circumstances of the emergency, a health cluster may or may not be formally activated. A health cluster is the main coordination mechanism in 24 of the 47 countries where WHO is currently responding. Regardless of the coordination mechanism in place, established practices of good coordination, clear commitment by partners, accountability to affected populations and transparent communication must be followed, and close linkages and active collaboration with other sectors (such as nutrition or water and sanitation) must be created, supported and utilized.

36. Experience with health clusters is illustrative of some of the issues related to the coordination of large-scale emergencies at country level. Of the 24 active health clusters, 22 are country-focused and two (the Whole of Syria and Pacific Regional health clusters) have a subregional focus. The health ministry co-leads the health cluster in 47% of cases, while a non-State actor partner co-leads in 37%. Eighteen clusters (75%) are operating in settings of a complex emergency or conflict; the others operate primarily in climate-related emergencies.

BUDGET AND RESOURCE MOBILIZATION

37. Financing the work of the new WHO Health Emergencies Programme will require a combination of: core financing for staff and activities at the three levels of the Programme; financing of the US\$ 100 million WHO Contingency Fund for Emergencies; and financing for ongoing activities in acute and protracted emergencies.

38. To implement the core activities of the new Programme, WHO must raise US\$ 485 million in 2016–2017; a gap of 44% remains. Appeals linked to humanitarian response plans have a funding gap of 66% (the total requirement for funding from appeals is US\$ 656 million).

39. The WHO Contingency Fund for Emergencies has raised US\$ 31.5 million of its US\$ 100 million target capitalization. Allocations to date total US\$ 18.16 million in support of WHO activities in response to humanitarian crises, disease outbreaks and the impact of natural disasters.

ACTION BY THE HEALTH ASSEMBLY

40. The Health Assembly is invited to note this report.

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