
WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies

Report by the Secretariat

1. At its 130th session in January 2012, the Executive Board considered an earlier version of this report;¹ the Board then adopted resolution EB130.R14.²

BACKGROUND

2. Over the last 10 years, an average of 700 disasters have been reported every year. Annually, an estimated 268 million people are affected by disasters. In 2010, humanitarian emergencies requiring international assistance occurred in 32 countries. The epidemiological profile associated with disasters and conflicts is changing and, although most of the associated mortality continues to be due to infectious diseases, noncommunicable diseases are increasingly among the top five of causes of morbidity and mortality in such settings. Global trends in urbanization are providing a further impetus for the adaptation of intervention strategies.

3. The mandate of WHO in humanitarian emergencies derives from Article 2(d) of the Constitution and resolutions WHA34.26, WHA46.6, WHA48.2, WHA58.1, WHA59.22 and WHA64.10. WHO's role is substantially influenced by United Nations General Assembly resolution 46/182 on strengthening the coordination of the humanitarian emergency assistance of the United Nations, which was adopted in 1991. The resolution established the Inter-Agency Standing Committee which, chaired by the Emergency Relief Coordinator, is now the key coordinating mechanism for major humanitarian actors including WHO.

4. In working with Member States in the context of humanitarian emergencies, the Organization has focused on twin objectives: to build national capacities for emergency and disaster risk-management and integrate the latter into national health policies, strategies and plans; and to support acute and protracted emergency response activities. The Secretariat's development work with Member States includes the provision of technical guidance and support for assessing risks and strengthening early warning systems. In addition, support for national and community capacities involves the

¹ See document EB130/2012/REC/2, summary record of the twelfth meeting.

² See document EB130/2012/REC/1 for the resolution, and for the financial and administrative implications for the Secretariat of the adoption of the resolution.

integration of disaster risk-reduction and preparedness activities into health planning, including promotion of the safe hospitals programme.

5. In 2005 the United Nations General Assembly adopted resolution 60/124 on strengthening of the coordination of emergency humanitarian assistance of the United Nations. Work in response to this has involved: (i) the introduction of further humanitarian reforms, including the “cluster” approach; (ii) financial reforms, including pooled funding mechanisms; and (iii) the strengthening of the humanitarian coordinator function in countries. WHO was proposed to serve as the lead organization for the Inter-Agency Standing Committee Global Health Cluster with the goal of improving the coordination, effectiveness and efficiency of health action in crises.

6. In December 2010, the United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, together with the Principals of the Inter-Agency Standing Committee, launched a one-year review – the “transformative agenda” – in order to tackle major deficiencies in the international response to humanitarian emergencies. This initiative was the result of a frank acknowledgement of substantial shortcomings in the leadership, speed and coordination of the response to the mega-emergencies experienced that year in Haiti and Pakistan. Concurrent with both the Inter-Agency Standing Committee’s transformative agenda and its own internal reforms, WHO has undertaken a candid review of its performance in humanitarian response, involving broad consultation across the Organization and partner agencies. The present report summarizes the context for this review and the major findings. It also outlines a proposed way forward, the centerpiece of which is a new WHO emergency response framework that communicates core commitments, performance standards and procedures and policies for enhancing the quality and predictability of the Organization’s response to both public-health and humanitarian emergencies at country level.

WHO AS GLOBAL HEALTH CLUSTER LEAD AGENCY FOR EMERGENCY HUMANITARIAN ASSISTANCE

7. In 2003, in order to scale up the Organization’s capacity and competency to meet its expanded responsibilities in responding to humanitarian emergencies, WHO established the health action in crises cluster. Standard operating procedures were adopted to prioritize and accelerate administrative procedures in support of emergency operations; a partnership agreement was established with WFP to allow the stockpiling and rapid deployment of medical supplies from four regional warehouses; and a training process was initiated and a roster of experts developed, with eventual expansion to include Health Cluster Coordinators. Working groups were also established to draw on resources and expertise from all areas of the Organization in support of both longer-term and acute technical needs and an orientation programme on health cluster management was developed for heads of WHO country offices and integrated into their induction training course. Between 2005 and 2006 WHO assumed its leadership role in the Global Health Cluster, which centred on building consensus on health priorities, policies and best practices in humanitarian emergencies and strengthening the capacity of all health sector stakeholders to deliver effective and predictable responses. WHO established a secretariat for the Global Health Cluster in order to facilitate dialogue between the members and to convene an annual meeting of the Cluster, which is currently made up of almost 40 international humanitarian health organizations.

8. Based on generic terms of reference that have been defined by the Inter-Agency Standing Committee to guide and measure the work of clusters at country level, the Global Health Cluster defined 10 core functions and benchmarks for its performance in countries. Within the health cluster at country level, particular emphasis is given to ensuring that health partners jointly assess and analyse information, prioritize interventions, build an evidence-based strategy and action plan, monitor the health situation and health-sector response, adapt or replan as necessary, mobilize resources and

perform advocacy for humanitarian health action. As lead agency for the cluster at country level, WHO also has the responsibility to act as provider of last resort. Ideally, the Ministry of Health co-chairs meetings of the health cluster. Where this has not been possible, WHO has chaired the meetings, often in concert with a nongovernmental organization. The Head of the WHO Country Office represents the health cluster in the humanitarian country team, supported by a Health Cluster Coordinator.

9. Since 2005, the Emergency Relief Coordinator has activated the cluster approach in a total of 43 countries; in 31 of these, the approach is still active, including the health cluster. In large-scale crises, such as those that occurred in Haiti and Pakistan in 2010, more than 300 humanitarian agencies may be registered under the health cluster, posing enormous challenges for coordination. In these settings, WHO has had a dual role of managing the health cluster and implementing its technical functions, particularly the provision of policy guidance and health information management, including the compilation of health data on mortality, morbidity, nutritional status and health services delivery.

10. As Global Health Cluster lead, and working with partners, WHO has elaborated the health components in the Consolidated Appeal Process. Health sector requirements in these appeals increased from US\$ 718 million in 2006 to US\$ 1400 million in 2010, with the funding received covering 32% of requirements in 2006 and 56% of those in 2010. WHO's programmes within these appeals were on average funded at 42%. As at 30 September 2011, WHO had received US\$ 272 million in extrabudgetary contributions for humanitarian emergencies in respect of the biennium 2010–2011. This sum includes US\$ 79 million from the United Nations Central Emergency Response Fund and US\$ 35.5 million from country-based pooled funds.

CHALLENGES EXPERIENCED IN RESPONDING TO HEALTH NEEDS IN HUMANITARIAN EMERGENCIES

11. The Secretariat has encountered a combination of capacity, operational and financial difficulties in optimizing its support to Member States and affected populations during acute humanitarian emergencies, and in discharging fully the functions of the health cluster.

12. First, the Secretariat has experienced difficulties in identifying and deploying adequately trained health cluster coordinators, technical experts and support staff in adequate numbers and with sufficient speed to enable both the health cluster and the technical support functions of the Organization to be scaled up and sustained. This difficulty is particularly acute during large-scale humanitarian emergencies. As a result, the quality and completeness of rapid needs assessments, gap analyses, sector strategies, appeals and performance monitoring have been compromised.

13. Secondly, the Organization has had difficulty balancing its function as the lead agency coordinating the health cluster with its role as a cluster partner providing technical support – an inherent problem at country level. For example, in some emergencies it has proved difficult for the health cluster to fulfill its health information function as cluster partners have not all adhered to agreed common protocols for data collection, while some national authorities have been reluctant to disseminate potentially sensitive health data.

14. The third difficulty experienced derives from the limited operational capacity of WHO, as a United Nations technical specialized agency, to meet the full range of expectations of Member States, members of the Inter-Agency Standing Committee, cluster partners and donors with regard to direct programme implementation in acute humanitarian emergencies. For example, although WHO is able to provide appropriate policy guidance and establish functional early warning and response systems for diseases, the Organization's structure does not allow it to implement major field-level operations,

particularly for the direct delivery of life-saving interventions. In some settings, WHO's efforts to provide basic services may have compromised its core functions in the areas of health-sector coordination, information, surveillance and policy.

15. The fourth major problem has been insufficient financing, particularly for dedicated health cluster functions. Although donors supporting humanitarian action now expect cluster lead agencies to integrate the funding of cluster coordinators and cluster functions into the mainstream of their funding, this is not possible for a United Nations technical specialized agency such as WHO, which requires dedicated funding for this purpose.

16. A fifth issue concerns the fact that most health clusters have no clear process or criteria governing their deactivation or transition to another arrangement in response to, respectively, the resolution of an acute emergency or its transformation into a protracted emergency. As a result, health clusters have difficulty making the transition to more appropriate mechanisms for managing the health needs of the affected population, either through a proper recovery programme or by means of a programme of work that is adapted to a protracted emergency and that provides for at least a minimum level of predictable service delivery.

STRENGTHENING WHO'S RESPONSE TO HUMANITARIAN EMERGENCIES

17. Over the last 10 years, the Organization has invested significant resources in order to build the Secretariat's capacity to support Member States and health cluster partners to prepare for and respond to the health needs of people affected by disasters and emergencies. However, in view of the challenges mentioned above, the continuing work on humanitarian reform and the Organization's own reforms, WHO needs to become faster, more effective and more predictable in delivering high-quality action in response to humanitarian emergencies, with clear benchmarks for measuring performance. In mid-2011 WHO undertook an internal and external consultative process as a basis for enhancing its work in response to humanitarian emergencies, particularly given the acute financing gap for WHO's core functions in emergency risk management.

18. This consultative process informed the development of a new, cross-organizational approach to improve the speed, consistency and predictability of WHO's response to both humanitarian and public health emergencies. Central to this approach is a new WHO emergency response framework that will serve as a common operational platform for the Organization's work in such emergencies. The major elements of the new framework are: (a) a clear statement of WHO's core commitments in acute emergencies, for which the Organization will be accountable, emphasizing the Organization's central role in respect of partner coordination, expert policy and technical advice, information, and communicable disease surveillance and control; (b) performance standards and timelines for measuring the speed and quality of WHO's work within an emergency response, with the enunciation of key deliverables to be provided within, for example, 12 hours, 72 hours, 7 days and 14 days; (c) a process and criteria for grading the local capacity to respond to an emergency so that all acute emergencies can be classified within 12 hours in terms of the support that a country office will require from each level of the Organization, with coordination through a global emergency management team comprising emergency focal points from all six regional offices and headquarters; (d) common WHO emergency response procedures that clarify the management of WHO's major functions in emergencies, including the roles and responsibilities of each level of the Organization, in order to ensure that in an acute emergency WHO's key leadership, information, technical and enabling functions can be competently and rapidly performed at country level; and (e) WHO emergency

policies in the areas of surge capacity, application of the “no-regrets” principle¹ and the appointment and deployment of a prequalified “health emergency leader” to help country offices to ensure a more predictable response to major emergencies, building on the experience of other United Nations agencies and the reforms of the Inter-Agency Standing Committee’s response to major humanitarian emergencies that were undertaken in 2011.

19. The full application of a new WHO corporate approach to emergencies will require further investments. These will be needed at the headquarters and regional levels, and in countries affected by protracted and repeated emergencies, so that the necessary core staffing for the management of such a programme of work can be established and sustained. At the global level, the programmes of the health action in crises cluster have been restructured and adapted to form the new Department of emergency risk management and humanitarian response. This streamlined structure was established to deliver more efficiently the five key global functions that were identified in WHO’s consultative process and which fall into two categories, as follows: (a) technical functions – intelligence, information and monitoring; policy, practice and evaluation; and surge and crisis support; and (b) core programme functions – resource management; and external relations. Under this new structure, the Department will focus on coordinating and managing WHO’s broader assets in the context of humanitarian emergencies, with a strong emphasis on a coordinated programme of work, involving the Secretariat cluster responsible for health security and environment and regional counterparts, particularly in the areas of emergency risk reduction, preparedness and emergency response. In 2012, the Organization is focusing on operationalizing the new corporate approach to humanitarian response, at all levels and in keeping with the 2011 reforms of the Inter-Agency Standing Committee. This effort includes a year-end review of lessons learnt and will involve further reform, if required.

20. At the interagency level, further policy work is required to establish guidelines for deactivating health clusters and transitioning more rapidly either to an early recovery approach or, for protracted emergencies, to a coordinating mechanism that is more appropriate for ensuring the predictable delivery of basic health services. This will require WHO to provide effective support to national authorities in implementing a formal recovery plan or transition process, and to work with health cluster partners, enabling them to align their programmes with national policies.

21. Strengthening resilience from the level of national institutions down to local communities is fundamental to improving health outcomes in humanitarian emergencies. In 2012, WHO is undertaking a further consultative process to inform the development of a stronger and more comprehensive programme of work in emergency risk management, encompassing emergency risk reduction, national emergency preparedness, institutional readiness and institutional business continuity planning.

ACTION BY THE HEALTH ASSEMBLY

22. The Health Assembly is invited to provide guidance on the continuing reform of WHO’s work in response to humanitarian emergencies, and to adopt the resolution recommended by the Executive Board in resolution EB130.R14.

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¹ According to this principle, practices and actions for dealing with expected problems are supported even if the problems concerned are not yet certain to occur.