Regional Office consultation with the Chair of the Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences

Meeting with the WHO Pan-American Regional Office by Teleconference
1500-1545 (CEST), 3 September 2015

The Chair of the Advisory Group opened the meeting providing background on the Director-General’s decision to establish an Advisory Group on a time-limited basis, and noting that extensive face-to-face and teleconference consultations were needed with Regional emergency counterparts to inform the reform process.

1. Needs of national governments and partners from WHO in outbreaks and emergencies

Representatives from PAHO identified several issues related to the needs of national governments and other partners from WHO in outbreaks and emergencies. Rapid deployment capacity within 24 hours of technical assistance to field level is important. There is a need to provide support to countries quickly. During the disaster WHO should provide technical assistance in the field but also with other partners within 24 hours which is the most crucial moment to make a difference and provide key advice to countries. If at the begin countries take a wrong path it is difficult for WHO to take corrective actions.

From a political and strategic view it is important for WHO to be seen as the leader in the emergency response. Scope of work with governments must be clear and WHO remains accountable to governments. There are also other agencies better placed to respond to other types of crises but WHO will be part of their response by providing support for logistics, HR, shipment of samples.

Member States will require some funding for field operations even middle income countries. Partners will need activation of networks; this is where GOARN is key. Most countries request support to assess damage to health facilities, impact on health and require support to coordinate international health assistance through WHO’s Health Cluster leadership. They often seek specific technical cooperation and supplies and need support on international and national resource mobilization.

2. Expectations of what WHO should provide in case of health emergency

Governments want direct technical cooperation for development, review of preparedness plans, timely deployment of subject matter experts, support for the surge of the health workforce and support for medium-long term recovery. WHO must support critical response, and mobilization of critical supplies. The Ministry of Health always needs this from WHO.

Partnerships; WHO has the responsibility as leader of the Global Health Cluster. If partnerships are not established through visible presence and leadership it becomes fragmented and partners start doing their own things. Coordination, early presence, visible and effective leadership are essential elements in establishing and
maintaining partnerships. Partners need support on risk assessment, surveillance, risk communication, laboratory issues and access to logistics mechanisms. PAHO works closely with Ministries of Health in coordination the Health Cluster. There are situations where WHO have to exert leadership but always with due respect to the political leadership. Countries own capacities vary in terms of knowledge and implementation capacity, however, countries are the leaders and WHO co-leads the Health Cluster with them. The same system is in place for large epidemics. In Mexico for H1N1, the government asked PAHO to coordinate the arrival of experts; they were receiving bilateral requests and PAHO was able to coordinate that for them. To do that PAHO needs an operational capacity to support coordination, needs assessment.

3. Challenges WHO personnel face with responding to the needs and expectations

Human resource and staff make WHO and WHO is made of Member States. It is a cultural issue that WHO needs to switch from a development to an emergency mode. If we can switch in our minds, we can give a proper response in the first 24 hours. That is what happened with Ebola.

The challenge is core functions in an emergency mode are not well placed in the Organization. We tend to use the same people. The reform needs to look into the core functions needed and if the organization is properly staffed. If we are not adequately staffed we need to make sure our networks like GOARN are properly in place. There are also bureaucratic challenges related to deployment, logistics and too heavy processes. We need to change to the emergency mode and give a blank cheque to whoever is in charge. There is a lack of knowledge on existing response mechanism as well as lack of clarity of roles in emergencies. The entities that are involved in emergencies and outbreaks, WRs and RDs feel that the emergencies are there but they don’t feel the whole of the organization is feeling it is important enough to respond. There is need for more flexibility to switch from normal to emergency mode. In PAHO declares internal emergencies and releases certain bureaucratic functions and makes funds available. WRS know what they must do. They don’t have to go through long procurement and staffing mechanisms. It is important that the support systems have a plan for moving into the emergency mode. People have to practice roles and responsibilities for emergencies. Backup is needed for staff who deploy to an emergency as their work accumulates and they still have to provide technical role. If people are to do their emergency work, they must postpone other core/regular processes, and this is a big challenge. The creation of AMRO’s emergency programme, including procedures and response, took decades; this response mechanism is result of experience, failures and progress and extremely close work with partners and MSs. Disaster Risk Reduction is a regional priority. First priority is to have the country better able to respond to disasters.

4. Views about how the platform will function across the three levels of WHO,

The Operational Platform should not be HQ-centric and HQ must be cognizant of Regional capacities. It should support all areas of WHO and, through it, WHO should
be able to provide the support requested by Member States and other the 3 levels of
the Organization. No need to reinvent the wheel. We must avoid this being HQ in
their isolated stratosphere putting their own realities on the ground. It is important
to focus on the entire disaster management cycle. We can’t just be looking at
response without DRR, recovery, etc. System must be able to regularly revise its
emergencies and disease outbreak response mechanisms to cope with new
challenges and based on lessons learned. It must be rapid; our experts deploy within
24 hours. PAHO sent 3 experts to Mexico within 24 hours of H1N1; FMT initiative is a
result of PAHO’s work with Cuba in 2010 to review work with foreign field hospitals.
We have an EOC consultant functioning and have key policies and procedures; for
Ebola we implemented incident management system with one coordinator
appointed to coordinate response across the Organization. We need a unified body
to coordinate DRR and response. A fragmented approach doesn’t work. Working
with GOARN and other partners is important. There is a lack of clarity with roles,
responsibilities and decision making in the Organization.
We support the principle and idea of building the WHO Operational Platform but
there are some specificities in our Regional Office, sub-regional approach and
Country Offices. The WHO core business of responding to outbreaks must be
strongly reflected, where WHO should have the lead in coordinating national, sub-
regional, international responses. There are many complex outbreaks managed by
WHO and GOARN experts. GOARN is more than a provider of HR; in June 2014,
GOARN was the whistleblower on Ebola crossing borders. We would recommend the
AG to review these aspects; including the contributions of scientific partners. The AG
should have a working meeting with GOARN and PAHO is ready to join. Scope of the
platform should define areas that WHO has the leadership on; epidemics clearly
WHO but for radiation it is IAEA, zoonotics FAO/OIE etc. Roadmap requires strong
focus on risk analysis: IHR national focal points have developed detection,
verification, risk assessment, monitoring and response. On the platform text,
recommend a better organized structure on 1) what the platform will do in terms of
field operations and 2) how it will support field operations.

Operations platform: AMRO has a decentralized disaster response and preparedness
programme for 35 years with sub-regions, Caribbean, Central America, Dominican
Republic and Cuba, South America, Andean region, with sub-regional focal points.
This mechanism in AMRO goes across the entire Organization and is activated when
any emergency occurs. We combine efforts of all departments in one unified
mechanism to respond.

PAHO Communicable Disease Department has a core team and focal points in 28 of
the 35 Member States. Our emergency mechanisms are activated and implemented
in all emergencies, which we grade 1-3, and the activities are assessed through
internal and external mechanisms with exercises, drills and working close with
governments and partners. We work closely with USCD, Canadians, and Caribbean
Public Health Agency (CARPHA). Mix of high-income, middle-income and very poor
countries, with 8 priority countries. For H1N1 pandemic in Mexico, Haiti earthquake
and cholera outbreak PAHO incorporated into its management system the works of
all parts of the Organization in other words:
- EOC links to all COs;
- PAHO has a disaster fund and epidemic response fund with replenishment mechanisms to ensure deployment of staff and supplies available to RD. Since 1990, we have been able to mobilize human and financial resources including delegation of powers to WRs.
- PAHO has its own FMTs, GOARN. With Ebola preparedness, we had no cases in Latin America but did have in USA. We worked on an “All House Approach” with a task force across the region, activated an EOC, made available $1m for preparedness activities; and prepared framework for introduction of Ebola disease. The framework looking at the political and technical context.
- Regional Director approached every Head of State to ask to do missions, some with USCDC, plus other centres; we conducted 26 missions to 26 countries between Oct-Nov, wanted to do more than allow “self assessment.” We appointed an incident manager and that experience is being published in the American Journal of Public Health.
- We would like to see any advances/reports/reforms that will come after this process will support this mechanism and should be informed by the progress in the Americas;

5. **How the proposed platform for supporting WHO operations will dovetail with the work of governments and partners in country?**

Working with GOARN and other partners is important. Commonalities on complaints: HR, money/financing, response, coordination, focused a lot on repurposing

**Participants**

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