WHO’s new emergencies programme bridges two worlds

Peter Salama tells Fiona Fleck how the World Health Organization’s (WHO) new emergencies programme is changing the way the agency helps countries prepare for and respond to health crises.

Q: WHO’s new health emergencies programme aims to create one single programme, with one workforce, one budget, one set of rules and processes and one clear line of authority. How will you do this with WHO’s governance structure of seven entities: headquarters (HQ) plus six Regional Offices?

A: The programme has one workforce – and that is the critical point – one set of people we can rely on in emergencies, whether they are at regional level or at HQ, and, increasingly, we want the heads of Country Offices to see themselves as an integral part of the programme with the same philosophy, so that no matter where we are based we are focused on the same outcome. And that outcome is to support WHO Country Offices to deliver the needed response in the most difficult settings around the world. We have clear lines of authority for that single workforce. In addition, in what we call Grade 3 emergencies, the highest level of emergency requiring the largest mobilization of internal and external resources, emergency teams in Regional and Country Offices may be supervised directly by the Director-General if necessary. However, I think that the collaborative spirit of the new programme is just as important as formal lines of authority, protocols and standard operating procedures (SOPs).

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Q: WHO’s response to the 2014–16 Ebola virus disease outbreak in West Africa was heavily criticized. How has WHO’s emergency response changed since then?

A: We have dealt with the yellow fever outbreak in Angola and the Democratic Republic of the Congo (DRC), Zika in Latin America and across the world and an emergency in northern Nigeria due to population displacement and food insecurity, as well as outbreaks of Rift Valley fever on the Mali–Niger border, cholera in Haiti after Hurricane Matthew and many other situations. Some things have changed compared to the Ebola outbreak response. In all of these responses, we continued to learn and improve. WHO has been able to detect situations more quickly and respond more rapidly than before due to several factors. One is our incident management system that was introduced with the new programme which allows information to be shared better across the organization, and which makes our coordination and planning mechanisms clearer. Another is the Contingency Fund for Emergencies. In most cases the initial tranche of money was delivered within 24 hours of the request, which has helped us deploy people and deliver money more quickly than before. Another factor is that collaboration between the Regional Offices and HQ is stronger now that we have a common understanding that this is a partnership.

Q: What more needs to be done?

A: We are clarifying our roles and responsibilities at each level of the organization, improving communications with countries and identifying gaps in countries. Some of the technical units that form the backbone of the programme have been neglected over the years and we are building back critical expertise so that WHO can be the world’s best in areas where it needs to be. This means ensuring we have access to the world’s best disease-specific expertise and a strong system for detecting new events. We still need to establish more robust and predictable financing for the programme and ensure that our partners are fully on board. There’s a lot to do, but I am optimistic that the programme is on track.

Q: The United Nations (UN) introduced the cluster system in 2006 to improve coordination in emergencies, whereby one agency coordinates others in the response. As leader of the health cluster, how is WHO improving coordination of its partners in emergencies?

A: It’s a big challenge, partly because we are bridging the disparate worlds of infectious diseases and the world of humanitarian relief. For example, during the yellow fever outbreak in Angola and DRC, WHO worked well with its partners in the International Coordinating Group on Vaccine Provision – Médecins Sans Frontières, the International Com-

Peter Salama is leading the World Health Organization’s (WHO) efforts to reform its emergency work. He was appointed Executive Director of WHO’s new Health Emergencies Programme at the level of Deputy Director-General last year. Before that, he held senior posts at the United Nations Children’s Fund (UNICEF) including Regional Director for the Middle East and North Africa, Global Coordinator for Ebola and Chief of Global Health. Before joining UNICEF in 2002, Salama was an epidemiology intelligence service officer at the International Emergency and Refugee Health Branch of the United States Centers for Disease Control and Prevention, and a visiting professor in nutrition at Tufts University in the United States of America. He has worked with Médecins Sans Frontières and Concern Worldwide in Asia and sub-Saharan Africa. He graduated in medicine in 1993 from Melbourne University and in public health in 1997 from Harvard University. He was also a Fulbright and Harkness fellow in public policy.
Q: How is WHO bringing the worlds of infectious diseases and humanitarian relief closer together?

A: We have just finalized a set of procedures with the Office for the Coordination of Humanitarian Affairs (OCHA), as part of the work of the Inter-Agency Standing Committee. These procedures provide criteria for when OCHA should activate the humanitarian system in response to a major infectious disease outbreak, in consultation with WHO and the countries and humanitarian agencies concerned. That way we avoid the need to create a separate agency, as was the case during the 2014–16 Ebola outbreak. These procedures bridge the two worlds. In the past, if we had an infectious disease outbreak, WHO led the response by activating expert networks, such as the Global Outbreak Alert and Response Network, while working in parallel with humanitarian agencies. But during the Ebola outbreak, the cluster system was not activated, when it should have been and, as a result, the response could have been better coordinated. Under the new system, it will be clear from the outset whether the health cluster and other Inter-Agency Standing Committee clusters should be activated and what their role should be.

Q: Three United Nations organizations have long been operational in humanitarian emergencies: UNICEF, the United Nations Refugee Agency and the World Food Programme. How is WHO, best known for its normative role, finding its place as a newcomer?

A: WHO's duty to support countries in response to outbreaks is contained in the 1948 constitution and the Organization has been engaged in outbreaks and emergencies since its inception in 1948, when it responded to the cholera outbreak in Egypt. WHO has also been involved in the cluster system since the beginning in 2006. So the organization's role in outbreaks and emergencies is not new. What is new is that WHO is becoming more systematic in its response to such crises. WHO is not competing with these three large humanitarian and development agencies, but seeking to combine its technical and normative comparative advantage with a renewed operational capacity to be a more predictable partner in the humanitarian response. WHO needs to be at the heart of these health partnerships with a strong convening and coordinating role, and as a provider of last resort, which means that if any gaps remain in the health response, WHO must fill these.

Q: Some commentators say there are too many players in the humanitarian and health response and that too few of them are qualified to deliver what is needed. What is WHO doing to ensure that its partners in health emergencies can deliver the necessary?

A: In the past, sometimes too many partners delivering clinical health care in natural disasters landed in countries without sufficient quality control or coordination. That was the driver for WHO’s work on emergency medical teams. Now we have around 75 teams, from governments and civil society, working with WHO and others on standby to join the humanitarian response and support national capacity. We have developed a formal process of quality control and peer review in their selection, training and verification. I do not agree that there are too many partners in health emergencies. In some countries there are too few. What is clear, though, is the need for a strong WHO role in identifying gaps and convening partners as well as monitoring the outcomes of the health sector response.

Q: At WHO’s Financing Dialogue last October you told Member States that WHO flexible funds covered more than one-third of the new programme’s needs for 2017. Has funding improved since then?

A: The Financing Dialogue event was an important milestone. We have received several commitments including from Japan, the United Kingdom [of Great Britain and Northern Ireland] and the United States [of America] and there have been follow-up discussions with donors. I am confident that the funding situation will improve. We need funding that is flexible and predictable. Our programme is building core capacities, for example, for implementing the International Health Regulations in countries: what we are delivering in parts of this programme is a global public health good and should be treated as an investment and not a recurring cost.

Q: The Guidelines Review Committee now has a fast-track procedure for developing guidelines in emergencies. Have you used this?

A: We do a lot of normative and technical work and we use the Guidelines Review Committee procedure regularly, for example, for interim guidelines on Zika. Our normative technical work ranges from the development of a framework of event detection and surveillance – a common standardized tool for risk assessment to be used by WHO and partners so that we have a common way of assessing risks in outbreaks – to the development of technical standards and long-term strategies for infectious hazards.

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Q: What is the outlook for the programme in 2017?

A: It’s an ambitious programme of work and has never really been done at WHO on this scale before, so it will take time for everything to be running smoothly. We are not there yet but the early phase has been positive. In 2017, we will continue to focus on the most vulnerable priority countries and continue to build capacity at global and regional level, for each response, and we will be able to say what worked, what are the lessons learnt and how we will incorporate these lessons. That way the programme will be built on a robust foundation and will be ready to deliver across all humanitarian and infectious disease emergencies in 2017 and beyond.