Strengthening WHO's Institutional Capacity for Humanitarian Health Action

A Five-Year Programme 2009-2013

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Executive summary

WHO’s emergency work is carried out under the overall framework of Strategic Objective 5 (SO5) of its Medium-Term Strategic Plan (MTSP) for 2008-2013. SO5 seeks to "reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact".

Limited resources, increasing numbers of natural disasters, protracted armed conflicts and post-conflict transitions, as well as the new humanitarian challenges from climate change and the global food and financial crises, make it essential for WHO to strengthen its capacity in order to assist and protect vulnerable, affected people and those humanitarian actors who help them. The following pages set out WHO's strategic planning framework for building such institutional capacity so the priorities for health action in crises for the period 2009-2013 can be implemented. The framework and priorities are based on the recommendations of the many evaluations of WHO's work and the lessons learned from the 2006-2007 biennium.[1]

Priority objectives, activities and milestones for strengthening WHO's Institutional capacity for Humanitarian Health Action have been grouped under two pillars. Pillar 1 (support to countries responding to or recovering from crises) brings together two closely intertwined strands. One strand aims to improve collaboration with partners and consolidate the cluster approach. The other seeks to improve WHO's internal readiness and performance and its warning, response and recovery work, particularly at country level. Pillar 2 (strengthening the health emergency management capacity of countries at risk) aims to strengthen our emergency preparedness programmes to help Member States assess and map vulnerabilities and risks and, from there, identify strategies to reduce vulnerability, improve risk reduction measures and strengthen emergency preparedness programmes based on an all-hazard/multi-sectoral/whole-health approach.

Funds for WHO’s emergency work can be separated into two distinct components. For specific crises, voluntary contributions come from several sources, including Appeals and grants from the Central Emergency Response Fund. The rest of WHO's work, including the Health Cluster and WHO’s institutional capacity building programme – the core activities that underpin its humanitarian health work – is funded from both assessed and voluntary contributions (or 'donations'). This second component is severely under-funded, and requires support from partners in order to reach required levels of capacity and readiness. WHO is appealing to donors to redress the funding imbalance between these two components by contributing flexible funding to the institutional strengthening programme presented in this document.

[1] WHO Performance Assessment Report for 2006-2007

Introduction

The mission of WHO's work in Emergencies and Crises is to help reduce the suffering of affected people through the implementation of programmes that prepare the health sector to deal with emergencies and support efforts for improving health during and after crises, applying professionalism and humanitarian principles.[2]

Historical Background

After a succession of high-profile emergencies in the early twenty-first century, WHO's external health partners, Member States and senior management have given WHO a clear mandate to strengthen the Organization's work in crises. Health partners have made it clear that they expect WHO, as the global health agency, to provide authoritative health information and guidance during emergencies. Member States want WHO to be more visibly active in crises, and are ready to fund its efforts to become more operational, accountable and predictable in dealing with humanitarian emergencies. WHO's senior management understands the need to adapt to the challenges of a rapidly-changing world in order to retain the Organization's health leadership role. As a result of widespread internal and external consultations, in mid-2004 WHO launched its Three-Year Programme to Enhance WHO's Performance in Crises (see section 1.4).

Subsequent events have confirmed the importance of the Organization's humanitarian work. WHO's first major challenge came with the devastating tsunami of December 2004. Thanks to donations received under the TYP, WHO was able to deploy staff from all regions, dispatch emergency supplies and mobilize funds for the emergency response. In January 2005 the World Conference on Disaster Reduction provided further impetus by adopting the Hyogo Framework for Action (2005-2015) and its five priorities.[3] In May 2005, in an atmosphere of strong political and public interest generated by these events, WHO's Member States adopted World Health Assembly (WHA) Resolution 58.1 calling on WHO to improve the speed and efficiency of its emergency work (see below). WHA Resolution 58.1 emphasizes the synergies among risk reduction, emergency preparedness, response and recovery, and the need to "strengthen the ingenuity and resilience of communities, the capacities of local authorities, and the preparedness of health systems". A similar Resolution – WHA 59.22 – was adopted the following year. Lastly, the UN's humanitarian reforms of September 2005 ushered in sweeping changes that have given greater prominence to WHO's humanitarian role.

The following sections describe the evolution of WHO's emergency work in the context of the above developments.

WHO's Emergency Functions

WHO’s functions encompass the entire emergency cycle from preparedness to response and recovery.

Response and recovery

WHA Resolution 58.1 requests WHO to help all relevant groups prepare for, respond to and recover from disasters by carrying out four core functions:

[1] *"timely and reliable **assessments** of suffering and threats to survival, using **morbidity and mortality data**;*

[2] ***coordination** of health-related action in ways that reflect these assessments;*

[3] *identification of, and action to, **fill gaps** that threaten health outcomes; and*

[4] ***building of local and national capacities**, including transfer of expertise, experience and technologies, among Member States….*”

[2] This mission statement will be regularly reviewed and updated as WHO develops its programmes and engages with its humanitarian partners.
[3] 1) ensure disaster risk reduction is a national & local priority with a strong institutional basis for implementation; 2) identify, assess & monitor disaster risks & enhance early warning; 3) use knowledge, innovation & education to build a culture of safety & resilience at all levels; 4) reduce underlying risk factors; 5) strengthen disaster preparedness for effective response at all levels.

These four functions – providing health information, coordinating, filling gaps and building capacity – have become WHO's operational framework for emergency response. They reinforce the primacy of country programmes in WHO's humanitarian work. Day by day, WHO, emergency focal points in the field conduct assessments, help coordinate health activities, identify and fill gaps and work to restore and build local capacities.

These operational functions have been enhanced with the responsibility vested in WHO by the Humanitarian Reform as lead agency of the Health Cluster. WHO is now also responsible and accountable for making sure that the different humanitarian health partners at global and country level act in a coordinated fashion when working in response and recovery.

The above mentioned operational functions and cluster lead responsibility require a WHO capacity in place at global, regional and country level so there is readiness to act in a timely manner to carry out those response and recovery activities.

Risk reduction and emergency preparedness

WHO's six-year strategy for health sector and community capacity development guides WHO's work in health risk reduction and emergency preparedness in the following areas:

- Institutionalizing risk reduction and emergency preparedness approaches in governments and establishing an effective all-hazard/whole health programme in countries most at risk;
- Assisting Member States build national emergency management systems and advocating for greater investment in emergency preparedness;
- Assessing and monitoring baseline information on risks and improving/encouraging risk assessment, community-based risk reduction, emergency preparedness, response and recovery knowledge and skills in the health sector at regional and country level.

These strategies support Member States in building national emergency management systems and advocating for greater investment in risk reduction and emergency preparedness.

Humanitarian Reform and the Health Cluster

In September 2005, following the results of a review commissioned by the UN Emergency Relief Coordinator, the international humanitarian system adopted fundamental changes known as the Humanitarian Reform. These reforms aim to:

- strengthen the humanitarian coordinator system;
- improve emergency financing mechanisms; and
- improve the coordination of different sectors by grouping them into "clusters".

In December 2005, WHO was appointed lead agency of the Global Health Cluster (GHC).

Under WHO's leadership, the GHC has established and reinforced partnerships, built consensus, and created tools to support humanitarian operations. It has developed a roster of Health Cluster Coordinators to be deployed to the field during acute emergencies, and has trained candidates to ensure they have the managerial, personal and operational skills needed for the task. The GHC conducts regular assessments of cluster work (the "cluster approach") in countries, and delivers country-level training courses on GHC products and services. In many countries the cluster approach has helped improve the efficacy, accountability and predictability of the health humanitarian response. In this context, it aims to raise awareness, conduct advocacy, build technical capacities and strengthen management systems.

Three-Year Programme to Enhance WHO's Performance in Crises

WHO's Three-Year Programme (TYP) was implemented against this backdrop of overall reform. In 2003 WHO had a handful of emergency focal points. By 2007, it had contact points in over 120 countries and full-time, dedicated emergency staff in 40 more. As new emergencies have appeared or complex crises continued, the Organization has opened more than 20 field offices to reach closer to the people in need. The number of emergency staff in WHO's six regional offices has more than tripled (from six to twenty),

bolstered by more than 15 inter-country focal points dealing with the multi-country, cross-regional aspects of crises, starting with the exchange of health information across borders.

In WHO headquarters in Geneva, the Health Action in Crises Cluster (HAC) has collaborated with other technical departments on new guidelines, norms and standards for humanitarian settings. Using TYP funds, HAC built up its operational capacity, including a round-the-clock duty officer system, an emergency revolving fund, a roster of experts, revolving stocks of equipment and emergency standard operating procedures (SOPs). The TYP also financed expert consultations on preparedness and recovery in ongoing emergencies and transitions as well as a global survey on national disaster preparedness, and initiated public campaigns to make health facilities more disaster-resilient.

Programme Evaluations

Reviews of both the TYP[4] and the cluster approach[5] were commissioned in 2007. The conclusion of these two studies and other reviews conducted between 2005 and 2007[6] is that WHO is on the right track, and must continue to build its own capacity and that of its partners. This implies a continuous investment in the staff, supplies, logistics and administrative support services that WHO needs to maintain its emergency work. The recommendations of the TYP's final evaluation and WHO's follow-up actions are set out in Annex 1.

Lessons Learnt

WHO will integrate the following lessons learnt into its future operations:

Communities have an essential role to play in emergencies. At local level, much can be done to strengthen the response capacity of communities at risk and prevent and mitigate the effects of crises. In 2009-2013 WHO will focus on the community approach, including strengthening emergency preparedness plans at local level and improving communities' ability to map and manage risks and reduce vulnerability.

- The immediate humanitarian response needs to go hand-in-hand with early recovery planning and initiatives. Mainstreaming recovery in the work of the Health Cluster becomes a critical element for bridging between relief and development in the health arena.
- Experience in recent crises has revealed major gaps in humanitarian health interventions that require urgent attention. Further work with other WHO technical areas (health systems, nutrition, primary health care) will help address some of these gaps. WHO and its humanitarian partners need to strengthen their capacity to intervene in other areas including mass casualty management, management of chronic diseases, maternal and newborn health. Human resources must be developed, particularly in the fields of nursing and midwifery in emergencies. Equally importantly, WHO needs to focus on building national capacity in order for these gaps to be addressed within countries. Experience is even more important than training. This concept must drive WHO's capacity-building strategies. Exchanging experiences (through visits, publications, workshops) is essential to broaden overall knowledge.
- To be effective, emergency operations must be backed by solid, reliable data. WHO must continue to provide up-to-date information on morbidity, mortality, health services coverage and access and other health indicators essential to emergencies and crises as part of overall profiles of risk and vulnerability. Proper health information systems and tools are paramount for assessing needs and monitoring humanitarian performance. WHO's contribution to the Interagency partnership of the Health and Nutrition Tracking Service will be crucial in this area.
- Clear and agreed crisis management arrangements are essential. These should include a clear chain of command, and should define responsibilities and accountabilities at all levels. They will have to be harmonized and compatible with the proposed WHO Event Management Framework.
- Partnerships and networks are crucial to achieving results. WHO can bring its convening power and technical expertise to bear in both forging new and strengthening existing partnerships

[4] TYP Final Evaluation by C. de Ville, E. Eben-Moussi & A. Canavan, December 2007
[5] Cluster Approach Evaluation Report by A. Stoddard et.al., November 2007
[6] Under the TYP nine field missions were carried out with participants of WHO, ECHO, DFID and SIDA, as follows: Darfur (02/05); Sri Lanka (04/05); Indonesia (04/05); DR Congo (04/05); Chad (05/05); Liberia (12/05); Pakistan (03/06), Tajikistan (09/06); Uganda (02/07); Ethiopia (06/07). Each mission yielded a detailed report and recommendations for follow-up.

(nongovernmental organizations, private sector, Gates Foundation, World Bank, etc), while maintaining its identity and mandate. WHO will continue to strengthen collaboration with its health partners and with other humanitarian clusters, first of all Nutrition and Water & Sanitation, to ensure convergence and synchronised efforts.

- The ability to rapidly mobilize staff, equipment and money is essential to the success of emergency response operations. WHO will continue to build its operational capacity and strengthen alliances and joint work with key logistics partners including the World Food Programme.
- WHO's country office staff, starting with WHO Representatives, need a clear understanding of the Humanitarian Reform as well as insight into issues such as protection of civilians, civil-military relations and security. They need to project a strong presence with the UN Country Team and other humanitarian partners. To this end, negotiating, communication, media and chairing skills should be strengthened through training courses and simulation exercises. Country staff also need to be trained in reporting and writing effective proposals, and their performance must be monitored and evaluated through clear lines of accountability.
- During emergencies (particularly complex emergencies) WHO's relationship with the ministry of health must be guided by the humanitarian imperative. There needs to be a careful balance between establishing good working relationships with the governments of Member States and maintaining humanitarian principles. The extent to which the ministry is involved must be balanced with its understanding of these principles and the need for independence and neutrality of health partners.
- In some humanitarian settings, WHO is still perceived as non-operational. It is viewed as failing to respond rapidly and moving too slowly in providing independent health evidence for advocacy and action. WHO must address this, and meet the increasingly complex demands originating from climate change, increased migration, urbanization, the global food price and financial crises, demographic pressures, and global economic, social, political, and cultural shifts.

These lessons learnt, and the recommendations of several programme evaluations, have served as the basis for developing the content of the Strategic Objective 5 (SO5) in WHO's Medium-Term Strategic Plan for 2008-2013 (see next chapter).

International Framework for WHO's Emergency Work

Global level

WHO is a member of the Inter-Agency Standing Committee (IASC), the primary mechanism for the inter-agency coordination of humanitarian assistance. The IASC – a unique forum bringing together UN and non-UN humanitarian partners – was established in June 1992 in response to United Nations General Assembly Resolution 46/182 on the strengthening of humanitarian assistance. WHO participates in several IASC working groups and task forces that work on various aspects of humanitarian assistance. WHO also works with the Secretariat of the International Strategy for Disaster Reduction (ISDR) to incorporate a public health perspective in risk reduction programmes, and has pledged to help countries implement the five priorities of the Hyogo Framework for Action. WHO is also part of the Executive Committee on Humanitarian Affairs (ECHA) and participates in the UNDG-ECHA Working Group on Transitions.

Internally, HAC at headquarters leads the implementation of SO5, but it should not be viewed as a stand-alone humanitarian branch of WHO. HAC facilitated the design of SO.5, and now its role is to convene technical expertise from all areas and all levels of the Organization and to oversee and coordinate WHO's overall humanitarian efforts.

Regional level

The Regional Offices provide direct back stopping to WHO's country operations and work with WHO's partners at inter-country level to support capacity development and to create synergy from the resources spread across all countries.

Country level

The WHO country teams operate at national and sub-national levels working closely with a number of partners: national health authorities, the UN Country Team; the Security Management team; Health Cluster partners; other clusters; and the humanitarian and regional coordinators. By leading humanitarian health work, WHO country teams are the basic 'units of production' of WHO in emergencies and crises.

Strategy for 2009-2013

Priority-setting

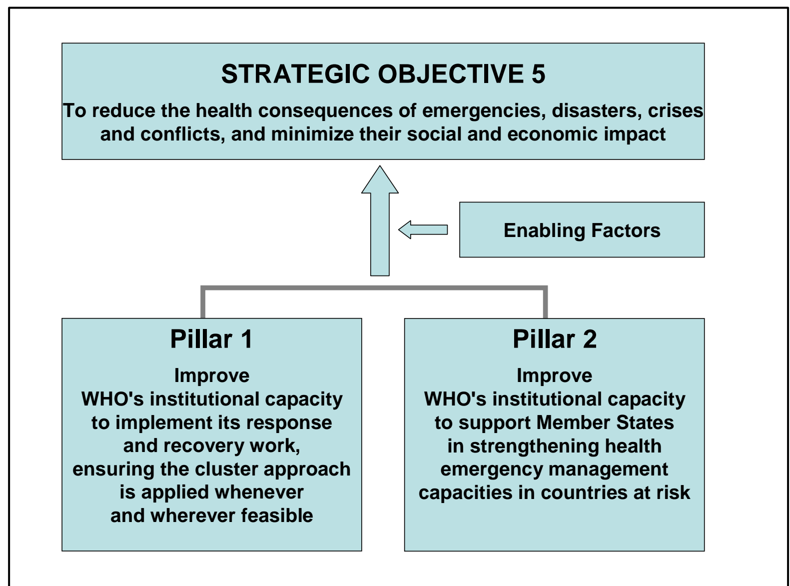
Limited resources, increasing numbers of natural disasters, protracted armed conflicts and post-conflict transitions and the new humanitarian challenges resulting from climate change and the global food price and financial crises make it essential for WHO to set clear priorities. Based on the recommendations of the many evaluations of its work and the lessons learned from the 2006-2007 biennium,[7] WHO has set the following priority strategies for the next five years:

1. Implement the Health Cluster approach in all priority countries
2. Improve health information and operational intelligence in coordination with humanitarian partners
3. Enhance response and recovery capacity
4. Support the development of health risk reduction, emergency preparedness and response capacities in countries most at risk
5. Support community-based best practices in emergency preparedness and risk reduction
6. Provide baseline information on health risks, health risk reduction and emergency preparedness
7. Build emergency preparedness knowledge and skills through training, guidance, research and information services
8. Strengthen the core enabling factors that underpin WHO's emergency work:
    - Fostering collaboration
    - Promoting a culture of change
    - Enhancing visibility
    - Improving implementation in the field
    - Increasing resource mobilization effectiveness
    - Monitoring and evaluation

Strategic Planning Framework of WHO's Medium Term Strategic Plan

WHO's emergency work is carried out under the overall framework of its Medium-Term Strategic Plan (MTSP) for 2008-2013. Strategic Objective 5 (SO5) of the MTSP is "to reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact". [8] This document is based on the core functions contained in the MTSP, but breaks down activities and objectives into greater detail grouping them into two pillars that provide the capacity that WHO needs to achieve the SO5 (see Figure 1).

Figure 1.



Pillar 1 (Support to countries responding to or recovering from crises) brings together two closely intertwined strands. One strand aims to improve collaboration with partners and consolidate the cluster approach. The other seeks to improve WHO's internal readiness and performance and its warning, response and recovery work, particularly at country level.

[7] WHO Performance Assessment Report for 2006-2007
[8] SO5 in the MTSP for 2008-2013 breaks down into biennial programme budget and into specific operational plans by Departments in Regional Offices and by Country Offices; these contain detailed activities and the benchmarks to monitor their implementation. See Annex 2 for details on the seven Organization Wide Expected Results for 2008-2013 as well as for the baselines, targets and indicators agreed upon by WHO Member States as basic accountability framework

Pillar 2 (Strengthening the health emergency management capacity of countries at risk) aims to strengthen emergency preparedness programmes by helping Member States assess and map vulnerabilities and risks and, from there, identify strategies to reduce vulnerability, improve risk reduction measures and strengthen emergency preparedness programmes based on an all-hazard/multi-sectoral/whole-health approach.

The planning framework sets out the priority strategies and key activities for both pillars and explains the enabling factors that underpin WHO's emergency work.

Planning Framework

Pillar	Priority Strategies	Key activities
Pillar 1 Improve WHO's institutional capacity to implement its **response and recovery work**, ensuring the cluster approach is applied whenever and wherever feasible.	1. Implement the Health Cluster approach in all priority countries	• Oversee Health Cluster roll-out • Increase WHO's presence in selected countries • Develop leadership training course for WHO Representatives • Conduct training courses for Health Cluster/Sector Coordinators • Ensure WHO's ability to implement agreed Health Cluster functions at country level • Develop coordination mechanisms based on clear definitions of roles, responsibilities & comparative advantages • Work with Health Cluster partners to identify and fill gaps • Develop, field-test and translate tools and guidelines for WHO and partners
	2. Improve health information and operational intelligence to guide implementation	• Encourage country-to-country and inter-agency flow of health information • Maintain a global system to monitor situations of concern, for early warning, contingency planning and alert • Support country-level management of morbidity, mortality, health services coverage and access data, for response and recovery planning and monitoring • Technical linkage with HNTS • Translate health information into simple key messages for the general public • Undertake health needs assessments and system analysis for guiding the design of humanitarian interventions in different moments of the crises
	3. Enhance WHO response and recovery capacity	• Develop an Organization-wide crisis management system and a common operational platform that serves several WHO Clusters • Develop the emergency roster and standby agreements with partners • Expand stocks of pre-positioned emergency supplies to cover all regions • Implement emergency SOPs • Ensure provision of technical assistance to the field whenever needed (South to south, region to region, where appropriate) • Reinforce internal emergency revolving fund • Equip country office staff with appropriate skills and knowledge • Increase readiness on security matters • Support the formulation and implementation of health components of CAPs and Transitional Appeals • Support the formulation of health recovery strategies in transition situations • Training on the analysis of disrupted health systems • Establish a central info. source on health recovery

Pillar	Priority Strategies	Key activities
Pillar 2 Improve WHO's institutional capacity to **strengthen health emergency management capacities** in countries at risk.	1. Support the development of health risk reduction and emergency preparedness capacities in countries most at risk	• Support Member States build national emergency management systems and advocate for greater investment in emergency preparedness • Facilitate a global system for health emergency preparedness and risk reduction • Support national programmes for safer hospitals in emergencies • Ensure that all new Country Support Strategies (CSS) incorporate risk reduction and emergency preparedness programmes
	2. Support community-based best practices in emergency preparedness and risk reduction	• Work with partners (UN agencies, NGOs, academic institutions) to integrate risk reduction and emergency preparedness into multi-sectoral community emergency management structures • Promote the integration of health risk reduction and emergency preparedness into primary health care at community level • Support the WHO Global Influenza Programme in strengthening community-based pandemic preparedness • Establish a health communication and social mobilization programme to build emergency preparedness in the community
	3. Provide baseline information on health risks, health risk reduction and emergency preparedness	• Conduct global survey to assess status of emergency preparedness and response capacity in countries • Conduct and facilitate detailed assessments of potential hazards, associated health vulnerabilities, and emergency preparedness in countries most at risk • Provide pre-impact evidence-based risk assessments on health status and health services to: 1) advocate for emergency preparedness and contingency planning; 2) help serve as a baseline for needs assessments during emergencies; and 3) serve as a baseline for monitoring the effectiveness of emergency operations • Develop and share methods, protocols and tools for the collection, analysis and mapping of health hazards, vulnerability and risks to support evidence-based decision making • Support the development of national and local capacity within Ministries of Health and other partners to enable countries to implement the Vulnerability and Risk Analysis & mapping (VRAM[9]) process
	4. Build emergency preparedness knowledge and skills through training, guidance, research and information services	• Develop guidelines, standards and technical information on health emergency management • Conduct and facilitate training, enhanced south-south and inter-regional exchange, coaching and country-to-country peer reviews • Establish a web-based internet portal to facilitate country to country exchange of lessons learnt and info. On health emergency management

Working Methods

Headquarters

At headquarters, HAC maintains a close, direct, daily dialogue with its regional and country offices to monitor situations of concern, support emergency operations and recovery programmes, as well as to promote risk reduction and preparedness programmes. HAC provides technical guidance and project management support and participates in joint evaluation missions and lessons learned exercises. HAC also acts as a catalyst in bringing together the different parts of WHO. It works closely with technical experts in other departments to produce technical norms and guidelines on various aspects of emergency preparedness and response (e.g. health systems, water and sanitation, nutrition, gender, mental health, reproductive health, maternal, newborn and child health, communicable and noncommunicable diseases, sexual and gender-based violence). When acute crises arise, HAC/HQ is the conduit through which these

[9] The Vulnerability and Risk Analysis & mapping platform (VRAM): Provides baseline information disaggregated geographically (sub-country levels) and by selected indicators (See page 17).

same experts are deployed to the field and supported to provide specialized technical guidance to staff at the forefront of the operations. Guidance is provided from the Strategic Health Operations Centre (SHOC). The WHO Mediterranean Centre (WMC) in Tunis hosts the Vulnerability and Risk Analysis and Mapping unit (VRAM), and provides a platform for WHO emergency-related training, social mobilization programmes and a web-based internet portal that facilitates access to information on health emergency management.

Regional
WHO's regional offices, technical advisers and their teams have responsibility for planning, organizing and implementing the Organization's emergency and humanitarian activities within the region. They provide back-up support to country offices. In cooperation with the WHO Representatives, they ensure that WHO's response complements rather than duplicates the response from other sources.

Country
In the WHO offices of selected countries, there is at least one HAC/EHA[10] focal point, usually a public health expert with a background of epidemiology and health planning who lead WHO's emergency response.

Leadership
From Geneva, WHO leads the GHC. WHO and its more than 30 GHC partners have been working over the past two years to build partnerships and mutual understanding and develop common approaches to humanitarian health action.

The **WHO Strategic Health Operations Centre (SHOC)** provides critical services to Member States during public health emergencies. It provides close collaboration, coordination and where appropriate, integration of intelligence for the chemical safety programme, department of food safety and radiation medicine as well as with disease-specific control programmes for emerging influenza and cholera and with HAC for humanitarian crises.
The Geneva HQ facility provides an environment for secure communications and coordination within WHO, and with member states and technical partners in external networks such as the Global Outbreak Alert and Response Network (GOARN).
Key activities since summer 2008 have included:

- Crisis management support during health emergencies of outbreaks of diseases including Rift Valley Fever and Yellow Fever and humanitarian disasters, including the China earthquake, the Myanmar Cyclone and the DRC civil disturbance.
- Design Consultation is provided to WHO Regional/Country Offices and ministries of health for the construction of emergency operation centres. The work is ongoing with regional offices to strengthen regional alert and response teams, to provide an efficient way to ensure sufficient capacity to deal with simultaneous emergencies and to manage events that frequently involve neighbouring countries.

Partnership
At global level, WHO also works closely with the ISDR system on the implementation of the Hyogo Framework for Action 2005-2015, including a focus on safe health facilities. Altogether, WHO's external humanitarian partners constitute a broad range, including Governments, other UN agencies, intergovernmental organizations, the Red Cross and Red Crescent Movement, national and international NGOs, academic institutions, professional associations, and donors. WHO has signed formal partnerships with the International Federation of Red Cross and Red Crescent Societies, the AMAR Foundation, the International Medical Corps and, most recently, Merlin.

[10] HAC/EHA: Health Action in Crises and/or Emergency and Humanitarian Assistance. The two names are inter-changeable

Activities and Milestones

The following section describes in more detail each of WHO's eight priority strategies for institutional strengthening and sets out the milestones for each one.

Pillar 1: Support to Countries Responding to or Recovering from Crises

Pillar 1 brings together the ingredients to build WHO's leadership skills, operational capacity and presence in the field and, by extension, improve the overall coordination and implementation of health humanitarian activities at country level through the cluster approach.

Implement the Health Cluster approach in all priority countries

As lead agency for the Global Health Cluster, WHO is expected to oversee implementation of the cluster approach in countries. WHO is responsible for leading, coordinating activities, setting standards, building capacity, identifying gaps and filling them as the "provider of last resort".

WHO's technical expertise and unique capacity to interface between national and international health partners give it a considerable advantage. However, as the recent evaluation of WHO's Health Cluster work points out, “the main challenges … stem from the still relatively light humanitarian operational presence of WHO as lead agency, as many believe a more operational footing is required to credibly lead in field operations”. As more and more countries adopt the cluster approach, WHO will need to gear up in order to meet this leadership challenge.

In addition to strengthening leadership and coordination skills in existing cluster countries, WHO must build capacity in new ones including at sub-country level where most emergency and humanitarian operations are concentrated.

Humanitarian health operations need to be tightly coordinated and managed as close as possible to beneficiaries. Those who are best placed to deliver services must be allowed to do so, with other partners playing a supporting role under WHO's overall guidance. To complement its own capacities, WHO will need to build relationships with partners who can act as co-lead or assume key support functions. While WHO builds capacity in priority countries, and as new countries emerge, it will assess its strengths and weaknesses in each location and determine whether a cluster partner may be better positioned to take on the lead role.

WHO will build its credibility and capacity to lead by:

Increasing its presence and predictability in priority countries
WHO cannot achieve a stronger field presence overnight, and will need to prioritize recruitments and proceed in phases. In line with the IASC cluster strategy, WHO will place additional staff in countries where the cluster approach has already been activated or where humanitarian coordinators have been appointed, but no formalized cluster arrangement exists. Second priority will be given to countries where no humanitarian coordinator has been deployed but where the situation on the ground justifies the setting up of coordination mechanisms. The list of countries where the cluster approach has been or is scheduled to be introduced is attached as Annex 3.

WHO will immediately deploy at least one international professional in Health Cluster countries, and will ensure they have operational capacity and funds. The presence of field staff dedicated full time to health cluster work will lead to greater predictability and enhance WHO’s credentials at country level. Depending on the availability of funds, the Organization will also recruit national professional officers at regional and provincial levels.

Improving its performance
WHO will invest in career development, mentoring and training programmes to equip staff with the personal, public health and management skills they need to work effectively, efficiently, and safely in emergencies. WHO will ensure that staff, partners, and counterparts are properly trained and able to play their assigned roles within the Health Cluster and in collaboration with other clusters. Staff must be

familiar with the public health aspects of emergencies and with basic documents and standard operating procedures.

WHO will develop training packages tailored to different levels of staff, and will guide and accompany staff in their career development. Increasingly competent, trained and experienced staff will ensure a professional, predictable emergency response that meets the expectations of partners. Ultimately, humanitarian field staff will have acquired the management and personal skills needed to fulfil the role of Health Cluster/Sector Coordinator.

Building its coordination capacity and ability to lead
WHO will build its coordination capacity and ability to lead through leadership training programmes for WHO Representatives (WRs) and other senior staff, and pre-deployment training for Health Cluster coordinators. WHO will further develop its roster of Health Cluster Coordinator candidates and will train candidates before they are deployed to ensure they have the managerial, personal and operational skills needed to coordinate cluster work at country level.

Showing institutional readiness
WHO will further develop its emergency logistics platforms and administrative support services. It will also work to ensure the staff of its regional and headquarters offices are able to provide technical and administrative support to field staff whenever needed.

Demonstrating technical leadership
WHO will continue to develop technical tools and guidelines for Health Cluster partners. WHO has already produced a Health Cluster guide, a tool to assess the availability of health services, an inter-cluster assessment tool, a gap analysis document, and guidelines on national capacity building and health sector recovery in countries in transition. These tools will be field-tested, translated and adapted for use in a broad range of countries.

Milestones	
End 2009:	• A health cluster coordinator from WHO or partner agency/organization deployed in a minimum of 10 Health Cluster countries to assure coordination and leadership. • A training course on Global Health Cluster issues for WHO Representatives held in 2009. • Two Health Cluster Coordinator training courses held in 2009. • MOH staff and partner agencies in all priority Health Cluster countries briefed on the cluster approach and Health Cluster activities. • Health sector interventions well coordinated at country level with regular coordination meetings; joint plans developed. • Workshop for Health Cluster Coordinators to exchange best practice. • Global standards, protocols, guidelines and monitoring tools adapted and adopted for use in countries
End 2013:	• Health Cluster approach & tools adopted as standard in all crisis countries. • WHO staff and partners trained on Health Cluster issues in all countries where the cluster approach is adopted or likely to be adopted. • WHO Representatives in all countries likely to be involved in cluster issues are trained and briefed on global cluster issues. • All Health Cluster Coordinators have received a standardized training package including relevant tools and skills training.

Strengthen health information and operational intelligence

The provision of health information and intelligence is one of WHO's four core functions in an emergency. Timely, good-quality information is essential for verifying crisis alerts and feeding early warning systems. HAC produces weekly reports on WHO's humanitarian activities and publishes monthly summaries. In-house sharing of this information with other WHO clusters is now routine. An effective 'emergencies' web site is constantly updated.

In coordination with humanitarian partners, WHO will strengthen its health information and intelligence by:

Enhancing its early warning system
Encouraging WHO regional and country offices as well as partners to actively exchange health information, HAC will set up an early warning system to detect, verify, and monitor high-risk situations that may evolve into humanitarian crises requiring WHO's rapid response. Information will be consistently shared within WHO and with humanitarian partners in order to ensure common understanding and collective readiness to act. Nevertheless, WHO will continue to access (and contribute to, when appropriate) IASC and other early warning systems.

Improving and maintaining data-gathering systems in priority countries
WHO will recruit a national data manager in each Health Cluster priority country. This data manager will develop a database that pools health information from WHO field offices, the Polio surveillance network, regional health delegations, international and national NGOs and other partners. This information will be published for wide dissemination in a periodical Cluster Bulletin. WHO's activities in this area link directly to the work of the Health and Nutrition Tracking Service. These Cluster Bulletins will also provide an effective tool for translating health information into simple key messages.

The **Health and Nutrition Tracking Service** (HNTS) was established in October 2007 as part of the Humanitarian Reform. Its aim is to collect and analyse humanitarian data using standardized methods, and disseminate the information to policy-makers, the wider humanitarian community and the public. WHO acts as the HNTS secretariat on behalf of the Global Health and Nutrition Clusters.

The HNTS is developing mechanisms to review, analyse, interpret and validate critical health and nutrition measures in selected humanitarian emergencies. Through its Expert Reference Group, the HNTS identifies key data gaps in selected countries and engages with relevant groups to address them. By working with local partners, the HNTS is able to build capacity for data collection, analysis and interpretation in countries.

Training WHO staff and partners on data collection and analysis
WHO staff and partners need to be able to gather data and communicate information in simple, structured and effective ways in order to influence operational decisions. WHO will emphasize data analysis and health information management in its humanitarian training courses, and will mentor and provide technical support to field staff. Staff will be enrolled in data management courses offered by other technical areas in WHO and by external organizations. They will also be trained in health communication and learn how to translate critical information into public health messages that can contribute to saving lives.

Defining and negotiating consensus with partners on the use of specific information
Together with partners, WHO will define different categories of information and agree on their use. For example, information on an evolving humanitarian situation, combined with health system data, can be used to procure and stockpile critical items that are in short supply.

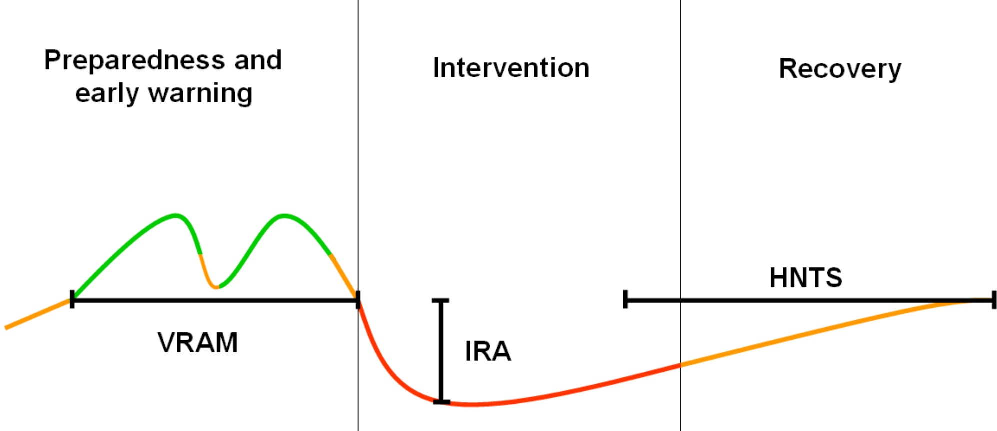
Undertaking health needs assessments and system analysis for informing the design of humanitarian interventions in different stages of the crisis
Needs assessments processes for identifying critical gaps and intervention priorities are essential to the work on emergencies and crises. Rapid Assessments after disasters strike must be produced under the auspices of the Health Cluster.

Ensuring information continuity throughout the emergency cycle
To meet the expectation for WHO support for emergency-related information management WHO and its partners from the Health and Nutrition Clusters have developed several complementary tools that apply to different phases of the emergency cycle. These are:

- The Vulnerability and Risk Analysis & mapping platform (VRAM): Provides baseline information disaggregated geographically (sub-country levels) and by selected indicators.
- The Initial Rapid Assessment (IRA) tool: Measures the deviations from baseline indicators that are caused by a given disaster or crisis. IRA is not possible or credible without having reliable data from a VRAM-like source.
- The Health and Nutrition Tracking Service (HNTS): It takes into consideration IRA and follow up assessments and measures performances of the humanitarian actors using the same type of indicators. It builds on VRAM and assessment's prior work and it uses the same or similar tools.

Each of them addresses a particular need during the overall emergency cycle (Figure 2). The chain of information evolves from VRAM to rapid assessments and finally to HNTS to track performance.

Figure 2.



Several of their components should be standardized in order to ensure an efficient and effective flow of information and decision-making process during the overall cycle. They should:

- use common indicators and determinants to the extent possible,
- rely on the same institutions and technical counterparts in recipient countries,
- use a set of common tools such as GIS or statistical packages to produce compatible outputs, and
- rely on staff having followed similar trainings.

During the coming years, WHO will ensure the connections and standardization of these different tools and maximize the use of available resources to each of them.

Milestones	
End 2009:	• One national data manager hired in all priority Health Cluster countries. • Global early warning system for public health humanitarian crises up and running. • Data analysis module included in at least two humanitarian training courses. • Regular Health Cluster Bulletins produced in at least 15 priority countries. • Decision-making analysis tool developed and applied to one target country. • Preparation of health component of PDNAs and PCNAs in at least 6 emergencies or crises
End 2013:	• All countries where EHA is active produce weekly Health Cluster bulletins • Completing health systems analysis for health recovery in at least 8 countries

Enhance response and recovery capacity

WHO's visibility as an effective humanitarian response entity in emergencies still needs to be enhanced. Too many country offices are still not equipped, trained, prepared and able to provide a response that meets expectations. WHO must improve its ability to deliver quickly and effectively at field level.

Surge and supplementary capacity is required whenever normal systems are unable to cope with increased demands, especially for emergencies of rapid onset. However, it can also be required in less dramatic instances; for example, following the resignation of a field coordinator. WHO will monitor its humanitarian presence worldwide and establish contingency plans to respond to shortages of capacity in any location. Capacity gaps in areas such as security, communication, IT, reporting should be filled as close as possible to where they occur. For example, in a rapid-onset emergency, human resources in the country office should be called upon first, followed by partner organizations, WHO offices in neighbouring countries, inter-country focal points, etc. For a large emergency, an organization-wide mobilization is required.

The key principles underlying surge capacity are readiness to respond and capacity to monitor operations. In emergencies, all WHO offices must be ready to deploy the necessary staff, equipment and supplies, backed up by a secure and safe environment and the necessary technical, logistics and administrative support.

WHO will strengthen its surge capacity by:

Developing an Organization-wide crisis management system
WHO will consolidate into a single, common crisis management system the mechanisms already set in place by the departments that have a mandate for rapid surge and country level operations (SEC, HSE, Polio and HAC, to mention only a few)[11] Closely connected with the Global Health Cluster, the IASC/WG and its relevant subsidiary bodies, this system will define benchmarks of performance, clarify roles and responsibilities of different levels of the Organization in emergency operations. It will be supported by a single chain of command, a common operational platform covering security and logistics needs, etc. and common standard operating procedures.

Developing the emergency roster
WHO will continue to expand its roster of pre-screened and medically-cleared emergency specialists representing a wide range of disciplines. Candidates who have passed WHO's two-week pre-deployment training course will have first priority for selection. WHO will also negotiate standing agreements, giving it access to public health expertise in partner organizations, and will negotiate accelerated recruitment procedures with its internal administration.

Expanding (and adapting, where necessary) emergency supply stocks
In 2007 the Organization signed a memorandum of understanding with the World Food Programme (WFP) giving it a stake in WFP's worldwide network of Humanitarian Response. WHO now has a good stock of emergency supplies in three strategic locations (Dubai, Accra and Brindisi), thus ensuring life-saving medical supplies are constantly available, close to those who need them, and ready for immediate dispatch anywhere in the region. WHO plans to expand the quantity and range of the emergency supplies stored in these three depots. The Organization will also position stocks in two more WFP-managed Depots located in Panama and Malaysia. All supplies will be managed by qualified logisticians and subject to strict quality controls. This expansion will improve WHO's global coverage and ensure its emergency supplies can be dispatched quickly and efficiently whenever they are needed.

Building logistics capacity
WHO will continue to develop its logistics partnership with WFP. A second memorandum of understanding signed between WHO and WFP provides for access by WHO to WFP logistics capacities and by WFP to WHO health sector expertise. WHO has placed several logisticians in WFP supply hubs to work alongside WFP logisticians. Similarly, WFP has seconded two of its staff members to WHO. Synergy between the two organizations is being further strengthened by joint logistics training programmes and the integration of a health component into the Logistics Cluster response strategy. Ultimately, this joint logistics capacity will play a major role in the emergency health operations of UN agencies, donor governments, international nongovernmental organizations and other partners.

Improving the emergency SOPs
WHO developed its emergency SOPs in late 2006 in a consultative process involving staff at all levels of the Organization. In January 2008, the Director-General authorized the automatic activation of the SOPs for all humanitarian operations in the field, subject to certain criteria. WHO is collecting feedback on the SOPs from emergency staff, and will refine and revise them based on user experience. The Organization will also continue to conduct SOP training workshops for technical and administrative staff in the field. Four workshops have been held in the African region, and additional workshops are planned for all WHO regions before the end of 2009. WHO will also hold briefing sessions to familiarize WHO Representatives and other senior staff members with the scope and purpose of the SOPs and their importance for WHO's emergency operations.

Expanding the Emergency Revolving Fund
WHO's internal Emergency Revolving Fund (ERF) was established in 2004, using seed funds provided by the United Kingdom. The ERF allows WHO to respond immediately at the onset of a major crisis and to

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[11] As a general rule all these mechanisms already include alert, decision making, surge activation, deployment of pre-positioned resources, and technical/administrative help-desk in support of WHO country offices facing an emergency.

finance humanitarian operations in neglected crises, where small but crucial injections of funds can make all the difference. WHO will appeal for funds from other donors to increase the ERF.

Maintaining readiness to act
WHO will ensure that regional office and headquarters staff provide technical support to emergency field staff at all times. WHO's emergency departments will mobilize WHO's overall response through HAC (at headquarters level) and the emergency regional adviser (at RO level).

In headquarters, WHO's SHOC is equipped with state-of-the-art IT, telecommunications and media technology. The SHOC is managed by full-time staff and operates round the clock. (See Box page 14). All WHO regional offices have established emergency operating rooms with similar facilities. The emergency SOPs contain guidance for WHO country offices on setting up an emergency operations room. WHO country offices are developing contingency plans for emergencies with technical guidance from Geneva and the ROs.

Supporting the formulation of CAPs, Transitional Appeals and Health recovery strategies
Humanitarian health partners will be supported through WHO headquarters country and regional teams for conducting the health components of the Needs Analysis Frameworks, for designing and implementing the health components of CHAPs, CAPs and Transitional Appeals and for formulating recovery strategies and integrating them within existing interagency processes at country level.

Training on analysis of disrupted health systems

A series of courses on Analysing Disrupted Health Systems in Countries in Crisis will be conducted to expand and strengthen the capacity of health professionals in this field, so they can be better prepared for developing adequate response and recovery sector strategies and for planning and implementing effective interventions

Establish a global clearinghouse on health recovery

A systematic repository of information of current policies and programmes on health recovery, country experiences and best practices will be established. It will not be limited to the collection of information, but will also conduct analysis and disseminate lessons learned.

Milestones	
End 2009:	• Respond to two new, simultaneous major emergencies • WHO emergency supplies pre-positioned in five WHO regions • Common logistics and training platforms established or initiated to serve all health partners • At least one SOP training workshop held in each WHO region • All WHO Representatives briefed on the scope and purpose of the SOPs. • Emergency roster operational and able to provide the necessary staff for all emergencies • Two public health pre-deployment training courses held in 2009 • Health recovery strategy implemented in at least 5 countries • Clearinghouse on health recovery established, incorporating at least 15 country landscapes • Four courses on the analysis of disrupted health systems implemented • Health components of CAPs formulated and implemented effectively in all ongoing emergencies
End 2013:	• Common logistics and training platforms fully functioning and WHO logisticians assigned to all WFP supply hubs • Expanded range of emergency supplies available in all supply hubs • All departments in WHO are acquainted with the emergency SOPs • Health recovery strategy implemented in at least 20 countries • Clearinghouse on health recovery incorporating at least 30 country landscapes • Ten courses on analysis of disrupted health systems implemented • Health components of CAPs formulated and implemented effectively in all ongoing emergencies • In key chronic emergency and transition countries, WHO will deploy a dedicated presence for ensuring the coordination and leadership of the international support to national efforts.

Pillar 2: Strengthening the Health Emergency Management Capacity of Countries at Risk

Pillar 2 aims to strengthen emergency preparedness programmes by assessing risks and capacities, from there, identifying strategies to reduce vulnerability, improve risk reduction measures and strengthen emergency preparedness programmes based on an all-hazard/multi-sectoral/whole-health approach. WHO's preparedness activities focus on local and national capacity building as well as international institutional readiness. These strategies will also help countries and communities adapt to the humanitarian health effects of climate change.

Support the development of health risk reduction, emergency preparedness and response capacities in countries most at risk

The health impact of emergencies can be substantially reduced if national authorities and local communities are well prepared. WHO has developed a six-year strategy for health sector risk reduction and emergency preparedness that sets out the priority areas and key activities to be implemented by both WHO and Member States.

WHO will strengthen countries' emergency preparedness by:

Supporting Member States to build national emergency management systems and advocating for greater investment in emergency preparedness
WHO will help countries develop national emergency preparedness strategies, programmes and plans using a multisectoral, all-hazard, whole-health approach. WHO will work with Member States on incorporating risk reduction and emergency preparedness activities into all new Country Cooperation Strategies. WHO will apply statistics on health risks and success stories to build awareness and advocate for greater investment in preparedness at national and community levels.

Helping Member States establish/strengthen health emergency management units
WHO will advocate for the establishment of a dedicated risk reduction and emergency preparedness unit in each Ministry of Health, reporting directly to the highest relevant authority. This unit should work closely

with other departments in the MOH as well as with emergency preparedness departments in other ministries.

Facilitating a global system for health emergency preparedness and risk reduction
WHO will work with partners to form a strong network of actors to provide guidance on programme implementation and advocate for health risk reduction and emergency preparedness at global, national and community levels. The network will advise WHO on developing the field of health risk reduction and emergency preparedness, including technical guidance and training packages.

Supporting national programmes for conducting global surveys
Information on the status of emergency preparedness and risk reduction efforts in countries can be used as baseline data to measure the development of emergency preparedness capacities in countries at risk. Building on the first global survey of 2007, WHO will undertake a global survey every two years to assess country emergency preparedness and response capacity. The survey will provide valuable information to help national authorities plan and budget health emergency preparedness programmes. The findings will also be used as a catalyst for action and to advocate for additional resources to strengthen national and sub-national programmes.

Promoting safer hospitals in emergencies
WHO will establish a global health facility emergency risk management programme to support countries to establish and strengthen programmes aimed at building health facilities which are safe and ensuring health facilities and workers are prepared for emergencies. Demonstration projects, national assessments of the safety of health facilities, technical guidance, training packages and courses will be supported. WHO will convene a global conference in 2009 and subsequent years on this topic., WHO will support the "Hospitals Safe from Disasters" global campaign with ISDR and the World Bank and will implement World Health Day 2009 (Health Facilities in Emergencies) with partners to advocate for safe health facilities which can deliver health services in emergencies.

<table>
<tr><th colspan="2">Milestones</th></tr>
<tr><td>End 2009:</td><td>• 30 percent of Member States have national emergency plans that cover multiple hazards
• National health emergency preparedness programmes and units in countries at risk supported and strengthened by WHO activities
• 10 percent of countries have initiated safe hospitals programmes
• World Health Day 2009 and the World Disaster Reduction campaign focusing on health facilities in emergencies implemented</td></tr>
<tr><td>End 2013:</td><td>• 70 percent of Member States have national emergency plans that cover multiple hazards
• Health emergency management programmes in countries at risk are institutionalised
• Global system for health risk reduction and emergency preparedness established
• Sustained WHO programme on health facility emergency risk management results in 50 percent of countries with national hospital safety programmes
• All new Country Cooperation Strategies incorporate risk reduction and emergency preparedness programmes.</td></tr>
</table>

Support community-based best practices in emergency preparedness and risk reduction

At local level, much can be done to strengthen the response capacity of communities at risk and prevent and mitigate the effects of emergencies. Involving communities in the design of emergency preparedness and disaster-risk reduction programmes helps ensure they are tailored to the needs of the population. Moreover, participatory approaches take account of gender, cultural and other context-specific issues, and can empower local groups to take action.

WHO will strengthen community-based preparedness by:

- Working with partners to promote and support community-based action to integrate risk reduction and emergency preparedness into existing multi-sectoral community emergency management structures;
- Using risk, vulnerability and early warning assessments as the basis for selecting priority countries for support;

- Promoting the integration of health risk reduction and emergency preparedness into primary health care approaches at community level;
- Supporting the WHO Global Influenza Programme in strengthening community-based pandemic preparedness within the framework of an all-hazards approach at community level; and
- Establishing a health communication and social mobilization programme to build emergency preparedness in the community.

Milestones	
End 2009:	• Guidance and training packages for the integration of health emergency preparedness and primary health care developed • Training packages for community health workers on community preparedness using an all-hazards approach created
End 2013:	• Health sector fully integrated into community-based emergency risk management in countries most at risk • Health emergency preparedness and risk reduction established as a key element in the primary health care approach • Evaluation of programmes for health communication and social mobilization demonstrating that communities in countries most at risk are better prepared for health emergencies

Provide baseline information on health risks, health risk reduction and emergency preparedness

Information on the status of emergency preparedness and risk reduction efforts in countries can be used as baseline data to measure the development of emergency preparedness capacities in countries at risk. WHO will strengthen health information on emergency preparedness by:

Mapping and analysing countries' vulnerabilities and risks
WHO's vulnerability, risk analysis and mapping (VRAM) programme based in the WHO Mediterranean Centre for Health Risk Reduction in Tunis will be responsible for monitoring emergency preparedness in countries and collecting and analysing emergency preparedness data. The objective of VRAM is to help countries develop capacity to assess health risks (mortality, morbidity and disability) and incorporate the results in emergency and response preparedness planning. VRAM will provide the necessary baseline data for countries to make evidence-based decisions on emergency preparedness strategies and action plans, and will assist in the decision making process. The VRAM programme will provide pre-impact evidence-based information on health status and health services in countries that can be used: 1) to advocate for better emergency preparedness and contingency planning; 2) as a baseline for needs assessments during emergencies; and 3) as a baseline for monitoring the effectiveness of emergency operations.

As its knowledge base grows, VRAM's goal is to become a centre of excellence in assessing health-related vulnerabilities and risks as well as a technical platform whose expertise can be utilized effectively by various partners (governments, UN and research organizations, NGOs or others) at an affordable cost.

VRAM is building long-term collaborative relationships with government authorities and research institutions and universities both internationally and within targeted countries in order to:

- conduct and facilitate detailed assessments of potential hazards, associated health vulnerabilities, and emergency preparedness in countries most at risk;
- develop and share methods, protocols and tools for the collection, analysis and mapping of health hazards, vulnerability and risk information, taking climatic changes into account;
- develop tools for evidence-based decision-making;
- provide the necessary training and in-country capacity that will allow countries to implement the VRAM process;
- promote and propagate methodologies, lessons learnt and best practices in health risk assessments;

- create and maintain a network of institutions working in health hazard, vulnerability, capacity and risk assessment.

Milestones	
End 2009:	• Second global survey on emergency preparedness initiated • Vulnerability and risk assessment and mapping programme established and implemented in three target countries • Decision making analysis tool developed and applied to one target country
End 2013:	• Biennial global surveys of health emergency preparedness used by national authorities and other key actors to advocate for and build health emergency management capacities in countries • VRAM methodology accepted as the standard baseline data collection tool for vulnerability and risk analysis in high risk countries • All countries where EHA is active are mapped and assessed for risks and vulnerabilities • Decision analysis tool adopted in the preparedness planning process in countries at risk

Build emergency preparedness knowledge and skills through training, guidance, research and information services

Building capacity is one of WHO's four core functions. In 2009-2013 WHO will work with national health authorities and other partners to build knowledge and skills in risk reduction and emergency preparedness in the health sector.

WHO will do this by:

Developing guidelines, standards and technical information
WHO will develop, field-test, translate and disseminate emergency preparedness guidelines, norms, standards and educational materials. WHO will establish a programme which will address research, development and performance evaluation priorities in health emergency management. The outcomes of this research will feed into the development of technical guidance and improved operational performance of WHO and partners.

Developing health risk reduction and emergency preparedness capacity through training, enhanced south-south and inter-regional exchange, coaching and country-to-country peer reviews
WHO will support and facilitate the development and delivery of training programmes in health emergency management which are tailored to meet the health human resource development needs of regions, countries and communities. WHO has established a training centre at the WHO Mediterranean Centre for Health Risk Reduction (WMC) in Tunis, Tunisia. The WMC will develop training and educational materials, conduct training courses for WHO and its humanitarian partners, and develop social mobilization strategies to promote emergency preparedness. WHO will also facilitate enhanced south-south and region-region exchange of expertise and knowledge, as well as coaching and country to country peer reviews.

Establishing a web-based internet portal for health emergency management
WHO will establish a web-based internet portal to facilitate access to evidence-based information on emergency preparedness and response. The site will include guidelines, norms, standards, case studies, best practice, e-learning packages and other material for the health emergency management community. WHO will also maintain its "Health Library for Disasters" (HELID), which is available in CD ROM and on the Internet. The HELID contains more than 650 full-text documents on a wide range of subjects including safe hospitals, public health management guidelines, disaster mitigation, and technical guidelines on the different aspects of emergency response. HELID is available in a variety of languages.

Milestones	
End 2009:	• Guidance materials on people with disabilities and elderly persons in emergencies developed and converted into training packages • Training courses are conducted at global, regional and country levels • Prototype web-based internet portal is developed based on health emergency management community consultation • Health Library for Emergencies and Disasters updated
End 2013:	• All technical areas relevant to emergencies are covered by specific guidelines • Relevant units within WHO are actively involved in updating emergency-related guidelines, norms and standards • Training platform at WMC provides the central venue for emergency-related training courses, and is able to provide technical expertise for training courses elsewhere • Fully functioning web-based internet portal is used and supported by the health emergency management community as a premier source of knowledge and information for health emergency management • Research programme is developed and implemented by a network of institutions

Strengthen the Core Enabling Factors that Underpin WHO's Emergency Work

WHO will create conditions to improve performance, expand collaboration with partners, build partnerships and promote its humanitarian work through public relations and communications campaigns. Internally, it will foster a culture of change by advocating for gradual systemic improvements and administrative reforms and a shift towards a "one WHO" approach in which emergencies are everyone's business.

WHO will do this by:

Fostering collaboration
WHO will establish a better structured, more formal collaborating network with its partners. WHO will sign memoranda of understanding that set out pre-determined divisions of labour and modalities for exchanging information. This more formalized collaboration will include not only other UN agencies and NGOs but other WHO technical departments. These agreements are expected to clarify issues and remove possible roadblocks during joint humanitarian interventions.

Promoting a culture of change
HAC will facilitate, within WHO, promotion of a culture of change through external evaluations and internal reforms. WHO will also work on a career development, mentoring and rotation system for its humanitarian staff, highlighting the importance of field experience. The change process will be managed through gradual technical and administrative reforms. The emergency SOPs will be further developed. WHO’s newly-launched Global Management System (GSM) will improve overall accountability and monitoring of field operations, as all management and financial information will be instantly available at all three levels of the Organization. External impetus for change will be generated through evaluations and lessons learning exercises, joint monitoring missions and feedback from implementing partners. (See section 3.4.)

Enhancing visibility
WHO will include media and communications in its humanitarian training workshops, and will ensure that a media and communications specialist is deployed to the field for all major new crises. WHO will streamline the production of press releases, situation reports and resource mobilization documents, and will develop training materials for staff on how to write effective media material. WHO will also do more to promote its key functions in humanitarian matters, including its work as lead agency of the Health Cluster and its role as the UN health focal point for the food security crisis. Country offices will be encouraged to call bi-annual information and reporting meetings for local donor representatives and the international community on health issues.

Improving implementation in the field
WHO will improve delivery at field level through closer technical and administrative monitoring of field projects and improved reporting to donors. The GSM will be gradually rolled out in all WHO regions. It will allow staff in the RO and HQ to monitor field implementation as it happens, and identify and resolve problems at an early stage. WHO will emphasize the full cycle of project management – from project

development to donor reporting – in its humanitarian training courses and SOP workshops, and will develop training materials for field staff.

Increasing resource mobilization effectiveness

WHO will strengthen its resource mobilization efforts. WHO Representatives will receive training on the implications of the UN reform and will be introduced to various funding instruments such as pooled funding. WHO will consider seconding a staff member to the CERF Secretariat in New York (co-funded by OCHA).

Monitoring and evaluation

Monitoring and evaluation (M&E) is crucial for proper follow up and continuous improvement of programme activities. A systematic monitoring and evaluation of the degree of accomplishments of the Organization-wide expected results (OWERs) of the SO5 of the MTSP will be conducted yearly at global, regional and country levels and reported to Member States during the statutory meetings of the Governing Bodies of the Organization. The fundamental parameters will be the indicators contained in Annex 2. Specific monitoring and evaluation of the key activities of the two pillars of the institutional strengthening programme contained in this document will be carried out at regular intervals against the defined milestones A mixed quantitative and qualitative methodology will be implemented. Lastly, an annual report confirming or re-orienting programme activities will be produced for donors.

Milestones	
End 2009:	• Media and communications module included in at least two training courses • 15 Memoranda of Understanding signed with members of network or partners and other WHO clusters • SOPs developed to cater to new processes of GSM • WHO Common Operational Platform created, in partnership with HSE, for operational activities • Train EHA staff in CERF bid preparation • Joint monitoring missions to 2 crisis countries • Develop mechanisms to allow faster fund allocation processes, particularly at field level • Media and specialised news coverage of all new major crises.
End 2013:	• Rotation policy for humanitarian staff implemented • Mainstream emergency work into WHO programmes

Planned Expenditures and Required Resources

Current Funding Arrangements

Funds for WHO's emergency work can be separated into two distinct components. For specific crises, voluntary contributions come from several sources, including Appeals and grants from the CERF. The rest of WHO's work, including the Health Cluster and WHO's institutional capacity building programme, the core activities that underpin its humanitarian health work, is funded from both assessed and voluntary contributions (or donations). This second component is severely under-funded, and requires support from partners in order to reach required levels of capacity and readiness. WHO is appealing to donors to redress the funding imbalance between these two components by contributing flexible funding to the institutional strengthening programme presented in this document.

Planned Expenditures

WHO expects to receive more than US$200 million through appeals and CERF for specific operational humanitarian health activities at country level during the 2008-2009 biennium. However, as shown in the table below, WHO needs around US$67 million per year[12] to finance its core activities and carry out the institutional strengthening programme described in the previous pages.

Resources Required between 2009 and 2013

This five-year institutional strengthening programme needs the following annual investments:

Pillar 1 **Support to countries responding to or recovering from crises**		**Pillar 2** **Strengthening the health emergency management capacity of countries at risk**		**Strengthening the Enabling Factors**
Priority area	**Annual budget**	**Priority area**	**Annual budget**	
Build institutional capacity for improved response and recovery services to countries in crises	US$ 7.78 million	Improve capacity to support the development of national health risk reduction, emergency preparedness and response capacities in countries most at risk	US$5.285 million	US$5.455 million
Enhance surge capacity	US$ 15 million	Support community-based best practices in emergency preparedness and response	US$ 1.25 million	
Implement the Health Cluster approach in selected countries	US$ 26 million	Provide baseline information on health risks, health risk reduction and emergency preparedness	US$ 2.0 million	
		Build emergency preparedness knowledge and skills through training, guidance, research and information services	US$ 4.25 million	
Total	**US$48,783 million**		**US$12,785 million**	

Pillar 1 of the institutional strengthening programme is connected to OWERs 5.2, 5.3, 5.4, 5.5. It requires a level of investment of US$ 48,783 million per year across the Organization.
Pillar 2 of the institutional strengthening programme is connected to OWER5.1. It requires an investment of US$ 12.785 million per year across the Organization.
The enabling factors to support institutional strengthening programme are cross cutting, and for ease of demonstration and purposes of management can be considered as OWER5.6 per year of US$ 5.455 million. It must be noted that OWER 5.6 also contains much of the coordination and enabling of the Global Health Cluster

[12] This amount is expected to increase slightly in the next two biennia ($70 million per year for 2010-2011 and $73.5 million per year for 2012-2013).

Annexes

Annex 1: Final evaluation of the Three Year Programme to Enhance WHO's Performance in Crises

Recommendations and follow up action

Status as of August 2008

Recommendations to HAC and WHO Representatives in Countries		
Recommendation		**Status of Recommendation**
1	WHO at country level should streamline its currently all-inclusive definition of humanitarian action. Not all life-saving activities caused by chronic poverty or minor crises qualify for extraordinary measures and funding. Determining WHO's operational priorities should not be driven by the availability of humanitarian funding.	To achieve this goal, WHO needs reliable baseline data for each country. WHO has recently initiated a project to analyse and map vulnerabilities and risks in countries & communities most at risk (e.g. Ethiopia, Yemen, DR Congo, Uganda, etc.). The project complements and builds on the efforts of other partners, e.g. WFP's Vulnerability Analysis and Mapping project.
2	HAC and the WHO Representatives should continue their efforts to mobilize funding locally. However, they should avoid competing with other Health Cluster partners by limiting WHO's operational involvement to activities that cannot be done by other partners or for which it has a definite comparative advantage (last resort). In other words, WHO should mobilize resources for public health and not uniquely for WHO as an institution.	Resource mobilization is increasing at country level, particularly in countries with Common Humanitarian Funds (Sudan & DRC) & those eligible for CERF grants. Although WHO's emergency funding has increased, the WHO component of many appeals remains under-funded. Under the cluster approach, action plans and appeals for the health sector are increasingly developed jointly with health partners. This should improve the assignment of roles and responsibilities according to comparative advantages. WHO has developed mechanisms (ad-hoc agreements) to channel humanitarian funds to international or national NGOs and other relevant national institutions (e.g. schools of public health) and local authorities.
3	HAC should improve the analysis and interpretation of the data collected in the assessment of needs to identify gaps for action and to provide partners and donors with clear guidance for their decision-making.	Assessments cannot be analysed in the absence of baseline data. The latter will be available once the WHO/VAM project is up and running. A rapid assessment tool has been developed and endorsed by the Global Health Cluster and the Nutrition and Water, Sanitation and Hygiene clusters. The Health and Nutrition Tracking Service (HNTS) will track and monitor performance through the evolution of mortality/morbidity data. HNTS has already helped WHO and partners in humanitarian assessments in Pakistan and Kenya. The HNTS is currently assessing changes in mortality in Iraq and Darfur, and is developing a long-term analysis of humanitarian conditions in areas of return in northern Uganda.
4	The WHO Representatives and HAC should provide increased WHO support to capacity building in the ministries of health by mainstreaming, when appropriate, this component in all humanitarian proposals submitted to donors	WHO has developed a global strategy on emergency preparedness and risk management for the health sector, as well as a community capacity building strategy. It has also conducted a global survey on emergency preparedness and developed a work-plan. Attracting funding for capacity-building programmes continues to be a challenge.

5	The WHO Representatives and HAC should give the highest priority to the provision of sufficient administrative and logistic support as well as technical backup to the HAC experts at local level.	One of the main obstacles to WHO's work in crises is the lack of predictable funding to maintain core capacity at country, regional and HQ levels. Although the number of emergency staff at country level has increased thanks to TYP funding, it is still not enough. In its Humanitarian Action Plan 2008-2009 WHO is appealing for $83 million to cover core activities at all levels of the Organization. WHO is developing a rapid response platform through pre-deployment training and a roster of experts. Logistic capacities are being strengthened in collaboration with WFP and with NORAD/NOREPS. In April 2008 HAC held its first inter-regional consultation on WHO logistics for response operations.

Recommendations to the Regional Offices		
	Recommendation	**Status of recommendation**
6	Regional Offices that did not do so should include the post of HAC Regional Adviser under their Regular Budget.	This is the case in most of the Regional Offices.
7	Regional Directors should formally activate the Standard Operating Procedures in all ongoing crises in their region. In particular, they should decentralize international procurement of supplies and recruitment of consultants to the Country Offices with large chronic humanitarian crises.	WHO's emergency SOPs have been automatically activated for WHO's emergency operations, subject to certain criteria. Four SOP training workshops have been held in the African region (Burkina Faso, DRC, Gabon and Uganda). Regional offices for EUR, EMR and SEAR are planning to hold SOP training courses later in 2008.
8	Regional offices should explore the convenience of setting up a Regional Emergency Fund on the model of those established in AMRO and more recently in SEARO.	The Regional Office for the Eastern Mediterranean has an emergency fund approved by its Regional Committee and supported by Member States of the region. The Regional Office for Africa is taking steps in the same direction.
9	Regional offices should offer fixed-term contracts to a pre-established percentage of the national and international professionals presently employed on a temporary basis. International experts offered fixed-term contract should be regional and available for extended assignment in any country of the region to adjust to the changing needs and funding. The pre-established percentage should be based on a conservative estimate of the humanitarian funding anticipated in the coming biennium.	The difficulty in providing fixed-term contracts to emergency staff undoubtedly affected performance. Staff turnover is high and institutional memory is often lost. Most of the WHO's emergency funds are earmarked for specific crises and are time-limited (six months to one year). This makes it difficult to offer long-term contracts to all staff. Other agencies are able to do so thanks to flexible funding provided on a yearly/biennial basis by donors. WHO is appealing for $83 million in 2008-2009 to cover core activities and staff costs. So far only 15% of that amount has been obtained.
10	Regional offices should include capacity building for preparedness and mitigation as a standard activity in all relevant humanitarian projects. A fixed 10% is suggested.	The Global Health Cluster has developed an advocacy paper urging donors, agencies and countries to devote at least 10% of relief funds to building risk reduction and emergency preparedness programmes, especially in countries and communities most at risk.

Recommendations to Headquarters		
	Recommendation	**Status of recommendation**
11	HAC should continue mobilizing humanitarian resources but should devolve full authority (allotment) for implementation to the respective technical clusters and departments while retaining the responsibility for reporting to donors.	Humanitarian funding received against Flash Appeals or Consolidated Appeals is transferred to the relevant country (except for a percentage kept at HQ and RO to support the operation). The WHO Representative has full authority to spend the funds according to priorities. This includes involving technical departments at HQ and RO levels and technical experts present in the country.

12	Roles and responsibilities between the two WHO clusters with primary emergency capability, HAC and Health Security and Environment (HSE), should be better defined stressing the coordination and resource mobilization responsibility of HAC and the thematic specialization of HSE.	This has been addressed through the work of the Global Health Cluster. Six key technical areas (communicable diseases, public health and environment, nutrition, noncommunicable diseases, mental health, and maternal, neonatal and child health) have been identified as priorities in emergencies. Engagement and capacity building for these areas started in the second year of the TYP; these efforts are already yielding positive results.
13	HAC's Global Cluster coordination should focus on a more limited number of initiatives (guidelines and others) keeping in mind that the real challenge and investment are not compiling technical documents but ensuring their use in current practice.	Because of the dearth of common technical guidance across the board, WHO initially focused on a good many initiatives during the two first years of the collaborative effort. After 2008, there will be a major shift towards support to country health clusters.
14	HAC should intensify its effort to implement its risk reduction and preparedness strategy in support to the ministries of health in particular through the Safe Hospitals Awareness Campaign launched by the UNISDR.	The global campaign was launched in Davos and in several regions. Joint funding proposals have been developed and activities are being implemented. WHO is dedicating World Health Day 2009 to this theme. However, less than 10% of the WHO/ISDR joint proposal has been funded.
15	The WHO Director General should give necessary instructions for the immediate application of the Standard Operating Procedures for all humanitarian projects, including the necessary adjustments that may be required in the Global Management System.	Recommendation implemented in January 2008. Emergency SOPs are now automatically activated for all humanitarian operations, subject to certain criteria.
16	WHO should consider submitting for the Executive Board's approval a significant increase of HAC budget for the biennium 2010-2011 as well as the establishment of an Emergency Fund at the global level.	WHO's Global Policy Group has decided to keep WHO's budget for 2010-2011 at the same levels as 2008-2009. WHO is consulting Member States on the possibility of establishing a global Emergency Fund.
17	HAC should finalize without delay a proposal for securing flexible and predictable funding unearmarked to specific activities or work plans. Priority should be given for sustaining WHO's field and regional humanitarian presence in countries most vulnerable to disasters by increasing the proportion of fixed-term contracts.	WHO launched its *Humanitarian Action 2008-2009: Biennial Work Plan to Support WHO's Capacity for Work in Emergencies and Crises* at the end of 2007.. The document sets out WHO's planned activities at all levels of the organization in support of Strategic Objective Five. Funds received against the work plan are being allocated to priority countries/regions.
18	WHO should convene a Pledging Conference with donors to seek long-term follow-up funding to the TYP.	The WHO Humanitarian Forum was held on 11 June 2008.
19	WHO should give full authority to the new Assistant Director General in charge of HAC to reassign functions, change posts and incumbents in order to minimize duplications and competition within HAC and achieve efficient communication and cooperation between units or persons.	The Director-General has voiced her support for WHO's emergency work and for the new ADG on several occasions.

Recommendations to Donors		
	Recommendation	**Status of recommendation**
20	Donors should allocate immediate bridge funding for one year to permit the retention of the most critical humanitarian staff.	So far WHO has received flexible funding against the WHO Humanitarian Work Plan 2008-2009 from the UK, Italy, Spain, the European Commission, and Sweden. Denmark has also pledged its support. However, as of June 2008 less than 15% of the funds needed have been received.
21	Donors should consider a favourable and generous response to a five-year proposal to further strengthen WHO's overall humanitarian capacity provided: i.) WHO has effectively implemented the Standard Operating Procedures; ii.) The proposal is the result of a joint consultation between the two major emergency actors in WHO, HAC and HSE; iii.) The provision and retention of expertise	i) As mentioned above, the SOPs have been officially adopted and implemented. ii) In the process of developing the Mid-term Strategic Plan (MTSP), HAC has involved all main departments in its emergency work (HSE, FCH, NMH and HSS Clusters, and all regional offices. iii) WHO has identified, selected and trained staff trained through HAC and Global Health Cluster training events. Retaining such expertise implies availability of resources other than those earmarked for emergencies, i.e. a level

	directly available at field level is a priority.	of flexible funding that is not yet available in WHO.
22	Donors should provide this follow-up funding unearmarked or lightly earmarked. Annual instalments for institutional strengthening of WHO should not be linked to detailed work plans denying WHO the necessary flexibility and predictability.	

Annex 2: Organization-Wide Expected Results

Strategic Objective 5: to reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impact					
OWE R N°	**Description**	**Indicators**	**Baseline**	**Target**	
				By 2009	By 2013
5.1	Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.	• Proportion of Member States with national emergency plans that cover multiple hazards. • Number of Member States implementing programmes for reducing the vulnerability of health facilities to the effects of natural disasters (60% by 2013).	25% 20%	60% 40%	70% 60&
5.2	Norms and standards developed and capacity built to enable Member States to provide timely response to disasters associated with natural hazards and conflict-related crises.	• Operational platforms for surge capacity in place in regions and headquarters ready to be activated in acute-onset emergencies. • Number of global and regional training programmes on public health operations in emergency response.	50% 5	100% 16	100% 20
5.3	Norms and standards developed and capacity built to enable Member States to assess needs and for planning interventions during the transition and recovery phases of conflicts and disasters.	• Number of humanitarian action plans with a health component formulated for ongoing emergencies. • Number of countries in transition that have formulated a recovery strategy for health.	6 8	12 15	18 20
5.4	Coordinated technical support provided to Member States for communicable disease control in natural disasters and conflict situations.	• Proportion of acute natural disasters or conflicts where communicable disease control interventions have been implemented, including activation of early-warning systems and disease surveillance for emergencies.	60%	100%	100%
5.5	Support provided to Member States for strengthening national preparedness and for re-stabilizing alert and response mechanisms for food-safety and environmental health emergencies.	• Proportion of Member States with national plans for preparedness, and alert and response activities in respect to chemical, radiological and environmental health emergencies. • Number of Member States with focal points for the international Food Safety Authorities Network and for the environmental health emergencies network.	30% 50	60% 75	70% 100
5.6	Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international non governmental organizations, academic institutions and professional associations at the country, regional and global levels.	• Proportion of Member States affected by acute-onset emergencies and those with ongoing emergencies and a Humanitarian Coordinator in which the IASC Humanitarian Health Cluster is operational in line with IASC cluster standards. • Proportion of Member States with ongoing emergencies and a Humanitarian Coordinator having a sustainable WHO technical presence covering emergency preparedness, response and recovery.	30% 30%	60% 60%	100% 90%
5.7	Acute, ongoing and recovery operations implemented in a timely and effective manner.	• Proportion of acute-onset emergencies for which WHO mobilized coordinated national and international action. • Proportion of interventions for chronic emergencies implemented in accordance with humanitarian action plans' health components.	60%	80% 100%	100% 100%

Annex 3: Countries using the cluster approach

Countries with Humanitarian Coordinators	Cluster Approach	
	Formally implemented	To be implemented by end 2008
Afghanistan	●	
Burundi	●	
CAR	●	
Chad	●	
Colombia	●	
Cote d'Ivoire	●	
DRC	●	
Eritrea		●
Ethiopia	●	
Guinea	●	
Haiti	●	
Indonesia		●
Iraq	●	
Kenya	●	
Liberia	●	
Myanmar	●	
Nepal		●
Niger		●
OPT		●
Russian Federation	●	
Somalia	●	
Sri Lanka		●
Sudan		●
Tajikistan	●	
Timor-Leste		●
Uganda	●	
Zimbabwe	●	

IASC criteria for cluster countries:
countries with Humanitarian Coordinators and countries faced with acute-onset crises

Annex 4: Generic terms of reference for sector leads at the country level

The cluster approach operates at two levels. At the global level, the aim is to strengthen system-wide preparedness & technical capacity to respond to humanitarian emergencies by designating Global Cluster Leads & ensuring that there is predictable leadership & accountability in all the main sectors or areas of activity. At the country level, the aim is to ensure a more coherent & effective response by mobilizing groups of agencies, organizations & NGOs to respond in a strategic manner across all key sectors or areas of activity, each sector having a clearly designated lead, as agreed by the Humanitarian Coordinator & the Humanitarian Country Team. (To enhance predictability, where possible this should be in line with lead agency arrangements at global level.)

The Humanitarian Coordinator – with the support of OCHA – retains overall responsibility for ensuring the effectiveness of the humanitarian response and is accountable to the Emergency Relief Coordinator.

Sector leads at the country level are accountable to the Humanitarian Coordinator for facilitating a process at the sectoral level aimed at ensuring the following:

Inclusion of key humanitarian partners:
- Identify key humanitarian partners for the sector, respecting their respective mandates and programme priorities

Establishment and maintenance of appropriate humanitarian coordination mechanisms:
- Ensure appropriate coordination with all humanitarian partners (including national and international NGOs, the International Red Cross/Red Crescent Movement, IOM and other international organizations), through establishment/maintenance of appropriate sectoral coordination mechanisms, including working groups at the national and, if necessary, local level;
- Secure commitments from humanitarian partners in responding to needs and filling gaps, ensuring an appropriate distribution of responsibilities within the sectoral group, with clearly defined focal points for specific issues where necessary;
- Ensure the complementarity of different humanitarian actors' actions;
- Promote emergency response actions while at the same time considering the need for early recovery planning as well as prevention and risk reduction concerns;
- Ensure effective links with other sectoral groups;
- Represent the interests of the sectoral group in discussions with the Humanitarian Coordinator and other stakeholders on prioritization, resource mobilization and advocacy;

Coordination with national/local authorities, State institutions, local civil society & other relevant actors
- Ensure that humanitarian responses build on local capacities;
- Ensure appropriate links with national and local authorities, State institutions, local civil society and other relevant actors (e.g. peacekeeping forces) and ensure appropriate coordination and information exchange with them.

Participatory and community-based approaches
- Ensure utilization of participatory and community based approaches in sectoral needs assessment, analysis, planning, monitoring and response.

Attention to priority cross-cutting issues
- Ensure integration of agreed priority cross-cutting issues in sectoral needs assessment, analysis, planning, monitoring and response (e.g. age, diversity, environment, gender, HIV/AIDS and human rights); contribute to the development of appropriate strategies to address these issues; ensure gender-sensitive programming and promote gender equality; ensure that the needs, contributions and capacities of women and girls as well as men and boys are addressed;

Needs assessment and analysis:
- Ensure effective and coherent sectoral needs assessment and analysis, involving all relevant partners

Emergency preparedness
- Ensure adequate contingency planning and preparedness for new emergencies;

Planning and strategy development:
Ensure predictable action within the sectoral group for the following:
- Identification of gaps;
- Developing/updating agreed response strategies and action plans for the sector and ensuring these are adequately reflected in overall country strategies such as the Common Humanitarian Action Plan;
- Drawing lessons learned from past activities and revising strategies accordingly;
- Developing an exit, or transition, strategy for the sectoral group.

Application of standards:
- Ensure that sectoral group participants are aware of relevant policy guidelines, technical standards and relevant commitments that the Government has undertaken under international human rights law;
- Ensure that responses are in line with existing policy guidance, technical standards, and relevant Government human rights legal obligations.

Monitoring and reporting:

- Ensure adequate monitoring mechanisms are in place to review impact of the sectoral working group and progress against implementation plans;
- Ensure adequate reporting and effective information sharing (with OCHA support), with due regard for age and sex disaggregation.

Annex 5: Budget tables

Table 1 below shows the resources required by OWER and by region.

Resources required for WHO's institutional strengthening in SO5: 2009-2013 (Thousands US$)						
Budget centre	**2009**	**2010**	**2011**	**2012**	**2013**	**Totals**
AFRO	18 155	19 063	19 063	20 016	20 016	96 313
AMRO	8 465	8 889	8 889	9 333	9 333	44 909
EMRO	4 044	4 246	4 247	4 459	4 459	21 455
EURO	6 650	6 983	6 983	7 332	7 332	35 280
SEARO	6 859	7 202	7 202	7 562	7 562	36 387
WPRO	2 814	2 954	2 955	3 102	3 103	14 928
HQ	20 036	21 038	21 038	22 089	22 090	106 291
Totals	**67 023**	**70 375**	**70 377**	**73 893**	**73 895**	**355 563**

Table 2 below shows the total resources required by OWER.

Resources required for WHO's institutional strengthening in SO5: 2009-2013 (Thousands US$)						
OWER	**2009**	**2010**	**2011**	**2012**	**2013**	**Totals**
5.1	12 785	13 424	13 425	14 095	14 096	67 825
5.2	18 565	19 494	19 494	20 468	20 469	98 490
5.3	15 519	16 295	16 296	17 110	17 111	82 331
5.4	8 360	8 778	8 778	9 217	9 217	44 350
5.5	6 339	6 656	6 657	6 989	6 990	33 631
5.6	5 455	5 727	5 728	6 014	6 014	28 938
Totals	**67 023**	**70 374**	**70 378**	**73 893**	**73 897**	**355 565**

Annex 6: Stakeholder analysis

The following analysis assesses the influence and attitudes of stakeholders involved in the entire strategy. Separate analyses will be developed for the different components of disaster preparedness and humanitarian response. The analysis covers both internal and external stakeholders. Listing them in two separate groups is for the purpose of readability and navigation only.

Assessment of impact is based on the following 3 criteria:

- What is the importance of the role the key stakeholder must play for the strategy to be successful?
- What is the likelihood the stakeholder will play this role?
- What would be the impact of a stakeholder's negative response to the strategy?

A = extremely important/likely
B = fairly important/likely
C = not very important/likely

Stakeholder/ Stakeholder Group	Stakeholder Interests in Strategy	Assess-ment of Impact	Potential Strategies for Obtaining Support or Reducing Obstacles
WHO Director-General	Overall commitment to humanitarian response & accountability for WHO	AAA	Keep informed and engaged
HQ technical depts with key humanitarian activities	Interested and affected by success of strategy	AAA	Implicate closely in strategy roll-out
HQ technical depts with potential for involvement	Interested but lack incentive or lacks interest	BBC	Try to win over with a reasonable effort
Administration	Weary of "emergency" way of work	ABA	Consult and involve deeply; keep informed about needs
Regional Directors	Political accountability vis-à-vis member states & DG	BBA	Keep informed and satisfied
DPMs and DRDs	Accountability for technical decisions vis-à-vis RD	ABA	Consult & involve deeply; keep informed on strategy developments
RO technical depts with key humanitarian activities	Interested and affected by success of strategy	AAA	Implicate closely in strategy roll-out
RO technical depts with potential for involvement	Interested but lack incentive or interest	BBC	Try to win over with a reasonable effort
WHO Representatives (WRs) in "preparedness" countries	Interest extremely variable & depends on individual experiences of WR.	ABB	Implicate and brief closely & provide support to actions
WRs in "response" countries with established health sector coordination	Interest variable and depends on individual experiences of the WR	ABA	Invest strongly (briefing support influencing etc) to win over
WRs in "response" countries without established health sector coordination	Interest extremely variable and depends on individual experiences of the WR	ABB	Assess reasons for lack of coordi-nation and make cost/ benefit analysis before investing. Esca-late extreme cases where feasible
Field-level technical staff	Highly interested and most strongly impacted by success of strategy	AAA	Heavily invest in supporting work & improve working conditions & career perspective
Other UN Agencies/IOs (or their emergency programmes)	Various degrees of potential for intra-/cross-cluster collaboration	AAA	Heavily invest in relations cross-fertilisation & joint initiatives
International NGOs active in areas that provide entry points for "preparedness" activities	Different levels of awareness and willingness to incorporate WHO advice and to collaborate	BBB	Assess reasons for non-involvement & make cost/benefit analysis before investing in long-term partnerships
International humanitarian response NGOs	Awareness & different degrees of willingness to engage in health sector coordination	ABA	Invest strongly (briefing support influencing etc) to win over. Possibly share responsibilities.

Stakeholder/ Stakeholder Group	Stakeholder Interests in Strategy	Assess-ment of Impact	Potential Strategies for Obtaining Support or Reducing Obstacles
Preparedness “fora” (e.g. ISDR IASC working groups)	Key vehicle for exchange of information and shaping of policies	AAA	Heavily invest in work of these fora and exchange of information/joint action with its members
Response “fora” (e.g. Global Health Cluster IASC working groups)	Key vehicle for exchange of information and shaping of policies	BAB	Maintain strong collaboration/joint action but prioritize energy in country-level collaboration
National/local “preparedness” NGOs	Interested to various degrees in financial/technical support and collaboration	AAA	Strongly invest to provide adapted guidance and predictable support. Foster long-term partnerships
National/local “response” NGOs	Interested to various degrees in financial/technical support and collaboration	AAA	Strongly invest into integration of NGOs in coordination mechanisms and provide incentives for collaboration
Governments & officials in “preparedness” countries	Interested to various degrees based on personal experience and expectations	ABA	Targeted advocacy and information efforts combined with incentives (study tours) etc. where advisable
Governments & officials in “response” countries	Various degrees of interest depending on political constellations and on pre-established trust in WHO	ABA	Strong investment to ensure full implication & ownership in coordination. Under certain conditions distance to government may be required to
International media	Degree of interest will depend on information that WHO has to offer	BBB	Maintain close relations to inform the public about efforts and provide visibility to WHO & partners
Local/national media	Interest in good information/ news stories	BAB	Establish relationships for win-win situation for media & health sector actors and ensures a constant flow of information to local stakeholders
Donors with an existing interest in health sector capacity building	Maintain support while the strategy produces satisfactory results to build upon earlier investments	AAA	Involve them deeply in strategy development implementation process & joint monitoring and evaluation Report regularly
Donors with a history of financing WHO emergency response or preparedness activities	Attitude varies from hesitant to hostile. Possible limitations due to aid policies	ABA	Strong investment in advocacy and lobbying. Visits to capitals where necessary & use of “friends of…” approach to share experience
Donor without previous funding support	Attitude varies from ignorant to hesitant to hostile. Possible limitations due to aid policies	ACA	Strong investment in advocacy and lobbying. Visits to capitals where necessary and use of “friends of…” approach to share experience
Direct beneficiaries of preparedness activities	Support may vary depending on measures	ABA	Critical to obtain ownership and understanding of issues. Strong investment required
Direct beneficiaries of “response” activities	Role varies depending on circumstances	BAA	Cultural sensitivity and respect and good levels of information need to be maintained

Annex 7: SWOT analysis

The following SWOT analysis addresses the strategy's two objectives. This analysis will influence the design of interventions proposed under the strategy in order to use internal **S**trengths; stop internal **W**eaknesses; exploit external **O**pportunities; and defend against external **T**hreats.

***Pillar 1**:* **Improve WHO's institutional capacity to implement its response and recovery work ensuring the cluster approach is applied whenever and wherever feasible**

	Helpful **(to achieving the objective)**	**Harmful** **(to achieving the objective)**
Internal Origin **(attributes of the organization)**	**Strengths** • WHO unique mandate & normative role • Positive "momentum" from precursor programs (TYP Cluster Appeal) • Commitment by Member States and senior management • Privileged access to & long-standing collaboration with national counterparts • Standard operating procedures facilitating emergency response • Access to world-wide network of public health expertise • Capacity to attract staff of a high calibre • WHO's continuing presence (before during and after crises) in almost 200 countries worldwide	**Weaknesses** • Often weak presence/ capacity at field level • Weakness in targeting scarce resources to priority activities/ comparative advantages • Tendency to follow funding opportunities based on lack of financial resources • Close relationship with MoH can be a weakness under certain circumstances • Engagement of WRs depends on personal experience & is not yet predictable • Unstable contractual situation causes high levels of unnecessary stress and loss of motivation • Challenges to get optimal use from existing rosters & stockpiles • Health Cluster guidance mainly a HQ product at this stage & requires country-level roll-out • Lack of a solid pre-financing mechanism
External Origin **(attributes of the environment)**	**Opportunities** • Recurrent media attention through humanitarian crises • Humanitarian reform environment & momentum conducive to collaboration and partnerships • Opportunities for win-win partnership with WFP around HRDs • Highly specialized and operational NGOs active in health sector humanitarian response	**Threats** • WHO's functions of assessment coordination & capacity building are taken for granted but funding mainly goes to life-saving "gap-filling" activities • Consequence: financial imbalance and • Verbal commitment to joint work not always accompanied by joint action

Pillar 2**:Improve WHO's institutional capacity to strengthen health emergency management capacity in countries most at risk.**

	Helpful **(to achieving the objective)**	**Harmful** **(to achieving the objective)**
Internal Origin **(attributes of the organization)**	**Strengths** • WHO Regional and Country Office support for strengthening country emergency management capacity and predictability. • WHO unique mandate & normative role to take this task forward • Commitment by member states (through WHA Resolutions) • Established country presence and access national counterparts • Increased emergency preparedness capacities at HQ and Regional Office levels • Access to technical expertise across WHO • Possibilities for visibility and creation of momentum around World Health Day 2009	**Weaknesses** • Still unsatisfactory exchange of information on emergency preparedness activities / learning material • Already stretched human resources (particularly at field level and regions) encounter difficulties dedicating time to preparedness while faced with disaster response • Incomplete information on the levels of preparedness of member states and difficulties of compiling reliable evidence

External Origin (attributes of the environment)	Opportunities	Threats
	• Targeting countries most at risk long before they get hit by a crisis and hence improving the predictability and efficiency of humanitarian action. • Integration of risk reduction in recovery and reconstruction programmes • Involvement in strong partnerships (ISDR system) • Integration of health in Hyogo Framework for Action • Mobilisation of stakeholders around “safe hospitals” theme and health risk reduction • Building of health sector preparedness based on the momentum of Health Cluster principles is possible in selected locations • Climate change: risk reduction and emergency preparedness as an adaptation mechanism • Less country reliance on humanitarian aid for management events	• Continued lack of financial support for risk reduction and emergency preparedness activities • Competition for attention of government counterparts at country level by other topics • Lack of visibility of successful preparedness activities (media attracted by crises) • Tendency of approaching preparedness through a specialized vertical technical approach rather than though multi-hazard multi-sectoral approach • Health sector is not as yet fully integrated into disaster risk reduction forums

Acronyms and Abbreviations

DG	Director-General
DRD	Deputy Regional Director
GHC	Global Health Cluster
GSM	Global Management System
HAC	Health Action in Crises Cluster headquarters
HCC	Health Cluster Coordinator
HELID	Health Library for Disasters
HNTS	Health and Nutrition Tracking Service
HRD	Humanitarian Response Depot
IASC	Inter-Agency Standing Committee
MoH	Ministry of Health
MTSP	Medium-Term Strategic Plan
OWER	Organization-Wide Expected Result
RD	Regional Director
RO	Regional Office
SHOC	Strategic Health Operations Centre
SO5	Strategic Objective five
SOP	Standard Operating Procedure
SWOT	Strengths Weaknesses Opportunities Threats
TYP	Three-Year Programme to Enhance WHO's Performance in Crises
VRAM	Vulnerability Risk Assessment and Mapping
WFP	World Food Programme
WHA	World Health Assembly
WMC	WHO Mediterranean Centre
WR	WHO Representative