WHO - Health Action in Crises
Current status and strategic directions

A presentation to the HAC Forum by
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Each year, one in five WHO Member States experiences a crisis that endangers the health of its people. The year 2005 was marked by several high-profile natural disasters that are still, months later, influencing the life of millions in Pakistan, the Gulf of Mexico and elsewhere. According to the United Nations International Strategy for Disaster Reduction (UN/ISDR), 2005 saw an 18% rise in natural disasters affecting an estimated 160 million people - seven million more than in 2004.

In addition, almost 20 major armed conflicts continue to disrupt countries throughout the world. A series of political and social crises resulted in almost 25 million internally displaced people and more than 9 million refugees worldwide.

For each major emergency that is reported by the international media, there are dozens of smaller crises that strike local communities and wreak havoc on the development and the health of their populations, with no or little external assistance for relief and recovery operations. Investing in capacity-building at community level for emergency preparedness and response is the only sustainable answer to redress this situation.

Major complex emergencies also tend to fall into neglect as soon as the media spotlight fades away. This translates into shortages of humanitarian funds to sustain vital relief and recovery operations.

Recovering from the disastrous effects of major and complex crises takes much longer than commonly supposed. Their impact on health services and on the health status of populations persists for years.

Lessons learned from recent crises

Experience in 2005 indicates that to respond effectively to any disaster, preparedness is essential. National capacity building for risk management and vulnerability reduction requires a) updated policies and legislation, b) appropriate structures, c) information, d) plans and procedures, e) resources and f) partnerships.
Immediate availability of up-to-date and credible information on health risks, vulnerability, morbidity, mortality and other health indicators is essential to assess and monitor developments in emergency settings as well as evaluate the impact of actions taken.

Evaluations of the Cluster approach implemented as part of the recent UN humanitarian reform, with WHO as the lead Agency for health, have been positive. The cluster approach is common sense. It is consistent with WHO mandate for health coordination and its implementation has been successful in the South Asia Earthquake. However, it requires additional efforts in management and institutional capacity building.

Health sector involvement in emergency and humanitarian action should be comprehensive. Better response is needed in a wide range of areas including, in addition to communicable disease control, mass casualty management, water and sanitation, nutrition, noncommunicable diseases, maternal and new born health, mental health, health information services, and management of health infrastructure. To address the gaps in future emergencies, much work will be needed through technical guidance and leadership and better coordination between the various clusters.

Although templates for rapid health assessment protocols are widely available, they are often forgotten in the flurry of crisis management. Consensus on which protocols to use in the field needs to be reached at the onset of the crisis.

The private sector and the military are frequently involved in disaster response operations. Given the appropriate role, the value of their cooperation is clear. Collaboration may be more difficult when working on foreign soil. It is important to agree on procedures and criteria for collaboration, including joint efforts.

Another potentially technical/operational gap highlighted by WHO field experience in 2005 concerns the medical aspects of the management of malnutrition, including issues of access and quality of care. Closer coordination and joint work is needed between the health, water and sanitation and nutrition clusters.

Experience in recent crises has confirmed that although disasters increase the vulnerability of women, children and adolescent girls, limited attention is paid to their needs in the early relief and restoration work. Collecting data disaggregated by sex, assessing the impact of all response activities on women and men, and fielding female aid workers are proven crucial measures to address these issues. Special efforts need to be made to provide adequate supplies and technical backup for reproductive health, emergency obstetrics care, newborn and child health services at the onset of any emergency intervention.

The experience of 2005 confirmed the importance of using local expertise to find local solutions. It is the local people that have in-depth knowledge of how systems are organized in their region. If local experts are trained to international standards, they will form a valuable resource for their region well after the disaster is over, providing long-term support.

It is important to find the right people with the right skills for the job immediately after a disaster: the faster the response, the better the outcome. Identifying and mobilizing hundreds of experts in a matter of hours is not easy: therefore, it is important to have a roster of appropriately trained experts on call.

**The imperatives of the UN Humanitarian Reform for health**

The main components of the humanitarian reform are: strengthened coordination through the Cluster system at global and country level, an improved central emergency response fund, and a strengthened Humanitarian Coordinator system. These reforms have major implications for the work of WHO at national, regional and global levels. Their implementation will require considerable adjustment in both the normative and operational capacities of the organization. Action is being taken to address these challenges.
The Health Cluster was set up in June 2005 with participation of UN and non-UN agencies, with WHO as the lead agency. In November 2005, the Health Cluster developed a joint action plan to strengthen health response during crises. At the global level, the Health Cluster aims to improve health system-wide preparedness and technical capacity to respond to humanitarian emergencies. At the country level, the aim is to strengthen the health coordination framework and ensure a more effective response. In March 2006, the Health Cluster met again in Geneva to agree on critical areas of coordinated action encompassing assessments of the health and nutritional situation in emergencies, training and capacity building, and advocacy. The members of the Health Cluster agreed to simplify the plan of action of their cluster that was included in the OCHA Consolidated Appeal for 2006. They also recommended to the Cluster Lead i.e., WHO, raise the concern of the lack of funding to the Health Cluster Appeal with the humanitarian donors.

The recent mandates from the World Health Assembly in the field of health action in crises

World Health Assembly resolution 58.1 calls on WHO to intensify its support to Member States affected by crises and disasters in the field of preparedness, response and recovery. WHO has been called on to enhance its capacity to implement health-related emergency preparedness plans, cooperate with the International Strategy for Disaster Reduction, and prepare for disasters and crises through timely and reliable assessments. WHO is also requested to enhance its capacity to respond to the critical health needs of people in crises, mobilize WHO health expertise for response operations, conduct timely and reliable assessments and strengthen its logistics services. In countries recovering from crises, WHO has been asked to enhance its capacity to plan and implement rehabilitation programmes and sustainable recovery, and develop models and guidelines for rapid health impact assessments after crises.

WHO emergency work will be discussed again during the fifty-ninth World Health Assembly in May 2006.

Action taken by the Secretariat: scaling up to the challenges

In order to address the growing challenges in this area of work and to implement the mandate issued by the 58th World Health Assembly, the Secretariat is introducing several changes across the three levels of the Organization for improving WHO performance in emergency preparedness and response.

In autumn 2005, the Department of Health Action in Crises at headquarters was reorganized around three main pillars of work (emergency preparedness, response, and transition and recovery programmes) in order to better respond to the needs of Member States.

- The Emergency Preparedness and Capacity Building Group is responsible for developing emergency preparedness strategies, programmes and partnerships with Member States and internal and external partners. The group is also responsible for training programmes and for developing systems, tools and capacities to improve performance.

- The Emergency Response and Operations Group is responsible for developing WHO operational and logistics capacity in support of countries during acute crises, as well as for developing standard operating procedures for emergencies in order to ensure a uniform approach of WHO to crises that demand an immediate response.

- The Recovery and Transition Programmes Group is responsible for developing, updating and disseminating methodologies, tools and standards for post-conflict and post-emergency recovery and transition programmes. The group also assists Member
States with the assessment, design, implementation, monitoring and evaluation of recovery and transition programmes in countries.

Based on World Health Assembly resolutions, the United Nations humanitarian reform and the lessons learned from recent emergencies and crises, WHO emergency work will focus during the coming years on the following:

- Technical assistance for the development of country emergency preparedness and response programmes, based on two main criteria (an All-Hazard focus with multisectoral approaches and multidisciplinary programmes with strong coordination and control mechanisms among health actors (public, private and nongovernmental organizations).
- The development of international standards in various technical areas including health emergency planning, legislation, risk mitigation and management approaches, human resource development, and partnership building.
- Close coordination and synergy with other UN agencies and programmes as well as other international humanitarian actors.
- Building on the expertise available in other WHO technical programmes in order to address the needs of communities and populations affected by crises. In other words, WHO will build on its strengths and comparative advantages and make them available to its Member States and other international health partners.

The following major initiatives have been launched:

- A strategy on the promotion of country emergency preparedness and response capacities is in the final stage of preparation. It is built on the outcome of an international consultation on this subject organized by WHO in February 2006. The strategy will provide a road map for WHO work in this area for the years to come.
- A global survey on the status of emergency preparedness at country and community levels has been developed for an initial phase of pilot testing. The survey protocol is meant as a tool for member states to assess the level of their emergency preparedness and response programmes in order to build on existing strengths and overcome weaknesses. It includes a chapter that assesses how best WHO and international health partners can help countries improve their preparedness and response capabilities.
- A partnership programme with the department of Violence and Injury Prevention to formulate guidelines, approaches and best practices to structure mass casualty management systems and develop the necessary manpower, tools and procedures for their efficient implementation at local level.
- The Three-Year Programme to Enhance WHO Performance in Crises began its second year of implementation in November 2005. The programme focuses on building WHO institutional capacity at field level. Since the beginning of the project sixty field staff have been recruited, briefed extensively on the goals of the TYP, and assigned to countries of strategic interest, mainly in the African region. Their performance is monitored and assessed by a WHO inter-regional team.
- The IASC Health Cluster approach, implemented in Pakistan under the leadership of WHO, has been evaluated by WHO and its donors as well as independently.
- WHO has launched, in partnership with other international health actors, a human resource development project (HEAR-NET). A pilot course was successfully implemented in November 2005. The project is now being adjusted to cater for country and regional needs. At least four more training courses are planned in 2006/2007.
Currently, mortality and morbidity statistics in emergency and crisis situations are heavily fragmented, poorly comparable, and lack standardization. Recent experience with the Tsunami, Darfur and other crises has placed the issue of mortality and morbidity tracking together with the quality criteria and the formulation of an explicit data audit trail, at the centre of concern for humanitarian actors. There is a pressing need for a credible and impartial Health and Nutrition Tracking Service measuring mortality, morbidity, nutritional indicators and health performance in emergencies and crisis settings. Based on consultations within WHO and with international health partners, a project proposal for a common health tracking service has been developed. A meeting of the key agencies involved, conducted at WHO on 25 April 2006, recommended the formation of a task group representing the main agencies and representatives of NGOs in the health and nutrition clusters to finalize the project proposal for submission to the next meeting of the IASC Working Group meeting which will be held in Geneva in July 2006.

Logistics, communication and other operational tools are the backbone of relief operations, especially in complex emergencies. Recent experiences have shown several weaknesses in emergency health sector operations. Investing in these tools is expensive and time consuming. Therefore WHO has engaged in discussions with partner UN agencies and programmes in order to build on existing systems that can best serve the purpose of health sector humanitarian actions.

Predictable funding for emergency health operation is a major challenge. Although the newly restructured United Nations Central Emergency Revolving Fund will help address this challenge, some Member States have proposed the establishment of a global Emergency Fund in WHO. At the regional level, the Eastern Mediterranean Regional Committee decided in 2005 to create a regional emergency solidarity fund supported by voluntary contributions from Member States of the Eastern Mediterranean.

WHO is organizing a global consultation on health aspects in transition and recovery situations and WHO role within the framework of the humanitarian reform and the core mandate of the Organization. Methodologies and tools for health action in transitional and recovery phases will be developed. This comprises work in the areas of needs analysis for the formulation of consolidated appeals, post-conflict needs assessment and planning and the preparation of master plans for sectoral recovery and reconstruction after disasters and conflicts.

Emphasis will be placed on inter-agency collaboration and partnerships for the transition and recovery phases of health action in crises, particularly joint work with the UNDG-ECHA Working Group, the World Bank and Regional Development Banks.