WHO Health Emergencies Programme (WEP)

Global Health Cluster Partner Meeting
23-24 June 2016, Geneva
Recent Developments

World Health Assembly (WHA)

Inter Agency Standing Committee (IASC)

UN General Assembly
WHA adopts new Health Emergencies Programme

“…..to deliver rapid, predictable, and comprehensive support to countries and communities as they prepare for, face or recover from emergencies caused by any type of hazard….”
“To help Member States build their capacity to manage health emergency risks and, when national capacities are overwhelmed, to lead and coordinate the international health response to contain outbreaks and to provide effective relief and recovery to affected populations”
5 major principles underpin the WHO Health Emergencies Programme

| Single approach for all emergencies (outbreaks, disasters, etc) | Standardized across all 3 levels & all 7 major offices | Leverage & facilitate UN, partners & disaster mgmt systems | Optimize WHO political access & technical expertise | Operate across the emergency management cycle |

SOURCE: Advisory Group report, Executive Board paper, independent assessment reports
The new Programme expands the role of the WHO in emergencies

a UN technical
specialized Agency

+ an operational
Agency
Scope: WHO manages infectious risks & takes an all hazards approach to response within the Int'l Emergency Architecture.
WHO's Major Roles in Health Emergency Risk Management

Infectious Hazard Management

Member State Preparedness & IHR

Risk Assessment & Health Emergency Info/Data

Emergency Operations

- Emergency Management & Support (acute & protracted)
- Operational Partners & WHO Readiness
- Operations Support & Logistics

Dedicated Core Services
The new WHO Emergencies Programme

- One workforce
- One workplan & budget
- One line of accountability
- One set of processes
- One admin. system

2 x staff; highly mobile; high-vulnerability countries & Regions

Single integrated plan across all 7 major offices

Director-General to ExD & Regional Directors

Risk Assessment, Grading, Incident Management

Contingency Emergency Fund, Rapid Deployment Processes
Functions & structure of the new Programme follow the scope and cover all phases of the Emergency Management cycle.

Org Structure – same structure at HQ, RO, and CO

Health Emergencies Programme

Infectious Hazard Management
- High Threat Pathogens
- Experts Networks & Interventions
- PIP Secretariat

Country Health Emergency Preparedness & IHR
- Core Capacity Assessment, Monitoring & Evaluation
- National Action Plans & Core Capacity Building
- IHR Secretariat

Health Emergency Information & Risk Assessment
- Detection, Verification & Risk Assessment
- Health Ops Monitoring & Data Collection
- Data Management, Analytics & Products

Emergency Operations
- Emergency Management & Support
- Operational Partners & WHO Readiness
- Operations Support & Logistics

Core services
- Management & Administration
- External Relations

Prevention ➔ Preparedness ➔ Response and early recovery

Emergency management cycle
One Programme

Organizational Structure - Overview

HQ/Central
- Infectious Hazard Management
- Country Health Emergency Preparedness & IHR
- Health Emergency Info & Risk Assessment
- Emergency Operations

Regional Hubs (6)
- Infectious Hazard Management
- Country Health Emergency Preparedness
- Health Emergency Info & Risk Assessment
- Emergency Operations
- Core Services

Event sites
- Country Health Emergency Preparedness
- Health Em. Info & Risk Assessment
- Emergency Operations

High vulnerability Sites (dedicated programme staff)
- Country Health Emergency Preparedness
- Health Em. Info & Risk Assessment
- Emergency Operations

All Sites (in Country Office workplan)
- Country Health Emergency Preparedness
- Health Em. Info & Risk Assessment
- Emergency Operations

1 Management & Administration, Comms, Advocacy and Resource Mobilization
The new Health Emergencies Programme core budget: $494M, representing a $160M increase from previously approved budget.

* Core budget does not include WHO Contingency Fund for Emergencies and health operations in protracted/acute emergencies in OCR.
Priority, critical gaps to address in 2016-17

Functional priorities
- Joint External Evaluations for Preparedness
- Risk Assessment Capacity
- Emergency Operations capacity

Geographic priorities
- Regional Offices, particularly AFRO and EMRO
- Health Cluster Countries
- Countries with acute emergencies

65% of budget increase

75% of budget increase
WHO health emergency operations capacity will reflect the burden of protracted crises and highly vulnerable countries\(^1\)

**Priority Level** (focus on 1 & 2 in 2016-17)

1. **10 health cluster countries with highest targeted population by health partners**

2. **Other health cluster countries**

3. **High vulnerability countries\(^1\) and countries with HRP**

4. **High vulnerability countries for high threat pathogens\(^2\) (tbd)**

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1. High vulnerability = countries with an INFORM index >5
Distribution of resources at Regional level reflects preparedness and response workloads
2016-17 biennium, FTEs

40% of the initial additional investment at regional level is in AFRO and 27% in EMRO

<table>
<thead>
<tr>
<th>Region</th>
<th># of Member States</th>
<th># of Health Clusters</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFRO (incl ISTs)</td>
<td>47</td>
<td>9</td>
</tr>
<tr>
<td>EMRO</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>EURO</td>
<td>53</td>
<td>2</td>
</tr>
<tr>
<td>SEARO</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>WPRO</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>AMRO</td>
<td>35</td>
<td>1</td>
</tr>
</tbody>
</table>

Existing staff
Additional

- AFRO: 75 existing staff, 16 additional, total 91
- EMRO: 52 existing staff, 20 additional, total 66
- EURO: 21 existing staff, 15 additional, total 36
- SEARO: 19 existing staff, 12 additional, total 31
- WPRO: 31 existing staff, 22 additional, total 43
- AMRO: 20 existing staff, 25 additional, total 45
IASC Decisions (7 June)

1. Use IASC/OCHA mechanisms to coordinate response to large-scale infectious emergencies (in addition to natural disasters and conflicts)

2. Within IASC, WHO & Director-General will have unique role as IHR secretariat & technical lead

3. New IASC SoPs for infectious emergencies by Sept 2016 (grading, leadership, coordination, etc)
Key, near-term milestones following the WHA

07 Jun: Inter Agency Standing Committee (IASC) & OCHA

21 Jun: UN General Assembly on health security/new Programme

22 Jun: Financing dialogue for new Emergency Programme

30 Jun: WHO Regional Committee papers (new Programme)

1 Jul: operating target for new Programme:

- Senior Management Team appointed (HQ & Regional Offices)
- new emergency processes (risk assess, grading, IMS) published pending 2nd ed. of WHO Emergency Response Framework (ERF)
- key staff/units realigned to new ‘functional reporting lines’
- new Results Framework, structure & positions in HQ and ROs established in GSM

4-5 Jul: Independent Oversight & Advisory Committee
The WHO Health Emergencies Programme’s mission

“To help Member States build their capacity to manage health emergency risks and, when national capacities are overwhelmed, to lead and coordinate the international health response to contain outbreaks and to provide effective relief and recovery to affected populations”

SOURCE: EB 138/55
Extra slides
Alignment of IHR & IASC processes in the new WHO Programme

1 UNISDR definition: a dangerous phenomenon, substance, human activity or condition that may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption, or environmental damage.

2 IHR definition: manifestation of disease or an occurrence that creates a potential for disease.

3 IASC definition: a situation threatening the lives and well-being of a large number of people or a very large percentage of a population and often requiring substantial multi-sectoral assistance.
**Major principles:**

- Standard processes across WHO for all hazards
- On-site assessment initiated w/i 72 hours for (a) high threat pathogens (b) unexplained clusters of deaths in risk countries (c) events at DG discretion
- Assessments & gradings to DG within 24 hrs
**One set of accountabilities**

*Division of responsibilities*

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td><strong>Director-General</strong></td>
<td>- Ultimate authority for WHO’s work in emergencies</td>
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<tr>
<td><strong>Executive Director</strong></td>
<td>- Technical standards &amp; oversight</td>
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<td></td>
<td>- Strategic &amp; operational planning</td>
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<td>- Budget &amp; staff planning</td>
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<td>- Risk &amp; performance monitoring</td>
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<td>- Management of major crises/outbreaks</td>
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<tr>
<td><strong>Regional Directors</strong></td>
<td>- Enforcement of standards</td>
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<td></td>
<td>- Implementation of organizational readiness &amp; Member States preparedness</td>
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<td>- Government relations</td>
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<td>- Day-to-day management</td>
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<td>- Core administrative support</td>
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<td>- Management of local crises/outbreaks</td>
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*GPG Statement, 30 March 2016, para 10; WHA paper A69/30*
### Priority countries for additional WHO capacity

<table>
<thead>
<tr>
<th>Priority</th>
<th>Criteria</th>
<th># of countries</th>
<th>Minimum core staff target (FTEs)</th>
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<tbody>
<tr>
<td>1</td>
<td>10 health cluster countries with highest targeted population by health partners</td>
<td>10</td>
<td><strong>10 staff/country</strong> on average, up to:</td>
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<td></td>
<td></td>
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<td>- 1 HC coordinator</td>
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<td>- 1 Infectious Hazard Management</td>
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<td>- 1 Preparedness</td>
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<td>- 1 Health information &amp; risk assessment</td>
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<td>- 3 EmOps</td>
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<td></td>
<td>- 2 Core services (M&amp;A, EXR)</td>
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<td>- 1 G-staff</td>
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<tr>
<td>2</td>
<td>Other health cluster countries</td>
<td>14</td>
<td><strong>6 staff/country</strong> on average, up to:</td>
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<td></td>
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<td>- 1 HC coordinator</td>
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<td>- 1 Preparedness</td>
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<td>- 1 Health information &amp; risk assessment</td>
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<td>- 2 EmOps</td>
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<td></td>
<td>- 0.5 Core services (M&amp;A)</td>
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<td></td>
<td>- 0.5 G-staff</td>
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<tr>
<td>3</td>
<td>Other high vulnerability countries¹ and countries with HRP</td>
<td>13</td>
<td><strong>4 staff/country</strong> on average, up to:</td>
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<td>- 1 Preparedness</td>
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<td>- 1 Health information &amp; risk assessment</td>
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<td>- 0.5 Core services (M&amp;A)</td>
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<td>- 0.5 G-staff</td>
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<tr>
<td>4</td>
<td>Countries at risk for emergency of high threat pathogens² (tbc)</td>
<td>43</td>
<td><strong>2 staff/country</strong> on average, up to:</td>
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<td></td>
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<td>- 1 Preparedness and WHO readiness</td>
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<td>- 1 Health information &amp; risk assessment</td>
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</tbody>
</table>
Accountabilities – Emergency Programme Staff at RO & WCO levels

**Accountability to Regional Director**

- Implementation of organizational readiness & Member States preparedness
- Government relations
- Day-to-day management
- Core administrative support
- Management of local crises/outbreaks

**Accountability to WEP Executive Director**

- Technical oversight & standards
- Strategic & operational planning
- Budget & staff planning
- Risk & performance monitoring
- Management of major crises/outbreaks

**Accountability to WHO Representative**

- Implementation of organizational readiness & Member States preparedness
- Government relations
- Day-to-day management
- Core administrative support

**Accountability to WEP Regional Emergency Director**

- Technical oversight & standards
- Strategic & operational planning
- Budget & staff planning
- Risk & performance monitoring
- Emergency management activities (through Incident Management System)

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1 ExD is responsible for the development of the Programme budget and staff plan in consultation with Regional Directors, senior staff, and relevant WHO Representatives
2 Operating under delegated authority from the RD

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*For graded crises, an IMS will be set up in line with the delegation of authority*