Draft

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# Managing WHO Humanitarian Response in the Field

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The editors alone are responsible for the views expressed in this publication.

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## About this handbook

### Its purpose

This handbook provides guidance for WHO Representatives (WR), Country Office staff and consultants in assessing and managing the response to health needs during humanitarian crises. These are key elements of WHO action in relation to Strategic Objective 5: *to reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact*.

The Handbook replaces the 1999 *Handbook for Emergency Field Operations* (EHA/FIELD/99.1). It complements and cross-references the WHO-HAC *Standard Operating Procedures* (SOPs), existing *technical guidance* on specific health-related interventions in emergencies, and the guidance expected from the *Global Health Cluster*. It focuses on management, defining the role and responsibilities of a WR and country office and providing the overall planning and management framework within which decisions have to be taken.

It provides comprehensive guidance for what to do in case of a major disaster or humanitarian crisis. The majority of natural disasters do not require such an intense or prolonged level of engagement by the international community but, in all cases, the WR (or head of the WHO country office) has specific responsibilities in relation to staff safety, information and analysis, coordination, determining what assistance (if any) might be needed from WHO and ensuring the efficient delivery of that assistance. The principal responsibilities are summarized in the panel on the next page.

### Its structure

The handbook is structured in three parts. Part I (chapters 1 and 2) outlines the framework for WHO emergency response. *All* staff and consultants involved in an emergency operation *must* be familiar with the basics summarized in Part I.

Part II (chapters 3 to 11) provides guidance on planning and managing the WHO response. In Part II, the chapters provide specific management guidance on what to do, when and why.

The annexes (numbered 1, 2, etc.) in Part III provide additional information.

Supplementary annexes (numbered A1, A2, B1, etc.) providing more detail, cross-cutting material, and selected tools are included on the CD-ROM that accompanies the Handbook together with other documents that are cross-referenced, including the standard operating procedures (SOPs) for WHO humanitarian action.

## Acronyms and abbreviations

| | |
|---|---|
| AO | Administrative Officer (WCO) |
| CAP | consolidated appeal process (sometimes also “consolidated appeal”) |
| CERF | Central Emergency Response Fund (managed by OCHA) |
| CFSA | Chief Field Security Adviser (UNDSS) |
| CHAP | common humanitarian action plan (component of a CAP) |
| DO | Designated Official (for UN security, at country level) |
| EHA | Emergency and Humanitarian Action (WHO) |
| EMT | Emergency Management Team |
| FSA | Field Security Adviser (UNDSS) |
| FSCO | Field Security Coordination Officer (assigned by UNDSS to the Designated Official) |
| FSO | Field Security Officer (assigned by WHO or any individual UN agency) |
| HAC | Humanitarian Action in Crises (WHO) |
| HC | (UN/IASC) Humanitarian Coordinator |
| HCC | Health Cluster Coordinator |
| HeLiD | Health Library for Disasters (CD-ROM produced by PAHO and WHO) |
| IASC | Inter-Agency Standing Committee (for humanitarian action) |
| ICP | inter-country programme (WHO) |
| ICT | Information and communications technology |
| IHR | International Health Regulations |
| MOSS | Minimum operating security standards |
| MoH | Ministry of Health |
| NAF | needs analysis framework (used in a preparing a CHAP) |
| NGO | non-governmental organization |
| OCHA | U.N. Office for the Coordination of Humanitarian Affairs |
| PMR | project management, monitoring and reporting |
| PSC | programme support costs |
| RC | UN resident coordinator |
| RD | Regional Director (WHO) |
| RO | regional office (WHO) |
| sitrep | situation report (usually sent by email) |
| STP | short-term professional (WHO contract) |
| TOR | terms of reference |
| UNCT | UN country team |
| UNDP | UN Development Programme |
| UNDSS | UN Department for Staff Security |
| UNICEF | United Nations Children’s Fund |
| WASH | water, sanitation and hygiene |
| WCO | WHO country office |
| WFP | World Food Programme |
| WHO | World Health Organization |
| WR | WHO representative |

# Aide-mémoire for a WHO Representative (or head of country office) leading WHO humanitarian response

This aide-mémoire includes a brief synthesis of the principal responsibilities of the WR/head of country office in responding to an emergency and provides a format that can be used when assigning emergency-related responsibilities within the WCO.

The WR/head of country office and assigned staff must also be aware of the objectives, key functions and principles outlined in Chapter 1, and the response planning and management processes in Chapter 2, and refer to the relevant sections in Part II of this handbook, and to the other references provided there, for detailed guidance.

It may be particularly useful, at the onset of a crisis, to also refer to Annex 2 *Effects of and responses to different types of disasters*.

## Principal responsibilities of the WR/ head of country office

| Principal responsibilities | Action in all cases | *Additional* action in case of a major disaster or humanitarian crisis |
|---|---|---|
| Ensuring staff safety and security<br>*Section 10.1* | Checking the whereabouts and safety of all staff and consultants.<br>Ensuring that security plans exist, are adequate and known to everyone. | Ensuring minimum operating security standards (MOSS) compliance if in UN security phase 1 or above.<br>Requesting and budgeting for field security officer (FSO) support, if needed.<br>Briefing *all* UN FSOs on health action priorities. |
| Determining the scale of the emergency and whether WHO assistance may be required<br>*Chapter 3* | Contacting the MoH, UNRC, other UN agencies and NGOs to get information on the scale of the emergency and what others are doing.<br>Making a judgement concerning the need for WHO assistance and the role to be played by WHO. | Consulting immediately with RO and HQ-HAC |
| Ensuring office functioning and effective operational capacity<br>*Section 4.1*<br>*Chapter 10* | Ensuring that admin. and other office support systems continue to function.<br>Re-deploying staff temporarily to emergency-related tasks.<br>Requesting operational support from the RO, if needed. | Reorganizing the office, establishing an Emergency Management Team and operations room, defining responsibilities and lines of reporting, etc.<br>Requesting the emergency delegation of authority from the RD, and staff and consultant support from RO and HQ.<br>Ensuring adequate arrangements for information management, admin., finance, procurement, telecommunications, etc.<br>Monitoring the performance of operational support functions. |
| Ensuring adequate assessments, effective surveillance and good information management<br>*Chapter 5* | Ensuring that WHO (the WCO) collaborates with and assists the MoH and other partners as necessary in undertaking field assessments and establishing arrangements for health information management including the sharing and dissemination of information. | Taking the lead, with MoH and other Clusters, in organizing an initial rapid assessment and more detailed follow-up health assessments.<br>Ensuring monitoring/surveillance of the situation.<br>Ensuring information management both within the WCO and for the health sector. |

| Principal responsibilities | Action in all cases | *Additional* action in case of a major disaster or humanitarian crisis |
|---|---|---|
| Facilitating coordination *Chapter 9* | Collaborating in UNCT and related inter-agency coordination processes<br>Assisting MoH in assuring the coordination of international health assistance | Leading the country-level Health Custer or sector group in most cases. Assuring:<br>• coordinated assessments and information management;<br>• coordinated planning and the identification and filling of gaps:<br>Providing leadership to international health actors. |
| Helping to develop overall objectives and a health sector response plan *Section 4.2* | Assisting MoH, as required. | Taking the lead, with MoH and other partners (in the context of the Health Cluster or other sector group) in defining and getting agreement on overall objectives, specific strategies, and a health sector response plan. |
| Developing and overseeing the implementation of a WHO action plan *Chapter 6* | Developing a WHO action plan and priority project proposals<br>Reprogramming resources, if appropriate<br>Assigning responsibilities for managing, monitoring and reporting on implementation | Preparing applications for CERF funds.<br>Contributing to a flash appeal.<br>Contributing to consolidated appeals.<br>Re-deploying/recruiting staff for project implementation and management. |
| Ensuring that gaps in health service provision are identified and filled, to the extent possible *Section 4.4* | Helping to identify gaps and encouraging the MoH and others to fill them.<br>Using WHO resources to fill priority gaps that correspond to WHO's particular competences. | Taking the lead (in the context of the Health Cluster or other sector group) in identifying and prioritizing gaps.<br>Doing everything possible to mobilize resources from donors to enable other actors or WHO to fill priority gaps. |
| Promoting the (re-)building of the health system and capacities | Using WHO's influence to encourage all health actors (especially international agencies) to design their emergency activities to contribute to the re-building of the health system and capacities on a sustainable basis. | Working through the Health Cluster or other sector group to try to ensure that emergency assistance re-builds rather than undermines the health system and capacities.<br>Advising the MoH, health actors and donors concerning the most appropriate strategies for assistance. |
| Evaluating and learning lessons *Section 11.2* | Contributing to any health sector evaluation. Assisting the MoH in organizing an appropriate evaluation or lessons exercise. | Arranging for the systematic debriefing of staff and consultants before they leave at the end of emergency assignments.<br>Taking the initiative (in the context of the Health Cluster or other sector group and in consultation with the MoH and donors) to organize evaluations of overall health action and/or lessons exercises.<br>Collaborating with the RO and HQ in organizing the evaluation of WHO action. |

## Format for allocating responsibilities for specific functions within the WCO

| Activity (corresponding handbook section in brackets) | Responsible staff member | Reporting to… |
|---|---|---|
| **Determining whether – and what kind of – WHO response may be needed** | | |
| Preliminary contacts and actions (3.1) | | |
| Preliminary assessment/enquiries (3.2) | | |
| Establishing an initial working scenario (3.3) | | |
| Organizing or participating in assessments (5.2) | | |
| Making a judgement on the need for and nature of WHO action (3.4) | | |
| **Leading and enabling the WHO response** | | |
| Organizing the office; building a team (4.1) | | |
| Equipping the WCO for information management (4.2) | | |
| Accessing and mobilizing resources (4.3) | | |
| **Assuring health information, assessment, situation analysis and monitoring** | | |
| Ensuring good health information management (5.1) | | |
| Organizing – and ensuring the quality of – assessments (5.2) | | |
| Assuring surveillance of the situation (5.3) | | |
| Analysing the situation (5.4) | | |
| **Defining objectives and preparing an action plan** | | |
| Defining objectives (6.1) | | |
| Selecting response strategies (6.2) | | |
| Protecting and rebuilding national systems and capacity (6.3) | | |
| Defining priority projects and preparing a WHO action plan ((6.4) | | |
| **Planning and managing WHO projects** | | |
| Preparing project proposals (7.1) | | |

| Activity (corresponding handbook section in brackets) | Responsible staff member | Reporting to… |
|---|---|---|
| Identifying and working with partners (7.2) | | |
| Preparing CERF applications (7.3) | | |
| Providing inputs to UN appeals (7.4) | | |
| Managing (and monitoring) project implementation (7.5) | | |
| **Assuring effective communications** | | |
| Managing internal communications (8.1) | | |
| Internal reporting (8.2) | | |
| Managing internal communications (8.3) | | |
| Producing a health (cluster/sector) bulletin (8.4) | | |
| **Promoting coordinated health action and best practices** | | |
| Facilitating coordination (9.1) | | |
| Providing guidance and support to health sector actors (9.2) | | |
| **Planning and managing WHO programme support activities** | | |
| Assuring security (10.1) | | |
| Managing human resources (10.2) | | |
| Mobilizing/recruiting national staff for field operations (10.3) | | |
| Assuring admin. services (10.4) | | |
| Assuring finance services (10.5) | | |
| Procuring supplies (10.6) | | |
| Assuring in-country transport & storage of supplies (10.7) | | |
| Assuring ICT services (data systems & telecoms) (10.8) | | |

# 1
# Objectives, key functions and principles

This chapter provides brief aide-mémoire on the objectives and role of WHO in an emergency, WHO's key functions in the provision of support and services, and its role in relation to the Health Cluster that is established at country level to ensure an effective response through coordinated actions such as joint assessments, planning, gap filling, monitoring, etc. among all health actors. The first three sections thus provide the basic framework within which WHO responds to humanitarian emergencies. The last section summarizes the overall guiding principles for that response including the criteria for WHO emergency assistance.

These "fundamentals" must be understood and respected by all involved in decision-making, planning, implementing, monitoring or evaluating WHO humanitarian response.

# 1.1 WHO objectives, role and core functions in humanitarian response

## Overall objectives – goals

Human survival and healthy livelihoods are the ultimate goals and the true measures of success of humanitarian assistance. Within humanitarian assistance, the specific objectives of health interventions are:

- to reduce the risk of excess, avoidable mortality, morbidity and disability that could result from the disaster/crisis; *and*
- to restore the delivery of and access to preventive and curative health care as quickly as possible and in a sustainable manner.

## Role of WHO

The role of WHO in a humanitarian emergency is to:

- provide ***technical advice and guidance*** and, where needed, ***material support*** to national health authorities, when present, and to other health partners, in assessing the situation and needs and in planning, implementing and evaluating measures to (i) provide medical care and protect the health and safety of the affected population, and (ii) (re-)rebuild the health system and capacities; *and*
- provide ***leadership*** to the international community in relation to health and facilitate ***coordination*** of international health assistance and the coordination of that assistance with national efforts.

This includes ensuring, to the extent possible, that humanitarian and recovery activities in the health sector and closely related sectors (such as nutrition and water, sanitation and household/community hygiene) are appropriate and sufficient in terms of quality, coverage and accessibility.

There are thus two distinct but overlapping aspects:

(i) working with relevant national authorities, often as leader of the IASC country-level *Health Cluster* or an equivalent sector coordination group, to try to ensure that the overall – national and international – health sector response is appropriate, coordinated, effective and in line with the principles outlined in section 1.2; *and*

(ii) planning and implementing specific WHO emergency projects and activities within the framework of a coordinated humanitarian response.

The WR and other WHO staff must be careful to distinguish these two roles and fulfil each separately in a manner that assures partners that there is no conflict of interests.

In addition to leadership and technical guidance, WHO support may include the provision of essential ***supplies***, ***equipment***, ***training*** and ***services*** (including related logistic support) when needed to address serious, immediate threats to public health and the required assistance is not assured from other sources. WHO may take direct responsibility for specific ***operational activities***, when necessary (e.g. when specifically requested by the government or in areas where there is no functioning government).

For further details, see 🕮 WHA46.6 7 and 🕮 WHO manual XV, 4 (accessible via SOP 1.1).

See also: Annex 3 *Criteria for WHO emergency response*

## Core functions

Panel 1-1 summarizes the core functions of WHO in humanitarian response – what is expected of WHO. For each function, WHO is expected to provide leadership and technical guidance so that: (i) all health actors are aware of relevant international standards and best practices in emergency health (including IHR requirements), and (ii) the strategies adopted to address current needs and risks are appropriate.

Typically, this involves:

- providing information to MoH and all other health actors on international standards and regulations (including the IHR);
- providing technical advice and guidance on best practices to MoH and all other health actors in relation to current and potential health problems and service provision; *and*
- working with MoH and all other health actors to (i) agree on the most appropriate strategies to address current problems and risks, and (ii) develop an overall health sector response plan.

Panel 1-1

**Core WHO functions in emergencies**

| Function | Benchmarks (desired situation) | Some typical WHO activities (examples) |
|---|---|---|
| Ensuring the best possible **information, analysis** and **understanding** | ☑ Health needs, system delivery capacity and operational constraints known; information consolidated & displayed in a manner that facilitates consensus and decisions<br>☑ Priority health threats and system's critical capacities monitored regularly with possibility of early warning | → Promoting collaboration among all partners in assessments & situation monitoring.<br>→ Participating in assessments; initiating & organizing assessments when necessary.<br>→ Ensuring informed analysis of data and evidence-based conclusions.<br>→ Acting to ensure that data are verified, where necessary, and that gaps in information are filled.<br>→ Ensuring regular, adequate monitoring of the health situation and risks for health and health services.<br>→ Ensuring evaluations of health-sector response and lessons-learning exercises. |
| Facilitating **coordination** | ☑ Organized space and time for all health partners to discuss issues, decide actions to take and assign responsibilities; mechanisms for follow up, evaluation<br>☑ Work in all other sectors geared to the survival, health and sustainable livelihoods of the population | → Supporting existing mechanisms for coordinating international health assistance; providing effective leadership to the health cluster/sector coordination group, when designated as lead, including assuring information on who is doing what, where.<br>→ Ensuring agreement on overall objectives, priorities and a health sector response plan.<br>→ Ensuring the preparation and dissemination of regular health bulletins.<br>→ Contributing effectively to the work of other public-health-related clusters/sector-groups.<br>→ Working through formal mechanisms and informally to promote effective information exchange and, to the extent possible, joint strategies and action plans among all health actors. |
| Acting to **fill gaps in health service provision** | ☑ Life-threatening conditions prevented or promptly addressed, with CFR maintained within international standards<br>☑ Appropriate means applied to improve equitable access to health care in a sustainable way and according to international standards | → Identifying and prioritizing gaps in services or geographic coverage.<br>→ Working with MoH, other agencies and donors to try to ensure that priority gaps are filled.<br>→ Preparing and mobilizing resources for projects to fill priority gaps for which WHO has particular competence or that are unlikely to be filled by other actors. |
| Helping to (re-) build **systems & capacity** | ☑ National health partners fully integrated in, and supportive of, the delivery of humanitarian assistance<br>☑ International health partners effectively complementing national efforts | → Ensuring thorough analysis of the impact on national health systems and capacities (MoH and non-government).<br>→ Identifying weaknesses in and opportunities to reinforce existing systems and capacities.<br>→ Working with MoH and other health actors to ensure that humanitarian interventions contribute to (re-) building sustainable national systems and capacities, wherever possible.<br>→ Preparing and mobilizing resources for projects to (re-) build sustainable national systems and capacities. |

Ensuring the best possible ***information, analysis and understanding***, and facilitating ***coordination*** are specific *tasks* that must be fulfilled by WHO (see chapters 5 and 9). In some cases they may require special resources and projects to assure relevant activities. In other cases they may be fulfilled by limited support to MoH from existing WCO staff. Good information is a pre-requisite for facilitating coordination and the corner stone of appropriate response to humanitarian needs – see sections 4.2 and 5.1.

***Filling gaps*** is a *basic principle* for decisions on any WHO action. The WHO action plan and individual WHO projects should aim to fill critical gaps unfilled by others in the response plan for emergency health sector action – see section 6.4.

Helping to ***(re-) build systems & capacity*** is an *underlying principle* for the development of the overall response plan for health sector action (see section 6.3), the selection of strategies (see section 6.2), the design and implementation of individual WHO project proposals (see section 7.1), and the guidance to be given to other health actors for the design of their interventions (see section 9.2).

The framework within which WHO fulfils these core functions depends on whether Clusters are established and WHO is designated as country Health Cluster Lead (see section 1.3), but the responsibility is more-or-less the same in all cases. The core functions – particularly the first three – have also been identified as key functions for a country health cluster and WHO will work through the cluster to ensure that they are fulfilled to the maximum extent possible. Where there is no formal health cluster, WHO will work directly with the MoH and other health actors and through whatever sector group might exist.

Section 2.3 outlines the internal WHO/WCO planning and management functions that are essential to support activities to fulfil the four core functions listed above.

## 1.2 Overall guiding principles for WHO humanitarian response

This section summarizes the principles that guide all decisions on the design and implementation of WHO humanitarian action. The criteria for WHO emergency assistance are in Annex 3.

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### General humanitarian principles

Humanitarian assistance is provided on the basis of ***assessed needs*** and the principles of:

- ✓ ***humanity***: preventing and alleviating human suffering; protecting and respecting the life, health and dignity of each individual;
- ✓ ***neutrality***: not taking sides in a conflict; providing aid solely to non-combatants; *and*
- ✓ ***impartiality***: not discriminating on the basis of ethnic origin, gender, nationality, political opinions, race or religion; relief is guided solely by needs.

WHO respects, and expects its staff and NGO partners to respect, the *Code of Conduct of the International Red Cross and Red Crescent Movement and NGOs in disaster relief*, which has been adopted by many major NGOs (see *Humanitarian charter and minimum standards in disaster relief*, Sphere Project 2004, in HeLiD).

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### Specific humanitarian health action principles

WHO endeavours to ensure that its assistance (and that of other international health actors):

- ✓ is planned and implemented in the context of a coherent and carefully prioritized overall ***emergency health strategy*** that is adapted to local conditions and up-dated as conditions change and new information becomes available;
- ✓ focuses on the ***principal causes (and risks) of mortality and morbidity*** among the affected populations;
- ✓ reaches the largest possible number of ***people at risk***;
- ✓ promotes ***equity in access to health care*** for all population sub-groups;
- ✓ promotes and supports ***recovery*** from the earliest possible moment, ***reinforcing and rebuilding local health systems and capacities***, including the capacities of communities, in a ***sustainable*** manner; *and*
- ✓ promotes health-sector ***preparedness*** and ***risk and vulnerability reduction***, whenever possible.

In case of a complex emergency or a situation of collective violence, WHO advocates for the respect and ***protection of health personnel and infrastructure***, and promotes ***peace*** through health action.

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### Specific humanitarian health programme management principles

WHO programmes are planned and managed in the context of a coherent and carefully prioritized overall ***emergency health strategy*** that is adapted to local conditions and updated as conditions change and new information becomes available.

WHO seeks to ensure ***transparency*** and ***accountability*** in all its operations.

In applying these principles, WHO takes and advocates:

- ✓ ***a long-term perspective*** while ensuring that immediate problems are addressed and short-term needs are met. This includes ensuring that:
  - o national and local health authorities direct all health sector actions wherever feasible and are supported in that role; *and*
  - o health systems are reinforced and rebuilt as necessary. Alternative, parallel systems are established only as a last resort when necessary to save lives.
- ✓ ***a population-based approach*** to ensuring health security of affected populations:

- Populations at particular risk of poor health outcomes must be identified and the degree to which their needs are being anticipated and met must be monitored. It is not sufficient to make assumptions about vulnerability (e.g. that all women and children are *de facto* vulnerable);
- Clear evidence-based identification and enumeration of beneficiary populations and target groups is needed, as well as systematic monitoring of standard health and nutrition indicators including indicators of maternal-, non-communicable-, injury-, disability-, child-, adolescent-, elderly- and psychosocial- health status; *and*
- Communities and local institutions are involved as much as possible in assessment, planning and evaluation processes.

WHO works in ***partnership*** with other UN agencies, national and international NGOs, and other national entities to enhance the effectiveness of its own interventions and that of the overall humanitarian operation.

WHO's actions are planned and carried out in ***coordination*** with those of other health partners in the framework of established UN and inter-agency arrangements. (These include including the humanitarian coordinator, resident coordinator, UN country team, OCHA and UNDAC teams, flash appeals and consolidated appeals.)

## 1.3 The role of WHO in relation to country-level "Clusters"

In a major emergency, coordination of international health action will often be assured through a country-level health "cluster" and WHO is expected to lead that cluster in most cases.

The cluster approach is described in Annex 7. It is a mechanism for improving international humanitarian response by ensuring greater *predictability*, *accountability* and *partnership*. The IASC has agreed that this should be the framework for response in all ***major new*** emergencies and that it should eventually be applied in all ***complex*** or ***slow-onset*** emergencies where a Humanitarian Coordinator (HC) has been appointed.

Health is one of 11 sectors for which clusters have been established at the global level and WHO is leader of the Global Health Cluster. In most cases, WHO will also be designated as leader of the country-level health cluster and be a member of other clusters such as the nutrition and water and sanitation clusters. WHO must always be ready to fulfil these responsibilities. The HC or Resident Coordinator in consultation with the government and other IASC member agencies will decide which clusters to activate and may combine clusters: health might, for instance, be combined with nutrition and/or water and sanitation. Clusters may also be established at sub-national level, in the localities most affected by the emergency, led by the agency/ies that has/have the necessary capacity in each zone.

The responsibilities that WHO assumes as country cluster lead are summarized in Panel 1-1. Details are in Annex F1. Many of these responsibilities are similar to those that WHO is expected to carry out in promoting health-sector coordination in any emergency. The key difference is that under the cluster approach, the lead agencies are formally accountable to the HC/RC for the performance of their clusters. There are also some additional responsibilities including information management, addressing cross-cutting issues, and doing everything possible to ensure that gaps in humanitarian assistance provision are filled (referred to as "provider of last resort", see Panel 1-3).

Panel 1-2

**Responsibilities of WHO as country cluster lead**

When designated as leader of the country health cluster, WHO is accountable to the Humanitarian Coordinator for ensuring the effectiveness of the humanitarian health response. The responsibilities involved include

- ensuring that key humanitarian health partners are included in the cluster and establishing effective coordination mechanisms;
- ensuring that the cluster works closely with the Ministry of Health and other relevant national and local stakeholders in order to support national authorities in their response to the emergency;
- ensuring that rapid and comprehensive needs assessments are undertaken;
- identifying and addressing gaps in provision;
- ensuring the cross-cutting issues are addressed;
- ensuring inter-cluster coordination;
- developing joint plans to respond to identified needs;
- resource mobilization and advocacy; *and*
- acting as provider of last resort (see Panel 1-4).

***When a health cluster is formed and WHO is designated as the Cluster Lead:***

☑ WHO assigns a Health Cluster Coordinator (HCC) – see Panel 1-3 – and establishes a budget for core Cluster activities.

☑ The HCC takes immediate steps to set up the health cluster and ensure that all key health actors are involved.

☑ WHO liaises with the MOH to ensure that they are consulted and involved, and to make clear the role of the cluster in working in support of national authorities in responding to the emergency.

The WR as representative of the cluster lead agency, is accountable to the HC for the satisfactory fulfilment of the cluster lead responsibilities, provides general over-sight and guidance to the HCC, monitors the work of the cluster, and may participate in cluster meetings representing WHO, while also managing the WHO country office and programme.

***If a health cluster is formed and another organization is designated as country Cluster Lead at country or sub-country level***:

☑ WHO – the WR and WCO – will provide all possible support to that organization and the appointed HCC and will, in particular, help to ensure an effective, appropriate working relationship with the MoH.

***Whether WHO is Cluster Lead or not***:

☑ WHO will identify needs for WHO assistance and plan its own programme activities in the context of the Cluster, to the maximum extent possible consistent with its own mandate and objectives as outlined in section 1.1 and the referenced WHA resolutions.

☑ WHO will designate staff with appropriate competencies to participate – represent WHO – in the *other clusters* relevant to public health (e.g. water/sanitation/hygiene, nutrition and shelter).

***Where there are no formal cluster arrangements***:

☑ WHO will carry out much the same role, supporting the MoH as necessary in coordinating international health action, convening and managing (often jointly chairing) regular coordination meetings with international and national organizations active in the health sector and in activities that affect public health (notably water supplies, sanitation and nutrition).

N.B. In ***refugee*** situations, UNHCR appoints health and nutrition coordinators and WHO provides technical support and short-term assistance to UNHCR and the government on request – see the WHO-UNHCR memorandum of understanding summarized in Annex F8.

**Panel 1-3**

**Appointment by WHO of a Health Cluster Coordinator (HCC)**

When WHO is Cluster Lead, an individual with substantial operational emergency experience and the necessary analytical, coordination and facilitation skills must be assigned as health cluster field coordinator (HCC). The HCC may be an existing WHO staff member, a consultant or a secondee from another institution. For the standard TOR for an HCC, see the *Health Cluster Guide*, Global Health Cluster, expected 2008.

- Being a health cluster coordinator in a major emergency is usually a ***full-time*** job. It requires a dedicated individual/post. The individual assigned as HCC should not have responsibility for any part of WHO's own programme or operations.
- In certain circumstances it may be necessary for one person to fulfil the HCC function on a part-time basis while also serving as, for instance, WCO emergency coordinator, but this should be avoided if possible.

As soon as a decision is taken to establish clusters and WHO is designated as Cluster Lead, the WR should consult with the RD, RA-EHA and ADG-HAC concerning funding for the post and the identification and appointment of an HCC. An HCC for an acute emergency will be selected from the Global Health Cluster roster of suitable, trained candidates that is managed by HAC-HQ.

Funding for the post – and an operating budget for Cluster activities – should be sought through the flash appeal and subsequent consolidated appeals (CAPs). Pending receipt of contributions, funds from the emergency allocation from HQ-HAC or the Emergency Revolving Fund may be used (see SOP 6.2 and SOP 6.3).

**Panel 1-4**

**Cluster Lead agency as "Provider of Last Resort"**

Where necessary, and depending on access, security and availability of funding, the cluster lead, as provider of last resort, must be ready to ensure the provision of services required to fill critical gaps identified by the cluster. This includes gaps in relation to early recovery needs within the sector.

Where critical gaps persist in spite of concerted efforts to address them, the cluster lead is responsible for working with the national authorities, the Humanitarian Coordinator and donors to advocate for appropriate action to be taken by the relevant parties and to mobilize the necessary resources for an adequate and appropriate response.

[IASC *Operational Guidance on the Concept of "Provider of Last Resort"*, June 2008]

# 2
# The Response Planning and Management Processes

This chapter provides brief descriptions of the emergency response process within which 4 phases can usefully be recognized, the 6 principal steps involved in emergency programme planning and implementation, and the 3 main groups of internal planning & management functions. These elements provide the structure for planning and managing WHO humanitarian response.

## 2.1 Steps in emergency programme planning and implementation

The process of planning and implementing a WHO emergency programme in the context of a coherent, prioritized overall health sector response is shown in figure 2a.

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**Coordinated response from the outset, when possible**

The starting point, ideally, is a joint assessment and analysis of the situation, public health risks and possibilities for response (step 1) leading to agreed, overall objectives/goals and an overall health sector response plan including the allocation of responsibilities among all health actors (step 2).

WHO, the MoH and other health actors then plan their own activities within the framework of that sector plan. For WHO, this means preparing a WHO action plan (step 3) and individual project proposals (step 4), mobilizing the necessary resources, implementing and monitoring the activities (step 5).

The implementation of the overall health sector response plan is also monitored jointly (step 6) and joint, sector-wide evaluations and lessons-learning exercises are conducted at the end. Interim evaluations and lessons exercises may also be conducted at appropriate moments during the course of a protracted operation.

In practice, the process is iterative:

- initial objectives and response activities are developed and implemented in the first few days on the basis of preliminary information and analyses;
- more refined plans are developed and longer-term activities implemented as more comprehensive and detailed information becomes available; *and*
- activities are adjusted during implementation if/when needed on the basis of the findings of monitoring and any interim evaluations.

This process is outlined in section 2.2 and shown in Figure 2b.

The step-by-step, coordinated approach of joint assessment (step 1), agreeing a sector response plan (step 2) and then, in the context of that sector plan, a WHO action plan (step 3) should be feasible from the outset in two situations:

- in case of a ***slow-onset*** crisis; *or*
- in case of a sudden-onset crisis when an ***inter-agency contingency plan*** exists – had been drawn up in advance – and the arrangements for assessment, objectives and outline sector response plan foreseen in that plan can be quickly reviewed and adopted, or adapted, for the current situation.

---

**Improvised response initially, when necessary**

In the absence of an inter-agency contingency plan, collaboration in joint assessment and planning during the first few days of a ***sudden-onset*** crisis will be difficult and action cannot be delayed while waiting for broad-based agreement on how to proceed. In such cases, steps 2 and 3 in Figure 2a will be undertaken in parallel. Specifically, WHO will have to:

- undertake a preliminary analysis of the situation working with the MoH and a few other partners and, on that basis, draw up an initial WHO action plan taking account of what is known about the response plans of other actors; and simultaneously,
- work to bring together as many as possible of the main health actors to share information and progressively develop a shared analysis of the situation and needs, and agreement on overall goals, response strategies and, eventually, an overall health sector response plan.

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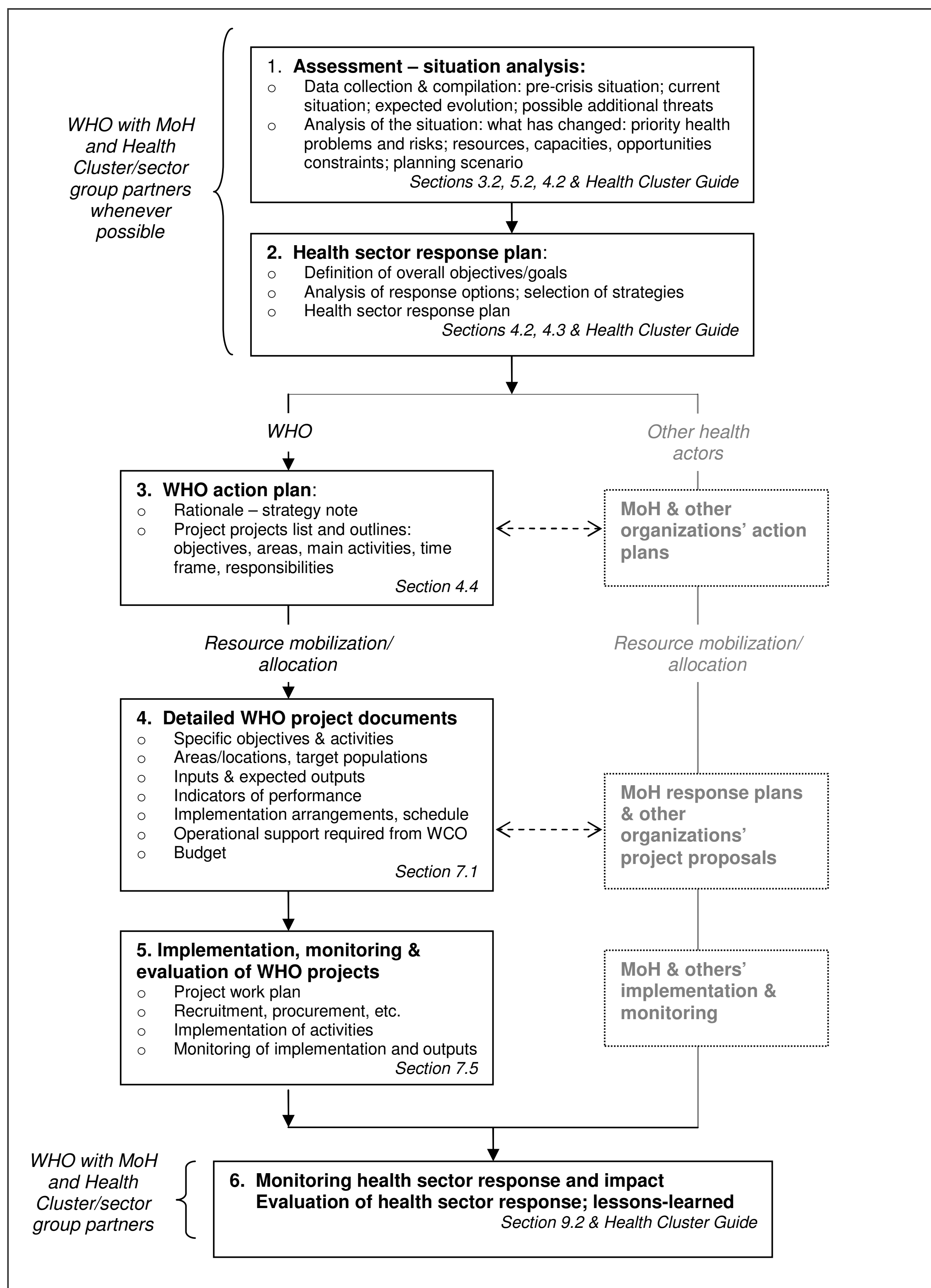
Figure 2a **Process of planning and implementing an emergency programme**

[*The notes in italics at the bottom of each box indicate where to look for guidance*]



## 2.2 The emergency response process: phases of response

Four phases can be recognized in response to a crisis as shown in Figure 2b which also shows the principal activities during each phase. Guidance in this handbook on many of the aspects of emergency response is provided in relation to these phases.

The time frames and the programme focus for the different phases vary depending on the nature of the disaster/crisis – see Annex 2. For certain emergencies, there is an early warning phase in advance of the onset of the crisis.

***For a sudden-onset crisis***:

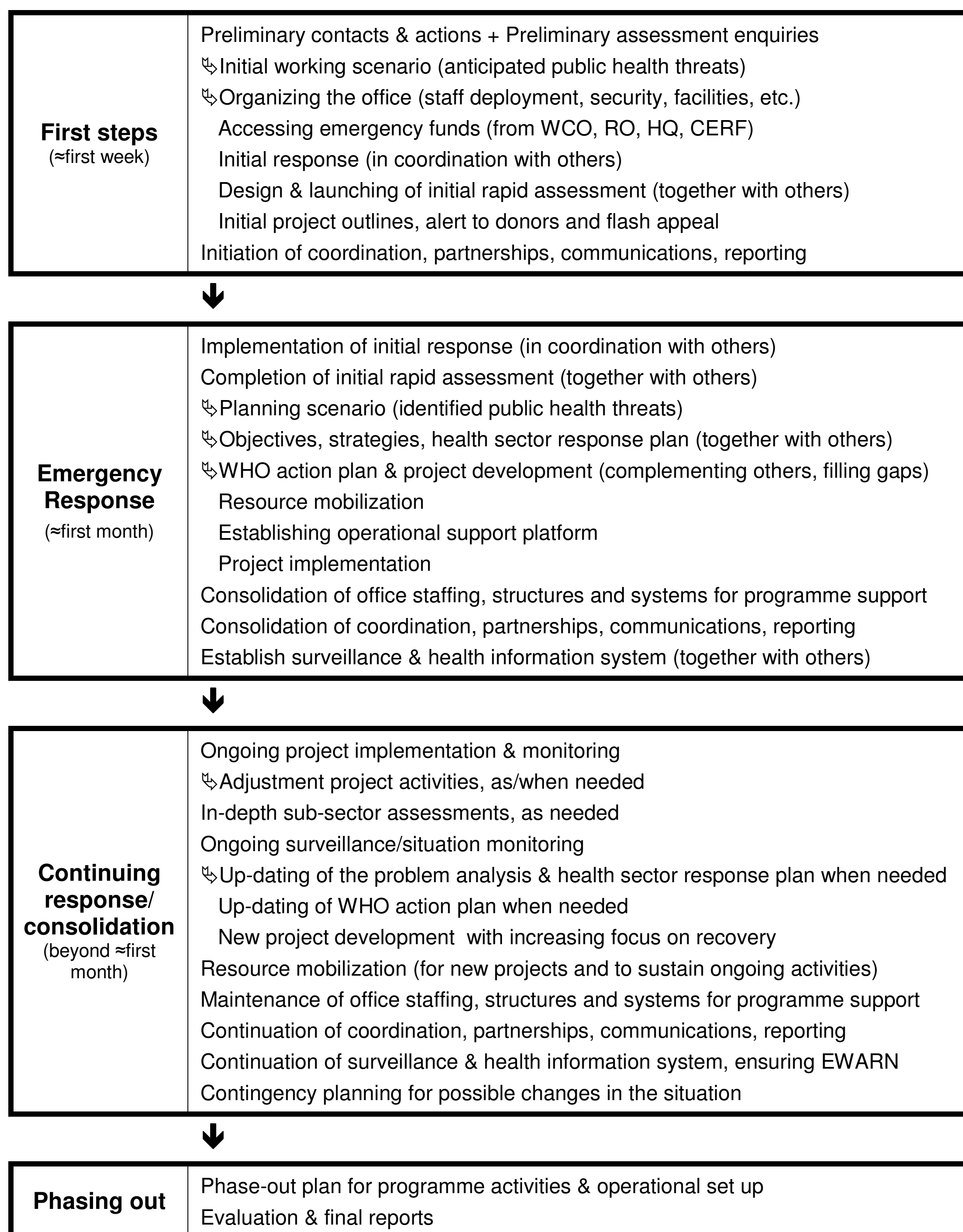
- the “first steps” – preliminary contacts and enquiries leading to an initial working scenario that provides the basis for organizing the office, initiating response, launching the initial rapid assessment and appeal, etc. – may take up to 7 days for a major disaster but be completed in 2 or 3 days for one of limited scale;
- the “emergency response” phase is the period during which initial response activities are implemented, operational capacities and systems established and follow-on activities planned and organized on the basis of the initial assessment and consequent planning scenario, strategic and action plans. It may take about 1 month for a natural disaster or several months in case of a conflict;
- the “continuing response” phase including support for recovery may be completed in 3 or 4 months for a disaster of limited scale but take up to a year for a major disaster. Certain crises may become “protracted” and this phase continue for several years with periods of apparent recovery followed by new setbacks.

***For a slow-onset crisis***:

- the “first steps” build on early warnings and are taken as soon as it is recognized that the situation has deteriorated to a point requiring humanitarian action. In this case, the first steps focus on launching a systematic assessment, ensuring coordination, building partnerships and organizing the office. That may take a few days in case of well-documented drought, a few weeks in case of a deteriorating social, economic or security situation;
- the “emergency response” phase during which humanitarian activities are launched may take several weeks;
- the “continuing response” phase may last for months or even years.

Particularly in case of a complex (conflict) emergency, the situation may evolve differently in different parts of the country and the “emergency response” phase last longer in some areas than others.

Figure 2b **Principal activities during the different phases of emergency response**



| Phase | Activities |
|---|---|
| **First steps** (≈first week) | Preliminary contacts & actions + Preliminary assessment enquiries<br>↳Initial working scenario (anticipated public health threats)<br>↳Organizing the office (staff deployment, security, facilities, etc.)<br>Accessing emergency funds (from WCO, RO, HQ, CERF)<br>Initial response (in coordination with others)<br>Design & launching of initial rapid assessment (together with others)<br>Initial project outlines, alert to donors and flash appeal<br>Initiation of coordination, partnerships, communications, reporting |
| **Emergency Response** (≈first month) | Implementation of initial response (in coordination with others)<br>Completion of initial rapid assessment (together with others)<br>↳Planning scenario (identified public health threats)<br>↳Objectives, strategies, health sector response plan (together with others)<br>↳WHO action plan & project development (complementing others, filling gaps)<br>Resource mobilization<br>Establishing operational support platform<br>Project implementation<br>Consolidation of office staffing, structures and systems for programme support<br>Consolidation of coordination, partnerships, communications, reporting<br>Establish surveillance & health information system (together with others) |
| **Continuing response/ consolidation** (beyond ≈first month) | Ongoing project implementation & monitoring<br>↳Adjustment project activities, as/when needed<br>In-depth sub-sector assessments, as needed<br>Ongoing surveillance/situation monitoring<br>↳Up-dating of the problem analysis & health sector response plan when needed<br>Up-dating of WHO action plan when needed<br>New project development with increasing focus on recovery<br>Resource mobilization (for new projects and to sustain ongoing activities)<br>Maintenance of office staffing, structures and systems for programme support<br>Continuation of coordination, partnerships, communications, reporting<br>Continuation of surveillance & health information system, ensuring EWARN<br>Contingency planning for possible changes in the situation |
| **Phasing out** | Phase-out plan for programme activities & operational set up<br>Evaluation & final reports |

## 2.3 Key internal WHO planning & management functions

Panel 2-1 below summarizes the key *internal management* functions that need to be fulfilled within the WHO Country Office (and any field offices) in order to assure an effective WHO response. It includes benchmarks of performance and provides examples of specific activities that might be required, depending on the situation and the structure and capacity of the WCO and any existing field offices. The guidance & backstopping that can be expected from the RO & HQ-HAC include:

- Technical advice & support for health actions.
- Releases from trust funds; mobilizing resource from donors.
- Mobilizing WHO staff and international consultants.
- Procuring & delivering supplies.
- Managing international communications.

See the sections and annexes indicated in the last column for specific guidance.

Panel 2-1

**Key Internal WHO Planning & Management functions**

| Function | Benchmarks (desired situation) | Some typical WHO activities (examples) | Chapters & annexes |
|---|---|---|---|
| **Overall** response management | ☑ An emergency management team meets regularly and ensures effective, coordinated, prioritized country office action<br>☑ Senior management, donors & newsmedia are regularly informed of WHO's assessment, progress and needs | → Representing WHO to gov't, UNRC/HC, UNCT<br>→ Organizing the office; establishing work priorities.<br>→ Mobilizing resources.<br>→ Managing country-level communications including relations with newsmedia.<br>→ Reporting to RO, HQ, donors. | Chapters 3, 4<br>Annexes B |
| **Programme** planning & management | ☑ Appropriate strategies are defined<br>☑ An action plan is prepared and implemented<br>☑ Quality project proposals are prepared in a timely manner<br>☑ Partnerships are developed and maintained in planning and implementing projects<br>☑ Projects are implemented on schedule and achieve the intended outputs<br>☑ Resources are properly accounted for<br>☑ Lessons are learned | → Identifying partners; building partnerships.<br>→ Preparing project proposals; contributing to flash appeals and CAP.<br>→ Managing project implementation, where necessary.<br>→ Monitoring the implementation and outputs of WHO supported or managed projects.<br>→ Arranging evaluations of WHO projects. | Chapters 7, 8<br>Annexes C |
| **Operations** planning & management | ☑ WHO staff and assets are safe<br>☑ Real-time exchange of information in place<br>☑ Assets in place and maintained<br>☑ No rupture in supply pipeline<br>☑ Staff and assets properly administered and accounted | → Preparing an operational strategy, organigram & work plan.<br>→ Ensuring staff security (and MOSS compliance).<br>→ Mobilizing staff and managing human resources.<br>→ Establishing and maintaining facilities.<br>→ Ensuring efficient administrative & financial services.<br>→ Procuring supplies; monitoring the pipeline.<br>→ Assuring in-country transport and storage (logistics).<br>→ Establishing and maintaining ICT systems.<br>→ Maintaining records of assets and supply distributions.<br>→ Monitoring operational performance. | Chapter 10<br>Annexes D |

# 3

# Determining Whether –and What Kind of –WHO Response may be Needed

This chapter provides a practical aide-mémoire for the main tasks involved in leading, and assuring overall management of, the WHO response in the initial stages. These tasks are the direct responsibility of the WR although, in a major emergency, s/he may be assisted by, and delegate certain of the tasks to, an experienced WHO emergency coordinator as soon as one can be mobilized.

The first three tasks – preliminary contacts and actions, preliminary assessment/enquiries, and establishing an initial working scenario – proceed simultaneously. They enable a judgement to be made on whether WHO action may be needed and, if so, what kind of action.

Organizing the office and the other actions described are initiated as soon as it is recognized that some sort of response by WHO could be needed. In case of a major sudden-onset disaster, however, preliminary actions such as convening an emergency management team (EMT) meeting and defining responsibilities and a "chain of command" within the WCO will normally be taken in parallel with the first three tasks listed above.

If a response is found to be needed from WHO, key tasks in leading and enabling that response are covered in chapters 4 (developing a strategy and action plan), 6 (resources), 7 (managing and disseminating information), and 8 (promoting coordinated health action and best practices).

Specific tasks related to planning and managing the WHO humanitarian emergency programme and WHO "operations" are described in chapters 5 and 9 respectively and would normally be the responsibility of designated senior programme and administrative officers.

## 3.1 Preliminary contacts and actions

Preliminary contacts and actions are the things a *WR/WCO* must do "immediately" – during the ***first 24 hours*** following receipt of information concerning a sudden-onset natural disaster or any other sudden crisis (such as an outbreak of fighting) or on receipt of reports that a slowly deteriorating situation (such as a drought or economic crisis) has reached a point at which emergency intervention may become necessary. A WHO field team leader may need to do the same things on arrival in a crisis-affected area.

These actions should be taken in parallel with the preliminary assessment/enquiries described in section 3.2 and initial actions to organize the office, described in section 3.5.

The effectiveness of both the WHO response (when needed) and coordination among partners is significantly influenced by the contacts made and actions taken at the onset of the crisis. In extreme cases, the lives and well-being of staff as well as the affected population may depend on the efficiency with which these preliminary tasks are fulfilled.

The government may, or may not, request WHO technical and/or material assistance. In either case, the WR has to make a judgement:

- If a request is received, whether it is justified in the light of the resources available nationally and from other sources and is appropriate in terms of the situation and what is being requested?
- In the absence of a request, whether to propose assistance and, if so, what type of assistance?

Panel 3-1 provides a checklist of actions to take on receipt of an (early) ***warning*** of an imminent disaster threat, i.e. before the event actually happens.

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### Guiding principles

Prompt, efficient and systematic attention to preliminary contacts and actions is an essential starting point for an effective and appropriate response.

A safe and effective WCO – and regular consultation and mutual understanding among the WR, RO and HQ-HAC – are essential for an effective WHO response.

WHO presence, visibility and the ability to collate, analyse and provide the best possible information to health sector actors from day-1 are essential if WHO is to offer leadership and facilitate coordination.

Where there is an existing contingency plan – especially an inter-agency contingency plan – or business continuity plan, this is used as a basis for action subject to review and adaptation to the actual situation.

Ongoing programmes in parts of the country not affected by the crisis must be sustained. Activities in the affected area(s) should be adapted to the prevailing situation and public health priorities.

The MoH is WHO's main counterpart but contacts and collaboration with other public-health-related entities, NGOs and community leaders are also essential.

Ensuring that the MoH makes the most of the public health opportunities offered by collaboration with other national and international partners is an integral part of WHO's global responsibilities.

WHO's role depends on the nature and scale of the crisis and the capacity of the government and others – particularly but not only the MoH – to cope with the health effects.

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### What to do – key management actions

☑ On the basis of rapid consultations with MoH, MoFA and the UN Country Team, make an early judgement concerning the *scale of the emergency and the level of engagement* that will be required of WHO.

☑ *Activate the contingency plan*, if one exists. Together with partners, examine the scenario on which the contingency plan is based, identify any differences compared with what you know about the present situation and adjust the planned actions accordingly.

☑ *Contact key individuals and organizations in country*: Adapt the list in Panel 3-2 to the country context and then use it to ensure that all required preliminary contacts are made and actions taken (or use any country-specific checklist already developed as part of a WCO contingency plan). List and prioritize key contacts to be made in the capital and the affected areas and the specific information to be requested of and provided to each of them. Panel 3-2 provides an abbreviated list of some of the key contacts and the information that may typically be exchanged.

☑ *Consult early and regularly with the RO and HQ-HAC,* agree on the level of support required from them.

☑ In the case of a WHO Emergency Coordinator mobilized from outside the country, prepare a contact plan before s/he arrives in the country.

☑ *Issue the first health bulletin* and *send a first internal operational sitrep* to the RO and HQ-HAC: see section 7.3.

☑ *Keep records* – concise but systematic – of all contacts, decisions, agreements and promises (formal or informal) as well as a list of things to be followed up.

☑ *Carefully prioritize attendance at meetings*: the initial number of meetings could be overwhelming. Put a meeting schedule chart on the wall of the operations room (see Annex B4 and F2) and make someone (e.g. the Communications Officer) responsible for keeping it up-to-date.

☑ *Propose specific agendas for teleconferences* in advance, and prepare well – send factual information in advance by email – to avoid wasting time during the teleconference.

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## Tools and other guidance

SOP 2.3

HAC website for up-to-date technical guidance materials

Panel 3-1

**What to do in response to a warning**

Immediately on receipt of warning of an imminent threat (e.g. a cyclone/ typhoon or flood):

☑ Contact the UN resident coordinator, the Government and other principal partner organizations to:
- confirm the threat
- obtain additional information
- coordinate preparatory actions
- activate any existing contingency plans

☑ Contact any WHO staff in the areas concerned to:
- exchange information
- arrange for them to take appropriate precautions for their own safety and the protection of WHO communications, vehicles, stocks and other property, to the extent possible
- agree on arrangements for initial on-the-spot investigations
- assessments and reporting if/when a disaster does occur

☑ Put all WHO staff on stand-by.

☑ Check the readiness of telecommunications and information management systems.

☑ Assemble:
- basic information on the threatened areas, and
- up-to-date information on transport and stocks of WHO supplies

☑ Inform the RO of the threat and the action taken by the country office. Include information on action by the government and others, if available, and whether any action is requested by the RO or HQ-HAC.

Panel 3-2

**Some key in-country contacts in the first 24 hours following a sudden-onset emergency**

| Contact | Information you need from them | Information they may need from you |
|---|---|---|
| WHO staff in the area | • Their location, personal safety and ability to work and communicate.<br>• What they know about the situation and the actions and capacities of health partners.<br>• What they need. | • What they should do.<br>(e.g. assure their own safety and security; contact the WCO at specified times; organize or participate in initial assessment visits with partners and what they should focus on;…) |
| UN Designated Official (for security) | • Whether there will be any change in the UN security phase.<br>• Information from the ministry of Foreign Affairs on security and access.<br>• Advice to be given to staff. | • Information on security conditions received from staff and contacts in the field. |
| UN Resident Coordinator & OCHA | • Information on the general scale and extent of the crisis.<br>• Actions being taken by the RC and OCHA.<br>• When the UNCT will meet, and what is being done to activate the inter-agency contingency plan (if any).<br>• Whether Clusters are being formed. | • What is known about the health situation and risks, and the capacity of the MoH and others to cope.<br>• Arrangements for health sector coordination and assessment.<br>• Actions being taken by the WCO and expected to be taken by WHO.<br>• The practical support that WHO might need. |
| Ministry of Health (crisis cell and provincial/ district offices) | • Information about the health situation and risks.<br>• Information about the impact on health services and their functionality.<br>• Actions being taken by the MoH and other government entities.<br>• Arrangements being made by MoH to assess the situation and needs.<br>• What support and assistance they need. | • Assurance that WHO is ready to help.<br>(e.g. with technical advice and support; assistance in assessing needs and coordinating international health assistance; supplies and logistics as needed, within the limits of the resources available…)<br>• Information about the situation that the WCO has received from other sources.<br>• Information about cluster (or other) coordination arrangements among international health agencies. |
| UNICEF and major NGO health partners | • Information about the health situation and risks, and the impact on health services.<br>• Information about the impact on the partners' own programmes.<br>• Actions being taken by the partners.<br>• Partners' readiness to coordinate efforts and collaborate in health sector assessments. | • Arrangements for coordination of health-related national and international action.<br>(e.g. arrangements for the first meeting of the health cluster or any other existing coordination mechanism)<br>• Actions being taken by the WCO and expected to be taken by WHO. |

## 3.2 Preliminary assessment/enquiries

Preliminary assessment/enquiries in the first 24 to 72 hours provide the basis for developing an *initial working scenario* (see section 3.3) and determining what, if any, *further action* should be taken. Further action may include: initiating a rapid assessment (see section 3.4); organizing the office and establishing initial operational support capacity (see 4.1); providing initial emergency assistance; and initiating the preparation of project proposals for inclusion in a flash appeal (see 7.4).

| Outputs required from the preliminary assessment/enquiries |
|---|
| *Preliminary* maps showing the area(s) affected including zones to be distinguished, and lists of distinct population groups concerned. |
| *Preliminary* indications of the numbers (rough estimates) of people affected, the *likely* impact on health and health services, and the expected evolution of the situation, summarized in the form of an initial working scenario. |
| *Specific* recommendations for: (i) immediate assistance to prevent avoidable mortality, morbidity and disability, if needed; and (ii) the localities and priority topics on which a rapid assessment should focus, if required. |
| *Preliminary* indications of the type and scale of external assistance, if any, that *might* be needed in the coming months and the kind of WHO operational arrangements that *might* be required. |

### Guiding principles

The nature of the impacts on health and health services and many of the health risks arising from particular types of disaster are predictable, given knowledge of pre-crisis conditions and epidemiology. The severity of impact, the numbers of people and institutions affected or at risk, and the speed with which the situation evolves, are situation-specific. The *preliminary* assessment will be based on knowledge of pre-crisis conditions and the typical, predictable effects of the particular type of disaster together with *preliminary* information on the extent and severity of the actual impact.

Systematic enquiries should be initiated within the first few hours of the onset of (or receipt of information about) the crisis and be completed within 1 to 3 days, depending on the scale and nature of the crisis.

Information should (ideally) be compiled as a joint effort of WHO, the MoH and other partners, within the framework of the country-level Health Cluster or sector coordination group, but enquiries should not be delayed waiting for such a group to convene or be formed.

Preliminary assessment/enquiries help to determine the need for and focus of an initial rapid assessment but do not substitute for such a structured assessment and must not delay the initiation of such an assessment.

Enquiries should be coordinated with efforts in other sectors (by other Clusters) and the UN disaster assessment and coordination (UNDAC) team, if present.

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### What to do – key (management) actions

***Assembling and analysing information available***

Contact key informants in the capital and the areas reported affected and, working with partners as much as possible, do the following:

☑ Consolidate information available on the *nature* of the shock/crisis, the geographic *areas* affected and the severity of the *impact*:

- In the case of a *sudden-onset disaster,* information may be available from: relevant government entities (Prime Minister's office; national disaster management authority; provincial and district authorities; meterological office), the UN resident coordinator, agencies with personnel in the area, and news media.
- For a *slow-onset crisis,* information may be available from early warning systems, government statistics and other offices, agencies with personnel in the area, and news media.

- In case of *conflict*, information may be available from U.N. and embassy sources and national human rights organizations.

☑ Draw contours on a *map* showing the areas reported to be most severely affected and those less affected. This may reflect the depth of flood water, the extent of physical damage, the intensity of fighting, etc.

☑ Having identified the area(s) apparently affected, examine *baseline secondary data* available (in the WCO, on the Internet and from other sources) on the normal situation in those areas and the impacts of previous similar events:

- compile data on the distinct *population groups* living in the area(s), their characteristics and numbers;
- identify endemic diseases and the health services normally available in the areas affected;
- prepare a *time line* showing the major events that have affected the whole area, or particular sub-areas or population groups, in the last few years and how those events may have affected health and health services either directly or indirectly through changes in contextual factors; *and*
- review information on the effects of *previous shocks/crises* in those areas and the lessons from the responses to those events.

In case of ***displaced populations***, focus on:

- their locations and what is known about the physical environment and resources in the localities where they are or towards which they are moving;
- their characteristics, leadership structures, ethnic/social divisions and demography – whether they are whole families or predominantly women, children and old people, for example;
- their numbers at present and the rate at which people are arriving; *and*
- whatever may be known about their general condition and the resources (if any) they have brought with them.

***Undertaking a few rapid field visits***

☑ If it is possible to make to make rapid, initial visits to a few key provincial/district headquarters (e.g. by helicopter together with MoH or other government officials) take the opportunity to meet quickly with local officials and visit a few vital health facilities and selected communities (e.g. urban neighbourhoods and/or displaced persons camps).

- Select a few sites that will enable you to identify areas where immediate life-saving assistance may be needed while at the same time getting first impressions concerning the situation throughout the whole affected area – see Panel 3-3.
- Adapt and use the standard Initial Rapid Assessment (IRA) data collection format (see section 6.1). Adapt it taking account of the nature of the crisis and focus on collecting data that will enable you to: fill gaps in the information already available from secondary sources; refine and cross-check the available information; and gain insights into the current situation and how it may evolve.
- Try to compare the current situation to the pre-crisis baseline and get a rough idea of the nature and severity of the change in the situation.
- If the situation involves conflict or social repression, be guided by the advice provided in Annex G7.

These few, rapid visits will not substitute for a systematic initial rapid assessment (section 3.4) but may be considered as the first phase of such an assessment.

Panel 3-3

**Selecting the sites to be visited in the first few days**

When possible, the selection of sites should strike a balance between (i) identifying the worst-affected areas that

are in need of immediate assistance and (ii) getting a representative overview of the entire area affected by the shock/crisis. Adopt an approach to maximize the degree to which both of these objectives can be achieved simultaneously. One option may be to identify zones where the health impact and risks are believed to be different and to plan one or more itineraries that bisect at least one of each of the different types of zone, taking account of any access and logistic constraints.

When lives are at immediate risk, there is an argument for prioritizing data collection and analysis in areas that are presumed to be the most affected by the emergency over the establishment of a representative overview. Other areas and groups may then be assessed in a subsequent stage of data collection. This may be justified in some cases but remember that: (i) initial reports can sometimes be misleading, and (ii) the investigation has to provide a basis for an educated guess as to the situation and potential needs in the whole affected area as well as informing action to save lives.

If you choose to prioritize the assessment of some areas over others, you must have a defendable rationale for doing so. Where this rationale does not exist or is questionable, a representative overview of the entire area affected by the emergency is a critical pre-requisite to identifying the most vulnerable areas and sub-populations, while still ensuring that critical health facilities and support systems are covered.

[Adapted from *Emergency Food Security Assessment Handbook*, WFP 2005, section 8.3]

## 3.3 Establishing an initial working scenario

*An initial working scenario is a concise statement drawn up at the onset of a crisis indicating:*

*(i) what you expect the impact on health and health services to be;*

*(ii) how the situation is likely to evolve; and*

*(iii) the kinds of interventions and assistance that are likely to be needed (and what may not be needed).*

Writing up an initial working scenario (hypothesis) at the onset of a crisis:

- helps to focus attention during the first few hours and days on what are likely to be the priority issues and inform the planning of the initial rapid (health) *assessment* by highlighting the critical issues the assessment should give particular attention to, the areas and the types of institutions that should be visited, and the specific information that should be sought; *and*
- provides the basis for an initial response and assistance *strategy* and initial decisions on the mobilization of human and material *resources*, including the preparation of an initial/"flash" appeal, while a rapid health assessment is being undertaken.

When drawn up together with partners, it can help to ensure *shared understandings* of the probable nature of the health crisis and risks, agreement on the scope of work and team composition for a collaborative rapid health assessment, and the complementary roles of different health-sector actors in responding to the crisis.

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### Guiding principles

The nature of the impacts on health and health services and many of the health risks arising from particular types of disaster are predictable, given knowledge of pre-crisis conditions and epidemiology. The severity of impact, the numbers of people and institutions affected or at risk, and the speed with which the situation evolves, are situation-specific.

An initial working scenario (hypothesis) should be drawn up rapidly in all crisis situations to provide a basis for initial decisions before an assessment is launched and produces specific, more detailed information. It should be refined progressively as more information becomes available and the initial assessment produces a detailed, evidence-based situation analysis and planning scenario.

The initial working scenario should be drawn up together with partners, whenever possible. Ideally, it should be a joint effort of WHO, the MoH and other partners, within the framework of the country-level Health Cluster or sector coordination group, where one already exists and functions, but preparation should not be delayed.

Where an inter-agency contingency plan exists, the scenario in that plan will provide a starting point.

***Following a sudden-onset crisis***:

- A preliminary "best guess" should be prepared within 12 to 24 hours of onset on the basis of experience, knowledge of the impacts of previous similar events in the same or similar areas, and preliminary reports (including from the news media).
- A more refined "initial working scenario" should be prepared within 1 to 3 days based on preliminary assessment/enquiries (see section 3.2) while the initial rapid assessment proceeds.

***In case of a slow-onset crisis***:

- As a first step towards organizing an assessment, a working scenario should be prepared, on the basis of available early warning and other data, within 3 days of an alert that a situation has deteriorated to a point where remedial action is needed.

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### What to do – key management actions

☑ *If a contingency plan exists for this kind of event*: Look at the scenario(s) used and consider how the present situation may differ from the one that was envisaged when the plan was prepared.

- ☑ *If no relevant contingency plan exists*: Review the typical effects of the kind of disaster/crisis situation concerned – see Annexes 1, A2 and A3 – and look at the reports of, and lessons-learned from, previous similar situations in the country or in similar areas of neighbouring countries.
- ☑ Conduct preliminary assessment/enquiries as described in section 3.2.
- ☑ Write up an initial working scenario using the format in Annex 6. Do this in an early meeting with key health sector partners, if possible (in the context of the health cluster/sector coordination group, where one already exists).

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## Tools and other guidance

Annex 6 - Format for an initial working scenario.
Section 3.2 - *Preliminary assessment/enquiries*

## 3.4 Making a judgement on the need for and nature of WHO action

Whether any intervention or assistance is required from WHO depends on the precise nature of the emergency public health needs and the capacities of the national health authorities and others to respond to those needs.

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### Guiding principles

The criteria for WHO emergency assistance are given in Annex 3. A corresponding checklist is provided in Panel 3-5.

The judgement as to whether WHO should provide or offer assistance or not, and discussion with the MoH and other partners must be based on:

- rapid but careful analysis of the available assessment data to identify the priority public health problems, the services available and required interventions as identified in the initial working scenario (see section 3.3) and the initial rapid assessment;
- rapid review of the resources available to the government and expected from other donors and agencies leading to the identification of any important gaps that might need to be filled;
- examination of the human and other resources available in the WHO country office and the country programme which can be mobilized;
- consultation with the RO concerning the possibility of ICP or other regional resources being available to meet specific needs; *and*
- consultation with HQ-HAC and donor representatives to determine the likelihood of donor funding being made available for WHO-supported interventions.

When assistance is needed, the WR must agree with the MoH/health authorities and Cluster partners on the form of WHO assistance that can be most effective – specific technical assistance and/or other assistance in relation to one or more of the core functions listed in section 1.2. This will then lead to the preparation of a WHO action plan – see section 4.2

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### What to do – key management actions

☑ Determine whether the basic *criteria* for WHO emergency assistance are met – see Panel 3-5.

☑ Make a judgement concerning the *need* for WHO emergency assistance.

☑ If the Government has not requested assistance, make a judgement whether to recommend to the RD to *offer* assistance.

☑ Make a judgement concerning the *type* and *level* of WHO actions that might be needed – see Panel 3-6.

☑ Consult with the RO (and HQ-HAC) if necessary.

| Panel 3-5<br>**Checklist of conditions for WHO emergency assistance**<br>**[Adapted from the Criteria for WHO emergency assistance – see Annex 3]** |
|---|
| Fundamental criteria:<br>❑ Has a request been received from the competent national authorities, from OCHA or other United Nations bodies?<br>❑ If not, it is reasonable to expect that such a request will be forthcoming but is delayed owing to the emergency?<br>Additional criteria:<br>❑ Is the situation a genuine emergency or one that threatens to become an emergency if appropriate preventive measures are not taken?<br>❑ Are national resources for meeting the situation insufficient?<br>❑ Are the additional resources from other countries or agencies available or foreseen also insufficient, or not |

available in practice, to fulfil the total needs?

- ❑ Even if the resources for meeting the situation are sufficient, might the emergency have effects in neighbouring countries that make WHO intervention to secure a coordinated response desirable?

Criteria for the WR to propose to the RD or to the Director-General that WHO should offer to the government technical cooperation and emergency assistance, even though no request has been received:

- ❑ Is it clear that WHO assistance would materially improve either the physical or the organizational resources available to meet the situation; *and*
- ❑ The situation is such that it threatens the public health of the country and of adjoining countries; *or*
- ❑ It is known that OCHA, other agencies or other individual countries have received a request complying with the criteria set out above.

Panel 3-6

### Examples of possible levels of WHO action

***Possible levels of action***

Technical guidance/assistance

Technical guidance/assistance + Assuring coordination and information management

Technical guidance/assistance + Assuring coordination and information management + Supplies, equipment or funds for specific activities to fill critical gaps

Technical guidance/assistance + Assuring coordination and information management + Supplies, equipment or funds for specific activities to fill critical gaps + Taking direct responsibility for specific activities

***Possible levels of resource requirements***

- use of existing WHO in-country resources (human and material)
- mobilization of regional resources (ICP and/or other)
- project proposals to be prepared and submitted to donors for funding

# 4
# Leading and Enabling the WHO Response

This chapter provides guidance on organizing the office (section 4.1), with special reference to arrangements for information management (section 4.2) and taking action to mobilize resources for the priority projects concerned (section 4.3).

These functions would normally be the direct responsibility of the WR supported by the WHO Emergency Coordinator or Emergency Programme Manager in a major emergency. In a lesser emergency the WR would be supported by the EHA focal point or assigned emergency programme officer.

WRs and all WHO staff and consultants must always keep in mind the overall objectives presented in section 1.1 and endeavour to ensure that the collective efforts of all health actors achieve those objectives to the maximum extent possible.

## 4.1 Organizing the office; building a team

The efficiency of the office is a major determinant of the effectiveness of WHO response. For an initial period, all necessary resources of the office should be mobilized to respond to the emergency. Clear direction and good leadership are required – see Annex B3.

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### Guiding principles

WHO's response to a humanitarian crisis is a *corporate* responsibility. All programme and support units within the WCO and field offices must provide support to the humanitarian operation as needed.

Responsibilities must be clearly defined within the WCO for the management of both the crisis and, separately, ongoing country programme activities. A WCO *emergency management team* (EMT) should be convened.

All WCO staff must be briefed on the actions being taken and, in a country with no ongoing or recent EHA programmes, on WHO's role and policies for humanitarian action.

Managers must provide responsive leadership and ensure a supportive climate for staff: see Panel 4-1

The EMT should:

- include members covering all relevant programme and operational support functions;
- be convened on day-1 and function throughout the humanitarian crisis and until the phase out has been completed;
- develop a work plan, monitor progress and up-date the plan regularly, whenever necessary.

It will initially be formed by redeploying existing WCO staff and any consultants already working in the country. For a major crisis, it will be augmented within a few days by additional staff or consultants specially mobilized for the crisis; some of the regular in-country staff may then return to their normal duties.

A large, dedicated EMT (full-time members) may be needed during the first few weeks of a major crisis but the size of the team and the frequency of team meetings can be reduced once the situation and response operations have stabilized.

For a *major emergency*, the EMT should be led by a full-time *WCO Emergency Coordinator* who reports directly to the WR. The WCO Emergency Coordinator should normally be separate from the Health Field Cluster Coordinator (see section 1.3).

For a lesser emergency, the WR may personally lead the team or delegate the EHA focal point to do so.

Temporary *emergency field sub-offices* may be established, when required, for a major, large-scale emergency (see Panel 4-2). The responsibilities and authority of each head of field-sub-office must be clearly defined and enable the sub-office to be effective in facilitating field operations (see Annex B5).

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### What to do – key management actions

*(The following guidance applies to any WCO where there is a WR and several programme and administrative support staff. In a country where there is only a liaison office, these actions would be taken by the head of office in collaboration with the supervising WR or the regional office.)*

***First steps – during the first day-or-two***

☑ Activate the WCO contingency plan, if one exists.

☑ Consult with the RD and, if considered necessary, request approval of the special emergency delegations of authority.

☑ Convene an internal coordination meeting within the WCO within the first few hours and establish an emergency management team. Annex 5 suggests an agenda for a first meeting.

☑ Review the organigrams/staffing plans provided in Annex B1, adapt one of them to the needs of the situation. Redeploy available staff and consultants as needed with specific roles and

responsibilities (terms of reference). Use the format on page 8 to assign functional and reporting responsibilities within the WCO. Ask for immediate staff reinforcement from the RO (or HQ-HAC) if required pending the establishment of additional posts and recruitment of personnel.

☑ Establish an operations room and information management system including a filing system and arrangements for the management of data files and emails – see Annex B4.

☑ Establish basic office procedures for the humanitarian response operation including working hours and a shift system, if needed, for the operations room (which may need to operate on extended hours – perhaps even 24/24 – during an initial, acute crisis period).

☑ Ensure compliance with MOSS standards.

☑ Check the status of all assets that might be needed – money, vehicles, stocks.

☑ Establish a daily schedule of WCO emergency task force meetings and telephone conferences with field offices.

☑ Provide visibility materials – WHO caps and t-shirts – to all staff being assigned to or visiting field locations. Order a suitable number of such materials.

***During the emergency phase/first month***

☑ Consolidate working arrangements in the WCO to ensure smooth functioning in all areas of work and avoid excess stress for staff.

☑ Establish field sub-office(s) in the affected areas, if necessary – see panel 4-2 and Annex B5.

☑ Adjust the frequency of EMT meetings and teleconferences with RO and HQ-HAC to what is necessary.

☑ Organize regular briefings for WCO staff not involved in the emergency.

☑ Ensure the availability of stress-counselling services for WHO staff engaged in or supporting the humanitarian operation.

***Once the situation has stabilized/beyond the first month***

☑ Monitor the performance of all functions.

☑ Ensure the development of WCO *contingency plans* for both (i) programme action in response to potential changes in health conditions and risks, and (ii) the continuity of operational services in the event of changes in operating conditions.

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## Tools and other guidance

Sample organigrams in Annex B1

Programme management structure (proposed) in *A template for planning WHO action in disasters*, WPRO, April 2007

Administrative checklist for a WHO country office (for a major emergency), in SOP 2.3

Tasks to be undertaken, section 4 in *Checklist for WHO country offices in an emergency*, WPRO-EHA, Dec.2004

*Possible agenda for a first internal WCO emergency management team meeting*, in Annex 5

*Establishing a field sub-office*, in Annex B5

*Team building: some hints for a coordinator*, in Annex F3

*Facilitating a meeting*, in Annex F4

| Panel 4-1<br>**Management responsibilities in relation to stress among staff** |
|---|
| WRs and other managers should provide the following for their staff: [from WHO Information Note 33/2006]<br>✓ Responsive leadership |

- ✓ Clear direction on expected results
- ✓ Attitude of open communication
- ✓ Availability to talk to staff
- ✓ Awareness of reactions
- ✓ Appreciation of efforts

They should:

- ✓ Create a supportive climate
- ✓ Monitor stress levels
- ✓ Organize team shifts

The WCO should also assure a stress counselling service for staff. This might be done through a common, inter-agency service at country level or in conjunction with services available through the RO, HQ or UNDSS, see SOP 7.9. For personal guidance on stress management, see Annex G5.

Panel 4-2

**Criteria for establishing an emergency field sub-office**

The WR can establish a field sub-office for an emergency operation if the emergency delegation of authority (see Annex 4 and SOP 5.1) has been activated *and* the following criteria are met:

- the emergency-affected area and population are large;
- a full-time WHO presence is needed in order to ensure the effective management and monitoring of WHO assistance in an area that cannot adequately be served from the country office or any existing sub-office;
- the Designated Official (DO) for UN security approves;
- the national and local governments agree/have no objection; *and*
- funds are available for at least 3 months operation of the office.

WHO should consider establishing a field sub-office in – or at least out-posting a staff member to – any location where other UN and IASC agencies are establishing sub-offices and that is therefore becoming a *humanitarian hub*. Only through such a presence will WHO be able to provide technical leadership, try to ensure appropriate standards, and facilitate coordination in the field.

## 4.2 Equipping the office for good information management

Emergencies generate a mass of disparate information that has to be organized systematically within the office. Information that is not easy to retrieve when needed loses its usefulness.

A good internal information management system also helps to reduce stress for emergency managers and staff.

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### Guiding principles

A separate, dedicated emergency ***filing system*** should be established for all the documents and CD-ROMs produced or received relating to the emergency. An inventory of the contents of CDs is also needed. This will greatly facilitate technical, administrative and advocacy work.

A ***sharepoint*** can be useful for making information, including sensitive information, available to authorized staff within WHO, but someone needs to be dedicated to maintain it, and each new staff member will need an account cleared by RO or HQ.

An ***operations room*** can be invaluable to ensure that information flows and is used effectively. Operations room staff should manage the receipt and organization of information, display it in an accessible manner, and manage its dissemination to all concerned. Workplaces should be designed to foster group interaction, to the extent possible. Equipment for teleconferences is essential.

A ***web-site*** can be a convenient way of making information available to a large number of users in different locations.

Responsibility for overall Information management must be assigned to a specific individual. (It may be a more-or-less full-time job in a major humanitarian crisis.)

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### What to do – key management actions

***First steps – during the first few days***

☑ Nominate/recruit a designated focal point to handle information in the office including distribution of in-coming e-mail from a common WHO e-mail address. That individual should:

- design and manage filing and database systems for storing and monitoring technical and administrative documents related to supplies, personnel, finance, budget and travel information – see Panels 4-3 and 4-4;
- set up electronic filing system (folders) in a share drive to store common access material on the server (reports, databases, photographs etc.); *and then*
- up-date databases each day and circulate the information to emergency management team members.

☑ Ensure that the information manager has full access to a high-performance computer and all necessary office supplies from day-1.

☑ With the MoH and other partners in the context of the Health Cluster or sector coordination group, discuss and agree: how health information will be reported, stored and shared; who will be responsible for what data; what information can be publicly used; what to translate (from and to local and the relevant international language) and what not. Thus define WHO's role and responsibility in information management on behalf of the cluster/sector coordination group.

***During the emergency phase/first month***

☑ Set up a system for joint/shared drives or shared folders in Outlook, and a workable filing system.

☑ Make sure that each member of the EMT is receiving, or has access to, the information s/he needs but is not swamped with a lot of additional information and communications that s/he does not need.

☑ In case of a major operation, secure the services of a good documentalist, if possible, and arrange for the regular scanning of news reports and the systematic filing of news cuttings concerning health-related issues.

☑ Arrange for the systematic cataloguing and filing of other agencies' reports.

☑ Establish arrangements for debriefing, wherever possible, perhaps in conjunction with the RO.

***Once the situation has stabilized/beyond the first month***

☑ Maintain and expand systems: e.g. by publishing bulletins (see section 8.4).

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## Tools and other guidance

The *HealthMap* database and geographic information system can be used to produce maps at village, district, country or sub-regional levels and show disease distribution or populations at risk of disease, see http://www.who.int/m/topics/health_map/en/index.html

Panel 4-3

**Possible structure of a filing system for a WCO operations room**

Filing systems differ greatly. A relatively simple one could be as follows:

- *Programme files* (for all documents related to WHO activities, by geographical area).
- *Fact-sheets files* containing baseline information (one for each geographical area of the Country, and one for each one of your operational partners).
- *Subject files* (for general reference documents, guidelines, etc.).
- One file with *descriptions of different Relief kits*, price lists, names of suppliers, etc.
- *One file with rosters* of experts, reference centres, CVs and addresses.
- *Correspondence in/out* files for covering memos, letters, etc.
- *Security files* containing sitreps and biodata of staff.
- *Donor files,* list the resources donated to the response, track their usage and location.
- *Financial files,* to keep track of expenditures and imprest accounts.
- *Asset file* for tracking WHO assets loaned or donated to/from other organisations.

When in doubt where to file something, e.g. a WHO report that also contains factual information on a certain area and some NGOs, make copies and file each of them in their respective file, highlighting the relevant passages.

Confidential information should be kept separately, and not in the operations room.

Panel 4-4

**Checklist to determine the adequacy of an information management system**

✓ There are systems for filing information in both electronic and paper (hard copy) formats that enable the information to be retrieved rapidly when needed.

✓ There are clear procedures for the registration, distribution and filing of incoming information.

✓ There are simple rules for the filing and storage of information.

✓ Concise notes-for-the-record are kept of meetings and, in particular, of decisions and follow-up actions.

✓ A diary of key events, decisions and the reasons for them is maintained.

✓ The following information is easily accessible to all emergency staff on the common server:

  - Office functions (list of WCO and temporary staff assigned to the emergency; their roles and responsibilities);
  - Contact information for emergency focal points in the RO, HQ-HAC, all MoH line departments involved in the management of the crisis, other UN agencies, NGOs;
  - Travel information;
  - File of key documents for experts' reference;
  - Contents of a technical briefing pack for all new arrivals and visitors (see SOP 7.5);
  - Financial reports (expenditures related to the emergency);

  - Copies of donor agreements and project proposals;
  - Records of items loaned to experts and others (laptops, office keys, mobile phones, etc.);
  - HR information (contract expiry dates etc.).
- ✓ There is an inventory of the contents of computer disks/CD-ROMs.
- ✓ Translated documents are systematically filed.

## 4.3 Accessing and mobilizing resources

The sources of funds available and used for emergency response during the first few days are indicated in Panel 4-5. Beyond that, response to any significant humanitarian emergency depends on special (extra-budgetary) grants from donors in response to appeals and, therefore, on resource mobilization efforts.

A Donor Alert may be issued in the first 48 hours of the event in order to keep donors informed of the situation and of WHO's activities and needs. The Donor Alert is normally issued by the ADG-HQ and shared with Geneva-based donors and capitals (see SOP 12.2).

A UN-IASC "flash" appeal, coordinated by OCHA and issued within a week of onset, is the principal mechanism for seeking additional funds from donors in the first few weeks. It also serves as an initial inter-agency, inter-sectoral planning document. A consolidated appeal (CAP) may follow a few weeks later and be repeated annually for a protracted humanitarian crisis. For guidance on providing WHO inputs into those appeals, see section 7.4.

Follow-up resource mobilization efforts by country offices are essential to complement those of the RO and HQ-HAC.

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### Guiding principles

WHO financial management is centralized in HQ-Geneva, and in the context of humanitarian assistance, the main reference for resource mobilization is HQ-HAC. However, the RO must be kept fully informed of any fund-raising initiative: it may provide advice in relation to negotiations with potential donors, and if these are successful it will have a primary role in their administration.

The prompt and regular communication of information to donors and the news media about the health situation and health-related needs is an important element of resource mobilization, see section 4.4.

Proposals for funding must be concise, convincing, and realistic in terms of outputs and timeframes. They should be based on assessed needs and on WHO's and partners capacity to implement.

Where possible, use – and demonstrate some use of – available country programme resources before requesting additional 'emergency' resources.

Contacts with donor representatives at country level – directly and through UN Country Team mechanisms – are important for resource mobilization as donors increasingly make funding decisions based on information received from their embassies.

All agreements with donors, even if initiated in country, must be cleared by WHO's Legal Department before signature. Terms and conditions of agreements, especially as regards as implementation deadlines and reporting, should be realistic. The timeframe for implementation should not be less than six months (except for CERF rapid response grants), and only one final narrative and financial report should be expected. The RO or HAC-HQ External Relations should be consulted before the negotiation of any agreement.

Presentations to and negotiations with ECHO and the EU in Brussels are coordinated through HQ-HAC.

In-kind donations may be accepted subject to the conditions in Panel 4-6. Offers that are inappropriate should be refused and the donor concerned informed of the reasons and encouraged to respect established "good donorship" principles and participate in coordination processes.

> Whether WHO is Cluster Lead or not, WHO must always do everything possible to: (i) identify gaps that have a significant impact on survival rates and levels of ill-health; and (ii) mobilize other entities to fill those gaps or mobilize the resources necessary to enable WHO to fill them. Commitment and good negotiating skills are needed to persuade donors and operational agencies to allocate resources to fill gaps.

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### What to do – key management actions

***First steps – during the first few days***

- ☑ Submit concise but well-thought-out proposals to the RO and HQ-HAC for releases from regional and global funds, and applications to the CERF, when required. Budgets should include correct programme support costs (PSC) and funds for project management, monitoring and reporting (PMR) .
- ☑ Prepare concise submissions for inclusion in the OCHA flash appeal. (Proposals should be submitted to the HC/RC on day-3 in most cases.)

***During the emergency phase/first month***

- ☑ Use the UN Country Team mechanisms to highlight the importance of addressing health issues and to present WHO and partners activities for health.
- ☑ Take initiative to contact donor embassies, ECHO and any foundations represented in the country to explain health priorities and WHO's resource needs. Inform the RO and HQ of all such contacts.
- ☑ Invite potential donors to participate in coordination meetings, assessment missions and project site visits.
- ☑ Provide proposals and detailed reports to specific donors according to their particular interests but do not let donor interests drive WHO's programme and encourage potential donors to provide un-earmarked contributions to the WHO programme whenever possible. Negotiate with donors to obtain the most favourable implementing conditions. When in doubt, seek advice from the RO or HQ-HAC.
- ☑ Keep the RO and HQ-HAC informed of all contacts with potential donors, any expressions of interest, and any issues raised or concerns expressed by donors. Coordinate strategies to ensure that WHO speaks with one voice everywhere.
- ☑ Ask the RO to assign an experienced project planning/resource mobilization officer to assist in preparing proposals and budgets, if needed.
- ☑ Establish system to record contacts with donors (proposals given, indications of interest received).
- ☑ Establish a tracking and filing system for extra-budgetary funded projects (project proposal, donor agreement, donor conditions, donor contacts, deadline for completion, technical and financial reporting requirements, etc.).
- ☑ Take the lead in preparing the health component of the CAP, and include specific WHO project proposals.

***Once the situation has stabilized/beyond the first month***

- ☑ Keep local donor representatives, UN agencies, NGOs, government counterparts and potential private-sector donors informed of WHO operational activities and resource shortfalls. Inform the RO and HAC of all contacts with potential donors.
- ☑ Take the lead in preparing the health component of the annual CAPs, and include specific WHO project proposals.
- ☑ Once the recovery phase is in sight and especially a post-conflict "transition" phase look for funding from – and partnerships with – the World Bank and regional development banks.
- ☑ Monitor implementation of the project and expenditure. Prepare narrative reports and submit through HQ. Request financial reports through HAC-HQ or through RO if contribution was received at regional level. (Central Finance will issue certified financial reports once all obligations are liquidated.)

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## Tools and other guidance

*Format for requesting a CERF grant*, in Annex C3.

Information on donor alerts in SOP 12.2

Information on calculating PSC and PMR in project budgets in SOPs 6.6 and 6.7

Information concerning emergency funds and procedures for their use in SOP 6

Information concerning the CERF and procedures for its use in SOP 12.4

Standard format for donor agreements in SOP 12.6Information on Flash Appeals in SOP 12.3 and in the OCHA Guidelines for “flash” appeals

OCHA Guidelines for Consolidated Appeals

Panel 4-5

**Financing of emergency response in the first few days**

WRs may re-programme up to $100,000 from their ***regular budget***, as deemed appropriate and in agreement with the MoH.

If the WCO has sufficient funds in its imprest account, HQ-HAC may authorize the WR to disburse up to $100,000 against an ***HQ emergency obligation number*** to initiate an emergency response and meet immediate needs. The authorization is sent by fax. If the fax in the country office is not working, a scan of the fax may be e-mailed or the fax be sent to the UNDP office for delivery. See SOP 6.2.

HAC may advance up to $80,000 from the HAC-managed DFID ***Emergency Revolving Fund*** on the basis of a well-documented request from a regional or country office which includes a budget estimate and a simple plan of action. Advances are reimbursed when donor contributions are received in response to an appeal. See SOP 6.3

The Italian Government may authorize HAC to immediately release funds from the ***Bilateral Emergency Fund*** in response to a donor alert or flash appeal. See SOP 6.4

A request can be made to the OCHA-managed ***Central Emergency Response Fund (CERF)*** for seed funds to jump-start critical operations and funds for life-saving programmes not yet covered by other donors. The application process starts at country level and it is coordinated by the UN Resident Coordinator/Humanitarian Coordinator. CERF grants for rapid response are for life saving activities to be implemented in three months. See section 7.3 and annex C3.

Some regional offices may advance/release funds from ***regional voluntary disaster funds***. Check RO instructions for the procedures to be followed.

Note that:

- The WR has an automatic delegation of authority to disburse up to US$100,000 for local purchases and local costs for an emergency or disaster response.
- None of the above is dependent on the special emergency delegation of authority described in Annex 4 and SOP 5.1.
- When a donor that regularly funds emergency activities makes a specific commitment to WHO, HAC may allot the committed amount as soon as the grant agreement has been signed, without waiting for the funds to be deposited into WHO's bank account.

Panel 4-6

**In-kind donations**

Inform the RO and HQ-HAC of any kind donations offered to WHO. Such donations may be accepted if:

- they correspond to specific items in the WHO action plan;
- the delivery would be completed in time for them to be used within the project(s) concerned;
- they are of suitable quality and would be delivered in a form in which they can be readily distributed and used; *and*
- the resources are available – or would be provided by the donor – to cover all reception, handling, transport and distribution costs.

# 5
# Assuring Information on Health and its Determinants

This chapter provides brief guidance on assuring health information and analysis for decision-making for the overall emergency health response as well as for WHO's own purposes. It includes ensuring good information management (section 5.1), organizing and participating in assessments (section 5.2), analysing the situation (section 5.3), and assuring good health information/surveillance systems (section 5.4). Together with information dissemination through external communications and reporting (chapter 8) these elements correspond to the first of the core functions listed in section 1.1.

Assessment and ongoing situation monitoring/ surveillance are complementary elements in a process that, together with an understanding of the pre-crisis situation, progressively enhances knowledge and understanding of: (i) the situation, the health needs and risks; and (ii) the possibilities for addressing those needs and risks and expediting recovery (the [re-]establishment of essential health services and equitable access to those services).

Together with promoting coordinated health action and best practices (see chapter 9), assuring information and analysis may be the core of WHO response in cases where services and the provision of supplies are assured by other actors.

The framework within which WHO fulfils these functions depends on whether the cluster approach is adopted and WHO is designated as Country Health Cluster Lead (see section 1.3), but the responsibility is broadly the same in all cases:

- Fulfilling these functions for the sector in a major emergency will be the responsibility of the WHO-appointed Health Cluster Coordinator (HCC), when WHO is Cluster Lead.
- If another agency is designated as Cluster Lead, WHO will give all possible support in promoting coordinated health action and best practices. This would normally be the responsibility of the WHO Emergency Programme Manager.
- Where there is no formal health cluster, WHO will work directly with the MoH and other health actors, and through whatever sector group exists. This would normally be the responsibility of the WHO Emergency Programme Manager in a major emergency or the WR supported by the assigned emergency programme officer in a lesser emergency.

**Desired levels of performance**

***For assessment***: Health needs, health system delivery capacity and operational constraints are known; information is consolidated, arranged and displayed in a manner that facilitates consensus and decisions.

***For surveillance and monitoring***: Priority health threats and system's critical capacities are monitored regularly and timely action taken to reduce threats.

(WHO will get much credit vis-à-vis partners when [if] they find that they can count on WHO for quick access to reliable health information.)

## 5.1 Ensuring good health information management

Good information is key to successful response in a crisis. It is also necessary for supporting requests for resources and providing leadership to others.

Assuring the availability and dissemination of the best possible health information is one of WHO's main responsibilities. Member States, donors and partners expect WHO to lead on this topic. WHO *must* know what is ongoing during a crisis.

*A health information system collects, processes, analyses, disseminates, catalogues and stores health-related data from primary and secondary sources and derived information products. It transforms raw* data *into useful* information *to support decision-making in the health sector.*

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### Guiding principles

The ultimate purpose of data gathering and analysis in a humanitarian crisis is to inform ***action***. The focus is therefore on data relevant to decision-making.

Data must be analysed and interpreted in context to become useful "information".

Ensuring that appropriate health-related data are acquired and analysed, and the information made available promptly to decision-makers, is a ***top priority*** from ***day-1*** in any humanitarian crisis.

Health information management in an emergency should build on a ***pre-existing health information system***, whenever possible. However, if the existing system is particularly weak or not designed for rapid response, a new or parallel system may be required. This determination is made in consultation with the lead health authority.

WHO should work with the MoH to strengthen an appropriate health information system or, when necessary, work with partners to establish one. The same information is needed – and needs to be managed – for both WHO's own humanitarian response and to assist partners in applying the best health practices.

There should be a ***single, unified*** health information system with standard data collection and reporting tools used by all partners in the health sector.

It must make available, on a continuous basis, the best possible information on the health effects of the crisis on the health status of the population and on the state of the health system in order to guide appropriate decisions and actions. It must also monitor progress in health-related humanitarian response and recovery efforts.

Data should be brought together from a ***wide range of sources*** including geographic health profiles, all kinds of assessments, ongoing situation surveillance, periodic surveys, government and other reports, and the news-media. This includes information on all aspects of the health sector including service delivery, clinical and public health outcomes, resource management, and the status and sustainability of the health system.

Rumours are also important They should be identified, verified, investigated, and addressed or dispelled.

A ***minimum data set*** should include, but not limited to, the following: crude mortality; under-five mortality; proportional mortality; cause-specific mortality; incidence for most common diseases and injuries, prevalence of malnutrition; health facilities utilization; number of consultation per clinician per day; availability of staff and supplies. Information is also needed on humanitarian and health services coverage. [Adapted from SPHERE Standards]

Data should be ***disaggregated*** by age and sex as far as is practical in order to guide decision-making.

Data analysis must start at ***field level***. Out-posted WHO emergency programme coordinators, supported by epidemiologists or other experienced data analysts, when available, should assure quick, local analysis in collaboration with district/provincial health authorities and other stakeholders. This should identify priorities for immediate action and provide the central HIS unit with local interpretation together with the raw data.

The health information system must be linked with the OCHA-managed humanitarian information centre (HIC), where there is one. In particular, common maps and population figures should be used.

Information must be handled and used ***responsibly***, see Panel 5-1.

***Clearance procedures*** for releasing information must be well-defined and rapid. The situation can evolve very quickly during a crisis and data rapidly become out-dated. Bureaucratic delays in producing and issuing information can therefore greatly reduce the validity and usefulness of the information.

Panel 5-1

**Handling and using data and information responsibly**

- ✓ Verify and record the sources and probable reliability of all data and information received.
- ✓ Cross-check – "triangulate" – data from different sources, whenever possible.
- ✓ Consider possible margins of error in data and the implications for decisions.
- ✓ Specify the sources – and the limitations – of any data issued or disseminated.
- ✓ When quoting data or reporting information, always provide analysis of its significance.
- ✓ Respect the confidentiality of medical records: ensure that any copies of documents that contain patients' names are stored securely and not copied, distributed or left lying around.
- ✓ In any situation of conflict or repression, respect the confidentiality of informants who do not wish their identities to be revealed (see annex G7).

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## What to do – key management actions

***First steps – during the first day-or-two***

- ☑ Ensure that adequate ***resources*** are ***dedicated*** to HIS. This would include: appointment/ designation of a Crisis HIS Officer and dedicated (full-time) national staff; workspace; dedicated computers, telephones and other ICT equipment (e.g. radios) as needed.
- ☑ Specify the information ***products*** – a health bulletin and any other products – to be produced for external stakeholders and the production schedule by which they will be generated.
- ☑ Establish clear, simple and quick ***clearance procedures*** for information products from day 1.

***During the emergency phase/first month***

- ☑ Consolidate arrangements for HIS with adequate, dedicated resources. This might include: appointment of a full-time Crisis HIS Officer, additional national staff; improved workspace, computers, photo and video cameras, other ICT; transport means.
- ☑ Monitor the performance of the HIS.

***Once the situation has stabilized/beyond the first month***

- ☑ Maintain and, as necessary, refine and strengthen the system. Continue monitoring its performance.

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## Tools and other guidance

Annex E7 – Key elements for planning a health information/surveillance system

*Guidelines for prioritization of disease surveillance*, WHO-CDS, 2007

*Communicable Disease Control in emergencies*, WHO 2005, chapter 3

*Natural Disasters – protecting the public's health*, PAHO 2000, chapter 7

*Epidemiological surveillance after natural disaster*, PAHO 1982

*WHO recommended surveillance standards*, WHO, 1999

## 5.2 Organizing – and ensuring the quality of – assessments

Assessment, in a crisis situation, *is a structured process of collecting and analyzing data to measure the effects of the crisis and provide an understanding of the situation and any related threats in order to determine whether a response is required and, if so, the nature of that response. An assessment is a time-bound exercise that produces a report and recommendations to inform decision-making at a particular point in time.*

Depending on the nature and duration of the crisis, there are different phases and types of assessment in which WHO should be involved. The most common are:

- preliminary assessment/enquiries (as described in section 3.2) in the first hours;
- initial, rapid assessment – an initial, rapid health assessment (RHA) or, preferably, a combined health, nutrition and water/sanitation "initial rapid assessment" (IRA), see Panel 5-2 – in the first days or as soon as an area become accessible
- detailed health sub-sector assessments focusing on aspects identified by the initial rapid assessment as being important and needing more in-depth assessment;
- multi-agency, inter-sectoral "post-disaster" and "post-conflict" needs assessments (PDNAs and PCNAs), led by UNDP and the World Bank, focusing on damage, recovery and reconstruction needs, once the situation has stabilized.

The notes below focus on what is involved in organizing, or helping to organize, a rapid assessment or subsequent sub-sector assessment. (For guidance on conducting assessments, see the materials listed at the end of this section.) The RO and HQ-HAC will normally arrange WHO participation in a multi-agency PCNA.

It is the role and responsibility of WHO to advise and assist the MoH, as required, and provide leadership (within the Health Cluster where there is one) in planning and coordinating health sector assessments and analysing the findings, determining priorities for public health action, and defining the specific requirements (if any) for international assistance.

If needs are urgent and the health authorities are overwhelmed, WHO should take the initiative to help organize the initial assessment. This may include mobilizing the human and logistic resources required to conduct the assessment.

### Guiding principles

Good ***preparation*** and ***planning*** prior field visits are essential for all assessments. Responsibilities and timeframes for all preparatory actions must be defined and fulfilled in advance.

Broad ***participation*** of agencies should be encouraged including MoH, UNICEF and major international and national NGOs as well as WHO. The health-related assessment efforts of different government entities (the MoH, civil defence, disaster management authority, etc.) and assistance agencies should be coordinated – carried out jointly, whenever possible.

Assessment teams should be ***balanced*** in terms of gender, professional backgrounds and skills (see Panel 5-3).

Standard data collection ***formats*** and ***methods*** should be used by all field teams. For rapid assessments, they may be based on the multi-sectoral Interagency Rapid Assessment tool and guidelines or local equivalents that adequately cover all essential elements and are familiar to in-country partners.

Assessments must examine not only current "needs" but also ***risks*** and ***threats***, and the ***resources*** and ***capacities*** available for health responses, as well as any operational ***constraints***.

Maximum use should be made of available ***secondary data***. Primary data collection should focus on determining what has changed, filling gaps in information, and identifying feasible options for response.

Regardless of its capacity to directly participate in all field assessments, WHO should serve as focal agency, together with MoH, for health data processing, ***analysis*** and dissemination.

Prompt ***reporting*** and ***dissemination*** of assessment findings are essential to ensure that responses are timely and appropriate, recognizing that the situation can change rapidly.

Assessment ***reports*** should meet the minimum standards outlined in Panel 5-4. The reports of rapid assessments should be finalized and circulated to all stakeholders – government departments, donors, UN and NGO partners – within a few days of completion of the field visits.

To the extent possible, the whole process should contribute to enhancing national and local capacities for future assessments.

The situation analysis provided by an assessment should be ***up-dated*** as and when necessary on the basis of information from ongoing situation monitoring/surveillance (see section 5.3).

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## What to do – key management actions

During the ***planning*** stage:

- ☑ *If the government reporting system is robust and the information reliable*, and especially if the emergency period is likely to be very short (e.g. few days), ***help the government*** consolidate and disseminate information.
- ☑ *In a major emergency or when government systems are weak or seriously disrupted*, work with MoH staff and other health partners – in the context of the Health Cluster, where there is one – to ***organize*** assessments.
- ☑ Ensure WHO presence in all inter-agency assessments that cover public health concerns.
- ☑ Ensure that all field assessment teams receive adequate briefings and have clear terms of reference, standard reporting formats, guidelines on the criteria and definitions to be used, and necessary means of transport and communication. They should also have, and be trained in the use of GPS, if at all possible.
- ☑ If additional human, logistic or financial resources are needed beyond those available to the WCO and partners, contact the RO immediately for the necessary support.
- ☑ Ensure that a maximum of available secondary data are reviewed and made available to field teams *before* they start field visits, so that interviews and primary data collection can be appropriately focused.
- ☑ Ensure that arrangements are in place to receive and rapidly collate and analyse incoming reports from health facilities, assessment teams, relief teams and other sources. (These arrangements *must* be made in advance, as part of the planning for the assessment. Too often, analysis of data from "rapid" assessments has taken several weeks!)
- ☑ To address many of the actions listed above, consider organizing a quick (few-hours) assessment planning workshop with key health partners:
    - *Where an inter-agency contingency plan exists* and arrangements for assessment have been agreed in advance, it should be possible to quickly agree on a standard format and approach for data collection and reporting as well as the coverage of all affected areas.
    - *Where no inter-agency contingency plan exists*, try to get quick agreement on a standard common core for data collection formats to be used by all actors, a reasonably standardized approach to data collection, and coverage of the main geographic areas.
- ☑ Carefully review all draft assessment reports to ensure that they meet minimum standards – see Panel 5-4:
    - Use the assessment report outline and evaluation checklist in annex E4 as a basis to judge the quality of the draft submitted by an assessment team.
    - Look out for possible sources of error and any bias towards what individual participating agencies normally do or are able to provide.
    - Identify any gaps or items that need verification, and ensure that recommendations for action are based on sound analysis taking account of pre-existing conditions.

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## Tools and other guidance

- Principles of assessment in annex E1
- The (3-cluster) Initial Rapid Assessment in annex E2
- Assessment management and planning checklist in annex E3
- Assessment report outline and evaluation checklist in annex E4
- *IRA Guidelines*, draft, Global Health, Nutrition & WASH Clusters, 2008
- *Analysing Disrupted Health Systems*, WHO-HAC 2008
- *Health Cluster Guide*, provisional version, Global Health Cluster, expected end-2008
- *Multi-lateral Needs Assessments in Post-Conflict Situations*, UNDP-WB-UNDG, 2004
- Guidelines for multi-agency post-disaster needs assessments (PDNAs) are expected in 2008/09

Panel 5-2

**Initial rapid assessment**

The health component of a multi-sectoral IRA – or a rapid health assessment – corresponds to step 1 in the response process chart in Figure 2a (in section 2.1). It should:

✓ provide an overview of the ***effects*** of the crisis on health status and health services, determine who is likely to be at ***greatest risk*** of mortality and acute morbidity and why, and thus establish a ***prioritized list of health problems*** and risks to be addressed;

✓ identify existing capacities and resources, gaps and operational constraints; *and*

✓ generate recommendations for initial health-sector action, based on an analysis of possible response options, and for follow-on more detailed, sub-sector assessments, when needed.

It aims at ***validity*** (not precision) and often relies substantially on the ***judgement*** of experienced public health professionals who are familiar with the areas concerned and the typical effects of similar crises.

The initial assessment is critical: relationships established and decisions made at this stage ***set the tone*** and direction for the whole operation; mistakes made and opportunities missed at this stage can be difficult to correct later.

An IRA (or RHA) will normally be conducted during the first couple of weeks of a new crisis but may also be undertaken during an ongoing humanitarian operation when access is obtained to an area that was previously inaccessible or when an area is affected by an additional shock or deterioration in conditions.

The IRA form itself can be used at any time, and by any agency, to record basic data on a particular location and feeding them into the central health information system.

For additional summary information on 3-cluster IRAs, see Annex E2.

Panel 5-3

**Assessment team composition**

Multi-disciplinary teams with a maximum of experienced public health generalists are needed. Balanced team composition is crucial, especially with regard to:

- *Knowledge and expertise*: primarily epidemiologists and public health generalists, but specialists may be included where specific aspects are clearly important during the initial period, e.g. mass casualty management (but be careful to ensure that the assessment is not unduly biased towards the concerns of individual specialists)
- *Organisational representation*: representatives from the government/MoH, UN and other international organisations, the Red Cross and Red Crescent Movement and NGOs should be included
- *Gender* for both team members and interpreters, where needed
- *National and international* experts: the former are familiar with the context, but may bring preconceptions; the latter lack familiarity, but can provide a useful unbiased perspective and experience from elsewhere

[Adapted from IRA guidelines, draft, Global Health Cluster, 2007]

Panel 5-4

**What a rapid assessment report should include**

An assessment report should include *at least:*

- an explanation of the method(s) used, any limitations on the data, and assumptions made;
- data on health status, causes of morbidity, causes of mortality, health determinants (nutrition, water, sanitation, etc.), current health services characteristics (coverage, capacity, access) and gaps in service provision including a map, highlighting what has changed;
- an analysis of priority health problems, resources, and operational constraints;
- specific recommendations for:
    - immediate action with enough information for formulating initial projects;
    - establishing an appropriate surveillance system (identifying the health care delivery units/partners to be involved);
    - further, more detailed assessment of specific aspects of sub-sectors, if required.

Findings should be presented in a manner that is easy to incorporate in a common (shared) health sector data base.

## 5.3 Assuring monitoring of the health situation and risks

Monitoring of the situation *is the ongoing systematic collection, analysis and interpretation of data in order to plan, implement and evaluate public health interventions.*

During crises, monitoring of the health situation and risks is essential to:

- continuously identify and update public health priorities;
- monitor the severity of an emergency by collecting and analysing ongoing mortality, morbidity and malnutrition data;
- detect and monitor outbreaks;
- monitor trends in incidence of major diseases and malnutrition;
- monitor the impact of specific health interventions; *and*
- provide information to the MoH, agency headquarters and donors to assist in health programme planning, implementation and adaptation, and resource mobilization.

It also provides information to improve preparedness for future crises.

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### Guiding principles

**Integrated** situation monitoring is needed during a crisis. This includes but is not limited to providing early warning of and response to outbreaks of priority communicable diseases. It also includes the collection and analysis of information (quantitative and qualitative) related to mortality in general, the incidence of injuries and non-communicable diseases, health service functioning, water quality, food safety, nutritional status and other key social and economic determinants of public health.

Such monitoring should cover the ***entire affected area*** (subject to security and logistic limitations) and be a collaborative effort in ***partnership*** with as many stakeholders as possible. It can never be a single-agency business. WHO should normally support the MoH in leading – establishing and sustaining – the process.

A ***central health situation monitoring team*** should be established at the level – e.g. provincial or national – at which the overall emergency relief operation is being managed.

Notwithstanding the need for “integrated” monitoring, it is not possible to monitor everything, especially during a crisis. A ***limited number*** of indicators of health status and health services functionality should be selected on the basis of the priority public health threats identified by the assessment. Experienced epidemiologists and public health generalists in the monitoring team should take the lead in choosing the indicators to be monitored.

In many cases, an ***Early Warning and Response Network*** (EWARN) should be established initially as outlined in Panel 5-5 … especially where there are large population displacements or existing systems are totally disrupted(?).

Specific ***expertise*** should be mobilized to establish an EWARN or design (and supervise the implementation of) a survey, especially a mortality survey, when needed.

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### What to do – key management actions

☑ Work with the MoH and other partners to:

- agree on appropriate mechanisms for overall situation monitoring and for early warning of and response to priority communicable diseases (EWARN or similar);
- agree on the (short) list of priority communicable diseases and corresponding syndrome-based definitions;

- o agree on nutritional surveillance indicators
- o ensure that a central monitoring team is in place, with precise tasks and responsibilities and in an appropriate location, within the first week;
- o ensure that analysed information is fed back to reporting units and disseminated to all other interested parties within one week from data collection and within few hours in case of an outbreak or other event requiring an immediate response; *and*
- o define a monitoring calendar/agenda ensuring regular follow-up visits to health facilities.

☑ Request technical advice and support from the RO (or HQ-HAC) for establishing an EWARN or designing a mortality or nutrition survey.

☑ Ensure that there is access to a competent laboratory, and that the means for collecting and dispatching biological samples are assured and safe.

☑ Promote and support, where necessary, the preparation and dissemination of associated guidelines and the training of field personnel, as needed. Include criteria or thresholds at which field units should take specified actions.

☑ Consider all possibilities for assuring prompt, regular reporting from health workers in the field – see the case example below.

Panel 5-5

**Early Warning and Response Network (EWARN)**

Disease surveillance in a humanitarian emergency requires the active participation of *all* humanitarian health actors in order to ensure the rapid ***detection*** of any outbreak, and must *always* be linked to arrangements for further verification, ***investigation*** and ***response***. It should be built around the pre-existing disease surveillance system as much as possible but that system alone will rarely be adequate. In most cases, it will be necessary to establish an ***Early Warning and Response Network*** (EWARN) initially .

An EWARN detects alerts/clusters and changes in trend. This type of disease surveillance is implemented early in an emergency and it's form is related to the risk of disease in the acute phase (a few diseases that could cause high mortality and morbidity). This system will evolve or be integrated into or replaced by a more routine disease surveillance system as the situation improves and the increased risk of disease transmission that existed early in the emergency lessens as public health interventions are implemented.

An EWARN is a sensitive, flexible, reactive and quick alert mechanism, established within the framework of an overall situation monitoring system, to rapidly detect selected epidemic-prone diseases and implement immediate outbreak control measures when needed. It should cover a very limited number of diseases with weekly routine reporting and immediate reports of specified critical conditions by both health facilities and health and medical relief teams.

Because denominator values are usually not known with precision in the acute phase of a crisis, it is difficult to calculate rates, which limits somewhat the overall utility of the system. It is a short-term solution to an urgent problem, focusing resources on the most immediate threats.

An EWARN needs:

✓ consensus and standardisation among all health agencies on the reporting forms, syndrome-based case definitions, and reporting mechanisms to be used;
✓ training of clinical workers at the primary and secondary care levels in the operation of the system;
✓ reliable and rapid means of communication;
✓ laboratory support capacity for diagnosis of the selected priority communicable diseases;
✓ stockpiles of sampling kits, drugs and vaccines; *and*
✓ contingency plans for isolation wards in hospitals.
✓

Panel 5-6

**The use of surveys during a humanitarian crisis**

*A sample survey is a structured and statistically analysable and comparable method for collecting information on a specific issue. It provides a* ***snap shot*** *of the situation (and respondents' perspectives) at the time when the data were collected, and/or means (and sometimes trends) in the case of retrospective mortality surveys.*

Sample surveys aim at validity and precision but may be subject to bias and the precision of the findings depends on a number of factors including the ***sampling procedures*** used and ***sample size***. They have an ***on-off*** periodicity and should be implemented at ***intervals*** if comparisons over time are required.

***Surveys can be useful for specific purposes***: During humanitarian crises, surveys are often used to estimate average mortality rates (CMR and U5MR), the prevalence of malnutrition and vaccination coverage. Those data are frequently used to assess the effect of the crisis on the health status of the population, identify priorities for intervention, and assess the impact and effectiveness of interventions. Survey results can also provide a potent advocacy tool to focus attention on, and mobilize resources for, a neglected humanitarian crisis.

But, ***surveys need careful planning and considerable resources*** (human, financial and logistic) if the results are to be reliable and useful. Several months may elapse from the survey design to the presentation of the results, and the results may sometimes be politically sensitive and need careful handling. Care must always be taken to avoid over-loading a survey by trying to respond to too many disparate demands for data!

Crude- and under-5 ***mortality rates*** may be estimated through surveys using trained enumerators and statistically-representative sampling procedures. ***Changes*** in mortality and malnutrition rates may be monitored by a combination of periodic surveys and cautious analysis of reports from health facilities and teams, bearing in mind that data from such reports will not be representative of the overall situation. (Mortality rates are a core indicator of the severity of the crisis and changes in rates an indicator of the impact of the humanitarian response.)

*Case example*

**The use of mobile phones and SMS messages for health reporting**

In Cambodia, provincial MoH rapid response team members going to the field to investigate suspected human cases of avian influenza are provided with mobile phone cards to enable them to report back quickly. The cards are purchased and distributed by the MoH using funds provided by WHO in the context of a project managed by the MoH.

Teams provided with the cards have been found to report very quickly. The teams do not have to account for their use of the cards which therefore represent a small incentive for the team members as they can also use the cards for personal calls. There is no evidence of major abuse and an investment of about $20 per person per month in Cambodia (a total $1440/month for 3 persons in each of 24 provinces) results in the MoH (and WHO) receiving timely and accurate reports.

## Tools and other guidance

*Communicable Disease Control in emergencies*, WHO 2005, chapter 3

*Natural Disasters – protecting the public's health*, PAHO 2000, chapter 7

*Epidemiological surveillance after natural disaster*, PAHO 1982

*WHO recommended surveillance standards*, WHO, 1999

*Guidelines for prioritization of disease surveillance*, WHO-CDS, 2006
http://www.who.int/csr/resources/publications/surveillance/WHO_CDS_EPR_LYO_2006_3.pdf

The management of nutrition in major emergencies. WHO, 2000

## 5.4 Analysing the situation

*Analysis is the detailed, methodical examination of constituent elements, structure and inter-relationships.*[2]

*Analysis of a crisis situation involves examining: what has changed, why, and with what effects; how the situation compares with the pre-crisis situation and what would be normal for the season, and with international standards; trends, expectations, further threats and risks; resources, opportunities, constraints, etc. (It is not a simple description of the present situation!)*

A thorough analysis of problems is the essential first step in developing a situation analysis prior to defining objectives and developing project proposals.

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**Guiding principles**

The analysis must always include:

- an analysis of ***health problems*** including nutritional status where relevant;
- an analysis of the ***context***; a*nd*
- ***lessons*** from previous experience in the country and in similar situations elsewhere, especially in neighbouring countries.

The analysis must result in (i) a prioritized list of the health problems to be addressed and their underlying determinants; and (ii) clear statement of the assumptions on which planning is to be based, preferably summarized in the form of a *scenario* in which "facts" and "assumptions" are clearly identified.

Specific analysis tools will be chosen according to the situation, the time available and the experience of the assessment team.

Situation analysis is an *ongoing process*, not a one-off exercise:

- A preliminary, "best-guess" analysis will be made on the basis of the preliminary assessment/ reconnaissance as described in section 3.2 and result in a preliminary working scenario (format in Annex 6) informing response action during the first few days.
- The initial situation analysis, based on the findings of the initial rapid assessment, will provide the basis for more substantial initial planning decisions. It can be useful to synthesize the analysis in a planning scenario (based on the format in Annex 6).
- The situation analysis, and the planning scenario, should be reviewed at regular intervals on the basis of monitoring/surveillance information, and be updated whenever necessary. It may need to be thoroughly revised – a new situation analysis be prepared – following any substantial change in the overall situation.

***Problem analysis***

The problem analysis must identify:

- *changes* in the levels/rates of mortality and morbidity compared with what would be normal for the season, and the numbers of cases involved;
- the *immediate causes* of avoidable mortality and morbidity (these may be injuries, communicable disease, malnutrition, etc.) and the numbers of people at risk;

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[2] Adapted from Oxford English Dictionary

- the *underlying (root) causes* of particular immediate problems – e.g. poor sanitation, polluted water, lack of access to or inadequacy of medical and health care services, food insecurity, poor feeding habits especially inappropriate infant and young child feeding practices, etc.
- *additional health threats* that can be anticipated including both seasonal and exceptional risks, and the numbers of people at risk;
- *gaps* in health service coverage or quality and the numbers of people concerned; *and*
- any important gaps in health *information*.

The identification of problems and gaps may be informed by comparing the current situation with pre-crisis conditions and international standards (SPHERE and WHO).

Problems should be prioritized on the basis of health risks – the number of people at risk of death or serious illness (or disability) due to each problem. Security conditions and other factors may affect ultimate management decisions on priority objectives and response activities but the problem analysis in the assessment report and situation analysis should be based on objective health criteria while highlighting contextual factors.

The process of identifying and prioritizing problems must be transparent and the criteria for prioritization recorded.

Problem trees can help in identifying hierarchies of problems and their causes – see, for example SOP 13.1. This can help to identify the problems on which attention should be focused to have the greatest effect.

***Context analysis***

The context analysis must include analyses of:

- the *political, social and cultural factors* that influence – positively or negatively – heath status, health care services, and the feasibility of health care interventions;
- the *security* situation including the causes of conflict and the implications for health action;
- the *resources* and *capacities* available, and what might reasonably be expected to be mobilized;
- the *opportunities* available for improvements or innovation in health-related behaviours or health service delivery;
- the *constraints* on health action, including logistic, operational, administrative and cultural constraints.

The analysis tools that can be useful include:

- stakeholder analysis (essential in all case) to identify the interests of all "stakeholders" that may affect or be affected by the health situation and health response actions – see Panel 5-7;
- SWOT (strengths-weaknesses-opportunities-threats) analysis; force field analysis (examining forces for and against a particular decision or course of action); impact analysis (anticipating the full consequences of proposed changes in a system); conflict analysis; "do-no-harm" analysis

Panel 5-7

**"Stakeholders" and stakeholder analysis**

"Stakeholders" include all agencies, organizations, groups or individuals who have a direct or indirect interest in a health, health services and the activities of the health cluster, and whose attitudes and actions could have an influence on health and the outcomes of humanitarian health activities.

A stakeholder analysis identifies the interests of all stakeholders, those that can be built on and those that conflict and could delay or even jeopardize particular forms of response action. It provides an essential understanding for analysing and selecting response options and developing strategies to help ensure that the response is successful.

A participatory stakeholder analysis can identify opportunities and build relationships that can improve the effectiveness and efficiency of the response.

N.B. Stakeholder analysis is distinctly different from, and covers a larger range of interested parties

than, a Who-What-Where-When analysis health service providers.

## What to do – key management actions

***First steps – during the first few days*** (“relief” focus)

☑ As soon as the initial working scenario (including preliminary affected population estimates) has been defined and agreed:

- analyse and prioritize the immediate problems and risks;
- analyse the impact on pre-crisis systems and staff, and pre-crisis weaknesses;

Where an inter-agency/health-sector *contingency plan* exists for the type of crisis concerned, the objectives envisaged in that plan should be rapidly reviewed and adjusted to the current initial working scenario. Where no relevant contingency plan exists, initial objectives should be developed from scratch based on the initial working scenario.

☑ Make efforts that analyses specifically look out for age- and gender-related differences (disaggregating data by sex and age), consider the different needs of men and women, girls and boys); *and* take account of protection and human rights issues, the impact of HIV/AIDS, security conditions and any limitations on access.

☑ Work with partners to identify critical gaps. Look out for, in particular, gaps in

- information: Is information on the current situation lacking from particular areas or on specific health aspects? Why? What pre-crisis information is on file on the affected areas?
- expertise and supplies for casualty care, emergency water & sanitation, measles vaccination, health communications, etc.;

***During the emergency phase/first month*** (predominant focus on life-threatening needs)

☑ In the context of the initial rapid assessment, work with the MoH (where possible) and other key partners to refine the analysis of problems and agree an overall situation analysis for the health sector.

☑ Look out for gaps in:

- care and rehabilitation of the injured and, for psycho-social reasons, the handling and disposal of dead bodies;
- organization and delivery of essential health services, particularly in neglected areas and for minority groups;
- management of malnutrition and protection and promotion of appropriate infant and young child feeding practices;
- emergency water and sanitation (especially for displaced people) including water quality;
- health communications – information to the public on how to protect their own health;
- logistic – especially transport – services for health teams and supplies.

***Once the situation has stabilized/beyond the first month*** (increasing recovery focus)

☑ Work with the MoH and other partners – in the context of the Health Cluster wherever possible – to monitor the implementation of the plan and agree adjustments as and when needed.

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**For guidance**, see:

SOP 13.1 section 3 *Problem Analysis*

Gap analysis – see Global Health Cluster materials (*Gap Guidance Materials*, Oct 2007, which may be developed into practical guidance before end-2008)

Health Cluster Guide: *Stakeholder analysis*.

# PART II – PLANNING AND MANAGING THE WHO RESPONSE

# 6
# Defining Objectives and preparing an Action Plan

This chapter provides guidance on defining objectives, selecting strategies and preparing an action plan. This corresponds to steps 2 and 3 in the process of planning and implementing an emergency programme outlined in Figure 2a, in section 2.2 (simplified version below).

As noted in 2.2, the process of agreeing a sector response plan (step 2) and then, in the context of that sector plan, a WHO action plan (step 3) should be feasible from the outset in case of a slow-onset crisis or when an inter-agency contingency plan exists and includes an outline sector response plan. In other cases, steps 2 and 3 will be undertaken in parallel and WHO will have to:

- draw up an initial WHO action plan taking account of what is known about the response plans of other actors; and simultaneously,
- work to bring together as many as possible of the main health actors to share information and progressively develop a shared analysis of the situation and needs, and agreement on overall goals, response strategies and, eventually, an overall health sector response plan.

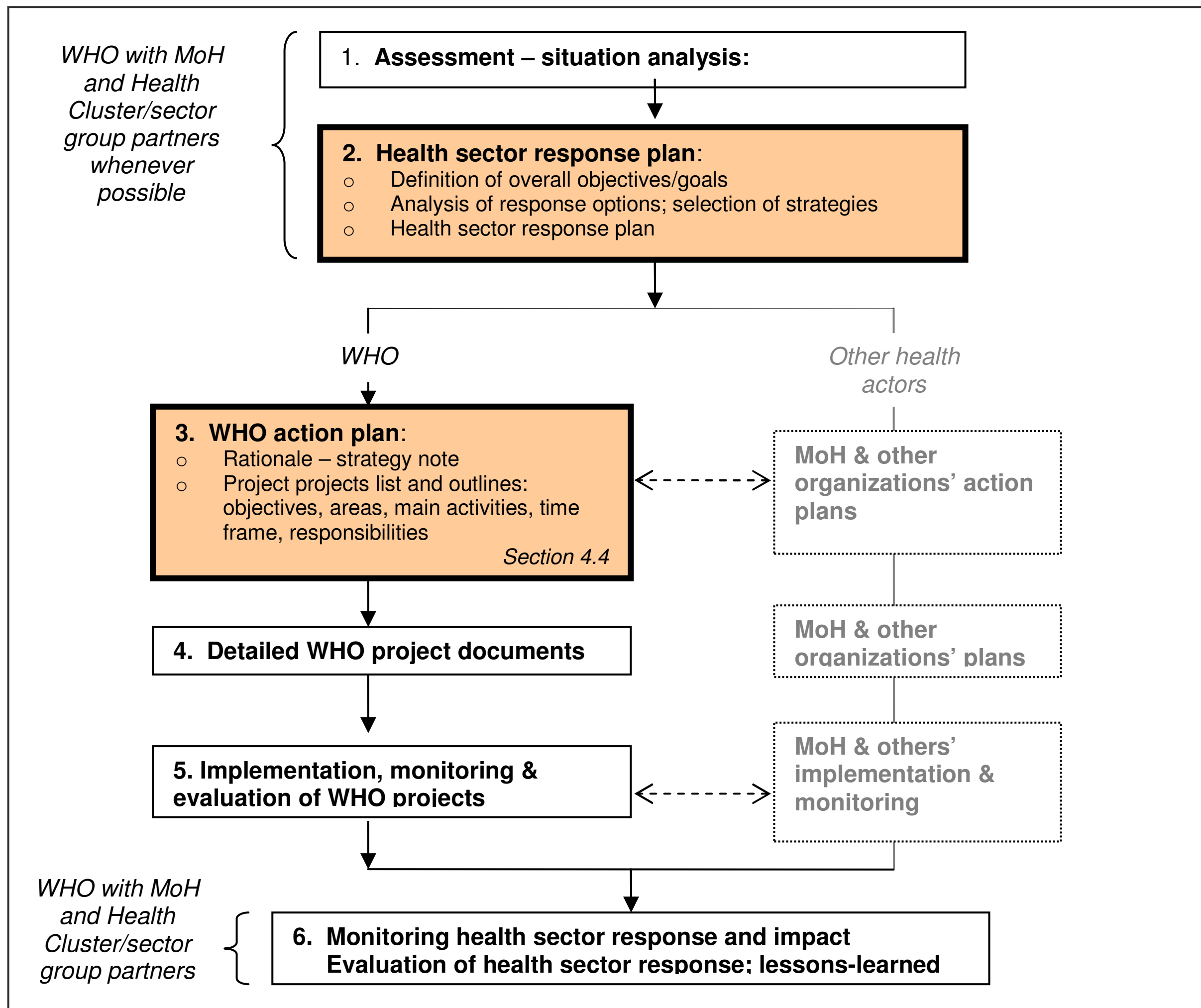
There must be a clear, demonstrated link between the situation analysis, priority problems, objectives and chosen strategies.

Existing structures and services should be used – built on and reinforced – as much as possible. Recovery should be promoted from the earliest possible moment. Potential negative effects must be considered, and minimized.

Clarity and agreement on objectives and response approaches are essential for coherent, coordinated humanitarian health action. They must be understood by all stakeholders and easy to explain.

> A clear, agreed set of initial objectives and approaches is an essential pre-requisite for appropriate, coordinated action during the first few days and weeks. They should be defined on the basis of the preliminary assessment and initial working scenario (see Figure 2a in section 2.1, and sections 3.2 and 3.3).
>
> Initial strategies and plans should be reviewed and adjusted in the subsequent days as the situation evolves or additional information becomes available. A detailed health sector response plan should be drawn up as soon as the initial rapid assessment has been completed.

[5] UNHCR Manual 1999


WHO with MoH and Health Cluster/sector group partners whenever possible
1. Assessment – situation analysis:
2. Health sector response plan:
Definition of overall objectives/goals
Analysis of response options; selection of strategies
Health sector response plan
WHO
Other health actors
3. WHO action plan:
Rationale – strategy note
Project projects list and outlines: objectives, areas, main activities, time frame, responsibilities
Section 4.4
MoH & other organizations' action plans
4. Detailed WHO project documents
MoH & other organizations' plans
5. Implementation, monitoring & evaluation of WHO projects
MoH & others' implementation & monitoring
WHO with MoH and Health Cluster/sector group partners
6. Monitoring health sector response and impact
Evaluation of health sector response; lessons-learned

## 6.1 Defining objectives

*An* objective *is the desired state that it is intended to achieve – the desired outcome. Objectives are defined at different levels – overall objectives (or "goals") of the emergency programme and specific objectives (or "purposes") of individual WHO projects that contribute to achieving the higher goals.*

Defining objectives is a key element of step 2 in the response process chart in Figure 2b (in section 2.2). It should be done jointly, collaboratively by WHO, the MoH and other main health partners, whenever possible.

**2/3. Health sector response plan/WHO action plan**:
- **Definition of overall objectives/goals**
- Analysis of response options; selection of strategies
- Health sector response plan/WHO action plan

Clarity and agreement on objectives are essential for coherent, coordinated humanitarian health action. They must be understood by all stakeholders and easy to explain. Achieving consensus on objectives is a key sign of leadership and coordination.

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**Guiding principles**

Objectives should be defined in relation to the priority health problems and risks identified in the situation analysis and within the overall framework of *reducing excess mortality, morbidity, malnutrition and disability* and *restoring the delivery and access to health care*. They must address the main causes of death and illness and the major constraints to delivery of and access to health care.

Objectives may include improving information as well as achieving direct health outcomes. While many will concern aspects that are the responsibility of the MoH (and the Health Cluster/sector coordination group), some may relate to aspects that are the responsibility of other ministries (and other cluster/sector coordination groups).

Objectives must be "SMART" – **s**pecific, **m**easurable, **a**ccurate, **r**ealistic and **t**ime-bound (e.g. "the risk of diarrhoea reduced by 50% in the target population in 6 months"). They must:

- address coherently the priority problems and risks identified in assessments;
- be tailored for specific phases of the response;
- differentiate among men and women, girls and boys, when appropriate; *and*
- take account of protection and human rights issues, the impact of HIV/AIDS, security conditions and any limitations on access.

Objectives may need to be reviewed and refined if there are significant changes in the situation or the resources available (including the number, interests and competencies of the health actors present), or when new information becomes available from assessment or monitoring activities.

When framing objectives, it may be useful to consider the factors listed in Panel 6-1.

Initially the focus will be on *ensuring that life-threatening humanitarian needs are met*, while always looking for opportunities to promote recovery and rebuild systems. As soon as *life-threatening needs* are met, the focus should shift progressively to *re-building national systems and capacities* while ensuring that any remaining humanitarian needs are met.

N.B. Assessment determines the effects of the crisis and provides conclusions in terms of intervention priorities in rank order. However, those overall sector priorities may NOT remain as WHO's organizational priorities as other stakeholders address selected needs according to their comparative advantages. WHO must be continually aware of overall priorities *and* unmet needs, and respond to the latter.

Panel 6-1

**Some factors to consider when formulating objectives**

✓ the *hazards*, or *threats,* that need tackling, e.g. malnutrition, measles and/or malaria,

- ✓ the *vulnerabilities* that need reducing, e.g. people living in crowded temporary settlements/accommodation,
- ✓ the *capacities* that need strengthening, e.g. health posts at community level/in camps,
- ✓ the *constraints* that need addressing, e.g. military insecurity,
- ✓ the *expectations* that must be met. (The policies and values of the various stakeholders that will affect the evolution of the overall situation and the implementation of activities.)

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## What to do – key management actions

***First steps – during the first few days***

- ☑ *Where an inter-agency/health-sector contingency plan exists* for the type of crisis concerned, review the objectives envisaged in that plan and adjust them to the current initial working scenario.
- ☑ *Where no relevant contingency plan exists*, develop initial objectives from scratch based on the initial working scenario.
- ☑ Ensure that the initial objectives defined for the first few weeks of response are realistic and focus on life-threatening humanitarian needs while capitalizing on any opportunities that may exist to initiate recovery straight away.

***During the emergency phase/first month***

- ☑ Elaborate objectives for the coming 6 to 12 months on the basis of the initial rapid assessment and as new information becomes available. Include both continuing humanitarian response and a progressively increasing focus on recovery.

***Once the situation has stabilized/beyond the first month***

- ☑ Keep the defined objectives clearly in view, and under review. During periodic progress reviews, check whether the defined objectives are still appropriate and realistic. Revise/refine them if and when necessary in agreement with all concerned stakeholders.

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## Tools and other guidance

SOP 13.1, section 4.

Annex C1 *Core-functions analytical framework* which shows how the core functions listed in section 1.4 may be used as a framework for analysis when developing objectives and an action plan.

Annex C5, *Key health services and functions* provides a list that may also help in putting together overall objectives and a health sector response/action plan.

## 6.2 Selecting response strategies

*Strategies are the methods used to achieve specific objectives. Where alternative strategies are possible, a choice has to be made among the different options. Achieving consensus among all health actors on the strategies to be adopted is a key sign of effective leadership.*

*A strategy note is a short (2 to 3 page) narrative outlining and explaining the objectives of WHO action and the strategies chosen to accomplish them. It provides the rationale for the WHO action plan and serves as the introduction to that plan.*

Panel 6-2 includes examples of some typical problems and the kinds of alternative strategies that could be possible and amongst which choices must be made.

Analysing options and selecting strategies is a key element of step 2 in the response process chart in Figure 2b (in section 2.2).

**2/3. Health sector response plan/WHO action plan**:

- Definition of overall objectives/goals
- **Analysis of response options; selection of strategies**
- Health sector response plan/WHO action plan

### Guiding principles

Strategies must be chosen on the basis of the situation analysis and an explicit, recorded analysis of the advantages and disadvantages of possible alternative ways of addressing specific problems and accomplishing particular objectives. They must be:

✓ *appropriate* – address the priority problems and risks effectively, coherently and efficiently in a manner suited to the local context; *and*

✓ *feasible* – able to be implemented in the local context and with the resources expected to be available.

The tabular format of Panel 6-3 may be a useful tool for the analysis of response options.

Careful analysis is necessary to identify the most appropriate strategies, ones that will achieve the defined objectives while minimizing any potential negative effects. Note that short-term actions taken to address an immediate systemic problem in service delivery may have significant distorting effects on the entire health system in the longer term – see the examples in Panel 6-4. The issues are complex and decisions often difficult.

To be "*appropriate*", response strategies must:

✓ be adapted to the context (including the geographical extent, causes of the crisis, the pre-crisis situation, current health status of the population, health risks, whether people are displaced, current trends and processes towards recovery, etc.);

✓ take account of:

- national health policy and international standards, and the characteristics and status of the health system;
- the interests and capacities of health-sector stakeholders;
- any protection and human rights issues – not increase risks for the population but, if possible, contribute to reducing them; *and*
- any potential unintended, negative effects that particular strategies might have (see Panel 6-4).

✓ be "gender-aware" – take account of the different situation and needs of men and women, girls and boys, where appropriate – and culturally sensitive;

✓ seek to protect and expedite the recovery and rebuilding of national systems and capacities as much as possible, especially once life-threatening needs have been met (see section 6.3);

✓ make services accessible equitably to all population groups including marginalized and disadvantaged groups (disabled people, minorities, etc.); *and*

✓ be as cost-effective as possible (because resources are almost always a constraint).

To the extent possible, they should also, from the outset:

✓ build on existing systems and optimize the use of existing resources;

✓ promote community participation and community-based planning;

✓ enhance the capacities and reduce the vulnerabilities of people and health services;

☹ avoid creating, or reinforcing, dependency.

To be "*feasible*", they must be:

✓ technically feasible;

✓ politically and culturally acceptable; *and*

✓ able to be implemented in the prevailing security conditions and in spite of other operational constraints.

The strategies (response options) adopted by ***WHO*** for its emergency programme should be in line with those of the overall health sector response plan once such a plan is drawn up and agreed among the MoH and main health partners.

The *reasons* for the adoption by WHO of a particular approach, or set of strategies, should be explained clearly and concisely in a ***strategy note***, see Panel 6-2. An initial strategy note should be prepared – and signed by the WR – within the first week of the WHO response. It should be reviewed regularly (e.g. monthly) and up-dated when necessary.

Panel 6-2

**A "strategy note" – what and why?**

The *strategy note* is a context-sensitive explanation of the objectives and why particular strategies/response options have been chosen. The rationale must be concise but provide the reason – the justification – for the proposed WHO actions. It should:

- provide a concise (1 page) analysis of the situation including the prioritized list of the main problems and their underlying causes;
- present the objectives for each main area of intervention (e.g. prevention and control of communicable diseases, injury rehabilitation, surveillance, management of severe malnutrition, drug supplies management) and the strategies proposed to achieve the objectives, and show how the objectives and strategies derive from the assessment findings and situation analysis;
- state whether, for specific activities, WHO would be acting on the basis of its comparative advantage or gap-filling (perhaps as provider-of-last-resort); *and*
- explain how specific programming principles and inter-sectoral cross-cutting concerns identified as being particularly important in the current situation have been taken into account. These principles and concerns may include particular consequences that must be avoided (sometimes referred to as "boundary conditions")

N.B. This is *not* a restatement of the needs assessment. It takes the situation analysis as a basis and develops the rationale for the precise plan of action.

The preparation of a strategy note is the occasion for the WR to establish and take responsibility for the strategic direction of the WHO response.

In case of an "improvised initial response" to a sudden-onset crisis in the absence of an inter-agency contingency plan (see section 2.1), it is also an opportunity for WHO and the WR to provide strategic leadership to the health cluster/sector group by sharing the WHO strategy note with partners and facilitating a process of expanding and adapting it to the sector response as a whole, in collaboration with the MoH.

**What to do – key management actions**

***First steps – during the first few days***

☑ Define strategies for *initial* response.

- Where an inter-agency/health-sector contingency plan exists for the type of crisis concerned, work with partners to rapidly review the current appropriateness and feasibility of the strategies envisaged in that plan and, if needed, adjust them to what is known about the situation.
- Otherwise, develop initial strategies from scratch based on the initial working scenario.

***During the emergency phase/first month***

☑ Define strategies for response during the coming 3/6/12 months based on the findings of the initial rapid assessment.

☑ Consciously work to protect national capacities and systems as much as possible from the outset of the emergency response and to initiate the rebuilding of those capacities and systems as early as possible – see section 6.3.

***Once the situation has stabilized/beyond the first month***

☑ Review the strategy note at regular intervals – perhaps every month during an initial period then every 3 months.

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Panel 6-3

**Analysing response options – a framework and some examples of options**

| **Problems** | **Some options**<br>(one or a combination could be adopted) | **Arguments for**<br>(advantages) | **Arguments against**<br>(disadvantages) |
|---|---|---|---|
| Shortage of drugs | Importing drugs in bulk | | |
| | Importing drug kits | | |
| | Purchasing drugs locally | | |
| Gaps in clinical service coverage | Strengthening existing services | | |
| | Temporary emergency services:<br>• mobile clinics | | |
| | • fixed services in new settlements | | |
| | • field hospitals | | |
| Certain populations cannot access services | Waiving/reducing user fees | | |
| | … | | |
| Shortage of funds for health services | Introducing/increasing user fees | | |
| | … | | |
| Shortage of qualified health personnel | On-the-job training | | |
| | Support for *ad hoc* local recruitment | | |
| | Temporary mobilization of WHO staff from other countries/regions | | |
| | Recruitment of international experts | | |
| Laboratory services | For personnel: see above | | |
| | For supplies & equipment:<br>• local procurement (in-country or from neighbouring countries) | | |

| | | | |
|---|---|---|---|
| | • international procurement | | |
| Inadequate disease and nutrition surveillance & early warning | Strengthening existing mechanisms | | |
| | Establishing:<br>• sentinel site reporting/surveys | | |
| | • health facility reporting | | |
| | • field team reporting | | |
| | • scanning news-media reports | | |
| Inadequate public understanding of health threats and behaviours to adopt | Radio broadcasts | | |
| | Loud-speaker announcements | | |
| | Social mobilization | | |
| | | | |

Panel 6-4

**Examples of alternative strategies and unintended negative consequences**

***Alternative strategies***

In a refugee camp, a specific objective may be to reduce the risk of an outbreak of severe diarrhoea. Possible strategies that might be considered include: public education for improved hygiene; improved water supplies; improved sanitation facilities; mass vaccination. In this case, the first three strategies would probably be adopted simultaneously but not the last one (as mass cholera vaccination is not recommended by WHO).

Following a disaster, the assessment reveals that there will be a shortage of drugs. Possible strategies include: importing drug kits; importing drugs in bulk, purchasing drugs locally. The arguments for and against each of these options must be carefully examined before deciding on the strategy to adopt. (Note that even establishing the fact that there is, or will be, a real shortage of drugs can be problematic, but importing drugs because it "seems" there could be a shortage can be very damaging – see below).

***Unintended negative consequences***

*Provision of drugs*: Large volumes of donated/imported drugs can have unintended negative consequences. Following the tsunami December 2005, large quantities were imported into Aceh, Indonesia and given out free by relief agencies. The local market for pharmaceuticals was totally disrupted forcing local private pharmacies to close and move to other provinces. The result was that:

- people with chronic diseases could no longer buy their insulin, blood pressure medicine, etc. (items that were not considered “emergency” drugs so not provided by the relief agencies); *and*
- the overall recovery of the health sector was compromised because, as relief NGOs closed their operations and left, local people had nowhere to buy medicines anymore.

*Waiving user fees*: User-fees can be a major financial obstacle to access to health care, especially during a crisis. However, in many countries, the managers of government health facilities in many countries depend on user fees (and selling drugs) to supplement their meagre budgets for staff costs and salaries. In Aceh, once the Government waived user fees and NGOs gave out free drugs, there was a big migration of government health staff out of the province. This created a long-term problem of manpower shortage that still persisted several years later.

## 6.3 Protecting and rebuilding and national systems and capacity

Helping to ***(re-) build systems & capacity*** as quickly as possible and in a sustainable manner is an *underlying principle* for the design and implementation of all response activities.

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### Guiding principles

The strengthening/re-building of local health systems and capacity can be initiated from day-1 of response activities by:

- taking care to *avoid undermining* existing systems and capacity, especially during the heat of response to acute needs in the early stages of response;
- choosing response strategies and designing implementation arrangements for all emergency health activities in ways that contribute to protecting and rebuilding national systems and capacities – e.g. by using, reactivating and repairing existing facilities and systems rather than creating new, parallel systems whenever possible – and by involving local personnel in all activities including participating in assessments, analyses, decision-making, project design, implementation and monitoring, preparing joint reports, and co-chairing meetings, as a conscious effort of on-the-job training; *and*
- specifically analysing the status and functioning – the strengths and weaknesses – of all the main components of the health system and developing specific project activities to reinforce and develop critical elements of the system and local capacities. This may include, for example, health sector policies and financing, human resource management and development, financial and information management, pharmaceuticals, physical infrastructure and equipment.

The post-disaster/post- conflict phase provides a window of opportunity to "build-back-better" in terms of policies and approaches to the delivery of health services as well as enhancing preparedness for future crises and instituting vulnerability reduction measures. All these opportunities must be seized.

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☑ Work with the MoH and other partners to identify all opportunities to protect and (re)build systems and capacities. Work directly and through the Health Cluster (or other health-sector coordination mechanisms) to try to ensure that:

  - existing facilities and systems are used, reactivated and repaired, whenever possible – and that new, parallel systems are avoided, unless absolutely necessary;
  - existing in-country competencies are identified and used as much as possible;
  - local personnel are involved in all assessment, planning and response activities;
  - (re)training needs are identified and appropriate, task-oriented training provided as early as possible.

☑ Try to get agreement among all the main health actors (in the context of the health cluster or other sector coordination group) on:

  - the importance of maintaining and, where possible, strengthening the MoH and sub-national level health structures; *and*
  - how to avoid denuding these structures. (Possibilities might include paying incentives to MoH staff to stay at their posts. Use imagination to find ways, together with partners.*)*

☑ Ensure that all WHO's own actions contribute to strengthening and rebuilding local systems and capacities by using, reactivating and repairing existing facilities and systems, whenever possible; and involving local personnel in all activities as a conscious effort of on-the-job training.

☑ Promote and participate in detailed assessment of the health system and critical sub-sectors to identify needs for reconstruction and opportunities for reform.

For detailed guidance in relation to re-building national capacity and systems possible, see *Analysing Disrupted Health Systems*, WHO 2008, and the *Health Cluster Guide*, draft 2008.

## 6.4 Defining priority projects; preparing an action plan

*A* project *is an undertaking intended to achieve certain specific objectives with specified resources, usually within an overall programme and within a specified timeframe.*[5]

*An* action plan *outlines the activities that the Organization plans to undertake, subject to the availability of funding, and the overall rationale. It lists the proposed projects and, for each, the objectives, main activities, expected outputs, intended time frame for implementation, expected cost (total budget), and responsibilities.*

**2/3. Health sector response plan/WHO action plan**:

- Definition of overall objectives/goals
- Analysis of response options; selection of strategies
- **Health sector response plan/WHO action plan**

### Guiding principles

The WHO action plan should focus on:

- addressing priority health problems and needs and filling critical gaps that are not, and will not be, covered by other health actors and donors in humanitarian response; *and*
- achieving the maximum health benefit for the maximum number of people in disaster/crisis-affected districts and populations.

It will be developed within the framework of the WHO core functions in humanitarian response (see section 1.1) and the context-specific objectives and strategies defined locally (see sections 6.1 and 6.2).

Priority needs and gaps in the humanitarian response will be identified during assessments, monitoring of the situation, and coordination meetings.

Activities should be directed towards achieving province-wide (or even country-wide) benefits and outcomes, wherever possible.

Gaps should be filled in ways that contribute to restoring basic public health functions in a sustainable manner, wherever possible.

Projects including supply of medical ***equipment*** should focus on equipment for public health purposes (public health laboratory, cold chain, etc.) and take account of maintenance considerations including the availability of spare parts and technicians.

Proposals for ***training*** activities must be carefully examined. In general, the focus during the early stages of response should be on in-service (on-the-job) training for specific technical tasks. More general training may be difficult to organize at this stage and not have an immediate impact. Any training activity *must* include follow up and evaluation.

The action plan should include, as annexes, ***contingency plans*** to deal with new crises that could arise in the course of the planned humanitarian operation.[6]

### What to do – key management actions

***First steps – during the first few days***

During the first phase pending completion of the IRA:

☑ Prepare an initial action plan for WHO assistance. Do this within the framework of the overall health sector response plan if there is one within the first 48 hours, but don't wait longer. Use/adapt the format in Figure 4a. See the dos and don'ts in Panel 6-5.

[6] The contingency plans referred to here are "in-crisis" contingency plans, prepared to deal with events ("contingencies") that could further complicate the current critical situation.

☑ Focus on identifying – and then trying, with partners, to fill – gaps in the availability of critical information or services in areas where large numbers of people are known, or believed, to be seriously affected (see Panel 6-6).

☑ Make sure that the WCO has, or will have, the capacity and systems to support the anticipated field activities:

- list the support functions to be assured by WHO (the WCO) during the first two or three weeks, and estimate the workload involved;
- assign responsibilities and prepare an office emergency programme support work plan in the form of a simple matrix: tasks; timeframe; responsibility; resources needed; resources available; additional resources to be mobilized; *and*
- include necessary provisions in the budgets of individual projects.

***During the emergency phase/first month***

☑ Up-date the action plan for WHO assistance within the framework of the overall health sector response plan. Use/adapt the format in Figure 4a. Critically review the first draft using the checklist in Panel 4-7.

☑ Build on any opportunities for capacity building of people and facilities for response to immediate needs. This may include:

- ✓ support and on-the-job training for communicable disease (CD) control: e.g. surveillance, vaccination and cold-chains, laboratories, reporting systems;
- ✓ support and on-the-job training for non-CD surveillance: e.g. water quality monitoring and sanitation measures;
- ✓ support and on-the-job training on management of severe malnutrition
- ✓ support to MoH operations room;
- ✓ support and on-the-job training for logistics – transportation, supplies management, (e.g. LSS/SUMA).

☑ Consolidate WHO operational support capacity and systems: Up-date the list of functions, estimates of workload, and the office emergency programme support work plan taking account of the programme action plan and the prospects for mobilizing resources for the planned projects.

***Once the situation has stabilized/beyond the first month***

☑ Maintain support for the health and nutrition information system, an appropriate EWARN system, health communications, critical public health supplies, etc., as needed, while working to progressively reduce dependence on WHO and other external assistance as and when possible.

☑ Focus on analysis of and planning for medium-term rehabilitation and recovery needs of health system facilities, human resources and equipment, keeping in mind the programmes planned by other partners.

☑ Prepare contingency plans for events (contingencies) that could impact on the health of the population and/or the ongoing humanitarian assistance operations of WHO and other health-sector actors during the coming months. Do this with partners in the context of the Cluster/sector coordination group, if possible. See Panel 6-7.

Figure 4a

**WHO action plan for** …[country]… **for the period** …/…/… **to** …/…/…

Explanation of objectives and strategies (the strategy note outlined in Panel 6-2 in section 6.2):

Arrangements for monitoring implementation of the plan and evaluating impact:

| Goals | Project | Objectives; expected outputs | Main activities | Timeframe | Cost | Indicators of performance |
|---|---|---|---|---|---|---|
| | 1. … | | | | | |
| | 2. … | | | | | |
| | | | | | | |

Panel 6-5

**Some dos and don'ts when preparing a WHO humanitarian action plan**

***What to focus on***

According to the context, give priority to projects aimed at strengthening:

- ✓ Health and nutrition information;
- ✓ health coordination;
- ✓ communicable disease control (including EWARN and environmental health);
- ✓ hospital-based management of severe malnutrition
- ✓ health system rebuilding (including human resource and supply management).

Typically, these are areas in which WHO has a "comparative advantage" and is expected, by partners, to act and make a difference.

In addition, give particular attention to the following aspects that are often overlooked by other partners: quality of injury care; water quality control; food safety; mental health; management of chronic diseases; management of essential drug supplies.

***What to avoid***

- ☹ Do not plan projects to provide direct services to people or communities unless urgent needs are not being met and there are severe and immediate risks to health or safety.
- ☹ Do not engage WHO in major infrastructural rehabilitation of buildings. Be ready to fill gaps for minor reactivation of facilities, provide advice on rehabilitation and reconstruction (location, coverage, retrofitting, etc.) or provision of power supplies to health facilities, but do not take direct responsibility for major physical works.

Panel 6-6

**Filling gaps**

- ☑ Work with partners to identify critical gaps. Look out for, in particular, gaps in expertise and supplies for casualty care, emergency water & sanitation, measles vaccination, health communications, etc.
- ☑ Use the Cluster or other coordination mechanisms, the UNCT, and bilateral contacts with agencies (and donors?) to try to mobilize competent organizations to fill the identified gaps.
- ☑ Use resources available to the WCO from regular programmes to fill priority gaps, where possible.

☑ Request emergency funds from RO and/or HQ, and seek donor contributions locally from embassies, etc. (see section 6.1) to fill outstanding priority gaps.

☑ Keep the RO, HQ-HAC, members of the Health Cluster/other coordination groups, and donors informed of outstanding priority gaps.

☑ Monitor (or support the Cluster Lead in monitoring) the funding and implementation of the emergency health sector response plan and advocate for additional resources when needed.

Panel 6-8

**Contingency planning during an ongoing humanitarian operation**

Events that could further impact on the health of the population or on the ongoing humanitarian assistance operations during the coming months must be anticipated. Contingency plans must be prepared to respond to possible new health threats and to ensure, as much as possible, the continuity of services and humanitarian assistance to the target populations.

***What to do***

☑ Decide, with partners, how the problems arising from such events will be managed- what strategies will be taken.

☑ Specify what additional resources – human, material, financial – would be needed.

***What to consider***

Events (contingencies) that might need to be anticipated include, for example:

- secondary disasters: recurrence of the primary hazard or secondary phenomena such as epidemics of communicable diseases and increased malnutrition or a forthcoming cyclone season;
- deterioration of the security situation, notably the possibility that renewed conflict could affect certain health facilities or disrupt supply corridors;
- breakdown of in-country supply chains due to overburdened provincial services;
- rumours and misinformation impairing relief activities.

## Tools and other guidance

Annex C1 *Core-functions analytical framework* which shows how the core functions listed in section 1.4 may be used as a framework for analysis when developing objectives and an action plan.

Annex C5, *Key health services and functions* provides a list that may also help in putting together overall objectives and a health sector response/action plan.

*Policy and strategy for WHO/EHA action in disasters*, WPRO, April 2005

*Humanitarian health response: south-central Somalia*, WHO-EMRO May 2007 [7].

**The management of nutrition in major emergencies. WHO, 2000**

[7] Note, however, that a "strategy" in that document corresponds to "objectives" as used in this handbook, while the "areas of intervention" in that document correspond to "response strategies" as used in this handbook.

# 7
# Planning and Implementing Projects; Preparing Appeals

This chapter provides guidance on the various aspects of planning and managing specific WHO projects within the framework of the WHO action plan. It covers preparing project proposals, Identifying and working with partners, and managing and monitoring project implementation. It also includes guidance on preparing applications for CERF funds and inputs to UN appeals (flash appeals and consolidated appeals).

These functions would normally be the responsibility of the Emergency Programme Manager in a major emergency. In a lesser emergency they might be the responsibility of the assigned emergency programme officer or EHA focal point.

## 7.1 Preparing project proposals

Project proposals describe specific activities or groups of activities to be undertaken within the framework of the action plan and specify the inputs required (human resources, material and financial), how the project will actually be implemented and the partners that will be involved.

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### Guiding principles

Concise, well-prepared project proposals and summaries are essential for resource mobilization.

All project proposals must be clearly linked to an overall health sector response plan and the WHO action plan (see 6.4).

Proposals may include projects to support assessment, monitoring/surveillance and coordination as well as to fill gaps in service provision (see section 1.1). This should include strengthening the WCO and/or emergency field sub-offices to help assure these activities, when needed.

Where there is insecurity and specific security measures are required to assure MOSS compliance and enable WHO to operate, consult with the RO and HQ-HAC on whether to prepare a specific project or integrate a security element, pro rata, in the budgets of the service provision projects.

Proposals should be prepared by experienced emergency planning officers, whenever possible.

Objectives must be "SMART" – **s**pecific, **m**easurable, **a**ccurate, **r**ealistic and **t**ime-bound (e.g. *risk of diarrhoea reduced by 50% in the target population in 6 months*). Expected outputs must also be SMART (e.g. *a specified number of safe water sources, latrines and garbage pits made available to specified target populations in # months*).

Careful attention to project design is essential to ensure that the proposed project will have the intended results and be able to be implemented as planned. Preparing a log-frame can help in this connection and is also a requirement for several donors.

The 2-page format for applications to the CERF may be used to prepare brief (outline) project proposals for first submissions to donors, the RO and HQ-HAC. Detailed project proposals can then be prepared if and when a donor shows interest.

Proposals prepared prior to the completion of the initial rapid assessment – during the first week-or-so – should normally be limited to priority activities that need to be initiated "immediately" and implemented within 3 months.

A project officer should be envisaged – budgeted for – for any large-scale or CERF-funded project.

Under normal circumstances emergency activities will be planned for a period of 3 to 12 months. Projects may be planned for more than 12 months in a complex emergency.

The monitoring and reporting on projects will be greatly facilitated if the different projects are consolidated within a simple strategic/programmatic framework. The WHO Core Functions Framework can help (see section 1.1).

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### What to do – key management actions

***Preparing project proposals***

☑ Prepare project proposals using the standard HAC outline shown in Panel 7-1 and following the guidance in 🕮 SOP 13.1 which also includes a WORD template for a project proposal and detailed guidance on preparing a log-frame.

☑ Request short-term support from the RO (or HQ-HAC) to help in project preparation, if required.

☑ Budget and plan for a project officer (and an information officer) if the total project cost is more than 250,000 USD, if it is multi-donor funded, or funded through the CERF.

☑ When preparing project *budgets* make sure that cost estimates are realistic and include justification for each budget line.

- o Use standard costs (not just salary estimates) for personnel and include installation allowances where relevant.

- Ask the FSO for requirements and estimates for security measures and equipment.
- Provide operating and maintenance budgets, where necessary, for vehicles and other common items (e.g. driver, fuel, local insurance, maintenance, communications equipment).
- Include provision for a local finance and administrative staff member to track expenditures and prepare spreadsheets, monitoring tables and reports and resources for project monitoring and evaluation.

See the list of typical budget items and sample budget in Annex C7.

☑ When defining the time frame for implementation, take account of the lead times required for recruitment and procurement. Be realistic!

☑ Use the checklist in Panel 7-2 to judge the appropriateness of the proposal before finalizing and submitting it.

☑ Consult with the RO (EHA) and HQ-HAC *before* preparing specific project proposals or discussing details with the government or potential donors.

☑ Clear draft project proposals with the relevant regional adviser(s) before finalizing and formally submitting them to the RC/HC or local donor representatives. (This enables the RO, in consultation with HQ-HAC, to a) advise on the likelihood of securing funding, and b) ensure that proposals benefit from the latest knowledge, experience and identified best practices (as well as conformity with WHO's technical guidelines).

***Preparing project summary sheets for inclusion in a CAP***

☑ Use the standard OCHA-CAP template shown in Annex C4 and downloadable at: http://www.reliefweb.int/cap/Policy/TechGuide/PROJECT%20TEMPLATE.doc

☑ Do not go over *1 page*, nor change the standard margins or font. OCHA will return any sheet that does not comply with the template, and not include the project in the appeal! The project sheet is only an “advertisement” and interested donors will contact WHO if they require additional information.

☑ If a project is a *joint project* with one or more other agencies, specify the funding breakdown per agency.

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## Tools and other guidance

SOPs 13.1, 13.3, 13.4

*Possible input requirements for projects in key functional areas* in annex C6

*Project budget items and sample budget* in annex C7

CERF application format in annex C2

CAP project summary sheet in annex C4

*Cheat sheet: appeals and CERF*, OCHA 2006

Sample: Action plan for South Sudan 2007

*Proposal templates* for Epidemic preparedness & response, Laboratory services, Malaria, Surveillance, WHO Communicable Diseases Working Group on Emergencies, Geneva

ToR for a project officer in SOP 7.1

Panel 7-1

**Outline for a project proposal**

**Basic project data** (a cover sheet)

**Background and overview** (an introductory section)

- executive summary

- problem statement
- background to the project
- project beneficiaries

**Project goal and objectives**

- overall (long-term) goal of the project
- specific project objectives
- activities to be implemented to achieve the objectives and overall goal
- inputs (staff, IT, transport, supplies, equipment etc.) needed to carry out the activities
- timeframe for completion of the work
- the indicators/means of verification

**Logical framework**

**Detailed budget**

Panel 7-2

### Checklist for evaluating proposed projects

- ❑ Does the project fall within the overall plan for health action? Is it approved by the MoH at national and/or local levels?
- ❑ If international health sector partners will be involved, will they and the project help to strengthen or re-build the national public health system, rather than create parallel structures?
- ❑ Does the project plan to make use of the capacities of local institutions and local NGOS whenever reasonable and feasible?
- ❑ Have communities and local institutions been part of assessment and planning processes?
- ❑ Is assistance, including that to displaced populations, provided on the basis of assessed need?
- ❑ Does the project meet SPHERE standards to the maximum extent feasible?
- ❑ How do the standards of provision (including construction) compare with those prevailing before the disaster? Are they compatible with the systems and practices of the country?
- ❑ Is the project feasible and the timeframe realistic? Are they compatible with the absorption capacity at local level?
- ❑ Does the project include measures to reduce disaster risks – by reducing hazards and/or vulnerability, and enhancing emergency preparedness? (This is particularly important for recovery and reconstruction projects.)
- ❑ Are resources provided for routine monitoring and for undertaking evaluations of outcomes and impact?

[Adapted from … WPRO]

## 7.2 Identifying and working with partners

Much more can be achieved by working together with partners than separately.

Partnerships in *assessment and situation monitoring* are important to achieve shared understandings of the situation and needs, and shared ownership of the conclusions; to enhance the quality of the assessment and speed up completion by taking advantage of the skills and other resources that are available in different organizations and institutions; to permit a comprehensive assessment, and increase confidence in findings and the interpretation of data, by creating conditions for cross-checking data from different sources, perspectives and sectors; *and* to increase transparency.

Partnerships in *planning and implementation are* important to ensure coherence in addressing priority health problems and the effective and efficient use of resources.

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### Guiding principles

Effective partnerships are based on shared objectives, mutual respect, joint ownership of the activity, and shared commitments to transparency and accountability. Developing and sustaining partnerships requires commitment and diplomacy.

Existing partnerships must be consolidated and potential new partners identified as quickly as possible. Partners may include other UN agencies, national or international NGOs, and other national entities including capacities in the private sector.

National partners can be particularly effective as they may be sensitive to the needs of the population, speak local languages, and have the necessary contacts to get things done. Collaboration with national partners also helps to build national capacity and enhances the sustainability of activities.

Collaboration with the International Committee of the Red Cross (ICRC) and certain international NGOs can be particularly important in conflict situations when they have access to areas that are not accessible to WHO.

During a recovery phase and especially a post-conflict “transition” phase, donor funding sources change; coordination and partnerships with the World Bank, regional development banks and trust funds become more important.

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### What to do – key management actions

***First steps – during the first few days***

- ☑ Contact WHO’s existing, established partners and identify how they and WHO can coordinate efforts and eventually collaborate in joint activities.
- ☑ Be proactive in identifying and contacting potential partners, national and international: assess their motivations and capacities carefully but rapidly.
- ☑ Contact embassies, bilateral aid organizations and EU-ECHO offices to seek their suggestions for potential partnerships, national and international, as well as their support for WHO and health sector activities in general.

***During the emergency phase/first month***

- ☑ Consolidate working arrangements with existing partners and continue to seek partnerships with additional/new health agencies arriving on the scene.
- ☑ Establish contacts with agencies that are new to the country even if direct partnerships are unlikely. Provide them with information and guidance on the national health system as well as the current situation and needs – see section 9.2.
- ☑ Look beyond the Ministry of Health for resources and capacities: ask national staff and others for ideas. Other health partners that may be able to provide assistance of one sort or another include:
    - the national Red Cross/Crescent Society and NGOs
    - private hospitals and clinics
    - private consulting companies

- professional associations
- religious organizations
- social organizations such as women's, youth and cultural groups
- pharmaceutical companies
- large corporations
- universities
- research laboratories

***Once the situation has stabilized/beyond the first month***

- ✓ Consolidate existing partnerships and intensify efforts to build partnerships with additional national entities.
- ✓ Look for opportunities to build the capacities of national partners.

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## Tools and other guidance

*Working with other agencies*, in Annex B6

*Fostering partnerships*, in Annex F5

*Link to UNDAC teams ToRs*, in SOP 1.4

## 7.3 Preparing CERF applications

The Central Emergency Reserve Fund (CERF) is a global fund managed by OCHA available to provide funds for *life-saving* actions: (a) rapid response at the onset of a crisis; or (b) under-funded activities on an ongoing humanitarian operation. Applications for CERF grants are made through the UN Resident Coordinator (RC) or Humanitarian Coordinator (HC) who prepares a consolidated submission for all priority sectors in consultation with the humanitarian country team and the cluster/sector leads.

The submission explains the overall context and justification including the decision-making process, the criteria used to identify priority area/sectors for CERF funding, and the method for vetting and selecting projects for inclusion in the grant request package.

When describing the context, the RC/HC is expected to: (i) refer to assessment findings and include key data such as mortality and morbidity rates and nutritional status, noting how the data differs among specific groups and/or geographic regions; and (ii) indicate the implications if the needs are not met. WHO should provide (or support the Cluster Lead in providing) such data to the HC.

NGOs as well as UN agencies are included in the process.

The HC has to confirm that neither agency internal reserves nor other donor funds are immediately available to fund the proposed activities.

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### Guiding principles

Projects proposed for inclusion in the grant request package for health must meet the life-saving criteria in Annex C3 and be in line with local decisions on priority areas/sectors. (Projects that do not meet the agreed criteria will not be considered by the U.N. Emergency Relief Coordinator. No activities for recovery or preparedness should be included otherwise the application will be rejected.)

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### What to do – key management actions

☑ Participate in UN/humanitarian country team meetings concerning the preparation of a CERF grant request package. Ensure that life-saving public health needs receive the priority they deserve.

☑ Convene (or participate in) a Health Cluster/sector group meeting to agree a set of priority health activities to include in the grant request package.

☑ Participate in other Cluster/sector group meetings and try to ensure that public health activities in those sectors are appropriately prioritized.

☑ Prepare concise project summaries for priority WHO project activities for which no other funding is available. Ensure that the objectives are “SMART” (see section 6.1) and the activities can be implemented within 3 to 6 months.

☑ Provide information to the RC/HC that demonstrates the critical importance of the public health actions proposed, and work with her/him to ensure that the package prepared for submission addresses critical public health issues.

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### Tools and other guidance

*CERF application format* in Annex C2

*WHO's CERF guidelines* in SOP 12.4

*Life-saving activities in health and related sectors for CERF* in Annex C3

*Cheat sheet: appeals and CERF*, OCHA 2006

Sample CERF application

## 7.4 Providing health inputs to UN appeals

Two types of appeal are prepared by OCHA and issued in the name of the UN Secretary-General: "flash" appeals and "consolidated" appeals.

The ***flash appeal*** is a tool for structuring a coordinated humanitarian response for the *first three to six months* of an emergency. The UN Resident Coordinator (RC) or Humanitarian Coordinator (HC) triggers a flash appeal in consultation with all stakeholders. Normally, the draft should be completed in the field within five days of an emergency and the appeal be issued by OCHA-Geneva no more than 48 hours later, i.e. within 7 days of onset.

A flash appeal contains early estimates and best guesses, focusing on urgent life-saving needs plus whatever early recovery projects can be implemented within a maximum of 6 months. It is a concise document (ten pages, excluding. tables and annexes). The HC and OCHA draft the general chapters. Usually, a revision is scheduled after about a month to incorporate fuller information and more recovery projects (especially connecting to government plans as they crystallize).

The flash appeal may be developed into a ***consolidated appeal*** if an inter-agency response is needed beyond six months. A first consolidated appeal may be prepared and issued within 2 months of onset. Further appeals, if required, are usually prepared and issued at the end of each calendar year.

The consolidated appeal process (CAP) includes the preparation of a Needs Analysis, using the Needs Analysis Framework (NAF), and a Common Humanitarian Action Plan (CHAP) that then provides the framework for the projects to be presented in the appeal.

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### Guiding principles

Cluster Leads are responsible for drafting the response plan for their clusters. This includes (a) reaching out to key NGOs plus the Red Cross/Red Crescent to include them in the cluster response plan (and list their projects in the appeal); and also (b) vetting or filtering projects to ensure that all projects listed in the appeal are relevant, high-priority, coordinated and dovetailed, and feasible.

The health sector component of a flash appeal should be prepared following the *Guidelines for Flash Appeals* and the appeal duration set by the RC/HC. Proposals normally have to be submitted to the RC/HC within 3 days of a decision (by the RC/HC) to launch a flash appeal.

The health sector component of a consolidated appeal should be prepared following the most recent *Guidelines for Consolidated Appeals* issued by OCHA.

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### What to do – key management actions

***Preparing a flash appeal***

☑ Participate in the UN RC/HC's consultation with the UNCT and/or the IASC humanitarian country team (where one exists) that determines whether a flash appeal should be launched.

*Day-2*

☑ Convene (or participate in) a Cluster/sector group meeting to agree general priorities, objectives, a strategy, and responsibilities.

☑ Inform HQ-HAC and the RO of any issues to be taken up at the level of the global IASC CAP sub-working group.

☑ Prepare proposals for projects to be implemented by WHO to be included in the sector tables (for health and other health-related sectors) of the format provided in the flash appeal guidelines.

*Day-3*

☑ Ensure that all health and health-related proposals are complementary and within the framework of the agreed strategies.

☑ Compile (or support the Cluster Lead in compiling) the health sector proposals and submit to RC/HC.

The schedule above is the standard schedule established in 2007. The RC/HC in consultation with OCHA may establish a different (slightly longer) schedule in certain cases.

***Preparing a consolidated appeal***

☑ Participate fully in the UN RC/HC's consultation with the UNCT and/or the IASC humanitarian country team (where one exists) that draws up the schedule for the CAP process and try to ensure that:

- as many as possible of the main health actors/Health Cluster members are involved in and contribute to the NAF process and the preparation of the CHAP as well a proposing their projects for inclusion in the final appeal document;
- the documents prepared relating to the health and other public-health-related sectors are based on sound analysis and reflect the real priorities; *and*
- WHO's own resource requirements are appropriately presented in project outlines.

☑ Make sure that the CHAP (health and other public-health-related sections):

- is evidence-based;
- presents a coherent overall strategy for addressing the priority problems and risks;
- is "gender-aware" (disaggregates data by sex and age, and considers different needs of men and women, girls and boys); *and*
- takes account of protection and human rights issues, the impact of HIV/AIDS, security conditions and any limitations on access.

☑ Vet health project proposals to ensure that they effectively address priority problems and are feasible and cost-effective; discuss with the proposing agencies, if needed;

☑ Use the checklist in Panel 7-3 to ensure that all the necessary information has been included. This will avoid unnecessary delays in finalizing the appeal document.

> If WHO is Cluster Lead, you will be responsible for preparing the health sections of the CHAP and CAP and accountable for the quality of those documents. If WHO is *not* Cluster Lead, you are expected to work with the designated Cluster Lead and other members of the cluster and do everything possible to ensure that the documents meet the standards indicated here.

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## Tools and other guidance

*Guidelines for Flash Appeals*, IASC CAP sub-working group, 2006

SOP 12.3

*Guidelines for Consolidated Appeals*

Panel 7-3

**Checklist for preparing (health) sector components of a CAP**

**Coherence of the CHAP and projects**

☑ Is the description of needs evidence-based, with sources footnoted?

☑ Is there a clear link between strategic priorities and sector response plans?

☑ Do the projects directly respond to needs and priorities identified in the CHAP?

☑ Have the projects been selected through a vetting process?

**Document, attachments and annexes**

Have you included:

☑ A table or chart showing humanitarian coordination structures?

☑ A monitoring matrix?

- ☑ Photos with captions and credits (agency or person taking the photo, place, year)?
- ☑ Other graphics (maps, charts, tables) to visualize data?
- ☑ Did you have a native speaker of the appeal language proof-read, spell- and grammar-check the document?
- ☑ Is every acronym spelled out at its first appearance in the text? Are acronyms used only for phrases that appear more than once?

**Project sheets**

- ☑ Does each project sheet have all necessary information?
- ☑ Is each project sheet maximum one page (with standard margins and fonts)?
- ☑ Do multi-agency projects show the breakdown of funding requirements per agency?
- ☑ Are all the project sheets gathered in one Word document?

[Source: *CAP Guidelines 2007*]

## 7.5 Managing (and monitoring) project implementation

Project implementation must be carefully planned, managed and monitored if activities are to be successfully implemented on schedule and produce the intended outputs and outcomes.

The submission of concise reports to donors in line with the schedules specified in agreements is essential to maintain donors' confidence and possibilities for further funding. The WCO is responsible for preparing reports but all reports, technical and financial, must be cleared by HQ-HAC before being shared with donor representatives. (This is necessary to ensure that all information, particularly financial information, is correct according to the contribution agreement.) Only certified financial reports issued from HQ should be submitted to donors.

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### As soon as donor funding becomes available:

☑ Develop a detailed project implementation work plan, see Panel 7-4.

☑ Designate a project officer to manage the financial aspects of project (including donor reporting).

☑ *If the entire project proposal is not funded*, review the planned strategy and adjust the project design specifying the objectives that can be met.

☑ Prepare a log-frame if the original project proposal did not include one.

☑ *Once the detailed work plan is established*, re-check the budget. If costs were under-estimated, request additional funds or adjust activities within budget limitations.

These aspects are particularly important if (as is often the case) the field office project manager was not involved in the drafting of the project proposal that led to the donor grant.

To avoid misunderstandings and disallowed costs, the project officer must familiarize her/himself with the donor's requirements including: obligation and disbursement deadlines, reporting requirements and formats, allowable, restricted or disallowable items, marking requirements and/or other specific donor requirements related to the grant.

For further guidance, see 🕮 SOP 13.3 which also includes a sample procurement plan.

Panel 7-4

**Contents of a project implementation work plan**

The project implementation ***work plan*** should:

- list all activities necessary for the completion of the project and specify the time frame within each is to be completed, the outputs expected and who is responsible;
- include a staffing plan (listing of the staff required during specific periods adjusted to the funds available and allowing time for recruitment);
- include a procurement plan for the purchase and delivery of supplies and equipment including local and international purchases (allowing time for placing orders, customs clearance, etc.);
- specify the contracts to be prepared, and when, and requirements for any training and public information activities;
- specify the administrative and logistic support required from the country office and agree arrangements for that support with the Operations Manager/AO;
- include the dates by which particular reports have to be submitted to the donor.

### During project implementation

The Emergency Programme Manager and project officer must:

☑ Establish agreements with NGOs or others partners contributing to the project using the standard format for an agreement with an NGO in Annex C8. (Note that the agreements have to be signed in HQ by ADG-HAC.)

☑ Provide copies of the approved project proposal and donor agreement(s) to all WHO staff working on the project, both administrative and technical. (Ignorance of requirements, roles and responsibilities is not a justifiable explanation for poor project execution.)

☑ Ensure that all project staff are aware of WHO/UN contracting procedures as well as their own benefits, entitlements, requirements and responsibilities.

☑ Ensure that sufficient trained and experienced administrative staff are available to complement the work of technical and medical officers (to enable the latter to focus their attention on their technical responsibilities).

☑ Closely monitor progress of all activities against the work plan. If the project is running behind schedule, find out whether the donor is amenable to a no-cost-extension. (Note that most donors will not approve a no-cost-extension on a 3-month project.)

☑ Be ready at all times to make project records, both technical and administrative, available to the WR and to regional and HQ emergency staff who make periodic visits to field sites and prepare project monitoring reports.

☑ Prepare reports for donors as required. Clear them with HQ-HAC *before* sharing them with donor representatives at country level.

☑ Prepare a mid-term progress review and report, as required. If multiple donors have responded to an appeal, avoid reporting the same information on two different projects.

☑ Prepare financial reports as described in SOP 13.5 in accordance with the grant agreement provisions. Do not provide reports to donors outside official reporting periods unless specifically requested. Do not provide reports to one donor to another even for information purposes.

***Financial aspects***

☑ Keep track of all obligations and expenditures by detailed budget line (normally using a simple spreadsheet for financial tracking).

☑ Ensure that all expenditures conform to approved budget line items (otherwise they may not be accepted by the donor). Request the donor's agreement to revise the budget, if necessary, *in advance*.

☑ Keep copies of all receipts to support expenditure reports.

☑ Review staff cost estimates regularly and work with the RO (BUD) to make necessary adjustments. This is important to avoid either unspent balances at the end of the project or over-expenditures.

☑ Adjust packing, freight and insurance estimates as soon as invoices are received.

☑ Liaise regularly with Operations Manager/WCO Finance unit to ensure adequate levels of funds in the imprest bank account to cover expected expenditures.

☑ Identify issues that may cause a deviation from the approved project and, if necessary, alert the WR/Programme Manager to negotiate a project amendment with the donor, in writing, *at least* 30 days before the project grant completion date.

☑ Monitor unliquidated obligations and ensure the timely liquidation of all project expenditures.

***Supply aspects***

☑ Provide specifications and delivery requirements to the Operations Manager/AO/Procurement unit as early as possible and follow up to ensure that price estimates are obtained quickly and orders issued. Request assistance from relevant technical units for defining specifications, when required.

☑ Make every effort to ensure that all items purchased with project funds are delivered, installed and made operational as soon as possible.

***Donor visibility*** (often an integral part of donor agreements)

☑ Provide donor visibility by arranging public donations with donor representatives present and adding donor logos to publications and other project material. Promote donor field visits whenever possible – see SOP 14.2.

***In the last quarter of the project*** undertake a thorough *last quarter project execution review*:

☑ Make sure all purchase orders (POs) have been issued: requests for POs that have not been placed should be cancelled if delivery is not guaranteed within a reasonable time period and the funds reprogrammed to meet other pressing demands. (Purchases placed in the final days of a project may be disallowed by a donor if it appears that the purchases have been made just to use up unobligated balances.)

☑ Review all unliquidated obligations and over-/under-spent budget line items, and agree on a course of action to ensure that no funds are left unobligated. If needed, negotiate a no-cost-extension amendment with the donor.

- If there are unliquidated obligations and payments are not foreseen to be made within a reasonable period after the grant expiration date, liquidate them completely and make provision to cover them with other sources.
- Consider whether certain staff contracts need to be extended beyond the termination date of the project and whether other project funds are available for that purpose. (Staff who will not be extended should be informed.)

***At the conclusion of a project***:

☑ The project officer must provide an exit debriefing report on the financial management of the project, including a list of all contacts made during the life of the project. A list of permanent contact addresses for staff and sub-contractors involved in the project may also be useful. This is a requirement for EC-funded projects.

☑ Consider organizing a lessons-learned meeting. This can provide information for the final report as well as lessons for future operations.

Remember that good reporting on emergency response activities can be a good mechanism to introduce related activities for future development projects.

For more detailed guidance, see 🕮 SOP 13.4.

# 8
# Assuring effective communications

*Communication is the process of transmission of information from an originator to a receiver. Receivers can be internal or external to WHO:*

- *"Internal" communications concern the transmission, within the WCO and among the WCO, field sub-offices, the regional office and HQ-HAC, of information concerning the humanitarian situation and operation in general, and the health sector and WHO activities in particular.*

  Internal communications *products* include regular internal operational sitreps and periodic programme implementation up-dates, as outlined in 8.2.

  Internal communications include formal and informal inter-personal communications within the WCO and telephone and email exchanges among staff in the WCO, RO and HQ – see 8.1.

- *"External" communications concern the transmission of information about the situation, needs and WHO activities to partners, donors, the news-media and other stakeholders. They also include the dissemination of information to the affected population, which can be a crucial element of effective humanitarian response.*

  External communications *products* include: a regular Health Bulletin (see 8.4); press releases; photographs, video films and recordings.

  These are complemented by question-and-answer briefings for news-media and other stakeholders – see 8.3.

During a crisis, rapid information flow both internally and externally is vital. Too often, management learns the need for "communication" by having to respond to the lack of it!

The prompt transmission of information is vital as the situation may be changing rapidly and information soon becomes out-dated.

"Multiple or parallel reporting lines often exist in emergencies, within and outside of the emergency team. This can reduce the effectiveness within agency-specific teams, but also reduce the credibility of inter-agency teams through mixed messages etc.

The ideal is a single communications unit producing periodic communications objectives in service to a locally-relevant corporate communication strategy.

Clear team structure has to be established, which team members understand, together with respected reporting lines and clear targets so that team members feel accountable for their work. Team leader avoids short circuiting the structure."

[***Emergency Team Leadership Competencies - IASC 10.04***]

## 8.1 Managing internal communications

*"Internal" communications concerns the transmission, within the WCO and among the WCO, field sub-offices, the regional office and HQ-HAC, of information concerning the humanitarian situation and operation in general, and the health sector and WHO activities in particular.*

### Guiding principles

Effective internal communication is vital to ensuring a common understanding at all levels of the Organization of the situation and what the Organization is and should be doing. This shared understanding, together with a clarity on the roles and responsibilities of staff at different levels, are crucial to the success (or failure) of the WHO response.

Internal communication is not an optional activity but a critical element in planning and managing the WHO emergency response. It is a time-consuming duty that needs to be managed and fulfilled in a systematic manner. Adherence to recognized communications ***procedures*** improves internal coordination and efficiency, reduces overlap and duplication, and minimizes stress.

Early agreement on communication procedures is vital to ensure that there are no information gaps between different parts of the Organization.

Systematic communication of information ***from the WCO*** is essential to enable the RO and HQ-HAC to: give appropriate technical and operational advice and support; keep donors informed and underpin resource-mobilization efforts; contribute to effective inter-agency coordination at the international level; and respond to questions from the media.

Systematic communication of information ***from field sub-offices*** to the WCO is essential for internal planning and management and to enable the WCO to follow up on issues and report to the RO and HQ.

Information on the progress of specific project activities should be communicated through ***programme implementation up-dates*** using, or adapting, the format in Panel 8-#, comparing progress with objectives and work plans.

Information on internal programme support activities and problems, and support required from the RO or HQ-HAC, should be communicated through ***internal operational sitreps*** – see Panel 8-#.

***Every staff member*** and consultant in the WCO must be familiar with the key objectives, strategies and activities of WHO's humanitarian response programme. This brings coherence and allows for better coordinated action. Staff who understand the basic goals and strategies of WHO's humanitarian response are better able to fulfil their own roles and take appropriate decisions and actions to facilitate and expedite operations (reducing the need for micro-management by senior staff).

Formal internal communication mechanisms are important but are usefully complemented by ***informal*** communications.

### What to do – key management actions

☑ Hold regular staff meetings, daily at first, then weekly. Provide information and solicit feedback using a round-the-table approach to hear, briefly, from each person.

☑ Ensure that all staff members and consultants receive clear terms of reference and copies of the organigramme, the WHO strategy note and action plan, and publications such as Health Cluster bulletins and press releases as soon as they are issued.

☑ Ensure that all supervisors meet one-on-one with their staff on regular basis and that staff members and consultants provide regular status reports to their supervisors.

☑ Convey important messages/instructions verbally – face-to-face – *and* in writing (a memo).

☑ Keep an open-door policy in relation to individual concerns and complaints.

☑ Plan and manage teleconferences carefully, otherwise a lot of staff time will be lost. Establish the agenda in advance by email. Don't use a teleconference to transmit information that is better and more accurately conveyed by email. Focus on specific issues that need discussion among the different levels of the Organization. Set, and stick to, a time limit for the conference.

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## 8.2 Internal reporting

Information on the progress of specific project activities should be communicated through programme implementation up-dates comparing progress with objectives and work plans.

Information on internal programme support activities and problems, and support required from the RO or HQ-HAC, should be communicated through internal operational sitreps.

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### Project (and programme) implementation up-dates

Regular project implementation up-dates summarizing the status – achievements, constraints and next steps – of each *project* provide essential information to WHO managers at all levels on the progress and any actions they may need to take. A format such at the one in Panel 8-1 may be used.

Individual project up-dates may be compiled in a single document as an emergency *programme* up-date.

Preparing these regular up-dates – and keeping them in safe, easily-retrievable storage – also greatly facilitates the preparation of donor reports.

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### Internal operational sitreps

The WHO internal operational sitrep is an essential tool for coordinated action by all levels of the Organization in support of programme implementation in the field. It is an internal communication tool not intended for public distribution (not to be posted on any public-access website).

It is generated by the WCO, usually by the Emergency Programme Manager and/or the WR in collaboration with the Emergency Management Team, and sent to the RO. The periodicity is agreed with the RO.

Operational sitreps should:

- ✓ be concise, to-the-point, and action-oriented;
- ✓ focus on internal operational/programme support issues – security, finance, procurement, logistics, etc. – leaving detailed information on the progress of individual project activities to the programme implementation up-date, and information on the overall health situation response to the Health (cluster/sector) Bulletin;
- ✓ up-date, not repeat, information provided in earlier sitreps.

The ***first*** operational sitrep should:

- ✓ be issued within a few hours of onset of the crisis;
- ✓ focus on immediate operational requirements that cannot be coped with by the WCO in terms of personnel, equipment, supplies and funds; *and*
- ✓ include the assignment of responsibilities to individual staff members and their contact information.

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### What to do – key management actions

- ☑ Establish a clear schedule for the preparation of internal operational sitreps (probably daily then weekly) and programme implementation up-dates (probably weekly then monthly).
- ☑ Assign responsibilities to specific individuals for the preparation of programme implementation up-dates on each project. Establish – and enforce – deadlines for the submission of those updates (e.g. by 09:00 on the 1st and 15th of each month).
- ☑ Assign responsibility to one individual for the compilation of the individual project up-dates into a consolidated programme up-date.
- ☑ Assign responsibility to one individual for the compilation of WCO internal operational sitreps integrating the inputs from all members of the EMT.

- ☑ Establish – and enforce – deadlines for EMT members to provide their inputs for the operational sitrep (e.g. by 17:00 each evening, or 08:00 each morning).
- ☑ Specify reporting requirements for field offices – normally this might include daily sitreps to be received in the WCO in time for information to be incorporated in the WCO sitreps to the RO

Panel 8-1

**Sample template for a programme implementation up-date**

| Country: | Date: …/…/… |
|---|---|
| Project code (CERF code or Flash Appeal Code or CAP code): | |
| Project title: | |
| Project objectives as stated in the project proposal: | |
| Expected outcome/outputs as stated in the project proposal: | |

Achievements:

Constraints:

Next steps:

## 8.3 Managing external communications

*"External" communications concerns the transmission of information about the situation, needs and WHO activities to partners, donors, the news-media and other stakeholders. It also includes the dissemination of information to the affected population, which can be a crucial element of effective humanitarian response.*

Donor reports are an essential component of external communications and vital to prospects for future contributions. Guidance on donor reporting is provided in SOP 13.5

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### Guiding principles

The prompt and regular communication of information to partners, donors and the news-media about the health situation and unmet health-related needs is a core function of WHO and an essential support to leadership, coordination, advocacy and resource mobilization efforts.

External communications need to be carefully planned and implemented. They must also be properly integrated with programme management activities and operations.

Each external communication builds or erodes trust. Maintaining or building ***trust*** in the Organization is a key goal of external communication for WHO.

***Reliability*** and ***transparency*** are the means to maintain or build trust. Promise only what is absolutely certain will be delivered, otherwise the Organization will lose credibility and trust. Responders have to refrain from being overly reassuring.

External communication actions have to be initiated from the ***earliest*** possible moment, without waiting for complete information, to control rumours and establish authority and leadership.

External communication is a ***skill*** that cannot be improvised. It needs expertise and dedicated ***resources*** from the start of a response.

It is important to ***listen*** to the public and ***respond*** to the public's concerns, even when those concerns seem unreasonable.

WHO should work with partners to agree on the importance of speaking with "***one voice***", and establish arrangements for common external communications (within the framework of the Health Cluster, where there is one). Such communications – notably a ***health (cluster/sector) bulletin*** – should present shared perceptions of the priority needs together with information on the response actions of the health sector as a whole. It should also convey the concerns of the affected community.

WHO' own external communication strategies must be discussed and ***agreed*** within the WCO and among the WCO, the RO and HQ-HAC at the early phase of the response.

All external communications products must be ***professional*** in their conception and presentation. To the extent possible, they should also be ***attractive***. Style, photos, lay out, and language quality are as important as the content in getting the message across.

***Visibility*** is a way to communicate presence and leadership.

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### What to do – key management actions

The guidance here applies particularly for a *major* humanitarian emergency involving an *acute* health crisis. Streamlined measures will suffice in other situations.

☑ Organize the office to deal with external communications:

- Immediately nominate spokesperson.
- Maintain close contact with communications staff in the RO and HQ.
- Include a communications officer in the staffing plan if a large-scale operation is in prospect.

  - Appoint a national external communications officer to support in liaising with local news-media, NGOs and other stakeholders.
  - Inform all WCO staff and visitors of internal rules concerning communication with journalists (how to respond to journalists' requests, referring them to the WHO spokesperson, etc.).
  - Order visibility materials, if required. Always wear WHO vest and hats, and have a flag backdrop for press conferences.

- ☑ Arrange for a ***health bulletin*** to be issued ***regularly*** (even twice daily during an acute health crisis) – see 8.4.
- ☑ Organize ***questions-and-answer*** briefings for new-media and other stakeholders. Prepare well – see Panel 8-3.
- ☑ Decide whether to establish a "health" ***website*** or provide inputs to be integrated in an existing, inter-sectoral humanitarian news and reporting forum. Where there is a humanitarian information centre (HIC), for example, health sector issues might be integrated in the HIC website.
- ☑ Ensure that WHO activities are properly communicated to and reported by other UN local coordination entities such as the UN Resident/Humanitarian Coordinator and OCHA.
- ☑ Encourage all staff to take photos and make videos documenting the situation and significant events. Establish a ***visual library*** and systematically collect and catalogue photos and videos of the health situation and significant events. These can then be used for external communications, training and resource-mobilization purposes.
- ☑ Don't overlook ***video*** needs. Emergencies are often visual events. Think of video press releases, and canned video interviews as well as film from locations that are not accessible to news-media camera teams.
- ☑ *In case of an acute health crisis*:
  - Establish a ***community communication surveillance system*** and coordination with HQ's international communication surveillance. The system should monitor what the community is thinking and worrying about so that specific messages can be developed to address their concerns.
  - Organize ***press releases*** and ***briefings*** on a regular schedule so that the journalists and the news-media can work around those times.

Panel 8-2

**Talking points and messages**

The communications officer (or other "communicator") must coordinate with other responders, develop daily talking points, and respond to all WHO news-media demands in the field and from the RO and HQ.

S/he should produce – each day in case of an acute health crisis – a set of "talking points" approved by the emergency programme manager/senior technical officer and specific "messages" to be communicated both in the country and at regional and HQ levels. External communications support at those levels can relieve the demands on staff at country level and talking points provided by the field will keep HQ and RO communicators (who will be responding to international media demands) literally on the same page.

Messages should reflect and respond to community concerns (identified through communication surveillance) as well as questions posed by news-media, as and when appropriate.

**Tools and other guidance**

*7 Steps to effective media communication during public health emergencies* in annex B7

*Effective media communication during public health emergencies – a field handbook*.

Sample health cluster bulletin (from Lebanon, 2007), (on CD-ROM)

## 8.4 Producing a Health (cluster/sector) Bulletin

The Health (cluster/sector) Bulletin is an essential health information dissemination tool produced by WHO with the contribution of and in collaboration with health partners (in the context of the Health Cluster, where there is one).

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**Guiding principles**

The Bulletin should provide up-to-date information on:

- ✓ the health situation – including the findings of assessments and surveys on the health status of the population(s) and the status of health services, the specific impacts of the crisis, recent changes and trends, current problems and unmet needs, and future health risks; and
- ✓ information on response activities, health actors, collaboration efforts, guidelines, training, etc.

Early editions focus on the ***health impact*** of the crisis presenting the preliminary assessment results with elements of analysis; focusing on unmet needs; informing on ongoing coordination and response activities; summarizing the resources available and; listing key contacts.

It should be attractive, include photos and graphics, easy to read, and ***widely disseminated***.

The Bulletin is a ***partnership*** product**,** it is not an exclusive WHO product. It presents the analysis and the response actions of the health cluster/sector as a whole. It should include concise summary reports on activities implemented by all the main health actors, including organizations that are not members of the cluster.

The first Bulletin should be issued within a ***few hours*** of the onset of the crisis with whatever information is available from preliminary assessment enquiries and key information on the pre-crisis characteristics of the health situation and services. If the cluster approach is not yet in place, the WCO should initially issue a WHO crisis bulletin that should become a Health Cluster Bulletin as soon as feasible.

The production of the Bulletin is a ***full time*** task in any major humanitarian crisis and needs dedicated resources.

Whenever possible, the Health Cluster Bulletin should be translated into the ***national language***.

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**What to do – key management actions**

- ☑ Assign an individual or (better) a small team to the task of producing the Health Cluster Bulletin. Get inputs from as wide a range of partners and health actors as possible.
- ☑ Define a recipient list including all staff of the WCO, all health partners in the field, relevant MoH officers, local media, local donor community, focal points in RO and HQ

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**Tools and other guidance**

Sample Health Cluster Bulletin in annex B8

# 9

# Promoting Coordinated Health Action and Best Practices

Promoting coordinated health action includes promoting the collective use of the available information and analysis to produce agreed overall objectives and strategies for health sector action in addition to the formal and informal processes of information exchange and discussion outlined here, in section 9.1.

It also includes providing guidance and support to other health sector actors, especially those that are new to the country or to health activities, as outlined in section 9.2.

The framework within which WHO fulfils these functions depends on whether Clusters are established and WHO is designated as Country Health Cluster Lead (see section 1.3), but the responsibility is the same in all cases:

- Fulfilling these functions in a major emergency will be the responsibility of the WHO-appointed Health Cluster Field Coordinator (HCC) when WHO is Cluster Lead.
- If another agency is designated as Cluster Lead, WHO will give all possible support in promoting coordinated health action and best practices. This would normally be the responsibility of the WHO Emergency Coordinator or the Emergency Programme Manager.
- Where there is no formal health cluster, WHO will work directly with the MoH and other health actors, and through whatever sector group might exist. This would normally be the responsibility of the WHO Emergency Coordinator or the Emergency Programme Manager in a major emergency or the WR supported by the assigned emergency programme officer in a lesser emergency.

**Desired level of performance**

- ✓ ***Health coordination***: Organized space and time for all health partners to discuss issues, decide action to take and assign responsibilities; mechanisms for follow-up, evaluation and readjustment. Agreement on a joint plan that defines the responsibilities of all partners.
- ✓ ***Coordination with other sectors***: Work in all other sectors geared to the survival and healthy and sustainable livelihoods of the population

## 9.1 Facilitating coordination / leading a country health cluster

The coordination of strategies, technical standards and field service operations among agencies and with national and local authorities is critical to the effectiveness of an operation. WHO must always seek to assure and facilitate coordination of all these aspects – formally or informally – among all entities whose actions concern or affect public health. This typically involves bringing different actors together, exchanging information, and fostering agreements on strategies, common standards, and complementary actions based on assessment findings.

> The aim of coordination is a situation in which all health sector actors share information freely, agree overall objectives and strategies, and plan and implement complementary activities in the context of an agreed overall health sector response plan. The role of a coordinator is to facilitate and encourage rather than to direct.

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### Guiding principles

The coordination of international assistance is the responsibility of the government.

WHO has a responsibility to help to *facilitate* the coordination of international health-sector assistance including appeals in all situations, whether a formal Cluster system is established or not, and whether WHO is designated as Cluster Lead or not – see section 1.3.

WHO's ability to facilitate coordination in any given country or crisis depends on the respect WHO has earned locally and what WHO can offer at the time in terms of analysis, information management and facilitation skills. Specific resources should be assigned – mobilized – for this function.

Existing health-sector coordination mechanisms should be activated on day-1. In the absence of an existing mechanism, all potential health-sector actors should be invited to a meeting. New mechanisms are established only if there are no existing ones that can be used.

Coordination must be assured among all Clusters/sector groups whose activities affect public health and safety.

Coordination meetings must be well planned and managed. An excessive number of meetings must be avoided. A clearing house for emergency health information should be established from the outset.

To keep meetings manageable, the representation of each agency should be kept to a minimum. (Where subgroups are established to address particular issues, some main Cluster/coordination meetings may be attended only by the chairs and vice-chairs of the subgroups.)

WHO should work with partners to identify critical gaps and use, or support the Cluster Lead in using, the Cluster or other coordination mechanisms, the UNCT, and bilateral contacts with agencies and donors, to try to mobilize competent organizations to fill those gaps.

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### What to do – key management actions

***First steps – during the first few days***

- ☑ *If there is an inter-agency contingency plan*, rapidly review whatever may have been agreed in relation to coordinating action at the onset of a crisis. Follow the agreed procedure.
- ☑ *If there is no inter-agency contingency plan*, take the initiative to telephone round to key government officials and WHO's traditional health-sector partners and work with the MoH (and the designated Cluster lead, if not WHO) to arrange a first health-sector/Cluster coordination meeting on day-1, if possible, with as many participants as you can get:
  - Include all relevant governmental and other national entities.
  - Get the MoH to chair or co-chair the meeting.
  - Get a good facilitator to keep discussions focused and enforce time-keeping.
  - Fix a realistic agenda – see, for example, the one in the *Health Cluster Guide*.

- Prepare as handouts the information, including maps, that you (and/or the MoH) have available to share from your preliminary assessment/enquiries (see section 3.2).
- Prepare formats and/or flip charts to record the information you want to get from others during or after the meeting – use/adapt those in annex F2 or the *Health Cluster Guide* (expected late 2008), as appropriate.
- Ensure the rapid preparation and distribution of a concise record of information shared in the meeting, decisions reached, and follow up actions with responsibilities.

☑ Work with the MoH (and the designated Cluster lead, if not WHO) to arrange further (perhaps weekly) coordination meetings with participating organizations providing important information to a central information focal point in between meetings.

☑ Work closely with any UNDAC or OCHA team present.

☑ Arrange WHO representation in the meetings of other Clusters/sector coordination groups (e.g. nutrition, water & sanitation, shelter) and promote coordinated efforts from the outset to address priority public health problems.

☑ Provide the RC/HC/OCHA with information on the health situation. Get from the RC/HC/OCHA information compiled on other sectors (especially shelter, nutrition and WASH).

☑ For a major emergency when WHO is country-level Cluster lead, prepare a project for "health sector coordination" with a budget for the Health Cluster Field Coordinator, a communications officer, and operating (including travel) costs for the cluster coordination activity.

> Although everyone is very busy in the first few days or a crisis, this is precisely the moment when it is important to combine forces, pool information, and jointly plan the use of available resources to address agreed priorities.

***During the emergency phase/first month***

☑ Arrange/ensure regular coordination meetings on an appropriate (probably weekly) schedule. Ensure that each meeting is well prepared and managed so that participants feel that their time is well-spent.

☑ Arrange/propose sub-groups or special thematic meetings in addition to the basic Cluster/sector coordination group meetings, when appropriate.

☑ Ensure the establishment and efficient functioning of a clearing house (focal point) for emergency health information – see section 5.3. In case of a major humanitarian emergency, work closely with OCHA staff and the OCHA-managed Humanitarian Information Centre (HIC).

☑ Arrange/help to organize the production and dissemination of a first emergency health (cluster) bulletin – see section 5.4.

☑ Develop relations with donor task forces, where they exist.

***Once the situation has stabilized/beyond the first month***

☑ Continue identifying and drawing in new partners and other stakeholders as participants in the health Cluster/coordination group.

☑ Reduce the frequency of meetings and shift the focus progressively towards the early recovery of the health system.

☑ Consolidate information management systems, see section 5.1 and 5.3.

☑ Arrange for new participating organizations, and new staff representing existing participants, to be well briefed. (Try to avoid the problems that often arise due to the rapid turnover of personnel and a lack of institutional memory.)

☑ Ensure the regular (perhaps monthly) preparation and dissemination of a health (cluster or sector group) bulletin – see section 5.4.

☑ Encourage the MoH to progressively take more responsibility for the coordination of international health assistance.

- ☑ Continue to provide the RC/HC/OCHA with information on the health situation; get from the RC/HC/OCHA information compiled on other sectors (especially shelter, nutrition and WASH).
- ☑ Maintain WHO's participation in and contribution to other health-related Clusters/coordination groups – nutrition, water & sanitation, shelter, protection.

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### Tools and other guidance

Global Health Cluster guidance materials

Annex F1: *Terms of reference for a cluster lead*

*Health Cluster Guide*

Simple coordination formats in annex F2

Health Cluster Bulletin Template in annex B8

## 9.2 Providing guidance and support to health sector actors[8]

WHO's primary responsibility is to provide technical and normative guidance to the MoH and other health sector actors.

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### Guiding principles

Information and guidance to MoH and other health sector actors may be provided based on the knowledge and experience of, and information available to, WHO staff in the country or it may be sought from the RO, WHO headquarters or other recognized regional or international sources.

> The Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response, 2004, and the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in disaster relief (reproduced in the SPHERE handbook) have gone a long way towards fostering common strategies and standards among most of the major NGOs. However, some NGOs may need to be made aware of these standards and national policies, and their relevance in the prevailing situation. Discourage any organization from actions not consistent with the established standards.

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### What to do – key management actions

***First steps – during the first few days***

- ☑ Offer and provide technical advice and guidance to the MoH and other organizations, when required/requested.
- ☑ Facilitate contacts among health-related government institutions, international and national NGOs, and donors.

***During the emergency phase/first month***

- ☑ Monitor the indicators of health status and public health service provision and, when necessary, draw attention to national standards and international best practice and suggest what could be done to improve standards.
- ☑ Take the initiative whenever necessary to:
  - provide the national and local health authorities and other organizations involved in public health-related activities with specific technical information and advice concerning possible public health consequences, appropriate responses and relevant international standards;
  - help define terms of reference for and brief assessment teams and ensure that an appropriate health and nutrition surveillance system is in place;
  - propose appropriate health strategies and help to prepare plans and guidelines for the implementation of appropriate health care and rehabilitation services, environmental health and/or disease control measures; *and*
  - advise the MoH and donors on the suitability of proposed medical donations; share WHO's donor questionnaire for in-kind donations with them and encourage them to politely decline any inappropriate offers. (See SOP 12.7.)
- ☑ Make sure that international NGOs and all organizations that work in partnership with WHO are aware of national health policies and priorities, and international protocols and best practice. Encourage them to respect those policies and protocols and to preserve and strengthen local capacity with a view to developing services (including health information/warning systems and health facilities) that are sustainable in the long term.
- ☑ Prepare and disseminate technical guidelines and provide training, if needed.

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[8] This section is adapted from WPRO *Emergency Response Manual*, 2003, section 3.2

- ☑ Encourage all health actors to look for and exploit all opportunities to protect and (re-)build national health systems and capacities.
- ☑ Emphasize the importance of maintaining and, where possible, strengthening the MoH and sub-national level health structures, and not denuding these structures.
- ☑ ***Brief newly-arrived organizations***: When required, help the MoH to arrange rapid orientation briefings for new organizations arriving in the country to work in the health sector. This may include:
  - the country's epidemiological profile, national health policies and programmes, and pre-emergency health service coverage;
  - national and international expertise available (e.g. for tropical diseases specific to the country which may be beyond the capacities of some foreign NGOs);
  - the structure of the MoH and the list of health focal points on other organizations;
  - details of arrangements for emergency health coordination.
- ☑ ***Look to the welfare of relief workers***: Provide foreign relief teams that are new to the country with advice on measures to protect their own health. If any teams – particularly organizations that work in partnership with WHO – are going to spend time in isolated areas, try to ensure that they have arrangements for emergency medical evacuations.

***Once the situation has stabilized/beyond the first month***

- ☑ Help organize training for field staff of concerned government and other organizations in assessment, reporting/surveillance, disease control and environmental health measures, and hygiene promotion.

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# 10
# Planning and Managing WHO "Operations"

This chapter provides guidance on what needs to be done to ensure that the WCO is able to effectively and efficiently support the planned field programme activities. This includes: Assuring security; Managing human resources; Mobilizing/recruiting national staff for field operations; Establishing a new field sub-office; Assuring administrative services; Assuring finance services; Procuring supplies; Assuring in-country transport & storage of supplies; and Assuring ICT services (data systems & telecommunications).

Planning and managing these WHO "operations" will normally be the responsibility of the Operations Manager, for a major emergency, or the Administrative Officer. Certain administrative and ICT functions may be delegated to the Operations Room Manager where this is a full-time position (unless s/he is also personally fulfilling responsibilities for information management).

A strategy and work plan for establishing and maintaining the operational capacity and systems necessary to support projects and staff in the field must be drawn up and incorporated in the WHO action plan, as described in section 4.3. This includes contingency planning for events that could disrupt any of the above support services.

## 10.1 Assuring security

In situations of conflict, civil unrest or widespread and violent criminality, measures to ensure the safety and security of personnel – and compliance with UN security requirements – are a prerequisite for the delivery of humanitarian assistance.

### Guiding principles

Security considerations must be integrated in programme and operational strategies, and contingency plans prepared for a possible deterioration of security situation.

The Designated Official for UN security (DO) supported by the UN Security Management Team (SMT) is responsible for the safety and security of *all* UN personnel in the country. S/he is assisted in this by a Chief Security Adviser (CSA) or Field Security Coordination Officer (FSCO) assigned by the UN Department for Safety and Security (UNDSS). Additional Field Security Advisers (FSAs) may also be assigned.

The WR is a member of the SMT and responsible for ensuring that UN security procedures are followed by all WHO staff members and consultants – see Panel 10-1. The head of a field sub-office is responsible for the security of staff in their area of operations.

The WR should participate actively in UNDSS-led security risk assessments and the establishment of specific MOSS for the country.

In a country (or area) in UN Security Phase 1 or higher, only staff members and short-term professionals (STPs) who have successfully completed the basic and advanced UN security training and test and have security clearance and permission to enter the country (or area) are covered by UN insurance including malicious acts insurance.

When a WCO or WHO field operation requires security support beyond what can be assured by the CSA or UNDSS-assigned FSAs, the RO or SEC-HQ may provide a WHO field security officers (FSO) temporarily, for a period not normally exceeding 4 to 6 weeks, while requirements are defined, resources mobilized, and a WHO FSO recruited to provide ongoing security support.

All security incidents involving WHO staff, assets or property must be reported by the WR (or head of office) to: the DO at the duty station; the CSA or FSCO; RO-DAF; *and* the Coordinator, SEC-HQ.

### What to do – key management actions at country level

***First steps – during the first few days***

☑ Contact any WHO staff in the affected areas to ensure their safety (see section 3.1).

☑ Attend SMT meetings convened by the DO and:

- obtain general security situation and any changes that might be envisaged in the UN security phase;
- provide any information relating to security that you have received from staff or other sources;
- (*where the security phase is 3 or higher*) find out whether/when UNDSS (the CSA/FSCO or an FSA) will be able to conduct security assessments of the sites of WHO's existing or proposed offices and operations, and accompany assessment team field visits.

☑ If the security phase is 3 or higher, or is expected to rise to that level, contact SEC-HQ through RO-DAF and the security focal point in the regional office:

- explain the security situation and the level of support expected from UNDSS/the CSA/FSCO;
- request, if necessary, the immediate, temporary assignment of a WHO FSO – see Panel 10-2.

☑ Participate in any meeting of the Security Management Team (SMT) convened by the DO, and follow the instructions of the DO and any actions agreed by the SMT.

☑ Issue instructions to all WHO staff and consultants. "Follow the rules; take responsibility; keep your supervisor informed; keep yourself informed."

***During the emergency phase/first month***

☑ Ensure that security considerations are integrated in programme and operational strategies, and contingency plans include possible deterioration of security situation.

☑ Establish a system to track staff movements (by the security and travel focal points).

☑ Ensure that all staff and visitors have an ID card (UN or WHO).

☑ Make sure all new staff and visitors undergo the UN security briefing (including advice on stress management) on arrival or on taking up their posts.

☑ Provide (or arrange) regular security briefings for all staff, if necessary.

***Once the situation has stabilized/beyond the first month***

☑ Monitor security arrangements and adjust to any changes in the situation and UN security phase.

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## Tools and other guidance

SOP 11.1, Security in the field

UN security phases in annex H2; Guidance on personal security precautions in annex H1

Section III.17 in the HR Manual: *Security of WHO Staff, their Dependants and Property*

See section 10.8 concerning telecommunications

Panel 10-1

**Security responsibilities in WHO Country Office**

The WR is responsible for ensuring that UN security procedures are followed by *all* WHO staff members and consultants. The WR has to provide the Resident Coordinator/Designated Official with the following:

- a list of all staff and dependants
- biodata fact sheet for each staff member
- a map showing residences of all staff members
- a list of radio frequencies and call signs
- security clearances for new staff members prior to their arrival
- weekly updates on all staff movements in and out of security phase areas.

In addition the WR has to:

- attend Security Management Team (SMT) meetings
- brief WHO staff on security issues: curfews; threats; precautionary measures etc.
- assure MOSS compliance for premises and vehicles in any situation Phase-1 or higher.

The WR may delegate certain tasks to the Administrative Officer or another senior staff member but the WR remains responsible!

Panel 10-2

**Criteria for requesting a WHO field security officer**

- Phase 3 or above;
- WHO has or is planning to have a "significant" field presence;
- The CSA/FSCO and UNDSS-assigned FSAs are unable to provide the required level of support to WHO operations; *and*
- Funds are available.

## 10.2 Managing human resources

The quality and effectiveness of humanitarian response is largely determined by the quality of the personnel and the efficiency of the systems that support them.

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### Guiding principles

Maximum use should be made of ***national*** personnel. (The WCO should maintain a list of national personnel who might be mobilized for response to an emergency. This might include recent retirees for both technical and administrative functions as well as other professionals.)

The movement of national staff out of their own areas should take account of any risks to which they could be exposed (especially in a situation of civil unrest).

MoH and other national staff in key health functions, offices and facilities should be encouraged and enabled to remain in their posts. The capacities of the MoH and local services should not be denuded by their personnel being recruited by other agencies including WHO.

***International*** personnel should be used for high-level contacts, where the political context requires independence (where national staff might not be objective or might be subject to excessive pressure from local authorities, political factions or interest groups) or where national staff would be at greater risk than internationals.

Individuals on the international roster or who have completed a pre-deployment course can be recruited on temporary contracts for less than 6 months without advertising but there should be rapid consultation with the RO and HQ.

Programme staff, especially those in decision-making positions, should have health system (rather than “relief”) orientation and experience.

Terms of reference (TOR) for consultants and short-term professionals should include de-briefing and the submission of final reports at the end of their assignments.

Deliberate efforts must be made to avoid excessive staff turnover. Rapid turnover among international staff is all-too-common in the early stages of an emergency operation: it is very disruptive both for response planning and implementation and for the relationships on which leadership and coordination depend.

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### What to do – key management actions

***First steps – during the first few days***

☑ Review the staffing plan and draw up a strategy and work plan for mobilizing/recruiting the required personnel – see section 10.3.

☑ Set up system to track recruitments, visa and contract expiry dates, etc.

☑ Recruit additional local staff (health professionals, drivers, receptionists, telephonists, security guards, secretaries, translators, etc.) as required and approved.

☑ Provide necessary supervision for local staff: assign tasks and monitor their performance.

☑ Ensure all short-term staff and consultants have necessary insurance.

☑ Organize briefings for all new staff and consultants (national and international) and those arriving on temporary assignments from elsewhere. Briefings should include security, social customs and sensitive political issues as well as programme and operational support aspects.

☑ Provide individual medical l kits, if required – order sufficient kits through the RO.

☑ Provide visiting experts with letters of introduction.

☑ Set up personnel files for all staff and visitors including checklists related to their personnel, financial and administrative needs.

***During the emergency phase/first month***

☑ Decide on policy for compensatory leave/overtime payments for national staff.

☑ Ensure clarity on rules and arrangements for payment of per diems for staff in the field in line with standard WHO rules.

☑ Organize a *roster system* and compensatory leave/overtime payments for regular WCO staff working extra time on the crisis.

☑ Establish a *leave recording* system for local and international staff.

☑ Keep careful track of the contract dates, TA and visa details of all staff and consultants, and plan well ahead for replacements.

☑ Where a temporary emergency field sub-office is being established, make arrangements for recruitments and ongoing HR management for the sub-office.

☑ Organize administrative briefings and debriefings for visitors.

☑ Organize a system of routine “debriefing” as well as performance evaluation for all professional staff and consultants at the end of their assignments. Debriefing should include both “administrative” issues for the individual and debriefing on their experiences to feed into a “lessons-learning” process (see section 11.2).

☑ Ensure proper *handovers* between staff/consultants who leave and those who take over:

- personnel leaving *must* prepare handover notes – see sample on CD-ROM;
- arrange a 2 to 3 day overlap for an effective handover, whenever possible.

☑ Inform all staff assigned in difficult or hazardous locations of the rules and arrangements for rest and recuperation (*R&R*), and set up a system to track R&R entitlements and leave taken.

☑ Where field conditions are difficult, ensure sufficient numbers of staff to enable individuals to take allowed rest and recuperation (R&R) at the prescribed regular intervals. Arrange for other staff to cover for them if necessary and take account of the financial and administrative implications when preparing budgets.

☑ In any major humanitarian crisis, particularly a complex/conflict emergency, consult with the Stress Management Counsellor in HQ-HMS to determine how *stress counselling* services should be assured for staff.

(This might include referrals to local psychologists, a shared stress counsellor as a common UNCT inter-agency service to which WHO would have to contribute financially, or remote support from the RO and HQ – see SOP 7.9. Training and support In case of a major incident by the provided by the Critical Incident Stress Management Unit in UNDSS-New York.)

☑ Where a stress counsellor is available, include her/him in debriefings of departing staff and consultants.

***Once the situation has stabilized/beyond the first month***

☑ Maintain HR management systems.

☑ Recruit STP staff and consultants for longer periods. Avoid very short-term contracts as programmes need continuity.

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## Tools and other guidance

Guidelines on stress management in annex G5

Possible input requirements for projects in annex C6

Standard job descriptions in SOP 7.1

Emergency delegation of authority to WRs in Annex 4 and SOP 5.1

Administrative briefing and debriefing checklists in SOP 7.5 (designed for HQ use but may be adapted for use by a WCO)

“Guidelines for employing local health personnel”

Template for a handover note – e.g. SARS, Mozambique

# 10.3 Mobilizing/recruiting national staff for field operations

The following guidance applies in particular to mobilizing staff for a field sub-office during an emergency but my also be relevant for mobilizing additional staff for the WCO.

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## Guiding principles

National staff can be the greatest asset in an emergency operation; their local knowledge and commitment is often invaluable. *Time spent in selecting staff is seldom regretted.*

All staff (and candidates) must be:

- legal residents of the area and have the right to work;
- not be related to another staff member; *and*
- physically fit (they will have to pass a medical examination before their appointment can be confirmed).

Local employment laws and regulations must be respected. Check with the UNDP office, if necessary.

Where ethnic or religious divisions exist, political sensitivity is critical in local recruitment. There should be a balanced representation of all groups in the WHO team/office. Include both men and women.

In the initial phase of an emergency, all new national staff will be given Special Services Agreement (SSA) contracts. At a later stage, these contracts may be reviewed and, if deemed appropriate, converted to short-term staff contracts.

Authorised medical examinations are arranged and paid for by WHO.

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## What to do – key management actions

☑ Draw up a list of core (national) staff positions and the skills needed. Use/adapt the job descriptions for secretaries, receptionists, interpreters, drivers, guards and cleaners in SOP 9.9.

☑ Give careful attention to the selection of staff. Devote the time necessary to identify suitable candidates and conduct interviews. Check the background and test the skills of each candidate.

☑ Ensure balanced representation of all ethnic and religious groups and look for individuals who are motivated to serve the population as a whole.

☑ Look for possibilities to get staff on loan or secondment from ongoing WHO programmes, other UN agencies, national institutions, or local authorities.

When recruiting national staff:

☑ Review WCO records of former staff including performance appraisals and job descriptions to find suitable candidates (who are already familiar with WHO and its procedures).

☑ Check with other UN agencies or NGOs established in the area before the emergency for records of their former employees.

☑ Give particular attention to the testing of drivers before recruitment as their skills and reliability can have important implications for the safety and security of other staff.

☑ Check with local authorities: They will have long lists of potential employees. Specify that you need staff with previous work experience on UN projects or programmes. Detail the type of experience and qualifications you require.

☑ When time permits, advertise through newspapers, radio or notices posted outside government and UN offices. Specify the education, minimum skills, languages, previous experience and legal requirements. See the hints in Panel 10-3.

☑ Arrange a medical examination and clearance by a UN accredited physician for candidates selected. If this is not possible, direct the candidate to the nearest clinic or hospital with x-ray facilities. Check with the RO, if necessary, concerning the type of examination necessary and the financial limits on any costs involved.

## Tools and other guidance

Driver's test in SOP 9.9.

Panel 10-3

### Some hints when advertising staff vacancies

In crisis areas, unemployment is generally high and people are anxious to find work and will respond in droves to vacancy notices. To ensure that your office is not inundated with applicants and that they are treated with respect, take the following steps:

- when advertising, clearly state that curriculum vitae and/or personal history forms (PHF or the UN P11 form) only will be accepted and that applicants will be contacted in due course;
- brief the receptionist to accept only curriculum vitae/PHF and/or the UN P11 form.
- reply to each unsuccessful applicant. This can be posted or left with the receptionist for pick-up. It is courteous to reply to applicants, and it stops them from hanging around the office waiting for a reply.

Each applicant should complete the Personal History Form. Birth certificate, identity document, curriculum vitae and references should be photocopied and placed in the applicant's file. Original diplomas should be checked and validated.

***Skill testing*** is a useful tool for evaluating the applicant's ability to perform to the standards required. A driver's skill test is provided in SOP 9.9. However, the score obtained in these tests should be considered as indicative only. Other qualities, i.e. personality, appearance, work experience and teamwork capacity must be taken into account. Applicants must be informed that an interview and a high score in a skill test do not necessarily mean employment.

## 10.4 Assuring admin. services

This section concerns the management of the office (especially the operations room), office transport and staff overtime, and arrangements for travel, visas, permits, etc. for personnel working on the emergency operation. These important functions may be fulfilled by a dedicated Administrative Assistant under the close supervision of the Administrative Officer or the Operations Room Manager.

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### Guiding principles

Efficient administrative services are essential for an efficient and effective office and to enable technical staff to concentrate on providing humanitarian assistance.

Administrative systems must be well organized with sufficient trained, experienced admin. support staff to avoid backlogs of work or excessive cumulative stress over a long period.

The administrative officer *must* participate in EMT meetings to understand the challenges being faced and provide the necessary support and encouragement to admin. staff to be proactive in supporting and facilitating the emergency programme operations.

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### What to do – key management actions

***First steps – during the first few days***

- ☑ Set up an operations room and arrange a meeting room and facilities for additional emergency staff to work.
- ☑ In consultation with RO and HQ, establish a system to ensure that you are informed in advance of all visitors and their status.
- ☑ Ensure sufficient office space for the number of staff and visitors expected. Consider renting additional office space if required.
- ☑ Negotiate space in reliable hotels as soon as possible (if available local hotels are likely to rapidly become fully booked).
- ☑ Secure warehouse space, if needed, in coordination with WFP – see Panel 10-6 in section 10.7.
- ☑ Organize work spaces and secretarial assistance for visiting experts.
- ☑ Order additional office supplies and consumables (paper, stationery, pens, etc.)
- ☑ Set up a technical briefing pack for visitors - in coordination with the technical units - and make sure it is kept up to date.
- ☑ Set up and maintain internal contact lists (WCO staff and visiting experts) and external contact lists.
- ☑ Make sure that all admin. staff are aware of the provisions of the emergency delegation of authority to the WR, if granted.

***During the emergency phase/first month***

- ☑ Arrange the setting up of emergency field sub-office(s) and guest houses, if required. (Logistics officers from HQ or the RO may help with this.)
- ☑ Nominate/recruit an Admin. Assistant to handle travel (changing air tickets; monitoring the flow of staff to the office; organizing hotel and airport pick-up arrangements; managing per diem advances; booking hotels; issuing in-country travel authorizations; security clearances; organizing visa extensions, etc.
- ☑ Establish system to track staff movement in-country, in close coordination with Security Officer.
- ☑ Ensure that visitors are accommodated in a safe place.
- ☑ Ensure there is enough food and water for staff and visitors.
- ☑ Make extra keys for the office and distribute to emergency staff for use at night/weekends and make sure that the security officer is informed of staff possessing office keys.

- ☑ Establish a system to track regular staff person-hours devoted to the relief operation. (This is a new requirement of the external auditors to quantify and document the Organization's contribution to the projects. The exercise can also be used to identify and later transfer permissible salary expenses as direct costs if budget balances remain available in the allotments at the completion of the project.)
- ☑ Ensure all new drivers are familiar with WHO's rules for drivers, see SOPs 9.9 and 9.12 (which also includes a driver's test).
- ☑ Track mobile phones, laptop computers and other ICT equipment loaned to staff and visitors, and monitor their safe return (adapt the Asset Handover Sheet in SOP 9.4).
- ☑ Arrange the purchase of additional mobile phones and SIM cards, as needed.

***Once the situation has stabilized/beyond the first month***

- ☑ Monitor the functioning of office premises, operations room, and any field sub-offices and guesthouses, and the efficiency of admin. services.

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## Tools and other guidance

*Asset handover sheet* in SOP 9.4

*Operations room checklist* in SOP 9.9

*Fleet Management Manual* in SOP 9.12

## 10.5 Assuring finance services

### Guiding principles

Efficient finance services are essential for an efficient and effective operation: they must be in place from day-1 and permit purchases to be made and other expenses incurred in the field (not just in the capital).

Finance systems must be well organized with sufficient trained, experienced staff to deal promptly with all financial transactions and recording (and to avoid excessive cumulative stress over a long period). Professional accounting/financial management experience is essential.

An *imprest bank account* should be opened for any field sub-office established. The imprest level should normally be set at 3 times the estimated average monthly expenditure.

*Petty cash* should be available for expenditures to facilitate emergency operations in the field.

Exceptionally, staff may need to carry substantial amounts of cash to the field when banking systems are unreliable, non-existent or disrupted by the emergency and/or suppliers of goods and services are unwilling to accept cheques or bank transfers against invoices but require immediate cash payment.

The WR may approve petty cash advances to staff members for programme activities if the emergency delegation of authority has been activated (see Annex 4 and SOP 5.1).

Normally, the maximum amount of petty cash provided is US$5,000 per staff member.

HQ-HAC may make/suggest allocations of petty cash to staff against the HQ-HAC allotment.

A staff member carrying cash to a field location should place it in a safe on arrival, either in another UN office or at the hotel, or purchase and install one in the field sub-office. The safe should be cemented into an inside wall of the office, whenever possible, and have dual access facilities, i.e. a combination (known by person A) and key (held by person B) or two keys (one for person A and one for person B).

### What to do – key management actions

***First steps – during the first few days***

- ☑ Make sure that all finance staff are aware of the provisions of the emergency delegation of authority to the WR, if granted.
- ☑ Check the balances in office bank account(s) and request replenishment by the RO if needed.
- ☑ Check whether the bank where WHO has its account(s) is functioning normally and whether branches of the bank in the affected areas are functioning or not.
- ☑ Provide clear instructions, in the name of the WR, concerning what funds can be spent on and accountability requirements.
- ☑ Provide petty cash to emergency staff travelling to the affected areas, as approved by the WR.
- ☑ Ensure that staff members who receive petty cash advances understand and fulfil their responsibilities as outlined in Annex D1.
- ☑ Contact the administrative officer in the RO and establish clear understandings of who will do what in relation to financial recording and monitoring to avoid gaps or overlaps.
- ☑ Establish resource tracking system.
- ☑ Establish project/grant management system.
- ☑ Produce regular financial status reports.
- ☑ Make arrangements to assign additional office costs to the emergency (overtime, phone, Internet, rent, postage, utilities, etc.)

***During the emergency phase/first month***

- ☑ Ensure that all financial transactions and recording for the emergency are completed promptly. Re-assign staff and work priorities as required and engage additional staff, if required and if funds are available.
- ☑ Monitor balances in the office *imprest bank account(s)* and expected expenditures in the coming month, and request replenishment by the RO in good time to avoid cash flow problems.
- ☑ Establish imprest accounts for any emergency field sub-office established, as approved by the WR.
- ☑ Ensure that any staff member responsible for an imprest account understands and fulfils her/his responsibilities as outlined in Annex D1.
- ☑ Arrange to transfer initial expenses incurred by HQ, the regional or the country office to the emergency allotment, if necessary, once project proposals have been funded by donors and funds become available through the allotment process. (These initial expenses may include logisticians and assessment teams as well as emergency procurement: these are direct costs that should not be charged to PMR.)
- ☑ Ensure the tracking of all programme expenditures and linking payments for local purchases to verification of reception of the goods concerned in conformity with the purchase order.

*When establishing a bank account for a new field sub-office*:

- ☑ Use the same bank as the WHO office, if possible. If that bank is not operating in the area, ask other UN agencies which banks they use and their level of satisfaction, and ask one of the agencies to introduce you to their bank. The bank must have good standing in the country and be linked internationally.
- ☑ If the emergency delegation of authority has been granted to the WR, open an account and transmit all pertinent information to Coordinator Treasury (TRY), HQ. Otherwise, transmit the information and request TRY to arrange for an account to be opened.
- ☑ At the end of each calendar month, reconcile the bank statement with the imprest account to ensure that it balances.
- ☑ Make an initial estimate of monthly expenditure based on estimated recurrent operating costs including recurrent local procurements and add 50%.
- ☑ Issue instructions to the head(s) of field sub-office clearly specifying their authority to spend funds (for emergency interventions in the context of an approved action plan).

*Where banks are not operating in the field*:

- ☑ Continue providing cash to staff members to carry to the area but, if that would be particularly dangerous, ask other agencies how they manage. If transfers through "money vendors" could be an option, consult with and seek the approval of RO-DAF.

***Once the situation has stabilized/beyond the first month***

- ☑ Monitor the cash resources, expenditures and the efficiency of financial services.

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## Tools and other guidance

SOP 6.8 with attached petty cash guidelines. (This SOP is addressed in particular to HQ staff who receive advances when going on emergency assignments but much is also relevant for in-country staff.)

Accounting forms (in Excel) appended to SOP 9.9.

Annex D1, *Responsibilities of staff members for imprest accounts and petty cash*

## 10.6 Procuring supplies

The prompt acquisition and delivery of supplies is often a critical element of humanitarian assistance.

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### Guiding principles

Planning for the delivery of supplies must be realistic and take account of lead times for purchase and delivery. Place orders for goods and services as early as possible.

WRs have authority for individual procurements as delegated by their RD on a case-by-case basis. This may be increased to a maximum of US$100,000 in case the emergency delegation of authority is granted. All other procurements are undertaken by the RO.

Local procurement is often the fastest means of obtaining emergency goods, services or projects and purchasing from local vendors stimulates the local economy and can improve relations between the project and local government. However, it may ultimately be more expensive than procurement through WHO's normal Limited International Bidding procedures. When considering procuring locally, staff should examine the cost and benefits of local versus international procurement; the quality of local items; delivery delays; service availability; etc.

The provisions of WHO Manual VI apply but staff at all levels should accelerate action to expedite the ordering and delivery of urgently needed items.

All procurements of project supplies require endorsement by the WR and technical clearance of the relevant regional advisor (RA) and in consultation with HQ-HAC (ERO).

When proposing local procurement, the following must be considered and documented: availability of items for immediate delivery from stock, cost, urgency of need, payment in local currency, and after-sales service.

Distribution plans should be prepared in advance of the delivery/arrival of supplies in order to minimize delays in the supplies reaching the places where they are needed.

The WCO should follow up to ensure prompt reception, clearance and forwarding or imported supplies and verify the distribution of all supplies, imported and locally-purchased, according to plan. (This should be done by a logistician, whenever possible, and be included in the logistician's TOR.)

The WCO must maintain an inventory of all supplies and equipment purchased showing the cost and physical location for non expendable equipment valued at $500 or more and highly desirable items valued at $100 or more.

WHO's procurement rules do not recommend local procurement of drugs, and certainly not locally-assembled drug kits, due to problems of quality control. When establishing specifications for other supplies for which the country office has little experience, refer to *Emergency Relief Items: compendium of basic specifications*, vol. 2, *Medical Supplies and equipment, selected essential drugs*, UNDP/IAPSO.

In general, supplies should be handed over to the MoH. On rare occasions and at the WR's discretion, it might be appropriate for WHO to serve as the primary receiving agent for supplies and assure storage pending on-forwarding to end-user locations. This might be the case when the MoH supply management system is overwhelmed or otherwise unable to deliver supplies to certain areas.

Unfortunately, supplies delivered for emergency operations sometimes get stuck in ports, airports and other warehouses because documents are not presented or formalities not completed, or because they get overlooked – forgotten – by officials who are overloaded.

It is the responsibility of the WR to monitor the procurement and delivery process and to ensure that:

- ✓ *For local procurements*: goods are delivered in time and in good condition to the designated consignee.
- ✓ *For imports*: orders are correctly placed and shipments properly received, cleared and forwarded – this includes liaising with RO and following up locally when the Pre-Advice of shipment is received to ensure that the consignee is ready to receive, and then promptly clears and takes delivery of, the consignment.

***Acceptance of in-kind donations***

WHO only accepts in kind donations of health kits and pharmaceuticals that conform to WHO's standards and when the donor is willing and able to cover transportation and other handling costs – see SOP 12.

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## What to do – key management actions

***First steps – during the first few days***

- ☑ Prepare a procurement plan (see SOP 13.3) as part of the WCO emergency Action Plan.
- ☑ Request short-term staff support from the RO if significant or complex procurement actions are involved.
- ☑ Define responsibilities for clearing and authorizing procurements – authorization might be by the EHA officer in consultation with the technical unit.
- ☑ Ensure arrangements for the expeditious customs clearance of imported supplies – see SOP 9.6.
- ☑ Where goods are locally available, request local suppliers to provide price estimates as soon as possible.
- ☑ Where goods are not locally available, request CIP (cost, insurance and air freight paid to a named destination) price estimates from the RO, unless the WCO is authorized to make direct international purchases based on immediate availability.
- ☑ Establish a system to monitor the status of procurement actions, both local and international, and tracking consignments from point of purchase to arrival in in-country warehouses. (A spreadsheet is available in SOP 13.4.)
- ☑ Establish an inventory and asset-tracking system (with copies of all relevant documentation) for supplies and equipment purchased.
- ☑ Ensure an adequate inventory control and logistics management system; propose LSS/SUMA if appropriate.

***During the emergency phase/first month***

- ☑ Carefully prioritize any requirements for supplies and equipment to be delivered by WHO.
- ☑ Where needed items of assured quality are available locally, use the delegated authority or, for larger quantities, inform the RO of local prices and delivery conditions.
- ☑ Provide precise specifications and/or details of the intended use for all items required (see Panel 10-4).
- ☑ When requesting WHO Emergency Health Kits, specify the options required where relevant.
- ☑ Whenever supplies are imported, monitor all stages of the procurement and shipment process and follow up to ensure that the goods are promptly cleared and forwarded to the locations where they are needed.
- ☑ Arrange for WHO staff – a trained/experienced logistics officer whenever possible – to make spot-checks of warehouses where supplies for the emergency operation are stored.

***Once the situation has stabilized/beyond the first month***

- ☑ Keep the inventories of supplies and equipment up to date.

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## Tools and other guidance

Standard kits, in annex D3 and SOPs 9.2 and 9.3

Standard staff and equipment needs table in annex C6

Drug donation guidelines in annex D4

MOSS standards in SOP 11.4

Criteria of selection of vehicles: price, intended use, security/MOSS requirements, etc. (and be aware of the political issues).

Panel 10-4

**Preparing a procurement request/S&E list**

The request (normally formulated by the MoH and the responsible WHO staff member) must provide all necessary details for each item including, as appropriate:

- ***Full specifications*** – a specific reference to a manufacturer's catalogue with a note "or equivalent", or sufficient explanation of the circumstances and intended use to enable procurement staff to propose appropriate items. Specifications include, as appropriate:
  - required options/accessories
  - electric supply characteristics, or type of fuel
  - capacity and dimensions (e.g. for refrigerators, scales)
  - generic name and dosage (for drugs)
  - grade and purity (for chemical/diagnostic reagents)
  - quantity required
- ***Delivery point*** – port or airport for imports; office/warehouse/institution for local procurements
- ***Required/desired delivery date***
- ***Consignee information*** – complete name, designation, address, telephone, fax and/or telex numbers
- ***Packaging and labelling*** – any special requirements to facilitate reception and distribution

Justification (e.g. non-availability of servicing and maintenance facilities for other brands) must be provided in case a specific brand is requested, especially for complex or costly items.

For specifications for any items that staff of the country office are not familiar with, consult *Emergency Relief Items: compendium of basic specifications* vol.2, *Medical supplies and equipment, selected essential drugs*, UNDP/IAPSO, 199? in the WHO Emergency Library Kit, or at http://www.iapso.org/supplying/AgencyInfo.asp?AgencyID=18

## 10.7 Assuring in-country transport and storage of supplies

The need is to ensure that adequate, reliable arrangements are in place for the transport, storage and inventory control of medical and other health-related supplies.

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### Guiding principles

Existing national medical stores or other systems should be used wherever possible; they should be reinforced, where necessary.

WHO should take direct responsibility for logistics and the management of supplies only in extreme cases when existing systems have broken down or are otherwise unable to ensure deliveries to all of the emergency-affected areas, especially in a situation of conflict.

Logisticians with relevant skills and experience should be mobilized at the outset for any major operation where there are logistics problems and especially when WHO takes direct responsibility for supplies or there are a number of field sub-offices are to be serviced.

In all cases, a reliable inventory control and tracking system is essential. LSS/SUMA may be used/ proposed if existing systems are inadequate.

*Where WHO takes responsibility for in-country transport and storage*: suitable premises, staff, distribution and control systems must be assured from the outset.

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### What to do – key management actions

***First steps – during the first few days***

☑ Rapidly review the logistic problems and available health sector logistic capacities in terms of storage, transport, control systems and management. Do this in collaboration with the MoH and other partners, whenever possible.

☑ Ask the RO and HQ-HAC to immediately provide the services of an experienced logistician, if necessary. Mobilize logistic expertise available in the country, where possible.

☑ Discuss possibilities for the transportation and storage of supplies with WFP. In a major emergency, find out whether common air services or a Joint Logistics Cell (JLC) is being established and how WHO and the health sector in general can benefit from such services and what funding/cost-sharing arrangements are envisaged – see Panels 10-5 and 10-6.

☑ Estimate, on the basis of the initial working scenario, the quantities of supplies likely to be required and determine how the reception of incoming supplies/donations and their storage and delivery to the affected areas can be assured during the first few weeks.

☑ Work with the MoH and other partners to ensure (i) the efficient dispatching of available supplies to the affected areas, as required, and (ii) the reception, sorting, recording, interim storage and on-forwarding of incoming supplies from external sources and from local procurement. Where local systems are overwhelmed, take the initiative to put arrangements in place on behalf of the MoH.

***During the emergency phase/first month***

☑ Working with the MoH and other partners, review and refine estimates of the quantities of supplies to be handled and draw up a logistics plan – see Panel 10-7.

☑ Implement the logistics plan progressively.

☑ Establish agreements with WFP or other parties for the transportation of health/medical supplies, if appropriate.

***Once the situation has stabilized/beyond the first month***

☑ Monitor the performance of the logistic system in assuring the continuity of essential supplies in field facilities and keeping loss rates to a minimum.

☑ Monitor changes in the situation and the demands for supplies in different areas, and adapt the logistics plan as and when necessary.

## Tools and other guidance

Annex D5 - *Delivering and managing supplies*

Panel 10-5

### UN Joint Logistics Cells

In case of a major emergency, the UN Joint Logistics Centre (UNJLC) may, at the request of the UN humanitarian coordinator, establish a cell, integrated in the local UN coordination structure, to:

- ✓ collect, consolidate and disseminate information on logistic capacities and constraints;
- ✓ facilitate logistics coordination meetings;
- ✓ prioritize and schedule air cargo shipments via common air assets (UN or government);
- ✓ interface with military forces on the use of military logistic assets for humanitarian operations.

They do *not* handle logistics on behalf of individual agencies, run storage facilities or inland transport operations. For details of UNJLC operations, see http://www.unjlc.org

[Adapted from *Emergency Field Handbook*, UNICEF 2005, section 6.5.25]

Panel 10-6

### Possible support from WFP for in-country storage and transportation of supplies

Under the terms of an agreement signed in 2006:

- WFP provides in-country warehouse ***storage*** for WHO supplies wherever possible; WHO must provide the names and signatures of officials authorized to certify the release of supplies from a WFP storage facility;
- WFP, wherever possible, makes arrangements for the secondary (in-country) ***transportation*** of supplies to designated destinations on request from WHO; WHO must ensure that the consignee is present at the final destination to receive the supplies and make arrangements for unloading the cargo at the destination, and is responsible for demurrage or truck detention charges or any other such charges applicable to the mode of transport when WHO is at fault.

Agreements are signed at country level establishing the terms and conditions for any transportation by WFP. WFP charges WHO for services provided on a direct cost basis plus WFP's customary charge for UN system bilateral services. For combined shipments, costs are borne proportionately by the parties. Requests for payments are made by WFP on a quarterly basis.

For details, see *Technical Agreement between WFP and WHO for Logistics Co-operation*, Nov. 2006

Panel 10-7

### Contents of a logistics plan

A logistics plan should be drawn up by whomever is responsible for the reception, storage, handling and in-country transport/distribution of emergency medical and health supplies – normally the MoH, exceptionally WHO. The main components of such a plan are:

- A *map* and *table* showing:
    - the locations of different types of health facilities (hospitals, health centres, etc.) and any displaced persons camps that are to be supplied;
    - the population of the catchment area of each facility or camp;
    - the points of origin of supplies (ports, airports and locations of local suppliers);
    - medical storage facilities;
    - available transport routes including any points where transhipments are needed and specific constraints such as ferries or damaged bridges;
    - transport bases and maintenance facilities.
- Estimates for the *quantities* of health/medical supplies that need to be delivered to particular areas/locations

and along particular routes.

- A description of the *strategy* for the in-country transport, storage and handling of supplies including the locations of logistic "hubs" where needed (preferably co-located with the hubs of WFP and other UN agencies); the means of transport to be used on the various routes and in different areas; …
- A plan, with target dates and responsibilities, for: the establishment of storage facilities (when needed) and an inventory management and tracking system; the acquisition of transport units (trucks, boats, etc.); the management and maintenance of transport units; the use of common air services (if any); …

## 10.8 Assuring ICT services (data systems & telecoms)

Information and Communication Technology (ICT) equipment and services are essential for security and enabling staff to access information and communicate.

### Guiding principles

Stable, reliable in-country and external telecommunications and WCO information systems are essential from the outset.

Compliance with UN MOSS (minimum operational security standards) is a pre-requisite for operations in any area of security phase I or higher.

Telecommunication means must be selected on the basis of security/MOSS requirements, cost, the time to put into use, and the availability or otherwise of common services.

In a major emergency, OCHA may help to identify possibilities for and facilitate arrangements for agencies to collaborate and share resources and equipment for data and voice communications.

### What to do – key management actions

***First steps – during the first few days***

- ☑ Nominate an ICT focal point to manage ICT support to the operations room and the emergency operation in general including issuing new e-mail accounts, managing common access server files and group e-mail accounts.
- ☑ Contact RO-ICTfor technical advice and any support required to specify, supply, install and operate equipment. To the extent possible, provide the information indicated in Panel 10-7.
- ☑ Make initial arrangements for telecommunications and the filing and sharing of electronic documents in the country office and draw up plans for the coming months including sub-offices, where required.
- ☑ Organize additional capacity for the office server if required.
- ☑ Set up e-mail groups to facilitate the circulation of information.
- ☑ In consultation with regional office, establish a web page in the UN working language and the local language.

In a major emergency:

- ☑ Contact the ***WFP*** country office to determine whether and to what extent WHO may be able to rely on WFP for ***radio*** communications (WFP Fittest – a special team based in Dubai – is the UN lead agency for ICT support);

Panel 10-7

**Information to enable RO-ICT to help specify ICT requirements**
[From *ICT Deployment Guidelines*, WHO-ITT 2006]

| | |
|---|---|
| Sites | • The number of sites<br>• The location(s)<br>• The facilities<br>• The other agencies at those locations |
| Staff / consultants | • The number of staff per site<br>• The number of consultants per site |
| Equipment | • An overview and specification of personal equipment including mobile phones, laptops |
| Duration | • Estimated duration of the emergency response<br>• Estimated scale over time |
| Videoconference | • Yes/No |

***During the emergency phase/first month***

- ☑ Establish arrangements for the maintenance and repair of equipment.

***Once the situation has stabilized/beyond the first month***

☑ Monitor the use of telecommunications and the condition of the equipment (including antenna).

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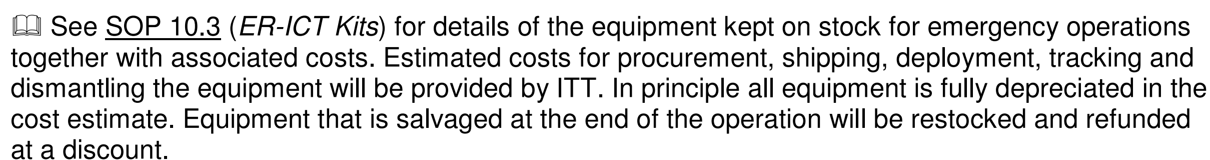
## Tools and other guidance

SOP 10

MOSS standards in SOP 11.4

Radio communication procedures



📖 See SOP 10.3 (*ER-ICT Kits*) for details of the equipment kept on stock for emergency operations together with associated costs. Estimated costs for procurement, shipping, deployment, tracking and dismantling the equipment will be provided by ITT. In principle all equipment is fully depreciated in the cost estimate. Equipment that is salvaged at the end of the operation will be restocked and refunded at a discount.

# 11
# Phasing Out

This chapter provides guidance on how to plan and manage the phasing out of emergency humanitarian assistance activities. This includes phasing out coordination activities (particularly important when WHO has been serving as Cluster Lead) as well as phasing out programme activities and closing down special operational support arrangements. It also includes organizing evaluations, or at least lessons-learning exercises for both individual projects and the overall health sector response. Planning and overseeing the phase-out and evaluation processes would normally be the responsibility of the WHO Emergency Coordinator for a major operation. For a lesser operation, the WR would be directly responsible.

## 11.1 Planning to phase-out

In principle, emergency humanitarian activities should be phased out when the exceptional needs arising from the emergency no longer exist and normal health and related services, together with ongoing development activities, can meet the needs of the population. Ideally, there would be a smooth transition from relief through recovery and into normal and development activities. In practice, humanitarian assistance sometimes has to be phased down, and perhaps even out, earlier because of a lack of resources. It is the responsibility of WHO, and the WR in particular, to do everything possible through advocacy and resource mobilization efforts to ensure a smooth, timely transition.

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### Guiding principles

The phasing out of emergency assistance and activities must be envisaged from an early stage of the operation – preferably at the time when projects are planned. The phasing out of individual activities and of the whole emergency programme and operational set-up (including any field sub-offices) must be carefully planned and managed.

An evaluation and/or lessons-learned exercise should be undertaken in all cases.

***Phasing out coordination activities***

Coordination activities must be continued as long as coordination is necessary but the resources dedicated to coordination may be reduced progressively as activities become more routine and the number of health actors decline (as many international and some national health actors withdraw).

***Phasing out programme activities***

To the extent possible, emergency projects should be phased out into ongoing regular programmes, transferring responsibility to the relevant technical programmes, or into the development activities of other partners. The scale of operations may be reduced progressively to a scale that can be sustained in the long term.

When this is not possible, try at least to ensure equality in treatment for different areas and population groups, the delivery of residual emergency assistance and services on the basis of need in line with the principles in section 1.4, and avoid leaving vacuums.

On completion of each emergency project, materials and equipment should normally be handed over as a donation to the MoH or another designated national entity:

- Equipment purchased with project funds normally should *not* be retained by WHO unless specified in the grant agreement.
- Equipment and materials purchased with project funds should *never* be given away to individuals or staff.
- All donations should be properly documented and properly transferred to appropriate government offices and personnel.

***Closing down the emergency operational support platform***

Special arrangements for operational support to the emergency programme activities should be progressively scaled down as the field activities are scaled down:

- Procurement arrangements may be phased out ahead of other aspects.
- Security and telecommunications elements must be maintained until all field activities that require WHO staff presence in the field are completed.
- Adequate HR and financial management arrangements must be maintained until all personal files are closed and all payments and financial reports completed.

On expiry of the emergency delegation, bank accounts opened for field sub-offices under that authority must be closed, and the balance of funds returned to the WCO or RO bank account, *or* the maintenance of the bank account must be approved by the Regional Director following normal procedures.

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## What to do – key management actions

***Phasing out coordination activities (when WHO has been responsible)***

- ☑ Progressively reduce the number of meetings, the frequency of bulletins, etc.
- ☑ Progressively hand over to MoH full responsibility for information management and convening and facilitating coordination meetings.
- ☑ Work with partners (in the context of the Health Cluster where there is one) to try to ensure a smooth handover of the activities, supplies and equipment of those that are withdrawing to the MoH or other health partners that will remain.
- ☑ Agree with the HC, MoH and other health partners (in the context of the Health Cluster where there is one), on the timing of the last emergency coordination meeting.

***Phasing out programme activities***

- ☑ Monitor the health status of the population, public health threats, and the performance (quality and coverage) of health services provided by (i) the various elements of the normal health system, and (ii) short-term emergency health actors.
- ☑ Discuss exit strategies, potential synergies, phasing-out and handover plans within the Health Cluster/sector group.
- ☑ Progressively focus WHO resources and efforts on the least well-served areas and least well-performing services, and encourage other international health actors to do the same in a coordinated effort.
- ☑ Consult with regional technical advisers and inter-country programme (ICP) team leaders to identify possibilities for activities that need to be continued to be taken over by regular programmes.
- ☑ In consultation with the MoH and other partners directly concerned, draw up a plan and timetable for handing over specific activities and terminating others, defining who will do what, when.

***Closing down the emergency operational support platform***

- ☑ With the DO and other Security Management Team members, monitor the security situation and how it is expected to evolve in the coming months, and agree on the implications for security measures to support continuing field operations.
- ☑ Monitor the levels of demand for support activities – the numbers of purchase requests, travel authorizations, HR actions, etc. being dealt with each month – and adjust staffing levels accordingly.
- ☑ Review the need for maintaining any temporary field sub-offices: do the criteria in Panel 3-6 (in section 3.4) still apply? While it may be "nice" to maintain the field presence for the final stages of the recovery programme or for future regular programme activities, is it really necessary and affordable?
- ☑ Determine the staffing requirements for the final stages of the recovery programme and future regular programme activities and draw up an HR plan to progressively transfer required staff from the emergency operation to other activities and to terminate others.
- ☑ Review (draw up, if necessary) inventory lists for emergency supplies and equipment including any "in the pipeline" and determine when, how and where they will be used.
- ☑ Determine, in consultation with the RO and HQ-HAC, what should be done with any vehicles, ICT kits (computers, mobile phones and satphones) and other equipment in the custody of WHO – whether the various items should be handed over to the MoH or transferred to other entities.
- ☑ Prepare handover documents for the transfer of remaining supplies and equipment.
- ☑ Progressively transfer the responsibilities fulfilled by the operations room to normal WCO sections and fix a date for closing the operations room.
- ☑ Ensure the debriefing of staff before they leave, and the compilation and analysis of their views on lessons to be learned.

## Tools and other guidance

SOP 9.10

Template for handover note in Annex D7

*An Introduction to Management in Emergencies: a manual for governmental and NGO partners,* J Telford, WHO-EHA, Dec. 2003, chapter 13

## 11.2 Organizing an evaluation or "lessons" exercise [9]

WHO has a responsibility to continuously improve the quality and enhance the cost-effectiveness of both its own emergency action and the overall emergency health response, and has also to demonstrate accountability. Evaluations and lessons-learning exercises including the analysis of debriefings are important contributions to both accountability and improving effectiveness.

Following a disaster involving a high level of international assistance, HQ-HAC may propose to the RO and donors a joint, independent evaluation of the international health response and, within this framework, of the role and contribution of WHO. Such an evaluation would normally be external and the conclusions widely circulated in line with WHO's commitment to transparency and accountability, and its concern for the quality and development-friendliness of the humanitarian contribution of external actors.

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### Guiding principles

Evaluations and/or least lessons-learning exercises should be organized – usually separately – at appropriate moments for both individual projects and the overall health sector response:

- They must be organized at a time when it is feasible to generate information that is accurate, reliable and useful.
- They may be organized at national level or within particular operational zones.
- They must enable WHO, the MoH and other partners to identify critical health and operational issues and fine-tune the techniques to address them. Areas of weakness must be identified so that steps can be taken to rectify them. The findings should lead to policy, operational and technical recommendations that will produce a faster and more effective response to future emergencies.

For any major crisis, a final lessons-learning exercise should be undertaken not later than one month after the end of humanitarian operations. It should cover both programme and operational aspects. This should be included in the work plan and budget of the Health Cluster and WHO.

The purpose of each evaluation or lessons exercise must be clearly defined, the terms of reference (TOR) drawn up with care, and an adequate budget established.

Projects and the overall sector response should be evaluated against the defined objectives and the benchmarks in section 1.2 taking account of international standards.

An evaluation manager must be designated for each evaluation or lessons exercise. S/he must be able to devote sufficient time to managing the process.

Evaluation teams should include a mix of relevant skills and experience, and be gender-balanced.

Reports, findings and recommendations must be promptly disseminated to all concerned and brought to the attention of the managers who need to know and take action.

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### What to do – key management actions

- ✓ Organize an internal lessons-learned review and/or an internal evaluation at the end of each distinct phase of a WHO-assisted operation: this might take the form of a workshop/retreat at WCO or field sub-office level.
- ✓ Arrange, in consultation/collaboration with the RO and HQ-HAC, an appropriate evaluation of any activity managed by WHO or that receives substantial WHO assistance.
- ✓ Take the initiative as Cluster Lead to organize, or otherwise encourage and support the MoH in organizing, a sector-wide lessons-learned exercise involving all stakeholders, or a sector-wide evaluation of health response, and ensure that findings are widely disseminated.

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[9] Adapted from WPRO *Emergency Response Manual*, 2003, section 3.5

- ✓ Arrange for the systematic compilation and analysis of the main points from the debriefings of staff when they leave.

In all cases:

- ✓ Define and agree with the MoH and other key partners on the purpose and scope of the exercise – is the primary purpose accountability or learning, is it to examine WHO's own performance or that of the overall health sector response – and, on that basis, select the approach to be used – see Annex B9.
- ✓ Draw up detailed TOR for the exercise – see Panel 10-1.
- ✓ Decide on the composition of the evaluation team or identify a good facilitator for a lessons exercise.
- ✓ Designate an evaluation manager (responsibilities outlined in annex B9).
- ✓ Establish a budget for the exercise.
- ✓ Consult with the RO and HQ-HAC and request assistance in planning the exercise, if required.

A national workshop with nationals and international health partners to identify lessons-to-be-learned from successes and shortcomings, and the publication of the experience, is probably the best means to ensure learning and institutional memory.

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## Tools and other guidance

Annex B9: *Planning an evaluation or lessons-learning exercise*

*Guidelines for Interagency Health and Nutrition Evaluations in Humanitarian Crises*, Inter-agency Health and Nutrition Evaluations in Humanitarian Crises (IHE) Initiative, August 2007

*Evaluating humanitarian action using the OEDC-DAC criteria*, T Beck, ALNAP 2006: see http://www.alnap.org/publications/eha_dac/index.htm

*Evaluation guidelines,* DFID <www.dfid.gov.uk>

Panel 10-1

**Drawing up terms of reference for an evaluation or lessons exercise**

Whatever the purpose and approach well-thought-out TOR are important. They should be directly relevant to the decisions to be taken by intended users. The time and effort invested in preparing good TOR have big payoffs in terms of resulting quality, relevance and usefulness.

- Do not overload the TOR! Overloading is a frequent problem when many people add their own questions, especially in joint agency evaluations. The need to focus requires a prioritization of the diverse needs of the various possible users or stakeholders.
- Limit questions to the most important issues and ones that can realistically be answered in the prevailing circumstances; prioritize them.
- Be cautious about combining lesson-learning and accountability purposes in a single evaluation – the issues and the intended users are different and it may result in ambiguity in emphasis and approach.

A framework for developing TOR is provided in Annex B9. Note that: TOR are as important for internal teams as they are for external teams, although external teams may require more detail on background context and on intended audiences and uses. TOR may need to be translated for in-country use

For a *sector-wide* evaluation, the TOR must be agreed among all partners/ stakeholders. The details of the methodologies and tools to be used may need to be adapted/developed and piloted during an initial design phase.

# Annexes

**Annex 1**

## Lessons learnt from WHO's humanitarian action 2005-2007

[extract from *WHO Humanitarian Action 2008-2009*, BIENNIAL WORK PLAN TO SUPPORT WHO'S CAPACITY FOR WORK IN EMERGENCIES AND CRISES]

WHO's experience with humanitarian actions in 2005-2007 has shown there are a number of considerations which, if appropriately addressed, will contribute significantly to helping communities affected by crisis:

- ✓ Communities have an essential role to play in emergencies. At local level, much can be done to strengthen the response capacity of communities … and mitigate the effects of emergencies…
- ✓ Experience in recent crises has revealed major gaps in humanitarian health interventions that require urgent attention. WHO and its international humanitarian partners will need to strengthen their capacity to intervene in several areas including: mass casualty management; management of chronic diseases; maternal and newborn health; and human resources development particularly nursing and midwifery…
- ✓ To be effective, emergency operations must be backed by solid, reliable data. WHO will continue to provide up-to-date information on health risks, vulnerability, morbidity, mortality and other health indicators for use in rapidly assessing needs and monitoring performance in response to health crises.
- ✓ 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, while maintaining its identity and mandate. WHO will continue to strengthen collaboration with its health partners and with other humanitarian clusters such as Nutrition and Water and Sanitation.
- ✓ The ability to rapidly mobilize staff, equipment and money is essential to the success of emergency response operations… WHO will … take advantage of existing logistics platforms by strengthening alliances and joint work with key partners such as the World Food Programme. WHO's operational platforms and public health expertise complement each other; the Organization must strive to find a balance between them, and endeavour to ensure undue attention is not focused on one at the expense of the other.
- ✓ …making prompt and proper use of whatever is left of local systems and knowledge can make the difference between success and tragic failure. Even in the worst crisis, there is often a considerable amount of local technical expertise that can be harnessed. Facilitating local partnerships and collaborations is a vital task as outsiders are often hampered by language barriers and lack of familiarity with local systems, social values and customs. WHO can and must make use of local expertise during humanitarian interventions and use the opportunity to build local and national capacity.
- ✓ …highly-specialized public health expertise is not enough in emergencies: these skills must be accompanied by the ability to adapt and translate knowledge and expertise to the particular circumstances of an emergency. WHO must focus on further training and guidance to ensure technical excellence goes hand in hand with sound emergency management at field level.
- ✓ During emergencies (particularly complex emergencies) WHO's relationship with the Ministry of Health must be guided by the humanitarian imperative, which overrides every other consideration. The extent to which the Ministry is involved must be balanced with its understanding of the humanitarian imperative and the need for independence and neutrality of health partners.

**Annex 2**

# Effects and response priorities in different types of emergency

Each emergency situation is unique and response (by the government, national organizations, and the international community including WHO) must be planned on the basis of an appropriate assessment. There are, however, a number of characteristics that are common to particular types of situation as indicated in the table below.

The arrowed bullet points → indicate the responses typically required.

| | Sudden, localized catastrophe | Widespread disruption of society & health services | Slow-onset crisis | Displaced populations (in specific locations) |
|---|---|---|---|---|
| Event | Earthquake<br>Flash food; Tsunami<br>Major industrial accident<br>Terrorist attack | Seasonal flood<br>Cyclone/hurricane<br>Conflict/civil disturbance | Drought<br>Economic collapse | Refugee influx<br>IDPs associated with one of the other causes |
| Principal direct effects on health and health services, and the responses typically required | **Mass casualties** (large numbers of deaths & injuries)<br>→ triage surgical treatment<br>→ injury rehabilitation<br>→ disposal of dead bodies<br>**Destruction of facilities**<br>→ temporary facilities<br>→ immediate repairs<br>→ replacement of supplies & equipment<br>**Deaths of health workers**<br>→ medical teams from other parts of the country (and sometimes beyond)<br>→ training & supervision of new auxiliaries & volunteers | **Some casualties** (generally minor?)<br>→ injury treatment<br>**Breakdown of health service delivery** – supplies, staff payments, supervision (sudden or progressive)<br>→ repair of damaged facilities<br>→ replacement of lost/ damaged equipment<br>→ provision of supplies & funding<br>→ restoration of supply, finance & supervision systems & capacity | **Progressive deterioration of health services** due to reduced funding and migration of health workers:<br>→ provision of supplies & funding<br>… | **Poor health & nutritional condition** if people have travelled far:<br>→ immediate medical care<br>→ nutritional rehabilitation<br>→ immunization (especially measles)<br>**Lack of access to health services, or overloading of local health services**:<br>→ reinforcement of local health services (staff, supplies, transport)<br>→ establishment of special health services (staff, supplies, transport)<br>→ training & supervision of auxiliaries & volunteers |
| Indirect health effects, risks, and the responses typically required | **Communicable disease** due to lack of clean water & sanitation:<br>→ emergency water supply<br>→ emergency sanitation<br>→ repair of water supplies & sanitation installations<br>→ vector control<br>→ public health campaign | **Communicable disease increase** due to breakdown of water supplies, sanitation and other disease control measures:<br>→ emergency water supply<br>→ emergency sanitation<br>→ repair of water supplies & sanitation installations<br>→ vector control<br>→ public health campaign<br>**Chronic disease increase** due to disruption of treatment:<br>→ provision of supplies & funding<br>→ restoration/maintenance of supply, finance & supervision systems & capacity<br>**Continuing deterioration of health services** due to lack of funding or insecurity: | **Communicable disease increase** due to reductions in water supplies, sanitation and other disease control measures:<br>→ water conservation<br>→ exploitation of new water sources<br>→ maintenance of water & sanitation installations<br>→ maintenance of vector control<br>→ public health campaign<br>**Chronic disease increase** due to disruption of treatment:<br>→ provision of supplies & funding<br>→ maintenance of supply, finance & supervision systems & capacity | **Communicable disease** due to lack of clean water & sanitation, and change of environment:<br>→ emergency water supply<br>→ emergency sanitation<br>→ expansion of any existing water supply & sanitation systems<br>→ establishment of new water supply & sanitation systems<br>→ vector control<br>→ public health campaign<br>**Chronic disease increase** due to disruption of treatment:<br>→ expansion of existing long-term treatment programmes |

| | | → provision of supplies & funding | | |
|---|---|---|---|---|
| | **Sudden, localized catastrophe** | **Widespread disruption of society & health services** | **Slow-onset crisis** | **Displaced populations** (in specific locations) |
| Timeframe of typical responses | **Phase 1** (week 1?):<br>→ triage surgical treatment<br>→ emergency water supply<br>→ emergency sanitation<br>→ temporary health care facilities<br>→ medical teams from other parts of the country (and sometimes beyond)<br>→ disposal of dead bodies<br><br>**Phase 2** (weeks 2-4):<br>→ initial injury rehabilitation<br>→ immediate repairs to health care facilities & replacement of supplies & equipment<br>→ repair of water supplies & sanitation installations<br>→ training & supervision of new auxiliaries & volunteers<br>→ vector control<br>→ public health campaign<br><br>**Phase 3** (weeks 5-?):<br>→ continuing injury rehabilitation<br>→ continuing public health campaign | **Phase 1** (days 1-3?)<br>→ injury treatment<br>→ emergency water supply<br>→ emergency sanitation<br><br>**Phase 2** (days 4-15?)<br>→ initial repair of damaged facilities<br>→ initial replacement of lost/damaged equipment<br>→ initial provision of supplies & funding<br>→ emergency water supply<br>→ emergency sanitation<br><br>**Phase 3** (weeks 3-?)<br>→ repair of damaged facilities<br>→ replacement of lost/ damaged equipment<br>→ provision of supplies & funding<br>→ restoration/maintenance of supply, finance & supervision systems & capacity<br>→ repair of water supplies & sanitation installations<br>→ vector control<br>→ public health campaign | **Phase 1** (week 1?)<br>(detailed assessment)<br><br>**Phase 2** (weeks 2- 4?)<br>→ water conservation<br>→ exploitation of new water sources<br>→ public health campaign<br><br>**Phase 3** (weeks 5-?)<br>as above, plus:<br>→ maintenance of water & sanitation installations<br>→ maintenance of vector control<br>→ provision of supplies & funding for chronic disease programmes<br>→ maintenance of supply, finance & supervision systems & capacity | **Phase 1** (week 1?)<br>→ immediate medical care<br>→ nutritional rehabilitation<br>→ immunization (especially measles)<br>→ emergency water supply<br>→ emergency sanitation<br><br>**Phase 2** (weeks 2- 4?)<br>→ reinforcement of local health services (staff, supplies, transport)<br>→ establishment of special health services (staff, supplies, transport)<br>→ expansion of any existing water supply & sanitation systems<br>→ establishment of new water supply & sanitation systems<br>→ vector control<br>→ public health campaign<br><br>**Phase 3** (weeks 5-?)<br>→ training & supervision of auxiliaries & volunteers<br>→ expansion of existing long-term treatment programmes |

***Complex emergencies*** have a significant impact on public health systems, for example: a substantial decrease in resources; large changes in the management and organization of health services, and the evolution of different models of health care delivery. The table below outlines the main disruptions of the health system during complex emergencies. *Economic and social collapse* can have broadly similar effects with degradation replacing the destruction caused by conflict.

Response priorities focus on re-establishing health services and public/environmental health measures as much as possible and ensuring surveillance of the situation and prompt response to any disease outbreaks.

| Effects of complex emergencies on health systems | | |
|---|---|---|
| Limited resource availability | Financial | ▪ Diversion of resources to military<br>▪ Reduced revenue<br>▪ Reduced control over funds<br>▪ Increased dependence on aid |
| | Health workers | ▪ Injured, killed and kidnapped<br>▪ Displaced to urban areas/out of country<br>▪ Disrupted training/supervision<br>▪ Poor morale<br>▪ Poorly paid, if at all |
| | Equipment and supplies | ▪ Lack of drugs / maintenance<br>▪ Reduced access to technologies<br>▪ Inability to maintain cold chain |
| | Service infrastructure | ▪ Destruction of clinics<br>▪ Disrupted referral and communication |
| Management & organization of health services | ▪ Diversion from development based programs<br>▪ More centralized, urban-based, vertical programmes<br>▪ Disruption of complex programmes<br>▪ Focus on the short term<br>▪ Limited scope for consultation<br>▪ Reduction in data for decision-making<br>▪ Limited management training<br>▪ Reduced ability to monitor funds and resources<br>▪ Increased fragmentation | |
| Changes in services delivery | ▪ Shift from primary to secondary care<br>▪ Urbanization of provision<br>▪ Decreased activity in periphery<br>▪ Disrupted campaigns, health promotion, disease control and outreach<br>▪ Reduced access and utilization (fear, curfews, landmines, charges)<br>▪ Increased private provision | |
| Source: Zwi A., Ugalde A. and Richards P., 1999, "Impact of war and political violence on health services". *Encyclopedia of Violence, Peace and Conflict, Volume 1*, p. 679-690 | | |

**Annex 3**

# Criteria for WHO emergency response

The criteria for WHO emergency response are given in the panel below. The provision of WHO emergency assistance does *not* require a formal government declaration of a 'state of emergency' by the government. WHO may take the initiative to *offer* technical cooperation and emergency assistance when considered appropriate.

**Criteria for Emergency Response**
(edited from WHO Manual XV.4 paragraphs 80 and 90)

The WR (or the responsible officer in the RO or HQ-HAC) initiates action when a request is received from the competent national authorities, from the United Nations [Office for the Coordination of Humanitarian Affairs, OCHA] or other United Nations bodies, or where it is reasonable to expect that such a request will be forthcoming but is delayed owing to the emergency, and if the following criteria are met:

- the situation is a genuine emergency or the situation threatens to become an emergency if appropriate preventive measures are not taken;
- the national resources for meeting the situation are insufficient;
- the additional resources from other countries or agencies available or foreseen at the time are also insufficient, or not available in practice, to fulfil the total needs;
- even if the resources for meeting the situation in individual countries are sufficient, the effects of the emergency across the borders of those countries make WHO intervention to secure a coordinated response desirable.

The WR (or the responsible officer in the RO or HQ-HAC) may propose to the RD or to the Director-General that WHO should offer to the government technical cooperation and emergency assistance, even though no request has been received, provided that:

- it is clear that WHO assistance would materially improve either the physical or the organizational resources available to meet the situation; *and*
- the situation is such that it threatens the public health of the country and of adjoining countries; *or*
- if it is known that [OCHA], other agencies or other individual countries have received a request complying with the criteria set out under paragraph 80 above.

When providing assistance in ***conflict situations*** WHO, like other UN agencies, requires:

- sufficient security to operate in accordance with UN security standards (see …;
- safe and unimpeded access for humanitarian staff and beneficiaries;
- independent communications;
- independent assessment and monitoring by WHO and partners.

(See Annex H3 concerning the security measures including the use of guards and escorts for protection.)

# Emergency delegation of authority

The WR's emergency delegation of authority is automatically activated for all emergency and humanitarian projects meeting one or more of the following criteria:

a. all grants received from the Central Emergency Response Fund (CERF);
b. all projects funded under a Consolidated Appeal, Flash Appeal, Common Humanitarian Action Plan or similar joint humanitarian work plan;
c. all humanitarian projects funded by the UNDG Iraq Trust Fund;
d. other projects to be cleared by the Comptroller on an ad hoc basis.

This includes authority to, for the specific purposes of the emergency:

1. Recruit and hire competent short term staff for periods of up to 6 months;
2. Procure locally or internationally immediately available goods and services that are urgently needed up to $100,000 per transaction or up to the amount of the available allotment issued, whichever is lower. (With the exception of the procurement of pharmaceuticals, vaccines and biologicals for which normal procurement policies apply, this authority includes a waiver of bidding requirements as set forth under Manual VI.I);
3. Re-programme available regular budget funds up to $100,000 in consultation with national authorities, as appropriate, or re-programme extra-budgetary funds up to $100,000 in consultation with the corresponding donor;
4. Establish a sub-office to support field personnel, if required. This would include the setting up of a local bank account, renting office space, and establishing a local petty cash account in accordance with emergency standard operating procedures; *and*
5. Pay daily subsistence allowances to local volunteers for periods of up to 30 days. The amount of the stipend will be established by the WR in line with locally applicable, government-set per diem rates, and depend on the availability of funding as well as local emergency conditions.

The WR may re-delegate some or all of these authorities at his or her discretion to appropriate WHO personnel working in the country. All delegations must be made in writing. The WR remains responsible and accountable to the RD for all emergency actions taken under the re-delegation of authority.

Annex 5

# Possible agenda for a first internal WCO emergency management team meeting

The first meeting should be chaired by the WR. The agenda might be as follows:

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1. The situation: briefing by the EHA focal point with as much as is available of the following:
   - a map (as detailed as possible) of the affected area showing the distribution of the event, the affected populations and the locations of key health infrastructure;
   - an outline of national emergency response arrangements and key national legal, policy and technical issues that may be relevant;
   - a brief summary of current information on the extent of damage and losses, public health conditions, the needs of the population, the capacity of local authorities to meet those needs, weather forecasts, etc.;
   - an outline of the key elements of a preliminary working scenario (see #.#) and the main gaps in information;
   - arrangements for health-sector coordination (Cluster or other), and for an initial rapid assessment;
   - security issues, if any.
2. Role of WHO: discussion of the role WHO should play, the implications for the WCO, and the need (if any) for support from the RO and HQ.
3. WCO resources: inventory of the resources currently available to the WCO (staff, consultants, funds, supplies, transport, telecommunications, etc.).
4. Responsibilities: establishment of an organigram and assignment of responsibilities to specific units and individual professional and support staff for:
   - emergency programme and operations (administrative and logistic) functions, and external relations/communications; *and*
   - continuing regular programme activities.
5. Office facilities: allocation of space and office and ICT equipment for an operations room and any additional emergency personnel expected.
6. Priority requirements: a preliminary estimate of the emergency programme and operational/ administrative needs for activities during: (i) the coming week; and (ii) the coming month.
7. Next meeting: day, time, place, main agenda items, and what specific individuals need to do or prepare in the meantime.

Annex 6

# Format for a Working Scenario

| Working Scenario | |
|---|---|
| **Context** | |
| **General context** | |
| Nature of the crisis | |
| Geographic area(s) affected | |
| Total population – with breakdowns by area and population group, if available | |
| Affected population: a) directly affected b) indirectly affected | |
| Accessibility and security | |
| Type of initial accommodation of the affected populations | |
| Special concerns (e.g. ethnic or gender issues) | |
| **Pre-crisis health context** | |
| Pre-disaster epidemiology – endemic & chronic diseases, immunization coverage, health service coverage, health information management system, seasonal factors, … | |
| **Likely health-related effects and & implications/capacities to cope** | |
| **Direct impacts on health status of individuals** | |
| Main causes of death and illness | |
| **Direct impacts on health services** | |
| … on buildings, water & electricity supplies | |
| … on health personnel | |
| … on clinical services | |
| … on public health services | |
| … on management (& supervision) capacity | |
| **Likely indirect impacts on health status of individuals – risks** | |
| … on living conditions (shelter, crowding, etc.) | |
| … on water supplies, sanitation & hygiene | |
| … on vectors | |
| … on food security and nutrition | |
| … on environmental risk factors: waste management, chemical hazards, other … | |

| Priority aspects to be followed up in the initial assessment | |
|---|---|
| Geographic areas for which data are particularly lacking | |
| Key aspects on which more data are needed for decision-making | |
| **Proposed initial response** | |
| **Priority immediate health-related problems, risks and vulnerabilities** | |
| Problems, risks and vulnerabilities to be addressed in the first few weeks, in priority order | |
| **Proposed initial strategies/approaches** | |
| Strategies to address the priority problems in the first few weeks (with explanation why these strategies/approaches are preferred to other options – see section 4.2) | |
| Initial resource requirements | |
| Technical and/or operational personnel, supplies, funds, etc. required for response during the first few weeks | |

# The Cluster Approach

A cluster is a group of agencies that gather to work together towards common objectives within a particular sector of emergency response.

The cluster approach, instituted in 2006 as part of the UN Humanitarian Reform process, is an important step on the road to more effective humanitarian coordination. Ultimately the cluster approach aims to improve the predictability, timeliness, and effectiveness of humanitarian response, and pave the way for recovery. It strengthens leadership and accountability in key sectors. It also seeks to enhance partnerships and complementarity among the UN, Red Cross Movement, and non-governmental organizations (NGOs).

***At the global level,*** clusters have been established in 11 key areas to support the cluster approach as shown in the table. The global cluster leads report to the UN Emergency Relief Coordinator (ERC). WHO leads the global health cluster which includes over 30 partners and is developing normative guidance and tools (e.g. for assessment, coordination, information management and training) as well as seeking to ensure surge capacity (of skilled experts supported by appropriate supplies, logistics and security) and the development of national capacities. WHO is also a member of the nutrition, water/sanitation, emergency shelter and protection clusters and works with the leaders of those clusters to promote inter-cluster harmonization.

| Sector/area of activity | Global cluster lead |
|---|---|
| Health | WHO |
| Nutrition | UNICEF |
| Water, sanitation, hygiene | UNICEF |
| Emergency shelter | UNHCR conflict-generated IDPs<br>IFRC (convener) natural disasters |
| Agriculture | FAO |
| Camp management | UNHCR conflict-generated IDPs<br>IOM natural disaster-induced IDPs |
| Protection | UNHCR (OHCHR / UNICEF) |
| Early Recovery | UNDP |
| Education | UNICEF |
| Logistics | WFP |
| Telecommunications | OCHA overall<br>UNICEF common data services<br>WFP common security telecomms |

***At country level***, clusters (or "sectoral groups") will normally be established for any major emergency – any situation where humanitarian needs are of sufficient scale and complexity to justify a multi-sectoral response with the engagement of a wide range of international humanitarian actors:

- Clusters are established according to the needs of the situation; they may or may not correspond to the 11 global clusters (some may be combined, others not required);
- Country cluster leads may correspond to those designated at the global level or be adjusted taking account of the capacities and strengths of the humanitarian organizations present; any IASC member can be a cluster lead (it does not have to be a UN agency);
- Where a coordination group already functions with clear leadership, no new cluster or leadership is required for that sector;
- The country cluster structure and corresponding cluster leads are proposed by the UN Humanitarian Coordinator (HC) – or by the UNRC in a country where an HC has not been appointed – after consultation with Government authorities and relevant IASC partners at country level, and agreed with the ERC after consultation within the IASC at global level.

The general responsibilities of a country-level sector/cluster lead agency are outlined in the Panel below. The specific terms of reference of sector/cluster leads are reproduced in Annex F1.

| **Responsibilities of a country-level sector/cluster lead** |
|---|
| A "cluster lead" is an ***agency/organization*** that formally commits to take on a leadership role within the international humanitarian community in a particular sector/area of activity, to ensure adequate response and high standards of predictability, accountability & partnership.<br>• The Country Director/Representative of the agency/organization designated as sector/cluster lead is ultimately responsible for ensuring that relevant sector/cluster activities (as defined in annex #) are carried out effectively.<br>• The sector/cluster lead agency at the country level is responsible for appointing an appropriate person, with the necessary seniority, facilitation skills and technical expertise to be the ***sector/cluster coordinator***. In some cases, there may be a need for sector/cluster lead agencies to appoint dedicated, ***full-time*** sector/cluster coordinators with no other programme responsibilities.<br>• The Country Director/Representative of the agency designated as sector/cluster lead is responsible for ensuring that the RC/HC, OCHA and the Humanitarian Country Team are informed of the name and contact details of the person designated to be the sector/cluster coordinator and they are kept regularly informed of any changes.<br>• A key responsibility of sector/cluster leads at the country level is to ensure that humanitarian actors build on local capacities and maintain appropriate links with ***Government and local authorities***, State institutions, civil society and other stakeholders. The nature of these links will depend on the situation in each country and the willingness and capacity of each of these actors to lead or participate in humanitarian activities.<br>*By designating clear focal points within the international humanitarian community for all key sectors or areas of activity, the cluster approach should help governments and local authorities to know who to approach for support. This should help ensure more timely, predictable and adequate responses.*<br>[From *IASC Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response*, Nov. 2006; and *Designating sector/cluster leads in major new emergencies*, IASC Operational Guidance, April 2007] |

***Accountability*** is a key feature of the cluster approach: under the system, the HC – with the support of OCHA – retains overall responsibility for ensuring the effectiveness of humanitarian response and remains accountable to the ERC. Cluster leads at the field (country) level – in addition to their normal agency responsibilities – are accountable to the Humanitarian Coordinators for ensuring effective and timely assessment and response in their respective clusters (sectors), and for acting as providers of last resort. In addition, cluster leads have mutual obligations to interact with each other and coordinate to address cross-cutting issues.

For guidance on the specific actions that a WR/WHO country office should take to ensure coordination, see section 7.1.

For more detailed information on the Cluster Approach see:

→ http://ocha.unog.ch/humanitarianreform

📖 *IASC Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response*, Nov. 2006 (on the CD-ROM)

📖 *Designating sector/cluster leads in major new emergencies*, IASC Operational Guidance, April 2007 (on the CD-ROM).

# List of Supplementary Annexes on the CD-ROM

*Annex A – Materials on the effects and priorities in different types of emergency*

A1 Response priorities in particular kinds of disasters

A2 Demands on health sector of different types of emergency

A3 Some areas of work in relation to health services after a disaster

*Annex B – Materials for leading and enabling the WHO response*

B1 Possible WCO structures (organigrams) for humanitarian response

B2 Roles and responsibilities for management and coordination

B3 What is expected of a team leader

B4 Establishing an operations room

B5 Establishing a field sub-office

B6 Working with others

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B8 Sample format for a health bulletin

B9 Planning an evaluation or lessons-learning exercise

*Annex C – Materials for planning and managing the WHO programme*

C1 Core functions analytical framework

C2 CERF project summary (application format )

C3 Life-saving activities in health and related sectors for CERF

C4 CAP project summary format

C5 Key health services & functions

C6 Possible input requirements for projects in key functional areas

C7 Project budget items & sample budget

C8 Standard format for a country-level project agreement with an NGO

C9 Considerations related to the selection of NGO partners

*Annex D – Materials for planning and managing WHO programme support activities*

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D2 Local procurement – competitive bidding requirements

D3 Standard WHO kits

D4 Guidelines for drug donations

D5 Delivering and managing supplies

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E1 Principles of emergency assessments

E2 The (3-Cluster) Initial Rapid Assessment

E3 Assessment management and planning checklist

E4 Assessment report outline and evaluation checklist

E5 Checklist for an initial assessment

E6 Planning field visits – checklist

E7 Key elements for planning a health information/surveillance system

*Annex F – Materials relating to coordination*

- F1 TOR for cluster lead
- F2 Some simple coordination formats
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*Annex G – Personal skills and conduct*

- G1 Personal readiness checklist
- G2 Getting to the field (for international consultants)
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- G4 Arriving in the field – hints for a WHO emergency officer
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- G7 Special considerations when interviewing people in a conflict situation
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*Annex H – Security and critical incident management*

- H1 Personal security
- H2 UN security phases
- H3 Guidelines for the use of armed guards and escorts
- H4 Critical incident reporting
- H5 Medevac procedures
- H6 Death of a colleague