16 December 2015

From: Strategic Advisory Group of the Global Health Cluster

To: Dr David Nabarro, Chair, External Advisory Group on Reform of WHO

Cc: Members of the External Advisory Group on Reform of WHO

Dr Bruce Aylward, Executive Director, a.i. Outbreaks and Health Emergencies and Special Representative of the Director-General for the Ebola Response

Re: Points for consideration on essential aspects of WHO reform and the role of the Health Cluster

Dear Dr Nabarro,

On behalf of all Health Cluster partners, we are writing to submit to your attention the following suggestions, in the hope that they will inform final deliberations of the Advisory Group.

General aspects of WHO reform

1. We urge WHO to continue to proactively consult with health cluster partners, academic experts, and others as it continues to draft reform plans. Wide external consultation will enhance buy-in later and tap expertise on how best to set up WHO to deliver on commitments of the reform.
2. Given the Advisory Board will soon wrap up its deliberations, a permanent Independent Oversight Body for the new WHO emergencies programme, empowered to sign off on key strategy and budgeting decisions should be appointed very soon through a transparent, competitive process, and inclusive of representatives of humanitarian partners.
3. While creation of new structures to manage and deliver the new all-hazard crisis Programme of WHO is necessary, it is very unlikely that any new programme will result in the hoped for quantum leap in effectiveness unless two key provisions are in place:
    a. Explicit, inflexible, enforceable step-aside mechanisms, whereby the leadership of WHO country offices that are unable, for political or capacity reasons, to adequately lead and coordinate a response, is rapidly divested of authority in favour of a field Incident Management team appointed by and accountable solely to the Programme.
    b. Sufficient funding, without which commitments should not be made. We encourage WHO to mobilise internal funds as a pre-condition for leveraging external donor support.
4. We understand that WHO plans to pilot its package of reforms in a few selected countries. We suggest the following as interesting test cases: South Sudan, Afghanistan and CAR (protracted conflict crises compounded by high risks for several hazards including epidemics, with low or developing national leadership and coordination capacity, challenges for subnational coordination, and upcoming L3 de-escalation despite ongoing needs along a complex humanitarian-development interface); Yemen (insecurity and political instability which hampers humanitarian health access and timely delivery of services with very constrained in-country movement and subsequent remote programming); and Ethiopia (slow-onset complex emergency with a government that asserts its leadership role, in a region with recurrent emergencies requiring vigorous inter-sectoral coordination, epidemic preparedness and response, with needs for national capacity strengthening for Emergency and Disaster Risk Management (EDRM) functions, including IHR core capacities.
5. With regard to the functions of leadership and coordination, different crises may require different mechanisms for and intensities of support. The starting point should be to map out the decision tree

whereby a specific leadership & coordination option would be selected, based on the analysis of existing national capacity for leadership and coordination, the type of event and the context in which it takes place. The Health Cluster being a frequent but not inevitable mechanism for coordinating the support from international partners. This will illuminate situationally relevant partnerships and staffing levels.

6. Further operational roles for WHO could in future comprise pharmaceutical or light logistical support, but this should not distract from the priority to establish leadership and coordination functions.

Plans for the Global Health Emergency Workforce (GHEW)

7. The current GHEW concept is unduly complex and structure-heavy, and conflates leadership & coordination with service delivery and operational platform functions. Put simply, the GHEW should (i) oversee formation and capacity building of deployable leadership, coordination and IMS experts, based on all hazard types of events and response scenarios, (ii) oversee the formation, standardisation and capacity building of deployable response capacities for restoring and/or scaling up service delivery, for all hazards and all emergency contexts; (iii) mapping and classifying global capacities for Leadership & Coordination and service delivery, including identifying comparative advantages, of the various existing networks for different types of hazards and contexts in which they can be deployed, and (iv) strengthen the global networks in their ability to support national emergency management preparedness and EDRM capacities, including IHR core capacities.

8. The GHEW should react to field needs. The WHO emergencies platform, based on needs identified by the national operational platform under a health EOC or alternative coordination solution, should communicate requests for any type of support through the GHEW.

9. Greater clarity is needed in defining WHO's role related to the GHEW and it should be clearly articulated that WHO will be a facilitator in accessing the numerous capacities within the various GHEW mechanisms as needs are determined. It is also important that it be specified to what degree WHO will have ready its own surge capacity and staffing of its core functions in an emergency from within WHO.

10. The GHEW's priority should be scenarios where Leadership and Coordination, and support for service delivery, have the largest potential impact on excess morbidity and mortality (epidemics and other crises in fragile and under-resourced settings).

Evolution of and support to the Health Cluster

11. In addition to its key role of coordination, we note that the Health Cluster mechanism, being a partnership of agencies, provides a viable conduit for ensuring independence and impartiality in WHO's and partners' humanitarian health action. The cluster also has strong expertise in and commitment to performance standards.

12. We believe that health cluster coordination should more explicitly integrate strategic (sector plans and priorities) and technical (standards and protocols for specific interventions), leadership functions, by emphasising these in capacity building and revised terms of reference of coordination staff.

13. The need for WHO to more systematically commit to its mandate as Health Cluster Lead Agency is one of the rare points of very wide agreement among internal and external observers and stakeholders in the current reform process. WHO should indicate the seriousness of its commitment to cluster coordination by rapidly announcing an initial minimum funding allocation to the GHC Unit for activities related to agreed strategic priorities for 2016-2017, at no less than 1M USD per annum. This will allow the Health Cluster to immediately boost support to the response in current ongoing emergencies.

14. Beyond the above, we note that the estimated total annual global costs of staffing, deployment and capacity building for health cluster coordination are in the region of 50-60M USD, with a current estimated funding gap of 60-70% and chronic problems with staffing, retention and performance management and a multiplicity of inefficient, mostly mixed and unpredictable local funding models. To ensure predictability of cluster position staffing and to develop a technically and managerially

excellent work force, we propose that the GHC Unit be supported to establish a centrally managed multi-donor fund to offer long-duration contracts(>2 year) and a rigorous professional development pathway to a sufficient number of coordination staff, contracted through WHO and/or partners. Such a scheme would feature regionally managed pools and proactive talent management to identify promising partner and national staff to enrol in the pool.

15. In general, we would support a positioning of the GHC Unit within the new WHO Programme structure that recognises and enables its partial independence from WHO as a partnership accountable to WHO as well as partner agencies, and working under the IASC umbrella.

Many thanks for your consideration of the above points, and best wishes for your important work.

Dr André Griekspoor

Dr Pascale Fritsch

Co-chairs, Strategic Advisory Board, Global Health Cluster