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WHO Regional Office for Europe Centre for Preparedness for Humanitarian and Health Emergencies

This information document contains the technical profile for the new WHO Regional Office for Europe Centre for Preparedness for Humanitarian and Health Emergencies, approved by the Twentieth Standing Committee of the Regional Committee for Europe at its third session in March 2013. It should be read in conjunction with working document EUR/RC63/23, which presents the business case for the Centre.

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WHO Regional Office for Europe Centre for Preparedness for Humanitarian and Health Emergencies[1]

Introduction and background

1. In its decision EUR/RC62(2) on strengthening the role of the Regional Office's geographically dispersed offices (GDOs), the WHO Regional Committee for Europe, at its sixty-second session (RC62), requested the Secretariat to develop a business model for a potential new GDO on humanitarian crises, with the full involvement of the Standing Committee of the Regional Committee (SCRC). The scope of the proposed GDO, initially referred to as a GDO for humanitarian crises (EUR/RC62(2)), has been developed in consultation with the SCRC (see also footnote 1). A revised name, the WHO Regional Office for Europe Centre for Preparedness for Humanitarian and Health Emergencies, has been proposed to better reflect that scope. The reasons for changing the name of the Centre are explained below.

- The introduction of the word "preparedness" resulted from the SCRC's discussion at its session in November 2012 and subsequent consultations, in which it was decided that the GDO should focus on emergency preparedness. This makes it clear that overall emergency response management will always be run by the Regional head office in Copenhagen, which will coordinate its response with that of WHO headquarters.
- The introduction of "and health" after "humanitarian" indicates the multi-hazard scope of the GDO. This reflects the strategic approach taken by the Organization generally, and is in line with the draft twelfth general programme of work (GPW 12).
- Although the terms "crisis" and "emergency" are somewhat synonymous, the term "emergency" is consistent with the wording repeatedly used in EUR/RC62/Conf.Doc/5. It is a term often used in medical or health environment contexts, while "crisis" tends to be used is many other contexts beyond the health sector.

2. This document provides the technical profile, describing the services that such a centre would deliver. It is primarily intended to help Member States decide whether they might wish to express an interest in hosting such a centre. In order to help Member States with this decision, this paper also provides, in Annex 1, a short summary of the general principles and prerequisites

[1] Following consultations with the SCRC at its session in November 2012, the teleconference on 5 February 2013 and subsequent email consultations, the name of the GDO has been changed to "Preparedness for Humanitarian and Health Emergencies". The SCRC will continue to be fully involved in further discussions at its sessions in March and May 2013 (and as needed through teleconferences and email exchanges) and the final decision will be taken by the Regional Committee at its sixty-third session in Izmir, Turkey.

for establishing GDOs, specifying the conditions that the candidate host countries will need to meet, as well as clarifying the roles and responsibilities of the Regional Office in Copenhagen (which will be setting policy and directing and driving the GDO: item 2 of annex 1) vis-à-vis those of the GDO (which will be responsible for specific technical deliverables: item 3 of annex 1). These principles and prerequisites have been taken from the document on strengthening the role of the Regional Office's geographically dispersed offices, discussed at RC62 (EURO/RC62/11) and its accompanying decision (EUR/RC62(2).

Resolutions and decisions of governing bodies

Humanitarian emergencies

3. Resolution A/RES/46/182 of the United Nations General Assembly, on the strengthening of the coordination of humanitarian emergency assistance of the United Nations, confirms the United Nations' central and unique role in providing leadership and coordinating the international community's efforts to support countries affected by humanitarian emergencies, while ensuring full respect for international law. Pursuant to this resolution, the Inter-Agency Standing Committee (IASC) was established as the primary forum for coordination, policy development and decision-making involving the key United Nations and non-United Nations humanitarian partners. It reaffirms that national authorities have the primary responsibility to take care of victims of natural disasters and other emergencies occurring on their territory, and that the affected State has the primary role in initiating, organizing, coordinating, and implementing humanitarian assistance in its territory.

4. WHO's responsibilities and leading role in health emergencies are enshrined in article 2(d) of the Constitution of the World Health Organization, and are in line with the abovementioned General Assembly resolution. Humanitarian principles are the foundation for providing humanitarian assistance and are central to establishing and maintaining access to affected populations, whether in natural disasters, armed conflicts or complex emergencies. The principles of humanity, neutrality and impartiality are endorsed in United Nations General Assembly resolution 46/182. The principle of operational independence is enshrined in General Assembly resolution A/RES/58/114.

5. Countries' commitment to managing the health risks of emergencies is further expressed through a range of multilateral agreements, concluded at global and regional levels. Countries have been called on to invest in risk management (including in the health sector), guided by key agreements, including:

- United Nations General Assembly resolution A/RES/60/195, endorsing the Hyogo Framework for Action 2005–2015;
- Codex Alimentarius (International Food Standards);
- the Convention on Early Notification of a Nuclear Accident, the Convention on Assistance in the Case of a Nuclear Accident or Radiological Emergency and the Joint Radiation Emergency Management Plan of the International Organizations(with IAEA);
- the Rotterdam Convention on the Prior Informed Consent Procedure for certain hazardous Chemicals and Pesticides in international trade, Stockholm Convention on Persistent Organic Pollutants, and the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal; and
- the United Nations Framework Convention on Climate Change.

6. In 2011, the World Health Assembly adopted resolution WHA64.10 (2011), which "urges Member States to strengthen all-hazards health emergency and disaster risk-management programmes (including disaster risk-reduction, emergency preparedness and response) as part of

national and subnational health systems, … to improve health outcomes, reduce mortality and morbidity, protect health infrastructure and strengthen the resilience of the health system and society at large ….” This resolution also calls upon the WHO Secretariat to “provide the necessary technical guidance and support to Member States and partners for developing health emergency and disaster risk-management programmes at national, subnational and local levels.” More recently, WHO’s role with regard to response operations has been described by the WHO Emergency Response Framework (ERF) and approved by Member States through the adoption of resolution WHA65.20 (2012). The resolution takes note of the humanitarian response review undertaken in 2005, led by the Emergency Relief Coordinator and by the principles of the IASC, which aim to improve urgency, timeliness, accountability, leadership and surge capacity, and reaffirms WHO’s commitment to supporting the IASC agenda and contributing to the implementation of its priority actions, which are intended to strengthen the international humanitarian response to affected populations.

7. Annex 2 contains more background information on World Health Assembly resolutions related to health emergencies.

All-hazards preparedness

8. The proposal for a new GDO on preparedness for humanitarian and health emergencies will build on synergy between the capacity required to prepare for humanitarian and public health emergencies and the core capacity for surveillance and response required under the International Health Regulations (IHR) (2005). It will use an all-hazards and multi-sectoral approach. Experience from previous crises, ranging from natural disasters to pandemics, shows that generic core capacity is required to effectively prevent, mitigate and manage humanitarian and/or health emergencies and that all-hazards preparedness is more efficient than a series of parallel preparedness measures for specific risks. Based on each country’s history and vulnerability, preparedness for specific risks can be addressed by adding specific elements (such as specific indicators, supplies and procedures) to the generic core functions.

9. Since humanitarian and health emergencies may also constitute public health emergencies of international concern, the revised IHR (2005), which were adopted in 2005 (resolution WHA58.3) and entered into force on 15 June 2007, represent a relevant framework in many situations. Pursuant to the IHR (2005), States Parties (all WHO Member States) are requested to develop core capacity for surveillance and response. Such capacity shares all the key functions of humanitarian emergency preparedness (surveillance, alert, intersectoral coordination, risk management, crisis communication and case management) and should be addressed in a holistic way, in order to avoid duplication of effort and resources.

10. This approach is in line with the draft GPW 12, which highlights the close relationship between health security and humanitarian action. GPW 12 underlines “the need to be prepared for the unexpected, no matter whether an event results from new and re-emerging diseases, from conflicts, or from natural disasters”. It emphasizes that “a more holistic response to emergency risk management is required that integrates prevention, emergency risk reduction, preparedness, surveillance, response and recovery”.

The three levels of WHO

11. There is an increasing demand on WHO regional offices to take a more proactive role in preparedness for and response to humanitarian and health emergencies. In line with the WHO reform process, efforts are being made to ensure that the Organization becomes faster, more effective and more predictable in delivering and supporting high quality health responses by operationalizing the Emergency Response Framework (ERF). The Framework provides a

common approach to WHO's work during emergencies, clearly defining WHO's core commitments and performance standards.

12. The roles of WHO country offices, the Regional head office and WHO headquarters are complementary and can be adapted to the context and scale of each emergency. WHO headquarters plays a central role in the overall coordination of preparedness and response of events that involve several WHO regions, by setting global standards, procedures and guidelines, coordinating communication and supervising legally binding procedures such as those carried out under the IHR (2005). WHO regional offices play an active role in regional surveillance, early warning and risk assessment. The Regional Office for Europe is central to the coordination of response operations and the implementation of procedures and guidelines in the regional context. While country offices play a key role in day-to-day interaction with Member States, they also ensure that WHO technical support is made available, in an efficient and timely manner, when requested. In this context, a GDO can provide WHO with key technical and scientific resources, available to all Member States, under the supervision of the Regional head office.

13. Table 1 illustrates the respective roles of the three levels of the Organization and the proposed Centre for Preparedness for Humanitarian and Health Emergencies.

Situation analysis

14. Between 1990 and 2010, Member States in the WHO European Region were affected by almost 2000 events, mostly natural and man-made (technological) disasters, which caused over 132 000 deaths and affected almost 47 million people2. Storms, floods and earthquakes have been the most significant in terms of the number of people affected and the scale of economic damage. The highest death tolls have been caused by extreme temperature events and earthquakes.

15. As well as humanitarian emergencies, over the past decade, the WHO Regional Office for Europe has recorded and followed up on more than 570 events which fall under the International Health Regulations (IHR) category of public health emergencies of international concern. These included outbreaks of vaccine-preventable diseases, such as measles and poliomyelitis, food-borne outbreaks, some of significant size such as the *E coli* epidemic in 2011, outbreaks of mosquito-borne diseases such as dengue and West Nile fever, and outbreaks associated with emerging pathogens such as avian influenza and drug-resistant strains of bacteria. The influenza pandemic in 2009 was a particular test of emergency preparedness for Member States in the Region.

16. Although over the past decade, Member States in the European Region have significantly strengthened their capacity for the early detection and effective management of health emergencies, lessons continue to be learnt from health crises, which further emphasize the importance of health emergency preparedness and rapid risk management. As shown during the 2009 influenza pandemic and in the aftermath of many acute weather events (flood, storm, heat-wave, wild fire), as well as by the large number of Member States in the Region (20 out of 53) that have requested an extension beyond 2012 for acquiring the IHR (2005) core capacities for surveillance and response, it is evident that many countries need more support.

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[2] :"EM-DAT: The OFDA/CRED International Disaster Database, www.emdat.be - Université catholique de Louvain - Brussels - Belgium" © 2011 CRED

17. The Regional Office's currently limited capacity requires a significant investment to cope with the increasing Region-wide demand for health security. This is particularly true as the new WHO global ERF sets out the roles and responsibilities (with expanded capacity requirements) of WHO country offices and regional offices with regard to meeting country-level performance standards during emergencies. This extra capacity, which is essential if the Organization is to fulfil its four critical functions in emergencies: providing leadership, essential information, technical expertise and core services, as well as meeting its broader obligations as Global Health Cluster lead agency and fulfilling its obligations under the IHR (2005), is currently only partly available.

Objective

18. The objective of the proposed Centre for Preparedness for Humanitarian and Health Emergencies is to strengthen the Regional Office's capacity to assist Member States in prevention, preparedness, risk management and capacity-building for humanitarian and health emergencies and to help and support the Regional Office in mobilizing surge capacity to strengthen Regional Office- or headquarters-coordinated response operations.

19. Such emergencies include humanitarian and health crises due to natural hazards (earthquake, flood, heat-wave), conflicts (large number of injured individuals, internally displaced populations, refugees), due to industrial accidents (chemical spill, radionuclide exposure) and outbreaks of infectious diseases (food-borne outbreaks, emerging dangerous pathogens, epidemics, pandemics).

Proposal

20. In order to meet Regional needs under the relevant World Health Assembly resolutions, the Country Emergency Preparedness (CEP) Programme of the WHO Regional Office for Europe must further develop and expand partnerships and strengthen its capacity.

The CEP Programme

21. The proposed GDO will be an integral part of the Regional Office's CEP Programme. It will be under the direct supervision of the Director, Division for Communicable Diseases, Health Security and Environment, in coordination with the CEP Programme Manager.

22. CEP currently supports Member States in strengthening their emergency risk and crisis management capacities to prevent, mitigate, prepare for and manage public health emergencies. It interacts and coordinates daily with the Alert & Response Operations programme (ARO) and the IHR team in Copenhagen, as well as with WHO country offices, headquarters, including the WHO Lyon Office for National Epidemic Preparedness and Response, other WHO regional offices, key Regional institutions and WHO collaborating centres. This close collaboration has led to the development of new tools and technical guidance to improve all-hazards emergency preparedness and response capacities.

23. The financial and technical resources devoted to emergency risk management and capacity-building, however, remain limited, despite the fact that during emergencies solidarity between Member States, in the Region and globally, contributes significantly to meeting surge capacity needs. The Regional Office's stable and regular capacity has reduced substantially over recent years, particularly at country level (technical staff based in WHO Country Offices),

owing to the overall financial situation and the need to redirect funds towards priority and underfunded areas, such as noncommunicable diseases (NCDs).

24. Today, the Regional Office's CEP Programme counts only two professionals and two administrative support staff at the Regional head office in Copenhagen. The proposed Centre for Preparedness for Humanitarian and Health Emergencies will provide the Regional Office with significantly higher resources, allowing for more appropriate staffing and ensuring critical mass of professionals with adequate skills and capacity. It will put the WHO Regional Office for Europe in a position to effectively support country emergency preparedness and will provide WHO, under the guidance of the Regional head office in Copenhagen, with the means necessary to maintain registers of experts and to train, coordinate and mobilize them to provide the surge capacity to support regional or global response operations to humanitarian and health emergencies.

25. It is proposed that the Centre will be staffed with eight to ten professionals, supported by three administrative support staff. The professionals will have expertise in emergency management, risk assessment, epidemiology, logistics, disease surveillance, case management, community mobilization and communication.

26. The above human resources will provide high profile technical expertise and support functions including logistic capacity to support surge and rapid deployment of international teams under the direction and supervision of the Regional head office in Copenhagen and in co-ordination with WHO headquarters. The Centre will include a training venue with an operations support cell to mobilize surge capacity and coordinate simulation exercises and drills. It will be technically compatible and in synchrony with the Regional Office emergency operations centre (EOC) in Copenhagen, which will remain the Regional hub for the overall coordination, command and control of operations management at time of response to humanitarian and health emergencies.

27. The biennial cost associated with the proposed staffing is estimated to be in the range of US$ 3 500 000–4 500 000, depending on local costs in the host country. In addition the host country will need to ensure that proper logistics and infrastructure are available should the GDO be called on to support response operations directed by the Regional head office in Copenhagen.

Partnership

28. Building on the CEP's existing approach and partnerships, the WHO Centre for Preparedness for Humanitarian and Health Emergencies will coordinate its work closely with that of national health authorities, promoting a multisectoral approach (health, interior, transport, defense, agriculture, industry) along with the involvement of civil society organizations, such as national Red Cross and Red Crescent societies. At Regional level, the Centre will work with international partners in emergency preparedness and response (The United Nations Office for Humanitarian Assistance, the Office of the United Nations High Commissioner for Refugees, the United Nations Children's Fund, the United Nations Development Programme, the United Nations Population Fund, the Food and Agriculture Organization of the United Nations and the World Organization for Animal Health), the IASC, the Red Cross and Red Crescent system, WHO collaborating centres, institutions of the European Union (the European Commission, the European Centre for Disease Prevention and Control, the European Food Safety Authority and the European Environment Agency), WHO collaborating centres in Member States, major relevant nongovernmental organizations (such as Médecins Sans Fronitères and all those actively engaged in the global health cluster) and WHO specialized offices, such as the WHO Lyon Office for National Epidemic Preparedness and Response, which is dedicated to providing technical support for IHR(2005) core capacity.

Priority areas of work

29. The GDO's workplan will be fully integrated into the Regional Office's work on health security (Category 5 of the WHO Programme of Work 2014–2015) and will build on the g technical priorities outlined below.

- National health system capacity for crisis management will be assessed in selected countries using the tool kit developed by the Regional Office for Europe, which is already being used in several countries. These assessments are instrumental in identifying the strengths and weaknesses of health systems emergency preparedness and selecting priority areas for capacity building.
- With regard to capacity building for public health and emergency management, support will be given, at national and Regional level, to capacity-building initiatives for health professionals and emergency managers in public health and emergency management, with an all-hazards approach, based on country needs and requests and integrating efforts to strengthen and consolidate the IHR (2005) core capacities.
- In order to promote capacity building for hospital emergency preparedness and structural and functional safety, vulnerability of hospitals will be assessed and strategies developed to improve disaster resilience and emergency preparedness of health facilities, using WHO tools for analysing structural, non-structural and functional safety of hospitals and issuing recommendations and providing training and support for priority interventions, based on practical experience and expertise of national experts.
- With regard to mass gatherings and related public health challenges, support will be given to countries hosting such gatherings (large sporting, religious or cultural events) with technical support to enhance preparedness, conduct assessments, provide tools and international experts, to prevent or respond to potential public health consequences of the event, particularly within the framework of the IHR (2005).
- Regarding mass displacement and related public health challenges, steps will be taken to mobilize humanitarian and health support, experts and medical supplies to provide technical assistance in the form of assessments, guidelines and training courses for contingency planning and preparedness, in order to better adapt health services to meet the health challenges of mass displacement and migration.

30. The GDO will also contribute to building essential surge capacity, a network of experts and logistical resources, for Regional or global responses to emergencies. This surge capacity is currently insufficient and is provided by diverting WHO staff with past expertise in emergencies from other programme areas and operations (e.g. WHO representatives, technical staff working in the area of communicable diseases etc.).

31. Implementation of the above activities will allow two of the Regional Office's key priority outcomes (KPO) for 2014–2015 to be met in full.

- KPO 3: In support to national and regional health security, Member States have implemented and sustained IHR requirements, including strengthened core public health capacities for disease surveillance and response, as well as preparedness for epidemic-prone diseases (such as influenza).
- KPO 12: Enhanced preparedness and response capacities of Member States to emergencies and disasters through all-hazard risk management programmes, in line with humanitarian principles, needs and also IHR requirements.

32. It will also contribute directly to fulfilling a number of the Regional Office's other priority objectives (OPO).

- OPO 31: Member States are able to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases in collaboration and partnership with the international community (e.g. influenza, meningitis, haemorrhagic fevers, plague, smallpox) with effective prevention, detection, surveillance, preparedness and intervention tools, methodologies, practices, networks and partnerships.
- OPO 32: Member States and the international community implement effective and timely responses to declared emergency situations due to epidemic and pandemic-prone diseases.
- OPO 52: Member States are better equipped to establish effective partnership mechanism for collaboration and capacity development in health emergency and disaster risk management.
- OPO 66: All Member States have an active programme of work to assess, prevent and control epidemics and pandemics and to reduce/mitigate the impact of major hazards to public health resulting from environmental risks, food production and consumption, targeting specific risk factors, population groups, or implementing interventions in specific settings.

33. The required biennial amount to support activities corresponding to the above priorities, including the projected cost of staff salaries of US$ 3 500 000–4 500 000, would be in the range of US$ 4.3 million to 5.3 million in total (including activity costs).

Priority countries

34. The proposed GDO will considerably enhance WHO's capacity, at European Regional level, to support to humanitarian and health emergency preparedness for all Members States in the Region. Priority will be given to countries at greatest risk of disasters and other humanitarian and health emergencies and those in greatest needs particularly in Central Asia, the Caucasus, the Balkans, and Eastern and Central Europe.

Conclusion

35. Regional Office's unique contribution to health security in the WHO European Region will be substantially strengthened and expanded through the establishment of a WHO Centre for Preparedness for Humanitarian and Health Emergencies.

36. Such a GDO, as integral part of the Regional Office, will act fully in line with all international laws and will provide essential technical expertise and support functions and the surge capacity to reach the WHO Regional Office's priority objectives and effectively respond to countries' requests for technical assistance in the areas of preparedness, emergency risk management and capacity building for humanitarian and health emergencies.

Annex 1. Summary of the general principles and prerequisites of establishing geographically dispersed offices (GDOs)[3]

Background

The working document on strengthening the role of the Regional Office's geographically dispersed offices (GDOs): a renewed GDO strategy for Europe (EUR/RC62/11), was presented to the Regional Committee at its sixty-second session (RC62) in September 2012. The document defines and clarifies the role and functions of GDOs and describes the requirements and conditions that should be in place before a GDO can be established.

In its decision EUR/RC62(2), the Regional Committee requested that the Secretariat make use of the content in document EUR/RC62/11 when considering options for new strategic areas and the establishment of potential GDOs.

Below is a summary of the conditions and requirements for setting up a GDO, as described in the document EUR/RC62/11.

Definition of GDO

A WHO Regional Office for Europe geographically dispersed office is any Regional Office technical centre located outside Copenhagen, which is an integral part of the Regional Head Office in Copenhagen and supports its work by providing evidence and advice for policy research, tools and capacity-building and actively contributes to the implementation of the Region's work programme in key strategic priority areas.

General principles

1. A GDO is established to address a specific and explicit element of a European Regional technical strategic priority area, as approved by WHO's governing bodies, where:
    a. substantial additional human resources and funding are needed;
    b. there is sufficient capacity at the Regional Head Office in Copenhagen to guide and lead the GDO's work programme (a strong core team and programme at the Head Office in Copenhagen with a responsible programme manager or division director);
    c. the GDO's main technical focus is clearly defined and easily and succinctly reflected in its technical title; and
    d. the GDO covers the whole Region and all 53 Member States.
2. The GDO is a part of a Division of the Regional Office in Copenhagen, and reports to the divisional Director. All the core functions of drafting policy, maintaining the necessary evidence base and engaging in strategic collaboration with Member States and partners continue to be performed by the Head Office in Copenhagen.
3. The GDO is responsible for specific technical deliverables that are incorporated into the Regional perspective of the Organization's Programme Budget and approved by the Regional Committee. They support the work of the Regional Office for the mandated strategic priority areas by:

[3] EURO/RC62/11 and EUR/RC62(2)

a. generating knowledge and collecting and compiling evidence to help develop policies;

b. conducting research for the Regional Office's policies and programmes; and

c. developing tools and providing technical assistance and capacity-building for the implementation of the work programme.

4. The GDO is funded from the Regional Office's budget (which receives the agreed funding for the GDO from the host country and, where relevant, other partners).

5. The GDO is staffed by WHO technical and administrative personnel, who are governed by WHO rules, report directly and solely to the Regional Head Office in Copenhagen and are entitled to the privileges and immunities granted to international United Nations staff.

6. With regard to staffing, geographical balance across the whole of the European Region should be preferred and encouraged when setting up new GDOs, which should always meet at least the minimum requirements described below.

Prerequisites (and minimum requirements) for establishing a GDO

1. The Regional Office shall ensure that host country funding for the GDO covers all costs for staffing and running the GDO, as well as programme costs.

2. The minimum size of a GDO shall be at least 10 staff, which equates roughly to a minimum annual host country contribution of around US$ 2 million (depending on the grading of staff, cost of living in the host country and running costs). Consideration should be given to defining a more precise breakdown of the guideline of 10 staff members into professional and general service staff (in line with the staffing ratios at the Head Office in Copenhagen)

3. The host country shall second or fund a senior technical post at the Head Office in Copenhagen, to ensure full support, coordination and integration between the GDO and the technical programme in Copenhagen.

4. With regard to sustainability, the host country agreement must stipulate that the host country's provision of additional resources and expertise will be committed for a minimum period of 10 years, in order to enable a sufficiently robust programme, led by the Head Office in Copenhagen, to be developed and implemented. A "model" host agreement is attached, which also specifies that mid-term reviews will take place after 5 years. Continuation of the host agreement is by mutual consent and termination is by three months' notice in writing from either party.

Annex 2: Main World Health Assembly resolutions related to humanitarian and health emergencies

Number	Year	Title
65.20	2012	WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies
64.10	2011	Strengthening national health emergency and disaster management capacities and resilience of health systems
64.1	2011	Implementation of the International Health Regulations (2005)
61.19	2008	Climate change and health
61.2	2008	Implementation of the International Health Regulations (2005)
60.22	2007	Health systems: emergency-care systems
59.22	2006	Emergency preparedness and response
58.1	2005	Health action in relation to crises and disasters, with particular emphasis on the earthquakes and tsunamis of 26 December 2004
55.16	2002	Global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health
48.2	1995	Emergency and humanitarian action
46.6	1993	Emergency and humanitarian relief operations
42.16	1989	Fostering the goals and objectives of the International Decade for Natural Disaster Reduction in the health sector
34.26	1981	Promotion of Prevention of Adverse Health Effects of Disasters and Emergencies through Preparedness

The active role of the World Health Organization in fostering emergency preparedness has a long history marked by important thematic World Health Assembly resolutions. In 1981, the World Health Assembly passed a resolution stating that "despite the undoubted importance of relief in emergencies, preventive measures and preparedness are of fundamental importance.". During the International Decade on Natural Disaster Reduction (1990–1999), further resolutions endorsed the importance of preparedness in the health sector. In 1995, recognizing disaster reduction as an integral part of sustainable development and that each country bears the primary responsibility for strengthening its capacity, the World Health Assembly clearly differentiated WHO's role in emergency preparedness and disaster reduction from its responsibilities in emergency response and humanitarian action.

The importance of preparedness and the need to "strengthen the ingenuity and resilience of communities, the capacities of local authorities, and the preparedness of health systems.", were reiterated in 2005. Member States were further urged "to engage actively in the collective measures to establish global and regional preparedness plans that integrate risk reduction into the health sector and build-up capacity to respond to health-related crises and to formulate national emergency-preparedness plans that give due attention to public health, including health infrastructure".

In May 2007, the sixtieth World Health Assembly adopted a resolution on emergency-care systems. The resolution calls for, among other things, WHO to provide guidance for the creation and strengthening of mass-casualty management systems.

Resolution WHA 64.10, which was adopted in 2011, aims to strengthen national health emergency and disaster management capacities and resilience of health systems and urges Member States:

(1) to strengthen all-hazards health emergency and disaster risk-management programmes, supported by, and with effective enforcement of, legislation, regulations and other measures, to

improve health outcomes, reduce mortality and morbidity, protect health infrastructure and strengthen the resilience of the health system and society at large;

(2) to integrate all-hazards health emergency and disaster risk-management programmes into national or subnational health plans and institutionalize capacities for coordinated health and multisectoral action to assess risks, proactively reduce risks, and prepare for, respond to, and recover from, emergencies, disasters and other crises;

(3) to facilitate access by concerned government and other related agencies to information on types and quantities of hazardous materials stored, used or transported, in order to support effective health emergency and disaster risk-management;

(4) to develop programmes on safe and prepared hospitals that ensure: that new hospitals and health facilities are located and built safely so as to withstand local hazards; that the safety of existing facilities is assessed and remedial action is taken; and that all health facilities are prepared to respond to internal and external emergencies;

(5) to establish, promote and foster regional and subregional collaboration, as well as interregional cooperation within WHO, including sharing of experience and expertise for capacity development, in risk-reduction, response and recovery; and

(6) to strengthen the role of the local health workforce in the health emergency management system, to provide local leadership and health services, through enhanced planning, training for all health-care workers and access to other resources.

Resolution WHA 64.10 calls on Member States, donors and development cooperation partners to allocate sufficient resources for health emergency and disaster risk-management programmes and partners through international cooperation for development, humanitarian appeals, and support for WHO's role in health emergency and disaster risk-management matters, and requests the Director-General:

(1) to ensure that WHO at all levels has enhanced capacity and resources, and optimizes its expertise across all disciplines in the Organization, in order to provide the necessary technical guidance and support to Member States and partners for developing health emergency and disaster risk-management programmes at national, subnational and local levels;

(2) to strengthen collaboration with and ensure coherence and complementarity of actions with those of relevant entities, including those in the public, private, nongovernmental and academic sectors, in order to support country and community health emergency and disaster risk-management, which includes disaster risk-reduction, as well as ongoing efforts by Member States to implement the International Health Regulations (2005);

(3) to strengthen the evidence base for health emergency and disaster risk-management including operational research and economic assessments ;

(4) to support national and subnational assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national and subnational health emergency and disaster risk-management capacities, including disaster risk-reduction;

(5) to report to the Sixty-sixth World Health Assembly through the Executive Board at its 132nd session, on progress made in implementing this resolution; and

(6) to consider, as appropriate, providing support to regional and subregional networks, as well as interregional cooperation with WHO, in order to strengthen their collaboration on health emergency and disaster risk management.

Table 1: Respective roles of the three levels of the Organization and the proposed GDO on Preparedness for Humanitarian and Health Emergencies, in the context of preparedness and response to humanitarian crises and public health emergencies.

<table>
<tr><th></th><th>WHO headquarters</th><th>WHO Regional Office for Europe head office</th><th>WHO European Centre for Preparedness for Humanitarian Health Emergencies</th><th>WHO country offices</th></tr>
<tr><td>Preparedness for humanitarian crises</td><td>Led by the Emergency Risk Management & Humanitarian Response Department (ERM) using the readiness component of the global Emergency Response Framework (ERF).</td><td rowspan="2">Done through the Country Emergency Preparedness Programme (CEP) in a multi-hazards approach in coordination with WHO headquarters ERM, GCR and Pandemic and Epidemic Diseases (PED) departments.</td><td rowspan="2">This is the essence of the scope of the proposed GDO. The Centre will support CEP by carrying out all of its technical activities, which include:

a) country capacity assessment;
b) capacity building (training on surveillance, emergency management, humanitarian laws and principles; crisis communication etc.);
c) hospital emergency preparedness;
d) mass gathering public health preparedness;
e) IHR (2005) requirement; and
f) drills and exercises etc.</td><td rowspan="2">Contingency planning done jointly with the UN Country Team (UNCT). It is implemented through an all-hazards approach with specific WHO technical support for IHR (2005) implementation and influenza pandemic preparedness.</td></tr>
<tr><td>Preparedness for public health emergencies</td><td>Led by the Global Capacities, Alert & Response Department (GCR) including the Lyon Office (which provides specific technical support for IHR (2005) core capacity requirements)</td></tr>
</table>

Response to humanitarian crises	Led by ERM in coordination with the Global Health Cluster of the United Nations Interagency Standing Committee (IASC) for humanitarian assistance. The response is coordinated in WHO, under the ERF.	Emergency response is managed using Regional Public Health Emergency procedures under the ERF. ARO in Copenhagen receives technical support from CEP at time of humanitarian emergencies. The regional response is closely coordinated with WHO headquarters ERM or GCR depending of the nature of the emergency.	WHO GDO staff constitute valuable surge capacity for technical expertise should the Regional head office require additional support during the response to a humanitarian health emergency.	Implementation of the ERF under the supervision of the Head of Country Office: 1) during a humanitarian emergency activation of the United Nations cluster approach, with WHO country office leading the coordination of the health cluster; or 2) during a public health emergency, the response follows the IHR procedures.
Response to public health emergencies	Alert & Response Operations (GCR/ARO) and IHR Monitoring Procedures & Information (GCR/MPI). Responsible for management of events that may constitute a public health emergency of international concern. The response is coordinated in WHO under the ERF.			