WHO takes lead on health as UN tackles crises

The "cluster" approach – as a means of coordinating humanitarian action – emerged from United Nations reform in 2005. Nick Cumming-Bruce examines the challenges the World Health Organization faces in leading health clusters in 24 countries.

Rolling out a health cluster for Gaza at the height of the recent conflict met with some unexpected challenges. Arriving in Jerusalem in early January this year, WHO's Patricia Kormoss, like many other aid agency personnel, could not enter Gaza because of security problems. Even personnel inside the territory could not always move around because of the intensity of the fighting. Yet the need was great. Health facilities, some of them battered by shelling, were desperately struggling to keep up with the flow of injured.

Kormoss quickly instituted biweekly meetings in Jerusalem and Ramallah with medical partners, Palestinian authorities and donors, and set up a system to report the latest health developments in Gaza in regular updates posted on the internet. Together, they set out priorities for service delivery in the crisis, which were later used as the basis for a flash appeal to the UN's Central Emergency Rotating Fund and a revision of Gaza's application for humanitarian aid to the Consolidated Appeal Process.

But on top of these challenges, Kormoss was confronted by a massive surplus of medical supplies. Governments and organizations, trying to help, had shipped some 7000 tonnes of medical supplies to Gaza, often without packaging lists. The Palestinian Ministry of Health hired nine extra warehouses to accommodate these donations and the work of sorting through them is still under way.

Kormoss also found herself fielding phone calls from medical teams that had arrived unannounced in search of a role. Gaza's hospitals were short of some specialist skills – for example neurosurgeons – but "they did not need medical staff".

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These are the kind of problems that the cluster approach, in which one agency takes on overall responsibility for coordinating and implementing the response to a specific aspect of an emergency or protracted crisis, is designed to address.

WHO/Shareef Sarhan

Hospitals and other health facilities were damaged throughout the Gaza Strip during the recent three-week emergency.

The cluster approach emerged from the reform of humanitarian assistance launched by the United Nations (UN) in 2005 to address its failure to deliver timely assistance to Darfur and to manage effectively the flood of assistance after the 2004 Asian tsunami.

As part of that reform, the UN's Inter-Agency Standing Committee agreed to establish nine global clusters (later increased to 11) in a bid to strengthen leadership, coordination, accountability and predictability in tackling crises. The approach was first used in response to the Pakistan earthquake in 2005. Since then, it has been rolled out in 24 of the 26 countries where the UN has humanitarian coordinators, and it is the agreed coordination framework for all new emergencies.

For Dr Eric Laroche, assistant director-general of Health Action in Crisis at the World Health Organization (WHO) and its representative on the UN's Inter-Agency Standing Committee, health clusters mark a major step forward from the previous looser efforts at sectoral coordination, which depended largely on the willingness of partners to share information.

Most importantly, for Laroche, the approach makes the lead agency, or co-lead agencies, accountable for the performance of their cluster by clearly stipulating their responsibility to ensure adequate coordination of activities by partners involved in its specified area.

"Ten years ago accountability was shared among all the actors, now for health it falls on WHO," says Laroche. "When people see an epidemic spreading, they turn to us and say: 'What are you going to do?' That's quite new."

Second, the cluster system aims to push beyond unstructured information exchanges "to have a common analysis and a commonly agreed strategy," says Laroche, adding that this was not always the case with the sector coordination of the past.

Third, the approach seeks to deliver predictability in tackling emergencies and crises. "If something happens somewhere, we need to be predictable in our response and the coordination that we have to provide," Laroche says.

Greater cooperation between agencies on logistical support is also starting to contribute to the predictability of responses. WHO and the World Food

Programme now share five logistics hubs to store supplies and several non-governmental organizations (NGOs) are starting to use these as well.

"When you have the same stores, you know who has what, and if there is a big bang somewhere you know where there is going to be a gap in equipment and drugs. Our work is more likely to have reliable results by filling the gaps in a sustainable way, rather than just coming into an emergency [and then reacting to the situation]," Laroche says.

Supporting its development, the health cluster has proved to be one of the biggest recipients of funding from the Central Emergency Response Fund, which was created as part of the same UN reform effort to ensure responses to emergencies are not blocked by lack of money. Of a total of US$ 1.1 billion disbursed by the Fund since March 2006, a little over a quarter (or US$ 205 million) has gone to 16 health clusters; second only to the food cluster, which received 29% according to Brian Grogan, humanitarian affairs officer at the Fund.

Still, putting concepts adopted by the UN Inter-Agency Standing Committee into practice on the ground has not been easy. An independent evaluation it commissioned in 2007 concluded that "the costs and drawbacks of the new approach are exceeded by its benefits for sector-wide programming, and the new approach has begun, slowly, to add value".

But the evaluation also turned a critical spotlight on weaknesses. "There has been no observable increase in ultimate accountability," the report found, "there is acknowledgement that large gaps continue to go unfilled".

"Preparedness and surge capacity have improved at the field level," the report also noted, but "results of the global cluster capacity-building effort have not materialized in major ways in field operations". UN officials and NGOs share a perception that the performance of health clusters has varied and often depends less on the institutional structure than on the experience and competence of individuals on the ground.

Funding also remains a sensitive issue, particularly for NGOs. "The money is always dispensed through UN agencies and the trickle down to NGOs is not as quick or effective as it should be," says Linda Doull, director of Health and Policy at the United Kingdom charity Merlin, which co-leads the health cluster created in Myanmar after Cyclone Nargis in May 2008.

WHO/Shareef Sarhan

Ambulances and health staff were also affected by the recent violence in Gaza.

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"Certainly you can point to difficulties, it's not smooth yet, but people are continually seeing improvements. It's still a work in progress," says Erin Kenney, who manages the secretariat of the global health cluster in Geneva.

"There's been a lot of progress since Pakistan," says Kormoss, a veteran of that operation and of later clusters rolled out in Afghanistan and Indonesia. In Pakistan there were no tools, terms of reference or guidance documents. In Gaza, Kormoss found WHO's 4W (who, what, where, when) tool and Health Resource Availability Mapping System (HeRAMS) to be invaluable aides to managing the deployment of resources and services. "Partners really appreciated these tools, they could see what was going on, where there were gaps."

Substantial effort has gone into developing guidance for health cluster coordinators, explaining how the system works, how to handle a common needs assessment, how to undertake gap analysis and how to apply it in practice. "It's 99.9% complete and will be rolled out this year," says Doull, who is a member of the Inter-Agency Standing Committee Global Health Cluster working group dealing with these issues.

Other initiatives started in the past year include training to build up the core competence of health cluster coordinators and tri-cluster training for the Health, Water, and Sanitation and Nutrition clusters that has been developed to strengthen awareness of overlapping needs.

"The global partnerships that we are building are starting to translate into more cooperation and collaboration at the country level," Kenney says. "Staff at the country level are starting to have expectations about how things should work. We're not all using the same roadmap yet, but it's going in that direction." ■