TOWARDS A SAFER WORLD
PRACTICAL APPROACHES TO ADVANCE DISASTER PREPAREDNESS

Humanitarian Assistance

SUMMARY

A severe pandemic would disrupt critical services, particularly in the poorest countries. This would threaten the ability of vulnerable communities to access basic needs. It is important that humanitarian actors whose work entails supporting the basic needs of the most vulnerable communities in countries under stress are prepared to continue to deliver humanitarian services in pandemic and to support the additional humanitarian needs that a severe pandemic would create. Key humanitarian actors have sought to strengthen the capacity of the humanitarian system to continue to deliver during pandemic, including with support from USAID funding through the Humanitarian Pandemic Preparedness initiative (H2P) and the Central Fund for Influenza Action (CFIA). Agencies have found that preparing effectively for pandemic strengthens readiness for a range of threats.

Translation of lessons from broader disaster management into action within the smaller scope of pandemic influenza preparedness-related activities provided the possibility of examining a number of approaches. This contributed to the larger disaster response methodology. The special nature of a pandemic emergency has led to considerable focus on national and field level initiatives, often geared at capacity building with broader impact on humanitarian capacity. Pandemic funding encouraged preparedness activities addressing issues relevant to other emergencies, advancing humanitarian assistance strategies in general. Resources made available for the development of pandemic preparedness and response tools had a catalytic impact on implementing innovative measures in wider disaster preparedness and response. This included establishing new partnerships with non-traditional partners, including the civil-military sector and the private and commercial sector.

The IFRC-led H2P initiative delivered significant accomplishments in community-level communication and training, and strengthened global and local partnerships.

UNICEF used pandemic funding to support a multi-hazard approach. This enabled the advancing of IASC contingency planning guidelines, the integration of diverse and disjointed emergency risk management processes, and the development of sophisticated simulation exercises. UNICEF revised its planning policy so that emergency risks are a central component in all UNICEF planning and preparedness, and made significant progress towards bridging humanitarian and development work.

The Hyogo Framework for Action contains five priority areas: (i) ensuring disaster risk reduction is a priority (ii) identifying disaster risks and enhancing early warning (iii) using knowledge, innovation and education (iv) reducing underlying risk factors (v) strengthening disaster preparedness. The preparedness area has not been as well-resourced and as comprehensively addressed as some other elements of the framework. Some of the actors working on the preparedness element of the Hyogo Framework lack significant experience of emergency response. There is scope for

preparedness activity to be better-informed by response experience. The pandemic preparedness agenda has adopted a holistic whole-of-society approach. DRR practitioners can learn from the holistic approach of pandemic preparedness. Negotiations for a successor to the Hyogo Framework in 2015 will constitute a significant opportunity for changes in the international community's approach to the disaster risk reduction agenda.

Plans need to be better differentiated to trigger different actions depending on evolving levels of severity. Gaps include UN guidance on the definition and measurement of severity and on appropriate public health non-pharmaceutical interventions at community level for different levels of severity.

There is a risk that pandemic fatigue leads people to underestimate the ongoing threat of a severe pandemic. Strong communication and advocacy from WHO is required to sustain awareness of the continuing threat.

Key lessons from humanitarian sector pandemic preparedness

The power of funding and ambition	Through adequate funding, donor drive and motivation of partners, preparedness efforts can move rapidly. If this was replicated for all disaster preparedness we would be further along in preparedness for all hazards. Where there is funding and ambition, preparedness can be an urgent priority.
The need for a multi-hazard approach	It is less effective to focus on just one threat. It gains more traction to emphasise that pandemic preparedness strengthens resilience to a range of threats. Knowing how to prepare for one disease makes us more ready for any threat. Pushing pandemic as a separate vertical risk risked undermining government disaster management processes.
Business continuity planning is key	Business continuity planning is a key priority. The process by which contingency and business continuity plans are formulated is invaluable for preparedness, including threats beyond pandemic.
The value of simulation exercises	Simulation exercises proved a valuable tool for strengthening preparedness. Multi-sector simulation exercises helped to identify roles and responsibilities of different stakeholders and improve communication and coordination in the event of a pandemic or any crisis
High level commitment facilitates collaboration	Bringing together senior representatives from 23 agencies across the humanitarian community to sign a high level declaration committing to work together early in the process provided impetus, legitimacy and momentum to the H2P and HiP networks and to a collaborative approach.
Innovative coordination methodologies	UNSIC has taken an innovative approach, using a small, cost-effective, catalytic taskforce to build links and strengthen coordination of an informal network. The UNSIC approach has relevance to other complex areas of multi-sectoral work where there is a major global political profile, a wide range of stakeholders, and an urgent need to work in a more coordinated way.

ACHIEVEMENTS

1. The Humanitarian Pandemic Preparedness (**H2P**) Programme was a 3-year effort from October 2007 through September 2010 funded by USAID and DFID. The goal was to minimize excess preventable morbidity and mortality during an influenza pandemic and the specific objectives were to take preparedness and planning measures to some of the most vulnerable parts of the world, with a particular focus on developing district-level plans for the community and household level response. The main partners in this programme were the International Federation of Red Cross and Red Crescent Societies (**IFRC**), UN organizations such as WHO, WFP, UNSIC and UNICEF, US-based NGOs through the CORE Group, the Academy for Educational Development (AED) and InterAction.

2. Partner organizations worked to define performance standards and develop tools for civil society actors to mitigate the impact of a pandemic on risks to health, food security and livelihoods. The IFRC funded National Society (NS) projects in 94 countries. The CORE Group directly funded projects in six countries. Save the Children, CARE, Project Concern International, and other organizations, worked as partners with local NSs in dozens of other countries, first to prepare for an influenza pandemic at the national and district level and then, after the outbreak of the 2009 H1N1, to respond in as many communities as possible.
3. H2P led to an increased focus on pandemic preparedness among several international organizations and governments, an increased focus on community-level interventions, and increased involvement of National Societies and NGOs in pandemic preparedness work. Prior to H2P, several organizations and governments had focused more on avian than pandemic flu, and pandemic preparedness had focused only on national-level interventions and interventions for health facilities. In many countries, National Societies and NGOs had not been involved in pandemic preparedness work prior to H2P.
4. The most significant accomplishment included local adaptation of communication and training material. There were also important successes around partnership at both the global and local levels. H2P projects helped many INGOs, LNGOs, and NSs increase their visibility and credibility with government and among peers, expand their role in disaster preparedness generally, and increase their engagement in pandemic preparedness.
5. H2P provided global guidance on community-level Non Pharmaceutical Interventions (NPIs) for pandemic influenza.
6. The programme also helped many communities and a number of governments transform their planning from avian influenza to pandemic influenza. However, progress toward district level planning and formal adaptation by governments of civil society plans is not complete, with significant variation in degrees of success.
7. National Societies and partners in H2P countries are more prepared for an influenza pandemic today than before the H2P programme, mainly in the areas of trained staff and volunteers, adapted communication materials, and the development of, or at least the beginning of, pandemic preparedness and business continuity plans. Given the length of the projects, often less than eight months, and the timing of the 2009 H1N1 influenza pandemic, most countries focused on H1N1 response. While there

were only a few successes in the food security and livelihood sectors, there was significant progress in the health sector where country-wide, district level planning has begun in many countries.

8. IFRC has other Divisions that do work related to pandemic preparedness but the Secretary General decided to appoint a Special Representative for Pandemic Influenza. The separation of attention to pandemic influenza from other organizational structures led to delays at the start of their involvement in H2P.
9. Given the severity of the 2009 H1N1 influenza pandemic, the response was, for the most part, appropriate and at scale. Successes at scale included both the global reach of the program, which provided targeted funding in 94 countries, and country-wide coverage in many countries, typically around public awareness and education campaigns, and training. Partnerships were often most effective and visible at the district level, rather than national level. There was recognition among a number of partners at the global and national level that collaboration around pandemic influenza can have benefits on a broad range of health and disaster preparedness projects. Partnerships were most developed in countries that had the time to work together before the emergence of the H1N1 pandemic.

H2P: Kenya Red Cross Society training

10. **CORE** Group, a network of 48 International NGOs working in 180 countries, joined the H2P Initiative in September 2007 as the lead of the health technical materials for pandemic preparedness in over 20 countries and the convener of the NGO sector in preparedness and response. CORE supported NGOs in implementation of preparedness activities in H2P countries in coordination with the National Societies of the Red Cross/Red Crescent and other key partners in order to bring about a united response for the humanitarian sector. NGOs conducted trainings, disseminated materials and tools, and shared lessons learned with the NGO community in country in order to support preparedness and coordination at large scale. CORE held NGO pandemic orientation workshops, engaged the international NGO community at headquarter level with web-based trainings and presentations at CORE bi-annual meetings of NGO technical advisors, and in May 2008 conducted a table-top simulation exercise for 80 NGO headquarter representatives with UN OCHA/PIC.
11. **InterAction** held a table top simulation concerning pandemic for InterAction member CEOs as part of the annual CEO retreat. OCHA/PIC conducted the simulation. InterAction prepared and led H2P regional meetings which brought together national societies, NGOs, government representatives and resource organizations to assist H2P to move forward on its deliverables.

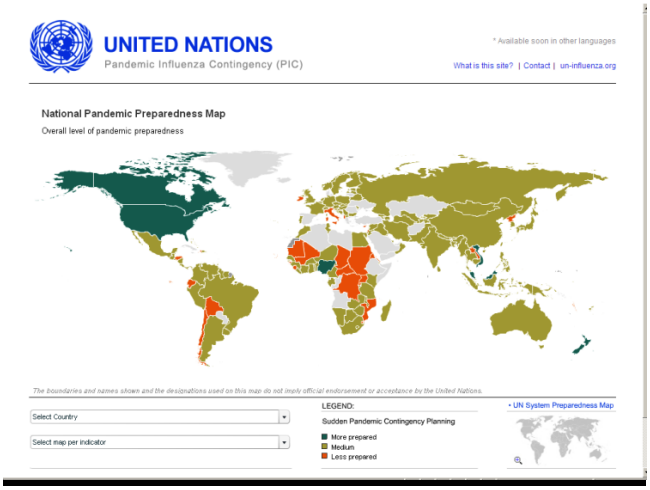
12. A useful example of an NGO working under the H2P umbrella is CARE. **CARE** used investments it received for pandemic preparedness, including from the H2P initiative, to strengthen country office capacity to design, plan and support community and sub-national level all hazards preparedness and response projects in Nicaragua, El Salvador and Honduras. It strengthened community and sub-national capacity for (i) risk and resource mapping for natural disasters and diseases, (ii) surge capacity planning, and (iii) disaster response.
13. CARE added an Avian Influenza section in 65 country office emergency preparedness plans. Investment in pandemic preparedness significantly increased the basic knowledge of CARE staff on emergency planning and response.
14. CARE's programmes strengthened community and sub-national capacity to implement Avian and Pandemic Influenza prevention, preparedness and response activities, resulting in improved bio-security and reduced risk of disease transmission at farm, market and slaughterhouse level; enhanced community-based disease surveillance systems for Avian Influenza and other important diseases; the establishment of district and community surveillance and response teams; and a trained pool of sub-national and community volunteers able to detect, report and respond to cases of Avian and Pandemic Influenza and other diseases.
15. CARE's work triggered cross-sector stakeholder engagement including animal and human health authorities and the private sector in many countries.
16. The increased preparation achieved by CARE and partners through H2P led to decreased panic levels during the H1N1 outbreak and a lack of unnecessary or drastic measures.
17. Pandemic preparedness investment has strengthened CARE's capacity for multi-sector collaboration, disease surveillance, scenario-based preparedness and response planning, and civil-military collaboration, which capacity is transferrable to other threats.
18. **ICRC** prepared specific operational guidelines to define a contingency plan for the whole institution (HQ and delegations), covering the three aspects of (a) crisis response or pandemic-related operations (b) business continuity for existing operations, and (c) staff protection. Context-specific plans for delegations and a plan for HQ were prepared.
19. **IOM** used pandemic funding provided by USAID through the CFIA, inter alia to develop a training of trainers manual ''Introduction to Basic Counselling and Communication Skills: IOM Training Manual on Migrant Community Leaders and Community Workers''. The need was felt to produce a tool that would enable migrant community leaders, humanitarian workers and other stakeholders to communicate with and counsel migrant and host communities in the event of a pandemic. When people are exposed to stressful events, some are able to work through it but others need support. Migrant community leaders and humanitarian workers often find themselves in situations where they have to counsel and communicate with migrants and host communities, but lack formal training. IOM developed a training manual that provides generic skills that can be used in the event of a pandemic or any crisis situation, and during day jobs of those in direct contact with beneficiaries. The manual was developed in 2008 and IOM has conducted multiple training of trainers sessions. Users have expressed particular appreciation of the skills provided by the training in their everyday work, even when not dealing with crisis situations. Counselling and communication skills are useful in crisis and post-crisis situations and everyday life.
20. **UNHCR** used pandemic influenza money to strengthen their overall disease surveillance activities. This is an example of the synergistic value that pandemic preparedness provided. UNHCR used funding from the CFIA to ensure that all major

UNHCR refugee camps have practical contingency plans in place, that include provision for stockpiling, isolation, improving water supply, and being ready to deliver a minimum critical level of basic needs. UNHCR response plans include all relevant actors – Government, Red Cross, other agencies – and focus on practical issues, (such as on how to do early warning, investigation, confirmation, how to involve vets, how to identify which laboratories to use, and how to transport samples).

21. UNHCR have used their pandemic funding to improve their management of pharmacies and drugs; and their infection control and prevention in hospital settings. The pandemic preparedness process led UNHCR to learn to be more systematic in its planning and preparedness, and to recognise the importance of raising awareness among beneficiary communities, staff and management.
22. A valuable tool that UNHCR is producing is a practical pocket guide on pandemic preparedness for field operations, so as to sustain readiness in the future – focusing on what has to be done, with easy-to-follow checklists, adapted to regions.
23. WHO were sceptical about including refugees as priority targets for H1N1 vaccination, including because Governments tend to have reservations about prioritising refugees, but UNHCR successfully advocated for WHO to take refugees into account in vaccination allocation. It is important to prioritise the more vulnerable sub-populations in disaster preparedness planning, as disasters hit them the hardest and they are the least able to cope with the impacts.
24. **UNICEF** from the outset used pandemic funding to support a multi-hazard approach. The significant funding UNICEF received from Japan ($49m) and Canada ($4m) for pandemic helped UNICEF to (a) significantly strengthen its communications for development work – including cooperation and advocacy with Governments, and developing messages and strategies (b) reinforce its vaccine branch (c) strengthen cold chain capacity in many countries (d) advance, develop and strengthen the Inter Agency Standing Committee multi-hazard contingency planning guidelines (e) integrate and harmonise previously complex, disjointed and diverse UNICEF emergency risk management processes and programmes (f) strengthen business continuity and (g) develop effective and sophisticated simulation packages.
25. UNICEF is revising its planning policy so that emergency risks are a central component in all regular UNICEF planning and preparedness and that preparedness considerations routinely inform PRSPs, SWAps, UNDAFs and CCAs. This is a historic step forward for UNICEF, funded by pandemic funds used in an integrated multi-hazard perspective. Pandemic funding helped UNICEF to make significant progress in bridging humanitarian and development work within the agency.
26. **WHO** developed tools for community-based interventions that are useful for all types of disasters and emergencies, including guidance on reducing excess mortality, community case management during an influenza outbreak and home care guidance. Pandemic brought WHO additional funding for risk reduction staff and programmes.
27. All of the pandemic preparedness efforts done by Health Action in Crises (HAC) in WHO were integrated into an all hazards approach.
28. Concern to be ready for pandemic led to an upsurge in business continuity planning, that is valuable for a range of threats. Recognizing the need to continue critical functions at all times, the United Nations established a Business Continuity Management Unit (**BCMU**), located within the Department of Management in New York, in 2007. The aim was to address the vulnerability of United Nations global operations, which cost almost $1 billion per calendar month. In the face of today's threats, which include transnational terrorism and possible pandemics, the initiative sought to strengthen the Organization's ability to respond to risks and maintain continuity of critical business processes following disruptive events.

29. Pandemic preparedness and response measures triggered a systematic change to the UN approach to operational continuity, highlighting its importance to the continuous provision of humanitarian assistance.
30. Material developed for pandemic preparedness contingency planning provided the basis for business continuity planning for the United Nations. Infrastructural and institutional mechanisms put in place for pandemic preparedness have been adapted to be applicable for general preparedness.
31. BCM activities shorten the time for organizational recovery after an incident and expedite the reinstatement or augmentation of humanitarian operations by the affected organization. An example is the adoption of a number of BCP initiatives which enabled the support of UN critical functions during the last Lebanon-Israel conflict.
32. Pandemic preparedness and response mechanisms created prior to and activated during the H1N1 pandemic crisis were instrumental in shaping and stress testing the UN Senior Emergency Policy Team (SEPT) and UN Crisis Operations Group (COG) and strengthening collaboration and coordination.
33. UNICEF, WFP and UNDP established a partnership with the United Nations Secretariat. Together, they rolled out business continuity training, developed based on the pandemic preparedness and response model, at field level. The initiatives provided opportunities for collaborative inter-agency country arrangements on business continuity and led to increased understanding amongst participating organizations at field level. It provided awareness of operational requirements for continuity of humanitarian response.
34. One example of the value of business continuity activity stimulated by pandemic funding relates to the UN Economic Commission for Latin America and the Caribbean (**ECLAC**) in Chile. On 27 February 2010, Chile was hit by an 8.8 magnitude earthquake. As a result of the earthquake, ECLAC premises suffered damage, especially the older part of the premises where about 300 work stations (50% of all ECLAC work stations) were located. As a consequence, ECLAC had to set-up temporary provisional work spaces for 300 staff. Having invested considerable effort in pandemic preparedness and business continuity planning prior to the earthquake, with BCMU assistance, ECLAC was well prepared to respond to the crisis and to continue its critical functions during the aftermath of the quake. Furthermore, ECLAC had received resources for pandemic preparedness and business continuity that had been invested to strengthen its response capacities. One week prior to the earthquake and during a visit from the BCMU, ECLAC conducted a crisis response with the Security and Safety Section and a telecommute test with its critical staff.
35. The work of the Pandemic Influenza Coordination (**PIC**) team in **OCHA** served as a stimulus for pandemic preparedness work that is now being undertaken by the UN Secretariat's Business Continuity Management Unit as well as within most agencies. Intensive support was provided to countries (through the links between PIC's Regional Planning Officers and Resident Coordinators), to humanitarian organizations (through the Humanitarians in Pandemics network and the Humanitarian Pandemic Preparedness programme), and to critical sectors. PIC worked with WHO to develop Whole of Society Pandemic Preparedness guidance. This preparedness work helped national authorities, the UN and non-governmental groups to be better prepared for pandemics and to handle the H1N1 influenza pandemic with confidence. PIC helped the UN to become much more prepared for continuity under pandemic conditions than it was at the end of 2005. More than 125 UN country teams prepared their contingency plans and over 30 assessments of mission response capacity were conducted in 2009. The contingency plans for

country teams, agencies, headquarter offices, regional units and missions were reviewed and tested by simulation. Essential principles of these plans were brought together in an overall Concept of Operations for the UN system in the event of a pandemic. Best practices based on the plans have been collected and made available within the UN and to other bodies. PIC also developed a readiness tracker website which contained interactive information on which agency was doing what pandemic preparedness interventions where, which helped agencies to identify opportunities for collaboration.



PIC/OCHA readiness tracker

36. Products and tools developed within the framework of **WFP's** pandemic preparedness, readiness and response strategy are applicable beyond pandemic to wider emergency preparedness and response; in particular to multi-hazard response and large scale emergencies.
37. In a strategic 3-phase approach, WFP began its preparedness initiatives focusing on (i) minimizing pandemic impact on staff health and safety; (ii) maintaining operational capacity in a pandemic, and (iii) supporting partners with common services.
38. Emphasis was placed on comprehensive, multi-sector preparedness planning, an ongoing gap analysis and adapting tools to emerging public health threats. Project activities developed from preparedness planning to more comprehensive readiness and response activities during the second phase of WFP's preparedness efforts. Key activities focus on: (i) strengthening internal pandemic readiness to minimise the impact of a pandemic event on WFP's critical functions and (ii) developing a preparedness and response capacity to support Governments, local communities and partners to deliver essential services to vulnerable groups under pandemic circumstances.
39. The third phase of implementation of WFP's strategy expands its initiatives to focus on harmonization of coordination mechanisms for operational partners and integration of outputs and outcomes into the wider preparedness agenda aiming at sustainability and increased capacity and capability at all levels.
40. Key outputs that contributed to increased capacity beyond WFP are:

(a) Pandemic Logistics Corridor Capacity Assessments (PLCCA): Assessment and analysis of major supply routes in regions expected to be most affected by a pandemic. The process encompassed multi-stakeholder awareness raising, support to capacity building, and hazard and risk analysis training for business continuity in logistics and supply chain management of operational partners. The methodology and output led to a more comprehensive approach to logistic corridor capacity assessments by the humanitarian logistics community, in particular partners of the Logistics Cluster.


WFP pandemic simulation exercise

(b) The implementation of simulation and capacity building exercises at the national, regional and interagency level supported planning for the continued provision of humanitarian assistance. A series of simulation exercises supported WFP's continuing work in capacity enhancement, with a focus on logistics networks, whole of society response and civil/military coordination and harmonization of response. A 7-day field-based simulation took place in Malaysia, with over 220 participants, including representatives from 20 different national entities, UN agencies, Red Cross/Crescent, CDC, international and local NGOS and military personnel. The exercise tested and validated processes and planning assumptions for port, airport and surface operations and trained participants to better respond to a pandemic. A pilot national simulation and capacity enhancement exercise took place in Zambia involving high level government participation. Best practices were then incorporated into a regional exercise, the Pandemic Readiness and Response Exercise (P2RX), simulating the onset and escalation of an international public health emergency, designed to strengthen the coordination of logistics networks across East Africa (Burundi, Kenya, Rwanda, Tanzania and Uganda) in response to a large-scale disaster.


WFP pandemic simulation exercise

41. WFP continues to undertake multi-stakeholder capacity building initiatives through training and simulations with partners including NGOs, national authorities and humanitarian actors. These capacity building activities also provide a platform to enhance pandemic planning for partners through technical guidance, and offer WFP an opportunity to influence national preparedness planning so that considerations are made for humanitarian response in the event of a global public health threat or other disaster.
42. WFP also heavily focused on the development of pandemic preparedness contingency plans, addressing operational continuity and seeking a harmonized

approach at country level between humanitarian actors and national governments in collaboration with operational partners and the commercial sector. Operational Action Plans, developed to enhance WFP's readiness to mitigate the risks posed by a severe pandemic to 78 offices, were integrated into the larger WFP Emergency Preparedness and Response Framework and established a norm of collaborating with operational partners at national level.

43. User-friendly online mapping and information software for the provision of Humanitarian Common Services in a pandemic has been created by WFP. This Internet-based tool links close-to-real-time data on food and non-food assets to a forecasting programme designed to generate on-demand pandemic outbreak scenarios. This initiative proved a powerful awareness raising tool for high level stakeholders to present the impact of a pandemic and its secondary and tertiary effects.
44. WFP designed, produced and piloted Emergency Management Kits (EMKs) to provide first responders with the equipment needed during a pandemic. The kit provides multiple users with data and voice connectivity and can also be used in other emergency settings.
45. During the process of its pandemic preparedness and response programme, WFP recognized the need to build on partnerships with non-traditional partners such as the military in supporting humanitarian actors in the event of a pandemic. This led to expanded activities in civil-military coordination.

CROSS-SECTORAL WHOLE-OF-SOCIETY COLLLABORATION

46. On 29 October 2007, IFRC, OCHA and UNSIC jointly organized a meeting at which senior managers from 9 UN agencies, 8 NGOs, IFRC, ICRC and 2 international organizations signed a Declaration committing to work together to get ready to respond to the consequences of an influenza pandemic on vulnerable populations. During the course of the following year, two further UN agencies signed the Declaration.

Declaration on humanitarian cooperation in pandemic preparedness and response, October 2007, (and follow-up simulations)

47. Building on this senior-level commitment to collaboration, humanitarian agencies established close and trusting partnerships under the auspices of the Humanitarian Pandemic Preparedness (**H2P**) and Humanitarians in Pandemic (**HiP**) processes. The collaborative, supportive working relationship would be of benefit to the humanitarian community if more widely replicated. The close-knit partnership

between Red Cross, NGOs and UN - inspired by generous USAID funding - built up trusting networks which stood member agencies in good stead to work together and share information effectively when H1 hit; and meant that humanitarian actors were well-positioned to work together effectively to deliver a complementary response in the event of a severe pandemic.

48. Face-to-face meetings of the HiP network were valuable for lesson-sharing, relationship-building and joint planning. HiP helped to give NGOs and the Red Cross/Red Crescent movement access to WHO and strengthen linkages between NGOs and WHO. The fact that HQ pandemic units were working closely together helped to incentivise field focal points to work closely together. Including USAID and DFID in inter-agency meetings helped to increase US and UK confidence in humanitarian agency pandemic efforts and galvanise continued funding. Donors, Red Cross, UN, NGO and military actors came together in a more harmonious and collaborative way than normally applies.
49. In the light of the H1N1(A) 2009 pandemic, and building on the good relationships established through the H2P and HiP fora, on 17 August 2009, WHO, IFRC, UNSIC, OCHA and UNICEF issued a 'Call to Action'. Prompted by the humanitarian imperative, these agencies committed to work together with Red Cross and Red Crescent National Societies, NGOs and civil society to help Governments and communities to reduce the impact of H1N1. The call to action established 5 key principles that the sponsoring agencies undertook to collaborate to promote: identify populations at increased risk of disease and death; reduce death by treating acute respiratory illness and pneumonia; reduce spread of the disease; continue critical services and plan for the worst; and plan and coordinate efforts.
50. Partnering for influenza pandemic preparedness strengthened advocacy, helped to build mutually beneficial relationships across organizations, and facilitated communication that enabled speedier, effective coordination during the response to H1N1. Pandemic preparedness and response activities set an example for multi-stakeholder cooperation in the area of humanitarian response. Regional collaboration between agencies and governments has led to stronger networking and partnership that will be useful for preparedness and response to other disasters.
51. Mutual interest in pandemic and the urgency and relatively non-controversial nature of the issue led to new partnerships being established that have wider relevance and value. Less barriers seemed to exist amongst diverse agencies when it came to discussing the pandemic agenda. A series of partnerships were formed entailing collaboration with non-traditional actors. Fora for discussion on pandemic preparedness have led to engagement with partners on preparedness measures beyond pandemic, based on mutual engagement established during the pandemic preparedness process. For example, WFP have formed new close alliances with military actors which have provided an entrée to discuss more generic logistics issues.
52. H1N1 demonstrated that established networks and partnerships supported the quick mobilization of services. WFP, UNOPS and others, for example, moved vaccinations to 86 countries at the request of WHO within 2 weeks of the request.
53. In September 2005, the United Nations Secretary-General appointed David Nabarro coordinator for support to national responses to avian influenza and pandemic threats. The Coordinator reports to a Steering Committee chaired by the Deputy Secretary-General and is supported by a small UN System Influenza Coordination (**UNSIC**) team which has varied in size from 1 to 33 staff. UNSIC's objective is to make the UN system work to its best effect when addressing the threats posed by avian and human influenza. The main elements of its work are: Global support for country-level influenza coordination; Regional UN system influenza coordination; UN

system inter-agency coordination; Support to partnerships and alliances; Synergy in risk communication; Joint approaches to pandemic contingency planning within the UN system; and Monitoring and impact assessment.

54. UNSIC was set up as and has remained a small taskforce supporting the Coordinator, comprising mainly secondees from national governments and the UN system. It was never intended to become an institution: it has taken a 'light' approach to coordination, characterised by working to catalyse others, and to develop and maintain a broad network of stakeholders inside and beyond the UN system, including national governments (donors and recipients), regional bodies (including the European Union, African Union, ASEAN and APEC), the UN specialised agencies, funds and programmes, the UN Secretariat, the World Bank and other international financial institutions, civil society, the private sector, academics and the media.
55. It also comprises a small inter-agency team based in Bangkok, the Asia-Pacific Regional Hub, which supports UN Resident Coordinators and Country Teams in the Asia-Pacific region.
56. In January 2006, the Avian and Human Pandemic Influenza: UN System Contributions and Requirements: Strategic Approach was published identifying specific outputs and activities of the UN system and partners under seven strategic objectives. The strategic approach formed a common basis for stakeholders to address pandemic preparedness and response concerns in line with their mandates, in synergy and in a complimentary manner. It provided guidance on areas of comparative advantage where various UN stakeholders should take the lead. It provided a blueprint to build upon disaster response capacities to prepare for addressing humanitarian needs during a pandemic.
57. UNSIC has generated strong buy-in from most of its stakeholders; established the UN's leadership role in Avian and Human Influenza and pandemic preparedness; strengthened coordination at global, regional and country level both within the UN system and with external partners; developed a number of specific reports and tools; and established a network of Avian and Human Influenza focal points in UN agency headquarters and country offices, with firm links to the International Financial Institutions, civil society and the media. Particular achievements include catalysing action between non-traditional partners within and beyond the UN system, and with the World Bank; helping the UN system and partners to raise pledges of over $2bn from donors; providing support to inter-governmental conferences in Beijing, Vienna, Bamako, New Delhi, Sharm-el-Sheikh and Hanoi to make real practical progress on AHI; raising the profile of Avian and Human Influenza within a number of national governments in an attempt to galvanize response and preparedness; and stimulating a culture of business/operational continuity planning within the UN system, with UN Country Team pandemic contingency plans developed rapidly for most countries with UNSIC support. Avian and Human Influenza is among the most successful examples of UN coordination.
58. The United Nations launched the 'Delivering as One' initiative in 2007 to respond to the challenges of a changing world and to test how the UN family can provide development assistance in a more co-ordinated way. The initiative seeks to capitalize on the strengths and comparative advantages of different members of the UN family and increase the UN system's impact through more coherent programmes, reduced transaction costs for Governments and lower overhead costs for the UN. UNSIC is a clear example of what the UN is capable of if it lives up to the ideals of 'delivering as one'. In addition, pandemic influenza preparedness has been at the leading edge of efforts to implement the 'one UN' concept in Vietnam.
59. Coordination by UNSIC through the UN Consolidated Action Plan for Avian and Human Influenza and the Deputy Secretary General's Steering

Committee on Influenza supported by the Technical Working Group ensured that the interventions of a large number of UN agencies were coherent and this helped to engender donor confidence.

60. The light coordination mechanism established by UNSIC contributed to establishing closer bilateral partnership amongst partners. It provided a forum for the facilitation of existing ties amongst humanitarian entities, governments and the private and commercial sector.

LESSONS

61. Through adequate funding, donor drive and motivation of partners, preparedness efforts can move rapidly. If this was done for all disaster preparedness we would be much farther along to prepare for all hazards. Where there is funding and ambition, preparedness can be an urgent priority.
62. It is less effective to advocate focus on preparing for just one threat. It gains more traction to emphasise that pandemic preparedness strengthens resilience to a range of threats. If we know how to prepare for one disease, this makes us more ready to be prepared for any future threat, as much of the process is the same. Pandemic funds were used by some agencies to strengthen multi-hazard approaches to preparedness. Pushing for preparing for pandemic as a separate vertical risk sometimes risked undermining wider government disaster management processes. It is preferable to mainstream pandemic, than to treat pandemic as a separate preparedness silo.
63. Business continuity planning is a key priority. The process by which contingency and business continuity plans are formulated is invaluable for preparedness, including for threats beyond pandemic.
64. Simulation exercises have proved a valuable tool for strengthening preparedness. Multi-sector simulation exercises have helped to identify roles and responsibilities of different stakeholders and to improve communication and coordination in the event of a pandemic or any other crisis
65. Bringing together senior representatives from 23 agencies across the humanitarian community to sign a high level declaration committing to work together early in the process provided impetus, legitimacy and momentum to the H2P and HiP networks and to a collaborative approach.
66. On the somewhat narrower issue of UN coordination, studies of UNSIC's work have highlighted lessons of value to coordination arrangements for other future global threats. UNSIC has taken an innovative approach, using a small, cost-effective, catalytic taskforce to build links and strengthen coordination of an informal network. UNSIC has been non-threatening to agency mandates, and responsive to the evolving political and global environment and new opportunities. The UNSIC approach has relevance to other complex areas of multi-sector work where there is a major global political profile, a wide range of stakeholders, and an urgent need to work in a more coordinated way. The appointment of Dr Nabarro to address issues relating to the food crisis is an acknowledgement that some features of the UNSIC approach to coordination can be transferred to other high profile issues

GAPS

67. As the *preview report of the IHR review committee* makes clear, the pandemic preparedness community failed to get across successfully the message that planning should include different actions to be triggered by different levels of severity and that the severity of pandemics is highly variable. We led some interlocutors to believe that a pandemic is a catastrophe, with a false assumption that radical action is required upon the declaration of phases 4-6, not commensurate with the severity of the episode. This generated unnecessary negative impacts and caused reputational damage. It is critical that everyone understands that we need differentiated plans that trigger differentiated responses depending on evolving perceptions of severity. WHO could do more to help this be understood. An important step in preparing for a severe flu pandemic is preparedness planning for an appropriate public health response suited to the severity of the pandemic wave. UN guidance for this does not exist. A UN severity index adopted by UN agencies would allow for scenario planning. A severity index would help to avoid confusion as to what interventions should be introduced when. Response triggers at community level need to be identified.
68. It has been difficult to gain traction for pandemic preparedness in Africa. Many countries in Africa face such a range of pressing and immediate challenges that are causing significant threats to morbidity and mortality now, that it is difficult to galvanise significant interest in a possible future threat whose existence, timing and severity are highly uncertain. In addition, the very limited prevalence of H5N1 avian influenza in Africa meant that influenza pandemic was much lower down on the public policy radar screen than in parts of South East Asia where avian influenza caused significant economic impact on livelihoods in the poultry industry and a significant number of well-publicised human fatalities. Moreover, H1N1 did not have a conspicuous impact on many parts of Africa. Attention to pandemic preparedness tends to correlate with GNI per capita, and many countries in Africa have very limited resources that they are able to invest in pandemic preparedness or indeed in preparedness for other threats.
69. It is difficult to sustain energy, funding, resources and staff for preparedness when many agencies and countries do not have sufficient resources or staff capacity to provide effectively for basic assistance needs. It is hard to sell the value of investing in protecting communities from the impact of future threats if those communities are suffering from life-threatening diseases and other hardships and challenges here and now.
70. The health sector tends to operate in a vertical mode, whereas pandemic preparedness brings an emphasis on multi-sector planning and coordination.
71. No specific organisation in the international development and humanitarian architecture is formally responsible for preparedness and preparedness can fall between the cracks between the development and humanitarian communities. This adversely impacts resourcing and implementation.
72. ISDR and the World Bank-led Global Facility for Disaster Reduction and Recovery's approach to DRR tends to emphasise structural, legislative, engineering, hazard science, livelihoods and economic approaches. The preparedness agenda in the Hyogo Framework for Action is not as well-addressed as some other elements of the framework. Some staff working in international disaster risk reduction agencies have limited experience of response – so some preparedness activity is insufficiently informed by response. There is scope for a more holistic approach. Negotiations for a successor to the Hyogo Framework in 2015 will constitute a significant opportunity for change. DRR practitioners can learn from the holistic approach to pandemic preparedness. ISDR is stronger on concept, policy, advocacy and communications

than on implementation. It would be desirable to see ISDR shift from a natural hazards oriented focus toward an all hazards focus including biological hazards.

73. There are concerns about how to sustain the knowledge and accomplishments of H2P, in particular, the impact of the loss of key staff with knowledge and experience, and the lack of ongoing donor support for community-based activities.
74. Many organisations were prone to dismissing pandemic as a health problem, or to denying its special nature and saying that they were dealing with it through existing disaster preparedness processes. Preparedness needs to find the correct balance between a general multi-hazard whole-of-society approach and the obvious specificities of different kinds of disasters.
75. In many organisations, separate entities are working on disaster recovery planning, crisis management planning, enterprise risk management, emergency risk management and/or other manifestations of risk management planning. There is a strong case for integrating and harmonising these separate processes. UNICEF provides one example of how to do so.

RECOMMENDATIONS

1) Countries and organisations should adopt an integrated multi-hazard, whole-of-society approach, in order to sustain capacity to respond to a pandemic and promote resilience to a number of other threats.
2) Countries and communities should develop plans that are simple, yet flexible enough to accommodate different levels of severity. Good plans accommodate different scenarios. WHO should provide guidance as to the definition and measurement of severity, and the appropriate response, particularly for NPIs.
3) Governments, national disaster management agencies and those who support them should always include vulnerable groups, populations of humanitarian concern and refugees in all disaster preparedness planning.
4) Development agencies should integrate emergency preparedness and risk reduction into existing development programmes and support national capacity-building to strengthen disaster preparedness for all hazards.
5) Preparedness and response planners should address and integrate pandemic, other biological hazards and epidemic in all-hazard analysis and risk assessment on a consistent basis.
6) WHO should continue to deliver effective communication about the ongoing threat of a severe influenza pandemic, and the importance of continued efforts to prepare to respond to a severe pandemic at international, national, and local levels.
7) Building on the Inter Agency Standing Committee and Emergency Relief Coordinator's recent and welcome decision to give greater attention across the IASC system toward preparedness, it would be desirable to appoint a lead agency to be responsible for overseeing attempts to strengthen the status of preparedness on the global agenda.

Annex A *List of key informants*

Jonathan Abrahams, WHO
Vincent Briac, IFRC
Anita Davies, IOM
Brian Gray, BCMU
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Heather Papowitz, WHO
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Eric Starbuck, Save the Children
Monica Trigg, CARE
Ron Waldman, USAID

Annex B *List of background documents*

Avian and Human Pandemic Influenza: UN System Contributions and Requirements: Strategic Approach, January 2006, UNSIC
Call to Action, August 2009, WHO, IFRC, UNSIC, OCHA and UNICEF
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H2P programme review, November 2010, IFRC
Introduction to basic counselling and communication skills, 2009, IOM
Preparing for AI: A case study for best practices from CARE Philippines, August 2007, CARE
Preparing for AI: Community-based systems for early warning, reporting and surveillance, September 2007, CARE
Preview Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza A (H1N1) 2009, March 2011, IHR Review Committee
Promising practices for community-based surveillance, December 2008, CARE
Strengthening training, outreach and prevention for avian influenza: STOP AI, February 2008, CARE