PART I. BACKGROUND, MEMBERSHIP AND TERMS OF REFERENCE

BACKGROUND

1 The humanitarian problems in the republics of the former Yugoslavia required an unprecedented effort by WHO to set up a field programme which could respond to the magnitude of the needs of the war-affected populations, in compliance with resolution EUR/RC42/R7. The emergency relief activities undertaken by WHO in the former Yugoslavia constitute, in the European Region, its largest involvement in humanitarian assistance to date. Since the start of operations in July 1992, voluntary contributions in cash and kind have totalled around US $43 million (EUR/RC44/13, Annex 1). As of June 1994, there is a staff complement in the operational area of 85, of which 32 are internationally recruited and organized around central offices in Zagreb and Sarajevo, with field offices in Belgrade, Skopje, Split, Tuzla and Zenica.

2. The explicit strategy for the field operations, which was presented in full to the Regional Committee at its forty-third session (EUR/RC43/15, page 3), included four key elements, namely to:

- help those affected by the conflict to maintain their health in a hostile environment;
- ensure that local health staff have the means to provide diagnostic, therapeutic and rehabilitative care in order to reduce suffering;
- mobilize emergency relief based on sound technical assessment of health needs; and
- monitor the health and nutrition situation to ensure that humanitarian action is targeted and effective.

3. Since the Regional Committee met at its forty-third session, the scale of operations has greatly expanded thanks to support from a large number of donors, many of whom have made repeated contributions. The Standing Committee of the Regional Committee was kept informed of developments at each of its meetings (EUR\RC43\SC\Rep, paragraphs 72 to 87). Particular attention was paid by its Members to the management of the programme, and the Standing Committee expressed concern about the welfare of staff serving in the former Yugoslavia. Its members asked for more attention to be paid to safety, as well as to the process of identifying, briefing and training staff, and the Committee sent a letter of appreciation to the staff serving in the field.

4. In addition to mechanisms to evaluate particular projects, the Regional Office undertook continuous administrative reviews of the capacity of the Copenhagen and Zagreb offices to support field operations. These reviews were complemented by a thorough internal managerial and administrative audit, initiated by the

Regional Director, who also invited three external reviewers plus an executive secretary from another WHO Region to make a strategic review of the programme This external review took place over a ten-day period in June 1994, two years after the initiation of field operations. The Standing Committee agreed, at its third meeting, to review the findings of the external evaluation and to inform the Regional Committee of its views on WHO's role in the former Yugoslavia

MEMBERS OF THE EXTERNAL EVALUATION TEAM[a]

5. The external evaluators were

- Dr Alfred Grech, Director, International Institute on Aging, Malta (Team Leader);
- Dr Brent Burkholder, Centers for Disease Control, USA,
- Mr John Telford, Consultant, Emergency Management Limited, Ireland (formerly UNHCR Head of Office, Sarajevo).

6. The Executive Secretary of the group was:

- Dr Claude de Ville de Goyet, Head, Emergency Preparedness and Disasters, Pan American Health Organization.

TERMS OF REFERENCE

7. The external evaluators were asked to concentrate on three strategic questions:

Was WHO following the right strategy in addressing health-related humanitarian needs in former Yugoslavia?
Were the management structure and technology WHO was using appropriate?
Were field operations on the right track?

8. The evaluation was designed to help WHO carry out its health mandate in the situation prevailing in the republics of the former Yugoslavia.

9 The team of external evaluators was asked to review and assess:

- the relevance of the mission statement and the objectives and activities of the humanitarian assistance programme to the health situation in the former Yugoslavia, the mandate of WHO and its role within the overall response by the international community;
- the overall effectiveness of the programme;
- WHO's responsiveness to changing health needs;

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[a] For details, see Annex 6.

- the relationships between WHO and local health authorities, funding agencies, other United Nations agencies and intergovernmental and nongovernmental organizations (IGOs and NGOs);
- the effectiveness of communication with the media and the public.

10. In the report that follows in Part II, the language, terms and views expressed are those of the external evaluators and not those of the World Health Organization The Regional Director, however, invited observations on the external evaluators' report from the three Special Representatives of the Regional Director who have led WHO operations from Zagreb over the two years of humanitarian operations – Sir Donald Acheson, Dr Nils Rosdahl and Dr Hannu Vuori. Their comments are summarized in Annex 8. Part III of the report contains brief comments by the Regional Director on the three strategic questions set out in the terms of reference.

PART II. REPORT OF THE EXTERNAL EVALUATION TEAM[a]

INTRODUCTION

Background to the humanitarian programme

11. Conflict erupted in Yugoslavia in 1991, briefly affecting Slovenia, then Croatia, and in 1992 Bosnia and Herzegovina fragmented into a triangular civil war. According to some estimates, between 150 000 and 230 000 people have been killed or declared missing, over 60 000 seriously wounded and close to 4 million displaced internally or across borders Amid the destruction, health services, particularly in Bosnia and Herzegovina, crumbled; pre-war health standards, systems and structures gradually deteriorated; as in other life-saving sectors, the need for health-related humanitarian assistance was undeniable. United Nations sanctions on the Federal Republic of Yugoslavia began in 1991 with the overall regional arms embargo and have been tightened through subsequent UN Security Council resolutions in 1992 and 1993 to include restrictions on transportation, trade, and professional contacts. Although technically excluded from sanctions, all humanitarian assistance must be explicitly cleared by the UN Sanctions Committee. These restrictions have slowed, and sometimes almost halted, humanitarian operations in the Federal Republic of Yugoslavia.

International humanitarian programme

12. WHO has a clear mandate for humanitarian relief operations (see Annex 1).

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[a] The team wishes to draw attention to the limited time available for this exercise (10 days) Normally, a major evaluation of this kind would take several months. The objective of the team was to produce a short report Notes and sources do exist to support statements in the text but, for the sake of brevity, substantiation is not always given

13. An international programme was set up by the United Nations to assist victims of the conflict in order to help them maintain good physical and mental health The goal was to prevent death, disability and suffering. The health of refugees, displaced persons, inhabitants of besieged areas and, in general, the more vulnerable groups, was of particular importance. The Office of the United Nations High Commissioner for Refugees (UNHCR) was nominated as lead humanitarian agency.

14. In July 1992 the WHO Regional Office for Europe (EURO) launched its Programme for Humanitarian Assistance in the former Yugoslavia. As public health adviser to the lead agency, UNHCR, WHO coordinates health-related activities in the overall UN humanitarian programme.

15. The following components make up the WHO programme: Public health, Supplies and logistics, Rehabilitation of war victims, Primary health care for refugees and Health care reform.

16. *Field presence.* Initiated with a handful of staff in mid-1992, the programme gradually reached the level of 80 international and local personnel at the time of the evaluation. Field offices have been progressively established and equipped (in Zagreb, Belgrade, Sarajevo, Skopje, Split, Zenica and Tuzla) to bring WHO operations closer to the place of need.

17 *Security.* Three offices are in central Bosnia and Herzegovina, an outright war zone, thus signalling a first for WHO. Armored cars, military escorts, helmets, flack jackets and sophisticated radio networks have become the everyday tools of humanitarian medical assistance. High risk to the staff is an unfortunate fact of life.

18. *Visibility and funding.* Unprecedented media attention failed to wane as months turned to years. Funding has roughly kept apace; approximately US $43 million in cash and donations in kind have been received by or pledged to WHO to date (see Annex 2 for list of donors and Annex 6 for an overview of expenditure).

THE EXTERNAL EVALUATION

19. The WHO Programme for Humanitarian Assistance in the former Yugoslavia represents not only a large investment in human and monetary resources but also an increased operational focus for WHO. In recognition of this factor, WHO requested an external evaluation team to assess the programme. The team visited the former Yugoslavia from 9 to 16 June 1994. The list of persons met is given in Annex 3. Consultants' reports and all other key WHO documents have been archived in the Coordination unit and these were readily available to the team.

Focus of the evaluation

20. The evaluation focused on the following questions.

Relevance. Are the mission statement, objectives and activities of the programme relevant to the mandate and role of WHO, one of many actors providing the international humanitarian response?

Effectiveness. Is the programme meeting its stated objectives?

Efficiency. Is the programme well managed and are the resources appropriately used?

Flexibility Is the WHO programme responding to the rapidly changing health needs?

Coordination. How does WHO interact with other key partners (local health authorities, sister UN agencies, funding bodies, IGOs and NGOs)?

Public information. Is communication with the media and the general public locally and internationally effective?

The evaluation team

21. The team was composed of four experts with extensive experience in international public health and/or disaster management and supported by a COR/EURO staff member (see Annex 4). The team's fields of expertise covered general international public health, epidemiology, logistics and operations management, and disaster management and coordination.

Methodology and approach

22. Contrary to traditional WHO public health programmes with quantifiable targets, a detailed plan of action and a controlled number of partners, the WHO Programme for Humanitarian Assistance in the former Yugoslavia attempts to respond to obvious but often unquantifiable health needs in a highly insecure and political situation. WHO is only one of the many agencies active in the health sector. In complex disasters, changes in the health situation may not be attributed to the impact, or lack thereof, of humanitarian assistance, and least of all to the efforts of one single actor. For these reasons, the usual epidemiological or operational indicators were inapplicable.

23 The method adopted consisted of extensive private interviews with a broad range of officials (from UN agencies, governments, NGOs and IGOs), experts and end-users, examination of archived material, as well as field visits to all areas of activities with the exception of the Former Yugoslav Republic of Macedonia. In the initial phase, interviews were conducted by the entire team to develop a common approach and identify the issues requiring special scrutiny. Thereafter, interviews were conducted by one or several team members according to the topic covered.

24. The WHO Programme for Humanitarian Assistance targets several countries or territories with distinct needs and operational problems To permit the most comprehensive coverage, each team member was given a separate travel itinerary (see Annex 5). Due to time constraints it was not possible to visit the Former Yugoslav Republic of Macedonia; however, all other field offices were visited, indeed a more geographically extensive programme was completed than had originally been intended.

PROGRAMME IMPLEMENTATION AND EFFECTIVENESS

Coordination of health assistance

25. Coordination of international health assistance is the main function and responsibility of WHO during emergency situations. This role is unanimously recognized by the agencies interviewed in former Yugoslavia. (*"No one else could do their [WHO's] role"* – UNHCR) There is a general consensus that WHO gained the respect of the local authorities, UN agencies and NGOs in its efforts to coordinate the activities of the numerous agencies active in the health sector.

26. One of the main functions of the heads of field offices consists in organizing and chairing interagency meetings on a broad range of health issues. These meetings, whether of a general or of a specific nature, have been routinely well attended at field level. In general, the coordination efforts were welcomed by the NGOs, a constituency normally critical of what they perceive as ineffective coordination by the UN system (*"WHO is the only organization effectively coordinating"* – IRC) The interlocutors familiar with humanitarian assistance in other conflicts noted the significant improvement in WHO coordination. Some NGOs, however, recognized the inherent difficulties in organizing multiple independent agencies with different agendas and personalities. (*"WHO had a difficult job, as NGOs in general do not desire to be coordinated"* – IRC). In Croatia, and particularly in Serbia and Montenegro, they even felt that coordination has been neglected and regarded WHO efforts to this end as ineffective.

27. The coordination of incoming health-related donations proved to be more difficult than anticipated. A significant proportion of the medical supplies (other than those from WHO sources) were either useless (e.g. expired) or of no immediate relevance to emergency needs. The Government of Croatia, the main point of entry of the supplies, *"was not in a position to manage the donations....because of the lack of a disaster management information system"*. This gap, frequently mentioned by agencies (UNHCR, IRC, IFRC, etc.), would require more assertive attention in the future through dissemination of guidelines to all donor countries through missions and other formal diplomatic channels

Assessment of public health needs

28 Health information is critical to all agencies active in an emergency setting. Because individual agencies have limited geographic and/or project perspectives, there is a general consensus that WHO should take the lead in gathering, evaluating and synthesizing this information in case of complex emergencies This role is especially critical in war zones, to which public health policy-makers and programme decision-makers often have limited access.

29. There was almost universal praise for the work of the WHO nutrition monitoring team (*"...the most useful contact with WHO has been on nutrition monitoring"* – WFP). In cooperation with UNICEF and several NGOs, this team was responsible for conducting surveys on nutritional status, breastfeeding practices and vaccination coverage. Ongoing nutrition monitoring was continued throughout the winter of 1993–1994 in several key cities, in order to assist the targeting of scarce resources to the most vulnerable groups.

30. Nutrition monitoring has proven to be a key activity that should be maintained in similar WHO operations in the future. However, given the potential disagreements that may be aroused by the findings of such monitoring, it is important to make greater efforts to include local public health officials in these projects so far as possible.

31. Given its limited staff and resources, the health monitoring unit has been able to provide sufficient data on epidemics and relevant technical information in specific areas. However a number of agencies felt that this effort could have been substantially expanded (*"I'm a bit disappointed in WHO's monitoring efforts – I expected them to do more"* – MSF; *"Health monitoring – a great idea with limited assets"* – ECTF/Zagreb; *"The WHO health monitoring function should be strengthened"* – IFRC).

32. Due to the virtual collapse of the public health information system and the war conditions, these efforts have been difficult to sustain without additional on-site presence of WHO staff. WHO should strengthen this function by putting more health monitoring staff in the field offices with the exclusive focus of providing essential public health information to the local authorities and the international community.

33. Finally, UN sanctions on the Federal Republic of Yugoslavia have been considered to be a major impediment to the UN humanitarian operation, including delivery of humanitarian assistance to areas in eastern Bosnia and Herzegovina. As part of its assessment role, WHO should develop methodology and tools to monitor the impact of sanctions on the health sector, and, along with other agencies, should advocate means of protecting the most vulnerable sectors of society

Scientific and technical advice

34 The local health authorities, IGOs and NGOs are turning to WHO for authoritative advice on all health matters (*"We see the WHO office as the medical or health reference, the natural umbrella"* – ICRC; *"When we need technical advice, we go to WHO"* – IRC, Tuzla). This constitutional responsibility has been discharged efficiently through the presence of field office staff and the frequent visits of experts from the Zagreb office or from WHO regional and global programmes.

35. WHO's partners – from UNHCR, the lead agency, to NGOs – stressed WHO's unique contribution in setting standards (for tuberculosis treatment, prostheses, etc.), issuing guidelines (such as those on donations and visits of medical teams) and providing specific expertise (in mental health, tuberculosis, disease control, etc.). However, several agencies suggested the need for more pro-active dissemination of consultants' reports.

36. Visits by specialized consultants have also occasionally raised unrealistic expectations on the part of the local authorities or NGOs unfamiliar with the slow and uncertain process of resource mobilization (for hospital equipment, for example, in the project on hospital engineering and spare parts).

Direct operational implementation

37. For the first time, WHO has assumed a major operational role in a conflict situation, in addition to its basic functions as coordinator, technical reference source and adviser Although obviously appreciated by the recipients of supplies or services and praised by some of the agencies, this "hands-on" approach is and should be the subject of considerable debate within and outside WHO. This operational role included the following ongoing or projected activities: specific public health interventions, supplies procurement and logistic support, and physical and psychosocial rehabilitation of war victims.

Specific public health interventions

38 As the lead health agency, WHO has taken the initiative in acting on information gathered through health monitoring by implementing specific interventions. As in other programme areas, these interventions reflect a mix of traditional and more operational WHO roles. WHO's responsibility for these specific interventions in the former Yugoslavia appears to have been widely accepted by local health officials, NGOs and other UN agencies.

39. Local health officials stressed the wide range of WHO contributions to epidemic preparedness and control. In several areas, WHO field officers have provided transportation and laboratory support, assisted in implementing control measures, and provided technical advice on appropriate treatment. Other agencies and NGOs often have the capacity to implement control measures, but WHO has the primary

responsibility (along with local health officials) of ensuring that all the necessary measures are actually carried out.

40. WHO has also taken a lead role in providing technical advice and treatment guidelines (along with drug kits) for tuberculosis control programmes. This is a project area where few other agencies are involved, and WHO tuberculosis drug kits are the primary source of these medications in the region. The WHO tuberculosis control policy has been somewhat controversial with some local clinical facilities, who are accustomed to their traditional approach. The technical support available from the WHO global programme has been instrumental in the successful operation of this project.

41. Scabies is a serious health problem. WHO, along with other agencies, has provided hygiene kits as part of a personal hygiene campaign.

42 WHO also has been active in supplying rat poison for rodent control in response to a pressing demand from the public and health authorities. The public health importance of the problem and the effectiveness of the proposed measures should be the subject of further evaluation.

43 Regarding water, the overwhelming concern was to provide a minimum quantity of water to the population, a responsibility falling outside WHO expertise. Despite many individual actors, no particular agency has assumed programme-wide leadership in assessing the needs for water and monitoring its quality. Several agencies suggested that WHO may have overlooked an opportunity in this area.

Procurement of health supplies/logistic support

44. WHO's role in past conflicts has been generally limited to reviewing requests for supplies and, subject to funding, procuring selected items for consignment to a ministry of health.

45. In the former Yugoslavia, WHO assumed a major ongoing operational responsibility for delivering a broad range of supplies (including drugs and medical equipment/supplies) directly to institutions and agencies in the war zone.

46. The standard WHO emergency health kit, originally designed for tropical countries, was duly adapted for use in the former Yugoslavia and complemented by 17 other kits addressing special diagnostic or treatment needs. The distribution of these supplies requires extensive (by WHO's traditional standards) logistic support (four trucks, warehouse space, logisticians, etc.). Both the funding and the core expertise were provided as a self-contained package directly by ODA, one of the most active donors in the area. Local WHO logisticians manage the field-level distribution network.

47 From a technical point of view, the identification of needs and priorities as well as the design of the kits were both recognized as being an integral part of WHO's expected role and very effectively implemented. The kits provided by WHO stood out for their standardized quality. Particular praise was given to the tuberculosis and laboratory kits which have included guidelines, a practice that is not common with supplies distributed by other donors. The relative and hopefully permanent return to some normalcy led most nationals and expatriates to recommend a more sophisticated approach based on local procurement and raw materials, rather than the continued distribution of kits designed for times of emergency. This shift is overdue. (*"As drug needs have increased, the move away from kits towards a full pharmaceutical chain was obvious, but has not occurred"* – ECTF).

48. A need most consistently expressed by national staff in all the republics is for scientific journals Obviously, a modest financial investment would have gone a long way towards gaining the support of the medical staff. The team recognized that steps are already being taken to provide such journals.

49. From the point of view of provision of supplies, considerable delays were routinely encountered. In general, WHO procurement time is considerably longer than that of any major NGO. Influenza vaccines, blankets and rat poison arrived too late and could only be used because the conflict lasted for another season. In another instance, local purchase of chlorine in Zagreb was delayed for almost a month while budgetary clearance was obtained from Copenhagen. The problem lies not with the competence and dedication of individual staff members but with WHO's structure, rules and "centralized corporate culture" that are not designed for, nor compatible with, rapid response and emergency field work In addition, this programme requires a level of logistic support with which WHO is not familiar.

50. From a logistic point of view, there is an emerging consensus that "*logistics is not a WHO strong point*" – MSF/Sarajevo). The team does not endorse some of the more critical views (for instance "*logistics were very poor*" – ECTF/Zagreb) and recognizes the commendable efforts made at all levels in WHO.

51. The relatively modest logistic capacity of WHO (four trucks, compared to 130 for ICRC) and the need for an administratively more agile response lead us to endorse the recommendation of a WHO consultant, Dr Atherton, (25 March 1994) that "*WHO should consider the wider use of other agencies in the procurement and delivery of supplies, rather than the development of its own systems*".

Physical rehabilitation

52. According to an interagency meeting held in May 1994, the total number of persons with amputations in need of rehabilitation is estimated to be around 3600. Around 90% have been fitted with a first prosthesis. WHO's rehabilitation programme has undoubtedly contributed to changing the life of many war victims.

53 The role of WHO consisted in:

- coordination with international institutions specialized in this field (Handicap International, International Committee of the Red Cross, GTZ, Project Hope 87 and Voluntary Relief Doctors);
- provision of technical support and training of nationals;
- donation of prostheses kits;
- assignment of mobile teams and engineers (fitting prostheses);
- direct support to programmes of NGOs such as Handicap International.

54. These undeniable achievements are to be credited to the competence and dedication of the rehabilitation experts. However, the impact of this activity on individual lives and its high visibility should not cloud the issue of whether WHO should consider similar involvement in future conflicts.

55. Interviews with ICRC medical coordinators clearly indicated that this agency with its long experience in war trauma rehabilitation, *"would have stepped in"* if WHO had opted for a more limited role. The criteria for assuming a responsibility over and above that of assessment, coordination and advisory functions should be, in our opinion, whether other agencies are willing and able to meet the needs and whether WHO has a significant "comparative advantage" over other agencies.

Psychosocial rehabilitation/mental health

56. Due to lack of adequate funding, the activities of this project have been limited to the distribution of mental health kits and the occasional services of consultants. National mental health experts accustomed to a large and somewhat unrealistic pharmacopoeia of drugs expressed some dissatisfaction with the limited selection of the mental health kit.

57. As in other fields, the health authorities are now looking to WHO more for its ability to mobilize resources for projects (for instance community-based mental health in Sarajevo) than for the donation of basic essential drugs.

58. The one-year WHO project on HEDIP in Split, Croatia was carried out jointly with UNHCR: 35 workshops were held to facilitate the social rehabilitation of refugees on the Dalmatian coast. Owing to the fact that it was directly supervised by the HEDIP centre in Rome (Italy), its integration into the overall humanitarian programme could be improved.

MONITORING AND ADAPTATION OF ACTIVITIES

59. Emergency situations, particularly complex emergencies, test the capacity of agencies to monitor changes, evaluate their own impact and quickly adapt to new

priorities. WHO's extensive field presence, its constant contacts with front-line NGOs and visits from experts stationed in Zagreb facilitated this process. The external evaluation team acknowledges that this evaluation is in itself an indication of WHO's desire to evaluate activities. Ongoing evaluation, however, needs to be systematically built into programmes.

60 Except in the case of the kits, little formal technical evaluation was carried out at the project level. Although commendable, the kit evaluation failed to address the concern of many users regarding the continuing relevance of the kits in a post-war situation.

61. The team acknowledges that formal evaluation in the middle of a conflict may be somewhat difficult. The trend towards the active participation of regional and global advisers in the technical aspects of this programme is most encouraging. This support, and especially visits by them to the field, will have a significant impact on local activities, as well as contributing to the development of a "culture of humanitarian assistance" within WHO As far as possible, an evaluation mechanism should be built into each programme from the outset.

MANAGEMENT

Management survey

62 An internal management survey was completed in EURO in April 1994. This decisive initiative will help solve some of the serious problems noted by the external evaluation team. It is a first step in the right direction

Resource mobilization

63. The programme has been funded exclusively from voluntary contributions. This total reliance on external contributions resulted in.

- a tendency to adjust the priorities of the programme to those of donors (distribution of supplies rather than coordination) Once a policy has been developed on the extent of its future involvement, WHO should perhaps be more selective in accepting funding for non-priority activities;
- an acceptance of unreasonable administrative constraints imposed by some donors. As a result, WHO lost credibility for not being able to meet its commitments on time;
- a shortage of unspecified funds for soft (non-supplies) activities. These activities are precisely those most essential to WHO fulfilling its mandate;
- lack of long-term funding: the time span covered by the UN Consolidated Appeals (six months) reflects the "relief" approach of donors. It does not yield the necessary continuity in a programme spanning over several years.

UNICEF early on adopted an annual and more recently a biennial budget and planning process (*"Bosnia and Macedonia is a 10-Year operation..."* – UNICEF special representative, Zagreb). WHO, a development agency, should similarly adopt a longer-term approach with donors.

- delays in the transfer of funds: Donors who are demanding immediate action from WHO are often slow to transfer funds. EURO should also clarify with WHO headquarters, the procedures for automatic transfer of these funds to the organizational level responsible for actual implementation.

Personnel

64. The quality of the WHO staff has been acknowledged and they deserve the highest praise for their efforts. The external evaluation team recognize the dedication and commitment of WHO staff, including long working hours both in the field and at EURO. In the field, staff have been working under trying and dangerous conditions (*"WHO staff are well educated and motivated"* – MSF). However, the frequent turnover of staff, particularly in the first year of operations, was a matter of general concern. UNICEF has opted to post staff in the field for a period of several years. Practical matters, such as estimating the post adjustment payment, are far from being settled. In spite of these practical problems, this initiative is sending the right message that UNICEF is not in the Federal Republic of Yugoslavia for short-term relief but for the long haul (relief merging progressively into development) The recommendation of the EURO management survey to establish a core of longer-term professional posts, although long overdue, is heartily endorsed by the evaluation team.

65. In addition, field level coordination, while generally well executed, requires specific skills and tools. These personnel attributes ought to be developed more systematically by EURO.

66. The distribution of personnel and other resources somewhat duplicates in Zagreb the top-heavy bureaucratic structure of WHO. In emergency management, technical and administrative resources must be assigned in priority to the field offices. High on the priority list is the early assignment of an experienced budget/finance/administration officer to field offices, regardless of their size. Identifying volunteers from the regional offices or WHO headquarters should not present an insurmountable problem.

Office facilities and communications

67 Communications between the field, Zagreb, EURO and WHO headquarters continue to be very difficult. Maintaining a structure which revolves around centralized administrative decision-making in Copenhagen and, to a modest extent, in Zagreb may require the use of convenient but expensive satellite voice and fax communications which are not currently available in all field offices. The

high cost of satellite voice and fax communications could be offset by the operational benefits.

Delegation of authority

68. Although the need for delegation of authority has been identified in the internal management survey, the solutions proposed fall far short of addressing decisively the heart of the problem. the inadequacy of WHO's operating rules and procedures in emergency operations. The proposed delegation of financial authority to the SRZ is a small step in the right direction. In our opinion, this should be expanded and extended to other field offices.

69. United Nations General Assembly resolution 46/182 states that *"Special emergency rules and procedures should be developed by the United Nations to enable all organizations to disburse quickly emergency funds, and to procure emergency supplies and equipment, as well as to recruit emergency staff."*. In this context, the revision of WHO's rules and procedures must be addressed by WHO headquarters in close consultation with the regional offices actually delivering WHO's humanitarian assistance. Ultimately, these changes will need to be reflected in the WHO Manual.

Security

70. Given the exceptional risk to WHO staff, WHO and sister UN agencies must design a strategy to prepare, equip and protect staff in conflict situations

Proposals

71. Annex 7 contains proposals for an expanded Emergency Preparedness and Response unit in EURO and sets out some key management issues that should be addressed.

RELATIONSHIP BETWEEN WHO AND OTHER PARTNERS

Local health authorities

72. Most health officials felt that WHO's role as coordinator of and liaison with other humanitarian agencies has strengthened the local health services. Establishing personal relationships with key officials has been critical to this process.

73. While acknowledging WHO's authority as a technical adviser, many officials were also quick to point out WHO's urgently needed tangible contributions (e.g. medical supplies and equipment). It is unclear whether supplying these goods has further enhanced health authorities' perception of WHO as the lead health agency or simply introduced a perception of WHO as another donor or NGO. In some instances, the request for WHO cooperation may result more from the perception

that WHO endorsement would greatly facilitate the mobilization of international support than from a recognition of its unique scientific competence.

74 In brief, one strong point of WHO's programmes most often mentioned by local health authorities and NGOs is the systematic involvement of local authorities (*"WHO works through the official system in setting up projects, and this better ensures sustainability"* – MSF).

Other United Nations agencies

75. Although the mandates of UNHCR, WHO, UNICEF and WFP are explicitly defined on paper, actual operations are often less clear-cut (*"In general, cooperation among UN agencies has been good but coordination is poor"* – UNICEF).

76. The opinions expressed regarding duplication of efforts between WHO and other UN agencies are generally positive (*"There is enough work for everyone with the magnitude of the needs .. there was no overlap..."* – UNHCR). However, specific instances of overlap are unavoidable and have been reported (e.g. nutrition surveys duplicated by WHO and UNHCR, similar drugs shipments by WHO and UNICEF, lack of coordination of consultants).

77. The excellent cooperation between UNICEF and WHO is also worthy of note (*"It is a most welcome return to the smallpox eradication days in the 1970s"* – UNICEF),

78. The nature of operating in a war zone has made it necessary for all UN agencies, including WHO, to rely on UNPROFOR, the UN military forces. This relationship has been problematic, for example, with reference to priority places on aircraft flying into and out of Sarajevo (*"Any military personnel outrank UN senior humanitarian staff!"* – UNICEF). In future, a more clearly defined set of operational guidelines will have to be established at the outset. WHO should take an active part in future consultations with UNHCR and other specialized bodies within the UN secretariat (particularly, the Department of Peace-Keeping Operations).

Funding agencies

79. WHO's humanitarian assistance was made possible by the generous contributions of many countries. So far as possible, the evaluation team met with experts from the funding agencies. With a notable exception (ECHO), the comments were most positive and in line with those of the other actors in the former Yugoslavia.

Nongovernmental organizations

80. NGOs are not known for being complacent about the shortcomings of the UN system. As noted above, the over 180 NGOs active in the former Yugoslavia have

widely acknowledged WHO's successful role as the lead agency in health. The sheer numbers and variable level of competence of NGOs involved have definitely strained WHO's resources.

81. WHO has had a limited relationship with the International Council of Voluntary Agencies (ICVA) Especially in emergency situations which attract large numbers of small NGOs, often with little previous international disaster experience, WHO should expand these links to ICVA.

82. Most major NGOs have welcomed the general principle of WHO's expanded operational role. (*"WHO's presence in the field is not only desirable but necessary"* – IRC) However, there has been some ambivalence regarding WHO's provision of medical kits (*"In general, I could take or leave the kits; except for TB and laboratory kits, others could have provided the drugs"* – MSF). The NGOs do not feel that WHO must be directly involved in providing medical supplies and services in order to have the credibility to coordinate the other agencies active in this operation.

83. The relationship between WHO, a specialized agency of the United Nations with a unique mandate and constituency, and MSF, a highly dynamic and competent NGO, merits special mention. Frequently, the local health authorities compared the relative merits or performance of both organizations (WHO not being necessarily ahead!). Some senior WHO field staff also tended to consider MSF as a "competitor". These observations point to the possibility of a mini "*identity crisis*" (ICRC/Zagreb) that should be cleared by a discussion and clarification of WHO's mission in humanitarian assistance ("*...clear targeting by WHO is missing*" – UNICEF).

IMPACT OF HUMANITARIAN ASSISTANCE ON DEVELOPMENT ACTIVITIES

In the former Yugoslavia

84. Even before the current hostilities, the republics of the former Yugoslavia had begun discussions on reforming their health care systems. These discussions have become even more critical now, as the republics attempt to restructure their economies and political institutions. Local governments and other UN agencies involved in the rebuilding process acknowledge WHO's pre-eminent role as technical adviser in this arena.

85. WHO has organized a series of seminars on health care reform in Zagreb and Sarajevo which included outside consultants and local health officials. Local field offices have also held informal discussions on the issue and distributed medical literature on the topic. There has been nearly universal praise for WHO's initiative in this area by health officials at all levels.

86. Even in an emergency situation, WHO, a development agency, cannot lose sight of its primary role of advising on health development issues. There were some comments that although WHO has taken an initiative on health care reform in Bosnia, this effort remains modest and should also have begun earlier in other republics (*"WHO should use the opportunity of this emergency in Bosnia to assist the health restructuring; they perhaps have missed the momentum in Croatia"* – UNICEF). The funding and staff time available for long-term concerns proved to be a limiting factor. Perhaps the programme support costs levied on donations and the Regional Director's Development Fund could be assigned in part to this objective.

87. Because it is difficult, if not impossible, to initiate development strategies with short-term consultants, WHO should consider specifically assigning this responsibility to the core staff to be selected on the recommendation of the internal management survey.

88. A matter of traditional concern to the international community and of great priority to the evaluation team is a smooth transition between relief and development. The establishment of a vertical humanitarian programme structure in Croatia, with little if any relation with the liaison office responsible for development cooperation, can only be justified as a very short-term transitory measure. It is overdue to reconsider this approach and to designate one WHO representative whose basic mission will be to merge both short- and long-term approaches into a model for other agencies. The considerable political credit gained by WHO through its effective humanitarian assistance work should be harnessed to promote basic but painful health reforms before it evaporates.

89. Aside from meeting essential needs, the donation of kits and other supplies has been justified by some agencies as a vehicle for gaining acceptance by the local country. Has WHO introduced an irreversible linkage between technical cooperation and the donation of equipment? The establishment of such a precedent has proven very detrimental in other regions of the world. The team does not consider as valid the argument that the donation of supplies was required to establish the credibility of WHO. The quality of the essential technical services provided by WHO should have spoken for itself.

90. Physical restoration of essential public services in Sarajevo is coordinated by an Interim Coordinating Body (ICBO), of which WHO is chairing the Health Committee. WHO should use this opportunity to help the health authorities set realistic priorities (funding is likely to be far below their expectations) and to aggressively defend the key interests of the health sector in the pledging meetings (health is often sidelined in favour of other sectors).

On EURO programmes

91. The basic question is: "Is the WHO humanitarian programme in former Yugoslavia diverting attention or resources from other priorities in the Region? Beyond any doubt, the extraordinary demand placed on EURO's administrative services and the External Coordination unit (COR) has not been without temporary impact on their normal activities. It is the very nature of emergencies to disrupt the status quo and the routine. As indicated in the internal management survey, additional resources have been assigned to minimize this interference with other duties (see paragraph 62 above)

92. One aspect often overlooked is the potentially extraordinarily positive impact of this programme on EURO by helping to reorient EURO and its regional programmes from a "committee of experts" attitude towards a country-oriented service approach. Should this programme result in structural adjustments to WHO's *modus operandi* (including its rules and procedures), the benefits for other Member States as well as for WHO itself may be immeasurable. It is hoped that this report will contribute to that result.

CONCLUSIONS AND RECOMMENDATIONS

93. The findings of the team are best introduced by a quote from Dr Brian McCloskey's end-of-mission report (April 1994), following his assignment as a health monitor.

> *"WHO needs to decide what role it wants to play in emergency situations. It already has a clearly defined, and much respected, role as public health adviser and as coordinator of health interventions. In that role it has been unquestionably successful in former Yugoslavia. UN agencies, IGOs, NGOs and local governments all look to WHO for advice and listen to what WHO has to say.... It is when WHO wants to go beyond advice and coordination and become operational that its structure lets it down. An operational agency in emergency relief needs a loose, flexible, decentralized and devolved structure. It needs budgetary responsibility at Field Office level and flexibility of purchasing. It needs the flexibility to sub-contract those areas where it has no internal expertise and the self-confidence to allow others to deliver its good ideas."*

WHO's presence in "complex emergencies"

94. Not one institution, agency or individual interviewed by the evaluation team in the former Yugoslavia questioned whether WHO should have been active in that conflict.

95. WHO must be present for the following reasons

- It has a clear mandate.
- The health needs and the importance of WHO's contribution were undeniable.
- A presence in times of crisis is indispensable to maintain credibility for future development work.
- WHO should assume its role within the UN-sponsored humanitarian assistance programme.

Recommendation 1

WHO must be present in complex emergencies as early and as forcefully as circumstances, particularly funding, permit.

WHO's "operational" role

96. A summary of our assessment of the relevance of humanitarian activities to the role and mandate of WHO is given in Table 1, while comments on the overall effectiveness of WHO's humanitarian activities in the republics of the former Yugoslavia are given in Table 2.

97 In the former Yugoslavia, WHO assumed a significant logistic role in the distribution of *general* medical supplies, principally in the form of kits. The wisdom of WHO undertaking this activity has been widely questioned by the other agencies.

98. WHO's active role in the area of physical rehabilitation (provision and fitting of prostheses) has improved the life of many amputated war victims. However, its relevance to WHO's mandate and expertise is doubtful.

99. Perhaps WHO should concentrate on the identification and promotion of unmet needs, coordination of other agencies' efforts, technical advice (for instance, on the design of kits or the most appropriate prosthesis techniques) and quality control (of donations in kind, for example).

Table 1. Relevance of humanitarian activities to the role and mandate of WHO

Project activity	Relevance	Comments
Health monitoring	++	Considered by most partners as one the most important functions of WHO.
Nutrition monitoring	++	As above.
Public health interventions	++	Investigations of epidemics are critical; otherwise, when required and cannot be implemented by other agency.
Water/sanitation	++	Focus on quality control.
Coordination and external relations	++	The *essence* of WHO's mandate in emergency situation.
Needs assessment and evaluation	++	Authoritative comments on needs are the key to effective coordination.
Procurement	??	WHO should advise on appropriate selection, but procure clinical supplies only in last resort. The kit strategy should evolve into a more sophisticated targeting of specific needs for pharmaceutical supplies
Logistic support	??	Most partners suggested that other agencies are better equipped.
Physical rehabilitation	??	Role should be limited to coordination and technical advice.
Psychosocial rehabilitation	??	As above
Identification of war victims	--	Outside of WHO expertise.
Provision of primary health care to refugees	??	Role should be limited to coordination and technical advice.
Strengthening of primary health care to refugees	++	As above.
Health care reform	++	WHO is the only agency with this responsibility and capacity.

Key: ++ Essential part of WHO's role.
-- Not a WHO function.
?? Activity to be undertaken directly only as a last resort.

Table 2. Effectiveness of WHO's humanitarian activities in the republics of the former Yugoslavia

Project activity	Comments on effectiveness
Health monitoring	Provided data on general epidemiological trends, but limited in scope and area. Not easily sustainable. Technical recommendations were an important contribution.
Nutrition monitoring	Considered to be an extremely valuable contribution. Produced essential information for programme implementation by other agencies.
Public health interventions	Assistance with epidemic investigations highly effective; other interventions often limited by logistic constraints.
Coordination and external relations	Generally very effective and accepted by other agencies. More successful at local level than regionally Only marginal success in limiting unnecessary drugs and assistance to the region.
Needs assessment and evaluation	Successful in locally directing complementary interventions; but monitoring dependent on NGO cooperation. Evaluations not always timely for effective response
Procurement	Prepackaged kits and other medical equipment met critical needs but, with certain exceptions, overlapped with NGOs.
Logistic support	Functioned under difficult circumstances, but deliveries often delayed; overlapped with other agencies.
Physical rehabilitation	Training and supplies filled gaps in some areas, but mostly limited to Croatia.
Psychosocial rehabilitation	Interventions delayed; however, now providing valuable coordination and programme support.
Strengthening of PHC to refugees	Provided necessary evaluations; limited primarily to Dalmatia Limited follow-up.
Reorganization of health care	Early initiatives much appreciated; high expectations for WHO in the future.

Note. No activities were implemented in the areas of "Identification of war victims" and "Provision of PHC to refugees".

100. The following criteria should guide WHO in establishing a policy regarding its role in complex disasters.

> **Recommendation 2**
>
> **The decision to assume operational responsibilities in addition to its basic role should be based on the following criteria:**
>
> - **there is an urgent and priority health need;**
> - **no other agency is willing and competent to meet this need or WHO has a particular expertise or "comparative advantage" over other agencies;**
> - **WHO's operational involvement will not divert resources or distract attention from its basic role;**
> - **WHO's involvement is important for its long-term development activities.**

Management of humanitarian assistance

101. The much-praised effectiveness of the programme is due to the competence and dedication of its international and local personnel working under bureaucratic rules and procedures that are utterly unadapted to emergency situations which call for rapid decisions under conditions of uncertainty. As a result, the procurement of supplies, the recruitment of personnel and financial transactions were considerably delayed.

102. While the team noted with satisfaction that WHO headquarters has assigned to EURO full responsibility for the response to this regional emergency, the lack of further delegation of authority from EURO to the field offices has affected the execution of the programme. The administrative authority granted to "Special representatives" in conflict areas must exceed that routinely enjoyed by a WHO representative in a Member State.

103. The "top-heavy" approach, concentrating power and resources in the Zagreb office, has not contributed to an efficient and flexible operation where it counts: at the front line.

Recommendation 3

WHO headquarters, in consultation with the regional offices and other UN organizations, should initiate a review of its rules, procedures and Manual for efficient response to emergency situations.

Broad delegation of authority must be given to WHO field consultants and staff members in situations requiring a humanitarian response.

Mobilization of resources

104. Humanitarian assistance programmes in general rely mostly if not entirely on extrabudgetary resources. This dependency can have drawbacks, including pressure to accept too readily donors' priorities and constraints.

105. Once WHO has clarified its primary role, it should give absolute priority to mobilization of the funding required for its own mission and function. The good track record of EURO in the former Yugoslavia and the direct benefit for the international community of effective coordination, assessment and guidance in the health sector strongly suggest that donors would respond favourably.

106. A rapid and sustained response should not be contingent on the actual receipt of funding. Although donors and WHO headquarters should accelerate the transfer of funds through, for instance, a loan from the UN Central Emergency Revolving Fund (CERF), interim means are also required *at regional level.*

Recommendation 4

WHO, in its effort to mobilize resources, should place top priority on fulfilling its own basic coordination and technical functions on behalf of the international community.

WHO's governing bodies should urge bilateral and multilateral funding agencies to increase the proportion of unspecified contributions for a specific complex disaster and, when applicable, to ease their policy and administrative requirements.

Preparedness and advance planning

107. Many of the shortcomings noted by the evaluation team result from a lack of strategic planning and from improvisation by successive professionals in charge of the respective aspects and levels of the programme.

108. However effective this improvisation may have been, EURO must be better prepared in order to avoid a repetition of past mistakes. A permanent administrative and technical mechanism or programme is necessary *at regional level* to ensure a minimum institutional memory and the rapid activation of a regional humanitarian response consistent with WHO's primary role. This regional programme must be assigned sufficient personnel and resources.

> **Recommendation 5**
>
> **A Regional Emergency Preparedness Programme should be established in EURO with the following responsibilities:**
>
> - **planning, supporting and coordinating WHO's response in case of emergency in the Region;**
> - **training of national and WHO personnel;**
> - **technical cooperation with Member States.**
>
> **Sufficient personnel and budgetary resources should be allocated from the regular budget for this purpose.**

Public relations

109. Too often agencies tend to overemphasize their achievements in their efforts to stimulate support from the public. In this case, however, EURO is on the verge of missing an opportunity to inform the Member States and the public of its real accomplishments.

> **Recommendation 6**
>
> **EURO should consider making a major effort to inform the public about the opinions of its Member States on this programme's objectives and achievements.**

Final conclusion

110. This programme has been highly successful in spite of its shortcomings. Even if none of the observed shortcomings were corrected before the next call for humanitarian action, this programme is well worth repeating.