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Nigeria mission report

28 February – 6 March 2017

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Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

INTRODUCTION

Since the Boko Haram insurgency in 2009, the conflict in the Lake Chad Basin (north-eastern Nigeria, northern Cameroon, western Chad and south-eastern Niger) has led to a massive displacement and a humanitarian crisis affecting some 17 million people.

The humanitarian needs in north-eastern Nigeria are acute and large-scale. Across the three most affected states of Adamawa, Borno and Yobe, almost 7 million people require emergency health services, an estimated 5.1 million people are facing food insecurity and around 1.8 million people are internally displaced. 2.6 % of children aged 6-59 months in Borno State have severe acute malnutrition and thousands more people living in famine-like conditions in urgent need of help. Throughout 2015-2016 the overall international response had failed to keep pace with these enormous needs, due to security threats and operational and political constraints.

In order to accelerate its efforts, WHO triggered an internal Grade 3 activation for the north-eastern Nigeria crisis in August 2016 and began deployment of the incident management structure. Numerous other UN agencies also triggered internal Level 3 activations around the same time.

The WHO's Grade 3 and other agency-level Level 3 activations prompted greater engagement and leadership by the Nigerian Government, concurrent with the UN agencies' scale-ups. WHO already had a presence in north-eastern Nigeria because of its polio programme, as did UNICEF. WHO has scaled up significantly since October 2016, as have most other UN agencies and major non-governmental organizations (NGOs).

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Dr Felicity Harvey and Mr Jeremy Konyndyk conducted the IOAC field visits in Nigeria from 28 February to 6 March 2017 with the support of the WHO Secretariat. The IOAC Nigeria Mission primarily focused on the field element in Borno State where the major crises are ongoing. The IOAC team spent a substantial amount of time in Maiduguri, the capital city of Borno State and interviewed WHO staff from both the Incident Management Team (IMT) and WHO Country Office (CO). The IOAC team also met with numerous key stakeholders including the national authorities, UN agencies, NGOs and donors both in Abuja and Maiduguri (*please see annex for agenda and list of participants*).

TOP-LINE FINDINGS

Significant improvements and progress are evident in WHO's Nigeria emergency programme since Grade 3 activation and implementation of the WHO Health Emergencies reforms. IOAC members observed this improvement directly, and it was affirmed by the government, other UN agencies, NGOs and donors.

However, **this progress is tenuous**. It depends heavily on the performance of key short-term surge personnel and a supportive Country Office, while reforms to systems and institutional changes appear to be lagging behind. Emergency team members and Country Office staff universally cited WHO systems and procedures as a major constraint on emergency operations.

Beyond systemic issues, **significant cultural constraints remain** throughout the organization, particularly around mainstreaming a **"no regrets" mentality** into all areas of a crisis response.

WHO's emergency programme in Nigeria thus serves as an **important proof of concept for the ongoing reforms**. The Grade 3 activation drove a tangible improvement in WHO's in-country response, and demonstrated that with the right team and delegation of authority in place, WHO can much more effectively deliver on its responsibilities in a crisis environment. However, the Nigeria programme also highlights **numerous areas where the reforms have yet to fully live up to their aspirations**.

SPECIFIC FINDINGS AND OBSERVATIONS

1. WHE structure implementation and relations among HQ, RO and CO

Whereas the structure of the WHE programme is implemented and aligned across the three levels of the Organization, the roles, responsibilities and reporting lines need to be further refined and institutionalized.

The Incident Manager liaises with the WHO Country Office and HQ focal point for the north-eastern Nigeria crisis and reports directly to the WHO Representative (WR). The IOAC team noted that the WR's role is to provide overall supervision, enable the Incident Manager to interact with the federal authorities and to obtain necessary resources to implement the emergency response.

Initial rollout of the Incident Management System in the country led to significant confusion about lines of authority and responsibility between the Incident Manager and the WR, creating tension between the IM Team and the CO. Relationships between the IM Team and CO were eventually clarified several months into the response, on 11 November 2016, when the EXD/WHE issued a memo on the Delegation of Authority to the WR in the context of the response to the humanitarian crisis in north-eastern Nigeria. The IOAC team recognized this progress but expressed concerns that the authority of the Incident Manager remains modest considering the magnitude of the crisis.

2. Effectiveness of the Incident Management System in health operations

The WHO emergency operations in north-eastern Nigeria are led by the Incident Manager.
The IOAC team observed that the Incident Management Team (IMT) is composed of highly skilled and experienced staff who have worked in various organizations with backgrounds in humanitarian crises. Within the IM Team, there are clear reporting lines and distribution of authorities under the strong leadership of the Incident Manager.

The Nigerian Government and partners recognize WHO's leadership role in technical health operations. The data management and information system is being improved through the Early Warning and Response System (EWARS), and weekly reporting for health information is welcomed by the partners. The recent case of Lassa fever in Maiduguri demonstrated WHO's ability to co-lead and manage the outbreak through the health authorities and co-ordinating across partners, and showed its impact in the humanitarian crisis context. Event verification, risk assessment, training and community sensitization, including in internally displaced person camps, is led by the WHO IMS surveillance officer who has expertise in epidemiology and significant experience in field work.

The IOAC team noted that the Polio Team in Maiduguri was not adequately leveraged to provide a platform for the IM Team to access hard-to-reach populations. Initially the two teams worked in silos, with the Incident Manager reporting directly to the WR while the State Coordinator managing the Polio Team reports to the Polio Responsible Officer at the Country office, and then to the CO WR. There has been modest progress in engaging the polio teams' capacities for the emergency response, but this improved coordination was slow to develop and could be further improved. The IOAC team was briefed that there is a perception that some GPEI partners were hesitant to support cross-collaboration, fearing it would dilute that Polio Team's effectiveness. However, IOAC outreach to Partners suggests that the major constraints were related to operational capacities given the major polio response that was underway at the same time.

While the IM Team is doing strong work, it remains largely dependent upon the strong leadership and experience of the IM and senior team members, and there is a risk that key lessons and methods of working could be lost as these personnel rotate out. Capturing these lessons and feeding them back into the reform process – in a systematic manner – will be key to continued improvement of the WHE Programme.

3. Emergency business processes and operational support

WHO staff in both the field and CO report that emergency operations face a constant struggle with the organisation's support systems and culture. WHO's normal systems and processes are not designed for a fast-moving emergency response in which lost weeks and months can equate to lost lives. This disconnect burdens staff at CO and field levels, ties up their time, undermines operational effectiveness, and affects morale. If unaddressed it could affect staff retention and detract from the willingness of seasoned emergency personnel to work for the WHE Programme in the future. The IOAC members see this as a potential Achilles heel for the WHE Programme.

Specific findings include:

In the initial phase, the IMT faced major security challenges. This hampered the effectiveness of WHO's response. The IMT logistics team has managed to set up WHO's own accommodation with security measures, safe office space and armoured vehicles, but faced a constant struggle with the WHO administrative system— finance, budget, procurement and recruitment that delayed significantly the above described work. The IMT noted that the lack of dedicated administrative support at the beginning of the response left the team without someone who understood key administrative systems such as GSM.

This left the Incident Manager and the team leads to navigate the HR, financial and procurement systems on their own, without the expertise or time to do so, which was ineffective use of their time. Once a dedicated administrative officer arrived, this situation improved. Relatedly, the IM team is totally reliant on the CO for administrative and operational support. The arrival of the emergency team puts a major burden on the CO that it may not be able to fully handle, without providing additional capacity to the CO.

Limits on CO fundraising authority are inhibiting the speed of the response. The maximum grant value that a WR can unilaterally accept is $1 million; any larger grants must be signed off by the Regional Director. This is a very modest amount of money for an emergency response. Staff reported at least one instance in which a major donation had been made but could not be spent for several months due to the slow process of circulating the grant for Regional Office approval. This delayed arrival of funds at the field office and hence directly delayed recruitment of surge staff and broader implementation—harming WHO's ability to deliver and potentially frustrating the donor.

It is clear that standard WHO administrative systems—for finance, budget, procurement, recruitment and IT—are inhibiting effective crisis response. While waiver authorities exist in theory, these are rarely used in emergency settings. Staff cited pervasive concerns that issuance of waivers would lead to negative audit findings, given the perception that WHO auditors would not accept emergency conditions as a defensible basis for waivers.

The operating environment has numerous constraints that all organizations face. However, WHO seems to struggle more than other partner organisations interviewed, due to administrative rigidity and bureaucracy. Other agencies have been

more creative and flexible in finding workarounds. WHO staff reported that when attempting creative solutions within WHO, they would frequently encounter a culture of risk-aversion and reluctance to pursue unorthodox options. This seems at odds with an organizational posture of "no regrets" in emergencies.

On a positive note, WHO staff cited the Delegation of Authority (DoA) memo to the Incident Manager as a "game changer" in terms of facilitating WHO operations in the field. It helpfully clarified roles and responsibilities between the Incident Manager and WR, enabling the emergency team to take decisions and make expenditures at field level, which are critical to maintaining operational agility amidst a fluid response. However, staff also noted that the Delegation of Authority memo was slow and cumbersome to develop and was not implemented until several months after Grade 3 activation and deployment of the team.

The current level of delegated authority for field expenditures—currently $50,000—is too low for a large-scale emergency. Larger expenditures must currently go to the WR for approval, and field and CO staff report that the WR has made a clear effort to respond quickly to such requests. However, delays have nonetheless occurred, as this process creates additional hoops that the field team must jump through, and requests can sometimes get lost in the shuffle in the CO.

4. HR planning, recruitment and retention

WHO has recruited and deployed a strong and robust field team with a broad range of capabilities. Key personnel include an Incident Manager/team leader, a programme specialist, an epidemiology and surveillance specialist, a coordination team including a cluster/sector coordinator and an information management specialist, an operations specialist, a finance specialist, and a range of other support positions. The IOAC members assess that this is a strong team with the right profiles to deliver in an emergency environment. Furthermore, much of WHO's enhanced ability to deliver on the WHE reforms in Nigeria hinges on the quality of this team.

However, there are several concerns about the sustainability of the current staffing model.

Specific findings include:

The people WHO has deployed are highly skilled and experienced. Most bring a combination of experience as former senior NGO field leaders and former WHO field experience. This profile of combined NGO and WHO operational experience brings an ideal skill set to these roles. However, the number of people with this combination of experience is limited, and candidates without WHO experience are reportedly disfavoured by HR. The IMT indicated that this limits WHO's recruitment pool given that many potential candidates who blend senior-level experience in both health and humanitarian response are to be found externally, particularly in the NGO sector.

Most field staff are on short-term contracts due to the WHO requirement that contracts be issued only for the duration of a specific funding source. This means that turnover is high and institutional memory will be lost quickly, which is a substantial risk to the programme. Conversations with peer UN agencies revealed that while they face similar structural constraints, they have identified means of navigating them that reduce staff turnover.

The recruitment process is seen as slow and cumbersome. This has meant lost opportunities to recruit strong candidates, who sometimes give up in the face of a protracted process or receive concrete offers from other employers and accept those while waiting for a response from WHO. Emergency team members noted that this also led to protracted delays in filling new or recently-vacated positions, in turn hampering WHO's operational readiness.

WHO HR systems do not allow further recruitment before money is logged on GSM. Many processes could and should be taken forward in advance of money such as development of specimen team member job descriptions that can be refined, adverts and interviews, with final appointments subject to

finance. The IOAC team noted that these are mechanisms used by many other partners to fast track and appoint staff in surge situations.

5. Partnership and coordination

WHO's investment in health sector coordination is widely appreciated and seen as added-value by the three levels of the Government (federal, state and local), UN agencies and international NGOs. Partners acknowledged WHO's role in coordinating health sector partners and for facilitating relationships between individual partners and Government.

However, provision of health services at the field level remains fragmented across various partners. Competition for visibility, duplication or sub-optimal resource allocation and quality of health services is of common concern to all actors on the ground. Partners acknowledged this fragmentation and indicated to IOAC that they would be willing to re-orient their programmes more optimally if donors provide sufficient flexibility. The new addition of an information management officer in the health sector coordination will be a crucial addition, and is welcomed by partners.

The IOAC also notes that all the different sectors/clusters need to co-ordinate with each other, and across the health cluster, since good health outcomes depend heavily upon all sectors—WASH, housing, nutrition, food, gender based violence, security—and not just health. Engagement with Government capacity – traditionally WHO's predominant partner – is an important asset to the WHE but requires strong coordination.

WHO co-leads the health sector coordination process in Borno State with the Government health authorities. This is crucial to success as NGOs, WHO, and the Government are all managing emergency mobile health teams in the northeast. The Government feels a strong sense of investment in its teams and sees these as a strong signal of its leadership.

Other findings include:

Fragmented and potentially duplicative health intervention delivery seemed not to make the best use of different health partners assets; however, WHO arrived quite late, and therefore was less able to direct partners.

Partners showed willingness to use their joint assets more efficiently, but this would require more flexibility on the part of some of the donors. Therefore, donors also need to recognize the role that WHO can play as a cluster lead, providing stronger coordination and liaison with donors, which could mean better impact from the funds donated for the crisis, whether or not they are for WHO.

Partners noted that the need in Maiduguri remains far greater than the current capacity.

Donor-driven silos impede health outcomes and confuse the population. We will address this concern in greater depth in future reports.

Partners highlighted other areas where WHO could support them, such as WHO having a role in drug importation and the allied regulations with the Government. The Ministry of Health expressed a willingness to work with WHO on this concern.

The Ministry of Health conveyed their concern that WHO issued an internal Grade 3 activation for Nigeria without prior government consultation. The IOAC notes this concern, but emphasizes that Grade 3 activations are internal to WHO and should be made by WHO HQ leadership objectively based on the merits of WHO's capacity relative to the scope of the crisis. However, IOAC also recognizes the value of confidentially informing governments of such decisions, prior to announcement, to allow the government to prepare an appropriate response.

Partners expressed their appreciation of the WHO logistics team's support for staff security and central medical storage.

Mutual understanding, and information and resource sharing among partners on the ground should be improved.

Where there had been a cross-sectoral needs assessment done on an IDP camp, it had enabled more effective health asset utilization through the health sector co-ordination mechanism, which should be commended.

The IOAC team heard that pushback from polio donors has inhibited use of polio infrastructure for supporting the emergency health response. The IOAC team felt that WHO's mobile clinic and Polio's hard-to-reach team could complement each other's efforts.

6. Security and staff protection

WHO and partners working in north-eastern Nigeria are exposed to a high level of security risk. The IOAC noted that working conditions in the field are hazardous and stressful. Staff based in Maiduguri are either out in the field, in their offices, or in the compound where they live. Most of them rarely manage to get home to see their families. Deployed personnel cited this as a constraint on accepting longer-term deployments.

At the beginning of the response, the support from the United Nations Department of Safety & Security (UNDSS) in Maiduguri was weak but there has been positive progress since. However, the IOAC team noted that the current advice is difficult to implement and somewhat restrictive for emergency operations.

The IMT instituted its own security measures based on MOSS requirements and previous working experience of the Operation support and logistics staff members from other organizations. In the absence of WHO protocols, they faced major challenges for obtaining timely authorizations for creation of a secure guesthouse. Safety, living and working conditions for the staff members in Maiduguri has been significantly improved but there is room for further progress.

Those deployed to Maiduguri qualify for 'Rest and Recuperation' (R&R) entitlements but these do not appear commensurate with the pace and stress of an intense field operation. Given the location of Maiduguri a five-day of R&R leave would only be sufficient to cover the travel time if the staff member wished to use it to visit family outside the African region. Also many are discouraged from taking the R&R because of the cost as they are paid only for the price of a flight to Accra, which is the WHO designated R&R destination. National staff are not eligible for R&R despite the fact that most of them are on detached duty and deployed from outside Borno State.

Staff working in emergencies should be supported, managed, and equipped properly. The IOAC team also noted that it is critically important to retain the staff and protect them from burning out.

CONCLUSION

Significant improvements and progress are evident in WHO's Nigeria emergency programme since Grade 3 activation and implementation of the WHO Health Emergencies reforms. IOAC members observed this improvement directly, and it was affirmed by the government, other UN agencies, NGOs and donors.

However, **this progress is tenuous**. It depends heavily on the performance of key short-term surge personnel and a supportive Country Office, while reforms to systems and institutional changes appear to be lagging behind. Emergency team members and Country Office staff universally cited WHO systems and procedures as a major constraint on emergency operations.

Annex. Agenda and list of participants

Tuesday 28 February - Abuja			
Time	**Agenda item**	**Venue**	**Participants**
5.50 AM	IOAC arrival in Abuja		Felicity Harvey, Munjoo Park
10:00 - 11:00	WHE Three level call on the Nigeria crisis	Teleconference	HQ, RO, IMS focal points
11:00 – 13:00	Follow up discussion	WCO	Jorge Castilla Mary Stephen Ziyad Qamar Ifeanyi Okudo
13:00 -14:00	Lunch break	WCO	
14:00-18:00	Meeting with the WCO	WCO	**HSS –** Tenin Gakuru **HIV/TB/Malaria –** Ilesanmi Olufunke **EPI –** Sisay Tegegne **DPC(HSE) –** Mary Stephen, Ifeanyi Okudo **Operations Officer**– Wadda Alieu **HR** – Paul Ndahayo **Budget and Finance** – Kofi Agblewonu **Resource mobilization** - Ziyad Qamar
Wednesday 1 March – Abuja			
Time	**Agenda item**	**Venue**	**Participants**
09.30-10.30	Interview with Nigeria Emergency response focal point	WCO	Mary Stephen, Health Security and Emergency Cluster lead
10.30-11.30	Interview with HR responsible	WCO	Paul Ndahayo
13.00-14.00	Lunch break	WCO	
14.00-16.00	Round table with Heads of UN agencies	WCO	UNICEF – Mohammed Fall, UNICEF Representative IOM – Enira Krdzalic, Chief of Mission UNFPA – Eugene Konguyuy, Deputy Representative
16.30-18.00	Meeting with the Minister state for health	MOH	Ehinare Osagie, Minister of state for health Shuaib Belgore, Minister's Senior Technical Adviser John Oladejo, Deputy Director NCDC and delegations
17.20	IOAC arrival in Abuja		Jeremy Konyndyk
Thursday 2 March – Maiduguri			

Time	Agenda item	Venue	Participants
09:00	Travel to Maiduguri by UNHWS		Felicity Harvey Jeremy Konyndyk Munjoo Park Mary Stephen Jorge Castilla
11.00-12.00	Security briefing	WHO office	Daniel Sheeran
12.30-13.20	Meeting with Health Commissioner		Haruna Mshelia, Commissioner of Health, State Ministry of Health (SMoH)
13.30-13.45	Meeting with Deputy Governor of Borno State		Usman M Durkwa, Deputy Governor of Borno State Haruna Mshelia, Commissioner of Health – SMoH
14.00	Meeting with MOH Permanent Secretary, Borno State Ministry of Health		On his behalf: Muhammad A Ghuluze, Director Emergency Medical Response
15.00-18.00	Meeting with the IMS team Briefing by the Incident Manager	WHO office	David Wightwick + IMS
Friday 3 March – Maiduguri			
Time	**Agenda item**	**Venue**	**Participants**
08.15	IMS daily briefing		IMS
09.00	Interview with the Incident Manager		David Wightwick
09.30	Interview with IMS Surveillance officer		Isabelle Devaux
10.00	Meeting with UNICEF Chief of Mission	UNICEF office	Chief of Mission Geoffrey Ijumba
11.00	Meeting with IOM Chief of Mission	UNDP building	Emma Khakula, Head of Sub office
13.00	Meeting with UNFPA acting coordinator	UNDP building	Sylvia Opinia, Gender-based Violence Coordinator Umar Mohammed, UNFPA Humanitarian Coordinator
14.30	Interview with IMS Health Operations Lead	WHO office	Veronique Urbaniak
15.30-16.30	Meeting with ICRC	ICRC building	Beat Armin Mosimann, Head of Sub-delegation
17.00-18.30	Meeting with MSF	MSF building	Aboubakar Bakri, Emergency coordinator MSF OCB Emergency coordinator: Axelles Ponses MSF OCBA Head of Mission, Armando Dana Krane, MSF-CH Head of Mission Heather Pagano, Intersection Humanitarian advisor

Saturday 4 March – Maiduguri			
Time	**Agenda item**	**Venue**	**Participants**
09.00-10.00	Internally displaced person (IDP) Camps visits	Medina IDP Camp	Felicity Harvey Munjoo Park Veronique Urbaniak Chima Onuekwe
10.00-11.00	Lassa fever sensitization campaign	Dalaram public primary school	Felicity Harvey Munjoo Park Veronique Urbaniak Chima Onuekwe Isabelle Devaux
09.00-11.00	Internally displaced person (IDP) Camps visits	Muna Garage IDP Camp	Jeremy Konyndyk David Wightwick Jorge Martinez Jorge Castilla
11.30	Emergency Operation Center building site visit	Eye Hospital	Stuart Zimble, Operations Support and Logistics Team Lead Dario Gramuglia, Field Support Logistician
13.00	Meeting with IMS Operations Support and Logistics team (OSL)	WHO office	Stuart Zimble Dario Gramuglia Desalegn Damtew George Olusula Daniel Akhimien Sunny Agbor
15:00	Meeting with Health Sector /Cluster Coordinator	WHO Compound	Jorge Martinez HSC
15.30	Round table with NGOs	WHO compound	PUI- Branko Dubajic Med Coord & Aurelie, Philipps PUI HQ Paris MDM - Ruth James Gen Coord FHI360 - Ibrahim Salihu Health Coordinator and Jimmy T ACF - Justin Maliro Kabuyaya Reg Nutrition & Health Coord IRC - Aisha Liman, Amin Sirat & Abdi Mohammed Jorge Martinez, Health Sector Coordinator
17.00	Interview with Deputy Humanitarian Coordinator	WHO compound	Peter Lundberg
Sunday 5 March – Maiduguri, Abuja			
Time	**Agenda item**	**Venue**	**Participants**
09.30-10.30	Interview with IMS Budget and Finance officer	WHO compound	Alemayehu Woldegiorgis
11.00-12.30	Central Medical Storage warehouse visit	NEMA Office and CMS	Stuart Zimble Stephen, SMoH CMS chief of Pharmacy and Store
	Departure from Maiduguri		
19.00-22.00	Round table with Donors/UN agencies	Al Basha Restaurant, Dinner hosted by WR	Linda Ehrichs, Head of Cooperation, Canadian High Commission in Nigeria Vibeke G Soegaard – Deputy Head of Mission, Embassy of Norway Friedrich Birgelen, First Secretary -

			Refugees, Migration, Humanitarian Assistance, Embassy of Germany Brian Kurbis, Deputy Team leader, USAID Douglas Mercado, Deputy Country Director, World Food Program Nigeria Eugene Kongnyuy, Deputy Representative, UNFPA, Nigeria WHO Wondimagegnehu Alemu (WR Nigeria) Mary Stephen Ziyad Qamar
Monday 6 March – Abuja			
Time	**Agenda item**	**Venue**	**Participants**
09.05	IOAC Departure		Felicity Harvey, Munjoo Park
10.00 -11.00	Donor meeting	WHO Office	DFID, Ruth Lawson, Senior Health Advisor OFDA, Katherine Dillon
14.00- 15.00	Debriefing with Honorable Minister of Health	Ministry of Health	**Ministry of Health**: Minister of Health – Prof Isaac Adewole Minister's Technical Assistant: Dr Bello Senior Technical Adviser Minister of state for Health – Dr Shuaib Belgore Director Special Projects (In-charge of Northeast Emergency) – Dr Ngozi Azodoh Director Planning Research and statistics – Dr Oyemakinde Deputy Director, Epid division FMoH – Mrs. Sanni **WHO/IOAC:** Jeremy Konyndyk Wondimagegnehu Alemu Tenin Gakuru – Health systems cluster lead Mary Stephen – Health Security and Emergency cluster lead
16.00 – 17.00	WR debrief	WHO Office	Jeremy Konyndyk Tenin Gakuru Mary Stephen
23.00	IOAC Departure		Jeremy Konyndyk