

Annex to the Final Report of the Global Health Crises Task Force

Progress on the 27 recommendations of the High-Level Panel on the Global Response to Health Crises (as set out in its report, entitled “Protecting humanity from future health crises” (A/70/723))

National level

Recommendation 1

By 2020, States parties to IHR, with appropriate international cooperation, are in full compliance with the IHR core capacity requirements.

In implementing the IHR core capacity requirements, States parties, under the leadership of Heads of State and Government, should:

1.1 Preparedness and response

- Incorporate planning for health crisis responses into national disaster risk-reduction preparedness and response mechanisms and plans
- Engage all relevant stakeholders to identify response capacities and resources
- Develop pandemic plans and carry out simulation exercises for all relevant responders, including security forces

Areas of progress

Incorporating health crisis response into disaster risk-reduction mechanisms and plans

- Adoption of Bangkok Principles for the implementation of the health aspects of the Sendai Framework for Disaster Risk Reduction 2015-2030 in March 2016 encouraging countries to promote systematic integration of health into national and sub-national disaster risk reduction policies and plans and the inclusion of emergency and disaster risk management programmes in national and sub-national health strategies.
- The Automated System for Customs Data (ASYCUDA) was set up by UNCTAD in 1982 to provide a common computerised platform to handle customs declarations and manifests. OCHA will shortly be rolling out ASYREC, as an additional module to the ASYCUDA platform. During an emergency, ASYREC will allow countries requiring humanitarian relief to identify priority needs, enable customs authorities to expedite the processing of humanitarian relief, to track the types and quantities of relief items, and to manage unsolicited donations.
- The Pandemic Supply Chain Network has been launched by World Food Programme (WFP), the World Health Organization (WHO), the World Bank, Becton Dickinson, Henry Schein, United Parcel Service (UPS) and the World Economic Forum (WEF), with the engagement of core partners including UNICEF, FAO, OCHA, US CDC, USAID, University of Minnesota, NEC, Johnson & Johnson, and GS1. The Network aims to address a critical area of vulnerability in pandemic preparedness – supply chain and logistics to facilitate the timely delivery of supplies to treat patients and protect health workers. Through the Network, public and private sector partners will collaborate in identifying supply sources for critical response items, mapping transport routes, and developing an information platform to give countries and emergency coordinators a real time view of the availability and location of response items.

Engage all relevant stakeholders to identify response capacities and resources

- The Joint External Evaluation framework, which is voluntary but a very valuable tool for IHR, examines whether public health risks and resources are mapped and utilized (Indicator R.1.2), and a system is in place to send and receive medical countermeasures and health personnel during a public health emergency (Indicators R.4.1 and R.4.2). The JEE and the host country participants are drawn from different sectors.

Develop pandemic plans and carry out simulation exercises

- Since 2016, 33 emergency preparedness exercises have been conducted in 18 countries, focusing on a wide range of emergency response functions and including table-top exercises, drills, and functional and field exercises. An after action toolkit is currently under development and was piloted in Burkina Faso following an outbreak of Dengue fever in February 2017.
- The Joint External Evaluation framework examines whether a multi-hazard national public health emergency preparedness and response plan is developed and implemented, including whether such a plan has been implemented or tested through a simulation (Indicator R.1.1). Voluntary simulation exercises are part of the new IHR monitoring and evaluation framework. For 2017, there are presently 17 simulation exercises planned. In February 2017, WHO published a Simulation Exercise Manual to provide guidance on planning, conducting and evaluating simulation exercises

for outbreaks and public health emergency preparedness and response.

- At a global level, pandemic simulation exercises were carried out by the World Bank for health ministers, by the WEF for an audience of CEOs from the private sector and during a G20 Health Ministers meeting. A future simulation involving IASC Principals is scheduled for the latter part of 2017.

Areas for further activities and monitoring

- Countries and organizations conducting simulations should provide for systematic follow-up to gaps identified in simulations.

Recommendation 1

By 2020, States parties to IHR, with appropriate international cooperation, are in full compliance with the IHR core capacity requirements.

In implementing the IHR core capacity requirements, States parties, under the leadership of Heads of State and Government, should:

1.2 Surveillance

- Establish a “One Health” surveillance mechanism to collect and analyse public health information in near-to-real time, combining data from all segments of society
- Ensure immediate notification of all unusual health events to the WHO Regional Director and the WHO Programme for Outbreaks and Emergencies Management (WHO centre for emergency preparedness and response — see recommendation 7)

Areas of progress*Establish a “One Health” surveillance mechanism*

- The Global Early Warning System for Health Threats and Emerging Risks at the Human-Animal Ecosystems Interface (GLEWS) was jointly established by WHO, FAO and OIE in 2006.
- WHO will launch the Epidemic Intelligence from Open Sources (EIOS) in June 2017.
- OIE has conducted Performance of Veterinary Services (PVS) Bridging Workshops to identify synergies and opportunities in intersectoral collaboration on PVS and IHR. IHR-PVS Bridging Workshops have to date been completed in Azerbaijan, Thailand, Costa Rica and Pakistan, and six more are planned

Ensure immediate notification of all unusual health events

- In March 2017, WHO revised the Emergency Response Framework. According to this Framework, the Detection, Verification and Risk Assessment Team in the WHO Health Emergency Information and Risk Assessment Department is responsible for detecting public health events of national or international concern and conducting risk assessments. When a risk assessment is performed for a verified event, the results are communicated to the Regional Emergency Director, the WHO Country Representative and the Directors of Health Emergency Information and Management and Emergency Operations at Headquarters. The Regional Emergency Director is responsible for informing the Executive Director of the Health Emergency Programme and the Regional Director of the outcome of the risk assessment and provide proposals for actions.

Areas for further activities and monitoring

- The Global Early Warning System for Health Threats and Emerging Risks at the Human-Animal Ecosystems Interface (GLEWS) needs to be strengthened. It will be useful for the Epidemic Intelligence from Open Sources (EIOS) platform to integrate data regarding human and animal health.
- The system for collecting information about public health events also needs to draw from community-based surveillance mechanisms.
- Progress on the operation of GLEWS, the development of the EIOS platform and the integration of data from FAO and OIE platforms need to be monitored.

Recommendation 1

By 2020, States parties to IHR, with appropriate international cooperation, are in full compliance with the IHR core capacity requirements.

In implementing the IHR core capacity requirements, States parties, under the leadership of Heads of State and Government, should:

1.3 Laboratory

- Establish at least one national public health laboratory equipped to analyse biological samples or, alternatively, ensure access to shared regional laboratories
- Develop a national system for the rapid and safe transport of samples to appropriate laboratories, including across borders

Areas of progress

National public health laboratory or access to shared regional laboratories

- The Joint External Evaluation framework measures whether a nationwide laboratory system able to reliably conduct at least five of the 10 core tests on appropriately identified and collected outbreak specimens transported safely and securely to accredited laboratories from at least 80 percent of intermediate level/districts in the country. (Indicators D.1.1 and D.1.2)

Areas for further activities and monitoring

- The Joint External Evaluation reports provide a useful source of information regarding the implementation of this recommendation in each country. Where gaps are identified, they need to be addressed in country action plans.

Recommendation 1

By 2020, States parties to IHR, with appropriate international cooperation, are in full compliance with the IHR core capacity requirements.

In implementing the IHR core capacity requirements, States parties, under the leadership of Heads of State and Government, should:

1.4 Human resources

- Define emergency workforce protocols to ensure adequate protection, training, equipment, payment and occupational safety
- Constitute an emergency workforce by training all public and private health workers in emergency protocols

Areas of progress*Define emergency workforce protocols*

- A report by the Secretary-General's High-level Commission on Health Employment and Economic Growth issued in September 2016 concluded that investing in the health workforce is needed to make progress towards the Sustainable Development Goals, including gains in health, decent work, global security and inclusive economic growth.
- A five-year action plan to support country-driven implementation of the Commission's recommendations to expand and transform the health and social workforce in support of the Global Strategy on Human Resources for Health¹ has been developed by WHO, the Organization for Economic Co-operation and Development and the International Labour Organization². Inputs and feedback from Member States, civil society, academia and health workers organizations were contributed through two consultations and multiple Member States consultative sessions³. The action plan was supported by the OECD Health Ministerial in January 2017, adopted at the seventieth World Health Assembly⁴ on 26 May 2017 and will be considered by the 331st Governing Body of the ILO in November 2017. The WHA resolution urges all Member States to act on the Commission's recommendations and immediate actions and requests the WHO Director-General to collaborate with Member States upon request, and with other relevant sectors, agencies and partners, in implementing the five-year action plan. The General Assembly will examine the operationalization of this plan in 2017.
- The action plan was supported by a meeting of the Ministers of Health hosted by the Organisation for Economic Co-operation and Development in January 2017, adopted at the World Health Assembly in 26 May 2017 and will be considered by the Governing Body of the International Labour Organization in November 2017. Momentum for action and investment on the Commission's recommendations will be further amplified at the 4th Global Forum on Human Resources for Health in Dublin, Ireland on 13-17 November 2017⁵.

Promote security of health workers

- In May 2016, the Security Council unanimously adopted resolution 2286, its first resolution ever to address the protection of medical personnel and humanitarian personnel exclusively engaged in medical duties during situations of armed conflict. In August 2016, the Secretary-General provided the Security Council with recommendations to prevent attacks and better ensure accountability and enhance the protection of the medical personnel and facilities (S/2016/722). The implementation of resolution 2286 has been examined by the Security Council in September 2016 and May 2017.
- In August 2016, the Global Outbreak Response and Alert Network conducted a workshop in Guinea on the Ebola response and security. The following recommendations were identified to ensure the integration of security in responses to health emergencies, directed at WHO and GOARN partners:

¹ World Health Organization. Global Strategy on Human Resources for Health: Workforce 2030. 2016.

² <http://who.int/hrh/resources/globstrathrh-2030/en/>

³ http://apps.who.int/gb/ebwaha/pdf_files/WHA70/A70_18-en.pdf

⁴ <http://www.who.int/hrh/com-heeg/action-plan-annexes/en/>

⁵ Resolution XXX

⁵ <http://hrhforum2017.ie/>

- Establish a stronger operational platform integrating security to support field operations
- Consult with international partners when updating WHO's security procedures;
- Security preparations and appropriate pre-deployment training for all staff and functions, targeted briefings on arrival, and end of mission de-briefings;
- Security teams should work with sociologists and anthropologists to better understand interactions, contexts and risks;
- Review the suitability of transport provided (so that it is compliant with Minimum Operating Security Standards (MOSS), with the security team being involved in the recruitment of drivers;
- Develop procedures for implementation of secure accommodation, field offices, and key sites (laboratories, hospitals and health facilities);
- Establish biosafety/biosecurity teams to review laboratory standards and treatment centres managing hazardous material;
- Provide stress management training and advisers for deployed staff and ensure that health insurance covers medical procedures, including medical evacuations;
- Ensure that communication and social mobilization precedes all community intervention; where possible hire local staff;
- Strengthen the role of logisticians in planning and implementing operations and update telecommunication systems to adapt them to the local context; and
- Set up a data management system for personnel tracking, dissemination of critical security information to staff, and establish security information feedback systems at the end of missions that are immediately incorporated into operations.

Constitute an emergency workforce

- In July 2015, WHO launched a system for the classification of Emergency Medical Teams through a process of quality assurance and peer review. As of June 2017, 11 teams have been classified and 70 teams have signed up for the classification process.
- Since early 2016, WHO has worked with OCHA to expand its virtual On-Site Operations Coordination Centre (OSOCC) tool to include a section on Emergency Medical Teams. Disaster managers are now able to see the lists of Emergency Medical Teams on standby for specific disasters.
- In 2016, the Global Outbreak Alert and Response Network (GOARN) Training Working Group commenced development of a strategically designed multi-faceted and multi-layered training programme for GOARN partners with the intention to build a predictable and interoperable multi-disciplinary outbreak response capacity that is well prepared to international standards. In February 2017, GOARN convened the first meeting of GOARN Training Partners, co-hosted by Public Health England, successfully bringing together 35 representatives of leading global public health institutions to explore the training and capacity development needs for international outbreak response, agree on the priority training actions and activities and identify specific areas of partner capacities and interest for the collaborative development of the training programme.
- In 2016, GOARN initiated a review of the flagship Outbreak Response Scenario Training Course, utilising online learning capabilities to reduce the formally 7-day course into a more effective and resource friendly 5 day simulation exercise. This unique training experience invites 24 carefully screened and selected individuals from GOARN partner institutions round the world to work in international multidisciplinary teams and explore the technical, operational and logistical challenges of coordinated response to an outbreak in a simulated training environment. This new version of the Outbreak Response Scenario training has since been conducted twice, with EMRO in Jordan in 2016 and with PAHO in Mexico in early 2017, with another 3 trainings planned for the remainder of 2017 (with WPRO and EURO). In total it is anticipated that over 120 outstanding public health experts, representing 80 public health institutions from over 45 countries will be trained in effective international outbreak response.
- In 2017, the Global Outbreak Alert and Response Network (GOARN) was mandated to organize Public Health Rapid Response Teams.
- A constitutive workshop of GOARN partners on Rapid Response Capacities (RRC) was hosted by the Robert Koch Institute together with WHO/GOARN in Berlin in March 2017. The workshop was

attended by experts from more than 20 GOARN partners who implement Rapid Response Teams (RRT) in their institutions/ countries or who are in the build-up phase of such teams. GOARN partners confirmed the high potential of the GOARN Rapid Response Capacities in combating outbreak events. Areas in which international cooperation will contribute to the improvement of RRCs were identified, including RRC training, operational research and safety and security. Thematic working groups were established under the leadership of GOARN partners to further develop the GOARN RRC initiative.

Areas for further activities and monitoring

- In resolution 71/159, the General Assembly requested a report on the operationalization of the five-year action plan of the High-level Commission on Health Employment and Economic Growth. This report should reflect progress on the integration of emergency management and response capacity in national health workforce and emergency strategies.
- In resolution 2286, the Security Council requested the Secretary-General to provide a briefing every 12 months on the implementation of this resolution.
- Health volunteers, including Red Cross volunteers need to be included within recommendations for both expansion of human resources for health and for protection.
- The use of Emergency Medical Teams should not just ensure adherence to minimum clinical standards but also adherence to humanitarian principles. The role for military medical teams needs to be well defined and limited to use in appropriate contexts only.
- Progress on the development of the Emergency Medical Teams and the GOARN Public Health Rapid Response Teams is critically dependent on adequate investments to support these national and international institutions, networks and capacities, and needs to be monitored.
- The continued collaborative development and implementation of the GOARN Training Programme, as it links to both rapid response capacities and the wider global public health emergency workforce, needs to be supported for timely development, testing and implementation, ensuring there is an effectively and adequately prepared rapid response capacity, now and in the future to meet changing public health emergency needs.

Recommendation 2**Governments increase investment in the training of health professionals and establish community health worker systems that are appropriate to country circumstances.**

- National Governments and partners fully fund the training of community health workers
- Incentive packages are employed to help to ensure that health workers are strategically deployed in poor and remote areas
- Community health workers are recognized and integrated as a labour category with important roles in prevention, surveillance and response

Areas of progress*Training community-based health workers and incentives for strategic deployment*

- The five-year action plan on Health Employment and Economic Growth (2017-21) recognized that professional, technical and vocational education, training and lifelong learning systems need to be strengthened for priority health and social workforce cadres, including community-based health workers. The five-year action plan also includes the development of guidance on practices to ensure an adequate proportion of the workforce in primary health care is appropriately distributed to underserved areas and marginalized groups (e.g., recruitment practices, education methods, professional development opportunities, incentive structures, etc.).

Recognition of community health workers as a labour category

- Community health workers are currently recognized and defined in the International Standard of Classification of Occupations (ISCO-08)⁶. WHO encourages the use of the term “community-based health workers” to reflect the breadth and variation in the types of health workers across countries. WHO is developing guidelines on the design, implementation, performance and evaluation of community-based health worker programmes. The guidelines will be launched by the end of 2017. The evidence from the guidelines process will also inform a future ILO review of the International Standard Classification of Occupations (ISCO), particularly with respect to the definition of community-based health workers.
- The WHO convened the community-based health worker guideline development group in October 2016 and is currently commissioning systematic reviews on health policy and systems support for programmes to optimize their results and impact and seeking expressions of interest to join the guideline External Review Group.⁷

Areas for further activities and monitoring

- The report to the General Assembly on the operationalization of the five-year action plan on Health Employment and Economic Growth should reflect progress made on the training of community-based health workers, training on health emergencies, and on the development of guidance on practices to ensure an adequate proportion of the workforce in primary health care is appropriately distributed to underserved areas and marginalized groups. The report should also provide information on the financing of the five year action plan.

⁶ http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_172572.pdf

⁷ <http://www.who.int/hrh/community/en/>

Recommendation 3**Governments and responders strengthen and streamline their community engagement and promote local ownership and trust.**

- National authorities and partners support the development and use of national social science research capacities, as well as an international network of social scientists capable of mobilizing in a crisis
- Principles of effective community engagement are featured in all training programmes for national and international responders
- National authorities and partners draw on the potential for South-South cooperation in this field
- Communication strategies are developed, with due consideration given to the cultural context.

Areas of progress

- IFRC recently published Guidelines on community-based surveillance, and are piloting in several countries.

Development of social science research capacities and culturally-appropriate communication strategies

- In October 2016, UNICEF and the Institute for Development Studies at the University of Sussex in the United Kingdom established a secretariat for a global partnership to carry out research on effective community engagement and risk communication needs. The partnership will aim to generate knowledge and summarise research on community engagement and building resilience in humanitarian contexts, including public health emergencies. It will also synthesise research on cultural practices and communities to guide response and recovery efforts, and develop a network of social science researchers in the global south who can be deployed during an emergency. The partnership is functioning, with the knowledge, evidence and research platform being updated since October 2016 with existing social, cultural and community dynamic related evidence across a range of humanitarian situations – www.socialscienceinaction.org Since March 2017, the research platform has been engaged in identifying social factors needed to address the cholera outbreak in the Horn of Africa, especially in Ethiopia and Somalia, with plans to expand to South Sudan. The secretariat currently has funding to operate to the end of 2017.

Integration of community engagement practices in training programmes for responders

- The Emergency Medical Teams Initiative and the Public Health Rapid Response Team initiative under GOARN will be developing programmes for training responders in 2017. The Task Force has recommended that best practices regarding effective community engagement be featured in these training programmes. UNICEF is working closely with the WHO Emergency Medical Team (EMT) Initiative to develop a training module aimed at improving culturally and context sensitive communication between first line responders and affected communities. At the April 2017 EMT technical working group training workshop, the content of this module was discussed with experts, with plans to complete the module as part of new EMT training curriculum that WHO and GOARN are developing.
- The GOARN Training Programme has community engagement at its core, with the flagship Outbreak Response Scenario training being recently revised to further ensure prominence of vital community engagement and accountability to affected populations thread throughout the simulation exercise. Furthermore, the GOARN Training Working Group is undertaking development of an eLearning module on community engagement for outbreak response, which will in the future be mandatory for all GOARN deployees responding to an outbreak.

Areas for further activities and monitoring

- Progress on the development of social science research capacities and culturally-appropriate communication strategies and the integration of community engagement practices in training programmes for responders needs to be monitored.

Recommendation 4**Outbreak preparedness and response efforts should take into account and address the gender dimension.**

- Since women tend to act as primary caregivers, specific attention should be given to their needs
- Efforts to address the economic and livelihood impact of pandemics pay particular attention to the situation of women
- Women must be included at all levels of planning and operations to ensure the effectiveness and appropriateness of a response

Areas of progress*Focusing on the situation of women during health crises*

- UN Women, IFRC and UN Office for Disaster Risk Reduction (UNISDR) have jointly developed a Global Programme in Support of a Gender Responsive Sendai Framework Implementation (GIR Programme). The Programme seeks to ensure that (i) the gender dimensions of disaster risk are understood and assessed; (ii) disaster risk management policy and risk governance structures are gender responsive and well-resourced; (iii) women's capacity to prepare for and recover from natural hazards is strengthened through enhancing access to services and livelihoods; and (iv) women's participation, engagement and leadership in disaster risk governance is supported and strengthened.
- The "Guidance for Managing Ethical Issues in Infectious Disease Outbreaks" issued by WHO in October 2016 included a chapter on addressing differences based on sex and gender, noting that these differences have been associated with differences in susceptibility to infection, levels of health care received, and the course and outcome of illness. Information collected by public health surveillance programmes should disaggregate information by sex, gender and pregnancy status to monitor variations in risks, modes of transmission, impact of disease and efficacy of interventions.
- The Emergency Medical Teams initiative has established a maternal and child health working group to develop principles and standards of care for EMTs delivering maternal and child health services. This will complement the work on maternal and child health that is coordinated through the health cluster.
- The Agreed Conclusions of the 61st Commission on the Status of Women adopted in March 2017 recognised that women constitute the majority of those employed in the health and social sectors and that by working in these sectors they make important contributions to sustainable development, and that investments in these sectors could enhance women's economic empowerment and transform unpaid and informal care roles into decent work by improving their working conditions and wages and by creating opportunities for their skills enhancement and career advancement.

Inclusion of women at all levels of planning and operations of a response

- The High-Level Commission on Health Employment and Economic Growth made a recommendation to maximize women's economic participation and foster their empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labour market, and tackling gender concerns in health reform processes. The five-year action plan on Health Employment and Economic Growth includes the development of a global policy guidance and the acceleration of regional and national initiatives to address gender biases and inequalities in education and health labour markets.

Areas for further activities and monitoring

- The report on the operationalization of the five-year action plan on Health Employment and Economic Growth requested by the General Assembly should reflect progress on the development of global, regional and national policies and initiatives to address gender biases and inequalities in education and health labour markets.

Regional and subregional levels

Recommendation 5

Regional and subregional organizations develop or strengthen standing capacities to monitor, prevent and respond to health crises, supported by WHO. This includes:

- Strengthening regional contingency and preparedness plans for health crisis scenarios, as well as prearranging emergency logistical and relevant medical licensing agreements that can be rapidly activated in the event of a health crisis
- Administering and operating shared regional disaster prevention and emergency response capacities, including advanced biosafety laboratories
- Enhancing regional research capacity and collaboration
- Maintaining a roster of medical experts and response staff for rapid regional deployment
- Facilitating the sharing of experiences and lessons learned among regional partners
- Maintaining, with WHO support, a commonly agreed list of pathogens posing a risk of health crises in the region
- Establishing a regional IHR update and support mechanism to strengthen compliance within the region
- Facilitating regional and subregional simulation exercises for health crisis responses, especially in border areas

Areas of progress

Supporting regional emergency response capacities

- WHO has conducted coordination trainings in five different regions to train regional experts to coordinate arriving Emergency Medical Teams and Public Health team.
- The Africa Centres for Disease Control and Prevention (Africa CDC) was formally launched in January 2017. WHO signed a framework for collaboration with the African Union on the Africa CDC to improve health security.
- The WHO EMT Secretariat has contributed to regional trainings and capacity building for regional workforces in collaboration with the European Union, the African Union, ECOWAS and the West African Health Organization, countries in South America, and countries in South East Asia under the ASEAN and East Asian Summit arrangements.
- In June 2016, the World Bank Group approved US\$110 million in International Development Association financing to strengthen disease surveillance systems in Guinea, Sierra Leone and Senegal. This initiative is part of the Regional Disease Surveillance Systems Enhancement (REDISSE) Program, which aims to address systemic weaknesses within the human and animal health sectors that hinder effective disease surveillance and response. The second phase of the REDISSE Program was approved on March 2017 for Liberia, Guinea Bissau, Nigeria, Togo for a total of US\$140 million. The third phase of the project will cover Benin, Niger, Mali and Mauritania (possibly additional countries) and is expected to be approved in February 2018.
- In September 2016, the first meeting of the “Project to Strengthen the ASEAN Regional Capacity in Disaster Health Management” was held. This three-year project, supported by the Japan International Cooperation Agency, is aimed at developing “regional mechanisms to ensure rapid and effective health sector response to disasters through the mobilisation of health resources of ASEAN Member States,” as well as enhancing the capacity of individual ASEAN Member States.

Regional and subregional simulation exercises for health crisis responses

- The WHO Emergency Medical Teams initiative has been working with the International Search and Rescue Advisory Group (INSARAG) Secretariat in OCHA to include the testing of health capacities in regional simulation exercises

Areas for further activities and monitoring

- In addition to the INSARAG simulations, system-wide simulations should be conducted at the regional and subregional-level, with sharing of results, analysis and lessons learned.
- The provision of WHO support in the following areas needs to be monitored: regional preparedness plans, regional prevention and emergency response capacities, regional research and collaboration,

rosters of medical experts and responders for regional deployment, facilitation of lessons learned among regional partners, regional lists of pathogens posing a risk of health crises, regional IHR support mechanisms.

International level

Recommendation 6

WHO strengthens its periodic review of compliance with the IHR core capacity requirements.

- States parties, in consultation with non-State actors, provide the WHO secretariat with an annual written assessment of their state of implementation of the IHR core capacities
- On a rotating basis, each country is subject to a periodic review, with all States parties to IHR reviewed over a four-year period
- For countries under review, WHO arranges an independent field-based assessment of compliance with the IHR core capacity requirements, and, where available, coordinates with other reviews
- Both a country's self-assessment and the WHO-arranged assessment are presented to the World Health Assembly (or a committee created by the Assembly) for discussion
- At the review, a senior representative of the country is invited to comment on both reports. Other members of the World Health Assembly also have an opportunity to comment
- Within three months of the meeting, the WHO secretariat develops a costed action plan for each country on the basis of the discussions, using the WHO costing tool
- On the basis of the review, the WHO secretariat consolidates a public report on the global state of implementation of the IHR core capacities, and outlines an implementation strategy with requirements for international assistance
- Once a State party has achieved full compliance with the IHR core capacity requirements, the periodic review process broadens to a wider assessment of a country's health system, on the basis of guidance to be developed by WHO. This assessment includes revisiting compliance with IHR core capacities

Areas of progress

- The Panel's recommendations call for a new process to monitor compliance with the International Health Regulations, with an emphasis on a number of principles. The process should involve an inclusive self-assessment and an independent field-based assessment. It should be transparent and allow for review by the WHA. It should lead to a costed action plan.
- WHO has established a new IHR Monitoring and Evaluation Framework which conforms to the criteria set out by the Panel in a number of important respects. In addition to the annual self-assessments by State Parties, the new framework includes three voluntary components: joint external evaluation, after-action review and simulation exercises. The Joint External Evaluation Tool, which was developed by WHO, in collaboration with the Global Health Security Agenda and Member States, and finalized in February 2016; a review of the tool was undertaken in April 2017.
- The Joint External Evaluation examines 19 technical areas, including the IHR core capacities, and contains recommendations for priority actions. The priority actions identified are to be used to develop a comprehensive national plan of action for IHR national core capacity strengthening. These costed plans allow countries to identify gaps requiring donor support. The new Strategic Partnership Portal centralizes this information.
- As of March 2017, 32 countries have completed JEEs; of these, WHO has scheduled country planning missions for 25 countries to support the development of national costed action plans for health security.
- After-action reviews (AARs) and simulation exercises provide complementary information to the JEE, related to functional capacity under the IHR Monitoring and Evaluation Framework. They assess whether capacities actually work during a real emergency or a simulated one. Their results contribute both to the identification of gaps and to the strengthening of capacities.
- In September 2016, G7 countries adopted the G7 Ise-Shima Vision for Global Health. In this document, the G7 countries affirmed their commitment to "offer concrete assistance to 76 countries and regions and support to these partners to develop national plans in close coordination with the WHO and other relevant organizations". This document also stated that the G7 countries will "use and leverage [their] commitment to offer support to 76 countries in the implementation of the IHR".

Areas for further activities and monitoring

- The Strategic Partnership Portal could also be developed as a broader knowledge management platform to share simulation reports, analyses and best practices.

- Civil society organizations and animal health experts (including OIE) need to be regularly included in JEE missions. Consideration should be given to conducting Performance of Veterinary Services (PVS) evaluations and JEEs concurrently.
- The Independent Oversight and Advisory Committee will examine the implementation of the IHR and the new IHR monitoring and evaluation framework as part of its on-going work programme.

Recommendation 7**WHO immediately strengthens its leadership and establishes a unified, effective operational capacity.**

- Taking note that WHO established the Programme for Outbreaks and Emergencies Management, but in the light of the need for unified command, the Panel proposes that such a Programme become a centre for emergency preparedness and response, with command and control authority
- The centre is the central command and control mechanism in case of health emergencies. It should be adequately funded and staffed, with clear lines of authority within the organization
- A standing advisory board is established to guide the centre in its activities. The advisory board should incorporate representatives from United Nations bodies, national Governments, NGOs and institutional partners to encourage a multisectoral approach
- During a health crisis, the centre takes full authority for the Health Cluster response and liaises closely with the Government and all actors
- The centre houses a workforce deployment management unit, to include the Global Outbreak Alert and Response Network and foreign medical team programmes, which coordinates the Global Emergency Health Workforce, deploying experts and foreign medical teams, as needed
- The centre establishes a transparent protocol to activate an immediate response to outbreaks and to call on political action where obstacles delay or prevent international action
- The centre also houses an open data platform that will collect, manage and analyse public data on epidemiological events globally. The centre will be responsible for making this data publicly available in real time
- The centre manages the proposed WHO contingency fund and has access to the pandemic emergency financing facility
- The centre collaborates closely with the WHO Health Systems and Innovation Department with regard to research and development in health crises
- The centre, in collaboration with IASC, establishes standard operating procedures for humanitarian actors operating in health crises

Areas of progress

- The Panel's recommendations call for WHO to establish a new operational capacity to manage outbreaks and health emergencies. These recommendations note the need for a centralized line of authority, an advisory body, and a programme that coordinates the Global Emergency Health Workforce, activates response to outbreaks, operates a platform for collecting, managing and analysing data on events, manages the WHO contingency fund, collaborates on research and development relevant to health crises and collaborates with the Inter-Agency Standing Committee.
- Within the new WHO Health Emergencies Programme, the units responsible for (i) emergency operations; and (ii) health emergency information and risk assessment perform the functions specified by the Panel. There are additional units in the new WHO Health Emergencies Programme responsible for (i) external relations (including communications and resource mobilisation), (ii) infectious hazard management, (iii) country health emergency preparedness and IHR, and (iv) management and administration.
- In 2016, WHO established an Independent Oversight and Advisory Committee (IOAC) for a four-year term which has been providing oversight and monitoring of the development and performance of the Programme and to guide the Programme's activities. In its report to the WHO Executive Board and the World Health Assembly, the IOAC noted significant progress in the establishment of the Programme, the field presence of WHO and the coordination efforts. But this progress remains fragile. The IOAC provided reports on progress with recommendations for action to the Executive Board in January 2017, and to the 70th World Health Assembly in May 2017.

Areas for further activities and monitoring

- The IOAC has the mandate to monitor the development and performance of the Health Emergencies Programme. Its reports are to the WHO Executive Board, the World Health Assembly, and are sent to the United Nations Secretary-General and the Inter-Agency Standing Committee.
- The Programme still needs to be consolidated by full implementation of the "No regret Policy" and more flexible and adequate management procedures. It needs also adequate funding.

Recommendation 8

In the event of a Grade 2 or Grade 3 outbreak that is not already classified as a humanitarian emergency, a clear line of command will be activated throughout the United Nations system.

- The Director-General of WHO reports to the United Nations Secretary-General on the response
- The WHO Regional Director reports directly to the Executive Director of the WHO centre to ensure the coherence of the whole system
- The Executive Director of the centre will be the Secretary-General's Emergency Coordinator, who will be tasked with leading an inter-agency response, if needed
- Given that WHO is the designated lead operational agency in a health crisis response, the Secretary-General should ensure that the IASC cluster system is fully operational in supporting the Emergency Coordinator in leading an inter-agency response, if needed
- The IASC remit, including the cluster system, is reviewed to enhance robustness, timeliness, coordination and the capacity to address health crises

Areas of progress

- In December 2016, the IASC circulated the “Level 3 Activation Procedures for Infectious Disease Events”, endorsed by IASC Principals. These procedures provide for the deployment of surge capacity and activation of appropriate field level leadership arrangements during infectious disease events. The procedures establish a link between the responsibilities of the WHO and its Director-General under the International Health Regulations and the capacities and emergency response tools of the IASC. They provide an opportunity for non-IASC actors to feed into decision-making on activation and on the response strategy.
- Upon activation of the IASC during an infectious disease event, the appropriate leadership model will be determined. The L3 Activation Procedures envisage that the WHO Representative may be appointed as a Deputy Humanitarian Coordinator or that a WHO Incident Manager may be appointed to assist a Senior Emergency Humanitarian Coordinator.

Areas for further activities and monitoring

- The activation procedures for infectious disease events are due to be tested in a simulation exercise in the latter half of 2017. While this simulation will involve IASC Principals and Emergency Directors, there also needs to be system-wide simulations at the technical-level, in order to identify gaps and address key operational issues.
- In the future development of standard operating procedures for the implementation of the IASC procedures, it will be necessary to clarify the role of clusters when an L3 is not activated (to mobilize early preventive action across sectors), coordination mechanisms for risk communication and community engagement , regional-level coordination mechanisms for multi-country outbreaks, and the provision of cluster support for national structures under the Emergency Operations Center (EOC). Engagement and coordination with the private sector is increasingly important. It would be important to consider these questions and develop models that are adaptable to the local context, clarify roles and functions, and test them in system-wide simulations.

Recommendation 9**The Secretary-General initiates the integration of health and humanitarian crisis trigger systems.**

- With immediate effect, every health crisis classified as Grade 2 or Grade 3, according to the WHO Emergency Response Framework, automatically triggers an inter-agency multisectoral assessment

Areas of progress

- In December 2016, the IASC circulated the “Level 3 Activation Procedures for Infectious Disease Events”, endorsed by IASC Principals. The new Emergency Response Framework states that “For Grade 2 and Grade 3 emergencies that are caused by an infectious hazard, the Director-General will inform the United Nations Secretary-General within 24 hours, with copy to the United Nations Emergency Relief Coordinator (ERC) and the IASC Principals.” In providing this information, WHO also advises on whether an activation of the IASC is required.

Areas for further activities and monitoring

- Progress on the management of outbreaks classified as Grade 2 or 3 and how they have been handled by WHO and IASC needs to be monitored.

Development and health

Recommendation 10

The international community must fulfil the commitments towards the Sustainable Development Goals, with a particular emphasis on health-sector goals.

- The Statistical Commission, in its deliberations on the indicators for the Sustainable Development Goals, should give consideration to measuring compliance with the IHR core capacity requirements and the strengthening of overall health systems as indicators towards the attainment of the health goals of the Sustainable Development Goals

Areas of progress

- The Statistical Commission has agreed that for means of implementation 3.d (“Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks”), the relevant indicator is 3.d.1 (“International Health Regulations (IHR) capacity and health emergency preparedness”).

Areas for further activities and monitoring

- The High-level Political Forum, United Nations is the central platform for follow-up and review of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals. During the High-Level Political Forum session in July 2017, Goal 3 (ensure healthy lives and promote well-being for all at all ages) will be reviewed in depth.

Recommendation 11

Partners sustain their official development assistance to health and direct a greater percentage to strengthening health systems under an agreed-upon government-led plan.

- ODA is strategically directed to an incremental, on-budget, five-year plan of strengthening health systems
- Benchmarks for transparency and good governance in financial management are clear and consistent
- NGOs operate with the same level of transparency and good governance as is expected of national Governments

Areas of progress

- In 2007, the International Health Partnership (“IHP+”) was established to promote more effective development cooperation in health. Partners in IHP+ sign a Global Compact to share a common view to support comprehensive, country-led national health strategies and to affirm their commitment to the principles of the 2005 Paris Declaration on Aid Effectiveness and the 2011 Busan Partnership Agreement.
- In 2016, consultations were initiated to expand the scope of IHP+ to focus on health system strengthening towards achieving universal health coverage by 2030. The expansion would also enable IHP+ to become a multi-stakeholder platform to support equitable and sustainable progress towards universal health coverage and global health security. The transformation process was launched in June 2016 and the roll-out of the new International Health Partnership for UHC2030 was announced by the WHO Director-General in September 2016. There are continuing consultations to develop a mechanism for the engagement of civil society organizations in the Partnership. In December 2016, the Steering Committee of the Partnership will meet to approve an updated Global Compact, adjustments in governance structures and working arrangements, and a new work plan for 2017.
- In March 2017, a UHC2030 working group on Sustainability, Transition from Aid and Health Systems Strengthening held its first face-to-face meeting. The working group will focus on developing guidance and principles for good practice.

Areas for further activities and monitoring

- Progress on the activities of the IHP for UHC 2030 including the emergency preparedness and response components needs to be monitored.

Recommendation 12

WHO works closely with development actors to ensure that development programming supports health systems and thereby helps to improve universal and equitable access to quality health.

Areas of progress

- The WHO Regional Office for Europe leads a regional coalition on health established by the Regional UN Development Group Team for Europe and Central Asia. The coalition has identified priorities to strengthen support from UN system entities to countries in implementing health-related targets.
- WHO and UNDP co-lead the IASC Task Team on Strengthening the Humanitarian-Development Nexus. The purpose of the Task Team is to support the implementation of a “New Way of Working” that promotes greater interoperability among humanitarian, development, and peacebuilding activities, plans, and programmes. For the “New Way of Working” to be successful, agencies must address the root causes of conflicts and crises, which often stem from violations and neglect of human rights, including inequality, persistent discrimination, impunity and violence. In the early phases of implementation, the Task Team will focus on four priority areas: (i) predictable and joint situation and problem analysis; (ii) better joined-up planning and programming; (iii) leadership and coordination; (iv) financing modalities that can support collective outcomes.
- In August 2016, the World Bank and WHO, together with the government of Japan, Japan International Cooperation Agency, the Global Fund, and the African Development Bank launched an initiative on “Universal Health Coverage in Africa: A framework for action”. To help countries implement their health reforms, the World Bank and the Global Fund to Fight AIDS, TB and Malaria (Global Fund) committed to invest \$24 billion in Africa over the next three to five years.

Areas for further activities and monitoring

- Progress made with the initiative on “Universal Health Coverage in Africa: A framework for action”, the work of the IASC Task Team and the support provided by WHO to the UN Development Group needs to be monitored.

Research and development

Recommendation 13

WHO coordinates the prioritization of global research and development efforts for neglected diseases that pose the greatest threat of turning into health crises.

- The WHO secretariat, informed by advisory groups on immunization and research, creates and maintains a priority list of the communicable diseases most likely to cause a health crisis, and which, therefore, require priority attention in the development of vaccines, therapeutics and rapid diagnostics. Prioritization should be based on clearly defined criteria
- WHO helps to identify technological platforms that have the capacity to accelerate the production of vaccines and therapeutics to address disease outbreaks from novel pathogens or strains

Areas of progress

- In December 2015, a group of experts convened by WHO identified five priority diseases needing urgent R&D attention. Additionally, it identified three serious diseases requiring action by WHO to promote R&D as soon as possible. The list will be reviewed annually or when new diseases emerge. On 26 January 2017, WHO published a revised list of priority diseases that need urgent R&D in order to prevent public health emergencies. The list includes 9 disease categories for which few or no medical countermeasures exist due to market failures or lack of scientific knowledge.
- The group of experts convened by WHO also identified nine prioritization elements, the weight to be given to prioritization elements and the factors to consider when prioritizing diseases. In November 2016, WHO convened an informal consultation to review a methodology for prioritizing diseases requiring accelerated research and development. It agreed upon two separate prioritization process: (1) an annual prioritization exercise to review and revise a list of prioritized diseases and pathogens; and (2) a separate process for dealing with a new disease or pathogen, or one that is presenting in a new manner and likely to cause a public health emergency. The methodology underlying these processes was validated through a silence procedure in January 2017. It is anticipated that it will be reviewed again before the end of 2019.
- In October 2015, WHO launched a public consultation to invite proposals for platform technologies that can develop health products to address more than three priority pathogens. The scope of health products considered included vaccines, therapeutics, diagnostics and enabling technologies. Of the 35 proposals received, ultimately, six proposals determined to be the most meritorious. The proponents of these six proposals were invited to give technical presentations to interested Member States and potential funders in July 2016. Subsequently, participants in the platform technologies public consultation responded to a questionnaire to assess the process. In their responses, the participants indicated that the process “generated a new focus on preparedness and renewed the urgency to respond to public health emergencies, while providing an opportunity to increase awareness about the R&D Blueprint.”

Areas for further activities and monitoring

- While the development of a list of priority diseases may help stimulate important areas of research, such a list should not have the effect of restricting research on pathogens that may not yet be recognized as potential disease outbreaks. The broad development and support of translatable platform technologies for diagnostics, vaccines, and therapeutics continues to be important.

Recommendation 14**Urgent measures are taken to ensure universal access to and affordability of medicines, vaccines and other life-saving products.**

- Given the gap between the need to recover investments and finance research, and the need for affordable medicines, additional public funds are made available to support universal access to and affordability of medicines, vaccines and other life-saving products
- Strengthen efforts to ensure access to and affordability of medical products through the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund and other initiatives such as UNITAID
- Increase the use of generic products so as to make medicines more affordable
- Countries and partners provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health. In this context, the full flexibilities of the TRIPS Agreement should consistently be used

Areas of progress

- The Coalition for Epidemic Preparedness Innovations (CEPI) was launched at Davos in January 2017. Focusing primarily on vaccines for which there is no commercial market, CEPI aims to advance the development of vaccines to the stage where it is ready for full trials or emergence use when needed. It will also manufacture and stockpile these vaccines, provide a global hub to coordinate vaccine development and partner with organizations that can help reach target populations. CEPI will initially focus on developing promising vaccine candidates against the MERS-CoV, Lassa and Nipah viruses. CEPI will also explore support for vaccines against multiple strains of the Ebola and Marburg viruses. CEPI has received initial commitments of \$460 million from the Governments of Germany, Japan, and Norway, leadership and commitment from the Government of India, a co-funding commitment from the European Commission and further support and financial commitments from the Bill & Melinda Gates Foundation and the Wellcome Trust. CEPI's first investments will focus on development of vaccines against Lassa fever, the Nipah virus and Middle East Respiratory Syndrome (MERS); and improving the latest DNA and RNA vaccine technology.

Areas for further activities and monitoring

- Progress on the operation of CEPI, and the development of systems and means of monitoring access of populations beyond government reach needs to be monitored.
- Given the scope of the CEPI initiative, additional efforts are needed to ensure that access and affordability of medicines, vaccines and other life-saving products are effectively achieved.

Recommendation 15

WHO convenes its member States to renegotiate the Pandemic Influenza Preparedness Framework with a view to including other novel pathogens, making it legally binding, and achieving an appropriate balance between obligations and benefits, in accordance with the principles of the 2010 Nagoya Protocol to the Convention on Biological Diversity.

Areas of progress

- A PIP Framework Review Group was established in December 2015 to conduct the first review of the PIP Framework after it had been implemented for 5 years. It issued its report to the Executive Board in December 2016 (EB140/16). In its report, the Review Group noted that it had considered the Panel’s recommendation that the PIP framework be expanded to include other novel pathogens. However, it rejected this recommendation, concluding that:

“...while the PIP Framework could serve as an effective model, an expansion of the PIP Framework itself to include other pathogens would be very challenging. A more pragmatic approach is reflected in the 2016 report of the IHR (2005) Review Committee, which recommended that WHO and States Parties should ‘consider using the PIP Framework or similar existing agreements as a template for creating new agreements or other infectious agents that have caused, or may potentially cause, [public health emergencies of international concern] PHEICs. These agreements should be based on the principle of balancing the sharing of samples and data with benefit-sharing on an equal footing’.

“Balancing the interests of different stakeholders to ensure equity in public health is complex. That the PIP Framework was the first global agreement of its kind has much to do with the uniqueness of the influenza virus itself – it mutates frequently and, because of the need for updated seasonal influenza vaccines, has a continuous product cycle, which therefore results in a consistent income stream for manufacturers, as well as a high quality production line that allows manufacturers to be ready to switch from seasonal to pandemic vaccine production. There is also a strong, established network of laboratories in GISRS, monitoring influenza, which provided the foundation for the PIP Framework.

“However, for most new and emerging pathogens, there is no established laboratory network that regularly shares samples and expertise with an associated established vaccine (or other product) production capacity. Thus, while the sharing of viruses and benefits on an equal footing could be applied to other pathogens, using the PIP Framework as a template is likely to present significant implementational and operational challenges.

- The Review Group recommended that the “PIP Framework is a foundational model of reciprocity for global public health that could be applied to other pathogens; however, the current scope of the PIP Framework should remain focused on pandemic influenza at this time.” It also recommended that “Member States should agree the timing of the next review of the PIP Framework, which should be before the end of 2021”.
- In May 2017, the World Health Assembly endorsed the recommendations of the Review Group.

Areas for further activities and monitoring

- Since the PIP Framework will not be extended to other pandemics, WHO and partners should consider using the PIP Framework as a model for other pandemic and pandemic prone diseases.

Recommendation 16**WHO leads efforts to assist developing countries in building research and manufacturing capacities for vaccines, therapeutics and diagnostics, including through South-South cooperation.**

- WHO and its partners accelerate technical and financial support to initiatives such as the Developing Countries Vaccine Manufacturers Network
- Efforts are made to leverage available South-South expertise
- Critical research programmes in the biological and social sciences, veterinary services, engineering and related fields are developed and supported

Areas of progress

- WHO has scaled up its efforts to strengthen regulatory capacity in developing countries, as a fundamental requirement for local production of vaccines, therapeutics and diagnostics.

Areas for further activities and monitoring

- Progress on efforts to strengthen regulatory capacity in developing countries needs to be monitored.

Financing

Recommendation 17

The Director-General of WHO leads urgent efforts, in partnership with the World Bank, regional development banks, other international organizations, partners, foundations and the private sector, to mobilize financial and technical support to build the IHR core capacities.

Areas of progress

- As of July 1, 2017, the 18th cycle of the World Bank’s fund for the poorest countries – the International Development Association (IDA), or IDA 18, will begin. An explicit provision in IDA 18 is to support the capacity of governments to prepare for and respond to pandemics. In this connection, IDA will support a minimum of 25 countries in developing and implementing pandemic plans and frameworks for governance, institutional arrangements, and financing for multi-sectoral pandemic preparedness, response and recovery. IDA 18 also avails a new instrument, the Catastrophe Deferred Drawdown Option, or “CATDDO” that allows countries to access contingency financing for emergencies, including health crises.
- In November 2016, the International Working Group on Financing Preparedness and Response (IWG) was established under the chairmanship of Peter Sands (Harvard Kennedy School), with the World Bank serving as its Secretariat. In its report⁸ launched at the World Health Assembly in May 2017, the IWG observed that despite several recent deadly outbreaks, an overwhelming majority of countries are unprepared for the next devastating epidemic. Noting the low priority given to investing in strengthening preparedness and building resilience in most low income countries, the IWG issued 12 bold but practical recommendations directed at incentivizing and channelling investments to strengthening public health capacities and capabilities. Using JEEs to better understand current gaps in country capacities, the IWG directs countries to practical costing and financing tools designed to help governments quantify resource needs and identify ways of raising the needed resources. Emphasizing the importance of domestic resource mobilization for strengthening preparedness, the IWG exhorts countries to strengthen tax collection and allocate more resources to investments in strengthening country health and disaster management systems, and calls upon development partners to leverage external assistance to increase domestic financing for preparedness. The IWG recognizes the potential of the private sector to be a strategic partner in the country’s preparedness efforts, and underscores the importance of enabling regulations to strengthen public-private collaboration. Finally, the IWG identifies several incentives, including development of country preparedness indexes, which could play a critical role in placing pandemic risks at the same level as financial risks and terrorism threats.

Areas for further activities and monitoring

- Progress on the IDA support for multi-sectoral health emergency preparedness, response and recovery, other resource mobilization initiatives to be undertaken by WHO and the implementation of the IWG’s recommendations need to be monitored.
- It is important to ensure that donors and countries meet their commitment and promises to support IHR core capacity strengthening.

⁸ <http://documents.worldbank.org/curated/en/979591495652724770/From-panic-and-neglect-to-investing-in-health-security-financing-pandemic-preparedness-at-a-national-level>

Recommendation 18

The WHO member States increase their assessed contributions to the WHO budget by at least 10 per cent.

Areas of progress

- The Draft Proposed Programme Budget for 2018-2019 submitted to the Executive Board in January 2017 contained an increase of US\$ 99 million. The proposed increase is mainly in the budgets for the WHO Health Emergencies Programme (US\$ 69.1 million) and for combating antimicrobial resistance (US\$ 23.3 million). Citing the recommendation of the Panel, the WHO Director-General proposed a US\$ 93 million increase in assessed contributions. The amount of assessed contributions has remained at US\$ 929 million since the approval of the 2008-2009 budget in May 2007.
- In the revised programme budget submitted to the World Health Assembly, the WHO Director-General reduced the increase in assessed contribution, asking for only a 3 per cent increase in assessed contributions. In the report of the budget, WHO explained that the reduction in the amount of assessed contributions requested has been offset by planned cost savings in the area of the budget that relates to “Corporate services/enabling functions”.
- During the World Health Assembly in May 2017, the 3% increase in assessed contributions for the 2018-2019 budget was approved.

Areas for further activities and monitoring

- The adequacy of financing for WHO budget and in particular funding for the Health Emergency Programme including the Contingency Fund need to be monitored.
- The Independent Oversight and Advisory Committee will assess the appropriateness and adequacy of the financing and resourcing for the WHO Health Emergencies Programme.

Recommendation 19

Ten per cent of all voluntary contributions to WHO — beyond programme support costs — are mandatorily directed to support the centre for emergency preparedness and response.

Areas of progress

- As noted in the report of the Programme, Budget and Administration Committee to the Executive Board in January 2017, the earmarking of voluntary contributions is not considered by the WHO Secretariat to be desirable as it unduly constrains flexibility in the use of funding.

Areas for further activities and monitoring

- The Independent Oversight and Advisory Committee will assess the appropriateness and adequacy of the financing and resourcing for the WHO Health Emergencies Programme.

Recommendation 20

Member states finance the WHO Contingency Fund for Emergencies with at least \$300 million by the end of 2016.

- The Contingency Fund is available for use by Health Cluster members, under the coordination of WHO
- To ensure predictable financing, the Contingency Fund is fully funded by member States according to the scale of their current assessment. It is fully financed by the end of 2016 and immediately replenished when depleted

Areas of progress

- Contributions to the Contingency Fund for Emergencies as of 30 April 2017 total US\$ 37.65 million, with US\$ 4 million in pledges.
- As the Contingency Fund continues to face a 67% funding gap, the increase of the Fund to \$300 million proposed by the Panel appears to be impracticable and unachievable.

Areas for further activities and monitoring

- The performance of the Contingency Fund and the outcome of advocacy efforts for the Contingency Fund need to be monitored.
- The Independent Oversight and Advisory Committee will assess the appropriateness and adequacy of the financing and resourcing for the WHO Health Emergencies Programme.

Recommendation 21**The World Bank rapidly operationalizes the pandemic emergency financing facility.**

- The annual premiums for the pandemic emergency financing facility for least developed countries are covered by additional resources from partners
- Payouts to the facility are prioritized by the national authorities of the affected country, in accordance with national response plans, with appropriate organizations providing technical support

Areas of progress

- In May 2016, at the G7 Meetings in Ise-Shima, the World Bank announced the creation of a new financing mechanism, the Pandemic Emergency Financing Facility (PEF), which will provide surge financing to IDA countries affected by a major outbreak that has the potential of becoming a pandemic. One component of the PEF involves private sector contingency financing – “an insurance window” - to respond to known pathogens with pandemic potential including orthomyxoviruses, filoviruses, coronaviruses and other zoonotic diseases (Crimean Congo, Rift Valley, Lassa fever). The PEF also includes contingency financing through a cash window to respond to other known and unknown diseases that may have the potential to take on pandemic proportions. The PEF will be able to disburse surge financing during an outbreak both to affected countries as well as to accredited international responders such as WHO, UNICEF, and WFP, among others. The PEF is governed by a Steering Body that includes its financial contributors (Germany and Japan), the World Bank Group as trustee, WHO and stakeholder countries. Following the first meeting of the Steering Body in late June 2017, the PEF will open its insurance window in July 2017 and its cash window in January 2018.

Areas for further activities and monitoring

- The performance of the Pandemic Emergency Financing Facility, including the degree to which communities beyond government reach and those supporting them can access this funding in an emergency, needs to be monitored.
- Synergy and complementarity among different financing resources for health emergencies must be ensured.

Recommendation 22

WHO oversees the establishment and management of an international fund of at least \$1 billion per annum to support the research and development of vaccines, therapeutics and rapid diagnostics for neglected communicable diseases.

- This fund is targeted at building protection against future health crises and should supplement existing mechanisms that are supporting research and development efforts to identify vaccines, therapeutics and diagnostics for existing endemic communicable diseases such as malaria, tuberculosis and HIV/AIDS
- The fund is used to incentivize research and development efforts on the vaccines, therapeutics and rapid diagnostics that are on the priority list of pathogens identified by advisory committees to the World Health Assembly
- Depending on each pathogen, targeted methods are used to incentivize research and development, so as to achieve rapid results with the least cost

Areas of progress

- The Task Force surveyed the initiatives and entities currently involved in the financing of research and development of vaccines, therapeutics and rapid diagnostics, including the Global Research Collaboration for Infectious Disease Preparedness, the Global Health Innovative Technology Fund, the Global Health Investment Fund, Innovative Medicines Initiative, the European & Developing Countries Clinical Trials Partnership, UNITAID, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Coalition for Epidemic Preparedness Innovations, Gavi (the Vaccine Alliance), and the International Vaccine Institute. These entities are in a better position to manage these funds than WHO.
- WHO has successfully convened research organizations to promote collaboration, synergy, and sharing of information.

Areas for further activities and monitoring

- WHO should continue to convene research organizations to promote collaboration, synergy and sharing of information, rather than to recreate its own research capabilities. WHO can also play a useful role in promoting coordination between R&D funds to avoid gap and duplication.

Recommendation 23

The IHR Review Committee considers developing mechanisms to rapidly address unilateral action by States and others that are in contravention of temporary recommendations issued by WHO as part of a public health emergency of international concern (PHEIC) announcement.

Areas of progress

- In its May 2016 report to the World Health Assembly, the IHR Review Committee declined to develop mechanisms to address unilateral actions that are inconsistent with WHO temporary recommendations. The IHR Review Committee noted that “[a]lthough States Parties are not precluded from implementing measures that are not recommended by WHO, they must meet a number of requirements specified in the IHR”. Accordingly, it recommended that “WHO should increase transparency about Additional Measures adopted by States Parties, and publicity about Temporary Recommendations, and develop partnerships with international travel and trade organizations, and engage with other relevant private stakeholders”.
- The IHR Review Committee further recommended that the WHO Secretariat should strengthen its practice of actively monitoring response measures, and the impact of such measures on other Member States. The WHO Secretariat should post a summary of unjustified response measures on the WHO website and bring this to the attention of the WHO Executive Board and the World Health Assembly, if States imposing the measures fail to provide justification or rationales or fail to reconsider them on a timely basis.
- As part of the draft global implementation plan for the IHR Review Committee recommendations, the WHO Secretariat has proposed to reinforce the current process for monitoring additional health measures during public health risks and emergencies. The reinforced procedures may include posting the public health measures adopted by States Parties and the rationale provided by Member States on a WHO website, and reporting on these health measures as part of the regular reporting on the implementation of the International Health Regulations.
- In its resolution WHA70(11), the World Health Assembly requested the Director-General to develop a draft five-year global strategic action plan to be submitted for consideration and adopted by the World Health Assembly in May 2018, through the Executive Board at its 142nd session in January 2018.

Areas for further activities and monitoring

- Health measures adopted by Member States that depart from WHO temporary recommendations and their impact on other Member States and the success of WHO’s actions need to be monitored.
- Stronger incentives for better compliance with IHR and avoiding unilateral actions by states and others must be identified and implemented by WHO and the UN system.

Recommendation 24

WTO and WHO convene an informal joint commission of experts to study possible measures to strengthen coherence between IHR and the WTO legal frameworks regarding trade restrictions imposed for public health reasons.

Areas of progress

- In the WTO, members recently agreed on a new tool for resolving differences under “sanitary and phytosanitary measures”. The new system of mediation (usually by the SPS Committee’s chairperson) is voluntary and not legally binding but bridges a gap between raising concerns in committee and full-scale dispute settlement.

Areas for further activities and monitoring

- Progress on the development and effective use of this tool and its applicability to disputes relating to the International Health Regulations needs to be monitored.

Recommendation 25

Countries and partners comply with the Paris Declaration on Aid Effectiveness, the Accra Agenda for Action and the Busan Partnership agreement, particularly with regard to the alignment of support, the harmonization of efforts and mutual accountability.

- All international actors systematically inform Governments of their aid contributions to countries and coordinate their programmes with relevant line ministries
- In an emergency response situation, the Emergency Coordinator is responsible for supporting the Government in ensuring that international assistance is effectively coordinated

Areas of progress

- This recommendation pertains to the overall development assistance framework and effectiveness. It has its own monitoring mechanisms.

Areas for further activities and monitoring

- The implementation of Paris, Accra and Busan principles with regard to health emergencies and health security needs to be monitored.

Follow-up and implementation

Recommendation 26

The United Nations General Assembly immediately creates a high-level council on global public health crises to ensure that the world is prepared and able to respond to public health crises.

- The high-level council monitors political and non-health issues related to prevention and preparedness imperatives for a potential epidemic of global proportions that could have unprecedented implications on economies, movement of people and stability, as well as recovery. It will reaffirm guidance during times of health crises and will intervene in affected fields outside the health field
- The high-level council monitors and reports regularly to the General Assembly on the implementation of the adopted recommendations of the High-level Panel on the Global Response to Health Crises at the country, regional and international levels
- The high-level council ensures that the adopted recommendations of the High-level Panel are implemented in a timely manner
- The high-level council is composed of political representatives of between 45 to 50 Member States, elected by the General Assembly
- The high-level council supports the substantive preparations for a summit on global public health crises

Areas of progress

- In his report on the Panel's recommendations, the Secretary-General raised concerns about this recommendation, noting that:

“I do not support the recommendation to establish a high-level council on global public health crises. In my view, the functions proposed for the council could be covered through more frequent exchanges between the General Assembly and the Economic and Social Council on the one hand and the annual World Health Assembly on the other. In addition, the establishment of such a council might have significant resource implications.”
- In its May 2016 report to the World Health Assembly, the IHR Review Committee considered that this recommendation risks “confusing or undermining the authority of WHO” and indicated that it did “not support the constitution of such a Council”.
- In the past year, the General Assembly has continued to remain engaged on health issues. Preparedness for global health crises has continued to be a focus of discussions in other multilateral settings, for example the African Union, the G7 and the G20. In 2016, the General Assembly held two high-level meetings on HIV/AIDS (July) and anti-microbial resistance (September) and the President of the General Assembly has held briefings on the global health in June and November 2016 and May 2017.
- An annual resolution on global health and foreign policy has been adopted by the General Assembly since 2008. In its resolution 70/183, the General Assembly requested that WHO provide reports “on the state of health security in 2016 and 2017, taking into account deliberation by the World Health Assembly on the matter, and acknowledging that the ongoing necessity of such reports beyond 2017 can be re-evaluated”. A continuation of these reports beyond 2017, accompanied by an annual briefing by WHO to the General Assembly on the state of health security, would provide a process for continued engagement in and oversight over global health issues by the Secretary-General and Member States of the General Assembly, while respecting the appropriate lead role of WHO and the World Health Assembly.

Areas for further activities and monitoring

- The General Assembly has not taken action to establish a high-level council on global public health. The General Assembly may consider the need for ongoing reports on the state of health security beyond 2017, following the submission of the 2017 report.

Recommendation 27

A summit on global public health crises is convened in 2018 to focus on preparedness and response to health crises.

Areas of progress/new development

- For 2018, there are currently two high-level General Assembly meetings scheduled, one on non-communicable diseases and another on tuberculosis. Additionally, the Secretary-General is to report on the implementation of the Political Declaration on Anti-Microbial Resistance in 2018.

Areas for further activities and monitoring

- The General Assembly has not requested a convening of a summit on global public health crises for 2018.