**IOAC Monitoring Framework for WHO/WHE**

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| **Area** | **Subject of monitoring and assessment** | **Current status** |
| **I. Key elements of the WHE Programme*****(Legacy from the previous IOAC)*** | **Management and administrative process*** WHO leadership in global health
* Delegation of authority, accountability, reporting lines and decision-making processes among Headquarters, Regional Offices and Country Offices

Standardization across the regions of WHO Representatives’ financial authority to accept funds | **WHO leadership in global health:** The thirteenth General Programme of Work (2019-2023) was adopted by Member States at the 71st World Health Assembly in May 2018. The GPW sets out three ambitious strategic priorities that will allow us to achieve the health-related SDGs. These are:1. Achieving universal health coverage – 1 billion more people benefitting from universal health coverage2. Addressing health emergencies – 1 billion more people better protected from health emergencies3. Promoting healthier populations – 1 billion more people enjoying better health and well-beingThe Emergencies Programme has three outcome measures that contribute to delivery of Strategic Priority 2. These are:2.1 COUNTRIES PREPARED FOR HEALTH EMERGENCIES2.2 EPIDEMICS & PANDEMICS PREVENTED2.3 HEALTH EMERGENCIES RAPIDLY DETECTED & RESPONDED TOWithin each of these are a number of output measures that will allow the programme to track whether progress is being made.WHO’s capacity to rapidly deploy surge personnel to respond to the DRC Ebola Outbreak in May has significantly improved confidence from partners and donors in WHO’s leadership in health emergencies. Several new initiatives such as the WHE learning and capacity development initiative/unit, and the DG’s, global health emergency corps improved data analytics for preparedness, and the Global Preparedness Monitoring Board are expected to further enhance WHO leadership in global health emergencies. The WHE leadership team made up of the EXD/WHE, two ADGs, the regional emergency directors and WHE HQ directors continually strengthens and demonstrates its effectiveness in building One Programme and ensure coherent work as a 3-level team.**Delegation of authority, accountability, reporting lines and decision-makingprocesses among Headquarters, Regional Offices and Country Offices:** The SOPs for the Delegation of Authority (DOA) for emergencies were published in 2017. Further guidance on DOA implementation in GSM was released in 2018 in coordination with a corporate initiative to harmonize approval levels across Major Offices. Decision-making processes continue to improve with IMS structure consistently established for graded emergencies. Following the WHO transformation, new delegation of authorities for Regional Directors, EXD/WHE, ADGs, WHO Representatives, Directors and Unit Heads have been developed of the WHO transformation, revised delegation of authorities are being developed for the 3 levels. This include a higher level of delegation below the RDs and the the ADGs to facilitate operations. New organigrams at WHO HQ and the regions have been issued to also reduce the number of reporting lines . |
| **Internal and external communication*** WHE external communication mechanisms and processes including communication with Member States (grading, risk communication)
* Effectiveness of communication within the WHE programme across the three levels

Consistency and coherence of corporate communications in relation to WHO’s Department of Communications and other programmes within WHO | **External communication mechanisms and processes:** Following the centralization of the communications function, there continues to be in the dept of communications (DCO) a fully dedicated emergencies team which works closely with WHE technical teams and other communicators at all three levels of the organization Since January 2020 the team has been augmented by surge staff (as have other teams in DCO) to communicate on the COVID-19 pandemic while still covering major G3 emergencies such as the Ebola outbreaking the DRC, Syria) and Yemen For priority countries facing a G3 emergency, a communications strategy is developed by country and regional office communicators with support from the emergencies team. Country communications officers are the main points of contact with MoH counterparts, either urging the ministry to communicate on a developing health issue (e.g. cholera in Zimbabwe), or jointly producing communication materials (e.g. DRC Ebola outbreak).WHO communicates on emergencies through the WHO country and regional web pages, social media accounts, and by reaching out to media directly. WHO also l amplifies Member State products, especially on joint actions (e.g. Uganda Ebola preparedness).The principles of risk communication are integrated into all communication, and emergency communications media colleagues will reach out to Member States to urge them to follow these principles, such as to flag when their health messages that could be misinterpreted, or to urge transparency when a Member State is hesitant to announce an outbreak. In country, health promotion officers work with ministries to develop mechanisms and materials for communicating with communities affected by emergencies. WHO regularly conducts communications training, including the Emergency Communications Network training that includes WHO staff at all three levels of the organization, and ministry communicators. For example, the training in April 2018 included the communications focal point from MoH DRC who became the lead communicator during the Ebola outbreak. **Communications within WHE across the three levels:** Communications across the three levels has been steadily improving. WHE Directors have biennial face to face meetings to review key strategic, programmatic and managerial issues of relevance for the Global Programme. Key themes have included delivering on GPW 13, monitoring and measuring impact, inspirational and accountable leadership and health systems in fragile, conflict and vulnerable settings.In addition, there are monthly teleconferences across the three levels with all the emergency directors. The output networks also have regular video/tele conference and network meetings. The HQ senior management team meets weekly for information sharing, problem solving, decision making and accountability. The expanded senior management team (SMT+) meets monthly to build a broader team of managers and leaders who are well informed and part of decision making processes. In addition to the weekly Round Ups, the office of the EXD regularly shares relevant information and documents with all staff in HQ and the regional offices. The EXD holds quarterly meetings with all HQ staff and regular meetings with an enhanced Senior Management Team which includes all unit heads in addition to the rest of the management team.**Consistency and coherence of corporate communications:** As mentioned above, the emergencies communications has been integrated in to the central department of communications a result of WHO Transformation. It are responsible for producing WHO’ is part of a unit that also includes the media team (press office). |
| **Human resource planning, recruitment and retention of talent*** Implementation of the Country Business Model
* Selection, recruitment, training and deployment of WHO Country Representatives and Incident Managers
* Recruitment rate of WHE positions in Country Offices versus Headquarters and Regional Offices
* Systematic application of fast-track standard operating procedures (SOPs) and contract arrangements for rapid deployment
* WHE staff rotation policy in the context of WHO geographical mobility
* Provision of incentives to attract/retain high calibre staff in hardship duty stations
 | **Country business model:** the percentage of occupied positions at the country level has increased from 37% in October 2017, to 53% in October 2018, 65% in October 2019 and 73% in December 2019. Progression has been slowed due to the lack of funding and focus put on current emergency response of key staff involved in recruitment. The model is also being reviewed in the context of the COVID-19 response to ensure fit for purpose for the future.**IM selection, recruitment and training:** WHE has launched a new IMS Leadership training programme to identify and train staff with demonstrated or potential leadership abilities in order to perform key leadership roles under IMS. The first-ever IMS Leadership Training has taken place in April 2019 in Dakar, Senegal, with 28 participants that included Incident Managers and IMS Operations Leads. A second training has been completed in EMRO in November 2019.**Recruitment rates:** In the last 6 months, recruitments have primarily been at Regional Office level (increase by 1 percentage points of occupied positions) and Country Office levels (8 points)**Fast-track SOPs** have not been systematically applied, as it was felt that the short announcement period did not allow the programme enough time to source qualified candidates, and there was a preference for temporary arrangements which were felt to be more rapid.Since September 2019, 7 new SOPs have been posted in the eManual and 2 existing SOPs have been improved, using feedback and experience from the field. HR SOPs are being restructured and further developed, including selection and placement from emergency roster, in the context of the centralization of the HR function.An operational toolkit is currently in development to ensure the systematic gathering and dissemination of good practices in relation to operational support for emergencies. The toolkit will include a central repository, an online training and face-to-face trainings to be conducted this year.**Mobility:** The implementation of WHO’s geographic mobility policy is currently subject to the review by a committee. WHE has been in discussion with a number of Major Offices concerning possible lateral transfers within the programme.**Provision of incentives:** WHE is working with HRD to pilot incentives to encourage staff to take positions in hardship duty stations, including one grade increase and conversion from temporary to fixed-term positions. Within the overall context of WHO Transformation Implementation, WHO Health Emergencies Programme will work closely with the Business Operations Pillar (largely composed of the previous GMG) in this area.**New organigram**: As part of the WHO transformation, WHE has completed it’s implementation of a new organigram and has been advancing on the recruitment of mission critical positions. The WHO transformation has led to the centralization of the resource mobilization and communication capacity previously in the programme (EXR department). The management and administration (MGA department) function has been restructured into 3 areas: centralized functions (roster management), embedded positions (e.g. HR support coming from Human Resources Department) and a new fully dedicated events-supports team located within the newly formed Strategic Health Operations department. |
| **WHE Finance*** WHE fundraising strategies
* Resource mobilization capacity at country level: level and effectiveness of engagement of WHO Representatives with in-country donor representatives who manage country-level programme funding

WHE donor portfolio and multiyear partnerships | A resource mobilization strategy was developed in 2019 and was presented to the EB at the 146th session held in February 2020. It provides information on the strategy for mobilizing the resources needed to deliver GPW 13, covers the period for 2019–202,3 and rests on four pillars, namely: • Established government partners: growing, diversifying or maintaining funding through regular and active engagement and policy alignment, taking a tailored approach; • Philanthropic partners: building on our most effective partnerships and seeking to grow funds from a wider range of philanthropies; • Funds, international development banks and multilaterals: maintaining funding from mature partnerships and developing funding streams from new sources and mechanisms; • Innovative financing and revenue-producing activities: exploring the potential in these areas.  Individual donor profiles and engagement plans have been developed for top donor to the emergencies programme, detailing key partner institutions, budget cycles, key dates/events for engagement. The profiles also include a mapping of donor priorities against the 10 output strategies to guide more strategic engagement with donors for 2020.The objective is to expand the profiles to also include potential donors, once capacity allows for this. Strategic dialogues were held with several donors to WHO, and all included representation of the emergency programme thereby facilitating high level strategic discussions and positioning with donors. As regards OCR funding, WHO continued to engage traditional humanitarian donors, while also seeking to engage new potential donors. WHO will continue to strengthen efforts for RM at country-level capacity to tap into e.g. ECHO funding and country-based pooled funds such as CERF funding. In 2020, specialized expertise has been brought on board to support efforts to strengthen capacity for RM for certain humanitarian donors, where considerable momentum exists such as with ECHO, for which an external specialist (certified ECHO trainer) has been brought on board to strengthen capacities for strategic engagement in the coming months. The External Relations team continues to mobilize resources for the CFE; in 2019 approx. U$ 54 million was raised from 16 donors, while $83 million was released to support more than 20 acute responses including 10 disease outbreaks, 7 natural disasters and 4 complex emergencies. The first multi-year agreement for the CFE was signed with New Zealand for a period of 3 year, with other donors indicating intent to follow suit. Despite the increase in funds raised; the addition of new donors; and signing a MY agreement, the continued drawdown of the CFE in 2019, especially for the Ebola response, left the Fund dangerously depleted at times. As a result, the CFE is being revisited with a view to strengthen replenishment, visibility, and accountability. As part of this, the replenishment strategy initially put forward in 2018 is being revisited, with a view to ensure alignment with the 4 pillars of the RM strategy to ensure adequate levels of funding at all times to the CFE. A road-map for how to better (re)position the CFE is being developed will include consultations with donors;**Resource mobilisation at country level**: Effective RM at country level requires partnership skills at the highest level of WHO, with the WRs, coupled with a thorough understanding of how different donors work. The Country Business Model for the health emergencies programme remains a priority and includes strengthening of partnership and RM capacities. Dedicated resource mobilization officers are already in place in five of ten WHE priority countries (Democratic Republic of Congo, Ethiopia, Nigeria, Somalia, Yemen) and the EHE team is in regular contact with colleagues at country level to support engagement with donors. Going forward efforts will be made to build capacities for partnerships and RM in additional priority countries, not only through partnership/RM officers, but also by developing capacities of WRs to engage the partner/donor community for fundraising. In 2020, the COVID-19 response has increasingly required the full attention of the EHE team, as well as the other units of CRM, and beyond. New ways of working, beyond those enabled by Transformation, are being rolled out and tested. Resource mobilization for COVID-19 is progressing well, with significant amounts pledged already. COVID-19 will undoubtedly impact RM for other parts of the Emergencies programme, which will require adjustments to RM for the remainder of 2020 across the 3 levels of the Organization.

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| 2018-19 Budget and funding |  |  |
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|   |  **Cat 12 WHE**  | **Cat 13 OCR** |
| Gap |  99,833  |  228,521  |
| Flexible funding |  179,868  |  15,792  |
| Voluntary contributions |  274,499  |  1,275,757  |
| Approved Budget |  **554,200**  |  **1,520,070**  |
|  |  |  |
| % of approved budget funded | 82% | 85% |

 **TOP 10 CORE FUNDING (CATEGORY 12) CONTRIBUTORS IN 2018-2019**

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| --- | --- | --- | --- | --- |
|   | **Top 10 Donors to Cat 12 WHE budget in 2018-19 ( Distribution US$ '000)** | **WHE Flex** | **Specified** | **Grand Total** |
| 1 | Department for International Development (DFID), United Kingdom | 38,900 | 28,388 | 67,288 |
| 2 | Centers for Disease Control and Prevention (CDC), United States of America |   | 40,945 | 40,945 |
| 3 | United States Agency for International Development (USAID) |   | 35,271 | 35,271 |
| 4 | Germany | 21,692 | 6,764 | 28,456 |
| 5 | Department of Foreign Affairs and Trade (DFAT), Australia | 9,712 | 2,732 | 12,444 |
| 6 | GAVI Alliance |   | 8,754 | 8,754 |
| 7 | Bill & Melinda Gates Foundation |   | 5,801 | 5,801 |
| 8 | Defense Threat Reduction Agency (DTRA), United States of America |   | 5,369 | 5,369 |
| 9 | Vital Strategies |   | 4,638 | 4,638 |
| 10 | Department of Foreign Affairs, Trade and Development (DFATD), Canada |   | 2,985 | 2,985 |
|  |  | **70,304** | **141,647** | **211,951** |

**TOP 10 OUTBREAK AND CRISIS RESPONSE FUNDING (CATEGORY 13) CONTRIBUTORS IN 2018-2019**

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|  | **Top 10 Donors funding Cat 13 OCR budget in 2018-19 (Distribution US$ '000, excl CFE)** | **Total** |
| 1 | United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) | 191,097 |
| 2 | United States Agency for International Development (USAID) | 171,321 |
| 3 | International Development Association (IDA) | 86,101 |
| 4 | United Nations Central Emergency Response Fund (CERF) | 83,784 |
| 5 | Department for International Development (DFID), United Kingdom | 79,607 |
| 6 | Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO), European Commission | 58,700 |
| 7 | Democratic Republic of the Congo | 54,589 |
| 8 | Kuwait | 51,158 |
| 9 | GAVI Alliance | 46,320 |
| 10 | Ministry of Foreign Affairs, Japan | 45,872 |
|  |   | **868,549** |

**CFE INCOME BY DONOR IN 2019:**

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| --- | --- |
| **Country** | 2019 |
| Australia | 354K |
| Canada | 741K |
| Estonia | 56K |
| Finland | 739K |
| Germany | 17,118K |
| Japan | 22,055K |
| Kuwait | 500K |
| Luxembourg | 556K |
| Netherlands | 2,353K |
| Norway | 1,173K |
| Republic of Korea | 1,000K |
| Sweden | 1,028K |
| UK | 5,236K |
| New Zealand | 1,004K |
| Philippines | 3K |
| Georgia | 5K |
| **Grand Total** | **53,920K** |

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| **Partnership and Coordination*** Engagement and support to the Global Health Cluster
* Health cluster coordination in priority countries
* high quality of the Health Cluster Coordinators’ (HCCs’) roster through adequate assessment of candidates, improved performance management of HCCs, training on field-level health cluster coordination prior to deployment, and adequate support on deployment to ensure satisfactory information management and coordination.
* Expansion and strengthening of the Global Outbreak Alert and Response Network, Emergency Medical Teams, standby partnership, etc.

Leadership role in outbreaks as per the Inter- Agency Standing Committee L3 protocol | Partnerships are an essential part of our collective ability to prepare for, prevent, detect and respond to health emergencies. The WHO Health Emergencies Programme works with numerous technical and operational partners to guide longer term preparedness and prevention work, as well as operational response in acute events and delivery of health care in fragile and conflict affected settings (FCVs). Since 2017 WHE has developed and is implementing a series of strategic engagement frameworks with a number of key partners including US Centers for Disease Control and Prevention, and the Korea International Cooperation Agency. The frameworks are aligned with GPW13 strategies to ensure targeted technical, financial and operational support across the scope of WHOs work in emergencies. In terms of emergency response, the WHE programme is working to optimize the synergies and complementarity amongst these mechanisms as part of our work towards having a Global Health Emergency Corps that would allow us to leverage capacity across the world. Below we consider three critical partners- the Global Outbreak, Alert and Response Network and the Emergency Medical Teams we are able to maximise our capacity in responding to humanitarian needs.**Global Health Cluster:** Since the last report, one new organization (John Snow International – JSI) has submitted a GHC membership application, currently under review by the GHC Strategic Advisory Group. JSI is a US based public health research and consulting firm providing technical and managerial support to public health systems worldwide. It is noticeable that recent applications for GHC membership are coming from technical organizations rather than operational NGOs; striking a balance between both cadres will be important to ensure the GHC can offer both timely surge capacity and good quality humanitarian health action. Technical and operational capacity gaps identified through recent partner surveys were discussed during the GHC Strategy Development workshop (23-24 October 2019) and are published on the GHC website.At regional level, the GHC supported the Operational Partnership Team Leads in EMRO to deliver the second regional Health Cluster Coordination meeting in Cairo, 8-10 October 2019 (see report on GHC website) and assisting AFRO to plan their 2nd Operational Partners Coordination Meeting on Health Emergencies in the African Region in March 2020 (postponed due to Covid). These activities develop WHE and partner capacities to implement more contextually appropriate cluster response through shared learning and concerns on common themes and supported roll-out of the latest IASC and GHC policies and guidance.Country Health Cluster performance was externally reviewed in three locations during this reporting period. External evaluations of Health Cluster performance and coordination architecture in NE Nigeria and Mozambique were completed between September 2019 and January 2020. Both evaluations explored aspects of WHOs role as Cluster Lead Agency and adaption of Health Cluster coordination to each evolving crisis, including the interface WHO Incident Management System and other outbreak coordination platforms. The evaluation summary findings concluded that overall the Health Cluster scored 60%, or ‘average’ across all evaluation criteria, only slightly below a rating of ‘good’. The cluster is therefore fulfilling its core role of providing a well-functioning coordination platform for health response in both countries despite significant challenges, in particular the lack of sufficient resources at national and subnational level in both capacity (skill set) and quantity (number of staff) with regard to the Information Manager and Health Cluster Coordinator (HCC). This undermines other key aspects of performance, such as monitoring, advocacy and Accountability to Affected Populations (AAP). The evaluation also found that roles and responsibilities must be clarified across WHE Incident Management System and the Health Cluster, but that overall, the WHE IMS structure was found to provide a positive environment. The full evaluation reports and recommendations can be found at GHC website. The GHC is currently developing a Management Response Plan to monitor implementation of recommendations by both the GHC and WHO – progress will be overseen by the GHC SAG. In addition, the IOAC mission to Gaziantep, Turkey, highlighted the effectiveness of the Health Cluster cross-border support to affected people in north-west Syria. As of December 2019, 22 out of 28 (73%) country health clusters/sectors have a dedicated Health Cluster Coordinators at national level. Six clusters (21%) have part-time/double hatting national level coordinators. Stagnation in the number of dedicated HCCs persists due to previously cited bottlenecks including lack of funding to implement the WHE Country Business Plans and delayed recruitment process. The GHC works closely with WHE HQ-HR to develop the WHE HCC rosters and with the Standby Partnerships team to deploy suitable candidates to fill outstanding HCC gaps Critical HCC in Burkina Faso has been resolved but persists in Cameroon despite suitable CVs presented The GHC continues to lobby WHE leadership at global and regional level to secure alternative funding and address recruitment bottlenecks to ensure timely and consistent HCC presence.Securing Information Management Officers continues to be challenging. As of December2019 only 14 (46%) of clusters have dedicated IMOs most hired on short term contacts linked to event-based funding or deployed through Standby Partners. Nine clusters (33%) have part time/double hatting IMOs and 5 clusters (21%) have no IMO. The strategic partnership with iMMAP continues to strengthen at global and regional (EMRO & AFRO) level to enhance country capacity, through funding from OFDA and CDC.The GHC continues to invest in capability building for cluster coordination through the development of new training materials and guidance including:* E-Learning course for Health Cluster Coordination. This 17-module course is suitable for both WHO staff and partners who currently or intend to perform key cluster functions. The course is available through the both the OpenWHO open to all external partners and the WHO internal iLearn platform for staff – both reachable via the GHC website. Since its launch December 2019, over 5, 400 people have registered for the course with OpenWHO.
* Simulation-exercise trainings – at the request of WHO and partners, 3 new scenario- based trainings have been developed in collaboration with WHO Regional Offices and partners. These trainings can be adapted to regional contexts and are targeted at WHO staff, national authority personnel responsible for humanitarian health action and international and local partners. Planning for 1 SIMEX to be delivered in SEARO commenced in January but has been delayed due to Covid19.
* Health Cluster Coordination Guidance for Heads of WHO Country Offices as Cluster Lead Agency – available in 5 languages, this guidance aims to assist WHO Heads of Office to fully understand their responsibilities and accountability as Cluster Lead Agency. The GHC has collaborated with Country Strategy and Support Unit in Office of the Director-General to include this guidance within the new WHO Head of Country Office handbook and training.

**The Global Outbreak Alert and Response Network*** As of 22 March, there are 265 partner organizations, agencies, and networks registered on the GOARN knowledge platform.

Steering Committee (SCOM)* In December 2019, IFRC hosted the 26th meeting of GOARN Steering Committee. SCOM26 reviewed the global and regional development and operations of the network in 2019 in alert and risk assessment, training, rapid response capacities and research; and major field operations - the options for alerting the world in cases where events do not meet the criteria of a public health event of international concern (PHEIC). In these sessions, SCOM also reviewed and confirmed plans for a year-long communications campaign to celebrate GOARN’s legacy and ambitions (GOARN 2020).
* Strategic discussions on GOARN next four-year strategy, included revised governance documents and procedures, and proposed monitoring and evaluation framework; endorsement of the main areas of work, and for major enabling factors – including regionalization of GOARN; closer collaboration with technical networks; and greater involvement in readiness and preparedness activities in the field.
* SCOM agreed to a framework for the overall strategy, and practical options for delivering the strategic objectives.
* On 16 March, we held a special virtual meeting of the SCOM to review the COVID-19 response to date. GOARN’s direct involvement in the novel coronavirus response started on 2 January, 2020; and since then involvement in weekly coordination, in risk assessment, and development of the strategic preparedness and response plan. In January and February, regional and global requests for assistance were issued to partner.
* The SCOM agreed strategic and operational priorities to support case and contact tracing (through mobilizations of global partners, and rollout and implementation of Go-data); risk communications and community engagement; and working to support EDCARN, and EMT with clinical /IPC concept of rapid response operations.
* In response to the call from WHO, GOARN partners have mobilized international technical assistance to support preparedness and response missions at country request, and to also support capacity in WHO regions and headquarters in Geneva. In addition, Public Health England, the Indo-Pacific Health Security Centre, the Australian government, and the Chinese Center for Disease Control and Prevention have seconded to WHO to work on COVID-19 response in Geneva, Switzerland; Manila, Philippines; and New Delhi, India.
* The WHO COVID-19 Incident Management Team is working with partners across all levels to provide support to countries, strengthen technical and operational networking and collaboration, and support operational coordination of the global response.
* To strengthen day-to-day operations, key agencies are embedded in the global team, including UNICEF, the United Nations Office for Coordination of Humanitarian Affairs (OCHA), the International Organization for Migration (IOM), and the International Federation of Red Cross and Red Crescent Societies (IFRC).
* A major focus of the response is on case detection and contact tracing. To support country activities, partners are working closely on the deployment and implementation of Go.Data, an outbreak investigation tool for field data collection during public health emergencies. Over 50 countries have requested support, and GOARN partners are implementing a strategy for wide-scale rollout including direct country support, technical briefings, webinar/online presentations, and comprehensive remote support.

GOARN ResearchEbola* OST support for bespoke research projects funded by ELRHA/ R2HC: (a) conducting research on production of trust through adaptation in provision of care for patients; (b) Bacterial co-infection. Deployment of staff to conduct essential research operations. More information on the research conducted, see: What do adaptations tell us about the production of trust? Shifing the burden of change from people to the response (Sung-Joon Park, Nene Morisho, Kennedy Wema Muhindo, Julienne Anoko, Nina Gobat, Hannah Brown and Matthias Borchert) https://odihpn.org/wp-content/uploads/2020/03/HE-77-web.pdf
* Collaboration with UNICEF to model their Cellulle d’Analyse de Science en Sociaux (CASS), an innovative approach to routine delivery of evidence -based social and behavioural insights to inform response operations. Deployment to DRC (Jan 2020) to co-conduct a detailed stakeholder consultation relating in modelling of the CASS of replication in future health and other emergencies.

COVID-19: * Knowledge management including information dissemination to partners including curated research findings, data collection tools and WHO early investigation protocols; identification knowledge gaps with operational partners; conducting systematic reviews and literature queries for operational partners.
* Working with WHO on the COVID-19 Research Roadmap to bring together an operationally focused social science research agenda that aligns with goals of the strategic response plan. Actively involved in coordinating academic partners and research being conducted through the COVID-19 Research Roadmap mechanism (ToR attached for reference). GOARN-Research aim is to bridge the academic research contribution with the needs and activities of GOARN network and response partners looking for tools to conduct their own research and/ or looking for social and behavioural evidence to inform response.
* Consultation with GOARN partners regarding their expectations, needs and views of GOARN-Research to refine vision, purpose and operations. Currently underway. Report anticipated for May 2020.

Risk Communications and Community Engagement (RCCE): Tripartite strategy of UNICEF, IFRC, WHO* GOARN has provided the coordination platform for IFRC, Unicef, and WHO as the 3 main international agencies that are shaping the Risk Communications and Community Engagement for the COVID-19 response since the start of the outbreak.
* Building on the experience of working together in the Ebola response in West Africa, and DRC, the tripartite collaboration was established early and is forging ahead rapidly, to deliver a clear strategy and a regular feedback mechanism from regional and country counterparts. This enables all agencies to deliver the most supportive and complimentary RCCE infrastructure for this response together.
* GOARN support has enabled the development of a Global Strategy for RCCE for COVID-19 outlining a way forward for the agencies to support all affected countries despite the complexity and challenges that present with this pandemic. The partners are able to effectively coordinate on the dissemination of existing guidelines, adaptation and development of new guidance and tools. Due to this collaboration, the three agencies have developed co-branded tools and guides for the field responders, with the aim of streamlining messages to common audiences.
* In the COVID-19 pandemic, the Tripartite Strategy enables each agency to deliver on respective RCCE mandates, by optimizing resources to address the needs of the response; and ensuring that the communities are enabled and at the centre of the response.
* Coordination with all RCCE stakeholders takes place on a weekly basis and tools and guidance are shared on the GOARN Knowledge Platform to ensure that they are disseminated to all.
* IFRC-Unicef-WHO are also coordinating regionally-focused webinars that address specific response needs according to disease transmission stage and country need, re-framing guidance for LMICs and ensuring RCCE tools developed in some regions are adapted for use in other regions.

GOARN Training Programme* Two national GOARN Orientation to International Outbreak Response trainings were organized in this reporting period, the first was targeted to Epidemiologists and co-hosted by Public Health Agency of Canada in Halifax, Nov 2019; and the second was for a multidisciplinary public health cohort co-hosted by the Ministry of Health, Labour and Welfare in Japan, with a total 74 experts from GOARN partner institutions trained.
* 28 representatives of partners Institutions of the GOARN Outbreak Response Leadership Training Working Group convened a meeting in November in Geneva to present the first outline of the collaborative training programme, review and discuss next steps for course roll-out.
* Arrangements were made for a GOARN Outbreak Response Scenario training that was scheduled to take place in March in Uganda, however was postponed due to the ongoing COVID-19 response. This training was being co-hosted by GOARN/WHO and TEPHINET, in partnership with AFENET, USCDC and UK-PHRST.
* Nine Go-Data user trainings delivered in Stockholm, Cox’s Bazar, Colombia, Brazil, Argentina, Mexico, Vietnam, South Sudan and Italy to introduce the tool to outbreak responders. Additional roll out trainings were held across multiple locations in Vietnam and other countries in response to the ongoing COVID-19 outbreak to train the epidemiological teams.

**Emergency Medical Team**The Emergency Medical Team (EMT) Initiative focus over the past years has continued to be training and capacity building of national medical response teams;Over 23 500 EMT responders from national EMTs are engaged in national capacity building activities.Over 250 national & international health responders have been trained on EMT coordination.Five Regional and international simulation exercises held with specific participation by EMTs and supported through the EMT Initiative, including three in collaboration with OCHA and the Search and Rescue Community INSARAG hosted at the regional level with over 400 participants each, and fully testing the national and regional EMT coordination mechanisms of the host country.There are 29 Internationally Classified EMTs globally. These teams have over 4 000 readily available EMT responders with nearly 100 other teams are in the mentorship process and receiving direct support to reach the minimum standards to achieve classification.The EMT initiative is working with all 15 countries with the highest risk index worldwide.Using the nationally led coordination approach, several countries have been able to coordinate medical team responses to emergencies such as Indonesia (Sulawesi earthquake 2018), Philippines (Typhoon Mangkhut 2018), Colombia and Ecuador in the context of the Venezuelan migrant crisis, and Palestine (humanitarian situation due to the mass demonstrations). Recent experiences in Mozambique with 20 deployed EMTs, and Bahamas with 7 deployed EMTs showed the mechanism of coordination of EMTs by the MoH within their Health EOC, with support from WHO and experts form other EMTs, is effective and an example of localization of coordination. In the last quarter of 2019, 18 international EMTs consisting of 557 total EMT personal were sent to the Samoa measles outbreak which saw a surge of nearly 6000 cases of measles in a short span of time.WHO continues work to set global standards for EMTs through consultation at regional and global level on updates to the Classification and Minimum standards for Emergency Medical Teams (also known as the “Blue Book”) which will be finished this year. The initiation of the drafting process of the guidance document on the engagement of EMTs in conflict settings (known as the “Red Book”) has now concluded its consultation and drafting and will be available at the same time as the Blue Book as its accompaniment. MSF, ICRC, IFRC and other key partners have fully engaged and contributed to both texts, which they see as a vital contribution to medical care standards and coordination in situations of armed conflict and insecurity. Final drafts of the minimum standards and recommendations for EMTs on maternal, new-born and child health as well as on burns care have been developed finalized and a technical working group on clinical care in highly infectious disease outbreak settings is set to start this year provided there are sufficient funds.The work of the EMTs has been endorsed by the WHO Regional Committee for South East Asia recently adopted Resolution SEA/RC71/R5 om “Strengthening Emergency Medical Teams in the South East Asia region”, and the European commission’s implementing decision (EU) 2018/142 “Emergency medical teams (types 1, 2, 3 and specialised care) are considered certified if they have undergone the verification process of the World Health Organisation (WHO). The registration and certification procedure of emergency medical teams in the EERC shall complement the WHO verification process.” Resolutions are now being considered in other regions, and have already occurred in PAHO/AMRO, and through regional bodies such as the European Union, ASEAN and UNASUR.Lastly, four out of six WHO regions have fully established their regional EMT governance platforms, which are the main forum at the regional level allowing for Member States, EMTs and other stakeholders to shape, guide and drive the implementation of the EMT Initiative in their region. The Global EMT community had its bi-annual meeting hosted in Bangkok in June 2019, with over 90 countries and 400 people attending. This was a practical and technical meeting with up to 6 parallel streams at any one time on topics on improved clinical care in disasters and outbreaks, public health messaging, logistics, training, conflict response etc. The IFRC have officially signed an MOU with WHO recognizing he value of the initiative in improving standards of clinical care by medical teams in emergencies, and aligned itself to the agreed terminology, standards, quality assurance processes and nationally led coordination in disasters and outbreaks (with special considerations in times of conflict outlined in the red book). While the EMT initiative continues to grow and resonate with countries and I-NGOs seeking to develop national and regional capacity to respond to their own health threats, the internal WHO transformation has taken a heavy toll on staff. With the recent hiring freeze staff numbers at HQ have dropped from 7 to 3 and coupled with no funding have severely limited the ability of the WHO EMT Secretariat to continue to support countries and teams for activities improving standards and responses in emergencies. Concerted efforts were made to strengthen the **Standby Partnerships** from August 2017 onwards, increasing deployments by 75% in 2018. 60% of these deployments were for the country support functions while 40% of these were for the Health Cluster.Some of these included:1. Raising awareness amongst the regional and country teams especially in priority emergency countries e.g.: Somalia, Kenya and DRC and regions ego: EURO, AFRO, SEARO and EMRO.
2. Proactively reaching out to some countries for possible options to support with deployments for the emergencies.
3. Coordinating with DFID – SBP, UK, to seek funding support for partners for deployment for EBOLA response in DRC and EBOLA preparedness to Rwanda and South Sudan.
4. Nearly 30 deployments were done in Bangladesh, Cox Bazaar and 15 in DRC.
5. 2 new partnership agreements were signed up with the Government of Iceland and with UK-Med.

Operational Support & Logistics’ (OSL) partnership activities have included collaboration and coordination with WFP, UNICEF and other operational partners on specific logistical efforts including camp and life support, transport, stockpile management and warehousing, and distribution during the DRC Ebola responses, Entebbe technical guidance on stockpiling for preparedness with WFP, Yemen supply chain management operations. Coordinating activities include providing technical guidance for safe and dignified burial guidance in partnership with IFRC, coordination of management of Ebola Treatment units with MSF, Alima and the Ministry of Health of DRC. Over the past 6 months ending October 2019, OSL has initiated approximately 140 different deployments to support health emergency operations including in DRC, Uganda, South Sudan, Mozambique, Tanzania, Yemen, Iran, and other countries. Supported and participated in AFRO leadership training in Senegal that integrated Incident Management and Operational frameworks for WHO staff. The leadership training included planning, health logistics and supply chain management and administrative support.Since the last reporting, WHO reinforced its coordination with the Inter-Agency Standing Committee in several ways:* A 3-days simulation exercise was organized by WHO in December 2017 testing the IASC L3 infectious events protocol in simulated conditions of a real event (scenario: severe air-borne new respiratory disease with high fatality rate in a remote mountainous border area of South-East Asia). This simulated an escalated approach from technical, to directors, to Principals level cumulating towards a simulated meeting of IASC heads of agencies to take decision on activation of the protocol and related urgent actions to be taken by the system.
* In follow-up to this simulation, lessons were collected on the protocol and WHO has revised the protocol which was shared with IASC Emergency Directors for review in November 2018.
* For the two Ebola outbreaks in DRC of 2018, WHO decided not to activate the IASC protocol but is nonetheless coordinating very closely with IASC and UN partners, with coordination meeting held at IASC Principals level by DG and WHE EXD, briefings organized for DG to the UN Security Council culminating into resolution 2439 unanimously adopted by the Council on 30 October 2018 urging Ebola responders’ safety in DRC. DG also briefed jointly with DPKO Principal the UN Chief Executive Board (CEB) in November 2018. In addition, WHO is coordinating the Ebola response in DRC actively with IASC Emergency Directors (weekly to bi-weekly teleconference organized for Ebola coordination with all IASC Emergency Directors).
* WHO also improved its engagement with the UN Crisis Management Group. WHO participated in 2018 in the UN stock-taking of the implementation of the UN Crisis Management Policy and is leading the development of a simulation exercise around this mechanism for a health crisis. WHO is recognized as UN lead Agency for health crises if the UN Crisis Management Policy is activated with delegated authority from the UN Secretary General for UN coordination of the response.
* Finally, WHO is an active member of the IASC beyond infectious events responses: in particular WHO coordinated certain aspects of the revision of the standard IASC response scale-up protocol revision and co-chaired the IASC task team on the humanitarian and development nexus (central IASC body for work in fragile, conflict- affected and vulnerable countries).
* WHO routinely submits memos to the UN secretary General regarding acute public health events that are high or very high risk at regional or global level as was done recently in the two outbreaks of Ebola virus disease in the DRC.

OSL and COVID 19Through the UNCMT OSL has established the COVID-19 Supply Chain Interagency Coordination Cell. This is currently staffed by WHO, OCHA and WFP. The SCICC provides updates on supply chain impact to the UNCMT but also coordinates through three mechanisms; supply and markets working group, the humanitarian logistics continuity group, and a process under development for handling donations. TOR’s for two of the groups are attached, as well as the latest UNCMT update |
| **Learning and Capacity Development** | Under the WHE learning Strategy, two concrete strategic directions were pursued. 1. Systematically increase the reach and scope of WHE’s OpenWHO online platform to support preparedness and response and, 2. Strengthen leadership capacity for health emergency repose in priority regions (AFRO and EMRO). In the former, the reporting period started with 131,000 course enrollments from 190 countries for 67 courses in 21 languages on the OpenWHO platform. The period ended with more than 750,000 course enrollments from 500,000 unique users for more than 90 courses in 21 languages. For the last quarter of 2019, most of the online courses supported the Ebola outbreak in west Africa, with the ePROTECT course to ensure that everyone working in the response was able to do so safely and efficiently, recording a 98% course completion rate. A study on how the platform is used also revealed that the course completion rate for all courses ranged between 35 and 40% in contracts to the industry experience of 4-15% for online learning platforms. Other courses that were most widely used included the Incident Management System (IMS) Tier 2 course intended to induct all health emergency personnel into working in a common response management system; as well as other courses on major hazards that were relevant during that period including Ebola Virus Disease and Cholera. New courses on the Global Health Cluster. Operational Readiness for national preparedness and Simulation Exercises saw high demand.As 2020 began, with the outbreak of novel Coronavirus in China, WHE’s Learning and Capacity Building Unit initiated its health response training package and launched the first course – An introduction to the Novel Corona Virus (now renamed Covid19) on January 26th. Since then four other courses have been launched: eProtect (occupational health and safety course for responders); Infection Prevention and Control; Severe Acute Respiratory Infections and National Preparedness planning for UN country teams. The courses were made available quickly in all UN official languages and Portuguese and have been translated into Persian, Bhasha Indonesia, Vietnamese, Japanese, Hindi and several other national languages. A collaboration to cross-post courses was operationalized with the PAHO Virtual Campus. Many national partners and volunteers are currently translating into more languages. The purpose of using a low bandwidth platform and multiple languages is to massively increase access to life -saving knowledge by health care workers, decision makers and response teams. At the time of reporting more than 500,000 people from 190 countries were accessing COVID19 courses on the palatiform. The numbers have been growing by an average of 40,000 new users a day over the past week. It is estimated that one million course enrollments will be reached by the end of March. The small Learning and Capacity Building team in WHE was able to scale up and manage this massive outreach and production because of effective work across WHE teams at HQ, in ROs and in countries; the managerial and administrative systems that were put in place for learning and training (including pre-selected service providers on long term agreements, and the Internal service provider mechanism in which the Learning and Capacity Building teams operates like an internal service provider using innovative approaches and technologies). Using COVID19 response resources, the team also quickly scaled up its capacity from 5 staff to a team of 22 (made up of service providers and consultants). It is important to note that the OpenWHO platform was established following the West Africa Ebola outbreak when WHO led the training response and is therefore a concrete example of WHO transformation of its health emergencies work. Secondly, the seed money for the platform was provided by Pandemic Influenza Preparedness Framework, and the team designed the platform to operate in a pandemic such as the one we are currently experiencing. The use of innovative technologies and approaches also means that the WHE Learning and Capacity Building team was able to fully shift into distance work and telework within 4 hours, with not only continuity of production, but a massive and continuing expansion. For the second main stream of work, the WHE Learning and Capacity Building team, in collaboration with WHE and Regional leadership in AFRO and EMRO, has further developed the WHE Leadership Programme. Built on the generic AFRO leadership Programme, WHE launched a tailored blended learning Programme for AFRO in 2018, and expanded to EMRO during the period under review. In the last quarter of 2019, leadership candidates from EMRO completed online learning, took personality preference tests and were debriefed and attended a 7 day face to face training and 48 hour simulation exercise at the Dead Sea ion December 2029. All candidates were observed for 49 behaviours under 6 core competencies for health emergencies work (drawn from the WHO competency model), and were debriefed individually and helped to map their learning pathway for the next 6-9 months. They then entered a period of one on one individual coaching to address their learning needs. Going forward, to maximize the use of resources, AFRO will take over the first level of training for WHE leadership candidates. Graduates of that Programme will then be required to follow a shorter health emergencies module run by the WHE Learning and Capacity building team, and undergo a simulation exercise and competency-based assessment. To support the Global health Emergencies Workforce, the Learning Unit is supporting WHE in AFRO to create a regional pool of pre-identified and screened health response personnel from Member States, ensure they undergo a standard core learning package and be available for work within their countries as well as deploy internationally. This work will provide valuable lessons for the operationalization of the DGH’s Global Health Emergency Workforce.  |
| **II. Issues****requiring corporate- level solutions*****(WHO******Transformation Agenda)*** | **Procurement and supply chain management*** Benchmarking analysis for the supply chain process to establish key metrics to gauge the timeliness and effectiveness of the process, and to estimate the necessary staffing and corporate investment level.

Emergency measures under the Framework of Engagement with Non-State Actors | **Benchmarking:** Benchmarking exercises were conducted by WHE/OSL in June 2017 and are also relevant within the context of the WHO transformation business process re-design. The current proposal is to reduce lead time from an average of 173 days to 49 days. WHE is heavily engaged in the supply chain business process re-design work, which will initially focus on five immediate initiatives (Developing categories for standard requirements of goods covering 80% of spend; development of standard procurement lists for emergencies working with EMRO; development of Warehouse SOPs; Annual import plans and; design of a control tower to oversee stock management. work. In addition, OSL are in discussions with the World Food Programme (WFP) to develop operational service level agreements to capitalise on the strength of WFP’s logistical capability including Camp/Life Support, Surface Transport, Communications, Air Transport, and EOCs. OSL is also exploring additional operational partnerships and service level agreements with other UN agencies and implementing partners.As part of the WHO Transformation agenda, the General Management (GMG) and departments across WHO including the WHE Health Emergency Programme (WHE) are collaborating on building a fit-for-purpose supply chain that will support WHO programmes and initiatives as well as provide the necessary supply chain support for health emergencies.OSL has developed a periodic dashboard outlining several key indicators of the supply chain operations for the DRC response. From August 2018 through September 2019, OSL has managed the following operations;* 592 international shipments
* 728 metric tons shipped
* 4,800 cubic meters shipped
* 212,600 doses of Ebola vaccine shipped
* 106,000 GenXpert Cartridges shipped

The OSL HQ dashboard is attached.The dashboard also highlights Total Value of Goods Received each month, Total Value of Goods Received per Unit, and metric tons and cubic meters received per port of entry. Additionally, EMRO has developed a dashboard which can be accessed at the following link; <http://dashboards.emro.who.int/EMDashboardHub>. OSL in EMRO has developed the Concept Note for kits management for EHKs. The Concept Note is also attached.OSL is also undergoing a standardization project for the WHO catalogue. Completed activities include;* Medicines: 182 items added to catalogue
* Field support items: 16 items included in catalogue
* Personal Protective Equipment (PPE): 49 items included in catalogue
* Satellite Communications kits: 30 items included in catalogue.

Current and ongoing activities include;* Lab items: ITB close, 450 items (60% new, 40% reviewed) and pending inclusion in catalogue
* Medical devices 1: 130 items approved and pending inclusion in catalogue
* Medical devices 2: 323 items, ITB ongoing.

OSL held in September 2019 a two day collaboration in Dubai of subject matter experts in procurement, contracting, and logistics to refine the medical supply management of EHKs. Summary of the workshop is attached.**Emergency measures** under the Framework of Engagement with Non-State Actors have been published on eManual XVII. In order to accelerate the engagement in a timely manner to support critical emergency response situations, a number of options exist. A decision tree and self-assessment checklist have been developed to guide responsible officers through application of the FENSA requirements in the context of emergency response. FENSA focal point in the regions will play a key role in facilitating the process. Following the evaluation of FENSA presented at the EB, WHE is working with CRE (custodian of the FENSA) to ensure that emergency provisions are incorporated in the training programme and key staff in the regions will be trained in their applications.COVID 19Dashboard on COVID 19 deliveries is attached<https://app.powerbi.com/groups/me/apps/92cc4823-5866-493f-aeef-1effe18d7583/reports/d08ca547-821d-44c6-b3ee-0492707994fd/ReportSectionad77b92e57a3edb2d316?ctid=f610c0b7-bd24-4b39-810b-3dc280afb590>A streamlined Pandemic Response donation process in currently being designed.There has been a lot of work with suppliers, the government and key individuals in China to begin releasing product to WHO* Through various organizations, China has released key items for WHO purchase:
* 8.5 million surgical masks
* 200k N95/FFP2 respirator masks
* Confirming a substantial number of gowns at this time
* Jack Ma Foundation to donate emergency medical supplies to WHO to our logistics platform in Dubai
* 2 million surgical masks
* 200k N95 respirator masks
* 20k protective gowns
* 20k protective goggles
* 50 ventilators

Establishing a donation policy to be managed by WHO as part of the Supply Chain Coordination Cell and the UN Crisis Management team. * Adhere to WHO regulations, technical standards
* Adhere to the needs as determined by Member States with support from WHO and UN agencies
* Comply with WHO and WFP health logistics guidelines and operations
* WFP with WHO guidance, coordination and technical support with the Log Cluster, L.E.T. and other PSCN stakeholders will be managing the mid to downstream logistics operations.
* Difficult situation arose when WEF began dictating donations to WHO based on the desires of Forum members including Unilever and AstraZeneca.
* Surveys are finalized and will be launched.
* Due to the specialized nature of the medical equipment and supplies, these surveys will be distributed to select group organizations.
* Approximately, 100 different organizations in total will be receiving the survey.
* It has been a very laborious process but with the help of the disease specialists and technical specialists in WHO and with organizations like the Clinton Health Access Initiative, FIND, and PATH, we will be sending the following surveys today.
* The sanitized and aggregated responses will be distributed to the greater PSCN.
* There are 3 different surveys going out:
* Liquid oxygen producers
* PSA (Pressure Swing Adsoprtion) Plants
* Medical equipment market
* We have been working with the Essential Medicines List team and various interagency networks to do similar activities with medicines to understand risks and potential drug shortages. The PSCN would welcome to make the connections to those PSCN stakeholders going forward.
* WHO has completed its country-based demand forecasting model for supplies based on the DCPs.
* Used for supply chain guidance to funding agencies,
* Provide demand monitoring to the Supply Chain Coordination Cell demand monitoring
* Collaborate with the various epidemiological teams of WHO and collaborating networks to continuously adjust supply needs
* With market insight via the PSCN, provide allocation support and guidance to private sector manufacturers.
* Potentially provide the political support and leverage to ensure the manufacturers can get their products in the areas in most need. The PSCN is exploring WHO mechanisms already in existence to secure the necessary products.
* In preliminary talks to secure significant portion of major manufacturers production of respiratory equipment.
* The talk was with Philips, one of 4 large equipment manufacturers who are worried that countries like the US and within the EU will invoke nationalization plans to secure all production of products within their borders.
* Philips has spoken with the other 3 (Draeger, Medtronic, GE) to find some solution to ensure that the rest of the world’s markets are able to receive their products.
* Philips expressed interest in a PIP-like structure from which WHO would secure 20 – 40% of its production which would then be distributed to non-US, non-EU countries. Philips stated that other companies would be interested in doing this as well.
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| **Security and staff protection*** Corporate strategy and investment level
* WHO security function in emergencies in relation to the United Nations Department for Safety and Security
* Adequacy of procedures and measures for protection of staff and deployed experts, including medical evacuation

Field application of WHO’s policy for prevention of and response to sexual harassment, sexual exploitation and abuse | **Corporate strategy and investment level:** The recruitment is in progress of a WHO Director of Security Services, whose function it will be to establish a Service that is fit for purpose for WHO’s needs and requirements, including the WHO corporate strategy for security, as well as related requirements and investments. This will include the development of a 5-year strategic plan that will encompass all needs. This is further complimented with the ongoing recruitment processes of a Security Coordinator (P5) and a Security Officer (P4) positions.**WHO security function in emergencies**: WHO is fully part of the UN Security Management System (UNSMS) and fully engaged in the Inter-Agency Security Management Network (IASMN), which translates to full integration and coordination with UNDSS in emergencies, as well as day to day functionalities at all levels (i.e. strategic, operational and tactical security management).**Adequacy of procedures and measures for protection of staff and deployed experts, including medical evacuation:** Procedures and measures exist within WHO, as part of the UNSMS, to provide adequate protection to staff and experts. Opportunities remain to improve preparedness of staff, enhanced frameworks and related procedural components, equipment, awareness and compliance. This is in the process of being addressed and remains a priority focus to ensure a sustainable and functional security apparatus within WHO.WHO SEC continues to conduct SSAFE training with priority attendees for staff who are most likely to deploy.Updated general medical evacuation (medevac) SOPs have been published, specific medevac procedures for response to highly infectious diseases (Marburg and Ebola) are also established for each operational response. Agreements for specialized medevac transport and care are in place, and new agreements are under development.**Field application of WHO’s policy for prevention of and response to sexual harassment, sexual exploitation and abuse:** More than 90% of WHE staff completed the mandatory training. The consequences of non-compliance are followed based on WHO Mandatory Training Policy within annual performance management cycle. This policy is also included in the draft WHE Global Surge Policy. |
| **Business processes in the areas of*** HR
* Administration

Finance | **HR:** In 2018 an in-depth internal roster validation process was implemented which has now been completed with 413 staff now in the roster. A Global Surge Policy is in the final stage of revision and will be presented to GPG and DG for decision. The draft policy aims to improve WHO’s corporate capacity to surge during emergencies by stipulating some enabling policy provisions such as availability for emergency deployment as a requirement for WHE employment, supervisors to be supportive for the release of staff, flexible entitlement during deployment, etc.Partnership roster SOPs as well as Guidelines on selection & request for deployment are in the final stage of development.Procedures for Medical Evacuation for non-staff are published. A key component of the newly published SOPs is to have WHO ensure up-front arrangements and financing is provided and then recover costs to the furthest extent possible afterwards. The detailed SOPs for provision of medevac by WHO for partner agencies is being developed.**Administrative Services** for Emergencies have been updated to align with the revision of activation of emergency SOPs, including streamlining the authorized officials to request emergency services in GSC. GSC has updated the Emergency on-call list for a variety of administrative services for graded emergencies.In line with WHO corporate FENSA policy, engagement of non-state actors during emergencies was published, outlining the simplified procedures to obtain approval to engage non-state actors (see section “Procurement and Supply Chain Management”)**Finance:** Consultant payment modality procedure is fully operational after GSM enhancement. Since April 2018, monthly travel request is no longer needed to generate consultant payment. Consultant contract consists of simplified single allowance and lump-sum for incidental cost.In line with CFE Replenishment Strategy, the key principles on how to request and management of CFE are further circulated to all country offices to further understanding of CFE management, especially on reimbursement of CFE.The revision of the Cost Recovery Policy is under discussion and will be critical to ensure that costs for the administrative, grant management and programme management functions are funded. The expansion in staffing for those areas, both in the centralized department and WHE, require a sustainable funding mechanism for non-technical functions. |
| **III. WHE Programmatic areas****1.**Preparedness for health emergencies | **Health emergency preparedness in countries, including implementation of IHR*** All-hazards emergency preparedness including IHR core capacities assessed and reported
* National Action Plans (NAPs): timelines for development and implementation, funding and technical support from WHO and its partners
* Support to Member States in reporting annual progress in implementing the Internatonal Health Regulatoions (2005) through the States Parties Annual Reporting (SPAR) process
* Review of assessment tools such as Joint External Evaluations (JEEs)
* Minimum core capacities for emergency preparedness and disaster risk management established in all countries
* Countries and WCOs operationally ready to manage identified risks and vulnerabilities
* Strategy for IHR capacity development in fragile states
* IHR (2005) data analysis to provide critical actions for countries to strengthen preparedness capacity building
* Link between WHE and other relevant programmes within WHO, in particular health care systems
* Scale down of IMS and transition process following major events to build national capacities on lessons learnt in a sustainable way
 | WHE is working closely with Member States to assess capacity gaps and the development and implementation of national action plans to strengthen country capacities for managing the range of risks they face in relation to health emergencies. WHE is working across WHO programmes to ensure this work is integrated within an overall approach to health systems strengthening, that best practices are shared and applied, and that community engagement is a component of all national capacity strengthening plans. States Parties Annual Reporting (SPAR), and other assessments of IHR (2005) capacities including Joint External Evaluations, simulation exercises and after-action reviews identify national IHR (2005) capacity levels, and the critical gaps that countries face in preparedness. Emergency preparedness strengthening is being implemented with MS and in WCOs to establish minimum capacities, as well as operational readiness for imminent threats. WHO is also supporting Member States and key partners to analyze data generated through the International Health Regulations (2005) in order to identify the critical actions that can strengthen national preparedness against health emergencies. WHO continues to work with Member States and partners to strengthen the coherence between the implementation of the SDGs, Sendai Framework for Disaster Risk Reduction, IHR and other global and regional frameworks for health security.**All-hazards and IHR core capacities assessments and reports:*** As of 6 March 2019, 113 countries have volunteered for a Joint External Evaluation; 125 Simulation exercises have been implemented (including country level and regional and internal exercises) and 62 After Action Reviews have been conducted. 31 IHR-PVS National Bridging Workshops have been organized in MS countries to encourage the contribution of the veterinary sector in the implementation of the IHR (2005).
* For the 2018 reporting period that States Parties were required to submit their annual reports, 191 (97%) of State Parties of all Regions submitted SPAR reports to the Secretariat for reporting at the World Health Assembly in May 2019. All levels of WHO are supporting State Parties to increase high quality reporting to WHA. The information received is being used to track progress against frameworks for public health. This includes the UN’s Sustainable Development Goal 3 and the WHO’s Thirteenth General Programme of Work (GPW 13).
* As of 6 March 2020, 64 countries developed their all-hazards disaster risk profile which supports countries to develop hazard specific contingency planning for emergencies and also provides an evidence base for all emergency planning including NAPHS and national emergency response planning.
* A monitoring tool has been developed and is in the process of finalization to better monitor the implementation of the Sendai Framework for Disaster Risk Reduction in countries. This will further support the implementation of disaster risk management action for emergency preparedness in countries.
* Safety assessments of health facilities is underway in all 6 WHO regions. An additional preparedness-readiness checklist has been developed to support countries in preparing effectively for COVID19.
* The FAO-OIE-WHO (Tripartite) guidance document “Taking a Multisectoral, One Health Approach: A Tripartite Guide to Addressing Zoonotic Diseases in Countries” (also referred to as the Tripartite Zoonoses Guide) has been cleared by the three Organizations and has been publishedand is available online. The guide aims at supporting national implementation of multisectoral, One Health approaches for a variety of topics and associated TZG Operational Tools. The first tool that has been developed id the Joint Risk Assessment (JRA) which has been piloted in 12 countries.

**National Action Plans (NAPs) and Country Health Emergency Response Plan:*** Since 2016, 67 NAPHS have been completed (31 in AFRO, 19 in EMRO, 1 in EURO, 8 in SEARO, 7 in WPRO and 1 in PAHO).
* A NAPHS toolkit was developed to support the planning of priority actions and to cost those actions using national standards. The toolkit includes a WHO guidance on Benchmarks for IHR capacities to guide the planning process.
* The NAPHS Framework to support the health security planning in countries based on country risk profiles and capacity assessments was revised and published: https://[www.who.int/ihr/publications/WHO-WHE-CPI-2018.52/en/.](http://www.who.int/ihr/publications/WHO-WHE-CPI-2018.52/en/) In addition, a Country Implementation Guide to operationalize the NAPHS framework is finalized and will soon be published.
* A WHO guidance has been drafted to support countries to develop an all- hazards response plan to country emergencies.

Multisectoral engagement actions to strengthen country health emergency preparedness* Support was provided to countries in establishing Multisectoral Preparedness Coordination platform. This effort for health emergency preparedness includes engagement with key national stakeholders as well as non-traditional actors beyond the health sector such as Parliaments, ministries of finance, foreign affairs, defense, transport and interior.
* The National Collaboration Framework for the Civilian and Military Health Sectors (NCF) was finalized in 2019 and will be piloted in countries in 2020.
* A Partnership for Health Security Preparedness and UHC was developed and an MoU signed between WHO and the Inter-Parliamentary Union (IPU). This collaboration resulted in the IPU adoption in October 2019 of the Resolution on achieving Universal Health Coverage (UHC) by 2030, linked to health security and calling on parliaments to advocate for the implementation of IHR (2005).
* WHO supported countries in integrating disease-specific plans with all-hazards national health security plans using the WHO Resource Mapping (REMAP) tool. In August 2019. an integration of NAPHS in Uganda linked and aligned with the Pandemic Influenza Preparedness Plan (PIPP), National Deployment and Vaccine Plan (NDVP) and Ebola Virus Disease (EVD) plan with the NAPHS. Combined Actions for Health Security were identified in the country that aimed to simultaneously improve preparedness for Ebola, pandemic influenza and broader health emergencies through NAPHS implementation. These actions are currently being prioritized by the government and partners for resource mobilization and implementation
* A Global Strategic Preparedness Network (GSPN) is being developed to coordinate the technical assistance provided to countries by stakeholders including technical institutions, networks, partners, NGOs and international organizations. This will include the engagement of national public health institutes, the International Association of National Public Health Institutes (IANPHI), private sectors, financial institutions, and other relevant non-traditional actors.
* The online SPH Portal (SPP) provides data and analysis to support alignment of country and partner efforts to strengthen preparedness for emergencies such as COVID-19, as well as provides health security investment information to match country needs.

**Review of assessment tools:*** WHO has published – and is implementing – the IHR Monitoring and Evaluation Framework (IHRMEF) which comprises of the four components (State party annual reporting, voluntary external evaluation, after action review and simulation exercise): https://www.who.int/ihr/publications/WHO-WHE-CPI-2018.51/en/
* WHO has published a Country Implementation Guide for Simulation exercises and After-Action Reviews which provides specific information on when to plan, execute and report on the voluntary AAR and SimEx: https://www.who.int/ihr/publications/WHO-WHE-CPI-2018.48/en/
* The WHO Guidance for AAR is now published on the WHO website and is currently available in English, French and Russian (https://www.who.int/ihr/publications/WHO-WHE-CPI-2019.4/en/). The translation into other WHO languages is ongoing. An introductory course on simulation exercises is available on the OPENWHO platform: https://openwho.org/courses/simex , and the AAR e-course is also available on the HSLP, ilearn and soon on the OpenWHO platform. In addition, WHO has been conducting regional trainings on the planning and management of Simulation exercises and after-action reviews. In total 8 regional trainings have been conducted, where a total of 221 individuals have been trained, including staff from MoH, WHO and partners.
* WHO has developed a Resource Mapping (REMAP) tool to support Member States to identify activities that are already funded as well as the technical assistance provided by partners. REMAP contributes to better alignment and harmonization of the work between governments and partners. It can also be used as a monitoring tool to follow-up on the implementation of plans at country level. Resource Mapping workshops have taken place in Sierra Leone and the United Republic of Tanzania.
* WHO is supporting MS to document their progress in strengthening emergency preparedness through implementation of IHR (2005) capacities. This includes identifying best practices that result in effective capacity building and scaling-up to other countries to ensure wider preparedness.

**Minimum core capacities established in all countries:*** The results of multiple country capacity assessments are being analysed with the objective of presenting comprehensive pictures of national capacities to Member States and partners.
* As recommended in the IHR 5-year strategic plan, development of a global National IHR Focal Points Knowledge Network / Community of Practice is ongoing. This will support functioning of regional knowledge networks, facilitating the exchange of experiences and lessons learned between NFPs, based on regional and common areas of interests / challenges faced (small island countries, south-to-south cooperation, etc.)
* WHO has provided guidance on the workforce development of the National IHR Focal Points and IHR implementation, including Orientation to the IHR, Senior Government Leaders, dissemination of WHO validated learning packages on the IHR (the IHR Training Toolkit and IHR related MOOCs).Testing of the functionality of national capacities in preparing for, detecting and responding to a public health event is ongoing through an online gaming situation, “The IHR Serious Game”
* Regional and sub regional Technical trainings have been organized to provide SOPs for prevention, detection and event management at Points of Entry (ports, airports and ground crossings) in WHO/AFRO countries, including vector surveillance and control. A number of meetings have been held in countries, e.g. in Pakistan and Iraq to map hazards and develop a public health preparedness and response plan in the context of mass gatherings. Cross border collaboration meeting to enhance surveillance and response in the context of mass gatherings have been also convened between Iraq and the neighbouring countries (Jordan, Bahrain, Kuwait, Qatar, UAE, Oman & Iran)
* WHO is working with partners and countries to develop a Disaster Risk Calendar to ensure timely response to emergencies by enhancing effective readiness capacity building and fast tracking the implementation of preparedness priority actions.

**Countries and WCOs operationally ready to manage identified risks and vulnerabilities*** WHO works with governments to identify potential and anticipated risks using standardized tools such as Strategic Tools for Assessing Risks (STAR), Vulnerability Risk Assessment and Mapping (VRAM), and where necessary, accelerate readiness activities for emerging or anticipated events. Since 2016, 47 risk profiling workshops were conducted with the support of WHO, most of which took place in the African Region. An operational readiness tier one online training is now available on OPENWHO: https://openwho.org/courses/operational-readiness-introduction
* Using information from risk assessments, early warning, the JEEs and other sources, WHO and MS are identifying priority public health risks and the capacities required to manage them. Based on this WHO is supporting countries to strengthen operational readiness including contingency plans and business continuity plans for WHO country offices. This was also done in the context of the Ebola outbreak in the Democratic Republic of Congo and in 10 countries neighbouring DRC. WHO and partners have supported these countries to enhance their readiness for the potential spread of EVD across a set of key capacities, including coordination and leadership, epidemiology and surveillance, laboratory support, case management, infection prevention and control, vaccines, points of entry, risk communication, rapid response teams and community engagement. WHO has also mobilized human and financial resources to enable countries, partners and WHO to support country readiness for EVD and other priority hazards including flood, cyclone, volcanic eruption.

**Research and development, advocacy , innovation tools*** WHO has established a thematic research network in coordination with WHO Kobe Center, Hong Kong University, Public Health England along with all six WHO regions and partners to support health emergency and disaster risk related research in countries. A Handbook on research methodology was developed to standardize research methodologies for health emergencies and disasters.
* In 2019 WHO coordinated the development of the background paper on the status of country preparedness capacities, to support the first annual report of the Global Preparedness Monitoring Board (GPMB) which was launched at the UN General Assembly in New York.
* WHO facilitated a new Inter-Parliamentary Union resolution on achieving UHC by 2030 which takes in to account the close links that health system have with health security.

**Strategy for IHR capacity development and Disaster Risk Management in fragile states*** WHO has developed and published a guidance document on conducting JEEs and developing and implementation of NAPHS in special context countries, including countries in conflict. A technical meeting was held in Geneva in December 2018 and the draft guidance has been updated.
* In addition, WHO works directly and indirectly with countries to build their capacity to meet IHR core capacity requirements.
* One example is WHOs work to provide financial, human resource, logistical and quality assurance support to build public health laboratory systems and networks to provide essential data to inform and monitor disease control strategies. This support helps progress efforts towards sustainable biosafety/security policies and measures including in collaboration with animal sector to strengthen policy dialogue with financial and technical partners, non-state actors, other international organizations and Member States and provide strategic and technical support to develop national public health laboratory systems. Work is ongoing to develop the WHO/USCDC/ECDC/FAO/OIE/APHL Global Laboratory Leadership Programme.
* WHO has supported the setup of national Rapid Response Teams in low-resourced and vulnerable countries in particular throughout AFRO.
* WHO published the Health Emergency and Disaster Risk Management Framework at the 2019 Global Platform for DRR in Geneva. The Framework will assist countries to develop/strengthen multi sectoral mechanisms to address disaster risks using IHR capacities and linking these closely with health system strengthening. The framework particularly focuses on health workforce development and partnership approaches for reducing disaster risks in communities.

**Link between WHE and other relevant programmes within WHO, in particular health care systems*** Mechanisms for strengthening collaboration between WHE and other parts of WHO working on health system strengthening have been put in place. There are two weekly meetings between the Deputy Director General of the WHE programme and Deputy Director-General for Programmes to oversee progress on implementing work to strengthen health systems in fragile, conflict and vulnerable settings.
* In Iraq WHO is leading on the planning of the health component and health system strengthening in the recovery and resilience plan; essential health services, referral, support to secondary care and outbreak management are being delivered to the 1.6 M IDPs remaining in camps and among host populations
* WHE conducted a workshop with multisectoral stakeholders in November 2018 to review and finalise the Health Emergency and Disaster Risk Management (Health EDRM) Framework, the WHO Glossary for Health EDRM, and technical guidance notes to Ministries of Health for monitoring and reporting of the health- related targets and indicators for the Sendai Framework for Disaster Risk Reduction.
* WHE has developed a draft framework on Leveraging Health Systems for Health Security and a global expert consultation will take place on 6-7 March in Geneva. The framework aims to i) Lay out key considerations for leveraging health systems for health security; ii) Identify elements that constitute preparedness capacity across different levels of maturity of the health systems and iii) Provide a methodology to estimate cost for financing the health systems for health security.
* At HQ, a joint scope of work around UHC in FCVs has been developed and discussions between HSS and IHR core capacity building are continuing. The key objective for this collaboration at HQ is to better align support to Regional Offices and Country Offices initially focusing on a small number of countries.
* At regional level. EMRO has strengthened collaboration between HSS and emergencies as part of their Health Systems and Emergencies Laboratory (HSEL).
* In Nigeria work is ongoing on joint WHE HSS interventions in line, both to deliver humanitarian aid by increasingly integrating the pillars of the health system and by strengthening health systems in more stable ares, in line with the Humanitarian Development Nexus (HDN), spirit. Joint support has been given to support the delivery of essential package of health services in Yemen and to strengthen pharmaceutical systems in CAR. WHE and UHC support jointly the FCV operational reviews which facilitate adapting flexibly to an evolving context and reviewing the strategy. A blueprint for FCV is developing from the Nigeria experiences.
* A joint mission from HQ and AFRO with participants from both WHE and HSS visited South Sudan from 16 -27th of September with the aim of developing a comprehensive Health Systems Stabilization and Recovery Plan and UHC Road map.
* In Yemen the WHO health system analysis was kick started with a first workshop organized in Amman reuniting different stakeholders to
* build common understanding bringing together information already available and look at gaps needing to be filled,
* align expectations for this analysis (approach, tools, outputs)
* WHE is working closely with other WHO departments, technical units, and partners to provide integrated support for preparedness among migrant and displaced populations by ensuring that these communities are part of all strategies, policies and practices for health emergency preparedness.
* WHO is closely working with the World Meteorological Organization (WMO) on managing climate risks, with UNDRR to implement and monitor Sendai framework for Disaster Risk Reduction.
* WHO is also working with IMFSA (International Medical Students Association) and other non-governmental organizations and private sector groups to reduce disaster risks.
* WHO is also working with other programmes to ensure the input and participation of relevant technical units that can support IHR monitoring & evaluation and associated preparedness capacity building activities
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| **2.**Epidemics and pandemics prevented | * Research agendas, predictive models and innovative tools, products and interventions available for high-threat health hazards
* Proven prevention strategies for priority pandemic/epidemic-prone diseases implemented at scale
* Mitigate the risk of the emergence and re- emergence of high-threat pathogens
 | **Research agendas, innovative tools and interventions*** Research agenda have been finalized for MERS-CoV, Zika virus disease, influenza and smallpox, and in development for Crimean-Congo haemorrhagic fever (CCHF), and roadmaps developed for Ebola virus disease, Nipah virus infection, Marburg virus disease and Lassa fever.
* The Research and Development Blueprint work is continuing. The list of priority diseases for the blueprint was revised in 2018 including disease X. The work of the Blueprint has allowed the introduction of 4 new therapeutics for case management and large-scale vaccination against Ebola in the Democratic Republic of the Congo (DRC) Eastern Equateur and North Kivu. More than 80,000 high-risk people have been vaccinated. In addition, modelling work by the WHO CC Imperial College has been used to support and guide the response.
* The GeneXpert technology was used in DRC to allow rapid diagnostic field capacity: >13,555 samples tested.
* There have been significant improvements in clinical care during the Ebola outbreaks with a paradigm shift from isolation to care, and implementation of randomized control trials with new drugs during the Ebola North Kivu outbreak especially.
* Stronger Risk Communication and Community Engagement (RCCE) with improved collaboration with partners (UNICEF, IFRC, and universities), the creation of a social science platform and the first-time ever publication of the WHO Guideline for Emergency Risk Communication policy and practice.
* Rapid transfer of knowledge to front-line responders has been enabled with >100,000 subscribers to OpenWHO with 18 knowledge packs, 56 courses; and the successful publication of the Managing Epidemics handbook (downloaded >16,000 times in 6 months).
* The Strategic & Technical Advisory Group for Infectious Hazards (STAG-IH) has been established and convened with 2 face-to-face meetings and 3 telephone conferences. TORs have been finalized, and bi-weekly newsletters shared since November. STAG-IH is a global advisory group comprising 13 members, providing independent recommendations to WHO on infectious hazards that may pose a potential threat to global health security, and technical and scientific advice on issues related to the Pandemic Emergency Financing Facility (PEF) and the Global Preparedness Monitoring Board (GPMB). In 2018, the group provided independent informal expert advice on strategies to contain the two Ebola outbreaks in DRC and recommendations on whether to convene the Emergency Committee.
* Other innovations in the pipeline include a potential antiviral for Monkeypox and discussion on global mechanisms for access and benefit sharing (influenza and beyond).
* A demonstration tool to forecast cholera epidemics has been successfully developed. This tool can be used to improve preparedness of countries against recurring outbreaks.
* WHO developed the first game-based table top exercise for deployment of pandemic influenza vaccine which has been piloted in three regions
* For the COVID-19 pandemic, the WHO Information Network for Epidemics (EPI-WIN) was established to fight misinformation, rumors and myths, as well as establishing trusted sources of information by establishing multi-partner amplification partnerships.

**Prevention strategies**The Secretariat develops global strategies for the prevention and control of epidemic-prone diseases, together with partners from a wide range of fields to bring together all globally available resources and scale these strategies to the regional and country levels, protecting billions of people.* CHOLERA: the “Ending cholera, a global roadmap to 2030” was adopted by the WHA in May and by the Regional Committee for Africa in October. Zambia and Zanzibar have formally launched comprehensive plans for cholera elimination, Bangladesh and Zimbabwe have finalized their plan and, while Ethiopia, Kenya, Mozambique, South Sudan and the United Republic of Tanzania Zimbabwe are currently developing their national cholera control plans along the lines set out in the Global Roadmap. In 2019 only, 23 million doses oral cholera vaccines had been shipped to 13 countries (totaling 60 million doses in 22 countries since 2013)
* YELLOW FEVER: The global strategy to eliminate yellow fever epidemics is in its third year of a ten-year plan. Vaccine supply has improved significantly, and it is estimated that 125 million people in Africa have been protected through a combination of routine, preventive and reactive campaigns to date. These numbers and the engagement of the African Region, the Region of the Americas and the Eastern Mediterranean Region, which are all affected by yellow fever with 40 high-risk countries, are unprecedented.
* INFLUENZA: The Global Influenza Strategy 2019-2030 was launched in March 2019, following consultation with >50 Member States. The strategy provides a framework for WHO, Member States and partners to approach influenza holistically through tailored national programmes – from surveillance to disease prevention and control – with the goal of strengthening seasonal, zoonotic, and pandemic preparedness.WHO has initiated implementation towards the strategy's two high-level outcomes for 2030: better global tools and stronger country capacities. In 2019, over 3 million specimens were collected by Global Influenza Surveillance and Response System laboratories, informing influenza vaccine strain selection and supporting influenza risk management. Also in 2019, it was estimated that more than 500 million people have been vaccinated against seasonal influenza. Through the implementation of the Pandemic Influenza Preparedness (PIP) Framework, WHO has secured approximately 10% of future global pandemic influenza vaccine production, which equates to >400 million doses of pandemic vaccines based on 2015 estimates of global production capacities. WHO has also secured 10 million antiviral treatment courses in case of a pandemic. Since 2012, WHO has collected nearly US$ 200 million from the Pandemic Influenza Preparedness Partnership Contributions (PC), and those funds have been used to strengthen national preparedness capacities in 72 countries. Additional impact is foreseen at the country level with the PIP PC High Level Implementation Plan II, which was published in 208 and outlines the use of the funds through 2023.-
* MENINGITIS: Defeating Meningitis by 2030: A Roadmap was considered favourably by the Strategic and Technical Advisory Group for Infectious Hazards and by the Strategic Advisory Group of Experts. A platform for integrated surveillance has been set up and implementation is starting in the African Region. Validation of a meningitis rapid diagnostic test is under way.

In addition, WHO is also the Secretariat for the governance of global emergency stockpiles, including the International Coordinating Group (ICG) on vaccine provision. In 2019, WHO deployed a total 17.5 million of doses of vaccines for emergency vaccinations through the ICG mechanism, saving millions of lives. **Emerging and re-emerging diseases: support to prevention, risk assessment, preparedness and response*** EBOLA: deployment of expertise to support the Ebola outbreaks in DRC, including updated strategy for laboratory; clinical management and therapeutics; infection prevention and control; vaccination and survivor programme; community engagement and safe and dignified burials.
* LASSA: important outbreak with 633 confirmed cases, including 17 deaths in Nigeria. Rapid response and excellent leadership of the country with the organization of the 1st international Lassa fever conference in January 2019.
* MERS-CoV: the “Global Prevention and Response Plan for Emerging Respiratory Diseases including MERS” has been finalized and significant improvements have been realized in surveillance and response (1 case in Korea with no further transmission).
* PLAGUE: development of 3 technical documents for addressing plague outbreaks in Madagascar (treatment, surveillance and rodent control).
* ZIKA: important steps in the technical agenda bringing together various partners to improve diagnostic and surveillance as well as vector control strategies in developing countries.
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| **3.**Detection and response to Health emergencies (acute and protracted emergencies) | * Potential health emergencies rapidly detected, and risks assessed
* Application of Emergency Response Framework (ERF): risk assessment and situation analysis, WHO grading, Incident Management System (IMS), response procedures, roles and responsibilities
* Acute health emergencies rapidly responded to, leveraging relevant national and international capacities
* Effectiveness of field operations
* Rationalization/standardization of production and dissemination of situation reports and risk assessments for each event
* Support affected countries for risk communication and community engagement
* Essential health services and systems maintained in fragile, conflict and vulnerable settings; working jointly between WHE and HIS
 | **Performance Standards (PS)*** From 1 January 2019 until 31 December 2019, a total of 111 Disease Outbreak News (DONs) were posted
* There were 1,328 geospatial information products produced by the GIS Team form 1 January 2019 to 31 December 2019. Of these, 1,261 (94.9%) were Ebola Virus disease-related products
* Number of Rapid Risk Assessments / from 1 January 2019 to 31 December 2019: 64
* Number of events created in EMS/ from 1 January to 31 December 2019: 500
* In 2019, WHO provided support to all 29 activated Health Clusters to implement the Public Health Information Services (PHIS) Standards. Amongst these, 22/29 have Public Health Situation Analyses (PHSA), 28/29 have an Early Warning, Alert and Response (EWAR) system, 24/29 conducted rapid health assessments (RHA), 29/29 have implemented the Surveillance System for Attacks on Health Care (SSA)(not all through the Cluster mechanism), and 25/29 have a regular Health Cluster Bulletin. Quality of service implementation varies by Cluster
* There are currently 63 active graded emergencies

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| **Active emergencies newly graded in 2020 (as of 22 March 2020)** |
| **Country/event** | **Grade** | **Date of initial grading** | **Type of crisis** | **PSs met** |
| COVID-19 | 3 | 26/01/2020 | Coronavirus | No info |
| CAR | 2 | 11/02/2020 | Measles | No info |

* IHR Secretariat has monitored international travel and trade measures for several events in 2018, and supported States Parties to improve compliance with the 43 regarding the additional health measures related to international travel and trade: MERS-CoV in the Republic of Korea, Nipah c of the Congo, Rift Valley Fever Kenya, Cholera, Zimbabwe.

 \*For some G2 outbreaks, a needed info on PSs in the vSHOC is missing, therefore the ERF MT is not activated yet.For G1 emergencies the ERF Monitoring Tool (MT) is not activated and delivery of Performance Standards isnot monitored. * WHO activated the Incident Management System (IMS), in accordance with ERF procedures for 100% of Grade 3 emergencies, to fulfil its six critical functions and scaled up its operational and technical support to immediately address health needs and risks of the affected population. The Grade 3 emergencies in Mozambique, DRC, and Yemen are also Inter-Agency Standing Committee (IASC) system-wide Level 3 emergencies. For Mozambique the IASC Level 3 designation was deactivated in May 2019, although WHO continued with its own internal Grade 3 declaration till 4 September 2019 when it was downgraded to G2. On 17 July 2019 the Ebola outbreak in the DRC was declared a Public Health Emergency of International Concern.
* Between 1 January and 201830 September9, WHO responded to52 graded emergencies in 43 countries. . From the acute emergencies, there were six emergencies classified Grade 3 emergencies and four acute graded emergencies were converted into Protracted Grade 3. This is the highest severity level based on the ERF. It requires a substantial and continuous organization-wide support needed for the collective response with health partners in the field to ensure that emergency health needs of the affected population are addressed in the most efficient, effective and sustained way. Out of these, a complex refugee crisis associated with the Rakhine conflict in Bangladesh and Myanmar was later downgraded from P3 to P2 grade.Responses have also leveraged key support from partners through the Global Outbreak Alert and Response Network (GOARN), on the ground and through strategic collaborations.
* For 2018, the total number of deployments was 1,980 with 189 administrative staff deployed. To date in 2019, there have been 260 deployments, including 38 administrative staff. The DRC North Kivu Ebola response alone has deployed over 30,000 combined person days thus far.
* The ongoing DRC North Kivu and Ituri Ebola outbreak is an example of WHO’s effective field operations this year: Over 700 people have been deployed to the field for operational and technical support, both WHO staff/consultants and through GOARN partners. Since 1 August 2018 $5.5 million worth of supplies have been mobilized to DRC. This has included 253 international shipments, measuring 311 tons. Beyond key operational necessities such as ambulances, PPE, IPC kits, syringes, freezers and other logistical requirements, WHO has also led the implementation of expanded access/compassionate use of an investigational Ebola vaccine (to over 85,000 people) and the administration of four investigational therapeutics for Ebola (to over 400 people to date, including enrolment in a randomized control trial). This complex operation exemplifies the increasing operational capacity of WHO and the leadership role it is playing in responding to acute health emergencies.
* In Bangladesh, WHO lead and coordinated the health sector response, in close collaboration with the Ministry of Health. A cholera outbreak was averted, due to early prioritization of oral cholera vaccination campaign and progressive expansion of health services achieved. Sphere standards were met for mortality (0.2 deaths/10,0007 day) and outpatient consultations (3.1 new consultations/person/year). A public health catastrophe was averted, despite high risks.
* In Northern Nigeria Sphere standards mortality rates were progressively reduced and remained below the emergency threshold. Progressive expansion of health services in a difficult operating environment resulted in Sphere standards being met (1.1 new consultations/person/year).
* In Syria, outbreaks of vaccine-derived polio (cVDPV2) were effectively controlled, in Raqqa and Deir Ez Zoor governorates despite extremely difficult operating environments. WHO and partners responded flexibly and effectively to multiple emergencies and hotspots in the Northeast, Raqqa, Eastern Ghouta, Northwest, and Southwest. A revitalized Whole of Syria approach strengthened the response.
* In Syria, outbreaks of bloody diarrhea and Hepatitis A were successfully controlled, and significant progress made on provision medicines to treat Leishmaniasis.

In Syria, WHO responded to acute deteriorations of the protracted crisis in several instances in 2018, which saw an intensification of the violence in the first two quarters of the year. WHO scaled up significantly its presence and response in NE and NW Syria, especially on trauma management, medical evacuations, strengthening the referral network for trauma management and setting up WHO PHC referral networks for the response in NW Syria. responded to public health consequences of alleged chemical events within the IHR framework, referral pathways and in ensure treatment and care. Access to health care was increased cross line and cross border where security situation and restrictions allowed unimpeded access. WHO advocated for the lifting of restrictions on importation of internationally procured medicines for humanitarian response and obtained the lifting of restrictions in early 2018. This allowed provision of medicines esp for NCDs and dialysis treatments in a more predictable way.* In Yemen, WHO supports 202 health facilities, including all 22 governorate hospitals, to deliver essential health services. Support includes essential medicines, training, equipment, fuel and monitoring. OCV campaigns in high risk districts have contributed to reduction in cholera cases compared to previous period last year, and further campaigns will continue.
* For the Zimbabwe Cholera response (2018), daily internal situation reports were disseminated to the IMST at three levels.
* For the Nigeria Lassa Fever response (2018), weekly situation reports were disseminated to the IMST at three levels.

**COVID-19, global response**: On 31 December 2019, the WHO China Country Office was informed of cases of pneumonia unknown etiology detected in Wuhan City, Hubei Province of China. The Chinese authorities identified a new type of coronavirus, which was isolated on 7 January 2020, and China shared the genetic sequence of the novel coronavirus on 12 January. As of 23 March, there have been over 335,000 confirmed cases reported from 190 countries/states/territories and one international conveyance (Princess Diamond cruise ship). WHO activated its Incident Management System on 1 January, with a team at WCO China, the Western Pacific Regional Office and HQ. As the outbreak spread to other countries and regions, IMSTs were set up across the regional and country offices. The Grade 3 event was declared a Public Health Emergency of International Concern on 30 January, and the Director General characterized it as a pandemic on 11 March. The current risk assessment classifies the risk as Very High at global level.* Response activities have included several country technical missions including China, Iran, Italy, Algeria, Bahrain, in addition to individual deployments to support countries. These missions have included WHO staff and GOARN partners.
* WHO developed extensive technical guidance on clinical management, infection prevention and control, surveillance, diagnostic strategy, preparedness and readiness actions for countries, travel advice, operational and logistic support, mass gatherings, risk communication and community engagement, and advice for healthcare workers and for the public. The guidance is reviewed regularly and updated as we learn more about the pathogen: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance>.
* A global Strategic Preparedness and Response Plan was developed with partners and launched on 3 February, to support countries to develop national plans for COVID-19.
* WHO is a critical partner in the Pandemic Supply Chain Network, which aims to coordinate and manage the limited global supply of PPE and other medical supplies. The global demand for PPE is unprecedented and there is a severe shortfall in the availability worldwide, and the work on Supply Chains is a key aspect of the response.
* The UN Crisis Management Policy was activated and WHO (EXD/WHE) chairs the UN Crisis Management Team. This interagency group meets regularly to ensure coordination and complementarity across the UN system.

**Ebola Virus Disease**, Democratic Republic of Congo. Since May 2018, WHO has responded to two outbreaks of EVD in DRC. Each response saw the rapid mobilization of resources, including the completion of rapid risk assessments, event grading, release of CFE, and the deployment of rapid response teams within 24 hours of outbreak declaration. The outbreak in North Kivu and Ituri provinces benefited from the capacities established in Equator, including laboratory testing (GeneXpert) available within 24 hours, ETUs open within 3 days, vaccination starting within 1 week, and therapeutics available to patients within 9 days. In response to the EVD outbreak in North Kivu and Ituri, WHO continues to maintain a three-level response with dedicated IMSTs at HQ, AFRO, and in DRC. Key partners, including UNICEF and CDC, have seconded Senior Liaisons to participate in and provide technical support as part of the HQ IMST. In addition to the Senior Liaison function, CDC has maintained continuous deployments to HQ to support work on vaccination, GIS/mapping, partner coordination, information management, and epidemiology. Since the start of the outbreak, WHO has deployed more than 1,500 people, including staff from across the three-levels, external recruitments, and partners, to support the response. In total, deployees have spent more than 360,000 person-days in the field. Despite operating in a complex and highly insecure environment, WHO, the Ministry of Health, and partners have maintained a robust response across an area larger than 1,000 kilometres. Highlights of the response include: * Epidemiology and Surveillance:
	+ More than 249,000 contacts registered since the start of the outbreak
	+ Since October 2019, nearly 5,000 alerts reported on a daily basis
	+ Only 1 health areas in Beni Health Zone affected during the 21 days prior to the last confirmed, compared with 72 health areas and 22 health zones affected when the outbreak was declared a Public Health Emergency of International Concern in July 2019
* Health Operations:
	+ Laboratory:
		- 11 laboratories operational, testing more than 181,400 samples since the start of the outbreak and 100% of results available within 48 hours or less
	+ Clinical Management:
		- More than 1,800 patients treated with therapeutics, including over 1,030 under the Randomized Control Trial
		- CFR of 33% for deaths that occurred 24 hours or more after admission to an ETC
	+ Vaccination:
		- Nearly 300,000 contacts and contacts of contacts vaccinated
	+ Points of Entry and Control:
		- More than 157 million screenings at PoE/PoC, preventing the exportation of 30 confirmed cases
	+ Survivor Programme:
		- More than 1,160 survivors to date
		- 5 clinical operational in Beni, Butembo, Mangina, Mambasa, and Goma
* Operations Support and Logistics:
	+ More than 1,000 metric tons of supplies mobilized
	+ 21 VSATs deployed
	+ Direct support to 10 treatment facilities (300+ beds)
	+ Direct support to 4 camps and more than 650 beds for response teams (WHO, MoH, and partners)

**Protracted Crises Update*** WHO responded to the emergencies in the Democratic Republic of the Congo (G3), in areas also affected by humanitarian crises arising principally from displaced populations, by ensuring delivery of essential medicines and supplies and by making available a minimum package of essential health services. WHO also continued to provide technical support and coordination for disease surveillance and response, and prevention of communicable diseases. In the reporting period, a cholera vaccination campaign was completed in the Greater Kasai region in response to ongoing outbreaks, reaching over 1.2 million individuals. A first round of cholera vaccination was implemented in north Kivu and in the Goma, Karisimbi and Nyiragongo health zones, reaching close to 800 000 individuals. Over 4million children were vaccinated against measles by WHO and partners in at least 116 health zones. The Organization declared the measles outbreak a Grade 2 emergency and released US$ 500 000 from the Contingency Fund.
* In South Sudan (P3), WHO responded to the health effects of increased displacements; outbreaks of violence; malnutrition; and increases in communicable diseases; it strengthened contingency planning against emerging communicable diseases. The Organization provided emergency supplies to bridge gaps at primary care level. To mitigate the risk of the cholera outbreak WHO in collaboration with the Ministry of Health and UNICEF immunized about 144,000 people against cholera in Renk, a county bordering Blue Nile state in Sudan where the cholera outbreak was declared in September 2019.
* In Nigeria (P3), mobile medical teams were strengthened in order to increase response capacities to acute events; WHO took action in respect of floods and increases in communicable diseases, including measles and cholera, and provided case management training to health care workers dealing with patients suffering from those diseases. The Organization assisted the staff of the cholera treatment centres by providing logistical support for the treatment of patients, as well as by prepositioning of supplies and commodities.
* In the Syrian Arab Republic (G3), WHO maintained a swift and scalable response to meet the health needs of the populations affected by conflict, continued to fill critical gaps in primary and secondary health care, ensure provision of essential medicines and medical supplies and strengthen cross-line and cross-border medical supply chains. Throughout 2019 WHO and its health partners conducted more than 25 million medical treatments including outpatient consultations, mental health and trauma care, deliveries by a skilled birth attendant. In the first half of 2019, WHO delivered life-saving medicines and medical equipment to fill gaps in primary health care services in 12 governorates; donated 15 ambulances and 15 mobile clinics to the Ministry of Health; and supported 79 hospitals across the country. The Organization provides monthly supplies of life-saving medicines and medical equipment to around 100 health facilities in the north-west of the country, prepositions sufficient stocks of health emergency kits in Aleppo, Homs and Lattakia, and supports five WHO-funded surgical units in Idleb. WHO continues to support building capacity of health expertise in such necessary fields as mental health and disability, increasing vaccination coverage rates, and expanding partnerships with civil society capacity to scale up referral networks and outreach services. These activities are concentrated especially in underserved areas and areas with massive population displacement such as Aleppo, Al-Hasakeh, Deir ez-Zor, Homs (from Rukban), Idleb and Raqqa. Across the north-east Syria WHO and health partners prepositioned at Qamishly hub lifesaving supplies and vaccines for almost 314,000 medical treatments as well as trauma and surgical supplies for 500 trauma patients. In addition, WHO continues to lead the health cluster from all response hubs (cross-line and cross-border) and improve the collection and analysis of real-time health information for evidence-based planning and response.
* In Yemen (G3), in cooperation with the Ministry of Public Health and Population and other health partners, WHO supported the provision of primary and secondary health care services to the affected populations in the north and south of the country. In response to a cholera outbreak, WHO scaled up its operations and supported the establishment of 333 multidisciplinary rapid response teams. At the same time, it conducted oral cholera vaccination campaigns in high-risk districts, vaccinating 2.2 million people. From January to August 2019, WHO and partners provided health assistance to 10.4 million people out of 15.8 million targeted. Throughout 2019, WHO managed to provide dialysis supplies to support 21 dialysis centres for 600 000 dialysis sessions in 13 governorates (Amanat Al Asimah, Aden, Taiz, Sana'a, Sa’adah, Ma’rib, Shabowa, Hadramout, Dhamar, Al Bidha, Ibb, Hudaydah, and Al Mahrah) to cover urgent needs of more than 3500 patients requiring life-saving dialysis sessions to ensure continued treatment. More than one million children were protected from vaccine preventable diseases; more than 100 000 children aged under 5 years have been saved from death by severe acute malnutrition; and almost 800 000 pregnant women have received antenatal care. In late 2019 WHO initiated a project on UN medical air bridge for transportation of patients who need specialized medical attention unavailable in Yemen to agreed locations abroad. Thanks to tremendous diplomatic efforts by UN and some Member States the first medical air bridge operation was launched in February 2020 and a group of Yemeni patients was delivered from Sanaa to Amman, Jordan.
* In Somalia (P3), in cooperation with the Federal Ministry of Health and other partners, WHO provided primary and essential health care services to the crisis-affected populations in the country. In response to an ongoing cholera outbreak, WHO scaled up its operations, supporting surveillance and oral cholera vaccination campaigns that protected over 600 000 people against cholera. Together, partners provided over 800 000 consultations through integrated health and nutrition mobile units and fixed primary health care facilities to serve a growing population of internally displaced persons and host communities. Reproductive health services were provided to over 230 000 pregnant women receiving antenatal care. Several partners provide specialized referral services, including services for gender-based violence survivors. As a result of a nationwide integrated polio and measles vaccination campaign 1.7 million children aged under 5 years had been vaccinated against polio and more than 1.5 million children aged six to 59 months for measles vaccination and vitamin A supplementation. In 2019, WHO delivered 130 tons of emergency medical supplies to health facilities across Somalia to support primary health care services of around 120,000 patients. Since the scaling up of response operations to drought in September 2019, about 162,000 internally displaced persons were reached out with emergency health services in 10 drought-affected districts of Hishabelle, Jubbaland and south-west states.
* The Grade 3 emergency in Bangladesh, which started in 2017, was downgraded to a Protracted Grade 2 emergency on 17 April 2019. That grade of emergency still requires a sustained WHO operational presence and response. In 2019 the Organization, working together with 119 health sector partners, continued providing emergency health support to the affected population. In 2019 WHO conducted over 3,6 million patient consultations and established a disease early warning alert and response system covering 95% of the affected population. Five mass immunization campaigns against diphtheria were undertaken by WHO and partners, averting further potential outbreaks. The OCV campaign was conducted for the Rohingya camps in December 2019 with a full coverage for all camps. In 2019, WHO provided essential medicines, supplies and equipment, set up a field laboratory in Cox’s Bazar and a water testing laboratory ensuring continuous water quality surveillance. An external review of the health services delivery led to further adjustments to the health partners’ planning in 2019. A joint WHO operational review in October 2018 resulted, as mentioned above, in the downgrading of the emergency to a protracted emergency, and the establishment of a WHO emergency sub-office at Cox’s Bazar.
* For the response to the Ebola outbreak in North Kivu, senior liaisons from UNICEF and IFRC were seconded through WHO’s Incident Management team in headquarters to enhance collaboration and effectively implement risk communication and community engagement in the country. Weekly coordination calls are held with partners (including NGOs and academic institutions) at the global level, and WHO teams support daily meetings of the risk communication, community engagement and social mobilization commission led by the Ministry of Health at the local level.
* WHO also works closely with GOARN social science research partners in deploying social science knowledge and interventions for better understanding of the community in the response, including in the context of the introduction of investigational vaccines and therapeutics.
* In 2018, a total of 90 Risk Communication officers were deployed as part of the IMS for 10 emergencies. In 2019, there have been 7 new deployments for risk communication for 1 incident (DRC Ebola).
* The IHR Secretariat is providing technical support and partner coordination for cross-border and travel measures at Points of Entry for the response to the Ebola outbreak in DRC. Travel advice has been published on the ITH website for Yellow Fever, Ebola, MERS-CoV, and Cholera.
* Essential health services and systems maintained in fragile, conflict and vulnerable settings; working jointly between WHE and HIS
* Joint work: Operationalizing WHO’s support for Universal Health Coverage in Fragile, Conflict-affected and Vulnerable (FCV) Settings document finalized and the SOP for UHC Joint Working Team was finalised.
* The Emergencies Programme and the Universal Health Care Programme agreed to focus comprehensive and sustained joint work in four crises in order to develop approaches that tailor the response to long term recurrent needs in volatile settings, increasingly integrating the pillars of the health system in the response, to foster resilience and a more robust response. Those efforts will translate not only on country support but on tested guidance that can be applied to other settings.
* For Nigeria: An operational review that maintained rapid response capacities while integrating increasingly the local pillars of the health systems for a more resilient response as part of dynamic and flexible process adapted to the changes in the context, ),. Key regular process indicators include a detailed monitoring framework, monthly TCs, work with different health systems pillars in HQ for exploring ways of support. and weekly SitReps which report in line with the plan objectives and results.
* UHC2030 Advocacy Briefing on UHC in Fragile Settings drafted to inform the broader UHC high level meeting and its outcome document next year.
* Specific examples: In Yemen, WHO and the World Bank have partnered to equip 72 hospitals with the Minimum Service Package (MSP). In Bangladesh, WHO has made significant contributions to infectious disease and outbreak control, expansion of and support to health services, capacity building of the national health system, and coordination of the health sector response. Coverage of health services meets international Sphere standards. In Nigeria, WHO has increase provision of health services through mobile teams, CORPS/CHW treatment for severely ill malnourished children, Malaria SMC, and health network expansion. In North-East Syria, trauma care referral pathways and the blood bank system were strengthened, as well as undertaking health facility resource assessments. Provisioned healthcare in displacement camps and provided support to the health system
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