>1000 Epidemic events globally, 2011–16

WHO data as of June 2016. Excludes Poliomyelitis.
Major Emergencies

Large-scale emergencies are becoming more frequent.

Diverse drivers of risk from climate change and urbanization, to terrorism, conflict, and state fragility.
The scale of the challenge

WHO RESPONDING TO 47 ACUTE AND PROTRACTED EMERGENCIES
Yellow fever in Angola and DR Congo

First suspected case in Luanda, Democratic Republic of the Congo

Outbreak officially declared

Reactive vaccination campaigns

Democratic Republic of the Congo reports imported cases

SAGE

23 June last reported confirmed case from Angola

3 February – 18 May 2016
ANGOLA: 11.8 million vaccine doses administered
DEMOCRATIC REPUBLIC OF THE CONGO: >2 million vaccine doses administered

Over 13 million people vaccinated in Angola and the Democratic Republic of the Congo

World Health Organization

HEALTH EMERGENCIES programme
Geographical Spread of Mosquito-Borne Zika
MERS CoV – Recurrent Nosocomial Outbreaks and Low level Ongoing Transmission, 2012-2016

Confirmed global cases of MERS-CoV
Reported to WHO as of 14 Oct 2016 (n=1806)

Other countries: Algeria, Austria, Bahrain, China, Egypt, France, Germany, Greece, Iran, Italy, Jordan, Kuwait, Lebanon, Malaysia, Netherlands, Oman, Philippines, Qatar, Thailand, Tunisia, Turkey, United Arab Emirates, United Kingdom, United States of America, Yemen

Please note that the underlying data is subject to change as the investigations around cases are ongoing. Onset date estimated if not available.
WHO’s coordination role in emergencies

All-Hazards
Preparedness/IHR, risk assessment and response

- NATURAL DISASTER
- CONFLICT
- INFECTIOUS OUTBREAKS
- CHEMICAL
- NUCLEAR DISASTER

IASC/OCHA
WHO LEAD ROLE
SPECIALIZED MECHANISMS

EVENT GRADING

IMS and RESPONSE
How is WHO meeting the challenge?

- Early warning, risk assessment, and emergency response
- Prevention and control strategies for high-threat infectious hazards
- All-hazards preparedness, IHR assessment and core capacities strengthening
- Health systems strengthening in high-vulnerability countries
# Lessons Learnt From Recent Responses

## Progress
- Early detection of risks
- Systematic use of IMS
- Access to contingency funds
- Pre-positioned prevention and control mechanisms
- Strong collaboration with technical programmes (child/maternal health, R&D, NCDs, vector control, polio, etc.)
- Improved strategic and joint operations planning with partners (GOARN, IASC, R&D, technical networks)

## Challenges
- Multiple competing demands
- Remaining capacity gaps
- WHO country business model
- Context for new IMS system
- Clarification of who does what across the three levels still required
- Limited/delayed funding
- Replenishing contingency fund
- Transition strategy
Joint External Evaluations (JEEs)

- 20 completed
- 15 scheduled
- 36 expressed interest
JEEs vs Self Assessment

Pakistan

Tanzania

Bangladesh

USA

1 Legislation; 2 Coordination; 3 Surveillance; 4 Response; 5 Preparedness; 6 Risk Communication; 7 Human resources; 8 Laboratory; 9 Points of entry; 10 Zoonoses; 11 Food safety; 12 Chemical events; 13 Radiation emergencies
Domestic resources + support by multilateral and bilateral partners to monitor progress and fully implement national action plan.

Country Self Evaluation is enhanced by the Joint External Evaluation (JEE)

Based on JEE (and PVS) results, costed action plan to address gaps

Targets and vulnerabilities inform country capacity evaluation

Country action plans

Country assessments

Partners’ commitment & Country investments
Implementation Status

1. One workforce
   HQ & regional office staff aligned to new programme structure by end-Oct ‘16

2. One workplan & budget
   Single budget, results framework & workplans aligned across all offices (Oct-Dec ‘16)

3. One line of accountability
   ExD, Directors, appointed, DG & RDs agreed on line of accountability for graded events

4. One set of processes
   New protocols for risk assessment, grading, incident management effective as of Aug ‘16

5. One admin. system
   Contingency fund & emergency standard operating procedures in use
Emergencies programme budget requirements

Core budget 2016–17 + appeals + Contingency Fund for Emergencies

- Core budget: US$485 million
  - Funded: 56% (US$272 million)
  - Gap: 44% (US$214 million)

- Appeals: US$656 million
  - Funded: 33% (US$442 million)
  - Gap: 67% (US$214 million)

- Contingency fund: US$100 million
  - Funded: 31% (US$31 million)
  - Gap: 69% (US$69 million)
Emergencies programme voluntary and flexible contributions*

- **Flexible funding**: US$ 77 million
- **Voluntary contributions**: US$ 125 million

**Country health services**: 41%
- IHM: 23%
- EMO: 20%
- HIM: 12%

**Core services**: 4%
- IHM: 14%
- EMO: 13%

*Excludes US$ 70 million pipeline*
Funding gap

Core requirements and projected funding gap (US$ millions) by quarter

- Cumulative Requirement per Q
- Cumulative Gap per Q

World Health Organization

HEALTH EMERGENCIES programme
Socio-economic impact of MERS outbreak in Korea May-August 2015

Economic influence during MERS Outbreak in Gyeonggi-do
(source: Gyeonggi research Institute, 2015)

<table>
<thead>
<tr>
<th>Period</th>
<th>Economic growth rate(%)</th>
<th>Production value (1,000,000 won)</th>
<th>Number of newly-employed(person)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month</td>
<td>0.22 ↓</td>
<td>1,661,474 ↓</td>
<td>26,826 ↓</td>
</tr>
<tr>
<td>2 month</td>
<td>0.57 ↓</td>
<td>4,355,279 ↓</td>
<td>71,442 ↓</td>
</tr>
<tr>
<td>3 month</td>
<td>0.93 ↓</td>
<td>7,049,086 ↓</td>
<td>116,058 ↓</td>
</tr>
</tbody>
</table>

Payment by Credit Card during MERS Outbreak in Gyeonggi-do compared to before outbreak (source: Gyeonggi research Institute, 2015)
Conclusion

• Programme is up and running
• Strong progress being made
• Continuous refinement still needed
• Major capacity gaps remain
• Major focus now on: a) results at country level b) strengthening partnerships
• Current funding gaps critical
• Sustainable, predictable investment financing model
Thank-you!