## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 OVERVIEW</td>
<td>Vision and strategy</td>
<td>4</td>
</tr>
<tr>
<td>2 UPDATE 2016</td>
<td>WHO response to health emergencies</td>
<td>6</td>
</tr>
<tr>
<td>3 KEY AREAS OF WORK</td>
<td>Working across the emergency-management cycle</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Health Emergency Information and Risk Assessment</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Emergency Operations</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Infectious Hazards Management</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Country Health Emergency Preparedness and IHR</td>
<td>12</td>
</tr>
<tr>
<td>5 FINANCIAL SUMMARY</td>
<td>Current picture</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Contingency Fund for Emergencies</td>
<td>14</td>
</tr>
<tr>
<td>6 NEXT STEPS</td>
<td>A small price to pay?</td>
<td>15</td>
</tr>
</tbody>
</table>
2016 has been a year of historic change for WHO. The creation of the Health Emergencies Programme (WHE) has been at the heart of that change. Since May, when Member States mandated the creation of the new programme at the World Health Assembly, we have made rapid progress towards building the operational capacities and capabilities that will enable WHO to respond more effectively to outbreaks and emergencies. We have established the structure and Standard Operating Procedures (SOPs) for the new programme, ensured consistent use of the new Incident Management System to coordinate responses to emergencies, and aligned our staff members to the new programme design at headquarters and regional offices. At the same time, we have continued to provide technical and normative support for our Member States.

We are in the midst of a transformative process that will enable WHO to meet the immediate health needs of populations affected by crises, whilst at the same time tackling the root causes of their vulnerability. Everything WHE does must contribute to the delivery of better results at the country level. The conceptual framework (above) that underpins the new programme is geared towards achieving those results. Strengthened capacity in the areas of early warning, risk assessment and emergency response enhances WHO’s ability to work with Member States and partners to rapidly detect outbreaks as they arise, and to provide a package of essential services to populations in times of need. In turn, the lessons learned from these responses tell us much about how best to remedy underlying vulnerabilities through prevention and control strategies for high-threat infectious hazards and other hazards. Crucially, these strategies must be integrated with health-systems strengthening. The health system as a whole provides the foundation on which to build the International Health Regulations (IHR) core capacities required to raise readiness and resilience across the board.

WHO’s responses to recent crises—including the 2016 outbreaks of Yellow Fever in Angola and the Democratic Republic of the Congo, Zika virus in several regions, and the situation in northern Nigeria—have shown that we are moving in the right direction, and that we continue to learn and refine how we work as we go.
WHE | OVERVIEW VISION AND STRATEGY

Maintaining momentum and building on that progress is now crucial. That is why I have set out four immediate priorities to consolidate the gains we have made so far, and keep WHE delivering for the people that need us most:

Increase core capacity
- Increase disease detection, risk assessment and emergency operations response capacity in priority offices
- Initially focus on the Regional Office for Africa, Regional Office for the Eastern Mediterranean, and countries with activated health clusters (priority 1 and 2 countries: see map below)

Optimize delivery at country level
- Develop standardized strategies and service packages for emergency response
- Strengthen WHO country office structures and support to Member States

Expand partnership arrangements
- Expand existing partnerships including Global Outbreak, Alert and Response Network, Emergency Medical Teams and the Health Cluster
- Finalize standard operating procedures for significant outbreaks in coordination with OCHA

and the Inter-Agency Standing Committee
- Work with partners to identify capacities and responsibilities for Grade 2 and 3 operations

Support country preparedness
- Strengthen national preparedness through an all hazards approach
- Support joint assessments of country capacities to implement the International Health Regulations (IHR) using the Joint External Evaluation tool

At the end of October, we welcome to Geneva the Regional Emergency Directors and WHO Representatives from the countries with the largest emergency-affected populations to discuss critical issues around how to increase our impact on the ground.

We are one Organization and we are pulling in the same direction: we all want to see results. But we can't get to where we want to go alone. The Financing Dialogue is our opportunity to reach out to you, and ask you to take the journey with us.

Peter Salama | Executive Director, WHO Health Emergencies Programme

Priority countries for core capacity strengthening: 2016/17

10 health cluster countries with highest population targeted by health partners: Afghanistan; Democratic Republic of the Congo; Ethiopia; Iraq; Mali; Somalia; South Sudan; Syrian Arab Republic; Yemen.
Other countries with activated health clusters.
At present WHO is responding to 31 acute graded emergencies. Five—Iraq, Nigeria, South Sudan, Syrian Arab Republic, and Yemen—are designated grade 3, denoting the highest level of severity.

In addition to the high-profile grade 3 emergencies, WHO is responding to the health needs of affected populations in 26 other acute grade 1 and grade 2 emergencies.

WHO is also responding to protracted crises in 16 countries.

**Grade 3 emergencies**
- Iraq
- Nigeria
- South Sudan
- Syrian Arab Republic
- Yemen

**Grade 2 emergencies**
- Angola
- Cameroon
- Central African Republic
- Democratic Republic of the Congo
- Ecuador
- Ethiopia
- Haiti
- Libya
- Myanmar
- Niger
- Ukraine
- United Republic of Tanzania

**Grade 1 emergencies**
- Afghanistan
- Bangladesh
- Democratic People's Republic of Korea
- Fiji
- Indonesia
- Kenya
- Mali
- Nepal
- Pakistan
- Papua New Guinea
- Philippines
- Sri Lanka
- Thailand
- West Bank and Gaza Strip

**Non-graded protracted emergencies**
- Burkina Faso
- Chad
- Colombia
- Djibouti
- Egypt
- Gambia
- Guatemala
- Honduras
- Jordan
- Lebanon
- Mauritania
- Senegal
- Somalia
- Sudan
- Turkey
- Zimbabwe

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.
From prevention through preparedness to early warning, response, and early recovery, the WHE programme represents a fundamental change for WHO, complementing its traditional technical and normative capacities with new operational capabilities to enable it to work across the breadth of the emergency-management cycle in outbreaks and humanitarian emergencies.

The structure of the Programme (below) directly reflects WHO’s major functions in the management of health emergencies, and is embedded across the three levels of the Organization. Led by the office of the Executive Director, the five technical and operational departments that comprise WHE reflect the major outcomes of the Programme:

- Infectious hazards management
- Country health emergency preparedness and the International Health Regulations (2005)
- Health emergency information and risk assessments
- Emergency operations
- Emergency core services
Information is the oil that keeps the emergency-response machinery moving. Independent reviews of WHO’s initial response to the Ebola outbreak in West Africa highlighted the fragmented nature of information management as a key factor that hampered early response efforts.

Through the Health Emergency Information and Risk Assessment (HIM) department, WHO is committed to investing substantially in information management across all three levels of the Organization in order to achieve one simple yet ambitious aim: to ensure that WHO is the most reliable source of information for public health decision-making in emergencies.

To achieve that aim, the HIM department is focused on delivering three key outcomes:

• **Assess the risk posed to public health by new events**
  Increasing HIM capacity in regional and country offices will enable round-the-clock event-based surveillance of a broad range of data sources. In turn, this will enable rapid risk assessment and, where necessary, response to identified threats, as was the case recently when an outbreak of Rift Valley fever was identified in Niger. SOPs for the identification and assessment of public health risks continue to be refined.

• **Provide accurate and timely information to guide public health interventions**
  In addition to assessing threats to public health, HIM also monitors the operational status and effectiveness of public health interventions.

• **Keep decision-makers, partners and the public informed**
  The HIM department produces and published regular situation reports for key emergencies, and will continue to refine the way information is communicated during emergencies to ensure that WHO is the go-to source for information during health emergencies.

WHO’s ability to deliver these outcomes is crucial to the success not only of WHO’s response to a health emergency, but of the health sector response as a whole. By having an established, accurate source of data available to all, WHO enables all partners to make informed decisions in response to emergencies.

On 30 August 2016, WHO received reports of unexplained deaths among people and livestock in northwest Niger. On 31 August, WHO staff were deployed as part of a multisectoral national rapid response team. The team quickly shipped samples for testing to Institute Pasteur in Dakar, Senegal, which detected Rift Valley Fever in samples from both people and animals. A rapid risk assessment by WHO concluded that there was a risk of further spread within Niger and internationally. WHO is now coordinating with the Food and Agriculture Organization, World Organisation for Animal Health, and the Global Outbreak Alert and Response Network, IFRC, and UNICEF to support the government response to the outbreak.

HIM publishes weekly situation reports, including on the yellow fever outbreak in Angola and Democratic Republic of the Congo, and the outbreak of Zika virus disease and associated complications that was declared a public health emergency of international concern in February 2016. Situation reports help keep policy makers and the public informed as outbreaks evolve.

Early Warning Alert and Response System (EWARS) is a WHO disease surveillance, alert and response initiative for early detection and containment of disease outbreaks in humanitarian emergency settings. As part of WHO’s response to the humanitarian emergency in north-eastern Nigeria in September 2016, the Organization has trained and equipped over 80 health workers to use the EWARS system to provide surveillance in areas currently home to approximately 1.2 million internally displaced persons.
The Emergency Operations unit aims to make sure that populations have access to an essential package of life-saving health services in times of health emergency. To achieve this, WHO has instituted protocols to establish a comprehensive incident management structure (IMS: see page 12), supported by the graded and protracted emergency desk teams, across all three levels of the Organization (headquarters, regional offices, and country offices) to coordinate health emergency partners.

The IMS is now in operation to manage all graded events that have occurred since the WHE was established, including the response to the outbreaks of Zika virus disease, yellow fever and Rift Valley fever, and the response to the humanitarian crisis in north-eastern Nigeria and Haiti in the wake of Hurricane Matthew.

Although WHO is increasing its own operational capacity, the strengths and expertise of operational partners will remain vitally important for delivering essential services to affected populations. For all graded and protracted emergencies WHO will develop strategic response and joint operations plans together with national authorities and partners. In recent months these plans have been developed (and refined) for emergency response operations including Zika, yellow fever and Nigeria. WHO supports national and field-level emergency operations through existing regional and global Emergency Operations Centres, and is supporting Member States to develop their own Emergency Operation Centres.

As the Health Cluster lead designated by the Inter-Agency Standing Committee (IASC), WHO is building capacity to ensure effective partner coordination mechanisms are in place for all graded and protracted events at national and sub-national levels. WHO has identified a number of Health Cluster Coordination positions that urgently need to be recruited, and is using WHO core funds to do so. Meanwhile WHO is establishing consistent technical standards for partner operations and will monitor implementation against standards. WHO is revising the Emergency Response Framework that guides the response activities of health partners: an updated version will be ready in early 2017.

For large-scale events that overstretch national capacities, the WHO Global Emergency Medical Team initiative is ensuring that international, independently verified teams are available to respond. Since the EMT verification process was launched in July 2015, almost 100 organizations and teams have applied to be listed and independently verified as capable responders. Teams include logistics specialists with the skills to rebuild damaged hospitals, incident managers and information managers, and technicians able to run mobile laboratories.

Within the Emergency Operations unit, the Operational Support and Logistics team ensures that essential logistics are established and emergency supplies distributed to points of service. In grade 3 emergencies such as Syria, Iraq, Nigeria and Yemen, WHO is responsible for coordinating the delivery of large volumes of supplies to affected populations. WHO is working closely with UNICEF, WFP, and other partners to ensure effective supply chain management so that medical supplies and equipment are available where required.
In northeastern Nigeria WHO is working closely with the State Ministry of Health in Borno to coordinate the health sector response, with a particular focus on reaching areas and populations most acutely in need. This includes delivery of basic health services such as vaccinations, enhancing surveillance for epidemic-prone diseases, providing life-saving interventions to manage common ailments among children and adults, and improving maternal and child health services at the community and facility level including mentoring of health workers.
Emerging and re-emerging epidemic diseases pose an ongoing threat to global health security. Technical expertise and scientific knowledge are the foundation of effective epidemic control strategies. The mission of the Infectious Hazards Management (IHM) department is to fulfill the mandate set by WHO’s Twelfth General Programme of Work 2014–19, which calls for “reducing mortality, morbidity and societal disruption resulting from epidemics ... through prevention, preparedness, response and recovery activities.”

The lessons learned from the epidemics and pandemics of Ebola, Zika, pandemic influenza, yellow fever and cholera are that it is crucial to:

1. Rapidly characterize pathogens; assess their virulence and clinical severity;
2. Protect health care workers, thereby protecting the investment in the health system;
3. Expand partnerships so that disease-fighting efforts are better coordinated and more effective during the next epidemic or pandemic;
4. Maintain global stockpiles of vaccine and/or treatments to ensure timely and equitable access to life-saving interventions.

Based on these lessons, IHM has started to implement important changes, including:

1. Strengthening expert systems and networks for the characterization of pathogens and assessment of risk and clinical severity of the disease;
2. Transferring technical knowledge and knowhow to all who need it—front-line responders in healthcare facilities and other settings, and the general public and affected communities;
3. Building global strategies to counter major infectious risks, embracing a wide range of partners that includes not only technical and scientific groups, but also experts from the arenas of social sciences, community engagement and risk communications;
4. Strengthening the mechanisms that govern the management of global vaccine stockpiles to ensure accountability, transparency, reliability and consistency;
5. Anticipating epidemics due to known pathogens to increase preparedness of countries.

The development of new areas of work requires the hiring of new talent. A rapid increase in technical expertise is needed to ensure that the new functions will be in place before the next major epidemic.

IHM also provides technical support to countries and communities to prevent and control epidemics. This includes prepositioning reagents and drugs so they are readily accessible, managing global vaccine emergency stockpiles, deploying technical field assistance, helping strengthen national response capacity and supporting preparedness plans.

IHM plays WHO’s normative and standards-setting role in the area of infectious hazards as applied to epidemics and pandemic diseases that are likely to threaten global health security. To carry out this role, IHM needs to develop additional assets to ensure that it can better assess risks and respond to outbreaks of any origin. As the recent identification of Zika virus as a major health threat has shown, that list of infectious hazards is growing.

Eliminating Yellow fever Epidemics (EYE) is a new strategy from IHM that aims to protect at-risk populations, ensure a ready supply of yellow fever vaccine, build resilience in urban centres, and prevent international spread. The strategy was developed by a broad coalition of partners who met at WHO headquarters in Geneva on 12 September 2016. The strategy will be further developed with partners in the coming months.

Engaging partners
IHM plays a major role in coordinating expert networks and systems, including:

- GISRS | Global Influenza Surveillance and Response Network
- GTFCC | Global Task Force for Cholera Control
- ECN | Emergency Communications Network
- EDCARN | Emerging Diseases Clinical Assessment and Response Network
- EDPLN | Emerging and Dangerous Pathogens Laboratory Network
The Country Health Emergency Preparedness and IHR (CPI) department within the WHO Health Emergency Programme is made up of three units. Each unit is undertaking critical work to ensure that vulnerable countries are prepared to face all-hazard emergencies and are engaged in fulfilling their obligations to develop core capacities under the International Health Regulations (IHR, 2005).

The Core Capacity Assessment, Monitoring and Evaluation (CME) unit is the main hub for support to national assessments, planning, costing, documenting, exercises, monitoring and evaluation of critical national capacities. The CME unit provides essential support to WHO’s regional and country offices in their effort to assess, monitor and evaluate status of implementation of the IHR core capacities for early detection, timely and effective response, including at the animal–human interface. It is composed of four teams: (i) One Health, (ii) Capacity Monitoring and Evaluation Framework, (iii) Joint External Evaluation (JEE) Secretariat, and (iv) Strategic Partnership Portal (SPP). The work of the unit is done in close collaboration and joint planning with regional and country offices, across the WHE programme and with other WHO departments.

Recent work includes delivery of 17 JEEs in 2016 (see panel). The unit has also recently developed the Strategic Tool for Prioritizing Risks (STAR), which has been used at country level in 13 African countries to analyse and characterise health risks. To help Member States strengthen their preparedness and test their capacities, between February and September ten table-top and one functional exercise have been conducted in Burkina Faso, CAR, Chad, Cote d’Ivoire, Ghana, DRC, Gambia, Guinea, Mali and Togo. WHO is also working closely with the Government of Germany to support the preparation of the G20 health expert meetings and the development of the scenario and exercise for the G20 health ministers’ meeting on responding to complex health crises.

The Preparedness, Readiness, and Core Capacity Building (PCB) unit is a hub working across WHO’s three levels to strengthen the ability of vulnerable countries to prevent, detect and respond to public health threats. It covers the critical capacities missing in the most vulnerable countries: (i) reinforcing epidemiological surveillance within the national health system; (ii) strengthening laboratory capacity, safety and quality; (iii) fostering intersectoral work with travel, tourism and transport and supporting capacities at points of entry; and (iv) supporting Member States’ workforce development on health security and IHR implementation.

The third unit, IHR Secretariat and Global Functions (IHR), is responsible for preparing, implementing and following up the IHR Emergency Committees (there were 12 such committees in 2015) and the IHR Review Committees. The Secretariat identifies, collates and monitors additional travel and trade measures during public health emergencies of international concern, and engages with States Parties on this issue. The IHR team maintains a roster of IHR experts, and the National IHR Focal Point database. The Secretariat also strengthens the capacity of the National IHR Focal Points. It provides the world with information for international travel and health advice.
Core budget: US$ 485 million

Appeals: US$ 656 million

Financing the work of the new WHO Health Emergencies Programme will require a combination of core financing for baseline staff and activities at the three levels of the Programme, financing of the US$ 100 million WHO Contingency Fund for Emergencies, and financing for ongoing activities in acute and protracted emergencies through appeals guided by humanitarian response plans.

To implement the core activities of the new Health Emergencies Programme WHO must raise US$ 485 million in 2016/17: at present a gap of 44% remains. The allocation of currently available funding is shown in the figure below.

Appeals linked to humanitarian response plans (HRPs) currently have a funding gap of 66% of the total requirement of US$ 656 million.

The third basket of funding for WHE, the WHO Contingency Fund for Emergencies (CFE), has raised US$ 31.5 million of its US$ 100 million target capitalization. Allocations to date total US$ 18.16 million in support of WHO activities in response to humanitarian crises, disease outbreaks and the impact of natural disasters.

WHE funding breakdown by organizational level and programmatic area

*Includes projected allocation of WHO internal funds. †Excludes projected funds.
The CFE has been a critical tool to enable WHO to quickly respond to emergencies, rather than wait for funds through appeals and applications to external donors. A number of other UN agencies operate similar internal emergency funds to enable rapid response. Importantly, the CFE makes funds available for the early-stage response to emergencies that would not fulfill the funding criteria of other key emergency financing mechanisms such as the Central Emergency Relief Fund (CERF). In 2016, the response to Zika virus disease and to the recent outbreak of Rift Valley fever in Niger are two examples of WHO emergency operations that would not have qualified for CERF funding.

The main challenge faced by WHO with respect to the Contingency Fund is the inability to replenish it. The original model of the CFE—front-loading funds and then asking WHO teams to fundraise to reimburse—has not been successful. Replenishment has not occurred because appeals are not fully financed or donors do not agree to direct their funds to reimburse the CFE but only for “additional” activities.

There are four main options for funding the CFE:
1. Continuing with the current model of ad hoc donations
2. Establishing an annual pledging cycle to secure additional funds
3. Identifying an income stream within WHO that could be used to replenish the fund
4. Using CFE funds deposited by donors to earn interest to help replenish the fund

Continuing with the current model is not feasible: at the current rate of use the CFE may be completely depleted within 12 months or less. Identifying an income stream within WHO to pay for the fund has proven difficult. WHO has limited core funding to begin with, and there are already multiple other demands for flexible funds. Globally, interest rates earned on deposits are too low to provide a viable income stream.

Establishing an annual pledging cycle would enable WHO to draw attention to the impact of the fund at country, regional and global level, and feed in to a wider discussion on funding for WHO and for the programme. WHO will circulate a discussion paper setting out the options for future financing of the CFE. In the meantime, WHO will continue to work with donors to secure additional funding for the CFE, and will request funds to help reimburse activities already carried out and paid for by the CFE.
As the Millennium Development Goals give way to the Sustainable Development Goals, we can reflect on 15 years during which important strides have been made towards improving the lives of many of the world's most vulnerable people. But the past 15 years have also seen a steady increase in the risk from hazards — natural and manmade — that have the potential to jeopardize much of that hard-won progress.

The update on WHO’s work in emergencies so far in 2016 (page 6) hints at the scale of the problem. As of 17 October WHO is responding to major emergencies in 47 countries, including 31 acute graded emergencies and 16 non-graded protracted emergencies. Five emergencies are designated Grade 3—the most severe grade. Unfortunately, equalling last year’s tally is a distinct possibility. In 2015 WHO responded to seven simultaneous Grade 3 emergencies—the most in a single year on record.

Climate change, increasing urbanization, globalization, and an intensification of civil conflicts are increasing the frequency and severity of emergencies with health consequences. Urban Yellow Fever outbreaks in Angola and Democratic Republic of the Congo have demonstrated once again how a changing world alters the risks posed by familiar pathogens, whilst the spread of Zika virus reminds us of the threat posed by emerging and re-emerging infectious hazards. It seems likely that 2016 will represent the fourth consecutive annual increase in the number of people displaced by violence and persecution globally, which in 2015 stood at 65 million. Again, the vast majority of displaced individuals remain in the Middle East, North Africa and sub-Saharan Africa.

In addition to disease outbreaks and conflicts, natural hazards — earthquakes, typhoons, and floods — continue to affect many tens of millions of people each year.

To meet the immediate health needs of crisis-affected populations at the same time as addressing the underlying causes of their vulnerability, WHO must be part of a broader change in the way the international community prevents, prepares for, and responds to crises.

From the Sendai Framework for Disaster Risk Reduction to the Sustainable Development Goals and the World Humanitarian Summit, there is now overwhelming support for reform of the way the world approaches crises. It is in this context that WHO’s new Health Emergencies Programme has taken shape. At the Sixty-eighth session of the World Health Assembly in May 2015, WHO Director-General Margaret Chan committed the Organization to creating a single, all-hazards emergency programme; to establishing a global health emergency workforce; and to raising a US$100 million contingency fund to enable rapid emergency response.

This document summarizes the swift progress that has been made since then. The Contingency Fund for Emergencies has disbursed more than US$ 18 million since its inception in May 2015, whilst the Programme as a whole has acted rapidly in response to outbreaks such as Zika and Yellow Fever, humanitarian crises such as the emergency in northern Nigeria, and natural disasters such as Hurricane Matthew in Haiti. Responses to the five most severe (Grade 3) emergencies — Iraq, Nigeria, South Sudan, Syrian Arab Republic, and Yemen — are being managed according to the newly adopted Incident Management approach, which requires substantial Organization-wide support.

There is much still to do. To deliver for populations affected by health emergencies we must strengthen WHO’s core capacity, particularly in areas directly related to providing direct help to affected populations. Building sustainable capacity will take time and, importantly, investment. At present the US$ 485 million core funding requirement for 2016/17 is 56% funded, whilst the CFE is 31% capitalized.

Taking into account the approximately US$600 million annual requirement for humanitarian response plans, the Programme requires US$ 1.8 billion to meet our obligations to crisis-affected populations in 2016 and 2017. To put this figure into context, by the end of 2015 the international coalition of donors to the Ebola response had collectively spent over US$ 3.6 billion. The moral and economic cases for investment in the WHE Programme are clear. The costs of failure are too great to bear.

Dr Peter Salama | Executive Director, WHE