Third Meeting of the Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences

Meeting by teleconference
1500-1630 (CEST), 22 September 2015

Email invitation from the Chair to the Members

Dear Colleagues

Preparing for the Meeting on September 22nd 2015

Our third Meeting of will take place on 22nd September 2015 at 1500-1630 European Standard Time and 0900-1030 US Eastern Time.

During the first half of September I was joined by several members of the Advisory Group in consultations by teleconference with (a) six WHO regional Offices, (b) members of the Global Health Cluster, (c) Geneva-based representatives of Member States, (d) the Steering Committee of the Global Outbreak Alert and Response Network (GOARN), and (e) senior WHO staff at the Headquarters in Geneva. Within the coming four weeks I anticipate continued consultations (a) senior Government officials and UN system (including WHO) in-country personnel within Ebola-affected countries in West Africa, (b) with representatives of Member States at the UN General Assembly in New York, and (c) with Senior Principals within UN system entities working most closely with WHO on outbreaks and emergencies.

The consultations have focused on expectations within countries, country needs, challenges faced by WHO in responding, personnel and resource requirements, practical challenges relating to partnerships, and options for strengthening WHO’s emergency capacities (including establishment of the operational platform).

I propose that on September 22nd we reflect on the results of the consultations, as well as what is in the Report of the Ebola Interim Assessment Panel - July 2015, and conclusions of the first two meetings of our Advisory Group: we should consider the implications of what we have heard for the priorities and direction of the reforms. This will prepare us for our Face to Face meeting on October 26th 2015, where we will be able to spend time with the Director-General and try to finalise some of our recommendations.

To assist us in our work on September 22nd, I attach a summary note of the consultations with regional offices. I have also prepared a personal reflection on the consultations as we advise on the design and operation of the Operational Platform to enhance WHO’s work in Outbreaks and Emergencies. I am keen that we use this note – titled WHO’s Programme of Work in Outbreaks and Emergencies (with Health and Humanitarian Consequences) and the Operational Platform for implementation: Reflections of the Advisory Group Chair – as the basis for our discussions. I would be pleased to know the extent to which the Advisory Group as a whole agrees with these reflections.
A proposed timetable for the meeting is as follows:

We will start promptly at 1500. I will ask whether any Advisory Group member has specific concerns to raise before the meeting starts. I will then briefly summarize our two items of business and invite Dr Chan to comment on them.

At 1515 we will start our discussions. I propose that if there is time we have two rounds of discussion with participants giving their main remarks on both agenda items in the first round (3 minutes per person). I will then offer a summary, invite Dr Chan to offer any clarifications that are requested by members.

At 1610 the floor will be open for a second round of shorter reflections for those who wish to speak, maximum 1 minute per person, about issues that have emerged in the first round and any major points that need further attention.

At 1625 I will offer a short summary: we will finish at 1630.

On ways in which we work together:

In the previous Advisory Group meetings members have spoken succinctly, focusing on the issues which are of greatest interest or concern to them. In between meetings I have received follow-up emails in which many of you explained your points of view in greater detail. I have found these messages very useful and I hope we can continue our active communication. Do not hesitate to send an advance email to me (and, if you wish, to other members of the Advisory Group) which indicates the issues on which you would like to focus before the meeting. If you wish to add further detail to what you said, or if you did not get a chance to speak as much as you would have wished, I would be particularly keen that you send an email after the meeting.

On face-to-face meeting

I am proposing a face-to-face meeting for 26-27 October 2015. This could supplement, rather than replace, our fourth teleconference on 20 October. I note that some members are not available on proposed dates: unfortunately I do not think we can offer an alternative at this time. I have attached a concept note on the face-to-face meeting. WHO has indicated that they will be able to cover travel costs for the Advisory Group members.

Looking forward to a very enjoyable third meeting.

Warm regards.

David Nabarro
Advisory Group Chair
The Chair of the Advisory Group, Dr. David Nabarro, held consultations with the six WHO Regional Offices by teleconference between 1st and 7th September 2015. In two cases, Regional-Directors led discussions. Senior WHO and emergency staff also contributed. Discussions focused on the following areas:

1. Establishing a unified WHO operational Platform and ensuring WHO’s leadership

A unified WHO emergency operations Platform must work as a “team” with clear-lines-of-command, stronger management systems, well defined scopes of work and an all-hazards approach across the three levels of the Organization. The Platform should focus on WHO’s core functions: leadership and coordination, intelligence and risk assessment, communications, country support for IHR core capacities and disaster risk management for health, WHO readiness and partnerships.

Country-led action and preparedness must be at the Platform’s heart. The Platform must work on both acute and protracted emergencies, with a strong focus on the latter so to draw on increased emergency capacities and support from the entire Organization, plus partners. The Platform must establish WHO’s leadership, facilitated by deploying staff to countries within 24 hours. The Platform could benefit from the establishment of Emergency Operations Centers in each Regional Office.

Professionals skilled and experienced in emergency action must staff the response Platform. Highly proficient management personnel are essential, and any scaling up of emergency resources must include strengthened management capacities. Stronger, improved logistics capacities must be a key component of the operational Platform.

The Platform must be sufficiently flexible to provide appropriate support given regional and country context. Some regions (EMRO) will require significant short and long term support from the Platform given the number of complex emergencies that are being managed there. All regions have different systems, capacities and experiences running outbreaks and emergencies; these will be considered when implementing a Platform across the 3 levels.

2. Insufficient funds impact WHO and partner emergency responses

WHO must find a mechanism to receive, maintain and sustain emergency response funds for supporting in-country response, in conjunction with the running of the unified emergency Platform. In many cases, funding is insufficient and Regional Offices must draw from their own funds to maintain in-country operations. Country Offices require a mechanism to access funds to do what they need to in emergency response. In many cases, developing countries require WHO funding for emergency actions, and in some cases developed countries seek such support.
3. Need for improved administrative, financial and human resource operations

Addressing shortcomings in WHO’s administrative, financial and human resource operations ranks among the most pressing needs for the emergency reform process. Limited human, financial and technical resources (such as challenges in deploying staff rapidly to emergencies from within WHO or sourcing external professionals quickly due to burdensome HR and staff contracting practices) leads to a suboptimal WHO emergency response. The Emergency Reform process must address the need to improve, streamline and simplify identification and hiring of qualified and required emergency staff.

Financial resources must be made available at the local level where the crisis is occurring, while Regional Offices require additional resources to play an active role in emergencies. It was noted that WHO, at all levels, has insufficient staff to perform emergency work, with emergency personnel being overstretched and WHO operational capacities in logistics and administration being low. Ensuring longer staff deployment periods was highlighted as essential.

4. Clarifying WHO’s scope of work in emergencies and the dynamics

The discussions highlighted that defining the scope of WHO’s roles and responsibilities in emergencies was essential for its own emergency management purposes, plus its interactions with national authorities and stakeholders. Knowing the in-country risks can help define WHO’s scope of work.

WHO’s technical areas also require strengthening so they can contribute effectively to the Organization’s emergencies work. Similarly, there is a need for the Organization to undertake a cultural change so staff at all levels recognize WHO’s emergency action mandate and responsibilities.

5. Strengthening emergency capacities, particularly at WHO Country Office level

Emergency response starts at country level, which means capacities available to the WHO Country Offices are critical, whether in terms of in-country staff or access to surge support from Regional level and other elements of the Global Health Emergency Workforce. Country capacities must be strengthened in emergency, technical, coordination and communications areas; these efforts will depend on country vulnerability. While Country Office capacities can support national responses to small-scale outbreaks, insufficient capacities exist for large-scale response.

WHO Country Representatives (WRs) and “non-emergency” technical staff must be trained in emergency work and responsibilities. WRs require flexible terms of reference that can be easily applied during emergencies, and that provide clear guidance to enable them to act boldly and decisively when needed. WHO Regional Offices are well placed to provide more rapid, contextually informed responses to emergencies, but require additional resources.

WHO’s has weaknesses in managing emergencies, and needs more and better emergency managers. Middle-management dilemmas can be addressed through better definition, understanding and application of SOPs and chain-of-command tools. Simulation exercises are useful.
6. The varied strengths of national governments, and how this impacts WHO

Each geographic region that WHO’s six Regional Offices serves possesses countries of varied sizes, populations and capacities. These differences require WHO to be ready to provide services tailored to needs of authorities and populations of each country. Implementing the International Health Regulations (2005) core capacities can strengthen national capacities for coping with health emergencies, but challenges and gaps in implementation exist in many countries.

In some countries, national emergency response capacities have increased through experience in emergencies. So their needs from WHO have also increased in terms of the quality of services they expect from WHO. But bureaucratic challenges in some countries impede health emergency notifications to populations, plus the response that WHO and other operational players can provide.

8. Maximizing partnerships with operational stakeholders outside of WHO

Coordination and leadership of WHO HQ and Regional Offices should be strengthened for efficiency. WHO must strengthen country and sub-regional capacity for multiplayer coordination, with WHO as Health Cluster lead. But increased capacities are needed for coordination and developing partnerships before emergencies occur and during “peacetime.” Such coordination must involve the Health Cluster, UN agencies and other key stakeholders. WHO’s establishment of the Global Health Emergency Workforce will provide additional surge capacity required for emergency response.

9. Communicating and advocating effectively on health needs and WHO/partner roles

For WHO to exercise its responsibility as the lead actor in emergency response, it must demonstrate a visible presence. By doing so, it will enhance efforts for cohesive coordination, effective response, strong leadership and resource mobilization. This will require communications capacity to be strengthened for advocacy, awareness raising and risk communications actions.
Annex: List of Participants

Dr. David Nabarro, Chair, WHO Advisory Group
Dr. Anarfi Asamoa-Baah, WHO Deputy Director-General
Daniel Kertesz, Lead of the WHO Project Management Team,

WHO Regional Office for South-East Asia (call held 1 September 2015)
Tawhid Nawaz, Director, Programme Management
Roderico Ofrin, Director, Health Security & Emergency Response
Dr Swarup Kumar SARKAR Director, Communicable Diseases,
Rajesh Bhatia, Chief Technical Advisor, RDO

WHO Regional Office for the Western Pacific (call held 3 September 2015)
Ailan Li, Director of Health Security and Emergencies
Reiko Tsuyuoka, Cambodia/WPRO
Nevio Zagaria, Manila/WPRO
CK Lee, China/WPRO
Liu Yunguo, WR South Pacific/DPS
Eric Nilles as observer, WHO Fiji

WHO Regional Office for Europe (call held 3 September 2015)
Guenael Rodier, Director, Division of Communicable Diseases, Health Security and Environment
Nedret Emiroglu, DCE
Imre Hollo, DAF
Pascale Goreux, DAF-HRS
Jukka Pukkila, DCE-ARO
Ute Enderlein, DCE-CEP
Thomas Hofmann, DCE-IHR
Caroline Brown, DCE-IRP
Cristiana Salvi, DCE
Srdan Matic, DCE-CEH
Leen Meulenbergs, RDO-PAR
Lucianne Licari, RDO-CCC
Michael Gerber, Chief, Emergency Response and Recovery Branch, US CDC*
Claus Sørensen, Director General, European Commission’s Humanitarian Aid and Civil Protection*

WHO Regional Office for the Eastern Mediterranean (call held 3 September 2015)
Ala Alwan, Regional-Director
Jaouad Mahjour, Director, Programme Management
Michael Gerber, Chief, Emergency Response and Recovery Branch, US CDC*

1 Members of the GHC Strategic Advisory Group are highlighted with an *. 
WHO Regional Office for Pan-America (call held 3 September 2015)
Carissa Etienne, Regional-Director
Ciro Ugarte, Director, Department of Emergency Preparedness and Disaster Relief
Marcos Espinal, Director, Department of Communicable Diseases and Health Analysis
Sylvain Aldighieri, Unit Chief of IHR, Epidemic Alert and Response, and Water Borne Diseases
Mary Pack, Vice President, International Medical Corps*

WHO Regional Office for Africa (call held 7 September 2015)
J. Cabore, Director, Programme Management
R. Thomas, Director of General Management & Coordination
I. Fall, Director of Health Security & Emergencies
Maria Guevara, Regional Humanitarian Representative in Asia, MSF*
Mary Pack, Vice President, International Medical Corps*
Claus Sørensen, Director General, European Commission’s Humanitarian Aid and Civil Protection*
FUNCTIONS EXPECTED OF WHO DURING OUTBREAKS AND EMERGENCIES

1. **Initial considerations:**

   1.1. There are some generic functions that are expected of WHO in all types of outbreaks and emergencies.
   1.2. WHO should provide support for all phases of a risk management cycle (from prevention and preparedness to response and recovery).
   1.3. WHO must have failsafe capability to address outbreaks and emergencies at an early stage before they develop into major crises.
   1.4. The specific functions expected of WHO depend on the nature of an outbreak or emergency, as well as scale and the capacity of the affected countries to manage.
      a. If it is an outbreak - what is the cause, severity and trajectory;
      b. if it is a humanitarian crisis, what is the extent, severity, duration and is access possible;
      c. if it is a biological, chemical, nuclear, environment, migration-induced or refugee emergency, what contribution is WHO required to make by the lead responder?

2. **Generic functions of the Programme of Work in Outbreaks and Emergencies:**

   WHO is expected to:
   2.1. **Provide overarching and high quality strategic direction on public health and patient care issues**—adapting it to the needs of specific situations, and anticipates the potential manner in which it may evolve (both worst- and best-case scenarios);
   2.2. **Offer leadership and coordination**, in collaboration with national authorities, engaging a broad range of national, regional and international actors, outlining clear roles and responsibilities for each (using IASC Health Cluster and IHR processes where possible);
   2.3. **Provide timely, consistent and reliable information** on current and potential risks to health, and on ways in which they can be averted - ensuring that this information is accessible to governments, partners and relevant sectors for immediate action;
   2.4. **Ensure local-level understanding of health risks** and ownership of actions through two-way communication with communities, through engaging them and through responding to their priorities.

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2 In outbreaks and emergencies, WHO will generally be expected to provide strategic direction and ensure implementation of public health functions (e.g. disease surveillance and implementation of interventions). Except in cases when WHO needs to be the provider of last resort, its role with respect to patient care will usually include standard setting, technical guidance and coordination.
2.5. **Contribute to cross-sector coordination and response mechanisms** (including national disaster management authorities and UN OCHA), advising on whether to escalate, adapt or stand down both alerts and responses;

2.6. Work with national authorities to **develop and publicize risk assessments and early warnings**; initiate systems for alert and incidence management; ensure risk-related surveillance, using both information on the situation and established coordination processes;

2.7. **Anticipate the expansion of risks to people in multiple locations or nations** and adapt advice and responses to the varied needs and contexts within these locations at the same time;

2.8. **Ensure the availability of relevant standards, guidelines and technical support** relating to risk assessment, readiness, response and recovery for upgrading and certifying national systems, including their clinical services, human resource and surge capacities, and management of supplies.

3. **External constraints**

WHO’s ability to implement a Programme of Work with these functions will be affected by:

3.1. Impediments to WHO’s engagement in specific issues when these are of acute concern to national authorities (especially if they provoke anxieties about negative economic impacts, possible trade restrictions, reductions in tourism or national security);

3.2. Circumstances under which local or national authorities seek an agreement that WHO will work on issues confidentially, keeping them outside the public domain;

3.3. Cultural and linguistic factors that restrict the response options available to WHO;

3.4. The degree of core public health capacity within a country or group of countries and the potential for interactions on functions (eg 2.6);

3.5. Constraints on the movement of staff or materials into and the evacuation of patients or specimens from a specific location – including legal obstacles, lack of physical access, or insecurity.

[Some of these constraints relate to WHO’s status as a specialized intergovernmental agency]

4. **WHO’s Commitments**:

WHO has a set of Core Commitments for Emergency Responses that were agreed by the World Health Assembly in 2012 and are the basis of the Organization’s Emergency Response Framework. They are detailed in an appendix. WHO now needs to build upon them and establish **Common Commitments that it will undertake to perform during an outbreak or emergency** that take into account relevant external challenges. This will help to establish the kind of systems and structures the organization needs while taking account of at least some of the constraints – thus limiting unrealistic expectations. The commitments should be revised at intervals (eg annually in the first instance). The following are offered – based on consultations to date and the 2012 commitments:
4.1. Quickly locate suitably skilled WHO staff close to the people most at risk, as well as the necessary operational support within the country (local level, district and national capitals and in WHO regional offices;)

4.2. Provide high quality technical assistance to local communities, national authorities and partners, helping to locate expertise within countries, engaging expertise from UN system entities and partners, from WHO regional offices and WHO headquarters, and from collaborative partners (including through leadership of the Global Health Cluster, engagement of GOARN, and activation of the Global Health Emergency Workforce), and other stakeholders;

4.3. Ensure that necessary finance, human resource and logistical support is quickly available in advance of and alongside the technical assistance being provided;

4.4. Offer strategic direction, identifying priority actions, focusing on critical decisions, ensuring follow-through;

4.5. Ensure that persons skilled in incident management (including leadership, collaboration and coordination) are quickly identified and located close to the situation(s) where risk is highest and/or where the greatest management challenges are being faced;

4.6. Encourage local-level appreciation of health risks, so enabling communities to respond effectively and develop their own strategies for managing risk;

4.7. Ensure effective management of information and issue timely communications to national authorities, partners, the global community on changing risks;

4.8. Measure performance against standardized benchmarks; continuously improving performance through practical exercises based on diverse scenarios

**Prerequisites for WHO to perform these functions: capabilities and partnerships**

5. The capabilities that WHO will need to perform its core functions during outbreaks and emergencies fall under four broad categories: personnel, funding, materials and information.

5.1. **Personnel:** WHO will need to access personnel with a broad range of skills and experience. These include staff with relevant technical skills, as well as staff to undertake the administrative, operational, communications, logistic, technical, coordination and leadership roles necessary to support operations in-country.

5.2. **Funding:** WHO will need increased of **predictable and accessible core funding** to sustain specified levels of human resource and system capacity for this programme of work – especially to support staff performing WHO’s core functions in outbreaks and emergencies. It will also need **reliable contingency funding to ensure that it has the necessary resources early on** to surge its efforts in a specific outbreaks or emergency setting. This funding needs quickly to be made available for use within countries and the contingency fund needs to be replenished promptly after resources have been disbursed.

5.3. **Materials:** **Procurement rules and processes** need to be reviewed and streamlined so that materials can be acquired and moved quickly to the locations where they are need.
5.4. **Information**: WHO needs to improve its ability to **collect and analyse health information**. Systems for collecting and disseminating this information at all levels – district, country, regional and global – must be interoperable, harmonized and eventually standardized.

6. **Strategic collaborations and partnerships** are vital to WHO’s capacity to perform core functions. WHO needs them to provide the capacities it lacks (and which would duplicate the good work of others if developed) such as heavy-lift logistics. But given the need for WHO to get close to the problem, it does need strong health logistics, communications, fleet management and personnel support capacity within its operations support systems. Ensuring that partners can be engaged in this way will mean that WHO is convening Inter-Agency Collaborative Approaches (such as the present Inter-Agency Collaboration on Ebola), where each entity provides expertise in their respective areas of specialization and where there is a strong emphasis on effective coordination. Sometimes partnerships permit actions to take place in areas or communities that WHO (as a UN system entity) is otherwise unable to reach. Taken together, these considerations suggest that WHO should adopt a strategic approach to strengthening and expanding partnerships (a) at all levels (community, national, regional and international), (b) across all sectors (civil society organizations, private sector groups, governmental entities, faith-based groups) (c) with an emphasis on national and community groups, and (d) ensuring effective joint working across the UN system, with GOARN members and the Global Health Cluster.

**The proposed Operational Platform**

7. The focus of this note is on a new mechanism that will enable WHO to work effectively in Outbreaks and Emergencies with Health and Humanitarian Consequences. It is useful to make a distinction between the overall Programme of Work in this area that will be implemented across the organization. It will have Core Commitments, Culture Change and Capabilities that will be central to the Programme. Its implementation will be an enormous transformation for the Organization. At the heart of the Programme is an organization-wide Operational Platform, that will enable the Organization to be ready to fulfil its commitments throughout the emergency risk cycle, acting as one, with no managerial, administrative or logistic constraints, with strategic collaborations and partnerships in place and working, and with a clear system of Command and Control that is understood by all, inside and outside WHO.

8. The Operational Platform could contribute to all WHO’s work related to outbreaks and emergencies, across the risk management cycle (preparedness, preparedness, response and recovery), for emergencies relating to all hazards, wherever they may be. It should enable WHO to implement Core Commitments in a predictable, dependable, capable, adaptable and accountable manner. The platform is the enabler: the effectiveness of WHO’s work will depend on the leadership, technical, coordination and diplomatic capabilities of its personnel and those who it engages through collaborations and partnerships. For the platform to be effective it needs to function in a standardized way across the organization – from inside countries, through country, subregional, regional and HQ locations, and to focus on strengthening the organization’s capacity to function within countries. The Platform will enable WHO to establish Emergency Operations Centres at the local level and to operate Incident Management Systems effectively.
9. As stated above the Platform will operate across the whole of the Organization enabling the overall Programme of work on outbreaks and emergencies to be implemented effectively. The Platform will combine a decentralized operational capability at country and regional level with a clear command structure and lines of authority across all levels of the Organization. The respective roles and responsibilities at the country, regional and Headquarters levels need to be clarified.

10. The design of the overall Programme and the functioning of the Platform will be governed by the following principles:

10.1. **Multi-level**: It should be designed to support local- and national-level operations within countries as well multi-country operations as appropriate.

10.2. **Speedy**: It should be capable of immediate deployment of personnel, materials and funds to ensure rapid response at national or sub-national level during acute or protracted situations.

10.3. **Versatile**: It should facilitate WHO’s contributions to all kinds of outbreaks and emergencies. The Platform should enable WHO to assist with preparedness and readiness as well as response and recovery.

10.4. **Adaptable**: It should be capable of supporting rapid scale-up, scale-down or prompt repositioning of WHO action in response to the assessed needs from skilled and trusted personnel on the ground.

10.5. **Multi-lateral**: It should enable the full integration of WHO’s contribution with the work of national authorities, in-country partners and international supporters.

10.6. **Clear accountability**: It should work with clear lines of authority and accountability according to Incident Management System practices.

11. The Platform will need to have its own systems and processes that are specifically designed to enable WHO to perform its core functions during outbreaks and emergencies. They need to be clear and streamlined so that they can implemented transparently and with minimum complexity. These systems and processes need to facilitate:

11.1. The rapid recruitment and deployment of staff and other personnel. The Platform will allow WHO to draw on capacities from anywhere in the Organization and enable it to establish partnerships needed to support rapid surge capacity;

11.2. The provision of appropriate care for the medical needs and wellbeing of personnel;

11.3. The rapid procurement and shipment of materials, supplies, and equipment to locations in-country;
11.4. The movement of funds to fulfil in-country and regional requirements. This would require establishing the necessary delegations of authority across the organization, as well as systems that permit the use of such funds by in-country implementing entities as well as by WHO and partners within and outside the UN system;

11.5. The development of protocols to provide guidance on the operation of the Platform.

12. The Platform will require new ways of working and thinking. The working of the platform will require new authority relationships:

12.1. **Within WHO**: The platform will enable WHO to function credibly as both a standard-setting and operational organization. The functioning of the platform will be under the authority of the Director General and managed by a suitable experienced and respected senior figure (at the rank of Deputy Director General) who will relate to and be directed by the Director General (and the Global Policy Group) on a regular basis both between and during outbreaks and emergencies. The response to all outbreaks and emergencies with health and humanitarian consequences (including protracted crises) will be under the authority of the Platform Manager. In the case of protracted or localized crises the Platform Manager may delegate it to Senior Platform officials within the Regional offices. The Platform Manager will determine the identity of those who are Incident Managers for any Outbreaks or Emergencies and will be their reporting officer. Upon request by the Platform Manager, all units and personnel within WHO must be prepared to delegate personnel to work within the Platform on a response and when they do so they are under the authority of the Platform Manager. If the delegations are for long term, the parent department will need to be compensated.

12.2. **Between WHO and the UN system**: The platform will enable WHO to have a revitalized role as the lead of IASC Health Cluster and a clearer role in humanitarian emergencies. Closer engagement with Resident Coordinators will be needed to strengthen WHO’s relationships with the Government and the UN agencies in-country.

12.3. **Between WHO and national authorities**: Strategic direction for work in outbreaks and emergencies are normally developed in consultation with national and regional leaders. The Platform should permit WHO to offer unambiguous direction when this is required. If national authorities are not in a position fully to exercise their responsibilities for responding to people’s health needs, the Platform should enable WHO to consider taking on some of the functions that the authorities would take if they had the necessary capacities. The Platform should enable WHO to have more direct interaction with affected populations.

12.4. **Between WHO and Member States**: If WHO is to deliver on its core functions in a predictable manner, certain posts needed for performing these core functions will require reliable funding through protected and predictable financing.
Appendix 1: WHO Core Commitments in Emergency Response

The core commitments are outlines in a 2012 Executive Board Resolution (EB 130 R14) and are listed in page 14 of the Emergency Response Framework (the Framework will be put on the Advisory Group web-site).

WHO’s core commitments in emergency response are those actions which the Organization will always deliver and be accountable for during emergencies with public health consequences. This will ensure a more effective and predictable response to and recovery from natural disasters, conflict, food insecurity, epidemics, environmental, chemical, food and nuclear incidents, political or economic crises and all other types of emergencies with public health consequences. In all countries experiencing emergencies, to support Member States and local health authorities to lead a coordinated and effective health sector response together with the national and international community, in order to save lives, minimize adverse health effects and preserve dignity, with specific attention to vulnerable and marginalized populations, WHO will:

1. Develop an evidence-based health sector response strategy, plan and appeal;
2. Ensure that adapted disease surveillance, early warning and response systems are in place;
3. Provide up-to-date information on the health situation and health sector performance;
4. Promote and monitor the application of standards and best practices; and
5. Provide relevant technical expertise to affected Member States and all relevant stakeholders.
Concept note on a face-to-face meeting of the Advisory Group of on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences

1. Background

The Advisory group has set up 8 meetings by teleconference and has so far met twice - on 28 July and 26 August. The third meeting will take place on 22 September. The members have expressed a wish to meet face-to-face on different occasions.

Whereas conference calls and the practice of exchanging views and ideas by email in between teleconferences remain the main method of working, a face-to-face meeting has been proposed for 26-27 October 2015. The face-to-face meeting could supplement or replace either the fourth teleconference on 20 October or the fifth teleconference on 4 November.

2. Structure

The Chair suggests meeting for half a day on the 26th and the full day on the 27th. The face-to-face meeting will be an opportunity to focus on issues which require extensive discussions and which will benefit from direct interactions between the members and with the Secretariat.

Members have proposed topics for the face-to-face meeting during previous teleconferences and through email exchanges. These topics may be changed or developed further following the third teleconference on 22 September and subsequent email communication. The Project Management Team will provide necessary background documents, and support the Chair in framing the issues/questions for consideration.

3. Issues to Be Covered

As of 21 September, these could include:

1. WHO Core Commitments in outbreaks and emergencies, and Capabilities needed.
2. Pre-arranged partnerships and collaboration.
3. The Operational Platform.
5. Standing Human Resource capacity and Scale Up mechanisms.
7. Implementation.

Advisory Group members are invited to propose refinements.

4. Venue

Location should be the most expeditious and least costly for travel and hosting the meeting. A member suggested that the meeting should be held in a country where vulnerabilities of health emergencies are higher. Some members expressed their preference for Geneva, Switzerland for the relatively central location. WHO HQ premises has the advantage in terms of preparations, logistical arrangement and meeting facilities.
5. Attendance

The meeting is for the members of the Advisory Group. Participation of key WHO staff may be requested for selected sessions. The D-G, DDG, Regional Directors and ADGs of concerned HQ clusters, the Project Management Team and other selected staff (including from countries) could be invited to join some or all as observers.

VTC facilities can be arranged for staff who cannot attend in person.

6. Logistics and Travel Arrangements

The WHO secretariat will make travel arrangements and, for this purpose, each member needs to be registered in the WHO system. Few members are already in the WHO system; others will need to fill in a WHO supplier form and return it to the WHO Secretariat in a timely manner.

As per WHO’s rule and regulations, the members will be given a status of temporary adviser. Business class travel will be authorized as appropriate.

Per diem will be paid accordingly to cover costs related to the meetings including accommodation, transportation, meal and other incidental costs during the meeting.

Hotel arrangements shall be made directly by members but the WHO Secretariat will be happy to provide recommendations or assistance with booking upon the members’ request.