### IOAC Monitoring Framework for WHO/WHE (as of 30 September 2019)

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| 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 coverage  
2. Addressing health emergencies – 1 billion more people better protected from health emergencies  
3. Promoting healthier populations – 1 billion more people enjoying better health and well-being  
The Emergencies Programme has three outcome measures that contribute to delivery of Strategic Priority 2. These are:  
2.1 COUNTRIES PREPARED FOR HEALTH EMERGENCIES  
2.2 EPIDEMICS & PANDEMICS PREVENTED  
2.3 HEALTH EMERGENCIES RAPIDLY DETECTED & RESPONDED TO  
Within 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 DDG, ADG, 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-making processes 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. As part of the WHO transformation, revised delegation of authorities are being developed for the 3 levels. |
| 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: The emergencies communications team works closely with other communicators at all three levels of the organization. For priority countries facing a G3 emergency, a communications strategy is developed with input from country and regional office communicators. 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 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, a weekly roundup of key activities across the programme is shared with all WHE staff. In addition, there are monthly teleconferences across the three levels with all the emergency directors. The Programme Area 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 DDG regularly shares relevant information and documents with all staff in HQ and the regional offices. The DDG holds quarterly meetings with all HQ staff. |
### Consistency and coherence of corporate communications

As a result of WHO Transformation, the WHE communications team has been integrated into the Department of Communications (DCO); the team is fully dedicated to emergencies while other DCO teams (media, social media, AV) also support emergency communications.

### 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 steadily increased in the last 6 months.

### 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 is planned with EMRO countries in November.

### 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

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 March 2019, 2 new SOPs have been posted in the eManual and 7 existing SOPs have been improved, using feedback and experience from the field. In addition, the OSL SOPs are in draft stage and will be published in due course. HR SOPs are being restructured and further developed, including selection and placement from emergency roster, etc.

### 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 its draft proposed structure at group and team levels. Mission critical positions have been identified, including 3 director positions, to capacitate the new structure. 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.
In 2019, WHO developed a corporate level fundraising strategy, which reflects the approach to fundraising for the organization as a whole include WHE. The corporate level strategy reflects the three principles that WHE has applied to resource mobilization including:

- **Sustainability**: WHE needs both quantity and quality/flexible funding and a broader donor base;
- **Integration**: (the RM effort should be aligned with external communications and advocacy strategies; and
- **Dynamism**: (progress towards achieving the targets needs to be regularly reviewed, and the strategy adjusted accordingly). The global RM strategy from 2019 has three pillars, which also apply to WHE and guide efforts for RM for preparedness and response:

  - **Institutional donors**: (over the course of 2017 and 2018, WHO has been deepening the relationship with existing major donors and reaching out to emerging donors). WHE has been focusing on the following major existing donors: Australia, Canada, EU, Germany, Japan, RoK, UK, UN, US, and the World Bank, and broadening the engagement with Nordic countries (Norway, Sweden), BENELUX, France, GCC (Kuwait, UAE, KSA), BRICS (China, Russia, India).
  - **Foundations**: WHE has been deepening the relationship the King Salman Aid & Relief Centre and, in cooperation with CRM, working to deepen and consolidate the partnership with the Bill & Melinda Gates Foundation and the Wellcome Trust.
  - **Emerging and innovative streams**: WHO continues to explore how to tap into new opportunities such as RoK’s Global Disease Eradication Fund.

Individual donor profiles and engagement plans have been developed for the top donors, detailing budget cycles, financial targets and key dates/events and matching WHE activities/projects to areas of interest for 2018. These are being revised and updated in 2019. As regards OCR and CFE funding, WHO has continued to target humanitarian funding and is strengthening country-level capacity to tap into country-based pooled funds such as CERF funding. The CFE attracted more than US$ 38 million in 2018 and from 13 donors, of which seven were new donors. As of September, 2019, WHO has raised some USD 30 million for the CFE, while $67 million has been allocated to 16 countries for 16 events, including 8 disease outbreaks, 4 natural disasters and 4 complex emergencies. The continued drawdown of the CFE in 2019, especially for the Ebola response, has left the Fund dangerously depleted. As of September, the balance stands at around US$ 8 million, well below an acceptable threshold. WHE rolled out a CFE replenishment strategy in 2018. This is as of September 2019 being revisited in light of the need to ensure adequate levels of funding at all times to the CFE. The revised replenishment strategy will be complemented by a road-map for how to better (re)position the CFE and consultations will be held with donors in 2019/early 2020 on this.

**Resource mobilisation at country level**: The Country Business Model for the health emergencies programme remains a priority. WHO continues to focus on priority countries having adequate capacity for key functions including RM. WHO is actively working across the three levels specifically with AFRO to support them in the implementation of their functional review roadmap, which includes clear targets to mobilize additional resources at country level. Dedicated resource mobilization officers are in place in five of ten WHE priority countries (Democratic Republic of Congo, Ethiopia, Nigeria, Somalia, Yemen).
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 partnerships, 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 WHO 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 WHO’s work in emergencies.

In terms of emergency response, the WHO programme is working to optimize the synergies and complementarity amongst these mechanisms as part of our work towards a Global Health Emergency Corps that would allow us to leverage capacity across the world. Below we consider three critical partners-the Global Alert, Outbreak 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 partner (Family Health International 360) has joined the Global Health Cluster (GHC), increasing membership to 56 organizations. The international partner capacity survey was conducted between 18 July 2018 and 30 August 2018. A total of 190 partners were invited to participate of which 93 (49% response rate) completed the survey. The national partner capacity survey was conducted between 17 April 2019 and 24 May 2019. A total of 698 partners were invited to participate of which 256 (37% response rate) completed the survey. Survey findings highlight significant technical and operational capacity gaps in key thematic areas including (maternal & newborn care; SRH/GBV; MHPSS; secondary & trauma care; IPC & surge capacity) which impacts on the quality and coverage of Health Cluster Response. These findings & action to address these gaps will be discussed with GHC partners and WHO representatives (including GOARN and EMT) during the GHC Strategy Development workshop on 23-24 October 2019. Survey reports can be found via https://www.who.int/health-cluster/partners/current-partners/partners-capacity-survey/en/.

At regional level, the GHC has supported Operational Partnership Team Leads in EMRO and AFRO to host their first regional cluster meetings in November 2018 and May 2019 respectively. The second EMRO meeting is planned for 8-10 October. Meeting reports can be found via https://www.who.int/health-cluster/news-and-events/events/EMRO-HC-Meeting/en/ and https://www.who.int/health-cluster/news-and-events/events/AFRO-HC-Meeting/en/. These activities develop WHO 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.

Operationally, the cluster continues to adapt its role at country and global level as WHO strengthens its leadership role in outbreak response including the more systematic application of Incident Management System and activation and/or support to EOCs. Whilst the ‘pillared approach’ to outbreaks response brings substantial benefits to plan and coordinate the response, the interface with existing health cluster/sector partners continues to present some challenges in respect of recognizing their presence, capacities and comparative advantages particularly to access hard-to-reach areas. Partners & donors have been pro-actively engaging with WHO to overcome these barriers and enable closer engagement and are requesting clear guidance on this interface which has yet to be developed. The GHC is currently launching external evaluations of Health Cluster performance and coordination architecture in NE Nigeria and Mozambique which will explore this coordination interface issue along with other aspects of WHO’s role as Cluster Lead Agency. Evaluations will take place on 29 September and mid-November respectively, with final reports available by end December 2019. In addition, the GHC and Global WASH Cluster have jointly undertaken an extensive review of how to improve the integrated response to AWD/cholera outbreaks within humanitarian crises. Findings highlighted considerable lack of clarity on leadership and coordination accountability between clusters, their respective lead agencies and other key stakeholders, resulting in discussion with WHO & UNICEF Emergency Directors; senior technical advisors and the Global Task Force for Cholera Control to provide clarification. Executive summary report is available via https://www.who.int/health-cluster/about/work/inter-cluster-collaboration/en/.

As of Sept 2019, 22 out of 29 (76%) country health clusters/sectors have dedicated Health Cluster Coordinators at national level (70% in 2018). Five clusters (17%) have part-time/double hatting national level coordinators. The original global HCC network recruited between Q4 2016 & Q2 2017 currently accounts for 34% of current dedicated HCCs (55% in 2018). Recruitment of new HCCs is undertaken through regionally-led selection processes supported by the GHC as requested. In addition, 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. During the last 12 months the most cited reason for HCC gaps at country level was lack of funding despite the national HCC position being included in the Country Business Model. Prolonged HCC gaps in Burkina Faso, Cameroon and DRC has resulted in direct criticism of WHO by their respective Resident/Humanitarian Coordinators. The GHC continues to lobby WHO 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.
HCC performance remains variable as in any work-force. When performance issues arise, the GHC offers support as requested to HCC first & second line supervisors at WCO and RO level, and contract terminated where.

The GHC delivered one global level face to face Health Cluster Coordination Trainings (joint HCC & IMO) to 38 participants in November 2018. In addition, at the request of the Ethiopia Health Cluster, a five-day Health Cluster Coordination Induction Training took place from the 27 to 31 May 2019 in country. The training was organized jointly by the Ethiopia Health Cluster in Addis Ababa, with support from WHO AFRO and the Global Health Cluster Unit. Twenty-six people participated in this training which targeted personnel who work with, or support Ethiopia Health Clusters at the sub-national level. Seventeen participants were WHO personnel, six worked with the Ethiopia Ministry of Health and three worked with NGO partners. Since 2015, in total 147 people have been trained during 5 Global Health Cluster Coordination Trainings.

From January to May 2019 the Global Health Cluster Unit conducted a progress review of the implementation of the Health Cluster Capacity and Development Strategy 2016 – 2019. The Progress Review evidenced good progress with achievement of the strategic objectives and that implemented activities have had a positive impact on the effectiveness of Health Cluster Coordination at country level. The main recommendations of the Progress Review 2019 were to extend the Capacity Development Strategy in line with the Global Health Cluster Strategy and for the development and implementation of regional Health Cluster Coordination Training based on regional needs and priorities. To implement these recommendations, the GHC established a Capacity Development Consultative Group to contribute to the development and content of the extended Capacity Development Strategy to reflect the specific needs of regional and global Health Cluster Coordination Training. The Consultative Group is made up of cluster partners, WHE Regional Programme Managers from (AFRO, EMRO, EURO, SEARO, WPRO), Health Cluster Coordinators and GHC staff. The Group is Co-Chaired by GOAL and the GHC.

The Global Outbreak Alert and Response Network

• Since October 2018, 231 experts from 35 GOARN Partners institutions were deployed to support response to 12 operations in 14 countries including response to Ebola, Diphtheria, Measles, Cholera and Lassa Fever.

• 3 regional and 1 national GOARN Orientation to International Outbreak Response trainings were organized in this reporting period (co-hosted by AFENET in Mozambique, Nov. 2018; co-hosted with EPIET/ELPHAM in Croatia, Apr. 2019; co-hosted with WCO Indonesia, Aug. 2019; co-hosted with TEPHINET in United States of America, Oct. 2019) with a total of 148 experts from GOARN partners institutions trained. Six Go.Data user training delivered in Berlin, London, Kampala, Cox’s Bazar, Ottawa and Atlanta based on a newly developed training package to introduce the tool to outbreak responders. Additional roll out trainings were held across multiple locations in DRC in response to the ongoing Ebola outbreak to train the epidemiological teams.

• Two GOARN Steering Committee (SCOM) Meetings took place in this reporting period (SCOM meeting #24, 13 and 14 December 2018 in Geneva, SCOM meeting #25, from 20 – 21 June 2019). These committee meetings have had a dual purpose- 1. a close review of the Network in the Ebola response under WHO leadership and 2. On revisiting the network structure and governance to ensure closer collaboration with a post transformation WHO. The meetings are designed as a forum for partners to review progress in the GOARN areas of work, review the current strategy, assess responses to public health emergencies which involved GOARN partners and adapt the workplan of GOARN activities.

• Global Selection process of the GOARN Steering committee October 2018- a network wide nomination process to identify the next steering committee was held in October, engaging most partners in seeking a place in the Steering committee of GOARN. The objective of the selection process is to establish a diverse and presentation committee that can provide direction and leadership to GOARN in the next 4 years to come. A new selection process was developed to ensure transparency and unbiased identification of candidate institutions and representative guided by the needs of the GOARN strategy and workplan.

• GOARN Weekly Operational calls have been instituted on 27 January 2017 and have been running on the regular basis since then, with participation of the GOARN SCOM members and key operational partners. Weekly Operational calls provide a forum to share information about acute events with key partners, and support coordination of response activities.

The Go.Data tool was launched in 2019 and deployed in the Ebola response to strengthen case and contact tracing and an understanding of the transmission chains. The software has been co developed by WHO and GOARN partners over the period of 2017-18 and formally concluded in February 2019. WHO is working with member States, GOARN partners, and stakeholders to ensure a rapid roll-out of the Go.Data tool. Go.data was in used as part of the outbreak alert and early warning system in Cox Bazaar, Bangladesh; and in the EVD outbreak in Uganda and most recently in DRC.

GOARN Mobile Laboratory Rapid Response capacities initiative was identified as a priority by European regional partners in 2016 in order to strengthen the quality standards of laboratory information management, biosafety, field logistics and operational support. Regional discussions were held in Saratov and Munich to establish a way collaborative forward to achieve mapping, standardization and workforce development for outbreak laboratory response capacity among partners.
Emergency Medical Team

The Emergency Medical Team (EMT) Initiative focus over the past year has continued to be training and capacity building of national medical response teams;

- More than 118 130 countries are aware of the EMT Initiative, with over 60 90 countries hosting national awareness workshops over the last 2 years.
- 9332 countries have active EMT capacity strengthening processes ongoing, with direct support from WHO in various stages of development, while 65
  International NGO EMTs are working with WHO to increase their capacity making a total of 158 teams and an estimated workforce of 150,000 staff. while
  another 25 countries are starting this process.
- 84 regional EMT Coordination courses and 22 15 national EMT coordination courses ran were conducted in the last 12 months, to train experts in national
  response team coordination and international request and coordination systems under national Health EOC structures.
- More than 128 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.
- 28 teams have completed a quality assurance process, been successfully been classified and placed on the WHO directory of internationally deployable EMTs.
  7975 other teams are in the mentorship process and receiving direct support to reach the minimum standards to achieve classification.

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.

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 December 2019. the initiation of the drafting process of the A companion guidance document on the engagement of EMTs in conflict settings (known as the "Red Book") has now concluded its consultation andrafting and will be available at the same time as the Blue Book in December 2019. MSF, ICRC, IFRC and other key partners have fully engaged and contributed to both texts, but in particular the red book, 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 in early 2019will meet in Berlin November 2019.

The work of the EMTs has been endorsed by the WHO Regional Committee for South East Asia recently adopted Resolution SEA/RC71/R5 on “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 assurances 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 and have severely limited the ability of WHO to continue to support countries and teams in improving standards and responses in

This has been escalated to senior management and we hope for a successful resolution to the issues in the near future.
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: 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 DDG, 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 asUN 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.
## I. Issues requiring corporate-level solutions

### (WHO Transformation Agenda)

| Procurement and supply chain management | 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 capitalize 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/TMDashboardHub](http://dashboards.emro.who.int/TMDashboardHub).

| 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. FENSA is currently also undergoing a formal evaluation by outside experts and WHE has contributed to providing feedback in this review. |

### 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 capitalize 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/TMDashboardHub](http://dashboards.emro.who.int/TMDashboardHub).

| 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  
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### 1. Issues requiring corporate-level solutions

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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 complemented with the ongoing recruitment processes of a Security Coordinator (P5) and a Security Officer (P4) positions. In addition, two security officers have been recruited on temporary contracts (1xP3 and 1xP4), specifically to bolster the security support in the current EVD response in DRC.

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.

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 fullest 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.

Cost Recovery Policy is under development and is being streamlined into WHE Resource Mobilization Strategy. The key principles under discussion include: ensure all staff and running costs required to implement projects are included in proposals.
## III. WHE Programmatic Areas

### 1. Preparedness for Health Emergencies

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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 manage the range of risks they face. 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. Capacity gaps are identified, and capacity strengthening is measured through IHR reports, independent assessments, simulations and after-action reviews and other forms of assessment. Emergency preparedness is being implemented with MS and in WCOs to establish minimum capacities, as well as operational readiness as required by ongoing events and early warnings. WHO is also supporting Member States and key partners to analyse 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.

### All-hazards and IHR core capacities assessments and reports:

- As of 4 October 2019, 105 countries have volunteered for a Joint External Evaluation; 112 Simulation exercises have been done (including country level and regional and internal exercises) and 54 After Action Reviews conducted. 27 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 Regionssent reports to the Secretariat to report to at the World Health Assembly in May 2019. WHO is supporting State Parties in all levels of the Organization 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).
- 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 published and 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 is the Joint Risk Assessment (JRA) which has been piloted in 12 countries.

### National Action Plans (NAPs):

- Since 2016, 64 NAPHS have been completed (30 in AFRO, 18 in EMRO, 1 in EURO, 7 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/. In addition, a Country Implementation Guide to operationalize the NAPHS framework is finalized and will soon be published.

### Review of assessment tools:

- WHO has published 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 exercises): https://www.who.int/ihr/publications/WHO-WHE-CPI-2018.51/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.

### 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)

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. This was 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 and community engagement. WHO has also mobilized human and financial resources to enable countries, partners and WHO to support country readiness for EVD.

Strategy for IHR capacity development in fragile states
• WHO has developed 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.

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 and 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 areas, 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)

Scale down of IMS and transition process following major events to build national capacities on lessons learnt in a sustainable way:

There is a clear process for scaling down the IMS and using learning to build national capacity sustainably. Following outbreaks of Plague in Madagascar, Ebola in Eastern Equateur province of the Democratic Republic of the Congo and Cholera in Zimbabwe a joint operations review was used to help guide the transition from acute event management to more sustainable learning. Transition activities included enhanced surveillance and retention of response capability. An After-Action Review helped identify key lessons and assist in risk mapping. Work is ongoing to strengthen the use of available data in defining risks and priorities.
### 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-IF) 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-IF 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.

### 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. Eight additional countries actively engaged in the global roadmap, and **20.8 million** doses vaccines were shipped to **10 countries**, including in complex emergencies settings such as Yemen with >725,000 vulnerable people protected.
- **YELLOW FEVER**: the “Eliminate yellow fever epidemics (EYE) 2017-2026” strategy was launched in the African Region in Nigeria in April; 27 country profiles to assess risks and guide EYE roll out were developed, and **61 million** people vaccinated against yellow fever in **24 African countries**.
- **INFLUENZA**: the “Global strategy for influenza 2018-2030” has been finalized, following consultation and > 50 Member States commentaries. In 2018, it has been estimated that more than **500 million people** have been vaccinated against seasonal flu. In additional, through the Pandemic Influenza Preparedness (PIP) Framework, >**400 million doses** of pandemic vaccines and **10 million** antiviral treatment courses are secured in case of a pandemic. Since 2012, over **$169 million**
in Partnership Contributions (PC) have been collected to support capacity building. In 2018 alone, 72 countries strengthened national preparedness capacities. Additional impact is foreseen at the country level with the PIP PC High Level Implementation Plan II, published in 2018, and outlining the use of the funds until 2023.

- MENINGITIS: the “Defeating meningitis by 2030” was drafted, with a first meeting of the Technical Task Force held in July. Strategic orientations have been defined.

In addition, WHO is also the Secretariat for the governance of global emergency stockpiles, including the International Coordinating Group (ICG) on vaccine provision. Through the ICG mechanism, WHO deployed **16 million of doses of vaccines for emergency vaccinations**, saving millions of lives. In 2018, the Accountability Framework was adopted by all partners (GAVI, UNICEF, UNICEF SD, MSF, IFRC), endorsing the need to continue the ICG, after 20 years of providing life-saving vaccines in disease outbreaks.

**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.

### 3. Detection and response to Health emergencies (acute and protracted emergencies)

| Potential health emergencies rapidly detected, and risks assessed | Performance Standards (PS) |
| Application of Emergency Response Framework (ERF) risk assessment and situation analysis, WHO grading, Incident Management System (IMS), response procedures, roles and responsibilities | From 1 January 2019 until 30 September, a total of 91 Disease Outbreak News (DONs) were posted |
| Acute health emergencies rapidly responded to, leveraging relevant national and international capacities | There were 934 geospatial information products produced by the GIS Team form 1 January 2019 to 30 September 2019. Of these, 887 (94.9%) were Ebola Virus disease-related products. |
| Effectiveness of field operations | Number of rapid risk assessments from 1 January 2019 to 30 September 2019 was 49. |
| Rationalization/standardization of production and dissemination of situation reports and risk assessments for each event | Number of events created in EMS: 1 January to 30 September 2019 was 402. |
| Support affected countries for risk communication and community engagement | WHO provided support for the enrolment of Public Health Information Services (PHIS) standard products in 16 Health Cluster Activated Countries. Among these 0/16 are implementing Public Health Situation Analysis (PHSA), 9/16 are applying the Early Warning Alert and Response System Estimation in place, 8/16 have a Surveillance System for Attacks on Health Care running, 12/16 are systematically producing |
| Essential health services and systems maintained in fragile, conflict and vulnerable settings; working jointly between WHE and HIS | 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 G1 emergencies the ERF Monitoring Tool (MT) is not activated and delivery of Performance Standards is not monitored.

- WHO activated the Incident Management System (IMS), in accordance with ERF procedures for 100% of Grade 3 emergencies, to fulfill 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 September 9, WHO responded to 52 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.
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.

**Ebola Virus Disease**, Democratic Republic of Congo. Within the last 17 months WHO has responded to two outbreaks of EVD in DRC. Within 24 hours of receipt of laboratory confirmation for each outbreak, the first surge teams were deployed, internal risk and grading assessments finalized under the ERF, and emergency funds mobilized. Capacities within critical response pillars, including laboratory, clinical management and therapeutics, vaccination, infection prevention and control, risk communication and community engagement, safe and dignified burials, and support to survivors were rapidly established and reinforced through joint strategic response plans led by WHO and Ministry of Health.

- **Equator, DRC**
  - 8 May –
    - EVD outbreak declared
    - Grade 2 declared
    - IMS established
    - CFE USD 1 million approved
  - 12-13 May – Mobile lab and ultra-cold chain deployed
  - 16 May – vaccine arrive in-country, mobile lab begins testing
  - 17 May – Grade 3 declared
  - 20 May – vaccination starts
  - 4 June – Use of investigational therapeutics approved

Response capacities established for the outbreak in Equator, DRC, including for the administration of experimental therapeutics and ring vaccination, were rapidly shifted to North Kivu, DRC within days of the new outbreak declaration.

- **North Kivu, DRC**
  - 1 August
    - Outbreak declared
    - Grade 3 declared
    - CFE USD 2 million approved
    - WHO response teams from Equator arrive in North Kivu
    - Labs with GeneXpert capacity established in Beni and Mangina
  - 4 August
    - CFE approved
    - ETUs established in Beni and Mangina
  - 8 August
    - Vaccination starts
  - 10 August
    - First patients receive investigational therapeutics

Preparedness within and external to DRC was and continue to be critical components of the EVD response, with additional resources mobilized to ensure at-risk areas have the capacity to rapidly detect, confirm, and isolate possible cases of EVD. A regional EVD preparedness plan was initially established for the outbreak in Equator and was revised to reflect the prioritization of countries based on their proximity to North Kivu.
Protracted Crises Update

- For Somalia humanitarian response (P3), the drought situation in Somalia has been deteriorated due to late and inconstant rains during the 2019 Gu’s cropping season (April to June). Climate shock coupled with long-lasting conflict, poverty, and the lack of sufficient health systems have struck and displaced millions of Somalis, and they have been suffering from hunger. To improve the situation with resilient health systems, WHO launched the country’s roadmap to universal health coverage (UHC) together with the Federal Minister of Health.

- Bangladesh – update: As the emergency in Cox’s Bazar enters into a more protected phase, WHO’s engagement is shifting towards a systems strengthening approach and a localization of the response. An operational review is planned from 18-24 October to take stock and formulate recommendations for the future.

- A revitalized Whole of Syria approach strengthened the response. The Whole of Syria response structure from four hubs incl cross border service delivery continued to be adjusted to the operational needs on the ground; the Amman hub for cross border response into southern Syria was therefore discontinued and the Whole of Syria health cluster coordination and information management in Amman strengthened. In 2019 the cross border health response into NW and NES Syria continued under a renewed Security Council Resolution for humanitarian response. WHO responded to the health needs of an increased number of people across the territory of Syria with increasing access, as military operations were abating in some parts of the country. Therefore WHO’s response strategy in north-east Syria revolves around expanding the availability of health care services, delivering medicines and supplies to hospitals to help them manage the influx of patients and improving the referral system.

- For the response to the Ebola outbreak in North Kivu, senior liaisons from UNICEF and IFRC were seconded through WHO’s Incidence Management and Communication for 1 incident (DRC Ebola). For the response to the Ebola outbreak in North Kivu, senior liaisons from UNICEF and IFRC were seconded through WHO’s Incidence Management and 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.

- 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).

- 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 finalized.
  - 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 TCTs, 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.

In Syria, monitored availability and functionality of health services through quarterly HeRAMs, and adapted WHO response and partner response to maintain essential services running for 12.3 M people incl an increasing number of displaced and affected host populations, incl through a high number of mobile clinics supported by WHO and health partners, to increase flexibility and access. Access to health services was expanded where security allowed in Q3 and Q4.