Pandemic Influenza
Preparedness Framework

Partnership Contribution High-Level Implementation Plan I.
Final Report 2014–2017
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Foreword

Few events have marked humanity as gravely as the influenza pandemic of 1918. With an estimated 50–100 million deaths, it remains one of the deadliest public health events on record.

Our highly interconnected world allows pathogens to spread at lightning speed, increasing the urgency to ensure that all countries are prepared to respond to an infectious disease outbreak wherever it may emerge. The World Health Organization (WHO) works to ensure that all countries, irrespective of their income or development status, have equitable access to the medical and other counter-measures necessary to respond to pandemics.

It is for these reasons that the Pandemic Influenza Preparedness (PIP) Framework holds such importance for public health: it shows that nations can come together and solve the most difficult issues through innovative solutions; that countries will undertake the work needed to strengthen their preparedness capacities; and that partners – public, private and nongovernmental – will sustain their commitment to achieving the highest level of preparedness so that our future global response is founded on solidarity and equity.

I am deeply grateful to all PIP Framework partners that have demonstrated their sustained commitment to this goal. I look forward to continuing this important work in the same spirit of partnership and solidarity.

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Tedros Adhanom Ghebreyesus, WHO Director-General
Acknowledgements

WHO thanks all stakeholders that contributed to the successful implementation of the Framework in the past four years.

This includes Member States, the Global Influenza Surveillance and Response System (GISRS), the PIP Advisory Group, influenza vaccine, diagnostic and pharmaceutical manufacturers (Industry), civil society and other organizations. WHO is thankful for the support of the GISRS network, including WHO Collaborating Centres for Influenza (CCs), WHO Essential Regulatory Laboratories (ERLs), WHO H5 Reference Laboratories, and National Influenza Centres (NICs).

We are deeply grateful to Industry and Industry Associations for their support over this time, notably through the payment of the annual Partnership Contribution that funded implementation.

We thank implementing units at WHO country offices, regional offices, and headquarters for facilitating implementation and supporting preparation of this final report.
Acronyms and abbreviations

AFR  WHO African Region
AMR  Antimicrobial resistance
AMR  WHO Region of the Americas
APSED  Asia Pacific Strategy for Emerging Diseases
ARI  Acute respiratory infection
BOD  Burden of disease
CC  Collaborating Centre
CO  WHO country office
CRP  Collaborative registration procedure
EBS  Event-based surveillance
ECN  Emergency Communications Network
EMARIS  Eastern Mediterranean Acute Respiratory Infection Surveillance
EMFLU  Eastern Mediterranean Flu Network
EMR  WHO Eastern Mediterranean Region
EQAP  External Quality Assessment Programme
EUR  WHO European Region
FAO  Food and Agriculture Organization of the United Nations
GISRS  Global Influenza Surveillance and Response System
HAI  Human-animal interface
HAS  Hospital admission survey
HLIP  High-Level Implementation Plan
HQ  WHO Headquarters
IATA  International Air Transport Association
IDP  Institutional development plan
IDSR  Integrated Disease Surveillance and Response
IHR  International Health Regulations (2005)
ILI  Influenza-like illness
ISST  Infectious substances shipping training
IVPP  Influenza virus with pandemic potential
L&S  Laboratory and surveillance
LMIC  Low- and middle-income countries
MA  Marketing authorization
MOH  Ministry of Health
NIC  National Influenza Centre
NIPH  National Institute of Public Health (Cambodia)
NRA  National Regulatory Authority
NRL  National Reference Laboratory
OIE  World Organisation for Animal Health
PAHO  Pan American Health Organization
PC  Partnership Contribution
PHEIC  Public Health Emergencies of International Concern
RT-PCR  Real-time polymerase chain reaction
PCR  Polymerase chain reaction
PIP  Pandemic Influenza Preparedness
PSC  Programme support costs
PV  Pharmacovigilance
QMS  Quality management system
RRT  Rapid response team
RSV  Respiratory syncytial virus
RO  WHO regional office
SARI  Severe acute respiratory infection
SEAR  WHO South-East Asia Region
SMTA2  Standard Material Transfer Agreement 2
SOP  Standard operating procedure
TFDA  Tanzania Food and Drugs Authority
UN  United Nations
UNICEF  United Nations Children’s Fund
US CDC  United States Centers for Disease Control and Prevention
WHO  World Health Organization
WPR  WHO Western Pacific Region
Executive summary

Pandemic influenza viruses respect no borders. All countries, rich and poor, large and small, must work together to prepare for and respond to an influenza pandemic whenever it may strike. Access to life-saving interventions, notably antiviral medicines and pandemic vaccines, made available in a timely and equitable manner to all countries, is essential for response.

To address these critical matters, the 64th World Health Assembly adopted the Pandemic Influenza Preparedness (PIP) Framework in May 2011. Its key goals include improving and strengthening the sharing of influenza viruses with pandemic potential, and increasing the access of developing countries to vaccines and other pandemic related supplies.

The PIP Framework contains an innovative benefit sharing system to improve global pandemic influenza preparedness and response, with equity, partnership, and transparency at its heart. One of its components is the Partnership Contribution (PC) which is an annual cash contribution to WHO from industry partners that use the Global Influenza Surveillance and Response System (GISRS).

Between 2014 and 2017, WHO implemented the Partnership Contribution High-Level Implementation Plan I (HLIP I), strengthening both global and national preparedness capacities. The plan focused on five areas of work in 72 countries in the six WHO regions: laboratory and surveillance, burden of disease, regulatory capacity building, risk communications, and planning for pandemic product deployment. Twenty-one indicators were developed to measure progress during implementation.

Collaboration and partnership were key to implementation. Funds were used in synergy with other investments from government agencies globally and bilaterally, the private sector, foundations, civil society, and multi-lateral agencies. By working together, partners contributed to improved pandemic preparedness.

This report presents the achievements and impact of the work undertaken. As highlighted in the ‘Summary of implementation’ on pages x-xi, and in more detail throughout the report, preparedness capacities improved globally, regionally and in priority countries during the four-year implementation period. Of the 21 indicators established to monitor progress, targets for 15 (71%) indicators were met or exceeded. Notable advances were made in each area.

Laboratory and surveillance (L&S, 43 priority countries): Implementation focused on improving country capacities to detect and respond to novel influenza viruses, and to monitor influenza trends. Virus and information sharing also increased through greater global collaboration under GISRS.

Key achievements include:

- 35 priority countries are now able to detect unusual respiratory disease events: this represents a five-fold increase from seven countries in 2014.
- 34 priority countries have functioning inpatient influenza surveillance: this doubled from 16 countries in 2014.
- 29 priority countries have a human-animal interagency coordination mechanism: this is four-times more compared to seven countries in 2014.
- 91 countries globally now share influenza epidemiological data through WHO FluID: this is a 65% increase from 55 countries in 2014.
- 130 countries globally now share influenza virological data through WHO FluNet: this is a 20% increase from 108 countries in 2014.
- 132 countries now routinely share seasonal influenza viruses with GISRS: this is nearly a 50% increase from 90 countries in 2014.
**Burden of disease (BOD, 19 priority countries):** Seasonal influenza burden estimates were derived to better understand how influenza impacts local populations. This information is important, as it can be used to design effective pandemic influenza preparedness and response policies. Key achievements include:

- Eight PIP priority countries estimated the influenza disease burden, of which three have published their findings in peer-reviewed journals.
- A new global influenza yearly mortality estimate was published by WHO.

**Regulatory capacity building (REG, 16 priority countries):** National regulatory capacities were strengthened to help ensure countries can access pandemic supplies in a timely manner in the event of a pandemic. Institutional development plans (IDPs) are a key foundation for regulatory capacities, and countries were supported to develop and implement these plans. Additionally, guidance was developed for all countries to improve their regulatory system readiness for pandemic preparedness. Key achievements include:

- 94% of priority countries established an IDP to build regulatory capacities.
- All priority countries with an IDP benchmarked at least one of their regulatory capacities.
- 48 targeted countries have a regulatory approach to facilitate the timely approval of pandemic influenza products during an emergency.

**Risk communications (RC, 38 priority countries):** At all stages of an influenza pandemic, fast, effective, and transparent risk communication can reduce morbidity and mortality. Capacities on a global scale were built through training experts for response when needed, knowledge sharing, and strengthening in-country risk communication capacities. Key achievements include:

- Risk communications IHR capacity scores increased by an average of 20% in priority countries.
- Eight influenza courses are available on the newly launched OpenWHO.org learning platform.
- A cadre of 180 communications experts were trained and are ready for emergency deployment.

**Planning for deployment (DEP, 16 priority countries):** Global and country supply chain systems need to be prepared to receive and distribute vaccines and pandemic products in an emergency. A global simulation tool was developed and used to identify key bottlenecks in product deployment, and to support countries in improving their national deployment processes. Key achievements include:

- World’s first vaccine deployment simulation portal ‘PIP Deploy’ was launched.
- A global vaccine deployment simulation involving countries, manufacturers and other stakeholders was completed.

Significant progress has been made, but more work is needed to address the vast requirements for preparedness. PIP will continue to support pandemic influenza preparedness globally and will transition to the implementation of the *Partnership Contribution High-Level Implementation Plan II (HLIP II)* starting in 2018.
Laboratory & surveillance
Capacity to detect and monitor influenza epidemics is strengthened in developing countries that have weak or no capacity

**ACHIEVEMENTS**

- Functional event-based surveillance
  - Baseline: 7
  - Target: 43
- Functional HAI coordination mechanism
  - Baseline: 7
  - Target: 43
- Active ILI surveillance
  - Baseline: 14
  - Target: 43
- Active SARI surveillance
  - Baseline: 16
  - Target: 43
- Consistent reporting to FluNet
  - Baseline: 108
  - Target: 124
- Consistent reporting to FluID
  - Baseline: 55
  - Target: 71
- National RRTs trained yearly and ready for deployment
  - Baseline: 14
  - Target: 43
- Routine seasonal influenza virus sharing
  - Baseline: 25
  - Target: 108

**IMPACT**

- National surveillance systems have improved to better detect and monitor influenza
- Global alert and response capacities have improved through GISRS including greater virus and information sharing

**$42.9M SPENT**
**ACHIEVEMENTS**

### Regulatory capacity building
Countries with weak or no regulatory capacity will be able to regulate influenza products, and to accelerate their approval in case of an influenza pandemic.

**IMPACT**
National regulatory authorities have improved capacities to better regulate products during a public health emergency.

**$3.3M SPENT**

### Planning for deployment
Plans for deployment of pandemic supplies will be developed and simulated.

**IMPACT**
The first global pandemic product deployment simulation was completed to improve response for when a pandemic strikes.

**$2.5M SPENT**

### Risk communications
Global risk communications capacities are strengthened with a special focus on pandemic influenza communications.

**IMPACT**
Global and national systems are available for emergency risk communications.

**$6M SPENT**

### Burden of disease
National policy-makers will have influenza disease burden data needed for informed decision-making and prioritization of health resources.

**IMPACT**
Influenza burden data are available to inform evidence-based policy.

**$2.1M SPENT**

### Risk communications
Global risk communications capacities are strengthened with a special focus on pandemic influenza communications.

**IMPACT**
Global and national systems are available for emergency risk communications.

**$6M SPENT**
The PIP Framework: working together for a safer tomorrow

There is no telling where or when the next pandemic influenza virus will emerge, nor how severe the resulting pandemic will be.

In 2003, avian influenza A(H5N1) – a virus with pandemic potential – re-emerged and caused human infections in different countries. By 2006, countries recognized the need for a formal arrangement to increase access to vaccines during influenza pandemics, particularly for countries in need. At the same time, countries recognized that ongoing, systematic virus sharing was critical for continuous global monitoring and risk assessment and to aid in developing safe and effective pandemic influenza vaccines. This started a global discussion to establish a more fair and equitable system to prepare the world for future influenza pandemics.

In 2009, the world faced an influenza pandemic due to a novel influenza A(H1N1) virus. Vaccines were in short supply, and there was slow distribution of donated vaccines to developing countries. While the exact numbers of deaths from this pandemic is unclear, estimates range from 151,000 to 575,400 in the first year alone.2

An after-action review of the International Health Regulations (IHR) in response to the 2009 pandemic found that the world was “ill-prepared for a severe pandemic”.2 Discussions were re-launched, and negotiations continued to create an agreement to improve preparedness for the next pandemic and increase the equity of vaccine access for all countries in need. These negotiations led to the Pandemic Influenza Preparedness (PIP) Framework.

Unanimously adopted by all 194 WHO Member States in May 2011, the PIP Framework is an international arrangement unlike any other. It establishes a unique benefit sharing system to improve global pandemic influenza preparedness and response, with equity, partnership, and transparency at its heart.

There is a high probability that the world will experience a severe outbreak in the next 10 to 30 years that could destabilize societies and economies; but it’s anyone’s guess when and where it might emerge."1

International Working Group on Financing Preparedness

1

A rapid response team travels to remote villages affected by avian influenza outbreaks to actively search for cases, Lao People’s Democratic Republic. © WHO/Jennie Musto
The best-documented success story is the Pandemic Influenza Preparedness, or PIP, Framework. The Framework was set up in 2011 as a bold and innovative preparedness tool that puts virus sharing and benefit sharing on an equal footing.\(^1\)

---

Margaret Chan, former WHO Director-General, in her address to the 140th WHO Executive Board, in 2017
The Partnership Contribution

The PIP Framework was developed by WHO Member States to improve global health security, by improving the sharing of influenza viruses with pandemic potential (IVPP), and increasing equitable access to pandemic influenza products for all Member States.

One of the most innovative aspects of the PIP Framework is its sustainable funding mechanism. Manufacturers of influenza vaccines, antivirals, and diagnostics who use the Global Influenza Surveillance and Response System (GISRS) make an annual financial contribution to WHO in exchange for use of the system. This is the Partnership Contribution (PC), which provides funds that are used to build capacities for national, regional, and global pandemic influenza preparedness and response.

Most PC Funds (70%) are used to strengthen global pandemic influenza preparedness. The High-Level Implementation Plan 2013–2017 (HLIP I) was developed to guide how the PC would be used to fill the gaps in preparedness. As recommended by the PIP Advisory Group, HLIP I focused on five areas of work that complemented and built on other capacity building efforts (Figure 1). Implementation began in 2014.

“Pandemic influenza is a most frightening global threat. The PIP Framework was developed as an innovative and ambitious instrument, inspired by the spirit of justice and equity. The PIP Framework Partnership Contribution provided by industry exemplifies these aims.”

Didier Houssin,
Chair of the PIP Framework Advisory Group (2011–2013)

Figure 1: The five areas of work under the High-Level Implementation Plan I

PC Response Funds

A portion (30%) of PC funds are set aside to be used at the time of a pandemic. These PC funds will be used early during the response and will complement other funding.

As of 31 December 2017, the available PC Response funds are US$ 36M.
Partnering for impact

Collaboration across sectors and partners is essential for effective and sustainable pandemic influenza preparedness at national, regional and global levels.

The PC is one part of this global investment. The generous support of government agencies globally and bilaterally, the private sector, foundations, civil society, and multilateral agencies all contribute towards achievements for pandemic preparedness.

By working together, partners combine their comparative advantages for success. Through building on synergies and leveraging the PC investments, PIP is generating momentum and has resulted in major gains for global pandemic preparedness and health security.

Thank you!

HLIP I implementation has benefited from the inputs of the partners who have positively engaged, supported, and provided feedback to improve implementation and preparedness. With deepest appreciation, thank you!
The Partnership Contribution has been efficiently used to build national capacities, mainly in low- and lower middle-income countries in such crucial fields as laboratory and surveillance, assessment of influenza burden of disease, regulatory measures and risk communication, among others. This report shows in a transparent way the outcomes accomplished so far in each one of the areas of work. We cannot forecast when and how severe will be the next pandemic, but we can assure that each country worldwide will be better prepared due to the PIP Framework and its Partnership Contribution.”

“The HLIP I constituted a big step towards ensuring the world is prepared for the next influenza pandemic; in an era of fast-emerging, quick-spreading epidemics and pandemics, the work of the WHO and the PIP Framework in ensuring global health security and contributing to public health has never been more relevant.”

Jarbas Barbosa, Chair of the PIP Framework Advisory Group (2016)
Implementing the Partnership Contribution for global progress

Developing sustainable change

**Improved surveillance enables burden of disease estimation**

Strong influenza surveillance is a vital foundation for pandemic preparedness. Countries can use surveillance data to estimate influenza disease burden. When some countries initiated work on these estimations, they realized that their surveillance systems were not equipped to deliver the data needed. Some issues were with the types of data available, or the processes for selecting and testing influenza cases. As a result, these countries prioritized surveillance system strengthening. Improved surveillance has countless benefits for pandemic preparedness, and notably has enabled countries to estimate burden of disease. This information ultimately helps countries make evidence-based policy decisions to support effective influenza preparedness and response.

**Sustainable influenza clinical management in low-resource settings**

Treating severe cases of influenza is challenging in many countries. Countries like Uzbekistan and Viet Nam are developing solutions. Both countries established national standards for clinical management.

Uzbekistan worked with international experts to develop the *National Guidance on Treatment of Patients in Critical Conditions due to Influenza*, and implemented trainings on these guidelines across the country. Viet Nam also worked with experts to develop a curriculum on severe acute respiratory infection (SARI) clinical management that was implemented in trainings for over 300 health workers.

Both of these initiatives have been sustained; in Uzbekistan the trainings will become part of curricula for postgraduate clinicians in intensive care departments, while the training in Viet Nam was certified by the Ministry of Health (MOH) for continuing medical education. As a result, these countries have set national standards for treating patients with severe influenza infections. During a future pandemic, the health workforce will be ready to implement these practices.

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"Many countries in less-resourced settings where data were previously lacking have now developed surveillance systems to measure burden of disease."

Vernon Lee, Director, Communicable Diseases Division, Ministry of Health, Singapore, and Member of BOD Steering Committee

"The impact of the *National Guidance on Treatment of Patients in Critical Conditions due to Influenza* will be invaluable. It is designed for clinicians providing care for critically ill patients (adults, children and pregnant women) with severe acute respiratory infections, including for medical facilities with limited resources."

Gulya Khamraeva and Marianna Krasnenkova, Associate Professors, Institute of Postgraduate Medical Education, Uzbekistan
Integrating influenza in national budgets

PIP has created a movement across many countries that previously did not prioritize influenza as a public health concern. While many countries are challenged with constrained budgets, PIP has kick-started influenza capacity building and policy-makers are seeing the value. Many countries have now integrated influenza activities into their national health and laboratory budgets:

**TAJIKISTAN**

PIP funds originally supported the transportation of clinical samples from sentinel sites to the National Influenza Centre (NIC), the development of a new data management system, and the monitoring of influenza surveillance system performance. These are now funded by the national budget.

**CAMBODIA**

Surveillance site staff are covered in full by the government, and surveillance activities will be integrated into the government’s budget.

**GHANA**

Sentinel sites now regularly ship specimens to the capital, Accra. This was originally funded by PIP, but has since been funded through health facility budgets.

**UZBEKISTAN**

The national budget now supports sentinel surveillance.

**ARMENIA**

PIP previously funded sentinel surveillance, a data management system and laboratory PCR testing. These are now primarily financed by the State.

**NEPAL**

Influenza surveillance and response has been added as a line item into the national budget.

**INDONESIA**

The government now supports procurement of influenza diagnostic materials, and funds sentinel surveillance.

**TURKMENISTAN**

The government now supports procurement of influenza diagnostic materials, and funds sentinel surveillance.

**VIET NAM**

Starting in February 2018, the government will support data entry from SARI surveillance into FluID. Previously, PIP funds were used for training laboratory staff, but now this will be supported from in-country government and national institute budgets.

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Leveraging the Partnership Contribution for global impact

Institutionalising risk communications for all outbreaks

During the 2009 influenza pandemic, risk communication was not well understood. WHO and many countries had limited systems for communicating risk to the public, highlighting the need for embedding risk communications in the response from very early on. PIP provided an opportunity to build the field of risk communication and strengthen global and national capacities to communicate risk in any health emergency.

Using the PIP risk communication project as a lever, for the first-time ever WHO has mainstreamed risk communications, integrating it as a public health intervention in any emergency response. The PIP risk communication project supported countries to build their capacity and to strengthen areas that allowed people at risk to take informed decisions to protect their health in any epidemic or pandemic. Today, unlike in 2009, countries and responding agencies consider the risk communication needs as a core intervention in a disease outbreak.

At WHO, the Emergency Response Framework now has a section dedicated to risk communication, and the WHO Incident Management System dedicates space for risk communications expertise and financial resources. The project allowed WHO to leverage additional stakeholder investments into risk communications - operational partnerships with UNICEF, the Red Cross, and many international agencies now jointly support national capacity building and response. In the first year of the project, PIP funds paid for 100% of WHO’s risk communication work. By the third year, PIP investment covered only 25%, and PIP funds helped to garner the remainder of stakeholder support required. With this tremendous success and diversified funding sources for risk communications, PIP funds continue to be leveraged to fill critical global gaps for pandemic influenza preparedness.

A growing community of practice around burden of disease

Global momentum has been created for estimating influenza disease burden. WHO is encouraging countries to estimate their influenza burden to inform programmatic decisions. More public health practitioners are getting involved to understand burden of disease, and are leveraging PIP investments to interpret, publish, and use the data. WHO has also engaged academia and other partners to identify the key questions that need to be addressed and to develop the methods for countries to generate the answers.

This global push is creating a better understanding of influenza’s impact in countries and within different populations, and has led to a new global mortality estimate for influenza. Increased momentum for estimating burden helps countries and organizations to identify high-risk populations for infection and severe outcomes.

Disease burden information will inform pandemic planning in areas such as health service delivery and clinical management, and will help in the selection of priority population subgroups for vaccination.

Communicating risk

PIP catalysed the development of the first evidence-based WHO guidance on communicating risk in an emergency.8

Risk communications training, Kenya. © WHO
Influenza preparedness advances IHR core capacities

Although the objective of all PIP investments is to strengthen global pandemic influenza preparedness, the impact has been greater. HLIP I targeted pandemic influenza preparedness by focusing on five areas of work. These contributed to capacity building objectives for six of eight IHR core capacities:

- Surveillance
- Response
- Preparedness
- Risk communication
- Human resources
- Laboratory

As can be seen in Figure 2 and Figure 3, IHR core capacities – the key elements for all country health emergency preparedness – improved in countries that received PIP funds. The average IHR core capacity scores for PIP recipient countries increased from the baseline, which was measured before HLIP I started. Major progress was made in risk communications where the average score increased by 20%, as well as preparedness and human resources where both average scores increased by 11%. When looking at all countries globally (Figure 3), countries that were targeted with PIP funds for improved pandemic influenza preparedness made similar or greater gains in their overall IHR core capacity scores. These findings highlight the collateral benefit of investing in pandemic influenza preparedness. These results alongside the investments made by countries and other partners showcase PIP’s broader positive contribution for enhanced emergency readiness.

What is the IHR?

The IHR (2005) is a legally-binding international instrument. It requires WHO Member States to build core capacities to detect, assess and report public health events, and to respond promptly and effectively to public health risks and Public Health Emergencies of International Concern (PHEIC).

Efficient global health crisis management can only be ensured through compliance with the International Health Regulations.”

Berlin Declaration of the G20 Health Ministers, 2017

Notes:

- PIP funds corresponded to six of the eight IHR core capacities except Legislation and Coordination
- Figures 2 and 3 compare the HLIP I baseline average score (2013 or 2012 data) to the latest available score (2016 or 2015 data)
Investing in influenza “value for money” in emergency preparedness

“Laboratory standard operating procedures (SOPs) have been developed, which helped to strengthen IHR laboratory capacities, and also to implement international standards and WHO recommendations.”

Gurbangul Ovliyagulova, Head, High Dangerous Diseases Department, Ministry of Health, Turkmenistan

“PIP has improved IHR core capacities specifically on real-time surveillance and laboratory capacity.”

Vida Mmbaga, Influenza Surveillance Coordinator, Ministry of Health, United Republic of Tanzania

“PIP has improved IHR core capacities, especially event-based surveillance. The influenza surveillance training was an opportunity to enhance laboratory practices.”

Ezzine Hind, Head, Epidemic Disease Services, Ministry of Health, Morocco

“Training of rapid response teams and surveillance activities have resulted in increases in IHR core capacity scores.”

Bouaphanh Khamphaphongphane, Chief, Epidemiology Unit, Ministry of Health, Lao People’s Democratic Republic