GLOBAL HEALTH CRISES TASK FORCE
Summary of Second Quarterly Meeting (11 November 2016)

1. The Global Health Crises Task Force held its second quarterly meeting in person, in New York on 11 November 2016. During the morning, the Task Force examined the functioning of systems for managing health emergencies. During the afternoon, the Task Force considered options for encouraging the right kinds of research and innovation, for ensuring ownership by communities and for preparing responses to unanticipated threats. The President of the General Assembly convened an informal briefing on UN system coordination during outbreaks and health emergencies during the lunch break. The Task Force members attended this informal briefing.

Functioning of systems for managing health emergencies

2. Mr. Jan Eliasson (the United Nations Deputy Secretary General) opened the meeting by thanking Task Force members for participating in the face-to-face meeting. He recalled that in his previous role as emergency relief coordinator, he had introduced a stronger emergency response system to trigger immediate actions in the event of an emergency. He expressed the view that a similar mechanism for health crises is needed. He invited the Task Force to examine (a) the use of the Joint External Evaluation Tool for assessing compliance with the International Health Regulations, (b) the capabilities of the WHO Health Emergencies Programme, (c) the simulation of responses in order to test capacities, and (d) means to ensure sustainable financing for responses to health crises. He emphasized the importance of interconnected (horizontal) working, and support for strong country ownership. He stressed that achievement of the sustainable development goals will require mobilisation of multiple stakeholders - Member States, civil society, the business sector, philanthropic sector and scientific community.

3. Dr. Margaret Chan (the Director-General of the World Health Organization) reported on WHO's work to support governments in preparing for and responding to health emergencies. The Joint Evaluation (JEE) tool has been completed in 30 countries, and 50 additional countries are scheduled to undergo the JEE exercise or have expressed an interest in doing so. WHO plans to train and certify 200 Emergency Medical Teams. Simulation exercises involving emergency medical teams have been performed in all regional settings. With regard to the new WHO Health Emergencies programme, the lessons learned during Ebola were applied to address the Zika outbreak, manage humanitarian crises in Nigeria and Iraq, and administer the yellow fever vaccine to 9 million people in the Democratic Republic of Congo. Within each of the WHO regions, the secretariat seeks to catalyse coordination of strategies across different countries. WHO is looking at the location of the next Zika outbreak to implement clinical trials for several prototype vaccines for Zika which have recently become available.

4. Dr. Chan noted that WHO is working with country teams and regional entities to improve impact through better coordination. Africa and the Middle East are the regions where coordination of responses will have the greatest impact on disease burden. WHO seeks to strengthen capacity within regions to improve data management and clinical practice. At the global level, new protocols have been developed to increase the impact of existing coordination mechanisms such as the Inter-Agency Standing Committee (IASC) and to improve the understanding of the International Health Regulations by humanitarian experts.

5. Dr. Chan highlighted ongoing financial challenges, with core capacity in the new Health Emergencies programme financed at only 44%. The WHO Contingency Fund for Emergencies, for

which USD 100 million is being sought, has only received USD 31.5 million of which USD 18 million has already been disbursed.

6. Dr. Jim Yong Kim (the President of the World Bank Group) observed a backlash against globalisation and the multilateral system in the current political environment. International organizations need to address aspirations and explain how multilateralism and the Sustainable Development Goals can contribute to prosperity. Automation can result in the destruction of low skilled jobs in developing countries. Countries that have 38% stunting in their populations will not be competitive in the global economy. Investments in infrastructure, in particular with private sector investments, can bring higher returns and development assistance can be targeted at other priorities, including health. Countries cannot compete in the economy of the future without investments in health, nutrition and education. Without these investments, countries will face the pathway of fragility, violence, conflict, extremism and then an outflow of refugees.

7. Countries will need assistance in building health systems to address multiple crises at the same time. Grant-based support and official development assistance will not be sufficient. A global concessional financing mechanism providing loans at 0% interest can become a source of financing for health. Other financial instruments traditionally used to create wealth can also be used to finance health, such as insurance and bonds. Purchasing insurance for an annual premium of USD 40 million can create a fund of USD 500 million to be triggered during a health crisis.

8. Dr. Kim underscored the importance of simulations to remind governments of the terror of Ebola and SARS. It provides a good way of testing the state of preparedness of systems.

Promoting compliance with the International Health Regulations

9. The Task Force members noted that the International Health Regulations require that nations establish systems for prevention, detection and response. They stressed the critical role of communities in surveillance systems, noting that the detection of risky or disease-avoiding behaviours can be captured through community surveillance. Once communities have been recognized as the frontline components of surveillance systems, they need to be financed so that they can perform this function effectively.

10. The Task Force members examined the challenges to the notification of events under the IHR, observing that there is distrust on many levels. Communities need to be convinced that it is in their interests to report people who are ill, and potentially infectious, as they may fear being subject to constraints as the result of public health measures (including involvement of security forces). Similarly, governments may have concerns that the notification of events will have an adverse impact on economic and political interests. The leadership and diplomatic skills of representatives of international organizations at the country level will be critical to handle such anxieties and prevent them from being reflected as mistrust. More work is needed to discourage the imposition - by governments - of unjustified measures to restrict trade or travel during health emergencies. This should include exploring possibilities for recourse to the World Trade Organization dispute resolution mechanisms.

11. Informal materials, including global media reports, serve as valuable sources of information in surveillance systems. They may learn of early-stage disease outbreaks or other health threats; such a system is now used routinely by WHO. The Global Outbreak and Alert Response Network plays a key role in confirming the accuracy of reports to ensure trust and credibility.

12. The Task Force considered that the roll-out of the IHR Joint External Evaluation tool marks a truly important development in efforts to promote compliance with the International Health Regulations, and the speed of roll-out in assessing countries' compliance will be important in catalysing donor support for health system strengthening. It would be useful if the JEE process also incorporated quantitative indicators.

13. The Task Force noted that the G7 has committed to assisting 76 countries with achieving IHR core capacities, and expressed interest in the progress on this initiative, so that WHO and other stakeholders can be aware of those countries where IHR capacity risk is greatest.

Working horizontally within the UN system and through the IASC

14. The Task Force members agreed that the UN system should operate using a horizontal approach at all stages of health crisis response: detection, prevention, care, support and coordination. In its recent trip to observe the response to Zika in Colombia, the Independent Oversight and Advisory Committee observed that some UN agencies at country level are competing for funds rather than working horizontally and inter-agency coordination could be improved. Strategic leadership, coupled with stakeholders' pursuit of common outcomes, as well as use of up-to-date evidence and agreed standards are required to stop a growing outbreak in its tracks and prevent it from enlarging. The IASC provides an important platform for UN and non-UN stakeholders involved in humanitarian action to come together. The IASC Principals were in the process of finalizing "Level 3 Activation Procedures for Infectious Disease Events" to guide future responses by IASC organizations to large-scale infectious disease outbreaks, as well as to provide a critical link to non-IASC public health actors through the phases of such responses. These Procedures were discussed during a General Assembly briefing on 11 November 2016.

Financing challenges

15. The Task Force members stressed the importance of engaging ministers of finance and establishing linkages between action for health and the investment of concessional finance. Attracting financing requires an improved narrative, to provide donors with a holistic and strategic view of how their funding will be used year by year. It requires assurances in terms of value for money and cost-effectiveness. One important way to add value is through coordination and collaboration of partners working at country level. It will also be necessary to articulate the rationale for a no-regrets policy and explain how prompt financing can help to avert larger crises. The insurance sector measures what happens if action is not taken, by placing a value on risk and incentivizing preparedness for the management of disaster risks – the more prepared countries are, the lower their risk premiums.

16. The Task Force members highlighted the difficulties in sustaining financing during calm periods before or after a health crisis; it is during these periods that funding is needed to build capacity, finance research and development, develop vaccines and recruit volunteers. The World Bank will be establishing a working group chaired by Peter Sands to examine financing for preparedness. It will report to the Task Force in six months with recommendations on how health risks can be valued, how resources can be mobilized for health at the country level and how development assistance can support the process. Domestic challenges such as increasing tax revenues, demonstrating value for money and cost-efficiencies, and stemming illicit financial flows need to be addressed.

Refining the political narrative

17. The Task Force members noted the need to refine a political narrative that presents health security as a global public good, emphasizing that health is essential for development and prosperity, in order to engage leaders in political forums like the G20.

Looking beyond the health sector

18. The Task Force members stressed the need to look beyond the health sector to address the needs of people who have no access to health personnel or functioning services. There are widening gaps in access between the centres and peripheries of cities, between the rich and the poor, and between men and women, urban and rural areas. Investments are needed to narrow these gaps, and to rebuild trust between governments and communities during the calm periods, rather than in the midst of a crisis or pandemic. To reduce these gaps, it will be critical to engage with communities, to expand social protection and strengthen the local capabilities to manage and respond to adversity. The Task Force members also highlighted the One Health approach, and the importance of looking at animal health together with human health, as many of emerging disease threats are zoonotic (animal endemic organisms causing disease in man), and emerging resistance to antimicrobials across animals and humans (AMR) is a global threat that requires urgent attention.

Options for encouraging the right kinds of research and innovation

19. The Task Force members reiterated the need to prioritise work on specified pathogens (such as through WHO's Blueprint), as well as to develop generic platforms that can be adapted in response to unknown or unanticipated threats. The Task Force members noted that the list of prioritised pathogens should not be restrictive since outbreaks often occur with pathogens that had previously been completely unanticipated. Tools to accelerate the development of treatments, diagnosis and vaccines are needed. WHO should coordinate this work. WHO should also drive forward its work on ensuring that sample sharing for infectious disease outbreaks and the subsequent development of diagnostics is not impeded by the Nagoya Protocol.

20. The Task Force members agreed that it would be useful to have greater clarity on what trials have been commenced but then ended at Phase I or II, in order to avoid duplication of work during an outbreak. A major challenge for WHO has been the lack of information sharing from both companies and countries on research trials that are underway. The September 2016 report of the High-level Panel on Access to Medicines highlighted the issue of transparency of clinical trial data. It would be preferable to make discrete improvements on existing mechanisms that are successful, such as the International Clinical Trials Registry Platform, rather than creating entirely new platforms. The Task Force members requested a mapping of current initiatives and entities involved in research and development and relevant to current or potential global health crises.

21. The Task Force members stressed the importance of pursuing scientific collaboration where an outbreak is taking place to develop capabilities and build trust. These collaborative partnerships with the host country organisations and others, need to be established before an outbreak. Once collaboration is established on the ground, laboratories and other resources can be adapted to address other diseases and threats. In connection with building trust, the Task Force members acknowledged the need for local researchers and clinicians to be full and equal partners in the design, conduct, and analyses of studies and for local partners and researchers to be given due credit and recognition.

22. The Task Force members considered that, to the extent possible, ethical, safety, regulatory and legal issues should be resolved in advance of an emergency. Coordination is needed for data and sample sharing. In the United States, the Public Readiness and Emergency Preparedness Act (PREP Act) has provided immunity for manufacturers from liability for claims related to the administration or use of unlicensed countermeasures to disease and a compensation fund, during public health emergencies. The development of appropriate legal mechanisms similar to the PREP Act to enable the global use of countermeasures when needed to stem the spread of disease outbreaks deserves further consideration.

23. The Task Force members considered the challenges of financing research and development. Governments provide funding to academic institutions but there are insufficient processes to ensure returns. Financing research and development should be linked to national financing for preparedness. The private sector needs to be incentivized to ensure their engagement. Regional collaboration and funding could fill gaps where it is not feasible for individual countries to develop their own expertise and infrastructure. The greater involvement of the European Union, which has one of the largest research institutions, should be encouraged. Investment in vaccine and development of medicines needs to be mobilized, including by the Coalition on Epidemic Preparedness Innovations and other stakeholders.

24. The Task Force members observed that gains achieved during outbreaks can also have beneficial spillover effects during periods of calm. For example, mechanisms for paying Ebola crisis response workers through mobile technology have been continued following the end of the Ebola outbreak.

25. The Task Force members stressed that in addition to the development of biomedical products, research and innovation is needed in other areas such as community engagement, crisis preparedness and management, ethics, anthropology, and other social sciences. Without community engagement, the introduction of the best vaccines and other products will not succeed.

Options for ownership by communities

26. The Task Force members emphasized that a national response is not just limited to a response by the government but also encompasses the activities of civil society partners. Similarly, a global response is not just the UN response. There are communities at the global level – a global civil society and global advocacy are needed to press for and contribute to action on pandemic preparedness and response.

27. The Task Force members expressed concern about the challenges of protracted health crises and the globalization and entrenchment of fragility. Communities are at the forefront of addressing health issues especially when governments are weak or absent. Ignoring traditional leadership and community fabric during outbreaks creates problems for responses. The Task Force members stressed the need to avoid disempowerment of communities. Communities should be involved in all health activities that relate to crises, including preparedness, prevention and research. Community engagement is an ongoing and permanent activity, not something to be done in the middle of a crisis. Community engagement is needed to encourage health seeking behaviours and to address bottlenecks such as rumours, exclusion, stigma and discrimination. The Task Force members cited instances in which community engagement and advocacy have made positive contributions to responding to HIV/AIDS, Ebola and yellow fever; to reducing the price of medication for meningitis, to diagnosing H1N1 in Bangladesh, and to vector monitoring in West Africa.

28. If external organizations are going to engage with communities in a sensitive manner, those concerned need to be aware of how they are perceived. There is a perception that health crises are only addressed by the international community when they pose a threat for other countries or regions. However, a health crisis can emerge anywhere, within every society, not just in low income countries. The role of communities in health is important in all countries – whatever the stage of development: the promotion of health literacy and the dissemination of health information are needed in all settings. The nature of communities has evolved over time with increased urbanisation, changes in social structures and internal and international migration. Further work is needed to understand the nature of different types of communities including the way in which information is communicated within and between different communities and where fragility, influence and resilience may lie.

29. The Task Force members stressed the need to have clear indicators for measuring the engagement of communities. One indicator suggested is the participation of women in the response. In north-eastern Thailand, if the chair of a community clinic is a man, then the vice-chair must be a woman.

30. The need to have sustained financing for community engagement was noted. For example, when countries graduate from eligibility for assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria, there are concerns that the support for NGOs will be cut. There is a long term need for the engagement of civil society and media in health crisis responses. The potential for intensive engagement by communities has to be institutionalized – for example, the skills associated with community ownership and engagement can be incorporated in the training of emergency medical teams.

Preparing for unanticipated threats

31. The Task Force members discussed the investments that will be needed to ensure preparedness for unanticipated threats. In general, preparedness should include investments in:

- Sensitive and reliable surveillance systems
- Research technology platforms and strategies that can be adapted to address new disease challenges
- Generic, appropriate technology platforms that are easily deployable to the field and across different types of pathogens
- Practical, rapid diagnostic tools that can be used in the field
- Rapid response teams and surge capacity
- Personal protective equipment and training for health workers
- Research in issues relevant to any outbreak
- Locally appropriate research infrastructures, including well-functioning laboratories, regulatory structures, and research support entities
- Mechanisms for community engagement
- Academic programs that generate well-trained researchers and care providers
- Health literacy
- Organizational, managerial and coordination arrangements
- Simulation exercises

32. It is also critical that urgent needs for finance in health crises are anticipated and that any such funding actually reaches those who need it in the event of a crisis. Governments need to be in a position rapidly to mobilize necessary resources in the event of a crisis. Planning should be based

on an all-hazards approach that anticipates the concurrent manifestation of multiple threats – including those due to biohazards.

33. The Task Force members considered that ongoing challenges with responding to unexpected health events include the lack of institutional capacity and insufficient sharing of information. Strong response capacity is needed within institutions at the national and international level. Data sharing is important: responses are weakened when restrictions constrain access to information. Strong political and public health leadership is required to dissuade governments from imposing disproportionate travel or economic restrictions, which create disincentives to the transparency and information-sharing required to control outbreaks.

34. At the political level, heads of state need to be briefed on preparedness for health emergencies and to be in a position to mobilize coordinated cross-governmental responses. Such inter-sectoral coordination mechanisms should be established before outbreaks, with Ministers of Health serving as the convenors of different sector actors. Close working relationships between governments should continue to be facilitated so as to encourage the sharing of relevant experience.

35. During any health crisis, a wide variety of stakeholders (whether public and private, national and international) is usually mobilized. The Task Force members stressed the importance of strategic leadership and coordination so as to encourage effective and collective action. The UN system needs to appreciate that governments face pressures to react rapidly to situations, and respond to a 24/7 media cycle. It is preferable for governments to react on the basis of available information, even though incomplete, as delayed communications may fuel the spread of rumours and disinformation, and potentially trigger unjustified measures, such as trade or travel restrictions during health emergencies.

Next meeting

36. Some Task Force members expressed interest in having another in-person meeting. Professor Levy offered to have INSERM host a meeting of the Task Force.

Participation in the Global Health Crises Task Force (11 November 2016)

1. Mr. Jan Eliasson
   UN Deputy Secretary-General
2. Dr. Margaret Chan
   WHO Director-General
3. Dr. Jim Yong Kim
   World Bank Group President
4. Mr. Stephen O'Brien
   UN Under-Secretary-General for Humanitarian Affairs and the Emergency Relief Coordinator
5. Mr. Gray Handley
   (sitting in for Dr. Anthony S. Fauci, Director, National Institute of Allergy and Infectious Diseases (NIAID) at the National Institutes of Health)
6. Dr. Mohammed-Mahmoud Hacen
   President, Mauritanian Public Health Association
7. Dr. Felicity Harvey
   Former Director General for Public and International Health, UK
   Member, Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
8. Professor Ilona Kickbusch
   Director, Global Health Centre, Graduate Institute of International and Development Studies in Geneva
9. Professor Yves Lévy
   Chairman and Chief Executive Officer, National Institute of Health and Medical Research (Inserm)
10. Dr. Poh Lian Lim
    Senior Consultant in the Ministry of Health, Singapore, and at Tan Tock Seng Hospital
    Member, Advisory Group on the Reform of WHO's Work in Health Emergencies
11. Dr. Shigeru Omi
    President, Japan Community Health Care Organization (*by telephone*)
12. Mr. Elhadj As Sy
    Secretary General, International Federation of Red Cross and Red Crescent Societies
    Member, Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
13. Dr. Chris Elias
    President, Global Development Program of the Bill and Melinda Gates Foundation
14. Ms. Vidhya Ganesh
    (sitting in for Mr. Anthony Lake, UNICEF Executive Director)
15. Ms. Mandeep Dhaliwal
    (sitting in for Helen Clark, UNDP Administrator)
16. Dr. David Nabarro
    Special Adviser on the 2030 Agenda on Sustainable Development and Climate Change

Additional participants accompanying Task Force members

17. Mr. Timothy Evans, World Bank Group

18. Ms. Natela Menabde, WHO
19. Dr. Julie Hall, IFRC
20. Dr. Nicole Bates, Bill and Melinda Gates Foundation