GLOBAL HEALTH CRISES TASK FORCE
Third Quarterly Report (January - March 2017)

Executive Summary

The Global Health Crises Task Force was established by the Secretary-General for a one year period beginning on 1 July 2016. The purpose of the Task Force is to monitor, coordinate and support the follow-up and implementation of the recommendations of the High-level Panel on the Global Response to Health Crises ("Panel"), issued in its report on "Protecting humanity from future health crises".   Through its work, the Task Force will seek to catalyse action on the Panel's recommendations, enhance the preparedness of the UN system, maintain the profile of global health issues, and make substantive contributions to the strengthening of the global capability for responding to health emergencies.

In the present report for the third quarter (January – March 2017), the Task Force provided the following observations and advice in nine priority areas:

1. **Strategic support for national health systems to prevent global health crises**:

    a. The Task Force members observed that recent increases in avian influenza underscore the importance of strengthening veterinary systems to tackle the source of outbreaks. The Joint External Evaluations of the International Health Regulations core capacities and the Performance of Veterinary Services (PVS) evaluations need to be brought closer together.
    b. The Task Force members were encouraged to see that countries are completing the Joint External Evaluations, with the support of WHO and partners. However, they stressed that financing must be made available to ensure that gaps identified in the Joint External Evaluations are addressed. They expressed their hope that the G7 health ministers meeting scheduled to take place in Milan in November 2017 will provide an update on how commitments to support IHR compliance in 76 countries have been implemented.
    c. The Task Force members welcomed the development by OCHA and UNCTAD of the Automated System for Relief Emergency Consignments to address the persistent problem of unsolicited shipments during emergencies. They stressed the importance of broad adoption of the ASYREC platform by countries, as any country is potentially vulnerable to natural disasters and health emergencies.

2. **Integrating communities in efforts to prevent global health crises**:

    The Task Force members welcomed the launching of the Communication and Community Engagement Initiative and its focus on health emergencies. They encouraged the Steering Group to find ways for the Initiative to contribute to preparedness for health emergencies, including by supporting Joint External Evaluation missions and contributing to the training of Emergency Medical Teams and Public Health Rapid Response Teams.

3. **Supporting regional arrangements to prevent and respond to health crises:**

    The Task Force members commended WHO for using its convening role to facilitate the development of and agreement on regional commitments on immunization which have subsequently led to concrete action. Where other regional entities, such as the

Association of South East Asian Nations (ASEAN), have demonstrated an interest in pursuing regional collaboration on health crises, WHO should similarly facilitate the development of regional commitments and capacities.

4. **Strengthening UN system capacity during health emergencies:**

   a. The Task Members shared the view of the IOAC that recruitment for core positions in country offices, including WHO Representative (WR) positions in key countries with protracted crises, needs to be prioritised. They expressed concern that in the absence of full funding for the Programme, the Organization would be forced to identify trade-offs.
   b. The Task Force encouraged WHO to ensure the integration of FAO and OIE in event detection and risk assessments, as it moves forward with the development of the new Epidemic Intelligence from Open Sources (EIOS) platform.

5. **Testing capacities and processes for global health crises response through simulations:**

   The Task Force members emphasised the critical importance of bringing together all stakeholders in country-level simulations. Involving the private sector, civil society organizations, United Nations and national governments in simulations will help to clarify the respective roles of different partners and to identify gaps in country-level coordination in the future. They welcomed the simulation to be conducted at the G20 health ministers meeting.

6. **Catalysing focused research and innovation relevant to global health crises:**

   a. The Task Force members commended WHO for its clarity in setting out the revised methodology for prioritising emerging diseases. The Task Force members agreed that it was important for the methodology to allow for the examination of a pathogen or disease that might need to be prioritised between annual exercises.
   b. The Task Force welcomed the collaboration between CEPI and WHO, and the alignment of CEPI's activities with the WHO list of priority diseases.
   c. The Task Force members encouraged the much broader development and support of translatable platform technologies for diagnostics, vaccines, and therapeutics.
   d. The Task Force members encouraged WHO to continue to serve in its role as a convening organization and promote coordination, but not create its own research capabilities. They endorsed the role of funding agencies and organizations with extensive experience in supporting and managing research activities to continue to fulfil this responsibility.

7. **Securing sustainable financing for work on global health crises:**

   The Task Force members expressed their hope that the World Health Assembly will respond positively to the proposal to increase assessed contributions for WHO's budget, particularly in view of the fact that the amount of assessed contribution has remained unchanged for a decade. The Task Force members were also encouraged by the

commitments of Member States to increase their own voluntary contributions even if the World Health Assembly does not adopt the proposal for increased assessed contributions.

8. **Focusing attention on the gender dimensions of global health crises:**

The Task Force members recalled the Bangkok Principles which call for the promotion of the systematic integration of health into disaster risk reduction policies and plans. They encouraged UN Women, IFRC and UNISDR to ensure that health dimensions are fully integrated into the new Global Programme in Support of a Gender Responsive Sendai Framework Implementation. The Task Force members agreed that access to sexual and reproductive health services is important and that sexual and gender based violence pose particular risks for women and girls. They noted that women and girls may also be exposed to unequally high health risks due to other factors, such as their role as caregivers, unequal access to education, and implicit gender biases that may influence diagnoses or treatment decisions.

9. **Ensuring health crises are a priority on global political agendas:**

The Task Force members welcomed the very first G20 health ministers meeting and observed that it would give a strong political message for the G20 to affirm their commitment to a coordinated global response to health crises, to financing preparedness for health emergencies at the national, regional and global levels, as well as their support for the new IHR monitoring and evaluation framework.

Introduction

1.   The Global Health Crises Task Force was established by the Secretary-General for a one year period beginning on 1 July 2016. The purpose of the Task Force is to monitor, coordinate and support the follow-up and implementation of the recommendations of the High-level Panel on the Global Response to Health Crises ("Panel"), issued in its report on "Protecting humanity from future health crises" (A/70/723).   Through its work, the Task Force seeks to catalyse action on the Panel's recommendations, enhance the preparedness of the UN system, maintain the profile of global health issues, and make substantive contributions to the strengthening of the global capability for responding to health emergencies.

2.   The Task Force meets on a quarterly basis and provides quarterly reports to the Secretary-General on the progress of the Panel's recommendations. During its first meeting, the Task Force identified nine priority areas:

   a. Strategic support for national health systems to prevent global health crises
   b. Integrating communities in efforts to prevent global health crises
   c. Supporting regional arrangements to prevent and respond to health crises
   d. Strengthening UN system capacity during health emergencies
   e. Testing capacities and processes for global health crises response through simulations
   f. Catalysing focused research and innovation relevant to global health crises
   g. Securing sustainable financing for work on global health crises
   h. Focusing attention on the gender dimensions of global health crises
   i. Ensuring health crises are a priority on global political agendas

Progress made in nine priority areas

3.   The present report covers key developments in the nine priority areas in the third quarterly period from January to March 2017 and key observations made by the Task Force during its meetings by teleconference on 15 February and 13 March 2017. In these teleconferences, the Task Force received updates on current and emerging health threats from the World Health Organization (WHO), the Food and Agriculture Organization (FAO) and the World Organization for Animal Health (OIE). The briefings discussed the increase in reports of various strains of avian influenza; the health dimensions of the famine and near famine in South Sudan, Nigeria, Somalia, Yemen and the Horn of Africa; and yellow fever in Brazil.

Strategic support for national health systems to prevent global health crises

Task Force observations and advice

- The Task Force members observed that recent increases in avian influenza underscore the importance of strengthening veterinary systems to tackle the source of outbreaks. The Joint External Evaluations of the International Health Regulations core capacities and the Performance of Veterinary Services (PVS) evaluations need to be brought closer together. The publication of the Handbook for the Assessment of Capacities at the Human-Animal Interface" provides a useful tool for identifying the synergies between the Joint External

Evaluations and the PVS Evaluations. The practice of including veterinarians in the Joint External Evaluation missions should be continued.

- The Task Force members were encouraged to see that countries are completing the Joint External Evaluations, with the support of WHO and partners. However, they stressed that financing must be made available to ensure that gaps identified in the Joint External Evaluations are addressed. They expressed their hope that the G7 health ministers meeting scheduled to take place in Milan in November 2017 will provide an update on how commitments to support IHR compliance in 76 countries have been implemented.

- The Task Force members welcomed the development by OCHA and UNCTAD of the Automated System for Relief Emergency Consignments (ASYREC) to address the persistent problem of unsolicited shipments during emergencies. They stressed the importance of broad adoption of the ASYREC platform by countries, as any country is potentially vulnerable to natural disasters and health emergencies.

- The Task Force members agreed with the importance of examining how low and middle-income countries can transition from aid to ensure sustainability of health systems strengthening. It recommended that the International Working Group on Financing Preparedness and Response address the particular challenges faced by low and middle-income countries in transition.

Implementation of the new IHR monitoring and evaluation framework

4.   The Panel recommended that WHO strengthen its "periodic review of compliance with the IHR core capacity requirements".[1] As mentioned in previous reports of the Task Force, WHO has introduced a new IHR monitoring and evaluation framework consisting of four components: (i) annual reporting to the World Health Assembly; (ii) after action review; (iii) simulation exercises; and (iv) joint external evaluations (JEEs).

5.   As of 30 March 2017, JEEs have been completed in 37 countries. For the remainder of 2017 and 2018, JEEs have been scheduled in 28 countries, and an additional 31 countries have expressed an interest in participating. In 25 of the 37 countries for which JEEs have been completed, WHO has scheduled missions to assist with the development of national action plans for health security to address the gaps identified by the JEE exercises. WHO is supported in this regard by the JEE Alliance, a multi-stakeholder platform established in May 2016 to support country assessment processes and building country capacity.

6.   In February 2017, WHO and OIE published its "Handbook for the Assessment of Capacities at the Human-Animal Interface".[2] This is intended to facilitate the annual reporting on country compliance with IHR (2005) requirements by using the results of the Performance of Veterinary Services (PVS) evaluations conducted by the World Organization for Animal Health (OIE). The PVS Evaluations assess the performance of national veterinary services against 47 critical competencies. The handbook provides a mapping of which PVS critical competencies are relevant for evaluating the indicators reviewed in the Joint External Evaluation framework.

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[1] Recommendation 6.
[2] Handbook for the Assessment of Capacities at the Human-Animal Interface.

Development of the Automated System for Relief Emergency Consignments

7.   The Panel recommended that governments should "[i]ncorporate planning for health crisis responses into national disaster risk-reduction preparedness and response mechanisms and plans." A critical component of disaster-risk preparedness is establishing streamlined processes for customs officials to handle the shipment of humanitarian relief items.

8.   The Automated System for Customs Data (ASYCUDA) was set up by UNCTAD in 1982 to provide a common computerised platform used by the customs officials of participating countries to handle customs declarations and manifests. At present, ASYCUDA is used by 95 countries. The implementation of ASYCUDA facilitates the streamlining of customs processes which is needed to expedite the processing of relief items. During emergencies, customs officials have been overwhelmed by the sudden increase in the volume of shipments, which frequently include unsolicited donations of items that are neither essential nor relevant for relief efforts. At the same time, other shipments containing life-saving items may be held at borders for long durations, resulting in substantial financial loss as well as loss of human lives. From previous humanitarian emergencies, OCHA has reported the following examples of unsolicited shipments:

   a. During the 2008-2009 conflict in Gaza, approximately 5,000 tonnes of unsolicited and largely unsuitable medical supplies and equipment were donated. An estimated 80% of the medical items received were not included in Gaza's essential drug list, including 100,000 flasks of cough syrup, while 65 essential drugs and 90 types of disposable medical products were urgently needed. At the end of March 2009, thousands of tonnes of donations remained unsorted and piled up at the Egyptian border, awaiting transfer to Gaza.

   b. The 2010 earthquake in Haiti triggered an influx of unsolicited donations, including 10 containers of refrigerators operating on a voltage unusable in Haiti, five containers of Red Bull, potato chips, tuxedos, and wedding dresses, and a shipment of toys.

   c. The volume of unsolicited donations sent to Fiji during the 2016 Typhoon Winston filled more than 33 Olympic-size swimming pools.

9.   During the Humanitarian Networks and Partnerships Partners Week in February 2017, OCHA introduced a new platform that it has designed with UNCTAD – the Automated System for Relief Emergency Consignments (ASYREC). Prior to an emergency, ASYREC will enable customs authorities to take preparatory steps, such as defining lists of emergency relief items, establishing streamlined customs procedures, and pre-registering humanitarian partners that may be involved in UN relief operations. Such organisations can be authorised in advance to use simplified declaration forms for relief shipments and to enjoy exemptions from import duties for relief items imported for humanitarian emergencies. At the time of an emergency, the national disaster management authorities can use ASYREC to list the relief items that need to be prioritised and the required quantities of these items. Humanitarian partners can lodge pre-arrival declarations so that their shipments will be recognized as containing humanitarian relief items and prioritised for processing. These processes will enable customs officials to track the types and quantities of relief items received and expedite their processing. OCHA plans to introduce ASYREC in a few pilot countries by mid-2017 and aims to launch the platform by the end of 2017.

10.   As ASYREC will be added as a new module to the ASYCUDA platform, only countries that currently use ASYCUDA will be able to benefit from the introduction of ASYREC. While it is particularly important for those countries that are vulnerable to natural disasters and health emergencies to adopt ASYCUDA and ASYREC, the broadest use of these platforms is desirable, as every country is potentially vulnerable.

Progress on the Pandemic Supply Chain Network

11.   In March 2017, the World Food Programme announced that it will be collaborating with the NEC Corporation, a Japanese informational and communications technology company, to design a logistics information system that would provide visibility of pandemic response items, such as protective clothing and medical equipment within a country facing an outbreak. The system would be part of an information platform that enables analysis of supply chain inefficiencies. This platform was jointly advocated for by the members of the Pandemic Supply Chain Network. The Government of Japan committed USD 1 million for the development of this information system.

Building a strong health workforce

12.   The Panel recommended that Governments establish and train emergency workforces.[3] The WHO Emergency Medical Teams Initiative has contributed to these efforts by verifying national emergency medical teams. In March 2017, the Initiative met with Philippine Emergency Medical Teams. Building on the work of Emergency Medical Teams Initiative, the Global Outbreaks and Alert Response Network (GOARN) will be launching a Public Health Rapid Response Team initiative. These response teams will identify epidemiologists, clinicians, anthropologists and lab technicians who can be deployed to respond to outbreaks. A first meeting of the GOARN Rapid Response Team was held in March 2017, hosted by the Robert Koch Institute in Berlin. GOARN intends to strengthen its training to enhance quality, predictable and accountable response to outbreaks through the development of online modules, outbreak response scenario training courses, and leadership and advanced technical training.

Strengthening health systems to achieve universal health coverage

13.   As discussed in previous reports of the Task Force, the mandate of International Health Partnership ("IHP+"), a partnership of countries and development partners, was expanded in 2016 to focus on health system strengthening and achieving universal health coverage by 2030 and renamed as "UHC2030". In March 2017, a UHC2030 working group on Sustainability, Transition from Aid and Health Systems Strengthening held its first face-to-face meeting. The working group recognizes that as low- and middle-income countries transition to lower levels of external financial support, it will be necessary to assess how governance, financing and service delivery are configured to ensure the sustainability of effective coverage for priority interventions. The new working group will focus on developing guidance and principles for good practice and exploring the types of reforms and investments needed to support an effective transition process.

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[3] Recommendation 1.

Integrating communities in efforts to prevent global health crises

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Task Force observations and advice

- The Task Force members welcomed the launching of the Communication and Community Engagement Initiative and its focus on health emergencies. They encouraged the Steering Group to find ways for the Initiative to contribute to preparedness for health emergencies, including by supporting Joint External Evaluation missions and contributing to the training of Emergency Medical Teams and Public Health Rapid Response Teams.
- It would be important to strengthen the area of risk communication and community engagement in the JEE tool, and for the JEE process to allow for the enhanced participation of community members.

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14.   The Communication and Community Engagement Initiative was formally established in early 2017, with the first meeting of its Steering Group. Members of the Steering Group include representatives from the Red Cross and Red Crescent Movement, UN agencies, civil society organizations and networks, as well as specialised media and communication organizations. The Steering Group guides the implementation of the workplan, and provides overall strategic direction.

15.   The Steering Group agreed to focus on testing and validating communication and community engagement approaches in different contexts, including health emergencies. It highlighted the importance of having country leadership champion the approaches as a key ingredient of success, the need for more predictable and timely resources to support communication and community engagement at country level, and the importance of integrating such approaches in preparedness activities, including some "social and anthropological awareness", and ensuring a good use of local knowledge and resources. Members of the Steering Group stressed the important synergy with the International Health Regulations which identifies risk communication as one of the key priorities.

16.   In October 2016, UNICEF led the establishment of the Social Science in Action evidence and research platform which provides summaries of existing social, cultural and community dynamics to inform the community engagement response across a range of humanitarian situations, including health emergencies (www.socialscienceinaction.org). Through this platform, an evidence base is currently being developed to inform the medium term response plan for the cholera outbreak in the Horn of Africa, by addressing the following domains to enhance community engagement: (a) socio-cultural practices, behaviours and wider factors that increase the risk of cholera/Acute Watery Diarrhoea transmission among communities in Somaliland and Somali region, Ethiopia; and (b) beliefs and other socio-economic factors (nutrition, education, environment, etc.) that influence decision-making for seeking treatment at a health facility/cholera treatment centre/unit in Somaliland and Somali region, Ethiopia.

17.   UNICEF is providing technical support to develop a community engagement and risk communication training module as part of the orientation package for WHO Emergency Medical Teams. The module specifically addresses previously identified gaps and the need to improve culturally and context sensitive communication between first line responders and

affected communities. Funding needs to develop, incorporate and roll out training of the community engagement components remains to be discussed with key partners.

Supporting regional arrangements to prevent and respond to health crises

> **Task Force observations and advice**
>
> - The Task Force members commended WHO for using its convening role to facilitate the development of and agreement on regional commitments on immunization which have subsequently led to concrete action. Where other regional entities, such as the Association of South East Asian Nations (ASEAN) have demonstrated an interest in pursuing regional collaboration on health crises, WHO should similarly facilitate the development of regional commitments and capacities.

18.   The Panel recommended that regional and sub-regional organizations develop or strengthen standing capacities to monitor, prevent and respond to health crises, supported by WHO.[4] Recent activities in Africa and Asia are noted below.

Africa

19.   In February 2016, the World Health Organization (WHO) and the African Union Commission (AUC) jointly convened a Ministerial Conference on Immunization in Africa, bringing together Ministers of Health, Finance, Education, and Social Affairs, and local governments. In the Addis Declaration on Immunization issued at the conclusion of this Ministerial Conference, the African Ministers pledged to ensure that everyone in Africa receives the benefits of immunization. In January 2017, this pledge was endorsed by African Heads of State when they adopted the Declaration on Universal Access to Immunization in Africa. In March 2017, WHO and UNICEF supported a synchronized polio vaccination campaign aimed at immunizing more than 116 million children in 13 countries across west and central Africa.[5]

20.   In February 2017, the World Health Organization (WHO) and the African Union Commission (AUC) met to take stock of progress in implementing their partnership agreement. The establishment of the Africa Centre for Disease Prevention and Control (Africa CDC) was cited as a milestone, and planning is underway for a meeting for experts from both organizations to define concrete modalities for implementing the collaboration framework.

Asia

21.   During the Humanitarian Network and Partners Week in February 2017, the Strategic Advisory Group (SAG) for the Emergency Medical Team (EMT) Initiative provide an update on ongoing work to support national and regional capacities to respond to health emergencies. There was a presentation about the three year "Project to Strengthen the

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[4] Recommendation 5.
[5] The 13 countries were: Benin, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Democratic Republic of Congo, Guinea, Liberia, Mali, Mauritania, Niger, Nigeria and Sierra Leone.

ASEAN Regional Capacity in Disaster Health Management" (ARCH), supported by the Japan International Cooperation Agency.   The ARCH project will aim to develop regional mechanisms and enhance the capacities of individual ASEAN Member States.

22.   The WHO Regional Office for South-East Asia will be conducting a mapping of current resources in the region and supporting several countries to register their national EMTs during 2017-18. Training for an EMT Coordination Cell for Asia Pacific Region has been planned for 2017. A regional planning consultation for developing the roadmap for strengthening national EMTs is also being planned for 2017.

Strengthening UN system capacity during health emergencies

> **Task Force observations and advice**
>
> - The Task Members shared the view of the IOAC that recruitment for core positions in country offices, including WHO Representative (WR) positions in key countries with protracted crises, needs to be prioritised. They expressed concern that in the absence of full funding for the Programme, the Organization would be forced to identify trade-offs.
> - The Task Force encouraged WHO to ensure the integration of FAO and OIE in event detection and risk assessments, as it moves forward with the development of the new Epidemic Intelligence from Open Sources (EIOS) platform.

Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

23.   In January 2017, the WHO Executive Board examined the report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC).[6] The IOAC is charged with providing oversight and monitoring of development of the WHE Programme and its performance in outbreaks and emergencies.

24.   The report of the IOAC examined eight thematic areas: structure, human resources, incident management, risk assessment, business processes, partnerships, International Health Regulations (2005) (IHR) and finance. With respect to each of these areas, the primary observations and conclusions of the IOAC were as follows:

   a. Structure: The IOAC noted that the regional offices have been aligning their structures for the management of health emergencies but the roll out of the Health Emergencies Programme at the country-level is still ongoing. The implementation of roles and responsibilities, authorities, accountabilities, reporting lines and coordination require continued monitoring.
   b. Human resources: Of the estimated 1,400 positions planned for the Health Emergencies Programme, 50% are at country level, 25% are in regional offices and 25% are at headquarters (HQ). The IOAC welcomed the recruitment of health cluster coordinators and urged the Programme to prioritise the recruitment of country-level staff.

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[6] Report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (EB 140/8).

c. Incident management: The IOAC noted that the incident management system established to address Zika in Colombia and to manage yellow fever vaccination in Angola and the Democratic Republic of Congo generally worked well. However, there is room for improvement in clarifying roles, responsibilities and reporting lines at all three levels of WHO.

d. Risk assessment: The IOAC noted that WHO will soon finalize a revised Emergency Response Framework and launch a new surveillance platform, Epidemic Intelligence from Open Sources (EIOS) in June 2017. The IOAC will monitor the implementation of these two initiatives in the field.

e. Business processes: The IOAC recognized that the WHO Contingency Fund had been very effective in supporting urgent action through the ability to disburse funds for 11 humanitarian crises within 24 hours in most cases under the new procedures for the Fund.

f. Partnerships: The IOAC emphasized that the Global Health Cluster and GOARN are major partnership platforms for WHO and encouraged continued investment in developing these platforms.

g. International Health Regulations: The IOAC will be assessing the Joint External Evaluation tool in its future work programme, including whether it is able to assess community level capacity and contribute to strengthening community engagement.

h. Finance: The IOAC highlighted significant funding gaps faced by WHO – the Contingency Fund for Emergencies has received only US$ 33.7 million of the target capitalization rate of US$100 million, while the US$656 million required to address humanitarian emergencies has faced a funding gap of 66%. The IOAC expressed concern that the funding shortfall will severely constrain WHO's ability to respond to future global health emergencies.

25. The IOAC concluded by reaffirming its commitment to providing oversight and monitoring of the implementation of the WHO Health Emergencies Programme and holding WHO accountable. At the same time, it emphasized that Member States must provide the required political and financial support.

WHO-FAO-OIE collaboration

26. In early 2017, the WHO-FAO-OIE Tripartite Executive Committee meeting undertook a strategic review of the WHO-FAO-OIE collaboration. Early warning and disease information systems were specifically identified as strategic priorities in the collaboration. The Tripartite Executive Committee reaffirmed its commitment to the Joint FAO-OIE-WHO Global Early Warning System for health threats and emerging risks at the human-animal-ecosystems interface (GLEWS), as set out in a 2013 concept note.[7] In this concept note, FAO, OIE and WHO affirmed a joint responsibility to minimize the health, social and economic impact from diseases arising at the human-animal interface by preventing, detecting, controlling, eliminating or reducing disease risks to humans originating directly or indirectly from domestic or wild animals, and their environments. A GLEWS Taskforce will meet in late April 2017 to discuss how to integrate the intelligence gathering mechanisms of WHO, FAO and OIE into a single platform to provide comprehensive situational awareness in support of risk assessments for high priority disease events. These discussions will inform the development of the Epidemic Intelligence from Open Sources

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[7] http://www.glews.net/wp-content/uploads/2013/12/04_GLEWSConcept-20-11.pdf

platform currently being developed by the WHO Health Emergencies Programme, which will be launched in June 2017.

<div style="background:#d0d8e8">Testing capacities and processes for global health crises response through simulations</div>

Task Force observations and advice

- The Task Force members emphasised the critical importance of bringing together all stakeholders in country-level simulations, including as part of the IHR Monitoring Evaluation Framework. Involving the private sector, civil society organizations, United Nations and national governments in simulations will help to clarify the respective roles of different partners, to identify gaps in country-level coordination, and to develop action plans to address filling the gaps. They welcomed the simulation to be conducted at the G20 health ministers meeting.
- Additionally, simulations need to be conducted at the global, regional, and sub-regional level, both at the high leadership level in order to sensitize senior officials, and at the technical level in order to identify and address key operational issues.

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27.   The Panel recommended that countries should "carry out simulation exercises for all relevant responders, including security forces".[8]

Country-level simulations

28.   Country-level simulation exercises are one of the four components of the IHR Monitoring and Evaluation Framework. Simulation exercises serve as a tool for monitoring, testing and strengthening of functional capacities to respond to outbreaks and public health emergencies. Simulations allow participants to learn and practice emergency response procedures in a safe and controlled environment. They test and evaluate emergency policies, plans and procedures and are used to identify and address issues before an emergency. Simulations were conducted in 20 countries in 2016, and are scheduled in 16 countries for 2017.[9]

29.   In February 2017, WHO published a Simulation Exercise Manual to provide guidance on planning, conducting and evaluating simulation exercises for outbreaks and public health emergency preparedness and response.[10] The manual covers four different types of exercises:

   a. Tabletop exercise: a facilitated discussion of an emergency situation;
   b. Drill: a supervised exercise to test a specific operation or function;
   c. Functional exercise: an interactive exercise to test the capability of an organization and the multiple functions of the organization's operational plan; and
   d. Field or full-scale exercise: a simulation of a real event to test most functions of the emergency management plan or operational plan, involving multiple agencies and participants physically deployed in a field location .

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[8] Recommendation 1.1.
[9] https://extranet.who.int/spp/simulation-exercise-calendar
[10] WHO Simulation Exercise Manual.

Pandemic simulation at the World Economic Forum

30.   In January 2017, a pandemic simulation was held at the World Economic Forum meeting in Davos. The simulation, which engaged 30 CEOs from the private sector, was co-chaired by Dr. Jim Kim, the World Bank Group President and Mr. William H. Gates, the co-chair of the Bill and Melinda Gates Foundation. The simulation exercise examined the implications of an outbreak for four areas: (i) tourism and travel; (ii) information and communication; (iii) in-country operations, logistics and supply chain; and (iv) training, education and workforce management. The CEOs acknowledged that developing preparedness and response capacity requires global collaboration across different private sector partners. These simulations will feed into a simulation for the G20 health ministers in May 2017. Results from these exercises will be considered by the G20 leaders in July 2017.

Catalysing focused research and innovation relevant to global health crises

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Task Force observations and advice

- The Task Force members commended WHO for its clarity in setting out the revised methodology for prioritising emerging diseases. The Task Force members agreed that it was important for the methodology to allow for the examination of a pathogen or disease that might need to be prioritised between annual exercises.
- The Task Force welcomed the collaboration between CEPI and WHO, and the alignment of CEPI's activities with the WHO list of priority diseases.
- The Task Force members noted that the broader development and support of translatable platform technologies for diagnostics, vaccines, and therapeutics is important to have in place and ready to respond prior to future outbreaks.
- The Task Force members encouraged WHO to continue to serve in a role of convening organization and promote coordination, but not create its own research capabilities. They endorsed the role of funding agencies and organizations with extensive experience in supporting and managing research activities to continue to fulfil this responsibility.

Progress on WHO R&D Blueprint

31.   The framework for WHO's work in research and development is set out in its "R&D Blueprint for Action to Prevent Epidemics: Plan of Action" ("R&D Blueprint) issued in May 2016 and was welcomed by the World Health Assembly in the same month.[11] The R&D Blueprint focuses on three clusters of activities: (i) assessing epidemic threat and defining priority pathogens; (ii) developing R&D roadmaps to accelerate evaluation of diagnostics, therapeutics and vaccines; and (iii) outlining appropriate regulatory and ethical pathways. Ongoing progress on the R&D Blueprint in the third quarter is summarised below.

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[11] WHO R&D Blueprint for Action to Prevent Epidemics.

Assessing epidemic threat and defining priority pathogens

32.   In February 2017, WHO issued a revised methodology for prioritising severe emerging diseases for research and development.[12] This methodology was the outcome of informal consultations in November 2016 to review the methodology developed in December 2015. It is anticipated that it will be reviewed again before the end of 2019.

33.   The new methodology relies on eight factors (i) human transmission; (ii) medical countermeasures; (iii) severity or case fatality rate; (iv) the human/animal interface (v) other factors (geographic range, absence of protective immunity, risk of occupational exposure, potential to cause outbreaks); (vi) the public health context of the affected area; (vii) potential societal impacts; and (viii) evolutionary potential. The methodology also establishes two separate prioritisation processes. First, there will be an annual prioritisation exercise to review and revise a list of prioritised diseases and pathogens. Second, there will be a process to examine an unusual outbreak involving a pathogen or disease that might need to be prioritised between annual exercises. The second prioritisation process may be applied if there is a brand new pathogen, or a pathogen presenting in a modified or altered manner.

34.   In January 2017, WHO published a revised list of priority diseases that need urgent R&D in order to prevent public health emergencies. The list includes nine disease categories for which few or no medical countermeasures exist due to market failures or lack of scientific knowledge. The list provides the basis for work on the WHO R&D Blueprint and builds on the first list developed by a coalition of international experts in November 2015. The main changes to the list are that diseases previously characterised as serious and requiring action by WHO to promote R&D have now been included as priority diseases needing urgent R&D attention.   There was an agreement that Chikungunya, while not on the priority list, still warrants attention and further research and development.

January 2017	November 2015
Priority disease needing urgent R&D attention	***Priority disease needing urgent R&D attention***
1. Arenaviral hemorrhagic fevers, including Lassa Fever	1. Lassa fever
2. Crimean Congo Haemorrhagic Fever (CCHF)	2. Crimean Congo haemorrhagic fever (CCHF)
3. Filoviral diseases (including Ebola and Marburg)	3. Ebola virus disease and Marburg
4. Middle East Respiratory Syndrome Coronavirus (MERS-CoV)	4. MERS and SARS coronavirus diseases,
5. Other highly pathogenic coronaviral diseases (such as Severe Acute Respiratory Syndrome, (SARS))	5. Nipah virus
	6. Rift Valley fever virus
6. Nipah and related henipaviral diseases	***Serious disease requiring action to promote R&D as soon as possible***
7. Rift Valley Fever (RVF)	7. Severe Fever with Thrombocytopaenia Syndrome (SFTS)
8. Severe Fever with Thrombocytopenia Syndrome (SFTS)	8. Congenital abnormalities and other neurological complications associated with Zika virus
9. Zika	9. Chikungunya

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[12] Methodology for prioritising severe emerging diseases for research and development

Expansion of the PIP Framework to include other novel pathogens

35.   The Panel recommended that WHO convene its Member States to "renegotiate the Pandemic Influenza Preparedness Framework with a view to including other novel pathogens".[13]

36.   A PIP Framework Review Group was established in December 2015 to conduct the first review of the PIP Framework after it had been implemented for 5 years. The PIP Framework Review Group issued its report to the WHO Executive Board.[14] In its report, the Review Group noted that it had considered the Panel's recommendation that the PIP framework be expanded to include other novel pathogens. However, it rejected this recommendation, concluding that:

> "….[W]hile the PIP Framework could serve as an effective model, an expansion of the PIP Framework itself to include other pathogens would be very challenging. A more pragmatic approach is reflected in the 2016 report of the IHR (2005) Review Committee, which recommended that WHO and States Parties should 'consider using the PIP Framework or similar existing agreements as a template for creating new agreements or other infectious agents that have caused, or may potentially cause, [public health emergencies of international concern] PHEICs. These agreements should be based on the principle of balancing the sharing of samples and data with benefit sharing on an equal footing'.

> "Balancing the interests of different stakeholders to ensure equity in public health is complex. That the PIP Framework was the first global agreement of its kind has much to do with the uniqueness of the influenza virus itself – it mutates frequently and, because of the need for updated seasonal influenza vaccines, has a continuous product cycle, which therefore results in a consistent income stream for manufacturers, as well as a high quality production line that allows manufacturers to be ready to switch from seasonal to pandemic vaccine production. There is also a strong, established network of laboratories in GISRS, monitoring influenza, which provided the foundation for the PIP Framework.

> "However, for most new and emerging pathogens, there is no established laboratory network that regularly shares samples and expertise with an associated established vaccine (or other product) production capacity. Thus, while the sharing of viruses and benefits on an equal footing could be applied to other pathogens, using the PIP Framework as a template is likely to present significant implementational and operational challenges."[15]

37.   The PIP Framework Review Group ultimately recommended that the "PIP Framework is a foundational model of reciprocity for global public health that could be applied to other pathogens; however, the current scope of the PIP Framework should remain focused on pandemic influenza at this time." It also recommended that "Member States

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[13] Recommendation 15.
[14] Review of the Pandemic Influenza Preparedness Framework (EB140/16).
[15] Ibid., pages 36 – 37.

should agree the timing of the next review of the PIP Framework, which should be before the end of 2021".[16]

Funding for research and development of vaccines

38.   The Panel recommended that WHO oversee the "establishment and management of an international fund of at least $1 billion per annum to support the research and development of vaccines, therapeutics and rapid diagnostics for neglected communicable diseases".[17] The Task Force members commended WHO for successfully convening research organizations to promote collaboration, synergy, and sharing of information. They encouraged WHO to continue to serve in this function, but not create its own research capabilities. They endorsed the role of funding agencies and organizations with extensive experience in supporting and managing research activities to continue to fulfil this responsibility. The Task Force members noted that the broader development and support of translatable platform technologies for diagnostics, vaccines, and therapeutics is important to have in place and ready to respond prior to future outbreaks and not be restricted by a prioritised list of emerging diseases.

39.   The Coalition for Epidemic Preparedness Innovations (CEPI) was launched at Davos in January 2017. CEPI aims to advance the development of vaccines to the stage where it is ready for full trials or emergency use when needed. CEPI will initially focus on developing promising vaccine candidates against the MERS-CoV, Lassa and Nipah viruses. CEPI will also explore support for vaccines against multiple strains of the Ebola and Marburg viruses, and Zika. It will manufacture and stockpile these vaccines, provide a global hub to coordinate vaccine development and partner with organizations that can help reach target populations. CEPI seeks to raise $1 billion for its first five years and has received an initial investment of $460 million from the Governments of Germany, Japan, and Norway, the Bill & Melinda Gates Foundation and the Wellcome Trust.

40.   In February 2017, the interim board of CEPI announced the appointment of Dr. Richard Hatchett as the CEO of CEPI. Dr. Hatchett had previously served as the Deputy Director and Chief Medical Officer of the Biomedical Advanced Research & Development Authority (BARDA) at the U.S. Department of Health and Human Services (HHS).

Securing sustainable financing for work on global health crises

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Task Force observations and advice

- The Task Force members expressed their hope that the World Health Assembly will respond positively to the proposal to increase assessed contributions for WHO's budget, particularly in view of the fact that the amount of assessed contribution has remained unchanged for a decade. The Task Force members were also encouraged by the commitments of Member States to increase their own voluntary contributions even if the World Health Assembly does not adopt the proposal for increased assessed contributions.

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[16] Ibid., pages 37 – 38.
[17] Recommendation 22.

41.   The Panel recommended that WHO member States increase their assessed contributions to the WHO budget by at least 10 per cent.[18]

42.   The Draft Proposed Programme Budget for 2018-2019 (EB 140/36) submitted by the WHO Secretariat to the Executive Board in January 2017 contained an increase of US$ 99 million. The proposed increase related mainly to increases in the budgets for the WHO Health Emergencies Programme (US$ 69.1 million) and for combating antimicrobial resistance (US$ 23.3 million). Citing the recommendation of the Panel, the WHO Director-General proposed a US$ 93 million increase in assessed contributions. The amount of assessed contributions has remained at US$ 929 million since the approval of the 2008-2009 budget in May 2007.

43.   The range of reactions by Member States to the proposal is reflected in the report of the Programme, Budget and Administration Committee to the Executive Board:

> "While several Member States supported the proposed 10% increase in assessed contributions, others were not in a position to support that proposal. Some Member States called on those countries that would experience decreases in contributions to maintain payments at existing levels. One Member State supported the proposed increase and indicated its readiness to implement the increase in 2018. A Member State also agreed to the increase on a one-off basis and under the conditions that it did not set a precedent, that country-level support was maximized, and the efforts to increase efficiency continued. Another noted that the call for the 10% increase came from the United Nations High-Level Panel on the Global Response to Health Crises, and asked whether the extra revenue would be allocated solely to work on emergencies."[19]

44.   Notably in the discussions at the Executive Board, some Member States indicated that even if the proposal for the increase in assessed contributions was not approved, they would be willing to increase their voluntary contributions by the same amount.

45.   In the revised programme budget submitted to the World Health Assembly, the WHO Director-General reduced the increase in assessed contribution, asking for only a 3 per cent increased in assessed contributions. In the report of the budget, WHO explained that the reduction in the amount of assessed contributions requested has been offset by planned cost savings in the area of the budget that relates to "Corporate services/enabling functions".[20]

Focusing attention on the gender dimensions of global health crises

Task Force observations and advice

- The Task Force members recalled the Bangkok Principles which call for the promotion of the systematic integration of health into disaster risk reduction policies and plans. They

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[18] Recommendation 18.
[19] Report of the Programme, Budget and Administration Committee (EB140/5), paragraph 31.
[20] Proposed programme budget 2018-2019 (A70/7)

encouraged UN Women, IFRC and UNISDR to ensure that health dimensions are fully integrated into the new Global Programme to address the Gender Inequality of Risk and Promote Women's Resilience and Leadership. The Task Force members agreed that access to sexual and reproductive health services is important and that sexual and gender based violence pose particular risks for women and girls. They noted that women and girls may also be exposed to unequally high health risks due to other factors, such as their role as caregivers, unequal access to education, and implicit gender biases that may influence diagnoses or treatment decisions.

46.   UN Women, IFRC and UN Office for Disaster Risk Reduction (UNISDR) have jointly developed a Global Programme in Support of a Gender Responsive Sendai Framework Implementation (GIR Programme). Noting the higher fatality rates of women and girls in natural disasters such as the 2008 cyclone in Myanmar and the 2015 earthquake in Nepal, the GIR Programme emphasizes the need to focus on the high and unequal risk exposure of women and girls to the impact of climate related natural disasters and its detrimental effect on individual, household and community resilience. The Programme highlights the following gaps: (i) lack of data and gender analysis to support gender responsive disaster risk reduction policy formulation and action; (ii) lack of substantive women's participation and leadership in disaster risk reduction; (iii) insufficient investment in addressing gender inequality in disaster risk reduction and building women's resilience; and (iv) lack of political prioritisation of the gender inequality of risk.

47.   The Programme seeks to ensure that (i) the gender dimensions of disaster risk are understood and assessed; (ii) disaster risk management policy and risk governance structures are gender responsive and well-resourced; (iii) women's capacity to prepare for and recover from natural hazards is strengthened through enhancing access to services and livelihoods; and (iv) women's participation, engagement and leadership in disaster risk governance is supported and strengthened. The implementation of the GIR Programme will be driven at the country level, starting with a number of select pilot countries in Asia, Africa (Horn of Africa and Lake Chad) and Latin America and the Caribbean. It will be supported with regional and global components to complement and support country level work. The regional and global interventions will bring further gender expertise and discourse in disaster risk reduction (DRR) related intergovernmental processes, and will provide guidance and tracking tools, while facilitating intra-regional and cross regional knowledge exchange.

48.   In March 2017, regional consultations in Africa and Asia/Pacific were held to identify priority countries under the pilot and define a locally led plan of action for support. The GIR Programme, including its regional components, will be launched at the special session on "Women's Leadership in DRR" at Global Platform for Disaster Risk Reduction at Cancun in May 2017. It is anticipated that as it develops, the GIR Programme will consider the health dimensions of disaster risks, such as women's sexual and reproductive health and rights and sexual and gender based violence.

Ensuring resilience and health crises are a priority on global political agendas

Task Force observations and advice

- The Task Force members welcomed the very first G20 health ministers meeting and observed that it would give a strong political message for the G20 to affirm their commitment to a coordinated global response to health crises, to financing preparedness for health emergencies at the national, regional and global levels, as well as their support for the new IHR monitoring and evaluation framework.

49.   In March 2017, health experts from G20 countries met in Germany to prepare the joint declaration of the G20 health ministers when they meet in Berlin from 19-20 May 2017. During the health experts meeting, the Health Working Group discussed G20 positions on antimicrobial resistance, strengthening health care systems, and global health crises management.