

GLOBAL HEALTH CRISES TASK FORCE

First Quarterly Report (July – September 2016)

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”.

The Task Force will highlight recommendations that are not being implemented fully, identify bottlenecks to implementation and propose ways in which progress on recommendations can be supported. The Task Force may support “tabletop” simulations or other mechanisms to assess the preparedness of the UN system to address health emergencies. 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 first quarter (July 2016 to September 2016), 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. Joint external evaluation tool of IHR compliance represents a “paradigm shift”, as it treats the attainment of core capacities as an ongoing process of maintaining and strengthening capacities, rather than a one-time exercise. Another benefit of the assessments is that they have catalysed in-country coordination, thereby contributing to a One Health, whole-of-government and whole-of-society approach.
- b. The Joint External Evaluation tool needs to be advanced robustly. The tool can be enhanced by including an assessment of the strength of community early warning and response, and ensuring greater participation by civil society organizations in the evaluation process. It will be important to monitor whether the gaps identified in these evaluations are reflected in national action plans, lead to concerted action and inform decisions by countries and donors on resource allocation. The Secretary-General should convey these recommendations to the WHO Executive Board.
- c. The expansion of efforts to promote universal health coverage will contribute to the strengthening of IHR core capacities and enhance emergency preparedness. WHO should integrate IHR core capacities into the planning, financing and monitoring of universal health coverage. The Secretary-General should use all possible opportunities to emphasize the need for Governments to deliver on universal health coverage within the context of the 2030 Agenda for Sustainable Development.
- d. The Task Force commended the Security Council for focusing on attacks against health workers and facilities, as well as the wounded and the sick, in armed conflict. The ability of the Security Council to collectively enforce its resolution on this issue will be critical for the protection of health workers and facilities. The Secretary-General should continue to encourage the Security

Council to prioritise the well-being of health workers in armed conflict. Data on attacks against health workers during armed conflict and in other contexts needs to be systematically collected by countries and by the UN system.

- e. The training of Emergency Medical Teams has contributed to the strengthening of national capacity to respond to health emergencies. Governments need to make pandemic-sensitive investments in its health workforce, so that health workers will be well-positioned to respond to outbreaks when needed.
- 2. Integrating communities in efforts to prevent global health crises:**
 - a. Community engagement deserves greater emphasis before and during outbreaks to ensure that preparedness and response activities are culturally sensitive, better understood and meet the needs of the people concerned.
 - b. Communities can be involved in surveillance, early action tools, prevention, promotion of health seeking behaviour as well as contact tracing, the identification of bottlenecks in response efforts, and the design and development of risk communication messages and approaches.
 - c. Research into effective community and risk communications needs to be supported.
 - 3. Supporting regional arrangements to prevent and respond to health crises:**
 - a. The Task Force members noted the need to map capabilities at the regional level for laboratory diagnostics and the sharing of data and samples.
 - b. The Task Force members encouraged WHO and its regional offices to continue to support regional arrangements and build research, diagnostic and response capacity.
 - 4. Strengthening UN system capacity during health emergencies:**
 - a. The Task Force members welcomed the progress made in establishing the new WHO Health Emergencies Programme and its corresponding oversight mechanism, the Independent Oversight and Advisory Committee.
 - b. The Task Force looked forward to updates from the Independent Oversight and Advisory Committee and the IASC-WHO standard operating procedures for infectious hazard management.
 - 5. Testing capacities and processes for global health crises response through simulations:**
 - a. Simulations need to be conducted at all levels of governance and inter-sectorally. Pandemic simulations should bring in issues across multiple sectors in addition to health, target audiences beyond health ministries, and look at both global-level and country-level systems. Newly developed tools and processes, including the WHO-IASC standard operating procedures, need to be tested in the simulation exercises being planned.
 - b. The Secretary-General should be informed of the outcomes and analyses developed as a result of these simulations.
 - 6. Catalysing focused research and innovation relevant to global health crises:**
 - a. The Task Force also stressed the need to build translatable platform technologies that incentivize the development of multi-pathogen diagnostics, vaccines, therapeutics and preventive measures.

- b. Data sharing and transparency of data is another area for improvement both in preparation for and response to outbreaks. This includes both epidemiological data as well as data specific to starting and conducting clinical trials in outbreak settings when time to determine clinical effectiveness is short.
- c. The Task Force members acknowledged WHO's strengths as a convener and encouraged WHO to convene a group of research organizations to promote collaboration, synergy and sharing of information, rather than to recreate its own research capabilities.

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

- a. The Task Force members expressed concern about lack of predictable and sustainable financing in a number of areas – implementing IHR core capacity requirements, initiatives to promote community engagement, health system strengthening and research and development.
- b. The Task Force members expressed concern about the significant funding gaps faced by WHO, including the recently established Health Emergencies Programme and the WHO Contingency Fund for Emergencies.
- c. Sustainable financing needs to come from a combination of both domestic resources from countries and donor funding, and be sufficiently flexible.
- d. New financing mechanisms should ensure that financing can flow to areas beyond government reach, as these are often the areas at highest risk of emergence and rapid spread of infectious diseases.

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

- a. Greater attention must be paid to the disproportionate burden on women during health crises in the health sector (as informal and formal caregivers) and with regard to economic and social impacts on women and girls.
- b. There is a need to prioritise major gaps around gender, and focus on developing normative standards, resourcing, and getting sufficient attention to gender during health crises. It is also important to engage women during the planning, implementation, as well as evaluation of response to health crises. Efforts to promote women and girls' right to health, to access to timely and accurate information, and to health care services, including sexual and reproductive health services, must be enhanced.
- c. A gender analysis is critical to understanding the different roles of women and men in caregiving and animal husbandry, and how such roles can result in a disproportionate exposure to health risks.

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

- a. The Task Force members stressed the importance of engaging with political processes to maintain health security as a priority on global political agendas. High-level political engagement on health issues is needed to ensure sustainable financing and advance recognition of health security as a global public good.
- b. Health should be integrated centrally into political processes, such as the G20, G7 and the relevant UN organs, as well as high-level regional conferences such as the Tokyo International Conference on African Development (TICAD). Another avenue for maintaining political focus on health crises is to mainstream this issue across the 2030 Agenda for Sustainable Development.

Introduction

1. *Remit of the Task Force:* 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).

2. *Ways of working of the Task Force:* The Task Force will highlight recommendations that are not being implemented fully, identify bottlenecks to implementation and propose ways in which progress on recommendations can be supported. The Task Force may support “tabletop” simulations or other mechanisms to assess the preparedness of the UN system to address health emergencies. 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.

3. *Priority areas for Task Force:* The Task Force will meet on a quarterly basis and provide quarterly reports to the Secretary-General on the progress of the Panel’s recommendations. This is the first of the four reports for the United Nations Secretary-General that will be produced by the Task Force during its one year term from July 2016 to June 2017. The Task Force held its first meeting on 23 August 2016, by teleconference. During this 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

4. *Structure of present report:* The present report covers key developments in these nine priority areas in the first quarterly period from July to September 2016. As it is the first report of the Task Force, it also notes relevant developments prior to July 2016. The positions developed by the Task Force, which form the basis of its advice to the Secretary-General, are indicated in the report within the sections on each of the nine priority areas. The positions will evolve over time and this evolution may lead to changes in the advice the Task Force offers to the Secretary-General.

Strategic support for national health systems to prevent global health crises

5. The Panel’s recommendations for the strengthening of national capacities related to two general areas – promoting compliance with the core capacity requirements of the International Health Regulations (2005) (“IHR”) and building health workforces.¹

Promoting compliance with the International Health Regulations core capacity requirements

Task Force observations and advice

- The Task Force members considered that health systems strengthening needs to be approached strategically, so that the urgent objectives of promoting health security are pursued in an integrated manner with the longer-term objectives of building strong health systems. The International Health Regulations are critical to strengthening health systems strategically – establishing IHR core capacities is central to building public health capacities and institutions.
- The International Health Regulations are the global legal instrument for ensuring that each State has a basic capacity for preparing for and responding to infectious disease threats. The well-documented challenge has been that States themselves monitor their compliance with the IHR and only a minority do this in a timely or robust way.
- Joint external evaluation tool to assess IHR compliance, developed by WHO in collaboration with the Global Health Security Agenda, was finalized in February 2016. Six evaluations using the JEE tool were completed and posted online by September 2016; more have since been completed and more widespread use will be implemented as soon as possible. The new IHR evaluation process has been characterized as a “paradigm shift”, treating the attainment of core capacities as an ongoing process of maintaining and strengthening capacities, rather than a one-time exercise. In the evaluation exercises conducted thus far, the assessments have been seen to catalyse in-country coordination and promote a One Health, whole-of-government and whole-of-society approach.
- The Task Force members highlighted the importance of a multi-sectoral approach in the evaluation and implementation of IHR core capacities, as well as community engagement, in assessing and building IHR core capabilities. Given the critical nature of effective community engagement before, during and after infectious disease outbreaks, the tools to assess the strength of community early warning and response need to be further enhanced as part of the ongoing development of the JEE process. All countries should be encouraged to ensure greater participation by civil society organizations in the evaluation process.
- It will be important to monitor whether the gaps identified in these evaluations are reflected in national action plans, lead to concerted action and inform decisions by countries and donors on resource allocation to support the implementation of priority actions identified in the national plans.

¹ Two additional areas (strengthening community engagement and addressing the gender dimensions of outbreak and response efforts) are discussed separately below.

- The Secretary-General should indicate to the WHO Executive Board that the Joint External Evaluation tool needs to be advanced robustly and enhanced.
- Lack of predictable and sustainable funding is a major constraint in implementing IHR core capacity requirements. Adequate technical and financial support must be urgently provided by the international community in line with the principles of alignment and harmonization emphasized in the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. If funding is limited, attention should be paid to prioritizing those components of IHR compliance that are more important for outbreak and epidemic preparedness than others.

6. The Panel recommended that States parties to IHR, with appropriate international cooperation, should achieve full compliance with the IHR core capacity requirements. In this connection, the Panel also recommended that WHO strengthen its periodic review of compliance with the IHR core capacity requirements.²

7. In May 2015, the World Health Assembly requested the establishment of a Review Committee to examine the role of the IHR in the Ebola outbreak. This Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response issued its report in May 2016.³ In its report, the Review Committee called for the full implementation of the IHR as an urgent goal, noting that only 65 countries reported having minimum core capacities as of November 2015.⁴ It presented 12 recommendations aimed at ensuring the implementation of the IHR and improving delivery of the IHR. Notably, the Review Committee welcomed the new WHO assessment framework, which consists of four components: a self-administered assessment tool, after-action review, simulation exercises, and an independent, external evaluation. The Review Committee characterised this new framework as a “paradigm shift”, as it treats the attainment of core capacities as an ongoing process of maintaining and strengthening capacities, rather than a one-time exercise.

8. The World Health Assembly requested the Director-General to develop a draft global implementation plan for the recommendations of the Review Committee.⁵ This proposal was considered by the Regional Committees in September 2016 and October 2016, and Member States inputs will be taken into account prior to submission to the WHO Executive Board in January 2017. Discussions at the global and regional levels have emphasized the importance of providing a succinct strategy on how resilient health systems and the global plan of IHR implementation can come together in a coherent manner through strengthening public health capacity and institutions.

9. The external evaluation component of the new WHO assessment framework is based on the Joint External Evaluation Tool, which was developed by WHO, in collaboration with the Global Health Security Agenda and Member States, and

² Recommendations 1 and 6.

³ Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response (A69/21).

⁴ The current implementation status of IHR core capacities can be found at the following link: http://gamapserver.who.int/gho/interactive_charts/ihr/monitoring/atlas4.html?indicator=i4

⁵ World Health Assembly decision WHA69(14).

finalized in February 2016. The Joint External Evaluation Tool examines 19 technical areas, including the IHR core capacities, and contains recommendations for priority actions. The priority actions identified are to be used to develop a comprehensive national plan of action for IHR national core capacity strengthening. Development of these plans will assure integration with wider health system strengthening and alignment with sector-wide national health development plans. National health development plans are part and parcel of overall national sustainable development plans and closely interrelated with the whole set of sustainable development goals. These budgeted plans allow countries to identify gaps requiring donor support. The recently developed Strategic Partnership Portal⁶ centralizes this information and provides a match-making platform for countries and donors.

10. As of September 2016, assessments using the Joint External Evaluation Tool have been completed in six countries (Tanzania, Ethiopia, Mozambique, Pakistan, Bangladesh, and the United States) and the reports have been made available online.⁷ The external evaluations are conducted by teams deployed by WHO in collaboration with Global Health Security Agenda partners and international organizations. The teams include experts and advisers from government departments, ministries and agencies responsible for health, defense, agriculture, disease control, nuclear and radiological regulation, and welfare; international organizations (WHO, FAO, World Bank and OIE (World Organisation for Animal Health)); and civil society organizations. The host country participants have involved representatives from a broad range of government departments, ministries and agencies dealing with health, social welfare, disease control, livestock and fisheries, agriculture, foreign affairs, internal affairs, environment, defense, energy, justice, security, labour, transportation, airport, commerce, and pharmaceuticals. The involvement of the civil society participants from the host country side has been generally limited to research institutions and universities.

11. The JEE reports note that the evaluation exercises have provided an opportunity to bring together different parts of a government, when there is traditionally a tendency to work in silos that have not been interconnected before. One report concluded that the “assessments have served as a strong catalyst for in-country coordination and networking, promoting the adoption and implementation of the One Health and whole-of-government, perhaps even a whole-of-society approach”.⁸ The JEE reports frequently note that cooperation between different levels of government could be improved.

12. During their summit in May 2016, the G7 leaders confirmed their intention to assist partners to achieve the targets of the Joint External Evaluation Tool.⁹ At the subsequent G7 Health Ministers’ Meeting in September 2016, the G7 committed to reporting on progress toward assisting 76 countries and regions to build IHR core capacities by the end of the year.¹⁰

⁶ <https://extranet.who.int/donorportal/>

⁷ <https://ghsagenda.org/assessments>

⁸ Joint External Evaluation of United States of America (Mission Report, June 2016). <https://ghsagenda.org/docs/2016-united-states-ghsa-assessment.pdf>

⁹ G7 Ise-Shima Summit Vision for Global Health.

¹⁰ Kobe Communiqué of the G7 Health Ministers.

Strengthening health systems to achieve universal health coverage

Task Force observations and advice

- The Task Force members noted that the expansion of efforts to promote universal health coverage will contribute to the strengthening of IHR core capacities and enhance emergency preparedness. When people have access to health services and governments perform essential public health functions, infectious disease cases can be identified, treated, reported and monitored more rapidly so that outbreaks are stopped from being large-scale pandemics.
- The adequate implementation of IHR will contribute to stronger health systems and to the universal health coverage. There are close links between the universal health coverage, and the overall process of achieving the sustainable development goals; both are mutually supportive. The Task Force encouraged WHO to integrate IHR core capacities into the planning, financing and monitoring of universal health coverage.
- The Secretary-General should use all possible opportunities to emphasize the need for Government to deliver on universal health coverage within the context of the 2030 Agenda for Sustainable Development.

13. The Panel considered that there is a “close relationship between compliance with the IHR core capacity requirements and the wider improvement of health systems.” Strengthening health systems and delivering essential public health functions will contribute to country preparedness and to the achievement of universal health coverage. Universal health coverage has the objective of ensuring that all people can use the full range of health services they need without suffering financial hardship when paying for them.

14. In 2007, the International Health Partnership (“IHP+”) was established to promote more effective development cooperation in health. Partners in IHP+ sign a Global Compact to share a common view to support comprehensive, country-led national health strategies and to affirm their commitment to the principles of the 2005 Paris Declaration on Aid Effectiveness and the 2011 Busan Partnership Agreement. At present, 37 countries and 29 development partners have joined IHP+. In 2016, consultations were initiated to expand the scope of IHP+ to focus on health system strengthening towards achieving universal health coverage by 2030. The expansion would also enable IHP+ to become a multi-stakeholder platform to support equitable and sustainable progress towards universal health coverage and global health security. The transformation process was launched in June 2016 and the roll-out of the new International Health Partnership for UHC2030 was announced by the WHO Director-General in September 2016. There are continuing consultations to develop a mechanism for the engagement of civil society organizations in the Partnership. In December 2016, the Steering Committee of the Partnership will meet to approve an updated Global Compact, adjustments in governance structures and working arrangements, and a new work plan for 2017.

15. In August 2016, the World Bank and WHO, together with the government of Japan, Japan International Cooperation Agency, the Global Fund, and the African Development Bank launched a framework for promoting universal health coverage in Africa.¹¹ The Framework notes that 11 million Africans fall into poverty every year because of high out-of-pocket health payments. The Framework identifies areas that will be critical to achieving better health outcomes, such as financing, service delivery, targeting vulnerable populations, mobilizing critical sectors and political leadership. It recognizes the importance of quality people-centred services, engaging in multi-sectoral action to address the determinants of health, as well as the inclusion of essential public health functions such as emergency preparedness within health planning.

Building a strong health workforce

Task Force observations and advice

- One component of health systems strengthening is training, retaining and protecting health professionals. The Task Force members stressed the need to avoid the infection of health professionals during outbreaks, by prioritizing frontline health workers for early vaccination in the event of vaccine-preventable disease outbreaks and making investments in personal protective equipment (PPE), PPE training and infection control networks. Creating a safe environment for health care delivery and protection from infectious disease exposure requires investments in broader infection prevention and control (IPC) infrastructure, including administrative, environmental and engineering controls, equipment and training at all levels of care and during transport. There is also a need to put in place appropriate occupational health policies and procedures for the treatment and care of health care providers and other workers (cleaning staff, burial teams, contact tracers, etc.) who become exposed or infected.
- Now that the report of the High-level Commission on Health Employment and Economic Growth has been issued, it will be important for the implementation plan prepared by WHO, ILO and OECD to include the capabilities needed to sustain community resilience and national, regional and global health security.
- In humanitarian crises, the shrinking of humanitarian space has meant that the safety of health workers is jeopardized and the most vulnerable are even harder to reach. The Task Force commended the Security Council's continuing focus on attacks against health workers and facilities, as well as the wounded and the sick, in armed conflict. The ability of the Security Council to collectively enforce its resolution on this issue will be critical for the protection of health workers and facilities. The Secretary-General should continue to encourage the Security Council to prioritise the safety and well-being of health workers in armed conflict.
- Other threats to the safety of health workers in contexts outside of armed conflict also remain a concern and need to be addressed by WHO and by national authorities. These threats include exposure to infectious diseases and the greater risk of physical and sexual violence and harassment faced by women in the health work force. Data on attacks against health workers in armed conflict and in other contexts needs to be systematically collected by countries and by the UN system.

¹¹ UHC in Africa: A Framework for Action.

<http://documents.worldbank.org/curated/en/735071472096342073/pdf/108008-WP-PUBLIC.pdf>

- The Task Force members stressed the importance of paying attention to human resources for health emergencies. The training of Emergency Medical Teams has contributed to the strengthening of national capacity to respond to health emergencies. Governments need to make pandemic-sensitive investments in its health workforce, so that health workers will be well-positioned to respond to outbreaks when needed.

16. The Panel recommended that Governments increase investment in the training of health professionals and establish community health worker systems that are appropriate to country circumstances including health emergencies.¹²

17. In December 2015, the General Assembly called upon the Secretary-General to consider establishing a commission on health employment and economic growth.¹³ The High-level Commission on Health Employment and Economic Growth was appointed in March 2016, with President François Hollande of France and President Jacob Zuma of South Africa serving as co-chairs and the heads of WHO, the International Labour Organization and the Organization for Economic Co-operation and Development serving as vice co-chairs.

18. The Commission delivered its report entitled “Working for Health and Growth: Investing in the health workforce” to the Secretary-General in September 2016.¹⁴ The Commission proposes actions to realize the broader socio-economic value with the projected creation of 40 million new health sector jobs, and whilst addressing the projected shortfall of 18 million health workers, projected by 2030. The Commission considers that the solutions proposed are not only essential to achieving universal health coverage and global health security, but also provide a unique opportunity to amplify gains across the 2030 Agenda for Sustainable Development. The Commission makes recommendations in ten areas relating to job creation; gender and women’s rights; education, training and skills; health service delivery and organization; technology; crises and humanitarian settings; financing and fiscal space; partnership and cooperation; labour mobility; and data, information and accountability. The Commission also proposed five immediate actions to be taken within the next 18 months to secure commitments for implementation; galvanize accountability and advocacy for action; advance health labour market data and analysis; accelerate investment in transformative education, skills and job creation; and establish an international platform on health worker mobility. An implementation plan for the Commission’s recommendations will be adopted during a two-day high-level summit in December 2016.

19. In August 2016, the Sixth Tokyo International Conference on Development (TICADVI) was held in Nairobi, Kenya. TICADVI highlighted health as one of the three priority areas and had active discussions on how to promote resilient health systems in Africa. The Nairobi Declaration and its Implementation Plan issued at the

¹² Recommendation 3.

¹³ General Assembly resolution 70/183 on “Global health and foreign policy”.

¹⁴ <http://www.who.int/hrh/com-heeg/reports/en/>

conclusion of TICADVI highlighted the importance of health workforce development and the need to increase global funding for health system strengthening.¹⁵

20. Building and maintaining a strong health workforce requires protecting the physical safety of health workers. The International Committee of the Red Cross has reported 2,400 attacks against patients and medical personnel, facilities and transports in 11 conflict-affected countries from 2012 - 2014. Médecins Sans Frontières has reported 75 attacks on its medical facilities in 2015. In May 2016, the Security Council unanimously adopted its first resolution ever to address the protection of medical personnel and humanitarian personnel exclusively engaged in medical duties during situations of armed conflict.¹⁶ In this resolution, the Security Council condemned attacks against the wounded and sick, medical personnel, humanitarian personnel engaged in medical duties, and medical facilities, transport and equipment. The Security Council emphasized the responsibility of States to comply with their international legal obligations and to end impunity. In August 2016, the Secretary-General provided the Security Council with recommendations to prevent attacks and better ensure accountability and enhance the protection of the medical personnel and facilities.¹⁷ The recommendations in the Secretary-General's letter were examined by the Security Council in a briefing session on 28 September 2016.

21. The Panel recommended that Governments establish and train emergency workforces.¹⁸ The WHO Emergency Medical Teams initiative has contributed to these efforts through its work to ensure coordination, quality and accountability of deployable national and international Emergency Medical Teams. In July 2015, WHO launched a system for the classification of Emergency Medical Teams through a process of quality assurance and peer review. As of July 2016, four teams (one in China, one in Japan and two in Russia) completed the classification process and the classification of 28 teams from 14 countries is in progress. There are a total of 79 teams from 36 countries that are being mentored by WHO. The WHO Emergency Medical Teams initiative has also established a training working group to develop a standardized curriculum, and training tools and materials for EMT training.

22. One specific recommendation of the Panel was that community health workers should be recognized and integrated as a labour category.¹⁹ Community health workers are currently defined in the International Standard of Classification of Occupations (ISCO-08)²⁰. WHO encourages the use of the term “community-based health workers” to reflect the breadth and variation in the types of health workers across countries. WHO is developing guidelines on the design, implementation, performance and evaluation of community-based health worker programmes. The public consultations on the scope of the guidelines concluded in August 2016 and reviews of evidence to inform the development of the guidelines will be conducted

¹⁵ Nairobi Declaration : http://www.mofa.go.jp/af/af1/page3e_000543.html

Nairobi Implementation Plan : http://www.mofa.go.jp/af/af1/page3e_000549.html

¹⁶ Security Council resolution 2286 (2016).

¹⁷ Letter dated 18 August 2016 from the Secretary-General addressed to the President of the Security Council (S/2016/722).

¹⁸ Recommendation 1.

¹⁹ Recommendation 3.

²⁰ http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_172572.pdf

until early 2017. The guidelines will be launched by the end of 2017. The evidence from the guidelines process will also inform a future ILO review of the International Standard Classification of Occupations (ISCO), particularly with respect to the definition of community-based health workers.

Integrating communities in efforts to prevent global health crises

Task Force observations and advice

- The Task Force members stressed that community engagement deserves greater emphasis before and during outbreaks to ensure that preparedness and response activities are culturally sensitive, better understood and meet the needs of the people concerned. Community empowerment is a holistic issue and synergy must be found between health emergencies and other development issues at the community level. Protecting individuals from health threats through community involvement is at the very core of resilience and human security.
- It is essential to have meaningful engagement with communities in the design and implementation, as well as the evaluation of health programmes. Communities can be involved in surveillance, early action tools, prevention, promotion of health seeking behaviour as well as contact tracing, the identification of bottlenecks in response efforts, and the design and development of risk communication messages and approaches. Initiatives to promote community engagement will need investment.
- All communications about disease threats and outbreaks need to be people-centred with an emphasis and focus on resilience in the face of threats through pro-active efforts in outbreak preparedness, and strengthening of communication and community engagement response mechanisms.
- The Task Force members expressed concern that research into effective community and risk communications is often lacking and missing in research agendas. New research is now being done to better understand the impact of community engagement and risk communications during the Ebola outbreak. The findings of this research will help improve work around engagement and behaviour change in future epidemics.

23. The Panel recommended that Governments and responders strengthen and streamline their community engagement by developing protocols for effectively engaging communities in developing responses to health emergencies and other community empowerment approaches with due consideration to the cultural contexts and by supporting the development and use of networks of social scientists.²¹

24. The Nairobi Implementation Plan of the TICADVI in August 2016 also highlighted the importance of the “engagement and capacity building of civil society and community-based organizations to strengthen community health systems”.

25. In April 2016, UNICEF and IFRC convened a workshop to discuss how the humanitarian system can engage and communicate with affected communities during a humanitarian response. Representatives from 57 civil society organisations, UN

²¹ Recommendation 3.

agencies, donors, academia and the media participated in the workshop. Participants in the workshop reaffirmed the importance of ensuring systematic participation of affected communities in shaping aid priorities and programme design. Participants agreed that a global support entity is needed to promote community engagement by strengthening local capacities, collecting and sharing good practices, developing standards, and building a roster of communication and community engagement specialists. For this purpose, a Communications and Community Engagement Platform will be established to engage all necessary stakeholders, supported by a secretariat based in UNICEF and in close coordination with other UN agencies and civil society organizations.

Supporting regional arrangements to prevent and respond to health crises

Task Force observations and advice

- The Task Force members agreed on the importance of regional arrangements, technically, bioethically, and politically. They noted the need to map capabilities at the regional level for laboratory diagnostics and the sharing of data and samples.
- The Task Force members encouraged WHO and its regional offices to continue to cooperate with and support regional arrangements and build research, diagnostic and response capacity. In addition, regional and South –South cooperation was stressed as key to enhancing prompt and effective responses and prevention. In this context, the Task Force members suggested that WHO should seek to engage with the United Nations Office for South-South Cooperation.

26. 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. Regional capacities can serve to augment or support weak country capacities. The Panel stressed the importance of maintaining a roster of medical experts and response staff for rapid regional deployment and facilitating simulation exercises.

27. In the past year, WHO has planned coordination trainings in five different regions to train regional experts to coordinate arriving Emergency Medical Teams and Public Health teams. Trainings were conducted in Australia for the Pacific region in October 2015, in Italy for Europe in July 2016, and in Costa Rica for the Americas region in August 2016. Trainings for the remainder of 2016 are planned for the Middle East, Southeast Asia and Africa.

28. The WHO Emergency Medical Teams initiative is also establishing partnerships with regional arrangements. It has a strong relationship with the European Medical Corps, which was launched in February 2016 and consolidates health emergency assets that can be mobilised for deployment at short notice. WHO and the European Union have established a process for joint verification and quality assurance to certify teams for registration with the European Medical Corps.

29. In November 2015, East Asian Summit issued a statement on enhancing regional health security.²² In this statement, government leaders committed to strengthening the capacities of national and regional human resources in the field of prevention, surveillance, laboratory capacity, epidemic investigation, and control of infectious disease outbreaks. The WHO Emergency Medical Teams initiative has been working with ASEAN and the ASEAN Coordinating Centre for Humanitarian Assistance to develop training standards and a training curriculum, as well as to integrate EMT coordination mechanisms into existing ASEAN standard operating procedures.

30. In June 2016, the World Bank Group approved US\$110 million in International Development Association financing to strengthen disease surveillance systems in Guinea, Sierra Leone and Senegal. This initiative is part of the Regional Disease Surveillance Systems Enhancement Program (REDISSE), which aims to address systemic weaknesses within the human and animal health sectors that hinder effective disease surveillance and response. The REDISSE program also received financial support from the Bill & Melinda Gates Foundation and technical support from the World Health Organization and the U.S. Centers for Disease Control and Prevention. The REDISSE Program will eventually engage and support all 15 countries in the ECOWAS region.

31. At the TICADVI in August 2016, participants agreed to enhance regional capacity for pandemics prevention, preparedness and response by accelerating the establishment of African Centres for Disease Control (CDCs). These will serve as continental and regional centers of excellence for research and control of infectious diseases. There was also an agreement to strengthen the network of regional institutions, including laboratories in Africa.

Strengthening UN system capacity during health emergencies

Task Force observations and advice

- The Task Force members commended the progress made in establishing the new WHO Health Emergencies Programme and its corresponding oversight mechanism, the Independent Oversight and Advisory Committee. The assessments of the Committee following its visits to the countries where the Programme is being rolled out, and stakeholder interviews will be essential to evaluating how the implementation of the reform programme is progressing, and how the new mechanisms and processes are impacting delivery with partners on the ground.
- The Task Force members expressed concerns about the potential impact of the recently established Health Emergencies Programme without adequate financing and look forward to reports from WHO as to the adequacy of resources available

²² East Asia Summit Statement on Enhancing Regional Health Security relating to Infectious Diseases with Epidemic and Pandemic Potential. The East Asia Summit is comprised of the 10 ASEAN nations (Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam) as well as Australia, China, India, Japan, New Zealand, Russia, South Korea, and the United States

for the Health Emergencies Programme and the WHO Contingency Fund for Emergencies (see section below on financing for details).

- The Task Force looked forward to the finalization of the IASC-WHO standard operating procedures for infectious disease events, which will be shared with the Member States of the General Assembly in due course.

32. The Panel noted the creation of the new WHO Health Emergencies Programme and emphasized the need for the operational capacities of WHO to be unified under a single reporting, command and control structure. It called for the establishment of a standing advisory board to guide the Programme and for the development of a protocol to activate an immediate response to outbreaks.

WHO Health Emergencies Programme

33. During the World Health Assembly in May 2016, the Director-General presented a report on the reform of WHO's work in health emergency management.²³ The report noted that the new Programme complemented WHO's traditional technical and normative role with new operational capabilities for its work in outbreaks and humanitarian emergencies. The Programme is headed by an Executive Director, Dr. Peter Salama, who commenced his functions in July 2016. The ultimate authority for the management of emergencies will rest with the Director-General. This authority will be delegated by the Director-General to:

- The Executive Director, in the case of major outbreaks and health emergencies, including Grade 3 events²⁴, Public Health Emergencies of International Concern and Level 3 emergencies under the United Nations Inter-Agency Standing Committee.
- Either the Executive Director or the relevant Regional Director, in the case of Grade 2 events, depending on the nature of the infectious hazard or health emergency event, the capacity and capabilities of the countries concerned.
- The relevant Regional Director, in the case of Grade 1 events.

34. To ensure a rapid response to outbreaks, the Programme will initiate an on-the-ground assessment within 72 hours of notification of a high threat pathogen, clusters of unexplained deaths in high vulnerability/low-capacity settings, and other events of concern at the discretion of the Director-General. The outcomes will be communicated to the Director-General through the Executive Director within 24 hours of completion of the assessment, together with recommendations of the Health Emergencies Programme on risk mitigation, management and/or response measures as appropriate.

²³ Report by the Director-General, Reform of WHO's work in health emergency management (A69/30).

²⁴ According to the 2013 Emergency Response Framework, the grading of events is set out as follows: Grade 1 event is a single or multiple country event with minimal public health consequences that requires a minimal WHO Country Office response or a minimal international WHO response. A Grade 2 event is a single or multiple country event with moderate public health consequences that requires a moderate WHO Country Office response and/ or moderate international WHO response. A Grade 3 event is a single or multiple country event with substantial public health consequences that requires a substantial WHO Country Office response and/ or substantial international WHO response.

35. In March 2016, the WHO Director-General established the Independent Oversight and Advisory Committee. The main functions of this Committee are to assess the performance of the Programme's key functions in health emergencies, determine the appropriateness and adequacy of the Programme's financing and resourcing, and provide advice to the Director-General, as well as to review and prepare various reports.²⁵ The Committee has held three meetings to date. The Committee is planning on conducting country visits and interviews to assess the implementation of the reforms, and resulting performance of the Programme with respect to the management of yellow fever in the Democratic Republic of Congo and the Zika virus disease in Colombia.

36. In May 2016, the World Health Assembly welcomed the progress made in the development of the new Programme.²⁶ As discussed below, the World Health Assembly approved an increase in WHO's programme budget but only authorized the Director-General to meet this additional financial need by mobilizing voluntary contributions.

UNICEF Health Emergencies Preparedness Initiative

37. In addition to the new WHO Health Emergencies Programme, other UN agencies have also strengthened their capacity to respond to health emergencies. In September 2015, UNICEF launched the Health Emergencies Preparedness Initiative in order to enhance the organization's capacity to respond to global health crises across phases from preparation to response, linking to recovery and building resilience, and serve as an effective partner to national governments, WHO and others. The Initiative will focus on four areas of work: (i) internal organization and prioritization; (ii) disease-specific preparation; (iii) institutional strengthening; and (iv) cooperation with partners. In consultation with partners, UNICEF is identifying disease categories of priority concern for which it will develop support packages consisting of guidance, resources and tools necessary for a well-coordinated and rapid multi-sectoral response in the event of an outbreak. In addition, the Communications and Community Engagement Platform will be supported by a secretariat based in UNICEF.

WHO-IASC standard operating procedures for managing infectious hazards

38. The Panel further recommended that the Programme collaborate with the Inter-Agency Standing Committee (IASC) to develop standard operating procedures for humanitarian actors operating in health crises.²⁷ In June 2016, the IASC Principals agreed to develop standard operating procedures to guide the use of existing humanitarian response tools and mechanism in large-scale infectious disease events. Review of the draft standard operating procedures is currently ongoing within the IASC Emergency Directors Group. They will be presented to the IASC Principals for final endorsement before the end of 2016. The final version of the document will be shared with the Member States of the General Assembly in due course.

²⁵ http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/en/

²⁶ Decision WHA 69(9) on the "Reform of WHO's work in health emergency management: WHO Health Emergencies Programme".

²⁷ Recommendation 7.

Expanding the virtual On-Site Operations Coordination Centre for use in health crises

39. The Office for the Coordination of Humanitarian Affairs and the International Search and Rescue Advisory Group have developed the On-Site Operations Coordination Centre (OSOCC) tool to assist affected countries in coordinating international relief resources during sudden-onset disasters. Following a disaster, an OSOCC is established to link international responders with the Government of the affected country, to provide a coordination system and to provide a platform for cooperation, coordination and information management.

40. One tool offered by OSOCC is a virtual platform which facilitates the exchange of information about ongoing disasters in order to coordinate international assistance. Since early 2016, WHO has worked with OCHA to expand the virtual OSOCC to include a section on Emergency Medical Teams. This section enables Emergency Medical Teams to register through a password-protected portal and see the latest messages from WHO and the Ministry of Health. Disaster managers are now able to see the lists of Emergency Medical Teams on standby for specific disasters. This mechanism was used successfully to respond to the earthquake in Ecuador in April 2016, and to Hurricane Matthew in Haiti in October 2016.

Testing capacities and processes for global health crises response through simulations

Task Force observations and advice

- The Task Force members agreed that simulations and table-top exercises should be used to test the functioning of systems and processes, as well as to ensure accountability. They were encouraged by the fact that health capacities are already being tested in the regional exercises conducted under the auspices of INSARAG. For both the INSARAG exercises and those being developed by the World Bank Group, the Task Force considered it useful to see the assessments of these exercises to understand what gaps were exposed in the course of the simulations. The Secretary-General should be informed of the outcomes and analyses developed as a result of these simulations.
- Simulations are useful and need to be conducted at all levels of governance and inter-sectorally. It is important that the World Bank and the G20 have included political decision-makers and finance ministers in these exercises. Pandemic simulations should bring in issues across multiple sectors in addition to health, target audiences beyond health ministries, and look at both global-level and country-level systems. This would include agriculture, animal health, the economic impacts of the disease, as well as potential reductions in travel, trade, and education. It will be important to highlight the risks and critical decisions in these other sectors, beyond those around the biomedical response.
- The Task Force emphasized the importance of ensuring that newly developed tools and processes, including the WHO-IASC standard operating procedures, are tested in the various simulation exercises that are being planned.

41. The Panel considered that an important component of preparedness is the conduct of simulations for all relevant responders. It stressed the need to facilitate regional and subregional simulation exercises for health crisis responses, especially in border areas.²⁸

42. The WHO Emergency Medical Teams initiative has been working with the International Search and Rescue Advisory Group (INSARAG) Secretariat in OCHA to include the testing of health capacities in regional simulation exercises. WHO has identified Emergency Medical Teams to participate in these exercises and assisted national authorities with the establishment and operation of simulated Emergency Medical Teams coordination cells. Emergency Medical Teams participated in INSARAG regional simulation exercises in Europe, hosted by Turkey in May 2016; in Asia, hosted by Indonesia in July 2016; and in the Americas, hosted by Colombia in September 2016.

43. The World Bank Group has been working with Germany, which will hold the G20 Presidency in 2017, to develop a series of simulation exercises. These exercises are aimed at raising awareness among G20 leaders about health systems strengthening, bolstering global collaboration, promoting understanding about IHR, testing the functioning of UN system structures and processes for health crisis management, and identifying gaps and solutions. The series of simulation exercises will include the following:

- World Bank-hosted simulation with Ministers of Finance (October 2016)
- First G-20 technical meeting (December 2016)
- Simulation amongst private sector partners during Davos 2017 (January 2017)
- Second G20 technical meeting (February 2017)
- Simulation amongst G20 Ministers of Health (May 2017)
- Simulation at G20 Heads of State Meeting (July 2017)

Catalysing focused research and innovation relevant to global health crises

Task Force observations and advice

- The Task Force members recognized the importance of creating a list of priority diseases that may stimulate research; however, such a list should not be restrictive since outbreaks often occur with pathogens that had previously been completely unanticipated. The Task Force also stressed the need to build translatable platform technologies that incentivize the development of multi-pathogen diagnostics, vaccines, therapeutics and preventive measures. Better approaches to clinical trials, improved regulatory pathways and additional funding are required. The Task Force members also considered that it would be critical to enhance research and research capacity, engage host countries at the time of carrying out research and to collaborate with the private sector.
- Data sharing and transparency of data is another area for improvement both in preparation for and response to outbreaks. This includes both epidemiological

²⁸ Recommendations 1 and 5.

data as well as data specific to starting and conducting clinical trials in outbreak settings when time to determine clinical effectiveness is short.

- The Task Force noted that the public consultations on platform technologies conducted by WHO and the new norms issued by the International Committee of Medical Journal Editors demonstrate that the culture and the environment in which research and development is pursued can be adjusted to encourage collaboration in public health.
- The Task Force members acknowledged WHO’s strengths as a convener and encouraged WHO to convene a group of research organizations to promote collaboration, synergy and sharing of information, rather than to recreate its own research capabilities.
- There is a need for UN member states to commit to biological sample cross border sharing based on appropriate benefit sharing as predicted under the Nagoya protocol and on WHO normative guidance.
- There is a need to identify options to ensure restricted liability (indemnification) for product developers and recipients of new medical countermeasures for response R&D, possibly through insurance solutions.

44. The Panel emphasized the need to prioritise communicable diseases that should receive public support for research and development. It considered that WHO should establish priorities among under-researched pathogens that pose a risk of health crises. The Panel further considered that WHO should identify technological platforms that have the capacity to accelerate the production of diagnostics, vaccines, and therapeutics to address disease outbreaks especially those resulting from infections with novel pathogens or strains.²⁹

45. 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” issued in May 2016.³⁰ The Blueprint identifies three main approaches: (i) improving coordination and fostering an enabling environment; (ii) accelerating research and development processes; and (iii) developing new norms and standards tailored to the epidemic context. This Blueprint was welcomed by the World Health Assembly in May 2016. Some of the key activities described in the Blueprint are noted below.

46. In December 2015, a group of experts convened by WHO identified five priority diseases needing urgent R&D attention.³¹ Additionally, it identified three serious diseases requiring action by WHO to promote R&D as soon as possible.³² The list will be reviewed annually or when new diseases emerge. The group also identified nine prioritization elements, the weight to be given to prioritization elements and the factors to consider when prioritizing diseases. Work to fine-tune the prioritization methodology is ongoing.

²⁹ Recommendation 13.

³⁰ http://www.who.int/csr/research-and-development/WHO-R_D-Final10.pdf

³¹ The six priority diseases are: (i) Crimean Congo haemorrhagic fever, (ii) filovirus diseases (i.e. Ebola virus disease and Marburg), (iii) Lassa fever, (iv) MERS and SARS coronavirus diseases, (v) Nipah virus and (vi) Rift Valley fever virus.

³² These three serious diseases are: (i) chikungunya, (ii) severe fever with thrombocytopenia syndrome, and (iii) congenital abnormalities and other neurological complications associated with Zika virus

47. A roadmap for research and product development against one of the priority diseases, MERS-Coronavirus, was finalized in May 2016.³³ The MERS-CoV Roadmap highlights the need for point of care diagnostics, therapeutic target product profiles, and vaccines for camels.

48. In October 2015, WHO launched a public consultation to invite proposals for platform technologies that can develop health products to address more than three priority pathogens. The scope of health products considered included vaccines, therapeutics, diagnostics and enabling technologies. Of the 35 proposals received, ultimately, six proposals determined to be the most meritorious. The proponents of these six proposals were invited to give technical presentations to interested Member States and potential funders in July 2016. During the discussions, it was observed that the majority of presenting companies accepted as a guiding principle that they would not seek a profit so long as they would not incur a loss (“no profit/no loss” principle), while others maintained that they were required to operate as profitable businesses.³⁴

49. Subsequently, participants in the platform technologies public consultation responded to a questionnaire to assess the process. In their responses, the participants indicated that the process “generated a new focus on preparedness and renewed the urgency to respond to public health emergencies, while providing an opportunity to increase awareness about the R&D Blueprint.” Additionally, participants noted that the consultation process led them to view each another as potential partners rather than competitors. For example, during the course of the consultation, two proponents agreed to merge complementary proposals, indicating that the process encouraged the alignment of research efforts.

50. New incentives to enhance collaboration in research have also been seen with respect to creation of new norms and practices for data sharing. In December 2015, the International Committee of Medical Journal Editors (ICMJE) amended its recommendations on the conduct and report of research to confirm that in the “event of a public health emergency (as defined by public health officials), information with immediate implications for public health should be disseminated without concern that this will preclude subsequent consideration for publication in a journal.”³⁵

51. In January 2016, the ICMJE published a proposal for sharing clinical trial data whereby authors would be required to share de-identified individual-patient data underlying the results reported in an article as a condition of consideration for publication in a journal. Following a public consultation on this proposal, the ICMJE will meet in November 2016 to consider whether revision to the proposal would be required. In presenting its rationale for the proposal, the ICJME observed that

³³ A Roadmap for Research and Product Development against Middle East Respiratory Syndrome-Coronavirus (MERS-CoV).

³⁴ WHO Report on “Evaluation of ideas for potential platforms to support development and production of health technologies for priority infectious diseases with epidemic potential”.
http://www.who.int/medicines/ebola-treatment/R-D-Blueprint_Evaluation-of-platform-technologies-for-priority-patho.pdf?ua=1

³⁵ International Committee of Medical Journal Editors, Recommendations for the Conduct, Reporting, Editing and Publication of Scholarly Work in Medical Journals (December 2015).
<http://www.icmje.org/icmje-recommendations.pdf>

“[T]here is an ethical obligation to responsibly share data generated by interventional clinical trials because participants have put themselves at risk. Data sharing is a shared responsibility. Editors of individual journals can help foster data sharing by changing the requirements of the manuscripts they will consider for publication in their journals. Funders and sponsors of clinical trials are in a position to support and ensure adherence to IPD sharing obligations.”³⁶

52. Another important development catalysing vaccine innovation is the Coalition for Epidemic Preparedness Innovations (CEPI). An interim Secretariat for this Coalition supported by the Norwegian Government will work with a core team comprised of the Bill & Melinda Gates Foundation, Wellcome Trust and the World Economic Forum. The Coalition’s first interim board meeting was held in August 2016. Focusing primarily on vaccines for which there is no commercial market, the Coalition aims to advance the development of vaccines to the stage where it is ready for full trials or emergence use when needed. It will also manufacture and stockpile these vaccines, provide a global hub to coordinate vaccine development and partner with organizations that can help reach target populations. The Coalition will be formally launched at the World Economic Forum Annual Meeting in Davos in January 2017.

53. Regarding research and development of medical products through public-private partnership, the Global Health Innovative Technology Fund (GHIT) could be a good example for others.

54. The Panel recommended that urgent measures be taken to ensure universal access to and affordability of medicines, vaccines and other life-saving products. Based on a recommendation by the Global Commission on HIV and the Law, the Secretary-General established a High-Level Panel on Access to Medicines in November 2015. This High-Level Panel was tasked with proposing ways to incentivize health technology innovation and increase access to medicines and treatment. The report of the High-Level Panel launched in September 2016 made recommendations in three areas: (i) intellectual property laws and access to health technologies; (ii) new incentives for research and development of health technologies; and (iii) governance, accountability and transparency.³⁷

Securing sustainable financing for work on global health crises

Task Force observations and advice

- The Task Force members expressed concern about the significant funding gaps faced by WHO. Resources continue to be needed for other activities, including community engagement, and research and development. The Task Force welcomed new financing mechanisms that have been created in recent years,

³⁶ Lancet, Comment (January 20, 2016), “Sharing clinical trial data: a proposal from the International Committee of Medical Journal Editors”.

³⁷ <http://www.unsgaccessmeds.org/final-report>

including the WHO Contingency Fund for Emergencies and the Pandemic Emergency Financing Facility. Some Task Force members expressed concerns about the feasibility of securing the necessary amount of funding, while others emphasized the need to generate political will and backing to invest in health as a global public good. In this context, Task Force members noted that WHO's global public good functions are largely funded through voluntary contributions.

- Significant financing is needed not just for WHO and for response efforts during and after outbreaks, but also for R&D, for countries to improve IHR compliance and for health system strengthening. Funding needs are sizeable but if financing is secured for broader platform and system areas, it will contribute to stronger efforts at addressing endemic diseases and improving routine disease surveillance and primary health care facilities.
- Sustainable financing needs to come from a combination of both domestic resources from countries and donor funding, and be sufficiently flexible so resources can be used across the UN system to prevent and address global health crises in the most efficient and effective way.
- The Task Force members stressed that new financing mechanisms should ensure that financing can flow to areas beyond government reach, as these are often the areas at highest risk of emergence and rapid spread of infectious diseases.

55. The Panel made a number of recommendations regarding the need for sustainable financing for four areas of work on global health crises – IHR core capacities, the WHO Health Emergencies Programme, emergency response activities, and research and development for neglected diseases with health crises potential.³⁸ Developments with respect to these areas are noted below.

56. In May 2016, the International Development Association (IDA) proposed the special theme of “scaling-up governance and institutions” for the next three-year replenishment period beginning on 1 July 2017 (IDA18). One component of this special theme will involve supporting the capacity of governments to respond to pandemics. In this connection, it is proposed that IDA will support a minimum of 15 countries in developing and implementing pandemic preparedness plans and frameworks for governance, institutional arrangements, and financing for multi-sectoral pandemic preparedness, response and recovery. Decisions on these proposals will be made at the Spring Meeting of the World Bank Group in April 2017.³⁹

57. In May 2016, the World Health Assembly noted that the WHO Health Emergencies Programme would require an overall budget of US\$ 494 million for the 2016-17 biennium. This would represent an increase of US\$ 160 million above WHO's current budget for the same biennium. The World Health Assembly authorized the Director-General to mobilize voluntary contributions to meet this additional financial need.⁴⁰ While US\$80 million has been reallocated from WHO's

³⁸ Recommendations 17 – 22.

³⁹ International Development Association Report No. 106107 on “Special Theme: Governance and Institutions”.

⁴⁰ Decision WHA 69(9) on the “Reform of WHO's work in health emergency management: WHO Health Emergencies Programme”.

regular budget to the Health Emergencies Programme, it continued to face a gap of US\$ 287 million, or 58%, as of September 2016.

58. With respect to financing emergency response activities, the World Health Assembly authorized the establishment of a Contingency Fund for Emergencies in May 2015 as a replenishable funding mechanism to rapidly scale up WHO's response in outbreaks and health emergencies. The Fund has a capitalization target of US\$100 million. As of September 2016, pledges and contributions to the Contingency Fund for Emergencies total US\$ 31.5 million.

59. In May 2016, the World Bank launched a new financing mechanism, the Pandemic Emergency Financing Facility (PEF), which will provide surge financing to IDA countries affected by a major outbreak that has the potential of becoming a pandemic. One component of the Facility will be a US\$500 million dollar facility to be used to respond to three viruses (orthomyxoviruses, flaviviruses and coronaviruses) and other zoonotic diseases (Crimean Congo, Rift Valley, Lassa fever). Additionally, there will be a US\$50 to US\$100 million cash window that may be used to respond to any disease outbreak that may have the potential to take on pandemic proportions. The Facility is expected to be operational by early 2017.

60. WHO has developed a Strategic Partnership Portal⁴¹ to highlight country needs, gaps, priorities and achievements in emergency preparedness. The Portal provides comprehensive, up-to-date reporting of the contributions made by donors and partners, and emphasizes the collaboration between various stakeholders in supporting countries to build their IHR capacities. This Portal allows for transparent coordination between countries, donors, partners and WHO, in line with the principles for aid effectiveness.

Focusing attention on the gender dimensions of global health crises

Task Force observations and advice

- The Task Force members considered that greater attention must be paid to the disproportionate burden on women during health crises both in the health sector (as informal and formal caregivers) and with regard to economic and social impacts on women and girls. They underscored the need to prioritise major gaps around gender, and focus on developing normative standards, resourcing, and getting sufficient attention to gender during health crises. Reaching out to those vulnerable populations is also crucial for achieving universal health coverage, which contributes to enhancing the capacity for prevention of and preparedness for global health crises.
- Women not only play a major role as part of the health sector workforce, but also as caregivers in the home and community. Women and girls may also face specific vulnerabilities during health crises, as highlighted in the example of the Zika epidemic. The Task Force members stressed the need to engage women during the planning, implementation, as well as evaluation of response to health

41 <https://extranet.who.int/donorportal>

crises; and enhance efforts to promote women and girls' right to health, including access to timely and accurate information, and to health care services, including sexual and reproductive health services.

- A gender analysis is also critical to strengthening health security in cases where infectious diseases related to animal husbandry disproportionately affect men who traditionally perform these roles.

61. The Panel highlighted the need to address the gender aspects of health crises, noting that health crises have particular and important effects along gender lines that can significantly impact preparedness and response. The Panel recommended that specific attention should be paid to the needs of women acting as primary care-givers and the situation when undertaking efforts to address the economic and livelihood impact of pandemics. The Panel further recommended that women must be included at all levels of planning and operations in a response.

62. In responding to the Zika virus, the UN system has been mindful of the gender dimensions of the outbreak. One of the complications associated with the Zika virus infection has been an increase in microcephaly (babies born with small heads) and other nervous system malformations and pregnancy-related complications. In view of the nature of these complications and their particular impact on women and girls, the UN system recognized that a particular focus on the needs of women and girls of child-bearing age is required. In developing risk communications, it is recognized that care must be taken to avoid blaming or stigmatizing women who have become pregnant, particularly in areas where lack of access to sexual and reproductive health services and high rates of sexual violence limit reproductive choices.

63. With respect to the issue of women as health workers and care-givers, the High-Level Commission on Health Employment and Economic Growth highlighted the need to focus on gender equality and rights. The High-Level Commission recognized that women constitute the majority of the health workforce but systemic gender biases and inequities in education and employment need to be addressed, including enrolment in education and training, unpaid care roles, lack of gender-sensitive policies, pay inequity and under-representation in positions of leadership and decision-making. Women in the health workforce are also at greater risk of physical and sexual violence and harassment.

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

Task Force observations and advice

- The Task Force members stressed the importance of engaging with political processes to maintain health security as a priority on global political agendas. High-level political engagement on health issues is needed to ensure sustainable financing and advance recognition of health security as a global public good.
- Health should be integrated centrally into political processes, such as the G20, G7 and the relevant organs of the United Nations, as well as regional high-level conferences such as the Tokyo International Conference on African Development

(TICAD). Another avenue for maintaining political focus on health crises is to mainstream this issue across the 2030 Agenda for Sustainable Development.

- The Task Force members also considered that there may be developments regarding human security that may be relevant to health crises, as health is an indispensable element of human security.
- The Task Force members expressed their hope that relevant stakeholders will consider their observations and advice when implementing the recommendations of the High-level Panel on the Global Response to Health Crises.

64. The Panel considered that global health crises should be elevated on the international agenda. In this connection, the Panel recommended that a council of Member States be created within the General Assembly and that a summit on global public health crises be convened in 2018.⁴² In his report on the Panel's recommendations, the Secretary-General raised concerns about the significant resource implications of creating a new sub-organ of the General Assembly, noting that the functions proposed for the council could be covered through more frequent exchanges between the United Nations bodies and the World Health Assembly. To date, Member States of the General Assembly have not yet taken a decision on the proposals for a high-level council or the 2018 summit.

65. Preparedness for global health crises has continued to be a focus of discussions in various multilateral settings. For example:

66. In May 2016, Japan hosted the G7 Summit in Ise-Shima. Health objectives were highlighted as one of the priority agenda in the Leaders' Declaration and Vision for Global Health. At the Summit, G7 leaders committed to take concrete actions for advancing global health as elaborated in the G7 Ise-Shima Vision for Global Health, highlighting that health is the foundation of economic prosperity and security. The leaders committed to promote universal health coverage as well as to endeavor to take leadership in reinforcing response to public health emergencies and antimicrobial resistance (AMR) which could have serious economic impacts. They also emphasized promoting research and development (R&D) and innovation in these and other health areas.

67. On 1 July 2016, the Human Rights Council adopted resolution on "Promoting the right of everyone to the enjoyment of the highest attainable standard of physical and mental health through enhancing capacity-building in public health". The Human Right Council called upon Member States to "take the primary responsibility for strengthening their capacity-building in public health to detect and respond rapidly to outbreaks of major infectious diseases through the establishment and improvement of effective public health mechanisms, including full implementation of the International Health Regulations (2005), and strategies for training, recruitment and retention of sufficient public health personnel, and systems of prevention and of immunization against infectious diseases".

⁴² Recommendations 26 and 27.

68. In August 2016, the Sixth Tokyo International Conference on African Development (TICAD VI) was held in Nairobi. The TICAD VI Declaration identified the promotion of “resilient health systems for quality of life” as a priority area. Within this area, the Declaration and its implementation plan highlighted health system strengthening, response to public health crises, and the promotion of universal health coverage.

69. In September 2016, the G7 Health Ministers issued the Kobe Communiqué. This statement included commitments to take action in four areas: (i) reinforcing the Global Health Architecture for public health emergencies; (ii) attaining universal health coverage and promotion of health throughout the life course focusing on population ageing; (iii) Antimicrobial Resistance; and (iv) research and development (R&D) and innovation.

70. In September 2016, world leaders adopted the New York Declaration for Refugees and Migrants. In this Declaration, they made commitments to ensure that the basic health needs are met and to provide access to health care services, including sexual and reproductive health-care services. Following a high-level meeting of the General Assembly on antimicrobial resistance, a Political Declaration was adopted calling on Member States, WHO, FAO, OIE and other Stakeholders to take actions to address antimicrobial resistance.

71. During the opening week of the General Assembly, there were a number of side-events sponsored by Member States and UN agencies to draw attention to various dimensions of health crises and health emergencies, including events on universal health coverage, migration and health and global preparedness for and response to health crises.