# GLOBAL HEALTH CRISES TASK FORCE

*Summary of Fourth Quarterly Meetings*

During the fourth quarter of the Global Health Crises Task Force (April to June 2017), one teleconference was held on 4 April 2017 and one face-to-face meeting was held on 1 May 2017. The summaries of the two meetings are attached.

**Summary of teleconference**
**Tuesday, 04 April 2017 (09:00 – 10:00 EST/ 14:00 – 15:00 CET)**

## Update on current threats and disease outbreaks (WHO, FAO, OIE)

Briefing by WHO (Dr. Margaret Chan), FAO (Dr. Juan Lubroth) and OIE (Dr. Gounalan Pavade)

- Avian influenza (H7N9) continues in China – as of 28 March, there are 1,300 cases and 300 deaths. The outbreak is believed to have peaked. The Chinese government has approved the sharing of viruses with laboratories in the Global Influenza Surveillance and Response System (GISRS). Two new candidate vaccine viruses are being developed by WHO collaborating centres.
- There are major concerns about yellow fever outbreak in Brazil, as new parts of country become at high risk. The Brazilian government has agreed to adopt a strategy of using fractional doses of the yellow fever vaccine, which was successfully used in the Democratic Republic of Congo, and to drop the second dose of yellow fever vaccine in their vaccination cycle requirements due to the global scarcity of vaccine. WHO is also concerned about large scale cholera outbreaks in Somalia.
- OIE reported that avian influenza continued to pose global risks, with highly pathogenic H7N9 in China; H5N1 from Asia and Africa, in poultry and wild birds; H5N8 from Europe and H5N6 from Asia. With the onset of spring, there is a possibility of further outbreaks due to bird migration and continued vigilance will be critical.
- FAO agreed that H7N9 is a concern, as there has been a change from low to high pathogenic cases in the Hunan province of China. H5, H7 and H9 have affected 60 countries in the last six months. FAO will be reviewing surveillance capabilities in China to tackle the problem at the provincial level. FAO also raised concerns about Rift River Valley outbreaks in the Horn of Africa countries. If heavy rain falls, preparation for Rift River Valley will be needed as immunity in livestock has waned since the last outbreak.

Observations on inefficiencies, inadequacies and gaps

- There are concerns about country-level capacity in human and animal surveillance, and the ability to pick up early signs and alerts. However, things have improved now that WHO, FAO, and OIE operate under the One Health umbrella.
- With the use of the fractional dosage strategy for yellow fever, the current global stockpile of yellow fever vaccine will be sufficient. Vaccine availability will improve by the end of the year. WHO has improved coordination under the International Coordinating Group (ICG) on Vaccine Provision and is looking at how to align short-term and long-term immunization strategies. WHO is also working with manufacturers on scaling up the production of yellow fever vaccines. The ICG's work is clearly of major importance for all stockpile management.
- There is a continuing need for guidance in proper use of pesticides for vector control so as not to increase dangers in the environment and food supplies.

## Review of the Joint External Evaluation Tool

Briefing by WHO (Dr. Peter Salama)

- The Joint External Evaluation (JEE) measures country specific status and progress in achieving the targets to prevent, detect, and rapidly respond to public health threats. The

JEE is a voluntary process that helps countries identify gaps in their human and animal health systems. JEE missions are multi-sectoral, including not only WHO experts but also experts from OIE and FAO. In keeping with the One Health philosophy, there is at least one veterinarian on each mission.

- The JEE Tool was originally developed as part of the Global Health Security Agenda (GHSA). However, in early 2016, the JEE Tool came under the auspices of WHO. The JEE is a component of the new IHR Monitoring & Evaluation framework which will be submitted to the World Health Assembly in May 2017. Prior to the use of the JEE, WHO was exclusively relying on self-assessments reported by countries. The JEE provides a more objective review of core capacities. To date, 34 JEEs have been conducted and 30 more are anticipated in 2017.
- WHO is committed to ensuring consistency between IHR annual reporting and the JEE. As such, the JEE tool includes all the IHR indicators. Formal annual reporting by States Parties (an obligation under the IHR) continues.
- After one year of implementing the JEE tool, a review meeting will be held on 19 April to review lessons learned from the implementation process and see which improvements can be made to the tool and process
- Some Member States have expressed concern that the JEE may not be entirely voluntary or consistent with the IHR. It is hoped that WHA will endorse new the IHR monitoring framework, as part of the global implementation plan.
- It is critical for the international community to ensure that the right incentives are in place to encourage acceptance of and follow up to recommendations from the JEEs. Countries need support to generate country-specific action plans following an evaluation. There also needs to be monitoring of financial commitments made to supporting IHR implementation, for example tracking of the commitments made by G7 countries to support IHR core capacities for 76 countries.

Observations on inefficiencies, inadequacies and gaps

- Financial and political support for the JEEs and subsequent follow-up (including the development of costed country plans and the tracking of assistance to support IHR core capacities) needs to be highlighted as a priority in the G-20 Health Ministers meeting.
- For the review of the JEE tool in April, suggestions were made to introduce a scoring system based on 0 to 100 and to strengthen the measurement of community engagement in the JEE tool.

**Encouraging acceptance of temporary recommendations on travel and trade under the International Health Regulations**

Briefing by WHO (Dr. Margaret Chan/ Dr. Guenael Rodier)

- One of the main objectives of the International Health Regulations is to avoid unnecessary interference with international travel and trade. Under Art 43, States Parties (SP) can implement health measures during a health crisis, but these should not be "more restrictive or intrusive than reasonably available alternatives" and must be based on scientific principles and evidence WHO has proposed to systematically monitor the health measures and post them online, while the rationale for such measures will be reported on a website to which Member States will have access. Every year WHO will report these measures systematically to the WHA.
- Building on Articles 43 and 56 of the International Health Regulations, mechanisms could be developed to allow countries to settle their differences regarding "additional

measures". In the WTO, members recently agreed on a new tool for resolving differences under "sanitary and phytosanitary measures". The new system of mediation (usually by the SPS Committee's chairperson) is voluntary and not legally binding but bridges a gap between raising concerns in committee and full-scale dispute settlement. WHO is prepared to work with WTO, to use the tool that WTO has recently introduced.

Observations on inefficiencies, inadequacies and gaps

- Inappropriate trade and travel bans are a significant barrier to transparency and to establishing safeguards. Countries that are in likely to take such measures should be identified.
- For countries experiencing large scale cholera outbreaks, the incentives for the accurate reporting of cholera will be critical. In countries experiencing famine and food insecurity, it will be important not only to include health and WASH in the humanitarian appeals but also to emphasize these components in advocacy and make sure that they are fully funded.

**Any other business**

- The face to face meeting of the Task Force in New York on 1 May 2017 was confirmed.
- Some topics suggested by Task Force members for discussion during the 1 May meeting included: improvements in country capacity, regional and international coordination mechanisms, research and development, financing and rest and recuperation entitlements for humanitarian workers. It will be important to look at progress made both within and outside of the UN system. Task Force members stressed the need to go back to the original recommendations of the High-level Panel on the Global Response to Health Crises to examine the progress made.

**Meeting summary**
**Monday, 1 May 2017**

1. The Global Health Crises Task Force held a face to face meeting on Monday, 1 May. The main issues and observations that were discussed by the Task Force were as follows:

National health systems and community engagement

2. The Task Force members noted that there has been substantial progress with the implementation of the Joint External Evaluations (JEEs), an invaluable part of the IHR compliance, which are designed to provide an objective and in-depth evaluation of national capacities. However, it is not enough to diagnose the problems, as highlighted by the IHR Review Committee, which called for the development of national action plans. Gaps identified through the process of monitoring and evaluating core capacities as defined by the IHR, including through the JEEs, need to be addressed through the national action plans and the provision of technical and financial assistance to the countries. Task Force members expressed concern at the low numbers of countries that have developed costed national action plans following the completion of JEE exercises.

3. The Task Force members discussed ways of strengthening the JEE framework, including ensuring that the animal and human health systems are examined together, involving anthropologists, social scientists and civil society organizations in the exercise, and refining the JEE tool to assess sub-national capacities for community engagement. Task Force members reiterated that communities are critical for understanding the local culture. Communities are the first to detect health threats and offer solutions. Modest revisions to the JEE framework will be piloted in 2017 and launched in 2018 for the second wave of JEEs. Members noted that the IOAC (Independent Oversight and Advisory Committee for the WHO Health Emergency Programme) will be looking at IHR, including JEEs and action plans in its next report in January 2018.

4. They stressed that countries need to have incentives to report accurately on health threats and on the weaknesses in their capacities. Financing to strengthen health systems constitutes a critical incentive. If disincentives (such as disproportionate trade and travel measures) are not addressed as well, countries will be punished for transparency. WHO will be reporting on trade and travel measures that have been adopted, and is examining the development of an informal resolution process with WTO to address travel bans.

Research and development

5. The Task Force members considered that the R&D Blueprint for Action to Prevent Epidemics" is an inclusive framework that provides a good model for how WHO can work with partners. They stressed that the Blueprint needs to be comprehensive and inclusive, and provide a good platform to promote coordination.

6. The Task Force members recognized that WHO plays an important role in convening partners to share expertise and information. WHO also exercises an important coordination role, by encouraging alignment with the R&D blueprint and establishing a list of priority

pathogens to promote alignment of efforts. In this context, the Task Force members welcomed WHO's collaboration with the Coalition for Epidemic Preparedness Innovations (CEPI). WHO can also help ensure that efforts are not duplicated and flag areas where increased R&D efforts are needed, for example, in tackling AMR for particular pathogens or the development of medical products and diagnostics. At the same time, Task Force members also stressed that the list of priority pathogens should not have the effect of limiting research on other pathogens that may lead to outbreaks. The Task Force members also 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 public health outbreaks.

7. While the High-Level Panel on the Global Response to Health Crises had recommended that WHO manage a centralized R&D fund, the Task Force members considered that such a role would not be suitable for WHO, when its strengths are primarily in the areas of convening and coordinating partners.

8. The Task Force members noted the difficulties encountered with testing medical products quickly when a disease outbreak occurs and underscored the need to build trust in communities and in countries, both at the time of outbreaks but also as an essential component of development assistance. The engagement of local researchers and communities and the development of local research capacity are vital to foster the trust needed to conduct clinical trials and other research activities. An essential element of preparedness is developing standardized protocols for clinical trials and regulatory pathways so that vaccines and other medical products can be quickly tested and approved for use when an outbreak emerges.

9. The Task Force members also observed that while the One Health approach has been accepted as the basis for surveillance and risk assessment, this approach still needs to be embedded in health systems and integrated in R&D strategies.

Financing

10. The Task Force Members expressed disappointment that financing for health systems at the country level, and for the work of WHO and other agencies and organizations at the country, regional and global levels all fell short of what is needed. This financing gap was also highlighted in the report of the Independent Oversight and Advisory Committee ("IOAC") to the 70th World Health Assembly (A70/8).

11. For WHO, the Health Emergencies Programme continued to face a funding gap of 41% for 2017/18, and the lack of year on year predictability has significantly hindered the long term appointment of staff. For the Health Cluster's work in humanitarian and protected crises, only 13% of its needs for 2017 ($67 million out of $523 million) has been met. Similarly, the WHO Contingency Fund for Emergencies continues to face a 67% funding gap. The Task Force members stressed that the inadequate financing of WHO and its partners on the ground to support the work in health emergencies was a matter of grave concern, and posed a significant risk to the success of the Programme.

12. The World Bank reported continued progress on many new initiatives to finance pandemic response. The first meeting of the steering body of the Pandemic Emergency Financing Facility (PEF) will be held in late May/early June. It is anticipated that the insurance window of the PEF will go live by 30 June, and the cash window will be open by January 2018. In the context of IDA 18, its contingency financing capacity has been augmented to cover crisis response in all health emergencies. An additional instrument, the Catastrophe Deferred Drawdown Option, also allows countries to access no cost contingency financing for emergencies, including health crises.

13. The Task Force was briefed about the discussions and preliminary recommendations of the International Working Group on Financing Preparedness (the "International Working Group"). The International Working Group considered JEE to be a valuable tool and will call on countries to commit to participating in the process, as well as in evaluations of the Performance of Veterinary Services to assess animal health systems. Following the completion of the JEEs, countries also need to develop costed national action plans to address the gaps identified and prepare a financing proposal.

14. The International Working Group considered different ways of mobilizing domestic and external financing. Countries need to explore ways of generating additional resources for preparedness, including by improving tax collection, introducing earmarked taxes and promulgating regulations to require private sector companies to invest in preparedness, where their economic activities contribute directly or indirectly to the risk of outbreak and spread of disease. Development partners should earmark and deploy resources to help finance preparedness at a national level to fulfil and build on commitments. To reinforce incentives for countries to invest in preparedness, the IMF and World Bank Group should work to facilitate the incorporation of the economic risks of infectious disease outbreaks into macroeconomic and market assessments. The World Bank Group, in collaboration with WHO and other relevant partners, should also examine pandemic preparedness capacity as a factor in assessing and scoring countries.

15. The Task Force members noted that the engagement of finance ministers is key to attracting attention to health issues within governments. The involvement of finance ministers in antimicrobial resistance led to greater political interest in this issue. The integration of health crises preparedness into assessments by the World Bank of a country's economic and financial development ("Article IV assessments") will help elevate the profile of health for finance ministers and their governments. The dangers posed by disease outbreaks to the functioning of economies and governance in general must be consistently highlighted.

16. The Task Force members suggested that it will be important for regional banks to also become engaged in generating financing for health systems, and factoring country preparedness for health crises into their policies. Support for laboratories and regional coordination mechanisms would be consistent with the role of regional banks in financing infrastructure.

17. The Task Force members stressed that insurance can create important incentives for preparedness. More opportunities should be explored for the insurance industries to provide

insurance for business interruption, including interruption due to infectious disease outbreaks or crises.

UN system capacity and coordination

18. With regard to the WHO Health Emergencies Programme, the Independent Oversight and Advisory Committee (IOAC) was of the view that the implementation of the Programme has significantly advanced, with particular progress in protracted emergencies, as evidenced by recent field visits and interviews with governments, partners and WHO staff at all levels. Improvements were observed specifically in WHO's health cluster co-ordination and leadership and its effectiveness on the ground, welcomed by partners on the ground who acknowledge encouraging signs in WHO's field presence and partnership engagement and their expanded role in humanitarian crises. However, the IOAC expressed concern that business processes have not developed at the pace of the Programme and are not sufficiently supporting the Programme, and that there remained constraints in the organizational culture regarding the adoption of a "no regrets policy". The IOAC also stressed the importance of establishing the baseline level of emergency operational and management capacity at country level, ideally including a deputy country representative to ensure sufficient bandwidth in priority countries if the WHO country representative is designated as the Incident Manager. In its report to the World Health Assembly (A70/8), the IOAC reiterated its concerns that the programme is underfunded and therefore the progress is seen as fragile.

19. The Task Force members observed that the Programme was designed in post-Ebola era with strong focus on short term response. It will be important for the development of the Programme to be informed by its experiences within the past year, which has highlighted the need to better manage a complex overlay of events (such as chemical threats) on top of protracted conflicts.

20. WHO reported continued collaboration between the agencies addressing human health (WHO) and animal health (OIE and FAO), particularly important in view of the number of emerging threats that are of zoonotic origin. The work on antimicrobial resistance is an example of good collaboration using the One Health approach, and underlines the importance of integration of animal and human surveillance systems. The three agencies are also working intensively on the rabies vaccines.

21. The UN is looking at the reforms needed by the development system to make sure that country level structures are fit for purpose, not only aligned with the 2030 agenda, but also factoring in the threats presented by climate change, conflict, weak health systems, zoonotic diseases and resulting health emergencies.

22. The Task Force members cautioned against strengthening capacity only during emergencies. The UN system needs to build capacities for preparation and demonstrate commitment and attention to global health in the highest levels of senior leadership in the UN system.

Simulations

23. The Task Force discussed the various simulations completed and under preparation, including those conducted in October 2016 by the World Bank and in January 2017 by the World Economic Forum, as well as the simulation to be held at the first ever G20 Health Ministers meeting from 19-20 May . These can be very important for raising the awareness of key decision-makers. Whenever possible, simulations need to be inclusive, involving the private sector, non-governmental organizations and other stakeholders that are operating within the countries and are close to the communities. Simulations are also a key plank for countries of the IHR Monitoring and Evaluation Framework (2005) and were supported by the IHR Review Committee (A/69/21, Annex, Recommendation 12.6). However, simulations should not be an end in itself; rather, where feasible and appropriate, the outcomes of the simulations should be reported, with lessons learnt, and there should be follow-up.

Political advocacy for health security

24. The Task Force members observed that health crises provide an opportunity to focus the attention of political actors on important health challenges and responsibilities, including the promotion of health and the strengthening of health systems. A high profile of health needs to be maintained in the General Assembly and fora such as the G7 and G20; it also needs to be raised in regional political bodies.

25. The Task Force members stressed that there should be multi-sectoral outreach to government ministries, beyond the Ministry of Health – the ministries handling development, research, environment, foreign affairs, finance and national security all need to understand that health threats will undermine their national security and economic interests. Along these same lines, the Task Force members recommended better communication and coordination within government across all their ministries. While a Ministry of Health will be aware of human health priorities, the development ministry of WHO's work within countries, and the ministry handling agriculture and animal health, as well as other ministries (including those with greater access to resources), may not necessarily be familiar with the impact of human and animal health issues, nationally or internationally. Advocacy for health requires not only engagement of the UN and the public sector, but also engagement by the private sector and civil society organizations (both professional advocates and local groups that can facilitate community engagement).

26. The Task Force members stressed that if health security is to remain a priority for political agendas, the monitoring of health crisis preparedness and response needs to speak to political decision makers. Senior level officials need to address health issues at regular intervals.

27. The Task Force members discussed the use of the term "health security", acknowledging that the reference to "security" may have unwelcome connotations because of possible associations with the military. However, the importance of health for human security and the security of communities can be stressed. Another term that was suggested was "universal health crises preparedness and response"

Future of the Task Force

28. The mandate of the Task Force is set to expire on 30 June 2017. During the 1 May meeting, the Task Force did not reach a conclusion on a recommendation for its future. Some of the options discussed included continuing the Task Force with its current configuration for a further six months to one year, or creating another mechanism, but the features of such an alternative mechanism or the purposes were not discussed in detail. In the coming weeks these options will be clarified, with a view towards reaching an agreement by the Task Force on an option for the future. The recommendation of the Task Force will be set out in its final report, which will be submitted to Executive Office of the Secretary-General for clearance on 15 June and for processing on 30 June. This report will comply with the mandate and terms of reference of the Task Force. Ultimately, the decision on the future of the Task Force will be made by the Secretary-General.