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- **Report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme Document**

Document A71/5

In accordance with decision WHA69(9) (2016)[1], WHO established the Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies (WHE) Programme to guide the development of the new Programme, monitor WHO's work in outbreaks and emergencies and provide oversight. In accordance with the terms of reference of the IOAC, the two-year term of office of the current members will end in May 2018. Therefore, this report is the incumbent IOAC's fourth and final report to the governing bodies.

IOAC monitors WHE progress under a monitoring framework[2] consisting of eight key thematic areas: structure, human resources (HR), incident management, risk assessment, finance, business processes, partnerships, and International Health Regulations (2005) (IHR). Monitoring modalities used included desk reviews, in-person meetings and interviews, secretariat briefings, group discussions via teleconferences, and field visits to WHE operations in Colombia, Nigeria, Mali, Iraq, and Pakistan.

Progresses and Challenges over the First 20 Months of the WHE:

The WHE Programme has been making steady progress over the past two years. The IOAC commends the important progress made by the WHE Programme over the past 20 months. In particular, the IOAC is pleased to see: progress in implementation of a "one programme" approach and structure across the three levels of the Organization; strengthened leadership in outbreak management and performance during emergencies.

The IOAC notes that major remaining constraints on performance of the Programme are increasingly related to corporate-level systems and cultural obstacles.

To track progress and to support its assessment, the IOAC applied a monitoring framework that was developed on the basis of the milestones laid out in document A69/302 and the indicators proposed in the WHE Programme results framework submitted to the 140th session of the Executive Board. In monitoring progress, the IOAC identified eight thematic

[1] WHA69/2016/REC/1 (http://apps.who.int/gb/ebwha/pdf_files/WHA69-REC1/A69_2016_REC1- en.pdf, accessed 15 January 2018)
[2] IOAC monitoring framework for WHE (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/ioac-monitoring-framework.pdf?ua=1, accessed 15 January 2018)

areas: structure, incident management, risk assessment, human resources (HR), finance, business processes, partnerships and the International Health Regulations (2005) (IHR). These should continue to be monitored by the IOAC.

Internal and external communication, coordination and management processes

Efforts have been made to share the WHE Programme roll-out plan with staff, to disseminate new policies and procedures to relevant offices, and to engage with staff at the different levels of the Organization in order to implement a coordinated response to crises. Recently, a dedicated communications team covering both internal and external communications was established as part of the WHE Programme. During its field visits, the IOAC observed that, for each outbreak, each of the three organizational levels of the WHE Programme produces a series of risk assessments and situation analyses. The IOAC has observed progress in coordination across the three levels of the WHE Programme.

The IOAC recommends that the WHO's Emergency Response Framework (ERF) should be consistently followed by staff at all levels of the Organization. Additionally, improved communication and decision-making processes should be developed between the senior managers at HQ and the Regional Directors, and among the staff at HQ, regional offices and country offices.

Incident Management System, delegation of authority and accountability

The IOAC recognizes that WHO activated the IMS for all 39 graded events between July 2016 and March 2018, in line with the ERF. The IOAC recognizes that flexibility is required to adapt to specific emergency contexts; in this regard, the IOAC recommends transparent and documented three-level decision-making to describe any required adaptation of roles and responsibilities as outlined in the ERF.

The IOAC acknowledges that the delegation of authority (DOA) to Incident Managers and WHO Representatives in a graded emergency have been developed and included in the WHO eManual. The IOAC is pleased to see efforts to systematically update SOPs to reflect lessons learned.

Human resource planning, recruitment and retention of talent

For the biennium 2018–2019, the WHE Programme has an allocated total of 1580 positions. As at March 2018, 751 of these have been filled. The IOAC acknowledges that the number of occupied longer-term professional positions in the WHE Programme has increased by 74% at regional level (from 78 to 136 positions), and by 37% at country level (from 77 to 107 positions), compared with 4% at HQ (from 119 to 124 positions). The IOAC welcomes the Director-General's decision to allocate US$ 200 million of core flexible funding to the WHE Programme in 2018–2019, compared with US$ 145 million received in 2016–2017. The IOAC observes that the WHE Programme's HR planning and budgets were initially determined through the emergency reform process in 2015–2016 by HQ and regional office staff.

Following the recommendations in the IOAC's third report, efforts are being made to allocate dedicated HR staff to the WHE Programme.

In its previous reports, the IOAC urged WHO to benchmark HR incentives for talent acquisition and management, and an appropriate policy for rest and recuperation in emergency settings, against those of peer United Nations (UN) agencies and development organizations, commensurate with the intensity of the work. The IOAC recommends that this should be under review by the Committee.

Financing the WHE Programme and resource mobilization at country level

The WHE Programme is funded in three parts: core budget, appeals and the Contingency Fund for Emergencies (CFE). During the biennium 2016–2017, of the total appeal for US$ 1073 million for humanitarian response, US$ 780 million was received and directed towards graded emergencies. Between the CFE's establishment in 2015 and December 2017, 11 Member States contributed US$ 45.4 million of a target capitalization of US$ 100 million. The IOAC reiterates its recommendations to strengthen resource mobilization capacity at country level and to standardize across the regions WHO Representatives' financial authority to accept funds.

Procurement and supply chain management

WHO's inability to rapidly procure and deliver goods in an emergency remains a major weakness in the reform process. The IOAC encourages WHO to conduct a benchmarking analysis for the supply chain process, to establish key metrics to gauge the timeliness and effectiveness of the process, and to estimate the necessary staffing and corporate investment level.

The IOAC is concerned that persistent delays in procurement and delivery could erode partners' confidence in WHO's capacity and accountability. Corrective actions, including emergency measures under the Framework of Engagement with Non-State Actors, must be fully implemented at all three organizational levels, to support field responses. This is another area that needs to be kept under review in the future IOAC work programme.

Security, staff protection and WHO's policy for prevention of and response to sexual exploitation and abuse

WHO's institutional capacity for ensuring security is weak. WHO's security staff fall under the budget and staffing plan of the General Management cluster. The IOAC reiterates that procedures and adequate measures, including medical evacuation, should be put in place for staff support and protection when delivering critical assistance to people in areas with limited infrastructure and increased security risk.

In its second report, the IOAC noted that staff protection measures were inadequate for the stressful working conditions in the field and recommended that psychological support

should be available to staff working in emergency settings, as well as protection against workplace harassment. The application of such guidelines in the complex emergency environments in which the WHE Programme operates is another issue that should be monitored as part of the IOAC's future agenda for work.

WHO's leadership in the Inter-Agency Standing Committee for health emergencies, health cluster coordination and partnership platforms

Significant progress has been noted in WHO's partnerships with other UN organizations, nongovernmental organizations and other relevant stakeholders. Evidence from field visits confirmed that deployment of experts through external partnership mechanisms is being promoted and has proved helpful. The WHE Programme is advised to assure the high quality of the HCCs roster through adequate assessment of candidates, improved performance management of HCCs, training on field-level health cluster coordination prior to deployment, and adequate support on deployment to ensure satisfactory information management and coordination. . In 2017, the WHE Programme undertook an exercise to map its partners' presence and identified a total of 711 partners across the 24 country health clusters providing around 70 million people with essential health services.

Assessing International Health Regulations (2005) core capacities, monitoring and planning

The IOAC notes that financing of NAPs is critical to filling capacity gaps: such gaps could pose obstacles to further progress in IHR implementation. The IOAC reiterates that building the capacities of national governments is a primary and ongoing role of the WHE Programme. WHO is advised to assist countries in making rational decisions, deploying effective measures to prevent public health emergencies and complying with the IHR requirements. This is another issue that should be looked into as part of IOAC's future agenda.

Concluding remarks

The genesis of the WHO emergency reform programme was the hard lessons learned from the West Africa Ebola outbreak and the perceived initial dysfunctional response. On the basis of its monitoring and review between the official launch of the WHE Programme in July 2016 and the end of March 2018, the IOAC concludes that WHO has demonstrated important progress towards reaching the key milestones set out in document A69/30 and that the WHE Programme has a track record of delivery that aligns with the principles of a single programme, and has brought improved speed and predictability to WHO's work in emergencies. The IOAC is encouraged to see that WHO senior management has included the need to improve the Organization's administrative system and business processes in the transformation agenda and is looking for solutions at a corporate level.

The Director-General has the honour to transmit to the Seventy-first World Health Assembly the report submitted by the Chair of the Independent Oversight and Advisory Committee.

Implication for the European Region

Some of the challenges highlighted in the IOAC report are also observed in the European Region, particularly in human resources, financing and business processes, despite no acute emergencies are currently occurring in the region.

In the European Region, WHE carried out 10 voluntary joint external evaluations, in Albania, Armenia, Belgium, Finland, Kyrgyzstan, Latvia, Slovenia, Turkmenistan, and Switzerland/Liechtenstein. Serbia, Lithuania and the Republic of Moldova, have requested to conduct these evaluations in 2018. Two National Action Plans following a voluntary joint external evaluation were undertaken by Finland and Kyrgyzstan and representatives of 10 countries were trained to develop them.

A voluntary joint external evaluation Team Lead Training was held for international experts in February 2018. In 2016 and 2017, WHE/Europe supported simulation exercises in Armenia, Turkmenistan, Georgia, Germany, Uzbekistan and Hungary and provided tools for After Action reviews in Netherlands and Iceland.

Various simulation exercises are planned; among WHE priority countries (15 in total). Tajikistan and Kyrgyzstan are the first group of countries planned for this type of exercise (flooding scenario) and a scoping mission is planned in February 2018. Other countries in the pipeline include Armenia, Albania, Azerbaijan, Macedonia, and Georgia (infectious disease outbreak scenario)

The Regional Office is working on development of a draft Regional action plan for accelerated implementation of IHR based on the Global Strategic Plan, which will be presented at the regional high level meeting in Germany in February 2018 and to the SCRC in March 2018.

In relation to the WHO's Emergency Response Framework (ERF): the WHE teams in the Graded emergencies (G3 in and from Turkey under the Whole-of-Syria, and P2 in Ukraine) are following the SOPs and the three-level decision-making process.

15 WHE European Priority Countries are now centered around 3 hubs (Georgia, Kyrgyzstan and Serbia) and are fully staffed and equipped, following the "country business model". In the protracted emergency in Ukraine, sustainable mechanisms need to be ensured in order to continue the life-saving operations and maintain the staff in the armed conflict zones.

- **WHO's work in health emergencies**

Document A71/6

The Executive Board at its 142nd session noted an earlier version of this report. The report A71/6 includes requests in resolution EBSS3.R1 (2015) on Ebola: ending the current outbreak, strengthening global preparedness and ensuring WHO's capacity to prepare for and respond to future large-scale outbreaks and emergencies with health consequences, and decision WHA68(10) (2015) on 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on Ebola.

WHO'S RESPONSE AND COORDINATION IN SEVERE, LARGE-SCALE EMERGENCIES.

A system for continuous event-based surveillance of public health events and verification and assessment of detected events is established, with on average, 3000 signals being received per month, of which 300 merit follow-up and 30 are investigated. Standardized risk assessment processes are used. Standard packages of care for high-priority high-impact pathogens and diseases including cholera, Zika and influenza have been introduced.

New administrative systems have been put in place, including pre-cleared staff rosters for deployments, emergency standard operating procedures, including delegations of authority, fast-track recruitments and procurement. The second edition of WHO's Emergency Response Framework, which includes application of the Incident Management System, is now used to manage all graded events.

During the period from 1 January to 20 October 2017, WHO responded to 47 graded emergencies in more than 40 countries and territories.. No new declaration of public health emergency of international concern was made in 2017.

Among the acute emergencies, nine were classified Grade 3 emergencies, which is the highest severity level based on WHO's Emergency Response Framework (Syrian Arab Republic, South Sudan, Iraq, Yemen, Nigeria, Ethiopia, Somalia, Democratic Republic of Congo, Bangladesh/Myanmar)

In accordance with the principles of the Emergency Response Framework, WHO activated the Incident Management System to address immediately the health needs of and risks facing the affected population. WHO also led or jointly led health sector coordination, including that of 23 activated health clusters. About US$ 16 million have been disbursed from WHO's Contingency Fund for Emergencies order to ensure rapid expansion of WHO's response in 28 graded emergencies.

Constraints on the health sector response include insecurity and limited access, limited capacities of national health systems and partners, shortages of health personnel, bureaucratic constraints and insufficient funding. During the biennium 2016–2017, WHO

has requested US$ 1033 million in appeals funding (that is, for outbreak and crisis response) to respond to emergencies and health crises, of which it has received US$ 776 million (75%).

In the Syrian Arab Republic, WHO has provided sufficient medicines and supplies for 10.5 million treatments (8.4 million from inside the country), and vaccinated 4.5 million children against measles and 2.4 million children against polio.

In response to the large-scale influx of more than 520 000 refugees fleeing violence in Myanmar's Rakhine State to Cox's Bazar in Bangladesh, WHO has mobilized more than 40 national and international staff from all three levels of the organization. Priority health interventions have included preventive campaigns against measles and cholera, the establishment of an early warning alert and response system, strengthening of health sector coordination, and rapid expansion of access to essential health services, including 20 mobile teams supported by WHO.

Other large-scale emergencies for which WHO supported the national response during the reporting period included the yellow fever outbreak in Brazil (Grade 2), Hurricanes Irma and Maria in the Caribbean (Grade 2) and the ongoing humanitarian crisis in Ukraine (Grade 2).

The interrelated issues of safeguarding our health security while promoting our health through universal health coverage are WHO's top priority. Strong health systems are our best defence to prevent disease outbreaks from becoming epidemics and to mitigate the risks caused by the breakdown of health systems in fragile settings, such as those caused by conflict

CHOLERA PREVENTION

Cholera kills an estimated 95 000 people per year and sickens 2.9 million more. The Global Task Force on Cholera Control, for which WHO provides the secretariat, is a network of organizations that are intensifying efforts to control cholera at all levels through a renewed global strategy through to 2030. The global roadmap focuses on three axes: a multisectoral approach, early detention and response, an effective mechanism of coordination. Focusing on the 47 countries affected by cholera today, the partners in the Global Task Force on Cholera Control provide support to countries in order to reduce deaths due to cholera by 90% by 2030.

RESEARCH AND DEVELOPMENT IN THE CONTEXT OF EMERGENCIES

In June 2015, the Secretariat initiated work on the Research and Development Blueprint for Action to Prevent Epidemics for potentially epidemic diseases. Its goal is to reduce delays between the identification of an outbreak and the deployment of effective medical interventions. Areas covered by the Blueprint include product research and development for diagnostics, vaccines and therapeutics.

WHO's list of diseases for priority research and development was updated at a meeting in January 2017 and will be reviewed at a consultation that will take place on 5 and 6 February 2018.

The Secretariat has developed six vaccine target product profiles (Lassa, Nipah, Zika, MERS, multivalent Ebola and monovalent Ebola Zaire vaccines) and two diagnostic target product profiles (Zika and Ebola) and is working on target product profiles for other key pathogens. Research and development road maps for prioritized diseases are being developed through expert consultations.

An initial workshop on Zika vaccine efficacy trials was organized on1 and 2 June 2017 and generic protocols for Zika vaccine evaluation are being finalized together with criteria for prioritization of vaccine candidates and selection of clinical sites.

The establishment of the Global Coordination Mechanism for Research and Development to Prepare for and Respond to Epidemics was finalized. In November 2017, its terms of reference and core membership were discussed and standard operating procedures for regular communication among members and interaction with existing independent advisory groups of experts informing the global research and development community were outlined. The Secretariat has also developed a visualization tool to facilitate access to information on stakeholders involved in research on various priority pathogens and products. The Coalition for Epidemic Preparedness Innovations has committed itself to working on the diseases prioritized in the R&D Blueprint.

Efforts to strengthen national regulatory and ethics bodies to respond to public health emergencies are under way, including an informal consultation on regulatory preparedness to address public health emergencies for vaccines, diagnostics and therapeutics for priority pathogens.

The Health Assembly is invited to note this report.

Implication for the European Region

In the European Region, WHE Health Emergency Information and Risk Assessment (HIM) functions as the Regional IHR Contact Point. It conducts continuous event based surveillance, with about 1500 signals on public health events received per month, of which 100 merited evaluation in more detail. Since 1 January 2017 until 9 May 2018, a total of 67

public health events (4 per month) were assessed in detail and responded to. Standardized WHE risk assessment process was applied to part of these events.

All these events were recorded in the WHO Event Management System. During the same period, there were 25 Event Information Site postings or updates published for the European Region, plus four (4) EIS announcements relating to the European Region.

With 22 360 measles cases and 36 related deaths, 2017 saw an increase of over 300% compared to 5273 cases reported in 2016 in the WHO European Region. This increase was mostly due to the large number of cases reported in just a few countries (Italy, Romania and Ukraine), having experienced a range of challenges in recent years, such as declines in overall routine immunization coverage, consistently low coverage among some marginalized groups and interruptions in vaccine supply. Most cases occurred in unvaccinated or under-vaccinated people. An additional 11 436 measles cases have been reported in 32 countries of the WHO European Region during the first two months of 2018 alone, including 14 measles-related deaths in 7 countries.

In the WHO European Region, WHO continued lifesaving operations in the two long standing humanitarian crises, in Ukraine (Protracted Emergency Grade 2, P2) and in Turkey, under the Whole-of Syria operations (Emergency Grade 3, G3). Under the Whole of Syria Initiative, the WHO operations in and from Turkey are graded 3

Cross-border operations, through WHO Field Office in Gaziantep, Turkey

WHO is leading the Health Cluster coordination of 70 NGO partners, many of whom provide health services in Syria. Over 1100 Syrian health professionals were trained in trauma management, mental health and chronic disease management in the northern part of the Syrian Arab Republic 70,000 Syrians assisted by 18 WHO-supported health facilities in Idleb. Four polio vaccination campaigns covering 750 000 children per round were conducted. 3.25 million doses of oral polio vaccine provided to children in northern Arab Republic of Syria. WHO provide operational cost for 70 ambulances and seven specialized health care facilities through partnerships with NGOs. Mental health support provided using different mechanisms, including a mental health telephone hotline for Syrian aid workers in Syria and Turkey. WHO delivered cross-border medical supplies under the UN resolution 2393 twice per month and ad-hoc deliveries. About 1,233,345 treatment courses were provided in north-west Syria. Supplies were distributed through 37 NGO partners to 230 medical facilities. Prepositioning in Turkey and Syria for rapid deployment (chemical attacks, population displacements) is in place.

Syrian refugees in Turkey:

Turkey is a flagship model for hosting 4 million Syrian refugees (the highest in one country ever) and providing them universal health coverage. The services are provided by more than 1200 Syrian health workers who were trained and certified to serve in the Turkish health

care system. In 2017, more than 433,000 free of charge, culturally and linguistically-sensitive health consultations were provided to the Syrian refugees. A model of 7 refugee health training centres is supported by WHO. About 413,000 Syrian children received routine immunization services in Turkey

The WHO operations in Ukraine are graded as protracted emergency (P2).

The crisis in eastern Ukraine continues since 2014. Over the last four years, the conflict exacerbated the already fragile health care system in this part of the country. The crisis directly impacts lives and livelihoods of 3.4 million persons, including 1.7 million internally displaced people (IDPs), located on both sides of the Contact Line. 2.2 million people are in need of essential health services.

The Health Cluster was activated and established when the crisis unfolded in 2015; with WHO as the Cluster Lead Agency. In 2017-2018 WHO coordinated emergency response of 25 international and 31 national non-governmental organizations ensuring effective delivery of humanitarian programs in the field. WHO is providing technical guidance and advice to all health partners operating in the Government Controlled Area (GCA) and Non-Government Controlled Area (NGCA).

In 2017, jointly with the Ministry of Health, WHO established a Health Resources Availability Mapping System (HeRAMS). Ukraine is as well one of the first countries in the world to implement newly established reporting system on 'Attacks on Healthcare'. During the conflict, over 150 health care facilities have been damaged or destroyed as a result of attacks on health care.

WHO in Ukraine maintains and expands surveillance and response for critical infectious diseases and hazards with potential significant public health consequences through providing technical support to 9 public health labs in both GCA and NGCA.

WHO is providing support to 3 hospitals in GCA. Project is a mixture of hospital rehabilitation (hardware) and capacity building in the area of IPC.

WHO supports a comprehensive network of mobile medical units to provide health services, including MHPSS to internally displaced people. 28,719 people benefited from primary healthcare consultations through the re-establishment of five mobile clinics for primary health care with psycho-social support for the population living in the Government-Controlled Area (GCA) of Ukraine;

A Trauma Seminar was delivered by the specialists from the WHO Collaborative Centre for Research and Training on Health Care and Public Health in Disasters of Karolinska Institut (Sweden) to NGCA. The seminar was attended by 69 specialists working in 8 facilities. Training was offered to complement the distributions of the 46 Surgical kits that allow 4,600 surgical interventions for major trauma have been delivered to 59 health facilities. The

rehabilitation training was successfully conducted by Handicap International (UK) in three (3) hospitals located in GCA.

About 750,000 people benefitted from the WHO-supplied deliveries in a total of 245 health facilities.