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Report of the Global Health Crises Task Force

Note by the Secretary-General

In its resolution 71/159, the General Assembly requested the Secretary-General to provide periodic updates on the work of the Global Health Crises Task Force and its recommendations, in close consultation with the Director General of the World Health Organization. The Secretary-General hereby transmits the final report of the Task Force.

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Report of the Global Health Crises Task Force

Summary

The Secretary-General established the Global Health Crises Task Force for a one-year period from 1 July 2016 to 30 June 2017. The purpose of the Task Force was 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, as set out in its report, entitled "Protecting humanity from future health crises" (A/70/723). In the present report, the Task Force concludes that over the past year, it has seen significant progress in many areas highlighted in the Panel's report. While the systems for advancing health security are developing in the right direction, potential vulnerabilities in health security must continue to be monitored.

I. Background

1. When the Ebola outbreak spread across West Africa in 2014, the response revealed weaknesses in the systems and mechanisms that were expected to address health emergencies at the country, regional and global levels. The outbreak triggered a number of reviews and evaluations of the response. One such review was conducted by the High-level Panel on the Global Response to Health Crises, established by the Secretary-General, which issued its report, entitled "Protecting humanity from future health crises" (A/70/723), in early 2016. The Secretary-General set out his observations on the Panel's recommendations in his report entitled "Strengthening the global health architecture: implementation of the recommendations of the High-level Panel on the Global Response to Health Crises" (A/70/824).

2. The Secretary-General established the Global Health Crises Task Force for a one-year period from 1 July 2016 to 30 June 2017. The purpose of the Task Force was to monitor, coordinate and support the follow-up and implementation of the recommendations of the Panel. The Task Force comprised 15 members, including three co-leads, namely, the Deputy Secretary-General, the Director General of the World Health Organization (WHO) and the President of the World Bank Group.[1] The Task Force and its secretariat received financial support from the Governments of Germany and Norway and the United Nations Trust Fund for Human Security.[2]

3. The Task Force held meetings every quarter: in total, four teleconferences and two face-to-face meetings were held. The Task Force also prepared quarterly reports to highlight progress on the Panel's recommendations. The quarterly reports and the summaries of the meetings can be found on the website of the Task Force.[3]

4. In the course of the year, the Task Force focused on ways in which health crises could be better anticipated and a dependable response could be assured. The Task Force highlighted positive developments, identified vulnerabilities, located bottlenecks to implementation and made proposals for improvements. The Task Force sought to catalyse action on the Panel's recommendations. At the same time, it enhanced the preparedness and capability of the United Nations.

II. Progress in advancing health security

5. In monitoring the implementation of the Panel's recommendations, the Task Force considered each recommendation individually. A document setting out the details of progress made on the 27 recommendations will be made available on the website of the Task Force.

6. At the same time, the Task Force was of the view that it would be useful to focus on priority areas relevant to advancing health security. The term "health security", as used in this context, refers to the range of conditions that need to be in place to ensure individual and collective health by preparing for, preventing and responding to health threats of animal and human origins. These conditions include, but are not limited to, compliance with the International Health Regulations (2005), access to health services and medicines, functioning health systems and strong health workforces.

[1] The composition of the Task Force is annexed to the present report.

[2] The members of the Task Force were reimbursed for their travel to meetings of the Task Force only when it was not otherwise covered by their respective entities and not prohibited by the rules of their employers.

[3] See www.un.org/en/global-health-crises-task-force/index.html.

7. The Task Force identified the following nine priority areas of work on preparing for, preventing and responding to health crises:

(a) Strategic support for national health systems;

(b) Integrating communities and civil society organizations;

(c) Supporting regional arrangements;

(d) Strengthening United Nations system capacity;

(e) Testing capacities and processes through simulations;

(f) Catalysing focused research and innovation;

(g) Securing sustainable financing for health security;

(h) Focusing attention on the gender dimensions of health crises;

(i) Ensuring health security remains prioritized on national and global political agendas.

8. Significant developments from January 2016 to May 2017 in those areas are set out below.

A. Strategic support for national health systems

9. The Panel recommended that States achieve full compliance with the core capacity requirements in the International Health Regulations and that WHO strengthen its periodic review of such compliance (see A/70/723, recommendations 1 and 6).

10. One key achievement has been the development by WHO of a new International Health Regulations monitoring and evaluation framework. The framework consists of four components: annual reporting to the World Health Assembly; after-action review; simulation exercises; and voluntary joint external evaluations.

11. The joint external evaluations have introduced more objectivity, depth and transparency in the assessment of national core capacities. As at 9 June 2017, 44 countries had completed an evaluation, 29 countries were scheduled for the evaluations and another 23 countries had expressed an interest in the evaluations. The evaluation teams — composed of experts from Member States, WHO and other international organizations — conduct the evaluations in close collaboration with national authorities across ministries. The reports are posted in full online. Importantly, the joint external evaluations are linked to the evaluations by the World Organization for Animal Health of animal health systems and the gaps identified are addressed in costed national action plans for health security ("national health action plans").

12. Through the composition of the joint external evaluation teams and the conduct of the evaluations, multisectoral collaboration has been embedded as a standard way of working. The Task Force welcomes this new framework and appreciates its application. The Task Force encourages the systematic integration of animal health experts and civil society organizations in the International Health Regulations monitoring and evaluation framework to promote the "One Health" approach and to highlight the critical importance of community engagement.

13. The Task Force welcomes the substantial progress made with the introduction of the voluntary joint external evaluations. However, it is not enough just to diagnose the problems; they must be remedied. Gaps identified in the evaluations,

as well as in after-action reviews and simulation exercises, need to be prioritized and incorporated within the national health action plans and addressed through the provision of technical and financial assistance to the country. As at 9 June 2017, country planning missions to develop national health action plans had been completed in 3 countries and are planned in 21 countries. The Task Force stresses the importance of completing costed national health action plans promptly and making available financial and technical support. Countries need to be motivated to report accurately on their capacities. One important incentive is to ensure that financing for health systems is both prioritized within domestic budgets and supplemented, as needed, by external partners.

14. The Task Force stresses the importance of promoting a culture in which national authorities adopt travel and trade measures consistent with the International Health Regulations and on the basis of the evidence of what is needed to address the spread of disease, thus avoiding undue adverse consequences for travel and trade. The WHO secretariat will reinforce the current process for monitoring travel and trade measures by posting the measures and the rationale provided by Member States on the WHO website. The Task Force considers that the public posting of this information could be useful in promoting greater transparency and accountability. WHO will be working with the World Trade Organization to develop dispute resolution mechanisms that can be invoked if a country considers that disproportionate measures have been imposed. The Task Force considers that work on these mechanisms needs to advance more rapidly.

15. The Task Force notes that the strengthening of national health systems and cross-sectoral response capacities should also address the vulnerabilities faced by children. The systematic collection of age- and sex-disaggregated data in national surveillance systems and in the monitoring of interventions is critical to understanding risks specific to children, the impact of the disease and the efficacy of interventions. Risk and vulnerability assessments should also consider the indirect impact of the disease outbreak on children.[4] In addressing the specific needs and vulnerabilities of children during large-scale outbreaks, it is critical to have cross-sectoral engagement.

16. The Panel highlighted the need to invest in the training of health workers so they are better able to respond to crises (ibid., recommendation 2). The report of the Secretary-General's High-level Commission on Health Employment and Economic Growth, issued in September 2016, concluded that investing in the health workforce is needed to make progress towards the Sustainable Development Goals, including gains in health, decent work, global security and inclusive economic growth.[5] A five-year action plan to support country-driven implementation of the Commission's recommendations has been developed by WHO, the Organization for Economic Cooperation and Development and the International Labour Organization.

17. Building and maintaining a strong health workforce requires the protection of the safety and security of health workers. In May 2016, the Security Council unanimously adopted its resolution 2286 (2016), its first resolution to address the protection of medical and humanitarian personnel engaged in medical duties during situations of armed conflict. In the resolution, the Council strongly condemned attacks against the wounded and sick, medical personnel, humanitarian personnel

[4] Such impact includes being at risk of violence, exploitation and abuse; loss of access to services resulting from the death or hospitalization of a parent or caregiver; and loss of access to education.

[5] World Health Organization, *Working for health and growth: investing in the health workforce. Report of the High-level Commission on Health Employment and Economic Growth* (Geneva, 2016).

engaged in medical duties, and medical facilities, transport and equipment. In a letter dated 18 August 2016 addressed to the President of the Security Council, the Secretary-General provided the Council with recommendations on measures to prevent attacks, better ensure accountability and enhance the protection of health-care personnel and facilities (see S/2016/722). Unfortunately, in a report issued in May 2017, the Safeguarding Health in Conflict Coalition concluded that "in the months since the passing of resolution 2286, attacks on hospitals dramatically escalated in Syria and continued without respite in other parts of the world".[6] The Task Force considers that the recommendations of the Secretary-General in his letter of 18 August 2016, as well as those in the report of the Safeguarding Health in Conflict Coalition, deserve urgent attention.

18. The issue of security for health workers has also been highlighted by the Global Outbreak Alert and Response Network.[7] Robust security systems and capacity are critical for the Network's operations and for a strong operational platform for WHO that can support countries and coordinate an international response. Security capability for emergencies must ensure safe and enabling operating environments. Security should be central to the planning, assessment and coordination of international responses, and staff safety must be a critical consideration for all operations. Safety for health-care workers also requires investment in adequate supplies of personal protective equipment and infection control training. During outbreaks, health-care facilities can serve to amplify the spread of infection. Losing health workers not only erodes capacity but undermines public confidence and staff morale. Health-care workers need to be prioritized for available countermeasures during outbreaks.

19. The Panel recommended that Governments establish and train emergency workforces (see A/70/723, recommendation 1). The WHO emergency medical teams initiative has contributed to these efforts through its work to ensure quality assurance, coordination and accountability of deployable national and international emergency medical teams. Building on this work, the Global Outbreak Alert and Response Network will be launching a public health rapid response team initiative.

20. Advancing health security requires more than just ensuring capacity to respond to health threats. Resilience-building and preparedness are essential to preventing health threats from developing into large-scale health emergencies. For that reason, the Task Force welcomes the Bangkok Principles for the implementation of the health aspects of the Sendai Framework for Disaster Risk Reduction 2015-2030, adopted in March 2016.

21. Another important area of ongoing work on preparedness relates to the development of the pandemic supply chain network, launched by the World Food Programme with other partners. The network aims to address a critical area of vulnerability in pandemic preparedness, namely, the supply chain and logistics to facilitate the timely delivery of supplies to treat patients and protect health workers. Through the network, public and private sector partners will collaborate on identifying supply sources for critical response items, mapping transport routes and developing an information platform to give countries and emergency coordinators a real-time view of the availability and location of response items.

[6] Safeguarding Health in Conflict Coalition, "Impunity must end: attacks on health in 23 countries in conflict in 2016". Available from www.safeguardinghealth.org/sites/shcc/files/SHCC2017final.pdf.

[7] The specific recommendations proposed by the Global Outbreak Alert and Response Network at a workshop on Ebola response and security, held in Guinea in August 2016, are detailed in the annex to the final report, entitled "Progress on the 27 recommendations of the High-level Panel", under recommendation 1.4.

22. Another logistical bottleneck that needs to be addressed in advance of an emergency is the streamlining of customs processing. Often, emergencies lead to an influx of unwanted donations: for example, following the earthquake in 2010, Haiti received 10 containers of refrigerators operating on an unusable voltage. The Office for the Coordination of Humanitarian Affairs of the Secretariat and the United Nations Conference on Trade and Development have designed an automated system for relief emergency consignments (ASYREC) to expedite the processing of relief items by customs authorities during emergencies. Prior to an emergency, ASYREC will enable customs authorities to take preparatory steps, such as establishing streamlined customs procedures and pre-registering humanitarian partners. During an emergency, national disaster management authorities can use ASYREC to list priority relief items and the required quantities, and fast-track the processing of relief items once they arrive. The Office plans to introduce ASYREC in a few pilot countries by mid-2017 and aims to launch the platform by the end of 2017. The Task Force welcomes the development of ASYREC to address the persistent problem of unsolicited shipments during emergencies and delays owing to customs formalities. Broad adoption of the ASYREC platform by all countries is critical, since any country is potentially vulnerable to natural disasters and health emergencies.

23. The Panel considered that there is a "close relationship between compliance with the IHR core capacity requirements and the wider improvement of health systems" (ibid., para. 132). The International Health Partnership (IHP+), established in 2007 to promote more effective development cooperation in health, has been adjusted to focus on health systems strengthening towards achieving universal health coverage by 2030. In September 2016, the new International Health Partnership for UHC2030 was announced by the Director General of WHO. Guidance on strengthening health systems for countries involved in UHC2030 should help to support the development of the core capacities under the International Health Regulations.

B. Integrating communities and civil society organizations

24. The Task Force stresses that community engagement deserves greater emphasis before and during outbreaks to ensure that preparedness and response activities are culturally sensitive and better understood and meet the needs of the people concerned. The protection of individuals from health threats through community involvement is at the core of resilience and human security. It is essential to have meaningful engagement with communities in the design, implementation and evaluation of health programmes. Communities can be involved in surveillance, prevention, early response and the 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, including integration into the joint external evaluations and costed national action plans, will need investment.

25. The Task Force welcomes three notable developments in the promotion of community engagement in health:

(a) A communication and community engagement initiative was formally established in early 2017, with a secretariat hosted by the United Nations Children's Fund (UNICEF). The initiative will develop mechanisms to provide affected communities with information, to establish channels for communities to provide feedback on humanitarian actions and to ensure that decision-making processes are informed by constructive engagement with communities. The initiative is participating in the development of training modules for emergency medical teams;

(b) UNICEF and the Institute of Development Studies at the University of Sussex, United Kingdom of Great Britain and Northern Ireland, established a secretariat for a global partnership to carry out research on effective community engagement and risk communication needs. The partnership will aim to generate knowledge and summarize research on community engagement and building resilience in humanitarian contexts, including public health emergencies. It will also synthesize research on cultural practices and communities to guide response and recovery efforts, and develop a network of social science researchers who can be deployed during an emergency. The Task Force considers that learning from the work of the global partnership should inform the joint external evaluations and country action plans;

(c) The WHO research and development blueprint has published guidance on good community engagement practices for conducting clinical research in emergencies.[8]

C. Supporting regional arrangements

26. The Panel recommended that regional and subregional organizations develop or strengthen standing capacities to monitor, prevent and respond to health crises, supported by WHO (ibid., recommendation 5). The Task Force supports regional initiatives while encouraging country-centred approaches with good regional coordination.

27. To support regional capacities, the WHO emergency medical teams initiative has been partnering with regional arrangements, such as the European Union, the Association of Southeast Asian Nations and the African Union. WHO is training regional experts on coordinating arriving emergency medical teams and public health teams. The Global Outbreak Alert and Response Network has held regional meetings in Europe and the Middle East and has implemented international training courses for regional response capacity in the Americas and the Middle East. In Africa, WHO co-hosted the West African Regional Conference on One Health in November 2016, in collaboration with the Economic Community of West African States and others to bring together ministers from various sectors to address zoonotic diseases. The Africa Centres for Disease Control and Prevention was formally launched in January 2017, with John Nkengasong named as its first director. WHO has signed a framework for collaboration with the African Union on the Centres to improve health security, and the Centres are now a partner in the Global Outbreak Alert and Response Network.

28. In March 2017, a subregional action plan to implement the recommendations of the High-level Commission on Health Employment and Economic Growth was adopted at a meeting of health and labour ministers of the West African Economic and Monetary Union. The action plan includes the revision of macroeconomic policy constraints on investments in the health workforce to create decent jobs, accelerated expansion and transformation of the education and training of health workers and coordinated strategies to develop emergency medical teams with the Economic Community of West African States. The regional action plan will be discussed at a meeting of labour and finance ministers in July 2017, in which health ministers will participate for the first time.

[8] Catherine Hankins, “Good participatory practice guidelines for trials of emerging (and re-emerging) pathogens that are likely to cause severe outbreaks in the near future and for which few or no medical countermeasures exist: outcome document of the consultative process”. Available from www.who.int/blueprint/what/norms-standards/GPP-EPP-December2016.pdf?ua=1.

29. In June 2016, the World Bank Group approved $110 million in International Development Association financing to strengthen disease surveillance systems in Guinea, Senegal and Sierra Leone. This initiative is part of the Regional Disease Surveillance Systems Enhancement programme, which aims to address systemic weaknesses within the human and animal health sectors that hinder effective disease surveillance and response. The second phase of the programme was approved in March 2017 for Guinea-Bissau, Liberia, Nigeria and Togo for a total of $140 million. The third phase of the project will cover Benin, Mali, Mauritania and the Niger (and possibly additional countries) and is expected to be approved in February 2018.

30. As recommended by the International Working Group on Financing Preparedness (see para. 69 below), attention to the sustainable financing of regional networks is critical insofar as the regional networks must develop a system for securing national contributions from network members in order to remain viable beyond initial contributions from donors.

D. Strengthening United Nations system capacity

31. The United Nations system, including WHO, must have the capacity to support countries in strengthening their health systems, preparing for health emergencies and responding to health threats. The Task Force is pleased to see the significant developments described below in augmenting United Nations system capacity over the past year.

1. World Health Organization Health Emergencies Programme

32. The Panel recommended that WHO strengthen its leadership and establish a unified, effective operational capacity (see A/70/723, recommendation 7).

33. In May 2016, the World Health Assembly endorsed the establishment of the Health Emergencies Programme to add operational capabilities for outbreaks and humanitarian emergencies to complement the traditional technical and normative roles of WHO. The Programme is headed by an Executive Director, Peter Salama, who commenced his functions in July 2016. The ultimate authority for the management of emergencies at WHO will rest with the Director General. This authority will be delegated by the Director General to:

(a) The Executive Director, in the case of major outbreaks and health emergencies, including Grade 3 events, public health emergencies of international concern and level 3 emergencies under the Inter-Agency Standing Committee;

(b) Either the Executive Director or the relevant Regional Director, in the case of Grade 2 events, depending on the nature of the threat and the capacity and capabilities of the countries concerned;

(c) The relevant Regional Director, in the case of Grade 1 events.

34. To ensure a rapid response to outbreaks, the Programme will initiate an assessment on the ground 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. Partners of the Global Outbreak Alert and Response Network may be activated to support risk assessment and early response, including by laboratory confirmation, epidemiological investigations and the activation of relevant technical networks. 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 Programme on risk mitigation, management and/or response measures, as appropriate.

35. Achievements of the Programme to date have included:

(a) Rolling out the early warning, alert and response system in 56 health facilities in Borno State, Nigeria;

(b) Deploying mobile health clinics to the city of Qayyarah, Iraq, which had been under the control of Islamic State in Iraq and the Levant from June 2014 to August 2016;

(c) Delivering 11 tons of medical supplies to health authorities in the north-eastern part of the Syrian Arab Republic;

(d) Supporting the medical evacuation of residents from eastern Aleppo, Syrian Arab Republic;

(e) Deploying vaccines to respond to the yellow fever outbreaks in Brazil and elsewhere;

(f) Supporting vaccination campaigns in Benin, Cameroon, the Niger, Nigeria and Yemen;

(g) Rolling out community health services in South Sudan;

(h) Expanding mental health-care services in the Syrian Arab Republic.

36. To provide ongoing oversight of the development of the Programme, the Director General of WHO established the Independent Oversight and Advisory Committee for four years. The main functions of the 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.[9] During its first year of work, beginning in May 2016, the Committee held eight meetings and conducted field visits to Colombia, north-eastern Nigeria and Iraq.

37. In its reports to the WHO Executive Board and the World Health Assembly, the Independent Oversight and Advisory Committee expressed the view that the implementation of the Programme has significantly advanced, with particular progress in protracted emergencies. Improvements were observed specifically in the health cluster coordination and leadership of WHO and its effectiveness on the ground. In-country partners acknowledge encouraging signs in the WHO field presence and partnership engagement, and their expanded role in humanitarian crises. However, the Committee expressed concern that business processes have not developed at the pace of the Programme and are not sufficiently supporting the Programme, and that there remain constraints in the organizational culture regarding the adoption of a "no regrets policy". The Committee stressed the importance of establishing a baseline level of emergency operational and management capacity at the country level, and reiterated its concerns that the Programme is underfunded and the significant progress to date is seen as fragile.

38. The Task Force observes with satisfaction the development of the Programme and is impressed by the rigorous monitoring of the Programme by the Independent Oversight and Advisory Committee. The Task Force shares the concern of the Committee that inadequate financing threatens to undermine the progress made by the Programme. It will be important to monitor the implementation of the Programme and see whether the financing enables the Programme to be sustainable in the long term. The Task Force stresses that collaboration between the agencies addressing human health (WHO) and animal health (the World Organization for Animal Health and the Food and Agriculture Organization of the United Nations

[9] See www.who.int/about/who_reform/emergency-capacities/oversight-committee/en/.

(FAO)) is particularly important in view of the number of emerging threats that are of zoonotic origin. The Task Force cautions against strengthening capacity only during emergencies. The United Nations system needs to build capacity for preparation and demonstrate commitment and attention to global health at the highest levels of senior leadership in the United Nations system.

2. Adoption of Inter-Agency Standing Committee procedures on activation during infectious disease events

39. The Panel recommended that trigger systems for health and humanitarian crises be integrated and that the processes for activating lines of command during a Grade 2 or Grade 3 outbreak be clarified (ibid., recommendations 8 and 9). The Task Force notes real progress in this area.

40. The Inter-Agency Standing Committee provides an important platform for United Nations and non-United Nations stakeholders involved in humanitarian action to come together. The activation of the Inter-Agency Standing Committee system in humanitarian crises is governed by a protocol on humanitarian system-wide emergency activation.[10] Given the specific requirements of mobilizing during infectious disease events, WHO and the Committee developed the level 3 activation procedures for infectious disease events,[11] which were endorsed by the Committee principals in December 2016. Both protocols are designed to ensure effective mobilization across the Inter-Agency Standing Committee community, to include the immediate deployment of surge capacity and activation of appropriate field-level leadership and coordination arrangements. The new activation procedures establish a link between the responsibilities of WHO and its Director General under the International Health Regulations and the capacities and emergency response tools of the Committee. The new activation procedures also provide an opportunity for actors not on the Committee, including the Chair of the Global Outbreak Alert and Response Network Steering Committee, to feed into decision-making on activation and on the response strategy.

41. The Inter-Agency Standing Committee procedures for infectious disease events will be tested in a simulation to be conducted among the Committee principals in the latter part of 2017. The Task Force considers that the future success of this mechanism is extremely important and the roles of the WHO Director General and the Emergency Relief Coordinator will be critical.

3. Improved information coordination on health threats within the United Nations system

42. The Task Force notes that the processes for information coordination on health threats have improved with the issuance of the new WHO Emergency Response Framework in April 2017, the upgraded role of the United Nations Operations and Crisis Centre in reporting on health threats within the United Nations system and the improved coordination of communications on health crises by the Department of Public Information of the Secretariat, working together with WHO.

43. The WHO Emergency Response Framework provides guidance on how WHO manages the assessment and grading of and the response to public health events and

[10] Inter-Agency Standing Committee, “Humanitarian system-wide emergency activation: definition and procedures” (PR/1204/4078/7). Available from https://interagencystandingcommittee.org/system/files/legacy_files/2.%20System-Wide%20%28Level%203%29%20Activation%20%2820Apr12%29.pdf.

[11] Inter-Agency Standing Committee, “IASC level 3 activation procedures for infectious disease events”. Available from https://interagencystandingcommittee.org/principals/documents-public/final-iasc-system-wide-level-3-l3-activation-procedures-infectious.

emergencies. When conducting a risk assessment, WHO engages a range of partners, including FAO, the World Organization for Animal Health and members of the Inter-Agency Standing Committee. The results of a risk assessment are communicated by the WHO Regional Emergency Director to the Executive Director of the WHO Health Emergencies Programme. All high-risk events are referred for grading within 24 hours. The Director General promptly notifies the Secretary-General of health events graded at levels 2 and 3. This notification is also sent to the Emergency Relief Coordinator and the Resident Coordinator of the affected country.

44. Upon receipt of those notifications, the Secretariat further circulates the information to relevant offices in the United Nations system, including the United Nations Operations and Crisis Centre. The Centre is mandated to serve as an enhanced and integrated information and crisis hub working to collate and consolidate timely and accurate information from across the United Nations system. In addition to disseminating information about graded health events, the Centre works with WHO to circulate information on reports of disease outbreaks. The Centre can ensure that information is brought to the attention of the Secretary-General promptly, if needed, so that he can act on this information in conjunction with the Director General of WHO and other senior officials in the United Nations system.

45. The Department of Public Information is responsible for providing support and guidance to the United Nations system on communications issues during health crises. Since November 2016, the Department and WHO have convened a regular conference call, which serves as a platform for coordination on communications by the United Nations system on health crises. Frequent participants include the World Bank Group, the United Nations Development Programme, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and the United Nations Foundation. The Task Force recommends that the World Organization for Animal Health and FAO also be regular participants.

4. United Nations Children's Fund health emergencies preparedness initiative

46. In September 2015, UNICEF launched a health emergencies preparedness initiative to strengthen the organization's capacity to respond to public health emergencies, from preparation to response, linking to recovery and building resilience, and to serve as an effective partner to national Governments, WHO and others. For selected diseases, the initiative has developed cross-sectoral guidance, tools and resources, including supply requirements and pre-positioning of stock for the highest priority diseases, and human resources guidance. These products will be made available for use and adaptation by partners.

E. Testing capacities and processes through simulations

47. The Panel considered that an important component of preparedness is the conduct of simulations for all relevant responders, at all levels (ibid., recommendations 1 and 5).

48. Country-level simulation exercises are one of the four components of the International Health Regulations monitoring and evaluation framework. Since 2016, 33 emergency preparedness exercises have been conducted in 18 countries. In February 2017, WHO published a simulation exercise manual to provide guidance

on planning, conducting and evaluating simulation exercises for outbreaks and public health emergency preparedness and response.[12]

49. The WHO emergency medical teams initiative has been working with the International Search and Rescue Advisory Group secretariat within the Office for the Coordination of Humanitarian Affairs to include the testing of health capacities in regional simulation exercises. Emergency medical teams participated in regional simulation exercises conducted by the Advisory Group in Europe, Asia and the Americas in 2016.

50. Simulations have featured prominently in meetings of intergovernmental entities or other forums. During its annual meeting in October 2016, the World Bank Group conducted a simulation exercise on pandemic preparedness for ministers of finance and policymakers, which promoted awareness about the economic impacts of pandemics and generated discussion on the roles of ministries of finance in supporting relevant sectors to strengthen pandemic preparedness. In January 2017, at the World Economic Forum meeting in Davos, Switzerland, a pandemic simulation involving 30 chief executive officers from the private sector was co-organized by the World Bank Group and the Forum. The chief executive officers acknowledged that developing preparedness and response capacity requires global collaboration across different private sector partners. A simulation exercise was also conducted at the first meeting of health ministers of the Group of 20 countries, held in Berlin in May 2017.

51. The Task Force would like to see more widespread use of simulation exercises to sensitize senior leaders and other decision makers to the importance of integrating pandemic preparedness in their operational planning. Simulations need to be conducted in different settings, at all levels (local, national, regional and global) and across countries. The Task Force stresses the critical importance of bringing together all stakeholders in country-level simulations. Involving the private sector, civil society organizations, the United Nations and national Governments in simulations will help to clarify the respective roles of different partners and identify gaps in country-level coordination in the future. Simulations should not be an end in themselves; rather, where feasible and appropriate, the outcomes of the simulations should be reported, with lessons learned and follow-up.

F. Catalysing focused research and innovation relevant to global health crises

52. The Panel recommended that WHO coordinate the prioritization of global research and development efforts for diseases that pose the greatest threat (ibid., recommendation 13).

53. The framework for the work of WHO in research and development is set out in "An R&D blueprint for action to prevent epidemics: plan of action",[13] which was welcomed by the World Health Assembly in May 2016 and further discussed in May 2017. The blueprint focuses on three sets of activities: (a) assessing epidemic threat and defining priority pathogens; (b) developing research and development road maps to accelerate evaluation of diagnostics, therapeutics and vaccines; and

[12] World Health Organization, document WHO/WHE/CPI/2017.10. Available from http://apps.who.int/iris/bitstream/10665/254741/1/WHO-WHE-CPI-2017.10-eng.pdf?ua=1.

[13] World Health Organization, "An R&D blueprint for action to prevent epidemics: plan of action" (Geneva, 2016). Available from www.who.int/blueprint/about/r_d_blueprint_plan_of_action.pdf?ua=1.

(c) outlining appropriate regulatory and ethical pathways. The Task Force commends WHO for the substantial progress made in each of these areas.

1. Prioritizing diseases and coordinating research and development efforts

54. A methodology for prioritizing diseases for research and development was first developed by a group of experts convened by WHO in December 2015 and revised in February 2017. A list of prioritized diseases and pathogens will be reviewed and revised on an annual basis using the methodology. Between annual prioritization exercises, an unusual outbreak may be reviewed and prioritized, if needed. It is anticipated that the prioritization methodology will be reviewed again before the end of 2019.

55. Of the nine diseases that have been prioritized for urgent research and development attention, shown in the table below, target product profiles for medical countermeasures have been developed.

Diseases prioritized for urgent research and development attention and their target product profiles

	Target product profiles	
	Vaccines	*Diagnostics*
1. Arenaviral haemorrhagic fevers, including Lassa fever	Apr. 2017[a]	–
2. Crimean-Congo haemorrhagic fever	–	–
3. Filoviral diseases (including Ebola and Marburg)	Nov. 2016[b]	Oct. 2014 (Ebola)[b]
4. Middle East respiratory syndrome coronavirus	May 2017[b]	–
5. Other highly pathogenic coronaviral diseases (such as severe acute respiratory syndrome)	–	–
6. Nipah and related henipaviral diseases	Mar. 2017[a]	–
7. Rift Valley fever	–	–
8. Severe fever with thrombocytopenia syndrome	–	–
9. Zika	Feb. 2017[b]	Apr. 2016[b]

[a] Date of latest public consultation on draft.
[b] Date of latest draft of target product profiles.

56. The Task Force welcomes the development of the blueprint by WHO and the WHO collaboration with the Coalition for Epidemic Preparedness Innovations. Launched in Davos in January 2017, the coalition aims to advance the development of vaccines to the stage at which they are ready for full trials or emergency use when needed. It will manufacture and stockpile these vaccines, provide a global hub to coordinate vaccine development and partner with organizations that can help reach target populations. The coalition seeks to raise $1 billion for its first five years and has received an initial investment of $460 million from governments and philanthropic organizations.

57. While recognizing the importance of establishing a list of priority diseases, the Task Force also emphasizes that the prioritization of certain pathogens should not have the effect of restricting research on pathogens that may not yet be recognized

as potential disease outbreaks. The broader development and support of translatable platform technologies for diagnostics, vaccines and therapeutics is also important.

58. While the Panel had recommended that WHO oversee the establishment and management of a fund of at least $1 billion, the Task Force notes that presently there are a number of initiatives and entities already involved in the financing of research and development of vaccines, therapeutics and diagnostics. The Task Force endorses the role of funding agencies and organizations with extensive experience in supporting and managing research activities to continue to fulfil this responsibility. However, the Task Force considers that the role of funding research would not be suitable for WHO. WHO plays an important role in convening and coordinating partners to align with common priorities, ensure that efforts are not duplicated and flag areas where increased research and development efforts are needed for particular pathogens or products. The Task Force recognizes that convening and coordination activities at WHO should be funded to ensure that efforts by the Coalition for Epidemic Preparedness Innovations and other new development initiatives provide optimal value for money. In coordinating research and development, WHO should also promote a One Health approach.

2. Outlining regulatory and ethical pathways

59. In October 2016, WHO issued its *Guidance for managing ethical issues in infectious disease outbreaks*,[14] in which it recognized that decisions during an outbreak often need to be made urgently and in the context of scientific uncertainty and social and institutional disruption. Some of the challenges addressed in the *Guidance* relate to allocating scarce resources, conducting public health surveillance, restricting freedom of movement, administering medical interventions, storing biological specimens, deploying foreign humanitarian aid workers and conducting research during infectious disease outbreaks.

60. In May 2017, WHO announced that major funders of medical research and international non-governmental organizations had agreed to require that all trials they fund, co-fund, sponsor or support be registered in a publicly available registry, such as the WHO International Clinical Trials Registry Platform. Moreover, all results of such trials would need to be disclosed within specified time frames in the registry and/or by publication in a scientific journal. The Task Force supports this significant move towards increasing transparency in clinical trial research and hopes that it will provide a basis for the development of a more comprehensive set of guidelines for data-sharing during emergencies.

61. In late 2016, the International Conference of Drug Regulatory Authorities met in South Africa, bringing together over 360 delegates from national regulatory authorities. The Conference recommended that WHO develop guidance and facilitate dialogue on regulatory pathways, platform technologies and trial designs for products to counter emerging infectious disease pathogens, while taking care to ensure that such guidance covers pregnant women, children and other vulnerable populations. The Task Force encourages WHO to share a plan and timeline for these work streams.

62. In March 2017, WHO, the Wellcome Trust and Chatham House met to discuss the terms of reference for a global coordination mechanism for research and development preparedness. The mechanism aims to provide a high-level discussion platform and framework for key partners to address global research and

[14] World Health Organization, *Guidance for managing ethical issues in infectious disease outbreaks* (Geneva, 2016). Available from http://apps.who.int/iris/bitstream/10665/250580/1/9789241549837-eng.pdf.

development challenges during epidemics. The mechanism has established working groups to focus on data-sharing, regulatory pathways, the streamlining of ethical reviews and Zika vaccine clinical trials. The Task Force considers that the mechanism will play a critical role in stimulating the development of vaccines, treatments and diagnostics for priority diseases and new zoonoses.

63. The Task Force recognizes the difficulties encountered with testing medical countermeasures quickly when a disease outbreak occurs, which underscore the need to build trust in communities and in countries. The Task Force stresses that the development of local research capacity and the engagement of local researchers and communities as full and equal partners in the design, conduct, and analysis of clinical studies are vital to fostering the trust needed to conduct clinical trials and other research activities.

3. Expanding the Pandemic Influenza Preparedness Framework to include other novel pathogens

64. The Panel recommended that WHO convene its member States to "renegotiate the Pandemic Influenza Preparedness Framework with a view to including other novel pathogens" (ibid., recommendation 15).

65. A Pandemic Influenza Preparedness Framework review group was established in December 2015 to conduct the first review of the Framework after it had been implemented for five years. In its report to the WHO Executive Board, the review group noted that it had declined to proceed as recommended by the Panel. The review group explained that the success of the Framework had "much to do with the uniqueness of the influenza virus itself — it mutates frequently and, because of the need for updated seasonal influenza vaccines, has a continuous product cycle, which therefore results in a consistent income stream for manufacturers ... There is also a strong, established network of laboratories in GISRS, monitoring influenza, which provided the foundation for the PIP Framework."[15]

66. Noting that those conditions are not in place for other pathogens, the review group concluded that the "PIP Framework is a foundational model of reciprocity for global public health that could be applied to other pathogens; however, the current scope of the PIP Framework should remain focused on pandemic influenza at this time". It also recommended that the Framework be reviewed before the end of 2021.[16] The recommendations of the review group were commended by the World Health Assembly in May 2017. While noting the review group's observation that the success of the Framework was linked to the particular characteristics of the influenza virus, the Task Force shares the view that it would be desirable to use the Framework as a model for other pathogens.

G. Securing sustainable financing

67. The Task Force is deeply concerned that public funds for maintaining health security at the national, regional and global levels continue to be a fraction of what is needed.

1. National and regional levels

68. The eighteenth cycle of the World Bank fund for the poorest countries, the International Development Association, will begin on 1 July 2017. International Development Association 18 explicitly supports the capacity of Governments to

[15] World Health Organization, document EB140/16, annex I.
[16] Ibid.

prepare for and respond to pandemics. A minimum of 25 countries will be supported in developing and implementing pandemic plans and frameworks for governance, institutional arrangements and financing for multisectoral pandemic preparedness, response and recovery. International Development Association 18 also avails itself of a new instrument, the catastrophe deferred drawdown option, which allows for countries to access contingency financing for emergencies, including health crises.

69. In November 2016, the International Working Group on Financing Preparedness was established under the chairmanship of Peter Sands, with the World Bank serving as its secretariat. In its report,[17] presented at the seventieth World Health Assembly, in May 2017, the Working Group observed that despite several recent deadly outbreaks, the overwhelming majority of countries are unprepared for the next devastating epidemic. Noting the low priority given to investing in strengthening preparedness and building resilience in most low-income countries, the Working Group issued 12 bold yet practical recommendations directed at incentivizing and channelling investments to strengthen public health capacities and capabilities. Using joint external evaluations to better understand current gaps in country capacities, the Working Group directs countries to practical costing and financing tools designed to help Governments quantify resource needs and identify ways of raising the resources needed. Emphasizing the importance of domestic resource mobilization for strengthening preparedness, the Working Group exhorts countries to strengthen tax collection and allocate more resources to investments in strengthening country health and disaster management systems, and calls upon development partners to leverage external assistance to increase domestic financing for preparedness. The Working Group recognizes the potential of the private sector to be a strategic partner in the country's preparedness efforts and underscores the importance of enabling regulations to strengthen public-private collaboration. Finally, the Working Group identifies several incentives, including development of country preparedness indexes, which could play a critical role in placing pandemic risks at the same level as financial risks and terrorism threats.

70. In May 2016, at the meetings of the Group of Seven, held in Ise-Shima, Japan, the World Bank announced the creation of a new financing mechanism, the Pandemic Emergency Financing Facility, which will provide surge financing to International Development Association countries affected by a major outbreak that has the potential to become a pandemic. One component of the Facility involves private sector contingency financing — "an insurance window" — to respond to known pathogens with pandemic potential, including orthomyxoviruses, filoviruses, coronaviruses and other zoonotic diseases (Crimean-Congo, Rift Valley and Lassa fevers). The Facility also includes contingency financing through a cash window to respond to other known and unknown diseases that may have the potential to take on pandemic proportions. The Facility will be able to disburse surge financing during an outbreak both to affected countries and to accredited international responders, such as WHO, UNICEF and the World Food Programme, among others. The Facility is governed by a steering body that includes its financial contributors (Germany and Japan), the World Bank Group as trustee, WHO and stakeholder countries. Following the first meeting of the steering body in late June 2017, the Facility will open its insurance window in July 2017 and its cash window in January 2018.

71. The Task Force acknowledges that while the Pandemic Emergency Financing Facility will play a key role in the future outbreak response, it is only one

[17] World Bank Group, *From panic and neglect to investing in health security: financing pandemic preparedness at a national level* (Washington, D.C., 2017). Available from http://documents.worldbank.org/curated/en/979591495652724770/From-panic-and-neglect-to-investing-in-health-security-financing-pandemic-preparedness-at-a-national-level.

component of a broader comprehensive solution to the needs of pandemic response financing. The Task Force recommends that the Facility be complemented by other financing mechanisms to help countries prepare for and respond to health emergencies.

72. The Task Force emphasizes that the engagement of finance ministers is key to attracting attention to health issues within Governments. The integration of health crises preparedness into assessments by the International Monetary Fund of a country's economic and financial development 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 highlighted consistently. The Task Force emphasizes that regional banks also need to 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.

2. Global level

73. The Panel recommended that assessed contributions to the WHO budget be increased by at least 10 per cent and the WHO Contingency Fund for Emergencies be financed at $300 million so that it could be made available for use by Health Cluster members (ibid., recommendations 18 and 20).

74. In May 2016, the World Health Assembly authorized the Director General of WHO to mobilize voluntary contributions for the Health Emergencies Programme. While $80 million has been reallocated from the WHO regular budget to the Programme, it continued to face a gap of 29 per cent as of June 2017. As the Contingency Fund for Emergencies continues to face a funding gap of 63 per cent, the increase of the Fund to $300 million proposed by the Panel, although warranted, appears to be unachievable.

75. In January 2017, the Director General of WHO proposed an increase of $93 million in assessed contributions for the draft proposed programme budget 2018-2019, reflecting a 10 per cent increase in assessed contributions. The amount of assessed contributions has remained unchanged since the approval of the programme budget for 2008-2009 in May 2007. In the revised proposed programme budget submitted to the World Health Assembly, the Director General requested only a 3 per cent increase in assessed contributions. At the seventieth World Health Assembly, in May 2017, that increase was approved.

76. The Task Force considers that the willingness of member States to provide predictable and adequate financing to WHO is a key indicator of their commitment to the health security of their people. It is also critical to the success of building the capability of WHO to support countries in their capacity assessment and development with regard to the International Health Regulations.

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

77. The Panel recommended that outbreak preparedness and response efforts take into account and address the gender dimension (ibid., recommendation 4).

78. The High-level Commission on Health Employment and Economic Growth recognized that women constitute the majority of the health workforce, but that systemic gender bias and inequities in education and employment need to be addressed, including enrolment in education and training, unpaid care roles, the lack of gender-sensitive policies, pay inequity and underrepresentation in positions of

leadership and decision-making. Women in the health workforce are also at greater risk of physical and sexual violence and harassment. The five-year action plan on health employment and economic growth includes the development of global policy guidance and the acceleration of regional and national initiatives to address gender bias and inequalities in education and health labour markets. The Task Force agrees 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 the economic and social impacts on women and girls.

79. The Task Force supports the chapter in the WHO *Guidance for managing ethical issues in infectious disease outbreaks* on addressing differences based on sex and gender, noting that these differences have been associated with differences in susceptibility to infection, levels of health care received and the course and outcome of illness. Information collected by public health surveillance programmes should disaggregate information by sex, gender and pregnancy status to monitor variations in risks, modes of transmission, impact of disease and efficacy of interventions. Policymakers and outbreak responders need to pay attention to gender-related roles and social and cultural practices, including vulnerability to interpersonal violence, when developing health intervention and communications strategies.

80. An additional positive development is the establishment of a maternal and child health working group by the WHO emergency medical teams initiative to develop principles and standards of care for emergency medical teams delivering maternal and child health services. This will complement the important work already being done on maternal and child health coordinated through the health cluster.

81. UN-Women, the International Federation of Red Cross and Red Crescent Societies and the United Nations Office for Disaster Risk Reduction have jointly developed a global programme in support of a gender-responsive implementation of the Sendai Framework. Noting the higher fatality rates among women and girls in natural disasters, such as the 2008 cyclone in Myanmar and the 2014 Solomon Islands floods, the programme emphasizes the need to focus on the high and unequal risk exposure of women and girls to the impact of climate-related natural disasters and its detrimental effect on individual, household and community resilience. The Task Force encourages UN-Women, the International Federation of Red Cross and Red Crescent Societies, the United Nations Office for Disaster Risk Reduction and relevant stakeholders to ensure synergies between the programme and efforts to strengthen the health dimensions of crisis prevention, preparedness and response.

I. Ensuring health security remains prioritized on national and global political agendas

82. The Panel considered that global health crises should be elevated on the international agenda. It recommended the creation of a council of Member States within the General Assembly and the convening of a summit on global public health crises in 2018 (ibid., recommendations 26 and 27). To date, Member States have not taken a decision on the proposals for a high-level council or the 2018 summit.

83. Preparedness for global health crises has continued to be a focus of discussions in various multilateral settings. Within the United Nations system, the General Assembly has focused on health through the convening of high-level meetings (on HIV/AIDS in June 2016 and on antimicrobial resistance in September 2016), as well as informal briefings on health emergencies in June and November 2016. In May 2017, the President of the General Assembly convened an informal

briefing on a range of health issues, including health systems strengthening, health emergencies, antimicrobial resistance and non-communicable diseases. Member States welcomed the approach of discussing the various issues in a holistic rather than a fragmented manner, recognizing that these issues are interlinked.

84. A resolution on global health and foreign policy has been adopted by the General Assembly on an annual basis since 2008. Pursuant to the request of the Assembly in its resolution 70/183, the Secretary-General transmitted two reports on global health prepared by WHO in November 2016. The first report, on the state of health security (A/71/598), discussed the drivers of international health crises: infectious hazards, political instability and insecurity, attacks on health care, population displacement and migration, urbanization and shifting demographics, and changing weather patterns and other climate-related risks. The second report related to the lessons learned in the public health emergency response to and management of previous international crises with health consequences (A/71/601).

85. With regard to the Group of Seven countries, health has featured prominently on the agenda of the Group summits, and meetings of health ministers of the Group have been convened. In September 2016, the health ministers of the Group issued the Kobe Communiqué, which included commitments to take action in four areas: (a) reinforcing the global health architecture for public health emergencies; (b) attaining universal health coverage and promotion of health throughout the life course, focusing on population ageing; (c) antimicrobial resistance; and (d) research and development, and innovation.

86. In December 2016, Germany assumed the presidency of the Group of 20. For the first time, a meeting of health ministers of the Group was convened in Berlin in May 2017. The declaration of the health ministers of the Group, issued at the end of the meeting, focused on global health crises management, health systems strengthening and antimicrobial resistance. The health ministers stressed the importance of complying with the International Health Regulations, providing assistance to countries to implement the Regulations and address gaps in core capacities, reporting on health emergencies and following WHO recommendations on trade and travel.

87. The Task Force stresses the importance of political processes in determining the extent to which people enjoy health security. Engaging with political processes is essential to maintaining health security as a priority on national and global political agendas. High-level political engagement on health issues is needed to ensure that health security is recognized as a global public good and that effective financing policies are in place to make best use of available funds. Those concerned about the adequacy of financing for health security, including the United Nations, should reach out to government ministries, beyond the ministry of health; the ministries handling development, research, the environment, foreign affairs, finance and national security all need to understand that health threats will undermine national and economic security. Coordinated action across different sectors is needed to address health crises effectively. To secure the financing they need, health programmes and initiatives must be ready to be held accountable for results in order to build confidence and trust.

88. The Task Force emphasizes that effective advocacy for health cannot only rely on the utilization of the United Nations system and intergovernmental processes and focus on international organizations and Member States as the primary actors and agents of change. Advancing health security in its fullest sense means engaging all relevant stakeholders and creating an inclusive space in which all non-United Nations stakeholders and non-governmental actors can come together, contribute and be heard.

III. Future actions

89. Over the past year, the Task Force has seen significant progress in many areas highlighted in the report of the High-level Panel on the Global Response to Health Crises. Key achievements include the introduction of the joint external evaluations and other components of the International Health Regulations monitoring and evaluation framework, the establishment of the WHO Health Emergencies Programme, the issuance of the Inter-Agency Standing Committee activation procedures for infectious disease events, the launch of the Coalition for Epidemic Preparedness Innovations, the implementation of the WHO research and development blueprint, the simulation exercises at the country and global levels, the formation of the Africa Centres for Disease Control and Prevention, the operationalization of the Pandemic Emergency Financing Facility, the development of the automated system for relief emergency consignments and the establishment of the pandemic supply chain network. At the same time, many of these initiatives are in their early stages of implementation and do not represent the finalized construction of a system that is predictable, dependable and effective. While the systems for advancing health security are developing in the right direction, potential vulnerabilities in the systems on which societies depend for health security must continue to be monitored.

90. In view of the developments in the past year and its assessment of the current state of global preparedness for health emergencies, the Task Force urges that careful monitoring of and increased efforts in the following areas are needed in the coming years:

(a) **Strategic support for national health systems.** The Task Force stresses the importance of the rapid roll-out of the voluntary joint external evaluations. These evaluations need to be enhanced by integrating animal health experts and civil society organizations. Following the conclusion of the joint external evaluations, costed national health action plans should be developed promptly with the support of WHO; in addition, it will be essential that adequate financing, both in-country and through donors, be available to implement the development plans. The Task Force welcomes ongoing initiatives to strengthen health systems and enhance preparedness, including the pandemic supply chain network, the automated system for relief emergency consignments and the International Health Partnership for UHC2030;

(b) **Integrating communities and civil society organizations.** The Task Force stresses that community engagement deserves greater emphasis before and during outbreaks to ensure that preparedness and response activities are culturally sensitive and better understood, meet the needs of the people concerned and involve and engage the communities. Assessment of community engagement needs to be strengthened in the joint external evaluations, and costed action plans developed that include community engagement and that are sufficiently financed through domestic and external funding;

(c) **Supporting regional arrangements.** The Task Force welcomes the WHO collaboration with the Africa Centres for Disease Control and Prevention and work to bolster the capacities of emergency medical teams in different regions. The Task Force encourages WHO to continue to support the capacities of regional organizations and coordinate actions to strengthen those capacities;

(d) **Strengthening United Nations system capacity.** The Task Force commends the Health Emergencies Programme for its strong first year, during which it has built up its capacity and clarified its processes for managing emergencies with the revision of the Emergency Response Framework. The adoption of the Inter-Agency Standing Committee procedures for infectious disease

events provides additional clarity on the roles and responsibilities of WHO, the wider United Nations system and non-governmental partners in responding to outbreaks. The Task Force reinforces the need for WHO to implement the recommendations of the Independent Oversight and Advisory Committee. Collaboration between WHO, the World Organization for Animal Health and FAO is important in view of the number of emerging threats that are of zoonotic origin. The Task Force welcomes improvements in the processes and mechanisms for information dissemination on health threats within the United Nations system;

(e) **Testing capacities and processes through simulation.** The Task Force confirms that simulation exercises are essential to sensitize all stakeholders to the importance of integrating pandemic preparedness in their operational planning. Simulations need to be conducted in different settings, at all levels (local, national, regional and global) and across countries. Simulations should not be an end in themselves; rather, where feasible and appropriate, the outcomes of the simulations should be reported, with lessons learned and follow-up;

(f) **Catalysing focused research and innovation.** The Task Force commends WHO for the advancements made in coordinating research and development, acknowledging that the research and development blueprint provides a valuable framework for coordination. The Task Force regards the development of a methodology to prioritize diseases to be a significant achievement, while emphasizing that such a list should not have the effect of restricting research on pathogens that may not yet be recognized as potential disease outbreaks and that the development of translatable platform technologies needs to be encouraged. The Task Force encourages WHO to promote a One Health approach to research and development;

(g) **Securing sustainable financing for health security.** The Task Force expresses significant concern that financing for advancing health security at the national, regional and global levels falls short of what is needed. The Task Force endorses the recommendations of the International Working Group on Financing Preparedness and welcomes the establishment of the pandemic emergency financing facility. The magnitude of the economic threat arising from health insecurity deserves greater attention from finance ministers. While WHO has made significant strides in implementing the Health Emergencies Programme, the Independent Oversight and Advisory Committee reiterated its concerns that the Programme is underfunded and the significant progress to date is seen as fragile, an assessment that is shared by the Task Force;

(h) **Focusing attention on the gender dimensions of health crises.** The Task Force welcomes the focus on gender equality and rights by the High-level Commission on Health Employment and Economic Growth. It agrees that greater attention must be paid to the disproportionate burden on women and children during health crises. The Task Force encourages UN-Women, the International Federation of Red Cross and Red Crescent Societies and the United Nations Office for Disaster Risk Reduction to ensure that health dimensions are fully integrated into the new global programme to address the gender inequality of risk and promote women's resilience and leadership;

(i) **Ensuring health security remains prioritized on national and global political agendas.** The Task Force stresses the importance of political processes in determining the extent to which people enjoy health security. Engagement with political processes is essential to maintain health security as a priority on national and global political agendas. High-level political engagement on health issues is needed to ensure that health security is recognized as a global public good and that effective financing policies are in place to make best use of available funds. There should be multisectoral outreach to government ministries beyond ministries of

health. To secure the financing they need, health programmes and initiatives must be ready to be held accountable for results in order to build confidence and trust. Effective advocacy for health cannot only rely on the utilization of the United Nations system and intergovernmental processes and focus on international organizations and Member States as the primary actors and agents of change. Advancing health security in its fullest sense means engaging all relevant stakeholders and creating an inclusive space in which all non-United Nations stakeholders and non-governmental actors can come together, contribute and be heard.

91. The Task Force reflected on next steps following the conclusion of its mandate on 30 June 2017. The Task Force recalled that the General Assembly requested WHO to submit reports on the state of health security in 2016 and 2017 and considered the possibility of continuing this reporting process beyond 2017. A majority of Task Force members recommended that the Secretary-General develop and implement a new time-limited independent mechanism for reporting on the status of the world's preparedness by: (a) monitoring system-wide progress towards increased health crises preparedness and response; (b) helping to ensure political visibility and accountability for efforts at the country, regional and global levels; and (c) providing an alert to the Secretary-General and other key stakeholders if the system is not functioning adequately.

Annex

Composition of the Global Health Crises Task Force

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