

Advancing global health security

from commitments to actions



Bali, Indonesia, 27-29 June 2016



World Health
Organization

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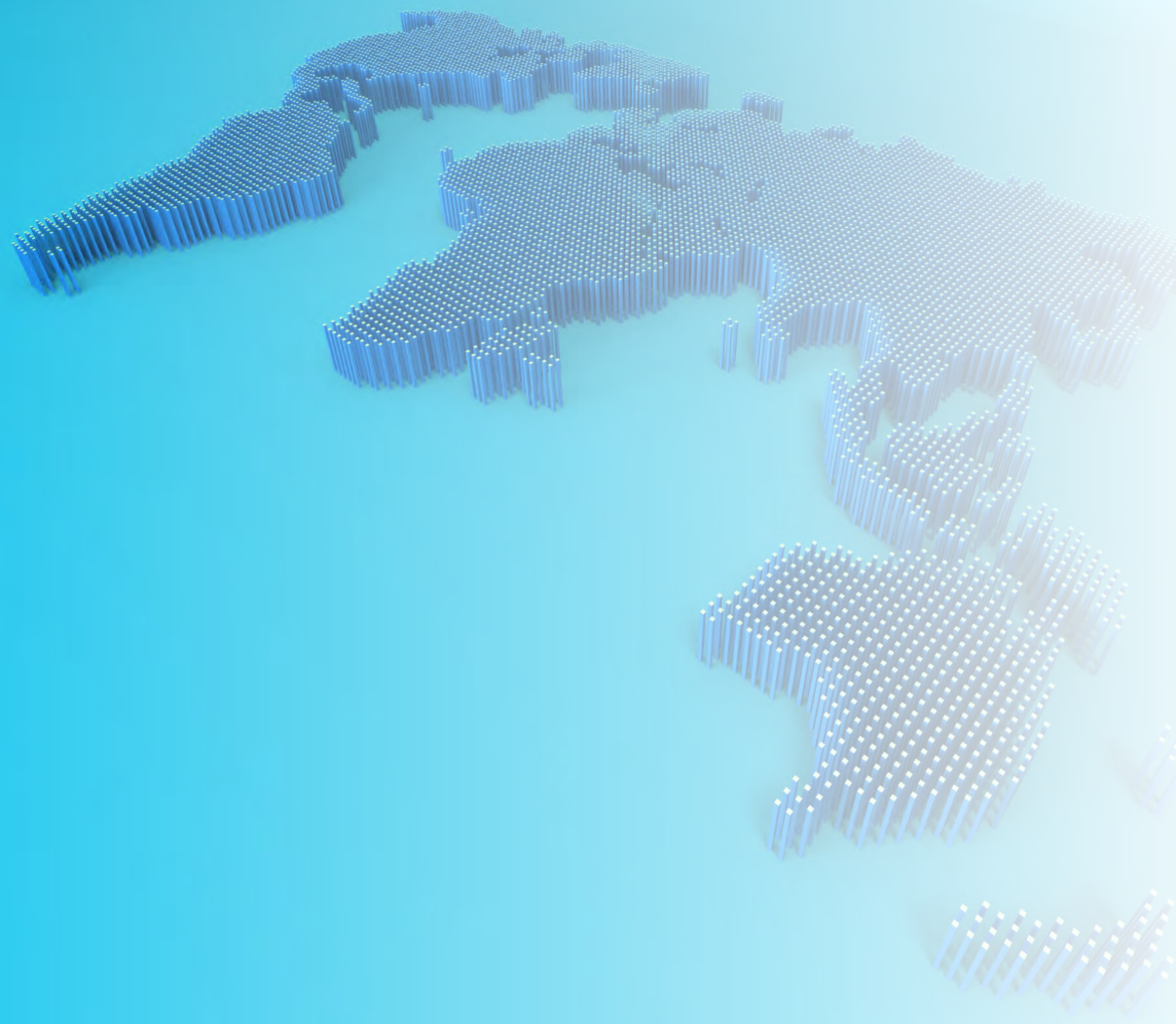
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Acknowledgements

The high-level meeting on *Advancing global health security: from commitments to actions* was jointly convened by the World Health Organization (WHO) and the Government of Indonesia. Side meetings were also hosted by the World Bank Group, the Government of Finland, and the Government of Indonesia.

WHO wishes to thank the Government of Indonesia for its warm and generous hospitality and for the exceptional organization of the meeting.

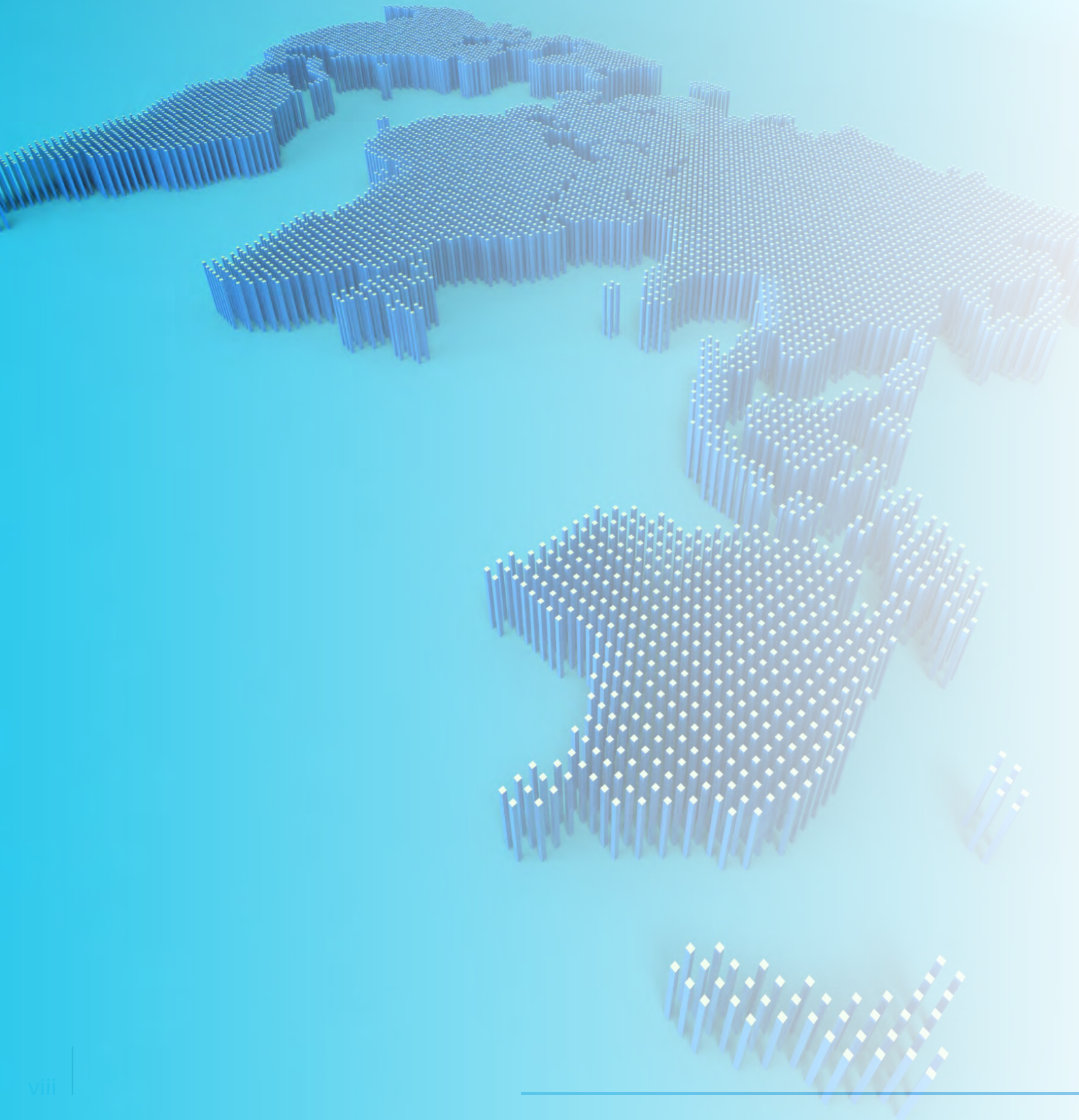
WHO would also like to thank the governments of Japan, United Kingdom, and the United States for their generous financial contributions to the meeting.

The success of the meeting would not have been possible without the outstanding contributions of all participating countries, partner organisations and invited experts.

Report and editing by Mark Nunn.

List of acronyms

AfDB	African Development Bank	NHSP(s)	National health strategic plan(s)
AFRO	WHO Regional Office for Africa	OCHA	UN Office for Coordination of Humanitarian Affairs
AMR	Antimicrobial resistance	OIE	World Organization for Animal Health
APSED	Asia-Pacific Strategy for Emerging Diseases	PEF	World Bank Pandemic Emergency Facility
CAPSCA	Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (ICAO programme)	PHEOC	Public health emergency operations centre
DFID	UK Department for International Development	PPE	Personal protective equipment
DRM	Disaster risk management	SARS	Severe acute respiratory syndrome
DRR	Disaster risk reduction	SDG(s)	Sustainable Development Goal(s)
EAC	East African Community	SEARO	WHO Regional Office for South East Asia
ECDC	European Centre for Disease Control	SOP(s)	Standard operating procedure(s)
ECOWAS	Economic Community Of West African States	TEPHINET	Training Programs in Epidemiology and Public Health Interventions Network
EOC	Emergency operations centre	UN	United Nations
EVD	Ebola virus disease	UNISDR	UN International Strategy for Disaster Reduction
FAO	UN Food and Agriculture Organization	USAID	United States Agency for International Development
FENSA	WHO Framework for Engagement of Non State Actors	USD	United States Dollars
FETP(s)	Field epidemiology training programme(s)	WHE	WHO Health Emergencies Programme
IASC	UN interagency standing committee	WHO	World Health Organization
ICAO	International Civil Aviation Organization	WPRO	WHO Regional Office for the Western Pacific Region
ICRC	International Committee of the Red Cross		
IOM	International Organization for Migration		
JEE	Joint external evaluation		
JICA	Japan International Cooperation Agency		
KEMRI	Kenya Medical Research Institute		
KOICA	Korea International Cooperation Agency		
KPI(s)	Key performance indicator(s)		
MSF	Médecins Sans Frontières		
MP(s)	Member(s) of parliament		



Executive summary

The *High-level meeting on advancing global health security: from commitments to actions* took place from 27 to 29 June 2016, in Bali, Indonesia, bringing together 250 participants and observers from 52 countries and 28 organizations with the goal of using current momentum and recent commitments to drive sustained actions for global health security. A number of side events also took place, notably a World Bank Group meeting on sustainable financing for preparedness, a joint external evaluation (JEE) Alliance meeting, and a meeting on zoonoses convened by the Government of Indonesia.

‘Never waste a crisis’

Since the Cape Town meeting on *Building health security beyond Ebola* in July 2015, there has been a concerted effort to use the lessons of Ebola, SARS, and other recent emergencies and humanitarian disasters to scale up global efforts to prevent, detect and respond to public health emergencies. Important initiatives such as the WHO Joint External Evaluation (JEE) tool and the WHO Strategic Partnership Portal (SPP) have taken off, and their early benefits were clear at the Bali meeting. The recent outbreak of Ebola Virus Disease (EVD) reminded everybody of the importance of resilient health systems, as clearly stated at the opening by Dr Matshidiso Moeti, WHO Regional Director for Africa:

“ *The bedrock of outbreak and emergency preparedness and response is a functioning, resilient national health system – with financing, human resources, infrastructure, information and supply management systems capable of detecting and responding to public health events.* ”

Many frameworks support countries as they prepare for health emergencies. These include the Pandemic Influenza Preparedness (PIP) framework; the Sendai Framework for Disaster Reduction; the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC); the Global Health Security Agenda (GHTSA); the Ise-Shima Health Agenda and other G7 initiatives; the One Health approach; Integrated Disease Surveillance and Response (IDSR); the Asia Pacific Strategy for Emerging Diseases (APSED); EURO 2020; the Essential Public Health Functions in support of Universal Health Coverage (UHC) resolution (WHA69.1); the Integrated People Centred Health Services Framework; and the International Health Partnership for UHC 2030.

Meeting participants in Bali voiced consensus on the need to use lessons from major events to reach new clarity on how emergency preparedness should be strengthened, and how to ensure it is as inclusive and sustainable as possible.

‘We need inclusive and accountable partnerships’

The meeting highlighted the importance of evidence-based joint planning, information sharing, and strengthening of intersectoral collaboration through national and international partnerships.

Participants highlighted the need for WHO to develop all components of the new monitoring and evaluation framework for IHR in addition to JEE. Countries underlined the strengths of the JEE tool, which include voluntary country participation, the multisectoral linkages made at national and subnational levels during the JEE process, and the transparency and openness of data sharing during and after missions. To drive the process forward, the need was highlighted for more experts to join JEE missions.

Investments in preparedness should start with strong ownership and supportive leadership at the highest level in countries. Country-owned action plans are needed that reflect national priorities, backed by secure domestic investments, engagement of all stakeholders, and optimized use of resources. Such domestic investment must be complemented by decisions on international assistance based on clearly articulated gaps and needs; and the provision of strategically planned, well-coordinated technical support.

‘Health security begins at the level of individual men, women and children and their communities’

Participants highlighted the many different critical roles that technical partners—including NGOs, UN agencies and humanitarian and other actors—play in strengthening national preparedness. They addressed globalization as well as the fact that many borders are not fixed, and are transcended by constantly mobile populations that need to be better understood.

Partners illustrated that health security is as important to individuals as it is to communities and countries: investing in the core health service delivery and workforce remains a top priority. When addressing the consequences of health emergencies, participants demonstrated the need for collaboration across sectors, and the consequent need to understand different underlying agendas, recognize WHO’s leadership, define areas of overlap, and develop solutions tailored to local systems.

‘Towards a strategic framework for emergency preparedness’

Effective investment in preparedness saves resources in emergency response. To take advantage of this, participants highlighted the importance of a strategic framework for guiding investment in line with priority preparedness actions in countries. The framework should reflect the combined knowledge and achievements of stakeholders in human health, animal health, disaster management and non-health sectors. Such a framework, once finalised, will lead to

more sustained support for health systems that are both operationally ready and sufficiently resilient to withstand shocks inflicted by emergencies.

This framework needs to drive the following action: adoption of an all-hazards approach based on prioritised risks; increased investment in risk mitigation and prevention; focus on sustained investment in health systems and vulnerable communities; assured political leadership and regional collaboration; promotion of self-reliance with mutual accountability; broader multisectoral approaches; engagement of communities across the whole of society; and widespread movement beyond the provision of short-term technical health expertise, to the development of resilient health systems.

Recommendations and actions for all stakeholders

The Bali meeting participants recommend the following:

- 1. Current momentum around health security must be sustained and scaled up through continued, coordinated action led by WHO.** Through concrete, step-by-step actions for preparedness, health systems must be strengthened towards the achievement of universal health coverage (UHC), thereby strengthening health security.
- 2. The new monitoring and evaluation framework for IHR represents a step forward.** Further concrete action is needed to translate identified gaps into financed action and, eventually, into preparedness outcomes. **Results of the JEE and/or other assessments should be used to review or develop plans and fund and accelerate actions to meet priority needs.**
- 3. In the finalization of the strategic framework for emergency preparedness, WHO must take into account key points from the discussions held during the meeting**—noting that the strategic framework aims to strengthen emergency preparedness across communities at sub-national, national, and international levels.

4. **In implementing the framework**, participants request that:

a. **The framework is used to reflect the common platform for stakeholder engagement and for fostering collective partnership for action.**

b. **The outcomes of emergency preparedness assessments are included as part of long-term national health strategic plans (NHSPs).** These should strive for outcomes linked to: (1) operational readiness; (2) resilience of health systems and workforces; (3) the One Health approach; (4) a whole of government, whole of society approach to preparedness; and (5) resilience of communities.

c. **Prioritized investments in preparedness are driven by country ownership, strong political leadership and sustainable domestic resources.** Operationalizing preparedness requires action and constant monitoring that needs continuous political and financial support. Countries—especially the most vulnerable countries—need these in order to reduce the human, economic and social costs of health emergencies.

5. **A sustained, long-term mechanism is needed through which financial and technical resources can be channelled to priority needs.** Alongside domestic leadership mentioned above, international financial and technical support remains crucial to support the preparedness activities of ministries, civil society and technical partners.

6. **All stakeholders must share information regarding ongoing and planned investments to strengthen global health security, and must use WHO’s Strategic Partnership Portal (SPP) to highlight needs, gaps, priorities and achievements in advancing health security and health systems resilience.** Participants drew attention to the SPP’s usefulness as a tool for transparent coordination between countries, donors, partners and WHO, in line with the principles for aid effectiveness as set out in the International Health Partnership for UHC 2030.

7. **An international parliamentary consultation forum** should be convened to draft legislation and strategies to support countries’ commit-

ments to sustainable domestic investment in global health security.

Immediate next steps

- In the month following the meeting, strengthen the strategic framework for emergency preparedness and share it with stakeholders
- Initiate the roll-out of the framework in all countries and territories, backed by strong national leadership and support from partners
- Monitor and assess the roll-out of the framework
- Update the SPP regularly with information from countries and partners
- Use the framework to inform decisions on country health emergency preparedness
- In close collaboration with relevant stakeholders, develop approaches to transform country JEE recommendations into long-term, costed, multi-sectoral national operational plans with linkages to the NHSPs
- Strengthen existing partnerships and develop new ones
- Continue discussions with financing institutions
- Share the outcomes of the Bali meeting, and advocate for the multisectoral implementation of emergency preparedness at every level, in accordance with national priorities.



Note to the reader

This report summarizes the themes of each session rather than attempting to provide a chronological summary of the discussion. The ‘recommendations’ sections list recommendations from all speakers, and do not necessarily imply consensus.

Welcome and opening remarks

The meeting was ceremonially opened by **Her Excellency Professor Dr Nila F. Moeloek**, Minister of Health of the Republic of Indonesia. Comments to the opening session were also provided by **Dr Poonam Khetrupal Singh**, WHO Regional Director for the South-East Asia Regional Office (SEARO); **Dr Matshidiso Moeti**, WHO Regional Director for the Regional Office for Africa (AFRO); and—via video message—**Dr Bruce R. Aylward**, Executive Director *a.i.*, Outbreaks and Health Emergencies and Director-General’s Special Representative for the Ebola Response, WHO.

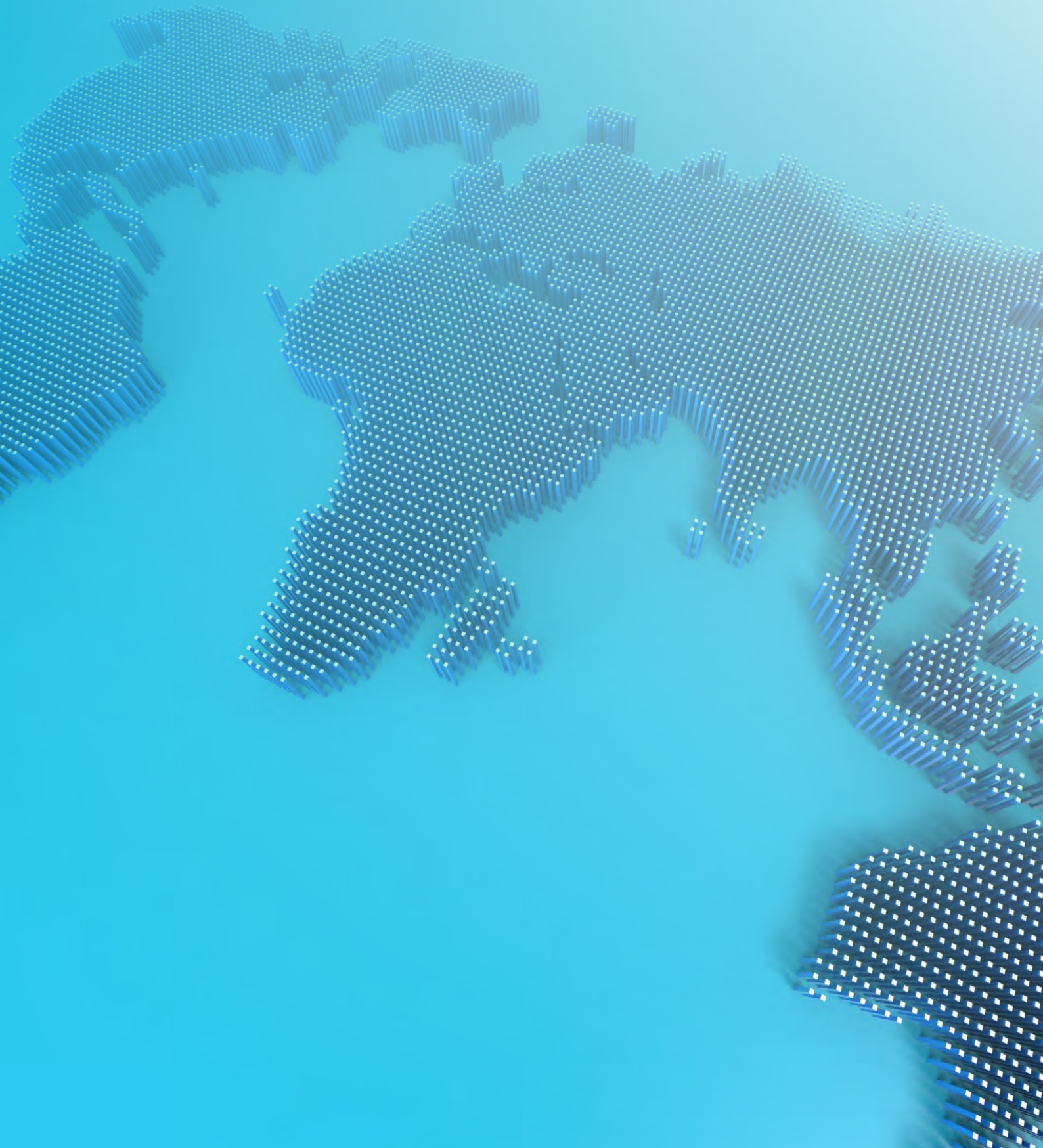
The current global health security landscape

The meeting’s opening speeches emphasised a number of key themes. Health security is of increasing importance in a world threatened by a wide range of infectious and non-infectious hazards. Despite this, preparedness is inadequate, with only one third of countries currently meeting the minimum requirements of the International Health Regulations (IHR). In this context, and exacerbated by recent epidemics of and Zika, health security is no longer a secondary strategic concern: it now touches on public health, diplomacy, and foreign policy, as well as more traditional spheres of health and emergency response. It is imperative that the international community makes the most of the current unprecedented momentum to build health security at all levels of society.

Health emergencies put intense pressure not only on health services, but on society as a whole. What begins as a health problem can become a social, cultural, or economic crisis. In today’s interconnected world, economies are also increasingly vulnerable. With new diseases emerging, old ones resurging, the rise of antimicrobial resistance, and increases in transnational food production and the volume of international travel, more advanced tools and approaches are needed to combat cross-border health risks. Transparency and trust, underpinned by the IHR, are crucial not only to adequate preparedness, mutual cooperation and capacity building, but also to ensuring that weaknesses in one country do not threaten all.

Within countries, coordinated, multisectoral solutions are needed, with buy-in from all of society; and while countries bear ultimate responsibility for IHR compliance, non-state actors must also take greater responsibility to provide guidance and assistance in contexts where it is most needed.

Speakers eagerly anticipated the chance for “south-south” exchange offered by the meeting, and expressed the hope that all attendees would maximise the opportunity to advance the new Strategic Preparedness Framework developed by WHO (see Part 2 and final session).



Part 1: Introduction and scene setting

Session 1.1: From Cape Town to Bali: what has been achieved?

Chair: Ms Malebona Precious Matsoso, Director-General, National Department of Health, Republic of South Africa

In this session, stakeholders' successes and challenges in advancing key elements of health security were presented and contextualized within the overall drive to achieve the Sustainable Development Goals (SDGs).

The Chair stressed markers of progress and contextual changes since the 2015 Cape Town meeting: the move from the Millennium Development Goals (MDGs) to the SDGs; the momentum around health security outlined in the opening remarks; and WHO reform and the establishment of the new WHO Health Emergencies Programme (WHE) and the Framework for Engagement of Non State Actors (FENSA).

Speakers were **Her Excellency Professor Dr Nila F. Moeloek**, Minister of Health, Republic of Indonesia; **H.E. Aishath Rameela**, Minister of State for Health, Maldives; and **Dr Ana Isabel F.S. Soares**, Vice Minister of Health, Timor-Leste; **Mrs Päivi Sillanaukee**, Permanent Secretary of the Ministry of Health, Finland; and **Mr Go Tanaka** of the Government of Japan. There was a short video address from **H.E. Ms Edith Schippers**, Dutch Minister of Health, Welfare and Sport; and interventions from the **United States of America (USA)** and the **World Bank**.

Key points of the discussion

Building health security through stronger health systems should be done within the context of the SDGs and the drive towards universal health coverage (UHC). Attention should be given to supporting WHO in a leadership role; advocating and adopting an all hazards approach; working

across sectors; strengthening health systems; and building capacity and bolstering health services provision, including through strengthening primary health care. Collaboration between different sectors of government is crucial and has been clearly stated in the One Health approach, which is essential in countering the threat of zoonotic diseases.

Multisectoral commitment is required both nationally and internationally: all health stakeholders—public and private, government and civil society—have important roles to play. Some potential partners might not be immediately obvious: for example, in the Maldives the construction industry has played an important role in plans to address dengue, Zika and other vector-borne diseases. Integrated multisectoral action is required from ministry to village level, and should include: integrating human and animal surveillance systems and training; integrating epidemiological investigation of zoonotic outbreaks; and mobilizing community support.

Health security has particular importance in countries that are dependent on trade and tourism, and to which any travel ban or situation restricting movement of tourists is an economic threat. Natural disasters and climate change also have strong potential impacts on health, through their effects on agricultural production, food security and tourism. Timor-Leste provides a current example: El Niño has reduced water resources and caused disputes over access, rising food prices in response to decreased supply, falling school attendance, households resorting to coping mechanisms, and environmental degradation. As a result, there has been a rise in health issues caused by poor food and water quality.

While building and sustaining capacity is the primary responsibility of national governments, these governments should be supported by other national stakeholders and international partners; and international/regional cooperation is of fundamental importance. While economic

difficulty may make commitment difficult, talk alone is insufficient; extended technical and financial commitment is required from all stakeholders, including a swift international response from WHO.

Internationally, data is needed on country level gaps. This can be provided by JEEs. The move from self-assessment to external assessment embodied by the JEE signals an important shift in thinking towards capacity building grounded on country commitment to prevent, detect and respond to all threats. To this end, Finland presented an Alliance that is being formed to support assessments in line with Article 44 of the IHR by functioning as a networking platform for stakeholders, helping coordinate different sectors and interested partners.

Recommendations

- Policy makers must ensure increased budgets to strengthen IHR policies and guidelines. These must be supported on a national level, with equal participation from all related sectors.
- Accelerate implementation of prevention and preparedness activities, and continue capacity building for disaster response and risk reduction. Strengthen primary health care and mobilize and strengthen at community level.
- Countries and partners should take concrete actions at national level on the basis of assessment outcomes, ensuring these are driven by national policy based on identified gaps and weaknesses, and backed by strong political leadership.

Session 1.2: Looking to the future: operationalizing preparedness for health emergencies

Dr Victor Bampoe, Vice Minister of Health, Republic of Ghana

This session took stock of country health emergency preparedness work by WHO and partners, highlighting the essential functions needed to manage emergencies from the outbreak, humanitarian and health system perspectives.

Panel speakers were **Dr Guénaël Rodier**, WHO Director of the Global Capacities, Alert and Response (GCR) department; **Dr Ibrahima-Socé Fall** of the WHO Regional Office for Africa (AFRO); **Dr Takeshi Kasai** of WHO's Western Pacific Regional Office (WPRO); **Mr Balla Jatta**, Ministry of Health and Social Welfare, the Islamic Republic of The Gambia; **Dr Radjesh Ramadhin**, Ministry of Health, Republic of Suriname; and **Richard Gregory**, UK Department for International Development (DFID).

Key points of the discussion

Health security relies on a number of essential functions, including:

- Political commitment and international partnership
- Reinforcing the IHR and strengthening national core capacities, particularly through assessments, evaluations and national action plans
- Adopting an all-hazard approach to multisectoral planning and support
- Integrating relevant sectors, including the transport sector, in disease prevention
- Creating strong links with donors and partners through the WHO Strategic Partnership Portal (SPP).

At the core of this agenda lie the IHR and the goal of Universal health coverage (UHC). The IHR emphasize the need to integrate health systems strengthening, core capacity building and emergency response in an international effort led by countries and championed by WHO. In this, they underpin WHO's work in preparedness,

which feeds into the new vision for achieving UHC based on three underlying strategies:

1. To build health system foundations in least developed and fragile countries
2. To strengthen health system institutions in least developed countries where foundations are already in place
3. To support health system transformation in countries with mature health systems.

Not only must systems be robust enough to handle crises, but care must also be taken to make sure they do not exacerbate them. Risks transcend borders, fields of responsibility, and social strata. In this context, adequate, timely preparedness is required in many countries to build capacity and reduce vulnerability of communities.

Investment in health systems is critical; and while partner support is required for this, without national leadership or ownership there is no way to sustain it. A number of things must shape this investment, including: thorough risk profiling and assessments; benchmarking; building health systems resilience; and country and regional level capacity building. Using agreed indicators to monitor progress across these areas will be crucial.

Context is important, however: in the African Region, for example, few countries have the national mechanisms necessary to achieve One Health, and community participation is weak. In Asia, implementation of APSED has revealed a number of lessons—most fundamentally, that preparedness takes time and must occur in a stepwise fashion, especially in lower- and middle-income countries. With regard to One Health, two distinct forms of collaboration have been employed: one is a knowledge-sharing platform; the other is through continuous close collaboration between ministries of health and agriculture.

Therefore:

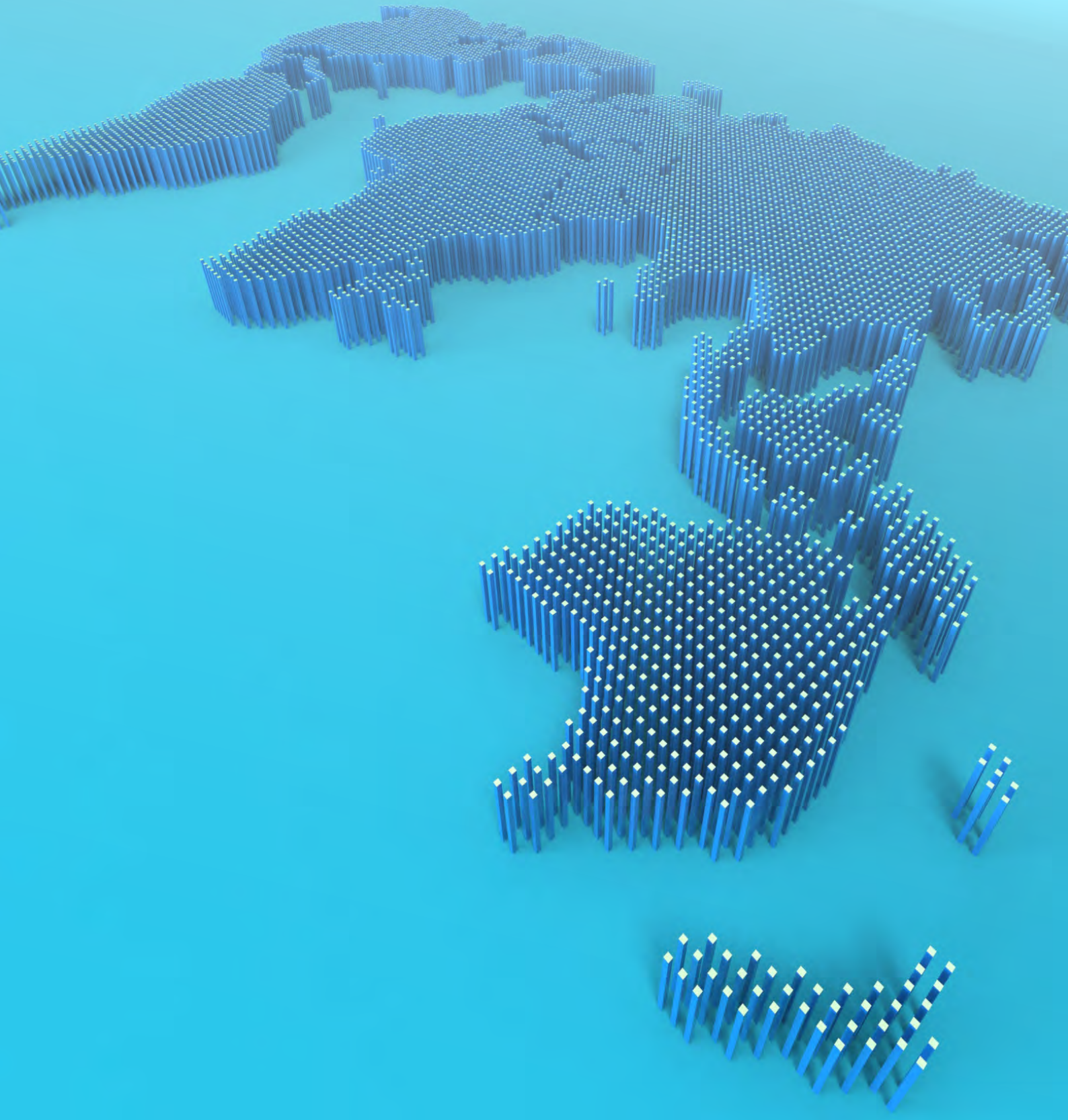
1. A longer timeframe for action allows WHO Member States to identify the right actions adapted to their stage of development
2. Wider mechanisms are required to help countries sustain their efforts

3. Those countries must remain in the driving seat
4. Countries must develop the culture of “doing better next time,” recognizing and implementing the lessons of real events
5. Partners must find their place in such plans and work accordingly.

In resource- and capacity- limited contexts, particular actions for early consideration include support for advocacy, communications, and social mobilization; fast, effective identification, isolation and management of cases; strengthening logistics; and forging partnerships with the animal health sector.

Recommendations

- WHO should be the lead technical agency in supporting countries in strengthening and operationalizing their preparedness capacity.
- Strengthening of the health system should incorporate partners beyond the health sector. In building effective collaboration across sectors, communications channels are as important as integrating functions.
- Prioritize investment in skilled, well-equipped and well-protected human resources.
- Empowering IHR National Focal Points should be a priority for countries. Many IHR National Focal Points require increased access to and influence among policy makers and multi-sectoral commissions (e.g. national disaster commissions) for prevention, preparedness, response and recovery.
- In recovery, stakeholders should adopt the “build back better” principle: after a disaster, investment in reconstruction and recovery must aim for a higher level of preparedness and prevention than existed before.



Part 2: From assessment to national planning

This part of the meeting opened with a presentation from **Dr Stella Chungong** setting out WHO's **Strategic Framework for Emergency Preparedness**, a unifying approach that builds on existing actions across three core areas—governance, capacities and resources. The framework is characterized by four strategic approaches and outcomes: operational readiness, the One Health approach, resilient health systems and a whole-of-society/whole-of-government focus. It aims to increase coherence between existing frameworks, promote integrated actions and alignment of support to national priorities, and improve financing. The framework is underpinned by the establishment of the new WHO Health Emergency Programme.

Session 2.1: Joint external evaluation of country capacities

Chair: Dr Poonam Khetrapal Singh, *Regional Director, WHO Regional Office for South-East Asia (SEARO)*

The session presented the WHO JEE tool, practical country experiences of using it, and best practices for how its results can drive national priorities.

Speakers were **Dr Hamid Jafari**, Centers for Disease Control and Prevention, United States of America; **Dr Safi Malik**, Ministry of Health, Islamic Republic of Pakistan; **Dr Janneth Mghamba**, Ministry of Health, United Republic of Tanzania; **Dr Salim Uzzaman**, Ministry of Health, People's Republic of Bangladesh; and **Dr Issa Makumbi**, Ministry of Health, Republic of Uganda.

Key points of the discussion

The WHO JEE tool produces high quality assessments, but a successful, valuable outcome relies on involvement of all relevant national and subnational stakeholders. The WHO JEE tool is a support tool for countries—not an inspection or a competition—and must be seen as such if it is to be used successfully as a roadmap

to build stronger health systems and health security. Countries must understand the tool and the JEE process, and will need adequate time for preparation and a deep commitment to transparent, multisectoral evaluation. In addition, it is essential that JEEs are of consistent high quality and standardized, and that they reflect country realities; while JEE scores are not comparable across countries, the JEE process must be. The JEE process also offers valuable opportunities for country staff and other stakeholders to network and learn from national and international experts, and to bring together a wide range of stakeholders to achieve consensus on national progress and needs.

The depth and quality of the external evaluation are determined by the depth and quality of the preceding self-assessment. The self-assessment brings with it important opportunities: fresh openness across government, and clear identification of capacities and strengths as well as weaknesses. Mechanisms are therefore needed to assure the high quality of self-assessments, transparency, selection of team members, the assessment process itself, and its linking to the identified gaps.

To prepare for self-assessment, WHO can provide technical assistance on request, helping teams compile and finalize self-assessment reports and collect supporting documents. Country experience so far suggests that the process requires a delegated national team that includes members at subnational level.

After the assessments, National Plans of Action should be developed under the leadership of the Government and with the support of WHO and stakeholders. The outcomes of the JEE will assure the existence of a baseline against which to measure progress. This process provides a platform to advocate for domestic funding, and a potential boost to regional processes.

Recommendations

- The JEE approach must be coordinated and led by WHO: this is a prerequisite for wide acceptance of JEE.
- Conduct pre-assessment orientations to help ensure that stakeholders understand the JEE process and related documents, and that the external evaluations run smoothly.
- Self-assessment is fundamental to success and care must be taken to ensure this stage is well executed. A good evaluation requires adequate time for preparation.
- It is important that donors, partners, representatives of different government sectors and high-level ministry of health officials are present during debriefs, to capture priority areas, strengths and lessons.
- Countries should volunteer for assessments and provide human resource capacity (experts) for JEE missions, ideally through a WHO-managed central roster of experts.
- Care must be taken to ensure veterinary, zoonotic and other systems are strengthened and integrated within the health system.
- A qualitative analysis may be required of the tool's scoring system, the clarity of its results and its adaptability to countries.

Session 2.2: Joint planning and information sharing

Chair: Dr Matshidiso Moeti, *Regional Director, WHO Regional Office for Africa (AFRO)*

This session encouraged technical and financial partners and WHO to participate actively in joint planning. The Chair opened with a reminder of the aid and development effectiveness agendas and partnerships (e.g. Paris/Accra/Busan), underlining several important principles: coherence; transparency; joint monitoring; coordinated support; ownership; alignment; harmonization; managing for results; and mutual accountability.

Panel speakers were **Dr Hedayatullah Stanakzai**, Ministry of Health, Islamic Republic of Afghanistan; **Dr Jordan Tappero**, Centers for Disease Control and Prevention, United States of America; **Ms Annegret Al-Janabi** Federal Ministry for Economic Cooperation and Development, Germany; and **Dr Daddi Jima Wayessa**, Ethiopian Public Health Institute, Federal Democratic Republic of Ethiopia.

Key points of the discussion

Post-evaluation action plans offer precious opportunities for country-led joint planning and information sharing. In a perfect world, every country would have a JEE first, then a government-led planning process, followed by implementation; but in reality all countries are doing different things at different paces in different orders. The required standardization will become more common in time.

Strong coordination is built on cooperation from the highest to the lowest levels, creating structures into which partners, donors and implementers can fit for smooth, effective responses. Community strengthening may be required to make this work; one example of this is Ethiopia's 'Health Development Army' system of community health workers, who report local level emergencies. Government ownership is important in such a system, and can be reinforced by legislation defining each sector's responsibilities in public health emergencies.

The integration of activities that strengthen preparedness and health security into national health strategies and plans is key in order to ensure ownership and sustainability (for example, through continuous financing, staffing and monitoring). In 2015, the German Federal Ministry for Economic Cooperation launched a programme to improve international crisis management in the African health sector, making funding available for bilateral and regional programmes focusing on health workforce development, reducing vulnerability, and improving response capacities of health systems.

Financing must also be integrated into planning processes, so development partners can see how they can contribute. Cross-sectoral aspects of health should be considered, especially with regard to health security plans. The climate change agenda provides an example: here, one ministry may have the lead role, but many related deliverables are responsibilities of other ministries; eventually, responsibility and accountability must be mutual.

Another initiative through which technical assistance and financial support can be provided

is the Global Health Security Agenda (GHS). The United States Centers for Disease Control and Prevention (CDC) has a library of ‘milestones’ that can be accessed to help ensure progress against GHS roadmaps, which are organized around technical areas or ‘Action Packages’. Four ‘critical’ action packages have been identified by CDC: national laboratory systems; surveillance systems; workforce development; and public health emergency operations centres (PHEOCs).

In emergency contexts, coordination mechanisms can be of heightened importance. Natural disasters and political instability can greatly reduce the coping capacity of the state, eroding community resilience, affecting health care services and increasing people’s vulnerability. Armed conflict situations present a further need for health services and medical care, usually far surpassing capacity. Consequent displacement and poor care also increase infectious disease risk; and all of this is compounded by overstretched basic social services, poor nutrition and insufficient access to water and sanitation. The risk of public health emergencies is high. Under these difficult conditions, non-country led planning is also sometimes necessary. The health cluster mechanism helps ensure partnership between international actors, national authorities, and government and civil society, nationally and regionally. It also contributes to improved coordination and prioritization; identification of available partners and capacity; access to information, expertise, opportunities and teamwork; and resource mobilization.

Recommendations

- Health system functioning is improved by focus on information sharing and involvement of ministries of public health in planning at all levels.
- Health security actions should be incorporated into national health strategies and plans.
- Information sharing and joint planning are of special importance; mechanisms may be needed to identify information gaps.
- Regional organizations such as the Economic Community Of West African States (ECOWAS) or the East African Community (EAC) should work with WHO Member States to help ensure linkages between country and regional work.

Session 2.3: Engaging technical partners in national preparedness

Chair: *Dr Joy St John, Director of Surveillance, Disease Prevention and Control, Caribbean Public Health Agency*

This session reviewed potential technical and operational inputs of technical partners—including NGOs and UN agencies—in national preparedness. It also examined country-level contributions of humanitarian and other actors.

Panel speakers were **Dr Teresa Zakaria** of the International Organization for Migration (IOM); **Dr Lorie Burnett** of the Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET); **Dr Monica Rull** of Médecins Sans Frontières (MSF); **Dr Massimo Ciotti** of the European Centre for Disease Prevention and Control (ECDC); and **Dr Christophe Bayer** of the German Federal Ministry of Health.

Key points of the discussion

Mobility of populations influences the spread of disease. Information on travel patterns and traveller congregation points therefore enables forecasting of disease spread. Borders, meanwhile, should be seen as spaces, not hard lines: they contain communities and systems that are all capable of contributing to prevention, detection and response.

Technical partners can contribute particular expertise to national preparedness, and a wide range of tools and resources is available to help with emergency preparedness and crisis management. For example, The International Organization for Migration (IOM) has developed tools to map mobility for public health interventions; as part of a larger framework to build mobility-competent health systems these have helped identify and prioritize locations and communities most at risk, allowing capacity-strengthening efforts to be targeted.

The European Centre for Disease Control (ECDC) supports countries through external evaluations, and publishes a range of resources including an imminent handbook on risk ranking methods

and a handbook on developing emergency simulations. ECDC also offers training and organizes technical meetings to reinforce public health preparation aspects in emergency preparedness, emergency risk communications, and training for emergencies. The UN agencies have a wide range of software and hardware that could be available to support health responses in outbreaks (e.g. as in the World Food Programme (WFP) supplying aircraft, trucks, housing and warehousing during the Ebola response).

The work of technical partners is often also a reminder that public health and global health security depend on the health of individuals: within UHC, preparedness planning must leave no one behind, regardless of status. Engaging and strengthening local communities in health security is critical, and frequently the weakest links are where NGOs work, often among the most vulnerable populations. NGOs should therefore be included in IHR assessments; national and international civil society can play an important role in operationalizing action plans. At community level, health security can be boosted by vaccination campaigns, and by research to improve tools and strategies for emergency response (including the use of community-based networks).

Research is crucial in ensuring that evidence generated during emergencies is fed into after-incident learning exercises, increasing understanding of how decision making changes over time, and strengthening the links between scientific advice and operational decision making. The health community must understand the outcome of its advice to decision makers, in order to smooth the pathways to implementation: decision-making processes should be part of the preparedness phase.

Partners also offer excellent opportunities to enhance preparedness by strengthening the workforce. For example, partner-run field epidemiology training programmes (FETP) can help strengthen capacity, and, as a first line of defence against outbreaks, epidemiologists (accompanied by suitable diagnostic capacity) are an important part of the health security agenda. A strong force of trained staff and teams available for rapid deployment in emergencies boosts host countries' public health systems in 'peacetime,'

while greatly strengthening global health security through their availability for quick response elsewhere. Emergency responders should not meet barriers, nationally or internationally, in their work; response must take precedence over everyday laws and processes.

Humanitarian preparedness capacity must be better integrated into the preparedness capabilities of governments and regional entities at the interagency level.

Recommendations

- Health planning must include the needs of mobile populations such as migrants, refugees and internally displaced persons.
- Strengthening primary health care in and around border spaces is as important as strengthening measures at points of entry.
- Health security strengthening through preparedness actions should be based on key performance indicators (KPIs), facilitating measurement of progress and contributing to transparency.
- NGOs and national and international civil society should be included in the full cycle of planning, assessment, implementation, and monitoring and evaluation.

Part 3: Implementing national preparedness plans

Session 3.1: Fostering intersectoral collaboration for greater impact

Chair: Dr Sinata Koulla Shiro, *Secretary-General for Health, Republic of Cameroon*

This session was dedicated to sharing lessons and addressing how collaboration can be improved, and support for countries better aligned. It was divided into three parts: One Health; Whole of society; and Whole of Government.

Session 3.1.1: One Health: emerging epidemic and pandemic threats

This session addressed relationships between ministries of health and those in charge of animal health and the environment, proposing ways to improve cooperation between services.

Panel speakers were **Dr Nguyen Ngoc Tien** of the Vietnam Department of Animal Health; **Dr Sigit Priohutomo** of the Ministry of Human Development and Culture, Republic of Indonesia; **Mr James McGrane** of the Food and Agriculture Organization (FAO); **Dr Apichai Mongkol** of the Thai Ministry of Public Health; **Dr Ikuo Takizawa** of the Japan International Cooperation Agency (JICA); and **Dr Susan Corning** of the World Organisation for Animal Health (OIE).

Key points of discussion

The integrated nature of the SDGs, the general goal of health security and the context of emerging dangerous pathogens require a multisectoral approach to achieving health improvements, and the One Health framework can be a very good means of spearheading such an approach. In outbreaks, the responses of the animal, human and environmental sectors must be coordinated, and national veterinary

capacities must meet international standards—but many countries do not have the capacity or infrastructure to achieve this. Legislative frameworks and collaboration mechanisms are needed to facilitate the multisectoral collaboration and surveillance required by the One Health framework; such frameworks should be chaired by the highest national authority in order to ensure the necessary political leadership and support. In an emergency, a country's PHEOC can be used to hold regular meetings of national and international experts from all relevant ministries. On a wider scale, bilateral agreements and regular meetings with experts from neighbouring countries can boost regional preparedness.

Research and training institutions should be strengthened, and guidelines, integrated training, and compliance infrastructure developed as tools for prevention. These should include guidelines for zoonotic outbreaks using One Health that cover the coordination and planning of emergency response. Laboratory networks can be strengthened by incorporating veterinary diagnostics and laboratories, backed up by an integrated surveillance database.

Community engagement and strengthening is important to One Health. Planners should remember that agricultural and animal workers can enjoy the trust of rural communities in situations (as in the Ebola outbreak) where it may have been lost by health personnel. In such scenarios, their role in awareness raising and containment is crucial.

There are always challenges to sectors working together, and leadership matters, as do champions at all levels. The playing field is often uneven, and well-resourced sectors must work with less-resourced sectors to help them raise their capacity. Implemented correctly, the WHO JEE and the OIE Tool for the Evaluation of Performance of Veterinary Services (OIE PVS) allow capacity evaluations and gap analyses that help countries consider priorities and devise costed strategies

to address them. Other opportunities exist: for instance, OIE's joint national bridging workshops, which enable countries to develop clear, robust joint national health strategies; and the USA's EPT (emerging pandemic threats) 2 programme.

Strong animal health capacity boosts detection and rapid response to health-threatening crises, and is important in assessing emerging infectious disease and viral amplification along livestock value chains. A wildlife and ecosystem perspective should be incorporated into preparedness; wildlife professionals should engage with Ministries under the One Health banner, contributing to triangulated surveillance at the human/livestock/wildlife interfaces. Workforces can be developed through joint FETPs for medical and veterinary personnel.

Practical, intersectoral interventions are urgently required to support sustainable agriculture in a manner that addresses AMR by engaging with agricultural stakeholders, livestock producers, and the aquaculture and food industries. Arguments that antibiotic health promoters are needed to make business efficient may not stand up to evidence: recent Dutch studies suggest there are ways to change animal management and remain profitable.

Recommendations

- Country preparedness plans must be urgently developed or updated, taking into consideration One Health, whole of society and whole of government approaches.
- Legislative frameworks are required for working together across ministries/sectors.
- Technical guides and controls should be used, or designed where necessary, to help ministries work together on zoonoses and shore up the legislative framework. These should be underpinned with training.
- Establish coordination mechanisms between sectors guided by a multisectoral steering committee chaired by a political authority of the highest level.
- Clear definitions should be used for common goals and areas of interest (e.g. AMR, One Health), underpinned by common frameworks or approaches to anchor collaboration.
- Exercises and simulations should be conducted to strengthen collaboration.

Session 3.1.2: Whole of society: globalization, federalism and overseas territories

Chair: Professor David O. Freeman, University of Alabama

This session examined the role of the trade and tourism sectors in health emergencies, and that of the state in developing capacities throughout federated jurisdictions and in overseas territories.

Speakers were **Ms Ansa Jordaan** of the International Civil Aviation Organization (ICAO); **Dr Lubunmi Ojo** of the Center for Disease Control and Prevention, Nigeria (CDC Nigeria); **Ms Nurhayati Ali Assegaf** of the Republic of Indonesia House of Representatives; **Dr Habib Millat**, Member of Parliament, People's Republic of Bangladesh; and (represented in a speech read by Dr Stella Chungong) **Dr Dirk Glaesser** of the UN World Tourism Organization (UNWTO).

Key points of the discussion

2015 saw 1.2 billion international arrivals; as of 2014, 47 per cent of these were in emerging economies, a figure expected to be 57 per cent by 2030. This volume of travel presents health risks, but it is also possible to view this dynamic in reverse: health concerns are barriers to travel that can have grave economic impact. Individual travel is not limited to tourism; it includes migrants and refugees, as well as movement to and from overseas and federated territories. The global economy also includes business travel, temporary labourers, aid and relief workers, and other mobile populations. Capacity building for global health security should therefore address travel medicine discipline and medical preparedness and risk communication to individual travellers. This is crucial to provide advice and reassurance, elucidate the transmission parameters of any given outbreak, and equip travellers to mitigate risk themselves. All these measures should be underpinned by the IHR and solid systems for contact tracing, monitoring and diagnostics.

Tourism is of great and growing economic importance; while it is resilient globally, it is highly volatile at destination level, putting the economies

of tourist destinations at heightened risk from health events. Health security therefore requires a strong focus on resilient tourism development, founded on an all-of-society approach to health security with fast, accurate reporting, transparent information sharing, risk assessments, and evidence-based decision making.

In this context, the International Civil Aviation Organization (ICAO) plays an important public health role. ICAO's CAPSCA programme (or Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation) builds capacity for health security, convening aviation stakeholders, carrying out assistance visits to states—often in partnership with WHO—to evaluate preparedness, performing gap analyses, and assessing national emergency preparedness plans and aviation-related emergency plans. One of the most important steps states can take to prevent the international spread of vector-borne disease is to institute airport vector control practices. As this is a complicated area in which different countries operate in different risk contexts, ICAO is working on improved health risk assessments.

Interagency coordination is particularly important in federated states; any national health crisis centre or similar body in such a state should have the authority to coordinate with other bodies, monitor cross border travel, and run risk communications and awareness campaigns to prepare society for action in emergencies. Outside national capacity building and programmes to strengthen health systems at all levels, federated states benefit from national level coordination forums in which states or devolved territories can interact. A PHEOC can achieve this in emergency scenarios; task forces around particular issues (for example, Indonesia's SDG Task Force) can provide direction and support; and networking is important. Organized gatherings of state authorities to increase buy-in, support for, and ownership of national initiatives can help ensure the necessary leadership at state level. This process is helped by centralizing training programmes, and making structured efforts to encourage states to send key health workers to these programmes.

Recommendations

- Capacity building for global health security should address medical preparedness and risk communication to individual travellers.
- Countries should prioritize travel medicine discipline, ensuring that those making journeys are vaccinated, and take appropriate prophylactics and other precautions.

Session 3.1.3: Whole of government: the health and security interface

Chair: Professor Vernon Lee, Deputy Director Communicable Diseases, Ministry of Health, Republic of Singapore

This session presented existing joint initiatives by the health and security sectors, focussing on shared values and responsibilities in risk management.

Speakers were **Dr Liana Torosyan**, Ministry of Health, Republic of Armenia; **Dr Mika Salminen**, National Institute for Health and Welfare, Finland; **Dr Hillary Carter**, Department of State, United States of America; **Dr Joel Lumbasi Lutomiah**, Kenya Medical Research Institute (KEMRI); and **Dr Saif Al-Abri**, Ministry of Health, Sultanate of Oman.

Key points of the discussion

Stable populations are crucial to health security. The health and the security sectors are aware of the causes and consequences that link them together, and seek the same end state of healthy populations and stable societies. While the health sector can focus on diseases of greatest burden, the security sector can focus on uncommon but dramatic events. Collaboration is often challenging but yields clear benefits. In smaller countries, resources can be saved by avoiding situations where redundant parallel structures operate across sectors.

Preparedness for emerging and re-emerging infectious disease threats requires engagement of the whole of government. Such collaborations can be based on legislation or contractual agreements between the health and security sectors, and may cover such areas as diagnostics for unusual

infections; national preparedness; raising awareness on biorisk management; legislative training; and ensuring cross-sectoral collaboration on risk assessment, epidemic intelligence, international collaboration in arms control, and joint research. Cross-sectoral activities can be overseen by subnational and national standing bodies for particular technical areas.

Areas in which technical collaboration may be particularly fruitful include border health security; certain communicable disease risks; development of standard operating procedures (SOPs) for elements of response; PHEOC design and operation; synchronicity in response, particularly through the use of military logistics and capabilities in outbreak situations; development and running of training and simulation exercises; laboratory cooperation and capacity strengthening; addressing AMR; systems for sharing knowledge and real-time communication of outbreak investigation; use of GIS and mapping data; strengthening surveillance; and disaster risk reduction and management.

Recommendations

- Focus on strengthening partnerships between the health and security sectors, particularly in resource-limited settings.
- Recognize the distinct role of the security sector in preventing destabilizing consequences of health emergencies.

Session 3.2: The WHO Strategic Partnership Portal

Chair: Ludy Suryantoro, *External Relations, WHO headquarters*

In this session, WHO demonstrated how the WHO **Strategic Partnership Portal (SPP)** can use the outcomes of measuring tools to capture and regularly update countries' needs, and provide transparency on partners' contributions to addressing them.

The session opened with a presentation by **Dr John Ojo** of the WHO Country Office in Ghana, introducing the WHO SPP web portal. The portal can be found at:

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

The portal is a Member State-mandated information-sharing web platform that was designed to enhance communication between countries, donors, partners, and WHO around financial and technical support to countries.

This comprehensive, open-access platform maps stakeholder contributions. It shows who is doing what, where, fostering complementarity and increasing transparency around countries' needs and gaps.

Dr Ojo outlined the interface of the WHO SPP and gave a brief demonstration of how to use it.

Panel speakers were **Dr Mathew West**, International Health and Biodefense, United States of America; **Dr Wondimagegnehu Alemu**, WHO Representative for Uganda; and **Ms Azusa Sato** of the Asian Development Bank (ADB).

Key points of the discussion

Experiences in countries with a number of different partners supporting IHR-related activities has shown that the actions of different partners and stakeholders can be unclear. As a result, work is prone to overlap and duplication. A major concern under such conditions is who is doing what, where, and with what resources; and how to harness opportunities to address gaps. The WHO SPP—which is populated with information from assessments and initiatives to strengthen

IHR core capacities such as the WHO JEE and the Global Health Security Agenda (GHSA)—provides a solution to this, easing coordination and increasing transparency. Supported by focal points liaising with stakeholders and collecting and communicating information, the SPP allows transparency of donor and government input and displays ongoing activities.

Adequate resources are not always available at country level. The SPP provides a means of helping ensure resources are matched to contexts where they make a difference. It places WHO in a key position to coordinate at country level, helping avoid duplication and offering the leadership role that Member States request.

Donors often face difficulties that could be eased by the SPP. For new donors in particular, abiding by standards of harmonization and alignment while building capacity can be challenging. An example was provided by the Korea International Cooperation Agency (KOICA). KOICA decided to prioritize avoiding duplication and establishment of standalone projects. This meant a great deal of travel to partners became necessary, in order to assess the often-complex operational situations in various countries so that duplication of ongoing initiatives could be avoided. This had severe cost implications. The SPP could increase its usefulness by sharing specific details of ongoing projects, enabling new donors to identify the best targets for support.

Following the launch of the SDGs, the International Health Partnership (IHP+) is being transformed into the International Health Partnership for UHC 2030. This partnership platform aims to improve aid effectiveness through better health partner coordination, in line with the principles of the 2005 Paris Declaration on Aid Effectiveness and the 2011 Busan Partnership Agreement. Presently it counts 54 member countries and multiple bilateral, international, UN Development organization and civil society partners. The International Health Partnership for UHC 2030 forms a solid platform to improve coordination of recipient countries and partner support for IHR capacity building and emergency preparedness and response.

Recommendations

- Ensure the WHO SPP is continuously updated with correct, up to date information.
- Devise a mechanism for ensuring the data in the system is up to date and of high quality.
- Use the WHO SPP to ensure harmonization and alignment between donors.
- The WHO SPP should share not only titles of ongoing projects but also specific details.
- The WHO SPP should also monitor progress and return on investment, so it can be used to develop business cases for investment.

Session 3.3: Breakout: thematic working groups with different scenarios

In this session, the meeting separated into four working groups, focused respectively on **national planning; global mechanisms; resource mobilization; and monitoring, evaluating and reporting**. These groups explored how the Strategic Framework for Emergency Preparedness can be operationalized in the context of a public health emergency. The emergency scenario was based on a fictitious country experiencing an outbreak of a fictitious disease, and was split into three episodes: preparedness; detection and initial response; and escalation and full response.

Group recommendations for action

3.3.1 Preparedness

National planning

- Each phase of a response requires rigorous, systematic planning by all stakeholders, taking into account the dynamic nature of risk. Risks should be prioritized, looking at hazards, vulnerabilities and seasonability. Slow and long-term risks, including climate change, should not be overlooked. Plans should adopt a multisectoral, all-of-society, One Health approach that develops IHR core capacities through training and other mechanisms, and protects vulnerable country interests (such as tourism).
- Perform full capacity assessments of both veterinary and health services; identify internal and external resources to assist preparedness and response.

- Ensure a laboratory mechanism is in place to scale up diagnostic capacity in an emergency, with planned methods for introducing new technologies.
- Emphasize risk communications. Ensure communities are sensitized and ready to contribute to responses.
- Identify vulnerable communities. Plan for how to continue routine services and deal with noncommunicable diseases (NCDs), especially maternal and child health, in emergency scenarios.
- Consider the background disease burden and decide on the nature of the continuum between routine and emergency responses.
- Ensure contingency plans are developed for high-risk events (e.g. mass casualty management).

Global mechanisms

- Ensure intercountry arrangements are in place, through subregional and regional integration mechanisms. International coordination should fit around national coordination.
- Perform a JEE if necessary and ensure the outcome feeds into planning.

Resource mobilization

- Consider insurance mechanisms for affected communities, possibly within the context of UHC. Determine how national resources and contingency funds can be used to address priority actions. Other funding mechanisms might include leveraging the Sendai Framework for Disaster Risk Reduction and/or the SDGs; the Pandemic Emergency Financing Facility (PEF); and regional solidarity funds.
- Coordination mechanisms should also serve for information management and sharing.
- Regional organizations should clarify their roles in resource and workforce mobilization for preparedness and response.

M&E

- Real-time incident review must be embedded in the planning phase, giving room to explore methods to identify what works in an emergency and adjust strategy in real time as it evolves.
- The international community should examine in-country coordination mechanisms, and partners should fit as much as possible into those mechanisms. This may be challenging and could require strengthening national mechanisms.

3.3.2 Detection and initial response

National planning

- Appoint an incident manager; inform government; and activate the PHEOC.
- Prioritize information sharing: partners need clear, accurate information in order to act quickly. Information must be shared with and beyond neighbouring countries in line with the IHR. Base this on enhanced surveillance but incorporate informal networks.
- Instigate a series of response activities based on the plans. These might include investigations; deploying rapid response teams; risk communications; triage; improving relationships with surrounding countries; and seeking further international response partners.
- Emphasize media management and communications.
- Develop protocols for contact tracing, case definitions, and training investigation and case teams.
- Ensure the health of health workers is protected.

Global mechanisms

- Ensure involvement of international partners in the initial response. Make sure the international community can see clear national leadership, as a focal point around which to convene international partners.
- Ensure responsibilities for cross-border collaboration and coordination are clear. Clarify the role of regional and subregional technical and economic integration mechanisms in the early phases of the response, both in political terms and in terms of aligning risk communication messages.
- WHO should facilitate information sharing, sample sharing, interactions with industry, and involvement and communication with other international organizations like the FAO and OIE.

Resource mobilization

- Maintain policy dialogue with donors; identify available finances and expertise.

3.3.3 Escalation and full response

National planning

- Declaration of a public health emergency of international concern (PHEIC) is a milestone in reviewing operation plans: revisit surge capacity and expand multisectorality. Each ministry and sector should have a clear role and responsibility.
- Ensure political leadership at the highest possible level.
- Emphasize social measures to prevent spread.
- Increase communications between ministries.
- Focus on media relations; it may be necessary to expand the traditional spectrum of partners and collaborators.
- Discuss sector-specific measures as determined by context (e.g. animal health, immigration, border security, etc.).

Global mechanisms

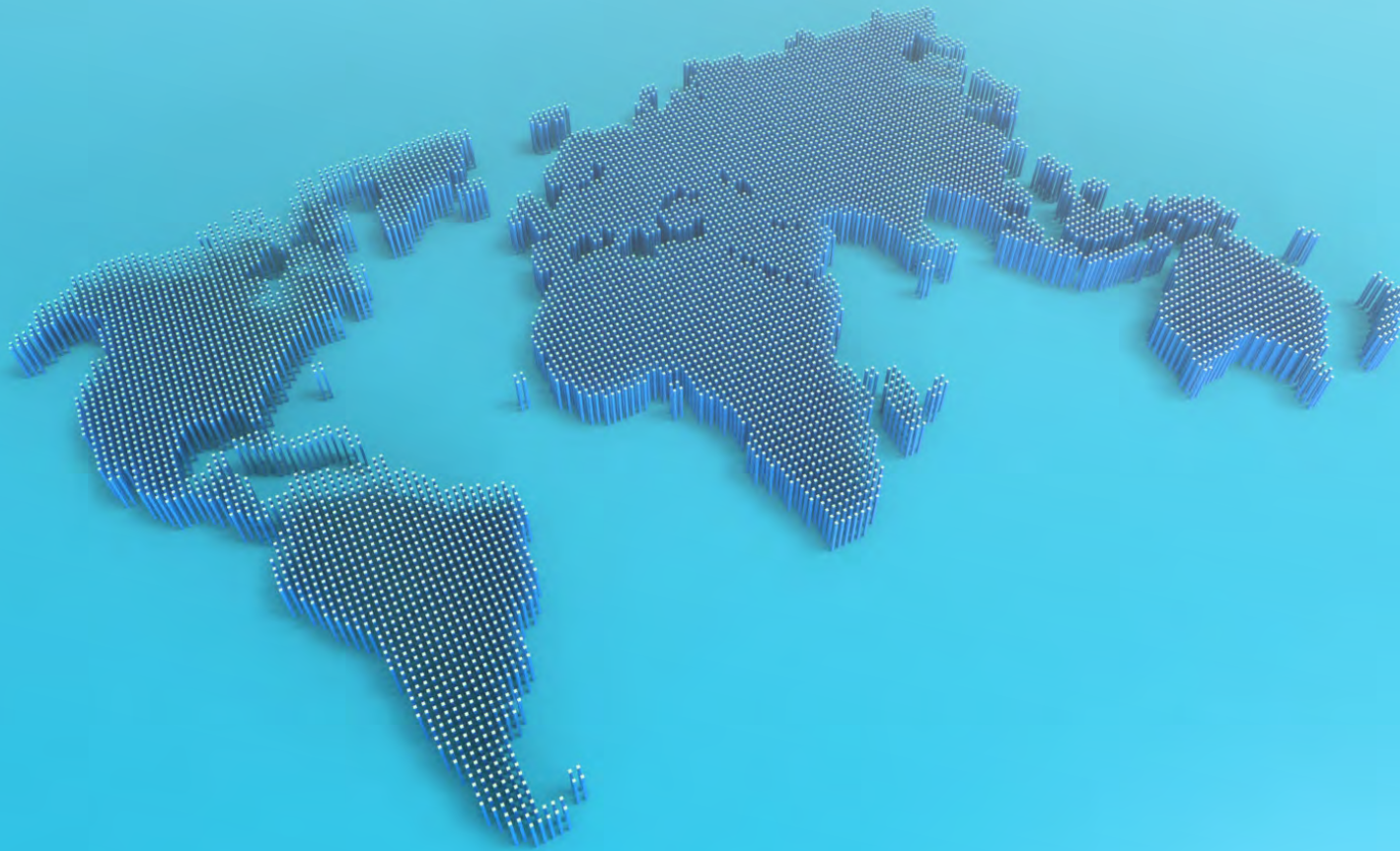
- Reporting must be prioritized and must take place at local, regional, country and international levels.
- Expect WHO to undertake a number of measures including the activation of technical working groups and incident management mechanisms, and mounting an operational response.

Resource mobilization

- Involve donors in direct dialogue with ministries of finance to ensure clarity on what government requires, and make sure that the response plan is costed and in accordance with ministry rules and regulations.
- Do not expect external parties to fund everything. Preparedness and response must be funded primarily at national level.

M&E

- Ongoing risk assessment is important; priorities will change over time and in response to events.



Part 4: Sustainable funding for national preparedness planning and implementation

Session 4.1: Securing domestic investment for preparedness

Chair: Ms Pia Locatelli, *Member of Parliament, Italy*

This session aimed to strengthen country investment in global health security with domestic resources, regional support and development aid. It highlighted the role of parliaments and governments in ensuring sustainable funding for health emergencies.

Panel speakers were **Dr Faustine Ndugulile**, Member of Parliament, United Republic of Tanzania; **Mr Hoang Minh Duc**, Ministry of Health, Socialist Republic of Vietnam; **Mr Ben Rofler** of the Asian Development Bank Malaria Initiative; and **Professor Simplicie Dagnan**, National Institute of Public Hygiene, Côte d'Ivoire.

Key points of the discussion

Speakers touched on contextual factors explored in earlier sessions, outlining the challenges and risks facing health security planners and responders. They expressed the hope that these will be addressed by the agenda of global health security, ensuring in-country commitment to action. They pointed out that countries must perform JEEs and national preparedness planning, and mobilize public and private domestic financing.

Domestic investment for preparedness is crucial; long-term sustainability can only come with effective use of domestic resources. This requires ownership, capacity, experience and good practice at country level, and good evidence for the overall welfare benefits of preparedness. In addition, it calls for transparent working relationships with international and private sector partners for joint assessment of capacities and gaps. This helps encourage and direct sourcing of public and private investment at national level. Though

they are often overlooked in dialogues around planning, the input of members of parliament (MPs) is central to achieving this.

These strategies require the buy-in of community leaders and representatives of the people, and MPs are the gateway to achieving this. They also have an oversight role in government—critical in ensuring that agreements are followed up, monitored and legislated—and an international role in ensuring adherence to health security commitments and setting wider priorities (mainly through interparliamentary groups). MPs can champion health security, engaging government and other stakeholders. With all this in mind, they also have an important role to play in ensuring funding through budget processes, and through using their familiarity with national structures to seek out additional, specific domestic resources to support technical agendas like One Health. Their engagement across all national level health security activity is crucial. Dr Ndugulile concluded: “We MPs are important partners: engage us; inform us; involve us.”

Because investment in health is indirect, often without obvious immediate benefits that generate political capital, it can also be useful to encourage technical partners to engage and advocate to decision makers. They should package the health security message in terms of numbers and constituency impact, and using available resources as effectively and efficiently as possible.

In countries with limited resources, assessment of the whole system is important in identifying priority areas for resource allocation. Locating resources in response situations may require different action plans for different pandemic situations. Systems for intersectoral collaboration are an important focus area that needs relatively few resources; laboratories and early warning systems are of particular importance; and so are logistics and stockpiling. Focusing on these priorities provides a clear basis on which to push for further investment. Efficiency is also crucial: resource-limited countries must do more

with what they have, looking for commonalities across concerns and ensuring holistic dialogue based on sound evidence. A focus on tracking available resources is important: constructive dialogue must be supported by clear evidence of financing—what is being spent and how.

Crises can be used to galvanize political leadership and improve health care access for marginalized populations. This can be done according to two basic principles: (1) never waste a crisis; and (2) ensure that when one does come about, it is met with a policy process supported by strong business cases and constructive partnerships between civil services, parliamentarians, academia and other knowledge partners. In Côte d'Ivoire, for example, the Ebola epidemic resulted in new and greatly accelerated systems for rapid mobilization of resources that have boosted IHR core capacities and which remain in place now that the epidemic is over. This change was backed by strong commitment from the health ministry, the President's direct support and supervision, and a framework underpinned by official Decree. A crisis properly exploited has meant a new, longer-term situation in which responders can count on central government support.

Development banks also offer channels through which sustainable domestic financing can be encouraged, such as the World Bank's multi-donor trust fund to ensure sustainable financing, which includes a fund for health security. Such channels generally leverage national financing to strengthen domestic systems.

Specific examples of innovative and sustainable domestic financing schemes include a tobacco tax implemented in the Philippines to raise funds for health financing; social health insurance for NCDs or health security measures; and investment from development banks looking at investment in health security as quasi-capital expenditure qualifying for concessionary lending, rather than as a recurring cost.

Recommendations

- Technical partners should advocate and engage all levels of government, focusing on constituency impact.
- Ensure MPs are engaged in global health security, and that they advocate upwards;

leadership and commitment from the highest possible level is critical. Attempt to build cross party alliances within parliaments to exert pressure for results.

- Never waste a crisis; when a crisis does happen, engage in a policy process to build back stronger.
- Ensure resources are tracked so that domestic policy is based on sound financial evidence.
- An international parliamentary consultation forum should be convened to draft legislation and strategies to support countries' commitments to sustainable domestic investment in global health security.
- Consider initiatives by development banks and others to strengthen domestic financing systems.
- Consider creative means of financing such as directed taxes, health insurance and concessionary borrowing.

Session 4.2: Financing national preparedness plans

Chair: Mr Patrick Osewe, *Global Lead - Healthy Societies, World Bank Group*

In this session, partners assessed recent commitments to investing in preparedness, and discussed sustainability. The session opened with a presentation from the Chair outlining the nature and achievements of the World Bank's Pandemic Emergency Facility, or PEF.

Panel speakers were **Dr Ron Waldman**, United States Agency for International Development (USAID); **Ms Caroline Jehu-Appiah**, African Development Bank (AfDB); **Mr Young Sik Park**, South Korean Bureau of International Cooperation; **Dr Vernon Lee**, Ministry of Health, Republic of Singapore; and **Mr Tran Van Ban**, Ministry of Health, Socialist Republic of Vietnam.

Key points of the discussion

A paradigm shift is needed for health financing, based on intelligent development finance that goes beyond filling existing gaps. State budgets can be targeted to achieve development goals and meet fundamental health indices, ensuring access to primary health care, quality health services, and safe, healthy living environments.

Communities are instrumental to surveillance and disease control, but often get insufficient attention in financing. Global health security is based on the health of individuals, families and communities, and funding to strengthen those communities is important. International initiatives exist to promote this—for example, USAID supports a number of projects to strengthen health security at community level, including through the International Committee of the Red Cross (ICRC) and through work with private sector consortia on supply and logistics for emergency preparedness and response. The African Development Bank also tries to support communities—for example, through a post-Ebola social recovery fund that attempts to increase availability to selected social services and build community resilience.

Lessons are often not learnt. For example, the many successes of family planning initiatives since the 1960s were not successfully applied to the HIV epidemic, leaving a lot of institutional value unused—family planning consultations, use of trusted health professionals, contraceptive distribution networks, etc. Now, after 40 years of HIV (the best funded disease ever and one that has inspired huge innovation) lessons identified around community mobilization, strategic planning, action planning and so on are not being applied to pandemic preparedness. They should be.

Not all health security scenarios are identical. Outbreaks and pandemics can be managed by ministries of health, but other ministries and groups will have to deal with events in which health ministries may play secondary roles; preparation is required for this, based on a whole-of-government, whole-of-society approach. Different sectors and ministries must bring different resources and financing to the table according to their own particular responsibilities. For major crises, countries must draw on national funds. In situations where funding is limited countries must enhance the effectiveness of what resources they do have, targeting efficiencies, collaboration and partnerships.

Priority should also be given to raising the profile of health security spending and maintaining momentum. Risk communication and high profile exercises such as simulations can be used to sustain efforts, build the agenda and exert

pressure on leaders. Ministries of finance must be targeted if national health security efforts are to be adequately resourced.

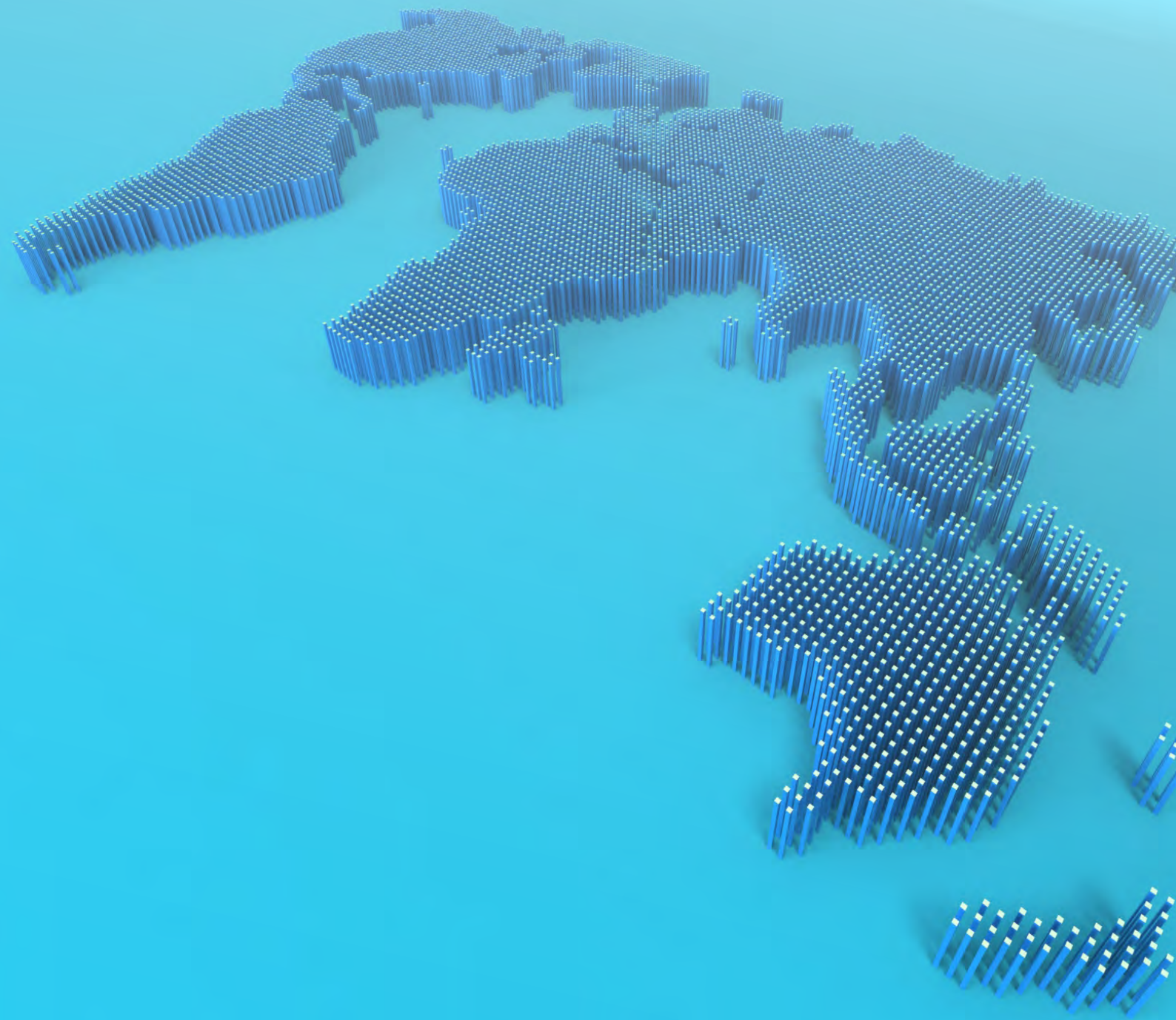
Many facilities exist to support countries in financing national plans: for example, the African Development Bank (AfDB) offers the transition state facility; a special relief fund; and a value for money trust fund. It is important to ensure joint approaches for resource mobilization and complementarity between existing funds.

It was suggested that the best way to achieve economies of scale may be regional initiatives, akin to the World Bank's 330 million US dollar grant to 15 countries in West Africa.

Planning must also consider that in a true pandemic situation, foreign assistance may not be available. Most countries could find themselves alone, and disrupted systems might include international banking. Preparation now is critical to mitigating potentially devastating mid- and long-term consequences.

Recommendations

- Ministries of finance must be fully engaged in preparedness planning.
- Preparedness must consider pandemic scenarios in which no external assistance is available and even the most fundamental systems break down.
- Development finance should go beyond filling existing gaps.
- A strong whole of government approach is required for financing national planning.
- Lessons from past epidemics and events (for example, the HIV pandemic) must be applied to health security.
- Good accountability frameworks are required to demonstrate that investments are making a difference.



Discussion of the Strategic framework for emergency preparedness

Chairs: Dr Ron Waldman, USAID; and Mr Richard Gregory, DFID

A summary of WHO's new holistic framework for emergency preparedness was presented by **Dr Stella Chungong**. The *Strategic framework for emergency preparedness* does not set out to replace existing resources, but rather to build on different frameworks, helping ensure coherence and outlining what is needed to strengthen emergency preparedness in countries. The framework presents areas where investment in preparedness could be directed, and is based on a number of key principles: keeping communities at the centre of planning; a One Health approach ensuring coordination at the human/environmental/animal interface; building and reinforcing resilient health systems; and an all-hazards, whole of society ethos backed up by a virtuous cycle of risk management, monitoring and evaluation that also provides a basis for coordinated financing.

Organized into different levels, the framework highlights: in country preparedness required for operational readiness; the need for continuous strengthening of multisectoral responses; mechanisms, plans and resources for health emergencies; and the actions, infrastructure and resources required for resilient health systems.

This session was an opportunity for those present to help improve the document.

The Chairs explained that the team working on the document would be happy to receive written feedback on the framework, and invited all who wished to contribute in detail to submit written comments to Dr Stella Chungong.

Participants were asked to highlight any resources that might have been overlooked in Appendix 3 of the framework, which contains links to other relevant frameworks and tools.

Key points of the discussion

A number of suggestions were made to improve the document. These included:

- Framing it more explicitly from the point of view of financing and implementation, with the addition of clearer objectives and goals.
- Making firm distinctions between capacities and capabilities throughout the framework—the former are system components; the latter are the abilities and performance of the system. The 11 points in the framework should “be distinguished in terms of what constitutes a fundamental capacity, and what is an ability that can be performed to reach a goal.”
- The document should contain conclusions on how plans can be organized and implemented according to specific risks.
- Since the Ebola epidemic, considerable discussion has taken place about the principles of the UN Inter-Agency Standing Committee (IASC), clarifying roles and responsibilities for IASC members in responses to health crises. It may be useful for the framework to flag the outcomes of these discussions. It should also reference the tools and services (financing mechanisms, for example) that IASC members can put at the service of national governments.
- The framework appears to assume the ability to identify risk; but it should emphasise the capacity (or lack thereof) of systems to do this in more marginalized areas. Risks emerge at community level, where more engagement is required.
- The framework shows what should be done, but should also consider how countries make choices about where to start. In resource-limited environments, this choice can be difficult. The document could attempt to address the sequence in which capacity should be put in place, considering tiered levels of importance and the role of regional collaboration to cover gaps while countries are building capacity.
- The 11 elements of emergency preparedness in the framework could be clearer on how

they relate to animal health and veterinary issues; or another element could be added that specifically addresses the One Health aspects of preparedness. This could contain more reference to the FAO/OIE/WHO framework in relation to information sharing and early warning systems. Further discussion may be required on whether to consider One Health a principle or a strategic approach.

- The document should attempt to differentiate what constitutes part of a routine disease burden from emergency preparedness.
- Approaches to strategic funding are required that address planning and funding preparedness as an element of health systems strengthening.
- In a true pandemic scenario where traditional donor countries are severely affected, external assistance to less-resourced countries is not assured. The specific needs of this scenario must be addressed. When systems break down, the document must consider community requirements such as routine immunization and access to and quality of health care services. Addressing these challenges in one overarching framework would be impossible—they require detailed planning that varies from country to country—but the document must stress the need to address them.
- The framework should make explicit reference to migrant populations caught up in crises; regardless of their status, these populations should be included in national plans.

Closing sessions

High level recommendations

Dr Guénaél Rodier presented a meeting summary including recommendations and next steps. Recommendations were as follows.

The Bali meeting participants recommend the following:

1. **Current momentum around health security must be sustained and scaled up through continued, coordinated action led by WHO.** Through concrete, step-by-step actions for preparedness, health systems must be strengthened towards the achievement of universal health coverage (UHC), thereby strengthening health security.
2. The new monitoring and evaluation framework for IHR represents a step forward. Further concrete action is needed to translate identified gaps into financed action and, eventually, into preparedness outcomes. **Results of the JEE and/or other assessments should be used to review or develop plans and fund and accelerate actions to meet priority needs.**
3. **In the finalization of the strategic framework for emergency preparedness, WHO must take into account key points from the discussions held during the meeting**—noting that the strategic framework aims to strengthen emergency preparedness across communities at sub-national, national, and international levels.
4. **In implementing the framework**, participants request that:
 - a. The framework is used to reflect the common platform for stakeholder engagement and for fostering collective partnership for action.
 - b. **The outcomes of emergency preparedness assessments are included as part of long-term national health strategic plans (NHSPs).** These should strive for outcomes linked to: (1) operational readiness; (2) resilience of health systems and workforces; (3) the One Health approach; (4) a whole of government, whole of society approach to preparedness; and (5) resilience of communities.
- c. **Prioritized investments in preparedness are driven by country ownership, strong political leadership and sustainable domestic resources.** Operationalizing preparedness requires action and constant monitoring that needs continuous political and financial support. Countries—especially the most vulnerable countries—need these in order to reduce the human, economic and social costs of health emergencies.
5. **A sustained, long-term mechanism is needed through which financial and technical resources can be channelled to priority needs.** Alongside domestic leadership mentioned above, international financial and technical support remains crucial to support the preparedness activities of ministries, civil society and technical partners.
6. **All stakeholders must share information regarding ongoing and planned investments to strengthen global health security, and must use WHO’s Strategic Partnership Portal (SPP) to highlight needs, gaps, priorities and achievements in advancing health security and health systems resilience.** Participants drew attention to the SPP’s usefulness as a tool for transparent coordination between countries, donors, partners and WHO, in line with the principles for aid effectiveness as set out in the International Health Partnership for UHC 2030.
7. **An international parliamentary consultation forum** should be convened to draft legislation and strategies to support countries’ commitments to sustainable domestic investment in global health security.

Immediate next steps

- In the month following the meeting, strengthen the strategic framework for emergency preparedness and share it with stakeholders
- Initiate the roll-out of the framework in all countries and territories, backed by strong national leadership and support from partners
- Monitor and assess the roll-out of the framework
- Update the SPP regularly with information from countries and partners
- Use the framework to inform decisions on Country Health Emergency Preparedness
- Strengthen existing partnerships and develop new ones
- Continue discussions with financing institutions
- Share the outcomes of the Bali meeting, and advocate for the multisectoral implementation of emergency preparedness at every level, in accordance with national priorities.

Closing statements

A number of participants made closing statements underlining their various national, international and organizational commitments to the priorities outlined over the preceding three days; reiterating the importance of global health security and the continuous implementation of the IHR; and welcoming the emerging consensus for action on global health security.

The meeting was then closed with speeches from **Dr Poonam Khetrpal Singh**, WHO Regional Director for the South-East Asia Region; and **Dr Siswanto**, Director General of the Indonesian Ministry of Health's National Institute of Health Research and Development.

Annex A – meeting agenda

MONDAY, 27 June 2016

All sessions will be held in the Balai Raya plenary room

8.00 – 9.00 **Registration and welcome coffee**

9.00 – 9.30 **WELCOME AND OPENING REMARKS**

- **Dr Poonam Khetrpal Singh**, Regional Director of WHO South-East Asia Region
- **Dr Matshidiso Moeti**, Regional Director of WHO for Africa
- **Dr Bruce R. Aylward**, Executive Director a.i., Outbreaks and Health Emergencies and Director-General's Special Representative for the Ebola Response (by video message)
- **Pr. Nila. F. Moeloek**, Minister of Health, Republic of Indonesia

PART 1 - INTRODUCTION AND SCENE SETTING

9.30 – 10.30 **SESSION 1.1** From Cape Town to Bali: What has been achieved?

Purpose: This session is a high-level discussion at which country representatives and stakeholders will present successes and challenges in advancing key elements of health security, and how this fits within the overall drive to achieve the SDGs.

Chair: Ms Malebona Precious Matsoso, Director-General of Health, South Africa

Panel Discussion:

- H.E. Ms Edith Schippers, Minister of Health, Welfare and Sport, The Netherlands (*by video message*)
- H.E. Nila. F. Moeloek, Minister of Health, Republic of Indonesia
- H.E. Aishath Rameela, Minister of State for Health, Maldives
- Dr Ana Isabel F.S. Soares, Vice Minister of Health, Timor Leste
- Ms Paivi Sillanaukee, Permanent Secretary of Ministry of Health, Finland
- Mr Go Tanaka, Counsellor at Office of Measures on Emerging Infectious Diseases, Office for pandemic influenza preparedness and response, Cabinet Secretariat, Government of Japan

Administrative Announcements

10.30 – 10.45 **Group photograph**

10.45 – 12.00 **Press conference for high-level dignitaries**

10.45 – 11.00 **Coffee break**

11.00 – 12.30 **SESSION 1.2** Looking to the future: Operationalising Preparedness for health emergencies

Purpose: This session will take stock of work done by WHO and partners in the area of country health emergency preparedness. It will highlight the spectrum of essential functions needed in the management of emergencies from the outbreak, humanitarian and health system perspectives.

Chair: Dr Victor BAMPOE, Vice Minister of Health, Ghana.

Video on Global Health Security (5 minutes)

Presentation by WHO (20 minutes)

Dr Guenaël Rodier, Director Global Capacities, Alert and Response on behalf of **Dr Edward Kelley**, Director, Service Delivery and Safety, **Dr Richard Brennan**, Director, Emergency Risk Management, and **Dr Sylvie Briand**, Director, Pandemic and Epidemic Diseases.

- Review the approach to health security with an emphasis on priority capacities for the International Health Regulations, recent recommendations of the IHR Review Committee, and programs to **ensure operational preparedness to prevent, prepare, respond, and recover from emergencies**.
- Highlight the importance of **health system resilience and of building health security** through an integrated health systems strengthening approach.
- Address how **epidemic-prone disease specificities** can be integrated into generic preparedness programs.
- Address health **emergency preparedness in the context of emergency and disaster risk management for health** and actions implemented through the Sendai Framework.

Panel discussion:

- Dr Ibrahima-Soce Fall, WHO Regional Office for Africa
- Dr Takeshi Kasai, WHO Regional Office for the Western Pacific
- Mr Balla Jatta, Ministry of Health, The Gambia
- Mr Richard Gregory, Department for International Development, United Kingdom
- Dr Salim Abdel Rahman Mohamednour, Ministry of Health, Sudan
- Dr Radjesh Johan Ramadhin, Ministry of Health, Suriname

12.30 – 13.30 Lunch

PART 2 - FROM ASSESSMENT TO NATIONAL PLANNING

Chair: Dr Poonam Khetrpal Singh, Regional Director, WHO Regional Office for South-East Asia

13.30 – 14.00 Presentation by WHO: Dr Stella Chungong, World Health Organization

Purpose: WHO will present the Preparedness Framework and will set out guidance for the appropriate investment in preparedness actions.

14.00-15.00 Session 2.1: Joint External Evaluation of Country Capacities

Purpose: The session will present the use of the Joint External Evaluation (JEE) tool, practical experiences from countries, and best practices for how the results of the JEE tool can help drive national priorities.

Panel discussion:

- Dr Hamid Jafari, Centres for Disease Control, United States of America
- Dr Safi Malik, Ministry of Health, Pakistan
- Dr Janneth Mghamba, Ministry of Health, United Republic of Tanzania
- Dr Salim Uzzaman, Ministry of Health, Bangladesh
- Dr Issa Makumbi, Ministry of Health, Uganda

15.00-15.30 Coffee break

15.30-16.30 **Session 2.2:** Joint Planning and Information Sharing

Purpose: This session aims at encouraging all technical and financial partners, together with WHO, to participate in joint planning through mechanisms such as the International Health Partnership (IHP+), intersectoral coordination etc.

Chair: Dr Matshidiso Moeti, Regional Director, WHO Regional Office for Africa

Panel discussion:

- Dr Hedayatullah Stanakzai, Ministry of Health, Afghanistan
- Dr Jordan Tappero, Centres for Disease Control, United States of America
- Ms Annegret Al-Janabi, German Federal Ministry for Economic Cooperation and Development, Federal Republic of Germany
- Dr Daddi Jima Wayessa, Ethiopian Public Health Institute, Ethiopia

16.30-17.15 **Session 2.3:** Engaging technical partners in national preparedness

This session will review the potential technical/operational inputs of technical partners, including NGOs and UN agencies, in national preparedness as well as the contribution of humanitarian and other actors at regional and country levels.

Chair: Dr Joy St John, Director of Surveillance, Disease Prevention and Control, Caribbean Public Health Agency.

Panel discussion:

- Dr Teresa Zakaria, International Organization for Migration (IOM)
- Dr Lorie Burnett, TEPHINET
- Dr Monica Rull, Médecins Sans Frontières (MSF)
- Dr Massimo Ciotti, European Centre for Disease Prevention and Control (ECDC)
- Mr Christophe Bayer, Federal Ministry of Health, Federal Republic of Germany

End of Day 1

TUESDAY, 28 June 2016

Plenary sessions will be held in Balai Raya room and breakout in both Balai Raya and Balai Ulu rooms.

09.00 – 09.30 **Day 1 Summary of discussions & Recommendations**

Dr Roderico Ofrin, WHO Regional Office for South-East Asia

PART 3: IMPLEMENTING NATIONAL PREPAREDNESS PLANS

Chair: Dr Sinata Koulla Shiro, Secretary-General for Health, Cameroon

09.30 – 11.00 **Session 3.1:** Fostering intersectoral collaboration for greater impact

Purpose: The session aims to share lessons learnt and address how we can improve collaboration and better align support provided to countries.

Session 3.1.1: One Health: Emerging epidemic and pandemic threats

This session will address the relationships between ministries of health and those ministries in charge of animal health and the environment, and will propose ways to improve cooperation between services.

Panel discussion:

- Dr Nguyen Ngoc Tien, Department of Animal Health, Vietnam
- Dr Sigit Priohutomo, Ministry Human Development and Culture, Indonesia
- Mr James McGrane, Food and Agriculture Organization (FAO)
- Dr Apichai Mongkol, Ministry of Public Health, Thailand
- Dr Ikuo Takizawa, JICA, Japan
- Dr Susan Corning, World Organisation for Animal Health (OIE)

11.00-12.30 Parallel Sessions**Room Balai Raya****Session 3.1.2:** Whole of Society: Globalisation, Federalism and Overseas Territories

This session will look at the role of the trade and tourism sectors in the context of health emergencies, and the role of the state in ensuring capacities are developed at all levels of federated states and in overseas territories

Chair: Prof. David O. Freedman, University of Alabama.

Panel discussion:

- Ms Ansa Jordaan, International Civil Aviation Organization (ICAO)
- Dr Lubunmi Ojo, Center for Disease Control and Prevention (CDC), Nigeria
- Ms Nurhayati Ali Assegaf, Indonesian House of Representatives, Indonesia
- Dr Habib Millat, Member of Parliament, Bangladesh

Room Balai Ulu**Session 3.1.3:** Whole of Government: The health and security interface.

This session will present existing initiatives between the health and security sectors and will be focussing on shared values and responsibilities between health and security in managing the risks.

Chair: Prof. Vernon Lee, Deputy Director Communicable Diseases, Ministry Singapore

Panel discussion:

- Dr Liana Torosyan, Ministry of Health, Armenia
- Dr Mika Salminen, National Institute for Health and Welfare, Finland.
- Dr Hillary Carter, State Department, United States of America
- Dr Joel Lumbasi Lutomiah, Kenya Medical Research Institute, Kenya
- Dr Saif Al-Abri, Ministry of Health, Oman

12.30-13.30 Session 3.2: Strategic Partnership Portal

Chair: Ludy Suryantoro, External relations, WHO

Purpose: During this session WHO will show how the Strategic Partnership Portal (SPP) is able to capture and regularly update countries' needs and gaps – based on the outcomes of the measuring tools – as well as the contributions of partners to address the identified gaps.

Presentation by WHO: Dr John Ojo, WHO Country Office in Ghana – Supported by Dr Grace Saguti WHO Country Office in Tanzania

Panel discussion:

- Dr Mathew West, International Health and Biodefense, USA
- Dr Wondimagegnehu Alemu, WHO Representative to Uganda
- Ms Azusa Sato, Asian Development Bank (ADB)

13.30-13.30 Lunch

13.30-13.45 **Introduction to Breakout Sessions**

13.45-15.45 **Rooms Balai Raya and Balai Ulu**

Session 3.3: Breakout Groups: Thematic working groups with different scenarios.

Purpose: The exercise will demonstrate how the Preparedness Framework can be operationalised in different settings and will illustrate how early investments in preparedness saves lives and prevents economic loss.

15.45-16.15 **Coffee break**

16.15-17.15 **Presentations by Breakout Groups**

Each working group will present the outcomes of their exercises. The outputs of the group discussions can be developed into short operational case studies that can be developed into annexes for the Preparedness Strategy.

17.15-17.30 **Summary of discussions & Recommendations**

Dr Sylvie Briand, WHO Headquarters

End of Day 2

WEDNESDAY, 29 June 2016

All sessions will be held in the Balai Raya plenary room

08.30-09.30 **PART 4 : SUSTAINABLE FUNDING FOR NATIONAL PREPAREDNESS PLANNING AND IMPLEMENTATION**

Session 4.1: Securing domestic investment for preparedness

This session aims to strengthen countries' commitments to invest in global health security with domestic resources, regional support and development aid. The session will also highlight the role of Parliaments and governance in ensuring sustainable funding for national health emergencies.

Chair: Ms Pia Locatelli, Member of Parliament, Italy

Panel discussion:

- Dr Faustine Ndugulile Member of Parliament, Tanzania
- Mr. Hoang Minh Duc, Ministry of Health, Vietnam
- Mr Ben Rofler, Asian Development Bank – Malaria Initiative
- Pr Simplicie Dagnan, National Institute of Public Hygiene, Cote d'Ivoire

09.30-10.30 **Session 4.2:** Financing national preparedness plans

During this session, partners will look back at the recent commitments on investing in preparedness and discuss sustainability.

Chair: Mr Patrick Osewe, Global Lead - Healthy Societies, World Bank Group

Presentation by the World Bank Group

Panel discussion:

- Dr Ron Waldman, USAID
- Ms Caroline Jehu-Appiah, African Development Bank (AfDB)
- Mr Young Sik Park, Bureau of International cooperation, South Korea
- Dr Vernon Lee, Ministry of Health, Singapore
- Mr Tran Van Ban, Ministry of Health, Vietnam

10.30-11.00 **Coffee Break**

11.00-12.00 **Discussion on the Strategic Framework for Emergency Preparedness**

Moderators: Dr Ron Waldman & Mr Richard Gregory

12.00-12.30 **Statements by Participants**

12.30-13.00 **Summary, High Level Recommendations & Next Steps – Dr Guenael Rodier**

13.00 **Close of the meeting - Dr Poonam Khetrapal Singh & Dr Siswanto**



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