DEVELOPMENT OF A GUIDE FOR MULTISECTORAL PREPAREDNESS COORDINATION FOR INTERNATIONAL HEALTH REGULATIONS AND GLOBAL HEALTH SECURITY

EXPERT ROUNDTABLE

MEETING REPORT
4−5 OCTOBER 2018
PARIS, FRANCE

World Health Organization

DEVELOPMENT OF A GUIDE FOR MULTISECTORAL PREPAREDNESS COORDINATION FOR INTERNATIONAL HEALTH REGULATIONS AND GLOBAL HEALTH SECURITY

EXPERT ROUNDTABLE

MEETING REPORT
4–5 OCTOBER 2018
PARIS, FRANCE

World Health Organization

© WORLD HEALTH ORGANIZATION 2019

This report of the expert roundtable was written by Dr Marcus Eder.

NOTE TO READER

This report aims to capture the key discussion points and recommendations to emerge from the presentations and discussion, rather than attempting a strictly chronological account of the meeting.

Some points were emphasized and re-emphasized across multiple sessions—in these cases, the points are not necessarily repeated in detail in the text for each session but do form the basis for key themes of the executive summary.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF ACRONYMS AND ABBREVIATIONS

AAR	After Action Review
CBRN	Chemical, biological, radiological and nuclear [threats]
CPI	WHO Country Health Emergency Preparedness and IHR department
DG	Director-General
FAO	UN Food and Agriculture Organization
GHSA	Global Health Security Agenda
GPW	General programme of work
IHR	International Health Regulations
IPU	Inter-Parliamentary Union
JEE	Joint external evaluation
MEF	Monitoring and evaluation framework
MoU	Memorandum of understanding
MPC	Multisectoral preparedness coordination
NAPHS	National Action Plan(s) for Health Security
NCDC	Nigerian Centre for Disease Control
NGO	Non-governmental organization
NSA	Non-state actor
OIE	World Organisation for Animal Health
PHA	Public Health Agency
PHE	Public Health England
PPP	Public—private partnership
SOP	Standard operating procedure
SPH	Strategic Partnership for IHR (2005) and Health Security
ToR	Terms of References
TWG	Technical working group
UN	United Nations
UN CBD	United Nations Convention on Biological Diversity
UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
WHO	World Health Organization

EXECUTIVE SUMMARY

The expert roundtable on multisectoral preparedness coordination (MPC) for International Health Regulations (IHR 2005) and health security was convened by the World Health Organization (WHO), at the World Organisation for Animal Health (OIE) headquarters in Paris on 4–5 October 2018. The aim was to develop a guide for multi-sectoral preparedness coordination for IHR (2005) and health security in order to provide Member States with tools to support the practical implementation of national action plans for health security.

Thirty-seven representatives from Member States, international organizations and non-state actors (NSAs) discussed best practices, models and lessons learnt from countries' experience in MPC, to inform key content and strategy of the guide. In interactive group sessions and plenary debates, the participants also reviewed the engagement of essential stakeholders and other relevant sectors such as public health institutions and non-state actors, the roadmap for implementing the guide and how different actors can support the process.

Since 2015, WHO has held a series of global health security meetings in order to build, advance and deliver global health security and preparedness. The guide on MPC forms part of the critical work undertaken by the WHO Country Health Emergency Preparedness and IHR (CPI) department, to ensure countries are prepared to face all-hazards health emergencies and are engaged in fulfilling their obligations under the IHR (2005) regulations.

KEY POINTS

▶ The tripartite collaboration between WHO, FAO, OIE and others is stronger than ever and forms the key pillars of MPC for IHR (2005), health security and preparedness. It is not exclusive, and engagement of additional stakeholders is crucial for true multisectoral preparedness coordination.

▶ Country ownership, WHO leadership and active partnership are the overarching guiding principles for MPC.

▶ Multisectoral coordination that reflects national priorities, sustainable financial resources and technical investments across sectors is critical for delivering health security.

▶ Strengthening country capacity through strong partnerships between stakeholders at national level is critical for countries to determine their own solutions for preparedness, reflecting their national needs and regional/global obligations.

▶ Multisectoral coordination is the acceptance of sectors to work together toward common objectives under a unique umbrella with equality, dignity and equity.

HIGH LEVEL RECOMMENDATIONS

▶ Seek high-level government support for multisectoral coordination from the beginning of the process to enhance whole-of-government approach and country ownership;

▶ Health security financing mechanisms need to be included in all preparedness planning efforts and re-quire endorsement and oversight by Ministries of Finance as part of a whole-of-government approach;

▶ Champions and effective leaders across relevant agencies beyond the traditional health sector are es-sential for strengthening multisectoral coordination for health emergency preparedness;

▶ Combine high-level representation and technical expertise in the coordination committee which is comprised of a core group of permanent members representing all relevant sectors and convenes regularly;

▶ Identify best practices for meaningful engagement with non-state actors and the community level;

▶ Ensure sufficient representation of countries experiencing context-specific challenges, such as small island states, conflict affected countries or countries with large refugee populations in best practice examples on multisectoral preparedness coordination to reflect all country contexts;

▶ Consider a WHO, OIE and FAO tripartite approach to country activities and promote engagement through sustainable IHR mechanisms for effective in-country engagement;

▶ Promote research to generate evidence for decision-making around multisectoral coordination on emergency preparedness and global health security.

INTRODUCTION

The WHO General Programme of Work 2019-2023 (GPW13) establishes the 'triple billion' targets which aim at ensuring that by 2023, one billion more people benefit from universal health coverage; have better protection from health emergencies; and enjoy better health and well-being. The Country Health Emergency Preparedness and International Health Regulations (IHR (2005)) Department (CPI) of the WHO Health Emergencies (WHE) Programme aims to meet the target of 'one billion more people better protected from health emergencies'.

As stipulated in the GPW13, countries must be better prepared to detect and respond to public health threats to prevent future health emergencies. Due to the complex nature of public health emergencies that can be cause by different risks, threats and hazards, the health sector alone cannot effectively address all aspects and thus a multisectoral approach that leverages and coordinates resources from multiple sectors is required.

By expanding efforts beyond of the health sector, countries engage a range of stakeholders that can support a coordinated approach to health emergencies preparedness and implementation of IHR (2005) core capacities. This extend to the development and implementation of the National Action Plans for Health Security (NAPHS). Relevant stakeholders that can provide valuable support include but are not limited to the, foreign policy, finance sector, security sector, transport and tourism sector, but also parliaments, the private sector and academia.

From the 4th to the 5th October 2018, an expert roundtable on multisectoral preparedness coordination (MPC) for International Health Regulations (IHR 2005) and global health security was convened by the World Health Organisation (WHO) at the World Organisation for Animal Health (OIE) headquarters in Paris. The aim of the round table was to review the draft guide for multisectoral coordination for emergency preparedness, IHR (2005) and global health security to provide Member States with tools to support the multisectoral implementation of the NAPHS.

The Strategic Partnership for IHR and Health Security (SPH) brought together thirty-seven representatives from Member States, international organizations and non-state actors (NSAs) to elaborate on best practices, case studies, and lessons learnt from countries' experience in multisectoral preparedness coordination as well as to discuss key elements of the guide. In interactive working group sessions and plenary debates, the participants also discussed the engagement of essential stakeholders, the implication for countries facing context-specific challenges, such small island nations, countries in conflict or large number of displaced persons as well as the roadmap for implementing the guide.

MEETING OBJECTIVES

> ▶ Identify best practices, case studies and models of functional mechanisms for multisectoral pre-paredness coordination for IHT and for global health security, underpinned by One Health approach-es, in both developed and developing countries;
> ▶ Map the sustainability, strength, weaknesses, opportunity and challenges as well as explore potential incentives and constraints of multisectoral preparedness coordination;
> ▶ Review a draft guide and identify key elements for effective multisectoral coordination and develop a roadmap for implementation of the guide;
> ▶ Develop a roadmap for the implementation of guide.

→ DAY 1

WELCOME AND OPENING REMARKS

Dr Monique Eloit, Director General, OIE; **Dr Ahmed El Idrissi**, Senior Animal Health Officer, FAO; and **Dr Jaouad Mahjour**, Director of the WHO Country Health Emergency Preparedness and IHR (CPI) department addressed the participants with opening remarks.

TRUE MULTISECTORAL COORDINATION IN THE PREPAREDNESS FOR HEALTH EMERGENCIES
The participants were reminded that preparedness and response to epidemics are complex and cannot be effectively addressed by one sector alone. There is need for the strengthening of mechanisms of working together and to improve the coordination between sectors responsible for human health, animal health and the environment, at national, regional and international levels. The tripartite collaboration between OIE, FAO and WHO is not exclusive and the need for engagement of additional stakeholders for true multisectoral preparedness coordination is crucial.

Health security is interdependent with food security, resilient communities and livelihoods. Tripartite work between the three organizations is stronger than ever and endorsed by a robust IHR Monitoring and Evaluation Framework (MEF). Their health security activities and One Health initiatives represent opportunities for countries to improve human health, animal health and livelihoods, as well as preparedness, as our readiness to act if events occur.

As seen recently, outbreaks pose a threat to economic development and can destabilize societies. Disease spread increases significantly where health systems are fragile, poorly functional and operate in silos. The world needs to be better prepared to respond to current health emergencies and prevent future health crises. WHO is

committed to supporting Member States and partners to ensure that countries and populations, in particular the most vulnerable, are prepared for all-hazards emergencies and are fulfilling their obligations to develop core capacities under the IHR (2005). There is a need for collective effort and a common vision for building multisectoral preparedness coordination (MPC) to tackle global health security. Governments need to commit to increased coordination in preparedness to keep the world safe, and advance global health and well-being in a sustainable way. The collaborative *Multisectoral Preparedness Coordination Guide*, led by the SPH team, provides support to Member States for hands-on leadership development and strengthened coalitions. It establishes transparent oversight and accountability mechanisms to support effective and coordinated country action that leads to good governance for IHR and health security.

The OIE was thanked for hosting and co-organizing the event, and the meeting was declared open.

SESSION 1:

SETTING THE SCENE AND INTRODUCTION TO MULTISECTORAL PREPAREDNESS COORDINATION FOR IHR (2005) AND HEALTH SECURITY.

Moderator:

Dr Stella Chungong, WHO

PRESENTATIONS

Dr Stella Chungong welcomed the speakers and set the scene for the session. Presenwwwtations from the World Bank, WHO and OIE focused on existing global collaborations around financing health security preparedness, the tripartite approach to zoonotic diseases, public—private partnerships (PPPs) for veterinary services, and the WHO IHR MEF and multisectoral preparedness coordination (MPC).

The speakers were **Dr Toomas Palu**, Global Health Adviser, World Bank; **Dr Elizabeth Mumford**, WHO; **Dr Isabelle Dieuzy-Labaye**, Senior Advisor, OIE; and **Mr Ludy Suryantoro**, WHO.

KEY POINTS OF THE DISCUSSION

Country ownership, WHO leadership and active partnership are the overarching guiding principles for multisectoral preparedness coordination. Strengthening country capacity through strong partnerships between stakeholders at national level is critical for countries to determine their own solutions that reflect national needs and their regional/global obligations.

Health security preparedness needs robust financing. In reality, funding is often inadequate and surge costs are not included in regular budget lines. The JEE tool has financial indicators built in: countries need to identify gaps and bottlenecks in the technical evaluation and include respective financing needs in their national expenditure frameworks, budgets and sectoral plans. Recurrent costs (to run preparedness systems) and start-up/capital costs (to improve preparedness, e.g. new laboratories) can be financed domestically through partners; surge costs (in emergencies) can be financed through domestic reallocation arrangements or contingency instruments offered by the World Bank and WHO. An increasing number of resource-tracking tools are being developed. Whereas more work on practical implementation is needed, recent data from Asia suggest that only a few extra expenses per capita may be needed for countries to improve and maintain their JEE scores. Health security financing needs Ministry of Finance buy-in and advocacy as part of broader systems strengthening.

The *Tripartite Zoonoses Guide* supports countries in addressing zoonosis across human, animal and environment health and all relevant sectors. It provides best practice in national multisectoral coordination mechanisms, surveillance, planning, risk assessment, monitoring and evaluation etc. After its publication later this year, an operational workbook with tools for each of these topic areas will be piloted in alignment with the MPC Guide.

In 2016, OIE started a collaborative project exploring the role of PPP initiatives strengthening national and regional veterinary services and health security. In 2018, partners supporting OIE's engagement submitted 100 success stories from 76 countries of various PPPs in veterinary services. A practical handbook will be released at the 87th General Session (2019) that will enable countries to exploit the potential of PPPs. Advocacy and research are important for evaluating financing need and economic and social impact. The three common PPP clusters are: transactional (initiated and funded by the private sector); collaborative (public and beneficiaries; on policies and agreed outcomes; driven by trade and export interests); and transformative (private companies establishing sustainable capabilities in otherwise unattainable major programmes).

The WHO IHR MEF and SPH contribute to the thirteenth General Programme of Work (GPW13), by supporting countries through the IHR MEF to accelerate development and implementation of national plans and to build health security capacities. In this context, the WHO Director-General (DG) has also highlighted the importance of inclusiveness and building partnerships between sectors. Thus, it is important to implement MPC in peacetime, driven by a culture of preparedness (rather than by events) and the strengthening of health systems. Products include resource mapping and prioritization, allowing countries to identify priorities, define key activities, and domestic versus international financing. Collaborative work with the World Bank is ongoing, focusing on national health financing and tools supporting health preparedness and IHR. The WHO's recent engagement with the Inter-Parliamentary Union (IPU) is an example of building country ownership at a high level in a sustainable way. The Strategic Partnership Portal as one-stop information provides essential information in this process.

PANEL DISCUSSION

The panellists **Dr Papa Serigne Seck**, Senior Advisor to the Prime Minister's Office, Senegal; **Dr Iwan Trihapsoro**, SpKK/SpKP, Indonesia; **Dr Jose Fernandez**, Deputy Director, GHS, HHS, USA; **Ms Outi Kuivasniemi**, Deputy Director for International Affairs, Finland; and **Mr Chalermsuk Yugala**, Lieutenant General, Royal Thai Army, Thailand, discussed lessons learned from experience of MPC.

KEY POINTS OF THE DISCUSSION

Senegal's experience combines MPC and the highest level of government authority to guarantee successful implementation of IHR and health security. The institutional structure of the One Health National High Council for Global Health Security (OH NHCGHS) and the IHR strategic framework create synergy between sectors for public, civil and food security. Important challenges are inclusiveness, ownership, resource mobilization and the need for legal frameworks for MPC mechanisms. Two senior advisers from the Prime Minister's cabinet coordinate the platform, comprising 22 cross-ministry focal points, over 300 technical and financing partners, a high council (led by the Prime Minister), a steering committee and regional (subnational) platforms. MPC is the acceptance of sectors to work together toward common objectives under a unique umbrella with equality, dignity and equity.

Indonesia's health security strategy is divided into a health cluster and a security cluster (military and police are among the key stakeholders). The civil–military coordination involves regulations and guidelines on public health emergencies, such as chemical, biological, radiological and nuclear (CBRN) threats and terrorism, and joint cross-sector coordination at regional or national level under the National Agency of Disaster platform. The Indonesian Armed Forces (TNI) support laboratory cooperation, shared weekly epidemiology reports, Indonesia's role as global chair for the Global Health Security Agenda (GHSA) in 2016 and hosting of the Managing Future Global Health Risk by Strengthening Civilian and Military Health Services meeting in Jakarta, 2017.

Health security in the United States of America is inherently multisectoral and combines high-level leadership and top-down structures at federal level and below (typically 15–20 agencies involved in any particular area). The National Security Council is a cross-agency engagement at technical and political level. National, multilateral, and bilateral national health security initiatives are all multisectoral. The latter are coordinated collaboratively through United States Agency for International Development (USAID) and Centers for Disease Control and Prevention (CDC) for the engagement with partner countries. Lifting health security items into national strategies can help them to get prioritized. It also can incentivize actors and drive participation towards achieving a common goal, by allowing individual agencies to give feedback (and have their priorities reflected) within the components of a certain strategy. Defining shared goals, objectives, strategies and the role and tasks of each agency helps to develop ownership and accountability. It is important to build relationships across sectors and know your counterpart in other sectors; also, to encourage and coordinate the meaningful engagement of NSAs.

Finland's national JEE process took a cross-sectoral, all-government and whole-society approach. High-level government support elevated JEE to the national security committee right at the start, which created a sense of ownership in every sector involved (with unique roles and their own budgets). The cross-sectoral IHR JEE coordination group formally reports to the national security committee, with high-level cross-ministry representation and rotating chairmanship. Health security has been integrated into the *Security Strategy for Society* (following a government resolution). It includes accountability frameworks and multiple theme groups (e.g. antimicrobial resistance, AMR; and CBRN threats) organizing collaborative activities and simulation exercises. Finland supports IHR implementation in countries through the JEE Alliance.

The military's engagement in disaster prevention and mitigation in Thailand includes engineering, military medicine and the CBRN unit. As part of the Thai cabinet's Threat Prevention and Reduction Policy, the Ministry of Interior (the Ministry of Defence in wartime) is leading the National Disaster Prevention and Mitigation plan. It lists various types of threats and specifies the lead agency, which all other agencies support as needed. Non-governmental organizations (NGOs) and the private sector are included under the action plan. The first response is civilian, with military support only if requested. An incident is led using a pre-allocated budget at district, provincial or national level, according to the scale of the event. Military and public health have a longstanding collaboration around detection, decontamination, healthcare support, training and simulation exercises.

RECOMMENDATIONS

▶ Health security financing needs to be included in all discussions and plans. It requires endorsement by the ministries of finance, and advocacy as part of efforts in wider system strengthening.

▶ For effective in-country engagement, WHO, OIE and FAO support visits should be tripartite and seek engagement through sustainable IHR mechanisms rather than parallel disease missions.

▶ Seek high-level government support from the beginning to enhance ownership and joint work.

▶ Embed high-level coordination into formal structures such as committees and steering groups.

▶ Create legal and accountability frameworks with clearly defined roles, SOPs and task forces.

▶ Adopting health security items into national strategies keeps them at high level and prioritized. This can incentivize actors and drive their participation towards achieving a common goal.

▶ Consider the use of supranational, regional coordination mechanisms for effective resource sharing and border control, e.g. Regional Disease Surveillance Systems Enhancement (REDISSE).

▶ Sectors are forced to work together during response. Build MPC for preparedness in peacetime, using mechanisms established during the response in a more formalized way.

▶ Use simulation exercises (involving all levels) to keep momentum going and integrate emergency capacity into day-to-day activities to maintain skills.

▶ Specific support might be needed for countries facing various practical issues, such as:

▷ Political structures might be insufficient to support accountability and sanctions.

▷ Coordinating multisectoral activities in countries with centralized structures and limited human resources and funding. Ensure sufficient funding is allocated to run the MPC.

▷ Armed conflicts: humanitarian response and military engagement are often challenging.

▶ Encourage discussion of ethical issues in joining national security and health security.

SESSION 2:

MODELS OF EXISTING MULTISECTORAL PREPAREDNESS COORDINATION AT COUNTRY LEVEL. POSTER SESSION

Moderator:
Dr Andreas Gilsdorf, WHO

This session summarized best practices and models of functional mechanisms for multisectoral preparedness coordination (MPC) for IHR (2005) and health security, submitted by participants as poster presentations for inclusion in the *Multisectoral Preparedness Coordination Guide.*

SUMMARY

Examples and experiences were submitted by Canada, Finland, France, Germany, Indonesia, Nigeria, Romania, United Republic of Tanzania, Thailand, Tunisia, the United Kingdom, the United States, Zambia and the EcoHealth Alliance.

The range of topics included IHR implementation, the collaboration between health and armed forces/security agencies, preparedness for specific diseases, emergency services and outbreak response.

Several countries faced similar challenges, including: working in sectoral silos as a barrier for establishment of multisectoral coordination mechanisms; differences between sectors in perspectives, responsibilities and priorities; limited resources; and differing objectives and concerns not being openly discussed, as well as the lack of comparability of existing data between different sectors is making a common understanding difficult. Important factors for successful establishment of multisectoral coordination included the adoption of regulatory frameworks for coordination, with clear chains of command, development of standard operating procedures (SOPs) and memoranda of understanding (MoUs); joint situation assessments were an important start for the coordination. Good experiences with performing joint training to build a common understanding and to get to know each other, as well as meeting on a regular basis were highlighted. Decisions should be transparent and traceable. It is important to avoid unnecessary new structures and overlap, and to plan a regular budget line for the coordination mechanism.

For monitoring of the coordination mechanism and ensuring sustainability at the same time, it was recommended to have Joint Simulation Exercises and After-Action Reviews (AARs) as well as joint training. It was also suggested to keep the intersectoral network beyond specific tasks. It can be used to jointly mobilize resources and ensure high-level political commitment.

The examples provided clearly identified a benefit in the establishment of multisectoral coordination. It led in many cases to more effective coordination, enhanced awareness of the topics and improved preparedness. The mechanism resulted in more inclusive communication and increased public trust in the system. Overall it also helped to save costs; therefore it is important to have IHR capacity-building embedded in the system and not separate. In general, the coordination mechanisms helped to establish multisectoral engagement as a standard.

SESSION 3:

EFFECTIVE MULTISECTORAL PREPAREDNESS COORDINATION FOR IHR (2005) AND HEALTH SECURITY: LEADERSHIP, TRUST AND TRANSPARENCY. INTERACTIVE GROUP SESSION

Moderator:
Ms Tracy Gibbons, Public Health Agency (PHA) of Canada.

Multisectoral coordination remains a challenge at the operational level for many countries, with important factors for the success of multisectoral coordination being leadership, trust and transparency. This session provided a forum to openly discuss the leadership that is required to establish coordination between sectors as well as the level of trust and transparency necessary for its operationalization and maintenance. After discussions within four working groups, the group leaders presented key aspects for effective leadership, trust and transparency (plenary session).

KEY POINTS IDENTIFIED

LEADERSHIP

To identify good leadership it is important to know the scope and purpose of the coordination mechanism. The choice regarding leadership depends on political and personal interests, the context, legislation and, the resources. Personal capacity and leadership skills are important and should match the level the technical and political leadership required for the role. Decision on leadership can be based on existing good examples in the country.

Leadership of the coordination mechanism could rest in a single ministry or department, and rotate among ministries on an agreed schedule or be shared. Besides the option of placing the leadership in the leading institution there are also arguments for selecting instead a neutral institution or person to ensure objectivity and acceptance by all. Leaders should act in the best interest according to principles of equity and respect.

TRUST, RESPECT AND TRANSPARENCY

The coordination requires a joint understanding on defined priorities and success shared across all sectors. A formalized process should clearly establish roles and responsibilities for each sector, and outline collaboration and leadership structures from a single point of coordination. The framework should specify type and frequency of information to be shared on a routine (real-time) basis and during an emergency, between sectors and outside the group (to enhance public trust). It should establish rewards and incentivize transparency (e.g. recording the number of zoonotic disease transmissions that have been averted). The process can be strengthened by joint training exercises and simulations, and multisectoral risk communication workshops.

The quality of coordination can be enhanced by clear Terms of Reference (ToRs) and records documenting the decision-making process; formalised data data-sharing mechanisms; feedback mechanisms and an agreed approach to conflict and mediation mechanism.

SESSION 4:

ESSENTIAL ELEMENTS OF MULTISECTORAL PREPAREDNESS COORDINATION FOR IHR (2005) AND HEALTH SECURITY: FORMALIZATION OF PREPAREDNESS COORDINATION MECHANISMS AND RESOURCES. INTERACTIVE GROUP SESSION

Moderator:
Dr Osman Dar, Public Health England (PHE).

The objective of this session was to identify what political context, measures, resources, supportive structures etc. are needed to establish effective coordination mechanisms for preparedness. There are different levels of formalization to consider, depending on the scope and country context. The four working groups discussed and presented key elements for effective multisectoral preparedness coordination (MPC) to the plenary session.

KEY POINTS IDENTIFIED

FORMALIZATION

The formalisation process should have involvement from different partners (in particular non-state actors) and high-level endorsement to enhance acceptance across sectors. Formalisation can be supported by legislation to provide mandate and allowing inclusion of a wider range of stakeholders. MoUs can define multisectoral coordination for preparedness between sectors horizontally. MoUs and organisational commitment can be reinforced through circulars and legal documents for implementation at all levels.

Formalized committees should have clear ToRs and chain of command (with defined roles and responsibilities of different partners) and include monitoring and evaluation. The implementation of coordination mechanisms at different levels should be facilitated through shared documents (preparedness plans, SOPs, inventories, etc.) endorsed by all sectors. Documents should allow flexibility, regular review and, adaption as required. Joint work can be supported by the establishment of informal groups and task forces that can provide agility and flexibility where needed.

RESOURCES FOR COORDINATION

MPC requires funding for development and implementation of plans; datasets; the creation and maintenance of IT platform for shared databases and documents; secretariat and associated running costs, office and meeting space; larger meetings including simulation exercises. The funding source should be national budget (general revenues), issued through department budget lines for heath security. Support through Ministry of Finance might be beneficial (more leverage if mechanism is at very high level). Financial management should be part of the coordination mechanism. At the beginning of its establishment an assessment of financial needs will inform funding requests to the government. The coordination committee should decide on distribution of funds allocated to the mechanism.

DAY 2

Ahead of the first session, **Dr Ahmed El Idrissi**, FAO, provided the participants with a recap of the key points from day 1 and **Mr Ludy Suryantoro**, WHO, presented a short video on *Managing Future Pandemics by Strengthening Collaboration between Civil (public health) and Military Health Services*, taken at the International Committee on Military Medicine (ICMM) meeting in Jakarta, 2017.

SESSION 5:

KEY ESSENTIAL STAKEHOLDERS INCLUDING FOR MULTISECTORAL PREPAREDNESS COORDINATION.
PANEL DISCUSSION

Moderator: **Dr Christophe Bayer**, Ministry of Health, Germany

This session focused on the engagement of a broader range of relevant sectors beyond health. The debate aimed to explore which other sectors are relevant, their potential roles and responsibilities, and how best to engage them in the preparedness of health emergencies.

The panellists were **Dr Olubunmi Ojo**, Nigerian Centre for Disease Control (NCDC); **Ms Tracy Gibbons**, PHA of Canada; **Ms Aleksandra Blagojevic**, IPU; **Dr Calin Alexandru**, Ministry of Internal Affairs, Romania; and **Dr Coralie Giese**, Ministry of Social Affairs and Health, France.

KEY POINTS OF THE DISCUSSION

The moderator highlighted that considering the scope of the IHR (2005) and its implementation, stakeholders beyond the traditional health sector need to be involved right from the beginning to ensure that effective measures are being fully implemented. The number and scope of partners involved in multisectoral preparedness coordination (MPC) may vary significantly, depending on the mission, tasks and respective objectives. However, the number of partners needs to be feasible to ensure functionality of the group.

The Nigerian IHR Technical Working Group (TWG) coordinates multisectoral IHR implementation in a cross-ministry approach (including security, transport and civil aviation) covering all 19 technical areas. There is one defined focal person in each stakeholder group, which enhances advocacy and accountability. A national security liaison office will be placed within the NCDC to facilitate information sharing and to build trust and collaboration. MoUs are being developed in all sectors, but legal frameworks are still needed to build sustainability. Regular meetings of the IHR TWG focus on national pandemic preparedness and emergency response, including: development of all-hazards SOPs for stakeholder coordination; training around core capacities across the technical areas; and simulation exercises and AARs, supported by disease-specific sub-technical working groups.

Emergency preparedness under Canada's *National Emergency Act* is multisectoral. The components of the *Federal Emergency Response* Plan are managed and overseen by bodies across government, with defined roles and responsibilities. Below the federal level, various territorial and provincial plans reflect different geography and population health needs in specific areas. Leadership in all emergency response in Canada is civilian, with military support only if requested.

A wide range of ministries supported the National Specialized Committee for Ebola Preparedness in Romania, set up by the Ministry of Internal Affairs during the West Africa outbreak of 2014–2016 to prepare for any potential cases in Romania. The Department of Emergency Situations (Ministry of Health), with the support of the State Secretary and the Deputy Prime Minister, coordinated the development of SOPs and numerous other activities. One major challenge identified was the lack of public procurement systems to allow purchasing of goods relevant for preparedness.

Parliament is another sector to engage to strengthen country ownership and political leadership around health security preparedness. Enhancing parliamentarians' knowledge about the need to build preparedness can enhance parliament support in passing/adapting laws, approving budgets and holding the government to account in support of the IHR implementation process. Parliament is a cross-party platform that can support political will for a long time and create political sustainability. At high level, a MoU is currently being developed between the IPU and WHO.

France engages a wide range of ministries and public health agencies for coordinating health emergencies and preparedness. Weekly high-level health security meetings are convened by the Ministry of Health and joined by other agencies as appropriate. The Interior Minister Crisis Centre (ICC) is activated in emergencies (usually by the Prime Minister) to facilitate high-level decision-making and crisis management. Its recent response to the hurricane crisis in remote overseas territories required broad collaboration due to widespread destruction and challenging logistics.

Additional points were made during the session regarding the implementation of preparedness.

- ▶ The Ebola crisis prompted the African Union to establish the African CDC, a mechanism for preparedness and response along with the formation of >20 public health institutes; this is an example of countries getting organized, all players being involved and regional coordination platforms facilitating sharing of protocols and checklists between Member states.
- ▶ Countries where the Ministry of Finance is specifically engaged in preparedness are Nigeria (ministry of finance focal person is part of the IHR TWG) and Finland (finance engaged in JEE areas that link to customs and the World Bank). Finance is not specifically involved in Canada (each ministry has its own budget), Thailand (central funding allocation to regions) and France.

RECOMMENDATIONS

▶ Mechanisms already established during the response can be used for preparedness in a more formalized way.

▶ Additional support might be needed for countries facing specific challenges, such as small island states or regions with armed conflict, disrupted systems and large numbers of refugees. Ensure these parties are sufficiently represented in debates and plans reflect such circumstances.

▶ Engage the Ministry of Finance to ensure common understanding around financing preparedness.

▶ Have defined focal persons in each agency supporting a health security committee or TWG. Have liaison mechanisms between key sectors, e.g. security and health, to build trust and collaboration.

▶ Use MoUs and legal frameworks to build sustainability.

SESSION 6:

PUBLIC HEALTH INSTITUTIONS AND NON-STATE ACTORS' ENGAGEMENT FOR IHR (2005) AND HEALTH SECURITY.
PANEL DISCUSSION

Moderator:

Dr Catherine Machabala, EcoHealth Alliance.

During this session, an expert panel shared country examples of how non-state actors (NSAs) can contribute to IHR implementation, and discussed the roles of public health institutions as well as the private sector in engagement for IHR and health security preparedness.

Panellists were **Dr Osman Dar**, Public Health England (PHE); **Dr Victor Mukonka**, Zambia National Public Health Institute; **Professor Hichem Bouzghaia**, Veterinary School, Tunisia; **Ms Elizabeth Peacocke**, Norwegian Institute for Public Health; **Dr Mohamed Ally Mohamed**, Health Quality Assurance, United Republic of Tanzania; and **Ms Amanda McClelland**, Resolve to Save Lives.

KEY POINTS OF THE DISCUSSION

The moderator stressed the critical role of NSAs for the implementation of IHR (2005) and health security. There is a need to identify scope and limits, and the most effective way to engage NSAs, as seen in activities around the NAPHS, simulation exercises and training.

The private sector often provides large and rapid mobilization to support response efforts, but it usually stops soon after the emergency has ended. Showing NSAs the key areas of preparedness that they could engage in in order to reduce risk to business and investments, can get them motivated to engage. For this, suggested areas need to be relevant for local context and situation, such as focusing on important disease threats (e.g. cholera). Recent examples are the Infectious Disease Risk Assessment and Management (IDRAM) project, working with the extractive industries to explore their potential contributing role to preparedness and response in remote areas; and, at a higher level, the synchronization of expanding infrastructure and advancing global health in WHO support to *One belt, one road, one health*. There are several potential entry points for engaging the private sector in health security and preparedness: embedding health as best practice into the industries' impact assessment tools, risk management and business continuity plans, or in the safeguarding mechanisms of developing banks; also, linking preparedness with occupational health mechanisms of companies that deploy staff to endemic areas, or sentinel surveillance systems to company health clinics in remote areas.

In the Zambian experience, NSAs have a lot to offer for implementation of IHR, with a comparative advantage in areas such as technical support, human resources and equipment. Moreover, with research collaborations generating evidence, the business community providing support during outbreaks and civil societies supporting community engagement and advocacy. Similarly, Tunisia has also seen crucial NSAs support in interventions to

reach a target population and thus contributing to the success of the National Rabies Control Programme for humans and animals. Partner mapping has been essential due to the large number of civil society actors and the need for adequate planning. In the United Republic of Tanzania, NSAs have played a critical role throughout the IHR implementation process, through support of simulation exercises and AARs, mobile technologies to assist disease surveillance, and private laboratory capacity to provide national Ebola testing.

The Norway Institute for Public Health has experience of NSA support of IHR implementation in Malawi, the Republic of Moldova, Ghana and Palestine through its Global Health Preparedness Programme. Support is oriented at country priorities and activities on needs and sustainability. Key challenges include communication and coordination between sectors and stakeholders.

Important points were made regarding responsibilities and legal aspects of NSA engagement. For example, the Red Cross and St John's providing private ambulance services in Canada. MoUs are being considered at federal level to establish jurisdictional responsibilities and relationships (different during a state of emergency, when the Red Cross acts as an auxiliary to the State, or when deploying abroad). In Finland, private services are legally bound to operate within surveillance and response systems.

With regards to best practice around NSA engagement in countries heavily relying on the private health sector, or with a complex network of healthcare providers. Following comments were made:
- ▶ Decide on separate models (high- versus low-income countries) versus one model that fits all.
- ▶ Find ways of how countries with JEE scores of 4 and 5 can help those with lower scores. Country examples included:
  - ▷ Romania – private ambulances not part of incident response (different training practices).
  - ▷ Thailand – vast network of public, private and university organizations providing healthcare.
  - ▷ Horn of Africa – difficult access to private sector ambulances in some regions.
  - ▷ Senegal – private stakeholders involved from the beginning, including a steering committee.

RECOMMENDATIONS
- ▶ Stakeholder mapping should include local companies, who are likely to be motivated to contribute to preparedness while reducing the risk for business.
- ▶ NSAs need to add value to the MPC. Countries should identify risks and determine NSAs best placed to address them, and how to engage them for adding value both ways.
- ▶ Identify the best ways for a meaningful NSA and community engagement; incentives, and also potential risks of engaging. Identify challenges and how to mitigate those.
- ▶ Engagement in early stages can add more value to important areas of preparedness, e.g. community trust and the media (community awareness; reducing the risk of false information).
- ▶ Consider new technical tools to map and categorize NSAs according to roles and activities; and in reverse, the same tool to help countries to identify gaps.
- ▶ For community engagement in preparedness it is important to frame global priorities around paradigms relevant for the target community.

SESSION 7:

DRAFT GUIDE ON MULTISECTORAL PREPAREDNESS COORDINATION FOR IHR AND HEALTH SECURITY.
INTERACTIVE GROUP SESSION

Moderator:
Mr Ludy Suryantoro, WHO.

In this session, **Dr Andreas Gilsdorf**, WHO, presented the draft outline of the guide, according to the document that had been shared with the experts prior to the meeting.
The objective of the session was to discuss the direction and topics to be covered by the guide, elements of effective coordination mechanisms and technical areas to be considered specifically when discussing effective coordination for preparedness. During the subsequent breakout session the four working groups discussed key topics of the guide and presented their feedback (shown below).

KEY POINTS IDENTIFIED

POSSIBLE PARTNERS FOR MULTISECTORAL COORDINATION
Government sectors to be considered include: Human health, animal health, agriculture, environment, food safety, livestock, fisheries, finance, transport, trade/points of entry, transport, travel, chemical safety, radiation safety, disaster management, emergency services, regulatory bodies, labour, education, foreign affairs, international treaties and convention, and the media. Possible non-government stakeholders include NGOs, donors, international organisations, academia, media, and the private sector.

STAKEHOLDER MAPPING
Stakeholder mapping is a fundamental step in the MPC around health emergency preparedness, and may require considerable amount of time depending on task, purpose and mechanism used. Existing mechanisms may be used to avoid unnecessary creating of new structures. The mapping could involve a government inquiry to identify stakeholders involved and responsible regarding a certain topic. The mapping can be a spot analysis, iterative or even a continuous process in which stakeholders can be added or excluded as per requirements along the way. Stakeholders need to be informed and sensitized about the process. The committee will select stakeholders according to identified health priorities, avoiding any gaps or duplication. The use of sector leads is recommended to support identification and coordination of stakeholders within their particular sectors.

JOINT ASSESSMENT
The joint assessment aims to identify tasks or problem needing to be addressed by the coordination. It should be as inclusive as possible, to allow a wide range of stakeholders to be considered in this approach. An internal assessment might be useful to identify needs for the group to fulfil its function (e.g. a secretariat, or other resources). The external assessment is an analysis of potential preparedness gaps needing to be addressed by the coordination mechanism. Sharing analysis between different sectors during the process might be useful, for an exchange of perspectives and identifying communalities. The assessment should involve ToRs with set parameters, deliverables, and timeline (business cycle), defining expectations participants and planned action. Monitoring should respond to any changes in workflow or demand.

COORDINATION COMMITTEE
The objective of the committee should be to provide efficient coordination to make decisions around preparedness activities. The committee should combine high-level representation and technical expertise. It should comprise a core group of permanent members representing all sectors, and invite additional members according to country context and risk. A secretariat should support the leadership. Even in the absence

of emergencies regular meetings should be held at a weekly or monthly basis as found appropriate for the coordination. Ad hoc meetings can be called as required, in form of workshops and other activities, e.g. simulation exercises, AARs, etc. The committee should be able to take relevant decisions that are accepted by all involved sectors.

COMMUNICATION CHANNELS

Effective communication is fundamental for the coordination mechanism both for preparedness and during a response. Internal communication involves regular communication within the group by various means of communication. Even in peacetime, this might include regular meetings in Emergency Operation Centres (EOCs) and regular reports to inform or seek validation/consensus across different sectors (may include items on budget, and Ministry of Finance included in the recipients).

External communication involves information of stakeholders outside the coordination mechanism (e.g. general public, parliament), through social media (fast but less controlled), press communiqués (if needed) and reports (to explain activities and share success stories). This can increase public trust around purpose and activities of the group. Periodic attendance by official spokespersons from the ministry and press office may be beneficial even in absence of an emergency, to keep tract of group activities (or to convey specific message on specific meetings). In emergency situation the media need to be present. Communications experts should be part of the MPC around risk communication on preparedness, and work with technical experts to develop communication material. Multisectoral training workshops can help to explain technical aspects to all communications experts. The use of the six principles of the WHO communication framework is recommended.

GENERATING EVIDENCE

Data and evidence are vital to inform decision-making around an area of concern. Different sectors should provide essential evidence on certain areas to the joint coordination committee. Mapping of required information from different sectors might be useful. External or internal assessments e.g. JEE, AAR results, or mapping of prevalence, risk or vulnerable populations can be valid source of evidence. Evidence generated can add value to the coordination mechanisms by supporting funding requests or, relevant journal publications.

MEASURING OUTCOMES

It is important to have clearly defined objectives that allow measurement of output, and outcomes. The coordination mechanism might develop its own monitoring and evaluation process, tailored to the situation. Feedback should be brought back to the committee, in order to influence change in its functioning, where needed. Members should see the purpose of monitoring and evaluation so that the value of coordination can be determined.

Potential measures of outputs should be as simple and easy to collect as possible, and may include: Records of meeting minutes, membership, and representation by number of different sectors and attendance, and surveys of participant satisfaction. For measuring outcomes, the IHR monitoring and evaluations can be used like the state party annual reporting or joint external evaluations.

MONITORING SUCCESS

The implementation of joint activities and risk assessments, or the inclusion of IHR (2005) in the sectoral planning could be used to measure the success of the coordination mechanism. Desirable impact would include earlier detection of public health hazard and faster, and more coordinated response to public health emergencies. One of the aims of the coordination mechanism is the better understanding of the needs and roles across sectors. This should be addressed in the monitoring of success.

SESSION 8:

ROADMAP – HOW TO MOVE FORWARD ON FACILITATING MULTISECTORAL COORDINATION ON IHR AND HEALTH SECURITY. PLENARY DISCUSSION

Moderator:
Dr Stella Chungong, WHO.

At this last main session **Mr Ludy Suryantoro** presented the meeting summary with the key outcomes. He invited additional comments on the guide from participants, and suggestions regarding the next steps and practical implementation.

GENERAL POINTS OF THE DISCUSSION

▶ Tripartite collaboration between WHO, FAO and OIE
  ▷ Suggestion to add "and others" to reflect a growing number of contributing partners.
  ▷ To clarify the sentence: "Strengthening tripartite". It was proposed that the guide should add value to establishing overarching coordination, and be inclusive (but not to implement the tripartite).

▶ Clarification of the term "independent referee" for committee leadership: one suggestion was that the chair could be someone who represents the broader government approach (instead of representing individual ministries or departments). However, it was acknowledged that level, response and leadership were very context-specific; that the guide should make reference to the form and quality of leadership (e.g. fair, equitable); and that Member States needed to make their own choice on how to do it.

▶ **GENERAL – GUIDE**
  ▷ Consider referring to the environmental sector, other bodies and conventions like the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA) and the United Nations Convention on Biological Diversity (UN CBD).
  ▷ Clarity and examples are needed of what the coordination mechanism is coordinating, i.e. specific tasks to take forward and things to do. The MEF was mentioned.
  ▷ The guidance should acknowledge the bottlenecks to success, e.g. to acknowledge the challenges and the effort it takes, but show the benefits of jointly implementing MPC.
    • The guide should capture and showcase the benefits to encourage countries to take forward the recommendations and actions in the guide.
    • Beware of the fact of not every country having JEE. Therefore the guide should refer to implementation improving scores (but directly link to the JEE tool).

- Clarification of the significance of initially having the word partnership in the title of the guide: this is due to the fact that working in partnership was highlighted as very important by the Director-General (DG) and in the GPW, and that country and partners are sitting at the same table.

The debate closed with thanks to the participants from the moderator and the SPH Team for the quality of discussions and also the feedback provided during the sessions, where a good balance was observed between strategic and practical discussions.

KEY RECOMMENDATIONS

CHOOSING PARTNERS AND STAKEHOLDERS (DRAFT GUIDE 4.1).

Possible partners for multisectoral coordination (draft guide 4.1.1).
▶ A wide range of government sectors and non-government stakeholders to be considered.

Stakeholder mapping and selection (draft guide 4.1.2).
▶ NSAs need to add value to the MPC. Countries should identify risks and determine NSAs best placed to address them, and how to engage them for adding value both ways.
▶ Identify the best ways for a meaningful NSA and community engagement; incentives, and also potential risks of engaging. Identify challenges and how to mitigate those.
▶ Stakeholder mapping should include local companies, who are likely to be motivated to contribute to preparedness while reducing the risk for business.
▶ Engagement in early stages can add more value to important areas of preparedness, e.g. community trust and the media (community awareness; reducing risk of false information).
▶ Consider new technical tools to map and categorize NSAs according to roles and activities; and in reverse, the same tool to help countries to identify gaps.

PROVIDING LEADERSHIP FOR THE COORDINATION (DRAFT GUIDE 4.2).

Leadership (draft guide 4.2.1).
▶ For effective in-country engagement, WHO, OIE and FAO support visits should be tripartite and seek engagement through sustainable IHR mechanisms rather than parallel disease missions.
▶ Seek high-level government support from the beginning to enhance country ownership.
▶ Consider the use of supranational, regional coordination mechanisms for effective resource sharing and border control.
▶ It is important to involve subnational level, e.g. the provinces.
▶ Champions and effective leaders across relevant agencies beyond the traditional health sector are essential for strengthening health emergency preparedness.

Joint assessment (draft guide 4.2.2).
▶ Joint assessment should include stakeholder mapping and be based on identified priorities.
▶ Joint assessment with clear objectives, expected outcomes and terms of reference (ToRs).
▶ Countries to determine their own solutions to preparedness and define legal frameworks for institutionalization (e.g. MoUs), reflecting their national needs and regional/global obligations.

FORMALIZING THE COORDINATION (DRAFT GUIDE 4.3).

Forms of coordination (draft guide 4.3.1).
▶ Create legal and accountability frameworks with clearly defined roles, SOPs and task forces.
▶ Build MPC for preparedness in peacetime, using mechanisms established during the response in a more formalized way. Use simulation exercises (involving all levels) to keep momentum going and integrate emergency capacity into day-to-day activities to maintain skills.

Coordination committee (draft guide 4.3.2).
▶ Embed high-level coordination into formal structures such as committees and steering groups.
▶ The committee should combine high-level representation and technical expertise. It should comprise a core group of permanent members representing all sectors and convene regularly.
▶ Define focal persons in each agency to support the health security committee or TWG.
▶ Committee leadership should rest in a single ministry or department, and regularly rotate. The leader should act in the best interest according to principles of equity and respect.
▶ Implementing MPC can save resources by stakeholders working together more efficiently.
   ▷ Aim to incorporate MPC into existing rather than separate, new activities.
   ▷ Articulating it as an overarching framework, based on sustainability, might allow the channelling of the whole range of initiatives related to global health security.

IMPLEMENTING THE COORDINATION (DRAFT GUIDE 4.4).

Mutual trust and transparency (draft guide 4.4.1).
▶ The coordination requires a joint view on defined priorities and success across all sectors; A formalized process should define roles/responsibilities, information sharing and joint activities.
▶ Adopting health security items into national strategies keeps them at high level and prioritized. This can incentivize actors and drive their participation towards achieving a common goal.
▶ Encourage discussion of ethical issues in joining national security and health security.
▶ Liaison mechanisms between key sectors, e.g. security and health, build trust and collaboration.

Generating evidence (draft guide 4.4.2).
▶ Promote research to generate evidence for decision-making around specific topics and activities.
▶ Additional support might be needed for countries facing specific challenges, such as small island states or regions with armed conflict, disrupted systems and large numbers of refugees. Ensure these parties are sufficiently represented in debates and plans reflect such circumstances.

Communication channels (draft guide 4.4.3).
▶ For community engagement in preparedness it is important to frame global priorities around paradigms relevant for the target community.
▶ Communication should include reporting to different departments and ministries, the parliament and the public to enhance shared view and trust.

Resources (draft guide 4.4.4).
▶ Health security financing needs to be included in all discussions and plans. It needs endorsement by the ministries of finance, and advocacy as part of efforts in wider system strengthening.
▶ Engage Ministry of Finance to ensure common understanding around financing preparedness, including the need for funding to run multisectoral preparedness coordination.

MONITORING AND EVALUATING THE COORDINATION (DRAFT GUIDE 4.5)

Measuring outcomes (draft guide 4.5.1).
▶ For measuring outcomes, the IHR monitoring and evaluations can be used like the state party annual reporting or joint external evaluations.

Monitoring of the success of the coordination mechanism (draft guide 4.5.2).
▶ Consider the implementation of joint activities, inclusion of IHR (2005) in sectoral planning, and earlier detection/faster response to public health events as potential measures of success.

NEXT STEPS

WHO
▶ Meeting report to be released by the end of 2018 (depending on feedback).
▶ Finalization of recommendations for the draft guide (first quarter of 2019).
▶ Finalization of the road map for implementation (second quarter of 2019).
▶ MPC Checklist (second quarter 2019).
▶ Pilot and test the MPC at country level (2019) – integration of IHR MEF.

PARTNERS
▶ To support WHO in finalizing the guide, piloting and implementation.
▶ Strengthen Tripartite WHO, FAO, OIE.
▶ Joint country missions – MPC integration

CLOSING SESSION

Mr Ludy Suryantoro, WHO, thanked the participants for their continuing support in this process, and extended his thanks to collaborators who were unable to attend the meeting.

The meeting was closed with remarks from **Dr Jaouad Mahjour**, WHO, and **Dr Monique Eloit**, OIE, thanking the participants for their contribution to the expert roundtable discussions.

It was stressed that joint learning and shared experiences in this expert platform will be very useful for countries who are building their system. The guide needs to be qualitative and understandable, and sharing this common objective and understanding will finally allow the successful implementation by the member countries. The strong collaboration between WHO, OIE and FAO should translate this commitment to joint work at regional and country level.

ANNEX 1 – MEETING AGENDA

EXPERT ROUNDTABLE DEVELOPMENT OF A GUIDE FOR MULTISECTORAL PARTNERSHIP COORDINATION FOR INTERNATIONAL HEALTH REGULATIONS (2005) AND HEALTH SECURITY

DRAFT AGENDA

The Expert Roundtable on **Multisectoral Partnership Coordination for IHR (2005) and Health Security** provides a forum to convene representatives from Member States, International Organisations, and non-state actors to present country case studies and best practices in order to discuss the key elements and strategies for multi-sectoral partnership coordination. The draft guide to be discussed during meeting aims at highlighting the key element needed to effectively establish and maintain multisectoral partnership coordination for IHR (2005) and health security.

4th October 2018

08:30-09:00	*Registration*
09:00–09:30	*WELCOME AND OPENING REMARKS* *The DG OIE will open the meeting and will value the Tripartite collaboration on One Health. The opening remarks will be complemented by FAO adding the aspect of agriculture/private sector/etc. WHO will highlight various global health security initiatives by different groups, and stress the importance of working in close partnership, coordinating with WHO and others to support countries in building multisectoral partnerships and liaisons for IHR (2005), public health preparedness and health security.* **Introduction:** *Dr Susan Corning, Senior Advisor to DDG, OIE* ▶ **Welcoming remarks** – *Dr Monique Eloit, Director General, OIE* ▶ **Partners` remarks** – *Dr Ahmed El Idrissi, Senior Animal Health Officer, FAO* ▶ **Introductory meeting remarks** - *Dr Jaouad Mahjour, Director CPI, WHO* **Group Photo**

09:30-11:00	**SESSION I: SETTING THE SCENE AND INTRODUCTION TO MULTISECTORAL PARTNERSHIP COORDINATION FOR IHR (2005) AND HEALTH SECURITY**

The session will outline the elements of the IHR MEF, from JEE assessment, through Simulation Exercises and After Action Reviews to the development and implementation of NAPHS and how the IHR MEF and Strategic Partnership for IHR and Health Security contribute to the GPW 13. Building upon the work of the Tripartite Zoonoses Guide, the session will highlight why there is the need to support countries in multisectoral partnership coordination for IHR and health security in "peace time", well before response to an outbreak is required.

Moderator: *Dr Stella Chungong, WHO*

▶ *Presentation –* **Financing Health Security Preparedness***, Dr Toomas Palu, Global Health Adviser, World Bank (5 min)*

▶ *Presentation –***Tripartite Zoonoses Guide** *– Dr Elizabeth Mumford, WHO (5 min)*

▶ *Presentation -* **The OIE Public Private Partnerships Initiative,**

▶ *Dr Isabelle Dieuzy-Labaye, Senior Advisor, Public Private Partnerships, OIE (5 min)*

▶ *Presentation –* **International Health Regulation Monitoring & Evaluation Framework (IHR MEF) and Multisectoral Partnership Coordination for IHR (2005) and Health Security** *– Ludy Suryantoro, WHO (8 min)*

▶

▶ **Debate:** *What are the key lessons learned from their experience on multi-sectoral partnership coordination? (plenary, 60 min)*

▶ **Panellists (tbc):**
  ▷ *Dr Papa Serigne Seck, Senior Advisor, Prime Minister`s Office, Senegal*
  ▷ *Dr Edward Owusu Narko, Surgeon Commander, OIC Public Health Division, Military Hospital, Ghana*
  ▷ *Dr Jose Fernandez, Deputy Director, Global Health Security, HHS, USA*
  ▷ *Ms Outi Kuivasniemi, Deputy Director for International Affairs, Finland*
  ▷ *Mr Chalermsuk Yugala, Lieutenant General, Royal Thai Army, Thailand*
  ▷ *Dr Iwan Trihapsoro, SpKK, SpKP, Indonesia*

Q&A (30 min)

11:00 – 11:30	**Coffee Break**

11:30 – 13:00	**SESSION II: MODELS OF EXISTING MULTISECTORAL PARTNERSHIP COORDINATION AT COUNTRY LEVEL (POSTER SESSION/MARKET PLACE)**

The objective of the session is to identify and share best practices, case studies and models of functional mechanisms for multisectoral partnership coordination for IHR (2005) and health security at the country level. Participants are asked to prepare posters for this session prior to the meeting and present in working groups. The identified good models, best practices and key elements are to be included in the guide.

Moderator: Dr Andreas Gilsdorf, WHO

▶ ***Working Groups: Market place*** *(60 min) (breakout rooms)*
Four working groups: Each expert presents their poster to the rest of their own group for 6 minutes; 10 minutes of discussion per working group; identification of the group highlights for presentation

▶ ***Open poster session and feedback/summary*** *(30 min)*
  ▷ *Open poster session (10min)*
  ▷ *Summary of submitted posters (10 min)*
  ▷ *Feedback from working groups (10 min)*

13:00 – 14:00	**Lunch**

14:00 –15:30	### SESSION III – EFFECTIVE MULTISECTORAL PARTNERSHIP COORDINATION FOR IHR (2005) AND HEALTH SECURITY: LEADERSHIP, TRUST AND TRANSPARENCY *Although the importance of coordination among national stakeholders from multiple sectors and disciplines for strengthening and implementing the IHR (2005) and health security is widely recognized, such coordination remains a challenge at the operational level for many countries. Important factors for the success of multisectoral coordination are leadership, trust and transparency. Examples have shown that a high-level political commitment and leadership can be beneficial for a positive outcome. Leadership can be organised in different forms, adapted to the respective situation, partners and objectives. This session provides a forum to openly discuss the leadership that is required to establish coordination between sectors as well as the level of trust and transparency necessary for its operationalization and maintenance.* *Moderator:* Ms Tracy Gibbons, Public Health Agency of Canada ▶ ***Working groups:*** *Leadership and transparency (breakout rooms, 60 min)* *Discussion and identification of key aspects for effective leadership and required transparency for multisectoral coordination in four working groups* ▶ ***Feedback and discussion – Representatives from working groups*** *(plenary, 30 min)* *Each group gives 5 minutes feedback from the highlights of the poster session followed by 5 minutes discussion (30 min)* *(Template of presentations provided)*

15.30 – 16.00	**Coffee Break**

16.00 – 17.30	### SESSION IV: ESSENTIAL ELEMENTS OF MULTISECTORAL PARTNERSHIP COORDINATION FOR IHR (2005) AND HEALTH SECURITY: FORMALIZATION OF PREPAREDNESS COORDINATION MECHANISMS AND RESOURCES

The objective of the session is to identify what political context, measures, resources, supportive structures etc. are needed to establish effective coordination mechanism for preparedness to establish and improve ongoing intersectoral coordination for IHR and health security. There are different levels of formalization of coordination possible, ranging from regular meetings, designated committees, Memorandum of Understanding, to decree or a law. While this will vary depending on scope and country context, it is a crucial aspect in order to guarantee participation and involvement from different partners.

Moderator: *Dr Osman Dar, Consultant Global Public Health, Public Health of England*

▶ ***Working groups: Formalization of coordination and preparedness coordination mechanisms and resources*** *(breakout rooms)*
▶ *Discussion and identification of crucial elements that ensure effective multisectoral coordination in four working groups (60 min)*
▶ ***Feedback and discussion – Representatives from working groups*** *(plenary)*
Each group gives 5 minutes feedback from the highlights of the poster session followed by 5 minutes discussion (30 min)
(Template of presentation provided)

End of Day 1

5ᵗʰ October 2018

09.00 – 09.15	**WELCOME TO DAY 2** **Recap day 1:** *Dr Ahmed El Idrissi, Senior Animal Health Officer, FAO* ▶ WHO SPH Video: Managing future pandemics by strengthening collaboration between civil (public health) and military health services (Jakarta, October 2017)
09.15 – 10.30	**SESSION V: KEY ESSENTIAL STAKEHOLDER INCLUDING FOR MULTISECTORAL PARTNERSHIP COORDINATION** *Considering the scope of the IHR (2005) and its implementation, stakeholders beyond the traditional health sector need to be involved right from the beginning to ensure that effective measures are being fully implemented. This session will facilitate a discussion on which other public sectors are relevant, what their roles and responsibilities should entail and how best to engage them continuously in the process.* ▶ ***Moderator:*** *Dr Christophe Bayer, Ministry of Health of Germany* ▶ ***Debate:*** *How to ensure the engagement of other relevant sectors such as finance sector, foreign affairs, parliament, military, transport, tourism, etc. (plenary, 45 min)*

▶ *Panellists (tbc):*
  ▷ Dr Olubunmi Ojo, Director Disease Surveillance/Epidemiology, Nigerian Centre for Disease Control
  ▷ Dr Mustakim Billa FARUQUI, Joint Secretary, Ministry of Civil Aviation and Tourism, Bangladesh
  ▷ Ms Tracy Gibbons, Chief, Situational Awareness Section, Pubic Health Agency of Canada
  ▷ Aleksandra Blagojevic, Program Manager, Inter-Parliamentary Union, (tbc)
  ▷ Dr Calin Alexandru, General Director, Ministry of Internal Affairs, Romania
  ▷ Dr Coralie Giese, Policy Advisor on International Affairs, Ministry of Social Affairs and Health, France

Q&A (30 min)

10.30 – 11.00	**Coffee Break**

11:00 – 12:30	**SESSION VI: PUBLIC HEALTH INSTITUTIONS AND NON-STATE ACTOR`S ENGAGEMENT FOR IHR (2005) AND HEALTH SECURITY**

The role of public health institutions and the non-state actor and other influencer haves become more prominent for IHR (2005) and health security, yet the discussion on what facilitates private sector`s engagement remains fluid. During this session, experts will share examples at the country level of why and how public health institutions and the non-state actors can contribute to IHR implementation and what is crucial for an ongoing exchange and coordination with the non-state actors including those influencers at national level.

Moderator: Dr Catherine Machabala, EcoHealth Alliance

▶ *Debate:* Public Health Institutions and Non-State Actors' Engagement for IHR and health security (plenary 60 min)
▶ *Panellists (tbc):*
  ▷ Dr Osman Dar, Consultant in Global Health, Public Health England
  ▷ Dr Victor Mukonka, Director, Zambia National Public Health Institute
  ▷ Professor Hichem Bouzghaia, Veterinary School, Tunisia
  ▷ Ms Elizabeth Peacocke, Norwegian Institute for Public Health
  ▷ Dr Mohamed Ally Mohamed, Director Health Quality Assurance, Tanzania
  ▷ Amanda McClelland, Senior Vice President, Resolve to Save Lives

Q&A (30 min)

12.30 – 13.30	**Lunch**

13.30 – 15.30	### SESSION VII: DRAFT GUIDE ON MULTISECTORAL PARTNERSHIP COORDINATION FOR IHR AND HEALTH SECURITY *WHO will present its draft outline of the guide on multisectoral partnership co-ordination on IHR and health security, which was shared with the experts prior to the meeting. The objective of the session is discuss the direction and topics to be covered by the guide, elements of effective coordination mechanisms and technical areas that need to be considered specifically when discussing effective coordination for preparedness.* ***Moderator:*** *Ludy Suryantoro, WHO* ▶ ***Presentation – Draft guide, key elements, strategies, resources*** *– Andreas Gilsdorf (15 min)* ▶ ***Working groups: Draft guide*** *(60 min) (breakout rooms)* ▶ ***Feedback from working groups (e.g. agreed key elements, strategies, re-sources of guide)*** *(40 min)*
15.30 – 16.00	**Coffee Break**
16:00 – 17:00	### SESSION VIII : ROADMAP - HOW TO MOVE FORWARD ON FACILITATING MULTISECTORAL COORDINATION ON IHR AND HEALTH SECURITY *Supporting countries on multisectoral partnership coordination for IHR (2005) and health security through the development of a guide is merely a first step. During this last session experts are to discuss a roadmap for the implementa-tion of the guide and how international organizations, partners and donors can support the implementation.* ***Moderator:*** *Stella Chungong, WHO* ***Discussion:*** *Feasible and practical next steps*
17.00 – 17.15	### CLOSING ***Closing Remarks*** *by Dr Jaouad Mahjour, WHO* ***Member States, Partners and Donors – statements*** ***End of Meeting***

ANNEX 2 – LIST OF PARTICIPANTS

CANADA

Ms Tracy Gibbons
Chief, Situational Awareness Section
Public Health Agency of Canada

Nicolas Palanque
Director, Multilateral Relations Division - Office of International Affairs for the Health Portfolio
Public Health Agency of Canada

FINLAND

Ms Outi Kuivasniemi
Deputy Director for International Affairs
Ministry of Social Affairs and Health

FRANCE

Dr Coralie Giese
Policy advisor on international affairs
Direction Générale de la Santé
Ministère des Solidarités et de la Santé

GERMANY

Dr Christophe Bayer
Specialist Advisor
Health Protection, Health Security,
Management of Biological Threats
Project Lead – International Health Security

Dr Maria an der Heiden
Deputy Head of Surveillance Unit
Robert Koch - Institut

INDONESIA

Dr Iwan Trihapsoro, SpKK, SpKP
Colonel Doctor
PUSAT KESEHATAN TNI
Indonesian Armed Force
Surgeon General Office

NIGERIA

Dr Olubunmi Eyitayo Ojo
Director, Disease Surveillance /Epidemiology
Nigeria Centre for Disease Control

NORWAY

Ms Elizabeth Peacocke
Senior Advisor, Department of Global Health
Norwegian Institute of Public Health

ROMANIA

Dr Călin Alexandru
General Director
Department for Emergency Situations
Ministry of Internal Affairs

SENEGAL

Dr Papa Serigne Seck
Conseiller Technique Elevage, Santé,
Productions Animales et Pêche
Cabinet du Premier Ministre

TANZANIA

Dr Mohamed Ally Mohamed
Director Health Quality Assurance
Ministry of Health Community Development Gender Elderly and Children

THAILAND

Mr Chalermsuk Yugala
Lieutenant General
Royal Thai Army
Chemical Department Advisory

TUNISIA

Professor Hichem Bouzghaia
Veterinary School and OIE Expert
Veterinary School of Sidi Thabet

UK

Dr Osman Ahmed Dar
Consultant in Global Public Health
Global Health Division
Public Health England

USA

Dr Jose A. Fernandez
Deputy Director, Global Health Security
Office of Pandemics and Emerging Threats
Office of Global Affairs
U.S. Department of Health and Human Service

ZAMBIA

Dr Victor M. Mukonka
Director
Zambia National Public Health Institute

INTERNATIONAL ORGANIZATIONS, NON-STATE ACTORS, ACADEMIA

Ms Catherine Machalaba
Policy Advisor
EcoHealth Alliance

Dr Ahmed El Idrissi
Senior Animal Health Officer
FAO

Aleksandra Blagojevic
Program Manager
IPU

Dr Monique Eloit
Director General
OIE

Dr Susan Corning
Senior Advisor to the Deputy Director General
OIE

Dr François Caya
Chef du Service des Actions Régionales
OIE

Dr Isabelle Dieuzy – Labaye
Senior Advisor, Public-Private Partnerships
OIE

Ms Amanda McClelland
Senior Vice President
Resolve to Save Lives

Dr Toomas Palu
Global Health Adviser
Health, Nutrition & Population
World Bank

WORLD HEALTH ORGANIZATION (HQ)
Country Health Emergency Preparedness and IHR

Dr Jaouad Mahjour
Assistant Director-General

Dr Stella Chungong
Director, Health Security Preparedness

Mr Nicolas Isla
Team Lead
EURO/CPI, Country Health Emergency
Preparedness and IHR

Mr Ludy Suryantoro
Team Lead, Strategic Partnership for IHR and Health Security

Dr Stephane De La Rocque
Team Lead, One Health Operations

Dr Elizabeth Mumford
Technical Officer, One Health Operations

Ms Romina Stelter
Technical Officer, Strategic Partnership for IHR and Health Security

EMRO
Ms Michela Martini
Technical Advisor
EMRO/WHE, WHO Health Emergencies
Programme (WHE)

Dr Marcus Eder
Public Health Consultant

Dr Andreas Gilsdorf
Public Health Consultant

CONTACT DETAILS

WHO STRATEGIC PARTNERSHIP
FOR INTERNATIONAL HEALTH REGULATIONS (2005)
AND HEALTH SECURITY (SPH)
Country Health Emergency Preparedness and IHR
World Health Organization
20 Avenue Appia
CH-1211 Geneva
Switzerland

sph@who.int
https://extranet.who.int/sph/

World Health
Organization