SEVENTIETH WORLD HEALTH ASSEMBLY **A70/8**
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Report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

The Director-General has the honour to transmit to the Seventieth World Health Assembly the report submitted by the Chair of the Independent Oversight and Advisory Committee (see Annex).

ANNEX

REPORT OF THE INDEPENDENT OVERSIGHT AND ADVISORY COMMITTEE FOR THE WHO HEALTH EMERGENCIES PROGRAMME

I. BACKGROUND

1. The Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies (WHE) Programme[1] provides oversight and monitoring of the Programme and advises the Director-General.[2] The IOAC's first report was noted by the Executive Board at its 140th session in January 2017.[3] The report was shared with the Secretary-General of the United Nations and with the Inter-Agency Standing Committee.[4]

2. That first report, based on activities during May to December 2016, reviewed the status of implementation of the WHE Programme across the Organization.[5] The report also provided observations on WHO's response to the Zika virus disease outbreak in Colombia via a field visit[6] and on the yellow fever outbreak in the Angola and Democratic Republic of the Congo (DRC) via a desk review.[7]

3. The findings from the first report suggested that the Zika incident management system was successful and that the declaration of a public health emergency of international concern led to urgent national and global action. Although the country response was led by the Colombian Ministry of Health and Social Protection, there was strong support from PAHO/AMRO through the WHO Representative (WR), who also acted as Incident Manager. This was a successful emergency response, but also emphasized the importance of WHO's role in responding to complex diseases with lasting sequelae.

4. The IOAC also commended the WHO's response to the outbreak of yellow fever. Although this was very different from that of the Zika outbreak and involved vaccinating 30 million people, the IOAC observed the use of one integrated incident management system with support from multiple partners in the transition to the new ways of working.

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[1] Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/en/, accessed 20 April 2017).

[2] Terms of Reference of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/Terms-of-Reference-Independent-Oversight-Committee.pdf?ua=1, accessed 20 April 2017).

[3] See document EB140/8 and the summary records of the Executive Board at its 140th session, second meeting, section 3 (document EB140/2017/REC/2).

[4] Inter-Agency Standing Committee (https://interagencystandingcommittee.org/).

[5] Headquarters, six regional offices and more than 150 country offices.

[6] Mission report of the IOAC: Colombia, 8–10 November 2016 (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/colombia-mission-report.pdf?ua=1, accessed 20 April 2017).

[7] WHO progress report on the yellow fever response for the review of the IOAC, 10 November 2016 (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/Yellow-Fever-Health-Emergency-Progress-Report-20Oct2016.pdf?ua=1, accessed 20 April 2017).

5. Between January and May 2017, the IOAC held its sixth and eighth meetings by teleconference and the seventh meeting in person in Amman.[1] In January, interviews were held with several Member States and six Regional Directors. In March, two field visits were conducted, in Iraq[2] and Nigeria[3], where the IOAC met with numerous partners and stakeholders. In Amman, IOAC members also interviewed other external partners and WHO staff including the WRs in Iraq, Jordan, Nigeria, Syrian Arab Republic and Yemen.

6. This second report to the governing bodies covers the IOAC's activities in its first year and provides its observations on progress in the eight thematic areas that were identified in the first report: structure, human resources, emergency business processes, finance, risk assessment, incident management, partnerships, and International Health Regulations (2005). The report focuses in particular on the impact of WHO's emergency reform in terms of delivery on the ground, functionality of the WHE Programme across the Organization, and barriers to effective operations.

II. OVERALL PROGRESS OF THE WHE PROGRAMME

7. In reaching its assessment, the IOAC adopted a monitoring framework[4] to track progress against the WHE Programme Results Framework indicators.[5] The Director-General's report to the Sixty-ninth World Health Assembly on the reform of WHO's work in health emergency management[6] remains the main reference for monitoring implementation. Furthermore, the IOAC carried out interviews, field visits and reviewed various public and internal documents.

8. The implementation of the WHE Programme has advanced since the IOAC's first report. Particular progress has been noted in WHO's response to the health needs of populations in protracted emergencies. The IOAC observes improvement in WHO's health cluster[7] coordination and leadership, which is welcomed by partners on the ground. The IOAC acknowledges encouraging signs in WHO's field presence and partnership engagement.

9. Evidence from the field visits[8] demonstrates that the WHE Programme is improving WHO's effectiveness in emergencies. However, the IOAC cautions that this progress remains fragile, and

[1] Seventh meeting of the Committee (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/7th-meeting-agenda.pdf, accessed 20 April 2017).

[2] Field visits in Iraq, 22–24 March (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/iraq-mission-agenda.pdf, accessed 20 April 2017).

[3] Nigeria mission report, 28 February–6 March 2017 (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/nigeria-mission-report.pdf, accessed 25 April 2017).

[4] IOAC 2017 Monitoring Framework for WHE Programme (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/ioac-monitoring-framework.pdf?ua=1, accessed 20 April 2017).

[5] Document EB140/36, Draft proposed programme budget 2018−2019. (http://apps.who.int/gb/ebwha/pdf_files/EB140/B140_36-en.pdf).

[6] Document A69/30. Reform of WHO's work in health emergency management, WHO Health Emergencies Programme, Report by the Director-General, 5 May 2016 (http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_30-en.pdf).

[7] Health Cluster (http://www.who.int/health-cluster/en/, accessed 20 April 2017).

[8] Colombia (8−10 November 2016), Nigeria (28 February–6 March 2017), and Iraq (22−24 March 2017).

WHO's "no regrets" policy[1] has not yet been fully embedded into all areas of crisis response. To date, the success at country level has been driven by the performance of dedicated country office and short-term surge staff in the field, support from WHE Programme staff in headquarters and regional offices, and partner deployments (e.g. the Global Outbreak Alert and Response Network(GOARN)[2] and Stand-by partners), while administration and support systems remain a serious constraint.

Structure of the WHE Programme

10. The IOAC acknowledges that the structure of the WHE Programme has been aligned across the three levels of the Organization. However, although some partners are aware of WHO's emergency reform programme, many country-level staff and some external partners are not. Nevertheless, partners interviewed during field visits have universally noticed positive changes in WHO's way of working. The IOAC recommends that both internal and external communication about the WHE Programme should be improved.

11. The IOAC recognizes that emergency management structures at country level are being adapted to manage the different types, magnitude and duration of emergencies. The establishment of an incident management system is well suited to new or acute emergencies where the country office (CO) may not be set up for emergency operations. In protracted emergencies where WHO puts in place leadership and emergency management structures, a stand-alone incident management system may not be needed. WHO may instead focus on provision of surge staff from the WHE Programme and partners to deal with the escalation of an emergency such as a disease outbreak within an existing humanitarian emergency.

12. WHO must take a coherent Organization-wide approach to staffing in emergencies to ensure sufficient flexibility. For example, in priority countries of the WHE Programme, including those in protracted crises, an appropriately trained and experienced WR could be designated as Incident Manager. The IOAC notes the importance of establishing a baseline level of emergency operational and management capacity at country level, ideally including a deputy WR. This is particularly necessary for ensuring sufficient management bandwidth in priority countries of the WHE Programme if the WR assumes the Incident Manager position. It is important that in biennial budgetary planning for the COs in priority countries that key senior staff positions are included in the CO's budget.

13. Clarity on roles, responsibilities, authority, accountability, reporting lines and coordination is of paramount importance. Noting the importance of the Delegation of Authority to Incident Managers and WRs, the IOAC recommends that a standard template for delegation of authority should be developed and adopted across all three levels of the Organization.

Human resources

14. As of March 2017, the WHE Programme has established a total of 1438 positions (684 existing staff and 754 vacant positions) compared to 1157 soon after its roll-out.[3] The increase is due to an

[1] WHO's no regrets policy: At the onset of all emergencies, WHO ensures that predictable levels of staff and funds are made available to the WCO, even if it is later realized that less is required, with full support from the Organization and without blame or regret. Emergency Response Framework, second edition, Chapter 4.

[2] See http://www.who.int/ihr/alert_and_response/outbreak-network/en/, accessed 20 April 2017.

[3] The WHO Health Emergencies Programme was launched officially on 1 July 2016.

increase in positions at CO level. However, recruitment has not kept pace with the creation of the new posts and no significant change has been made in the recruitment rate since December 2016: 35% of positions filled in the COs, 50% at regional offices and 70% at headquarters level.

15. While 469 CO level positions remain vacant, there are 386 temporary staff employed for emergency response, with the average length of contract of seven months. Given current funding gaps, the IOAC accepts that short-term contract staff can provide an interim solution to the vacancies, but warns that this will result in high turnover and difficulty recruiting motivated staff with the right profiles and emergency experience. There is also the risk that institutional memory will not be accumulated. Long-term sustainable financing for the WHE Programme needs to be secured to stabilize contractual arrangements for key staff.

16. WHO's enhanced ability to deliver on the WHE Programme hinges on the quality of its staff. In particular the IOAC recognizes the crucial role that national staff play in emergencies, and acknowledges the need for capacity investment and career support of national staff.

17. Following the IOAC's recommendation in its first report, the WHO Secretariat conducted a benchmarking exercise of the WHE Programme staffing. This Organization-wide analysis revealed that the proportion of positions in the WHE Programme that are at the senior level (P6 and above) at three levels of WHO is 4.3% against total professional staff, in comparison of the figure for the rest of the Organization of 17·5%. The proportion of senior level positions at headquarters only is 7.95% for the WHE Programme and 12.48% for the Organization as a whole. All these figures show that the proportion of senior staff in the WHE Programme is lower than for WHO as a whole (excluding the WHE Programme) at both headquarters and global level. The WHO Secretariat also reported that the proportion of senior staff in the WHE Programme is comparable to that of other humanitarian agencies.

18. The IOAC observes that the Organization shows strong preference for internal WHO candidates in staff recruitment. This limits the recruitment pool, given that candidates with senior-level experience in both health and humanitarian response can be found externally, particularly in the nongovernmental organization sector. While candidates without WHO experience may struggle to navigate the business rules and procedures of the Organization, such staff must be duly considered if WHO is to be effective on the ground. The IOAC recommends that a longer-term recruitment strategy should be developed which can attract, orient and support the best candidates.

19. IOAC field visits underscored the importance of administration and finance as core functions of the WHE Programme. Administrative support staff should be deployed at the beginning of an emergency activation in order to assist the team with its heavy field deployment demands and to navigate the business systems. During a response, a dedicated emergency administrative support officer should also sit in the CO to provide added capacity and facilitate support to the Programme.

20. Staff well-being and protection are essential for both national and international personnel in emergency settings. A clear staff rotation policy consistent with the WHO Geographical Mobility Policy[1] must be implemented in hardship duty stations to prevent staff from burning out, and special considerations and incentives should be given to staff working in emergencies at the most challenging duty stations. The IOAC observes that the United Nations' rest and recuperation entitlement is not commensurate with the stress and pace of WHO's emergency field operations. Therefore, WHO is

[1] Available at: http://www.who.int/employment/WHO-mobility-policy.pdf?ua=1, accessed 20 April 2017.

encouraged to develop its own ad hoc incentives and appropriate leave policies specifically for staff working in emergencies in accordance with WHO's human resources policies. Additionally, psychological support should be provided to staff working in the field, as well as protection against workplace harassment.

Emergency business processes

21. Based on the field visits and interviews, the IOAC observes that WHO's administrative systems are not suited to support emergency operations, particularly for recruitment, procurement, delegations of authority, and grant management. The IOAC recommends setting up a time-limited working group dedicated to addressing major issues for streamlining administrative and operational systems in an emergency response.

22. The IOAC acknowledges that the emergency business rules have been inserted into the WHO e-manual,[1] but feedback from staff and partner organizations indicates that they are not yet fully embedded in the Organization's culture. For example, although waiver authorities exist, these are rarely used in emergency settings due to lack of awareness, or reluctance to apply them. The IOAC recommends that the WHO Secretariat ensures automatic activation of the Standard Operating Procedures, makes issuance of waivers a standard default practice, and briefs auditors so that their audit expectations are aligned with WHO policy for emergencies. WHO should promote its processes in emergencies to all staff and invest in cultural change across the Organization.

23. According to the analysis in Iraq, the recruitment process takes an average of 87 days from initiation to a staff member arriving at the duty station. This is unworkable for health emergencies as it jeopardizes WHO's operational readiness. In surge situations, a fast-track recruitment process should be aligned with best practice from other agencies, including recruitment in advance of funding, with final appointments subject to funding availability. The IOAC welcomes the WHE Programme's practice of building up a roster of pre-screened and fully-validated candidates.

24. Delay in procurement of essential supplies will hamper emergency response and can be caused by lack of clear policies, inadequate delegation of authority or a culture of risk aversion. The IOAC urges the WHO Secretariat to streamline standard operating procedures for emergency procurement: increase the expenditure limits in the delegation of authority, apply standard waivers in accordance with the delegation of authority, systematize pre-qualified suppliers, simplify local contracts and payment processes, and fast track due diligence process as per the provision in the Framework of Engagement with Non-State Actors.[2]

25. The IOAC recommends that WHO should have a more consistent and robust approach to security across its emergency programmes and that this should be funded by an appropriate level of flexible corporate funding. Evidence from field visits indicates that the quality of work of the United Nations Department of Safety and Security (UNDSS)[3] and WHO's engagement with the UNDSS vary depending on the duty stations. WHO is encouraged to proactively work with the UNDSS on security risk assessment and management and put in place a coherent strategy for security in insecure field

[1] WHO e-manual, Section XVII – Health Emergencies.

[2] See Annex to resolution WHA69.10: http://www.who.int/about/collaborations/non-state-actors/A69_R10-FENSA-en.pdf?ua=1 (accessed 20 April 2017).

[3] See: http://www.un.org/undss/?q=home (accessed 20 April 2017).

settings, both for acute emergencies and outbreaks, and protracted crises. WHO should increase its investment and capacities in field security and other staff protection measures.

Finance

26. Findings from the field visits suggest that WHO's field performance is yielding increased donor confidence, as it demonstrates its ability to both coordinate the health cluster and respond effectively in difficult environments. Recent media coverage on WHO's response in Iraq reflects this as well.[1] However, the WHE Programme still faces financial challenges including lack of multiyear funding arrangements, management of large one-off contributions, competing humanitarian priorities, and ongoing shifts in donor investment.

27. Since the IOAC presented its first report, additional flexible funds have been received for the core budget for the biennium 2016–2017 and the funding gap has been reduced from 56% to 41% over the past three months. This allocation and the projections based on the pledges that the WHE Programme has received, indicate that 86% of the core budget could be funded over the biennium. The appeals budget (for humanitarian acute and protracted emergencies response plans) for 2017 led to receipt in the first quarter of the year of US$ 67 million out of the target US$ 523 million. Since the first report, there has been no change in the shortfall in the Contingency Fund for Emergencies:[2] a 67% funding gap for the target of US$ 100 million.

28. Of US$ 284 million raised for the core budget, US$ 82.5 million has been made available at the country level. The IOAC recognizes the progress made in resource mobilization at country level, particularly in Nigeria, South Sudan and Yemen where resource mobilization officers are deployed and resource mobilization strategies are being implemented. The IOAC urges WHO to increase the fundraising authority of COs during emergency response, to enable COs to secure large-scale funding directly rather than through the regional offices. This is critical to maintaining operational agility amidst a fluid response.

29. The IOAC notes that the WHE Programme aims to fill up to 50% of CO vacancies by the end of 2017, depending on funding availability. The WHE Programme does not intend to fund all the CO posts from its flexible funding, but instead COs will need to fund-raise at local level with support from regional offices and headquarters. The IOAC welcomes the plan to recruit greater numbers of national staff with fewer international positions in COs, which would allow the WHE Programme to balance costs and stay within the overall budget.

30. Although the Contingency Fund for Emergencies has shown clear value in addressing immediate needs in emergencies, it has failed to reach the total capitalization of US$ 100 million and replenishment by donors has been weak. As at March 2017, a total of US$ 19.95 million was allocated in support of WHO's response to 16 health emergencies. Having reviewed report of the WHE Programme on the Contingency Fund,[3] the IOAC believes that the Fund has been a useful tool,

[1] https://www.devex.com/news/for-first-time-who-as-implementer-in-mosul-trauma-chain-of-care-89840 http://www.un.org/undss/?q=home (accessed 20 April 2017).

[2] WHO Contingency Fund for Emergencies (http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/en/, accessed 20 April 2017).

[3] WHO Health Emergencies Programme. Contingency Fund for Emergencies: impact and achievements 2017 (available at: http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/CFE_Impact_2017.pdf?ua=1, accessed 20 April 2017).

particularly with respect to ensuring start-up funding in new emergencies. The IOAC believes that the Contingency Fund would be most effective if it was fully functioning as a revolving fund, but recognizes that it is not functioning as one currently, and recommends WHO to come forward with clear plans for its sustainability for the future.

31. The IOAC notes that the core budget projections for the biennium 2016-2017 are looking better, however, they are viewed as fragile, and therefore WHO is also encouraged to consider an appropriate funding strategy to identify additional revenue sources for the core budget of the WHE Programme, and strengthened budgeting at country level to ensure all project-related costs required for sustainable country operations are included in donor proposals.

Risk assessment

32. The second edition of the Emergency Response Framework[1] provides further clarification on risk assessment, the grading system, and application of the incident management system, with roles and responsibilities, performance standards and key performance indicators. The emergency response procedures with their specific timeframes indicate what is expected within 24 hours, 72 hours and up to 60 days.

33. The IOAC welcomes the progress on health emergency information management and risk assessment. With respect to grading decisions, the IOAC emphasizes that these are internal to WHO and should be made solely by WHO's leadership, based objectively on grading criteria as agreed by the Inter-Agency Standing Committee and described in WHO's Emergency Response Framework. Based on the experience with the crisis in north-eastern Nigeria, the IOAC also acknowledges the value of confidentially informing the governments concerned of such decisions immediately prior to their announcement, in order to allow the governments to prepare an appropriate response.

34. The IOAC notes that event detection, verification, risk assessment, and grading are complex processes involving many departments and levels of WHO. With specific reference to outbreaks, it is important to recognize that these processes are not necessarily linear, with risk assessment often requiring further field investigation and the implementation of immediate containment/control measures. In these scenarios, the WHE Programme sometimes supports and deploys a field investigation/response before the event is fully assessed and graded. The IOAC encourages the WHE Programme to further clarify roles and responsibilities between departments on leadership of investigation/response operations during the different phases of event management as well as coordination with and engagement of partners in GOARN in outbreak investigation. It is exceptionally important that such processes are carefully and efficiently managed to avoid delays in the response process.

35. The IOAC is pleased to see the development, testing and deployment of a range of core information management systems by the WHE Programme, including the preparatory work for the launch of Epidemic Intelligence from Open Sources in June 2017. The WHE Programme continues to use the existing Event Management System for data related to the verification, assessment and tracking of events but IOAC would advise that this system be assessed in terms of its all-hazards capabilities, utilisation throughout the WHE Programme at all levels and the potential need for this essential system to be updated.

[1] WHO. Emergency Response Framework. Geneva : World Health Organization ; (http://www.who.int/hac/about/erf/en/, accessed 20 April 2017).

36. The IOAC notes the field application of the Early Warning, Alert and Response System[1] and the Health Resource Availability Monitoring System[2] in different emergency settings. The further development and testing by the WHO Secretariat and GOARN of GoData, which is a field-deployable system for managing the complex data related to outbreak response, is a positive step. The IOAC thus advises continued investment in the development, deployment and institutionalization of standardized and supported field tools especially at CO level where WHO emergency information management platforms are not standardized.

Incident management

37. Based on country visits in Colombia, Iraq and Nigeria and in-depth briefings on the Democratic Republic of the Congo and the Syrian Arab Republic, the IOAC commends WHO on its improved emergency response activities driven by the strong leaderships of WRs and Incident Managers. The IOAC recognizes that the WHE Programme has strengthened teams by utilizing the skills and knowledge of national staff and surge capacity from regional offices and headquarters. The IOAC recommends building a critical mass of qualified WRs and Incident Managers ready for deployment through rosters, training and linkage to a career development programme.

38. The Executive Director of the WHE Programme and relevant Regional Director should determine whether a WR assumes the Incident Manager position in emergencies. The Incident Manager for acute emergencies and the Emergency Manager for protracted emergencies are typically supervised by the WR, unless alternative arrangements have been agreed by the Executive Director and the Regional Director. Regardless, Incident Managers should continue to have a direct line to the WHE Programme's leadership in order to ensure appropriate technical and operational oversight.

39. The WHO emergency operations in north-eastern Nigeria are led by an Incident Manager. The incident management system functions are largely self-contained in Maiduguri. The WR's role is mainly to ensure that the Incident Management Team gets the necessary support from the CO, on the basis of the delegation of authority. This model can be successful, provided that there is a supportive WR and that the CO has sufficient capacity to support the emergency response. The IOAC emphasizes that the Organization should retain overall accountability and that the WR should be held accountable for the performance of the incident management system. Delegation of authority to the Incident Manager must not negate the WR's accountability.

40. The IOAC considers that the actual level of authority being delegated to the Incident Manager is not adequate for the operational requirements of emergencies. The WHO Secretariat should give greater authority to the Incident Manager to expedite operational and administrative support requirements, particularly in relation to recruitment, procurement and finance. The delegation of authority should be issued concurrent with the activation of an Incident Management Team.

41. The IOAC recommends that Incident Managers should receive pre-deployment orientation on WHO systems, procedures, delegation of authority and its relationship to the CO so as to ensure that Incident Managers and CO staff share a common understanding of roles and responsibilities. The

[1] WHO's Early Warning, Alert and Response System, EWARS (http://www.who.int/emergencies/kits/ewars/en/, accessed 20 April 2017).

[2] WHO's Health Resource Availability Monitoring System (HeRAMS) (http://www.who.int/hac/herams/en/, accessed 20 April 2017).

Incident Managers should be engaged on a longer-term contractual arrangement—at least 12 months instead of three-month contracts with extensions.

Partnerships

42. External partners recognize and appreciate WHO's expanded role in emergencies, including on operational coordination at field level. The IOAC observed this improvement directly during the visits in Iraq and Nigeria. In Iraq, WHO was commended for effective coordination, proactive and transparent communication, and provision of technical, financial and operational support with a focus on delivery. In addition, the ability of the Regional Office for the Eastern Mediterranean and headquarters to provide specialist surge capacity (for example, for chemical hazards and trauma pathway management) as well as coordination of support from and deployments through GOARN have been highly appreciated.

43. WHO's investment in health cluster coordination is paying off. Partners acknowledged WHO's leadership role in coordinating health cluster partners as well as its critical role as an interface between the government and the humanitarian community. The IOAC reiterates that information management is an essential element of this coordination. Sufficient and consistent support for information management should be provided to the health cluster coordinator.

44. IOAC field visits noted that provision of humanitarian health services is often fragmented across individual agencies based on mandates or funding streams. The structure of care provision should be patient-centred rather than driven by mandate or funding source. Health cluster coordination should be operationally oriented, focusing on assessment of needs and gaps, and corresponding allocation of assets and services by individual partners. Partners interviewed by IOAC expressed willingness to use their collective assets more efficiently and cohesively, but this would require more donor flexibility. WHO's privileged relationship with host governments should also be used to foster constructive cooperation between governments and partners.

45. The importance of continued focus in building the depth and capacity of partner networks like GOARN and WHO's Emergency Medical Teams[1] was stated in the IOAC's first report. These networks allow WHO to leverage and deploy the specific expertise required to support partners already on the ground, drawing from a global pool of institutions committed to supporting outbreak and emergency response. The IOAC notes that such deployments are much more effective when WHO's country capacity and coordination role is already in place. Investment in these operational partnerships and networks will ensure that WHO has the best expertise available at short notice for field deployment, and is operating with clear structure, roles and coordination mechanisms.

International Health Regulations (2005)

46. The IOAC acknowledges that 37 countries from all six WHO regions have conducted Joint External Evaluations[2] since the beginning of 2016, with a further 28 scheduled by the end of 2017. The IOAC notes that only three countries have completed their national action plans following the joint external evaluation. The IOAC reaffirms the importance of all four components of the IHR

[1] Emergency Medical Team Initiative (https://extranet.who.int/emt/page/emt-initiative, accessed 20 April 2017).

[2] Joint External Evaluation mission reports are available at: http://www.who.int/ihr/procedures/implementation/en/ (accessed 20 April 2017).

(2005) Monitoring and Evaluation Framework as critical areas of work of the WHE Programme. The IOAC recognizes the importance of the regional offices supporting countries to share best practice and experience in developing the plans, and donor support for the implementation of these costed plans will be essential for building country capacity and health system strengthening.

47. The IOAC acknowledges that the Joint External Evaluation assesses the community, subnational, and national capacities, and includes indicators that reflect community strengthening and engagement. The IOAC wishes to investigate the Joint External Evaluation process through its future field visits programme and interviews. In the meantime, the IOAC also recommends that relevant community-based groups be systematically included in Joint External Evaluation processes to ensure that community-based surveillance and community early response systems are included in all evaluations.

III. CONCLUDING REMARKS

48. WHO is making efforts at all levels to transform itself into an operational organization in emergencies. Since the launch of the WHE Programme, progress has been noticed in emergency response at country level, with consistently positive feedback on WHO's expanded role in humanitarian crises. WHO is demonstrating that it can be a reliable and competent partner to governments, organizations in the United Nations system, health cluster partners, implementing nongovernmental organizations and the donor community. However, progress is fragile. WHO's administrative systems and business processes are not effectively supporting its operations, and the WHE Programme is struggling with a funding shortage. Cultural constraints on the emergency response throughout the Organization remain the main challenge for adopting a "no regrets" policy in practice. The Organization must ensure that the WHE Programme can fulfil its potential. Ensuring this success is ultimately a shared responsibility between Member States, WHO's partners and the Secretariat.

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