

Independent Oversight and Advisory Committee
for the WHO Health Emergencies Programme

Interim report on WHO's response to COVID-19
January-April 2020

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Background

1. Following the West Africa Ebola outbreak in 2014-2015 and WHO's organization-wide reform, the WHO Health Emergencies Programme (WHE Programme) and the Independent Oversight and Advisory Committee (IOAC) for the WHE Programme were established, in decisions taken by the World Health Assembly at its Sixty-ninth session.¹ The WHE Programme was officially launched on 1 July 2016 to reposition WHO as a United Nations specialized agency with operational functions for managing health emergencies while maintaining normative functions. The mandate of the IOAC is to provide oversight and monitoring of WHO's implementation of the reform and of its performance in health emergencies. Since the inception of the WHE Programme, the IOAC has been monitoring progress and providing independent scrutiny of WHO's work in outbreaks and emergencies.
2. The unprecedented pandemic of coronavirus disease (COVID-19) prompted the IOAC, in conducting its advisory and accountability function, to examine the performance of the WHE Programme during the first few months of the COVID-19 outbreak. The annual IOAC report, that would normally be submitted to update the IOAC report presented to the 146th session of the Executive Board,² will be submitted to the next full governing body meeting. This report is informed by WHO Secretariat briefings, desk reviews, and interviews with a select number of headquarters/WHE staff members, and external global health experts. The IOAC emphasizes that this is not a comprehensive assessment of the WHO COVID-19 response. Rather, in keeping with the IOAC mandate, it is a compilation of observations of how the structures and processes established by WHO, through the WHE Programme and related mechanisms, functioned from January to April 2020 in the context of the COVID-19 response. The IOAC notes that WHO is composed both of its Member States and the Organization's Secretariat. The present interim report makes it clear at whom specific recommendations are aimed throughout the document.
3. Significant progress has been made in WHO's health emergency management since the reforms approved by the World Health Assembly in 2016. The IOAC recognizes that the WHE Programme has, over the past four years, increasingly demonstrated its ability to function effectively across the three levels of headquarters, regional offices and country offices. In May 2020, the WHE Programme was responding to 174 acute events globally and a total of 60 graded crises, including five grade 3 crises and 29 grade 2 crises. WHO's

¹ See document WHA69/2016/REC/1, decision WHA69 (9) and Annex 10.

² Document EB146/16.

response to the Ebola virus disease outbreak in the Democratic Republic of the Congo, and its management of the ongoing serious health emergencies in Yemen and Syria and the Rohingya crisis in Bangladesh have in many respects been a proof-of-concept test for the WHE Programme. However, the international spread of COVID-19 has highlighted the challenges of handling a global pandemic and has tested WHO as never before.

Overall situation and global context of the COVID-19 pandemic

4. On 31 December 2019, WHO became aware of cases of pneumonia of unknown etiology detected in Wuhan City, Hubei Province of China.³ Since the notification of the first cases of COVID-19, the virus has spread around the globe. As at 14 May 2020, 4 218 212 cases of COVID-19, including 290 242 deaths, had been reported to the WHO Secretariat from 216 countries, areas or territories.
5. The virus was sequenced with great speed, and the WHE Programme began providing updates and guidance to WHO Member States almost immediately. Initial information on case fatality rate, severity, and transmissibility furnished by China in early January reflected an incomplete picture of the virus, but were updated by the WHO Secretariat following a country office mission to Wuhan from 20 to 21 January. An imperfect and evolving understanding is not unusual during the early phase of a novel disease emergence. Many uncertainties still remain about COVID-19, including the actual number of infections around the world, the mortality rate, its animal reservoir population and emergence, transmission patterns, the full range of complications, seasonality, immunity, and mutation of the virus. Since this novel disease only emerged five months ago, no vaccines or approved drugs for COVID-19 are available yet. However, investments have been made in research, and developments are taking place.
6. COVID-19 has overwhelmed health systems in several hard-hit countries, and the supply chain for personal protective equipment, testing kits and medical equipment such as oxygen treatment equipment and ventilators, is under immense pressure to meet global demand. Over 100 countries have implemented either a full or partial lockdown, in the effort to contain the spread of the virus and reduce pressure on their health systems. The lockdowns are exacerbating interconnected psychological, social and economic crises including poverty, unemployment, food shortages, xenophobia, domestic abuse and social unrest. The pandemic has heightened geopolitical tension and the public health crisis has become a major issue in domestic politics in many settings.

³ SITREP-1, 21 January 2020: https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200121-sitrep-1-2019-ncov.pdf?sfvrsn=20a99c10_4, accessed 25 April 2020.

International Health Regulations (2005) and country preparedness

7. The International Health Regulations (2005) (IHR),⁴ are a legally binding international agreement between 196 States Parties, including all WHO Member States, to work together for global health security. Through the IHR, countries have agreed to build their capacities to detect, assess and report public health events. WHO Secretariat plays a coordinating role and is required to adhere to IHR protocols in its conduct during a dangerous novel disease outbreak. While binding on member states, the IHR do not provide the WHO Secretariat with authority to impose sanctions on countries for non-compliance. The IHR stipulate that it is up to Member States to adhere to the Regulations, and that the WHO Secretariat may offer assistance, but has limited power or authority in its own right.

8. On 22 January 2020, under the IHR, the Director-General convened the IHR Emergency Committee to address the outbreak of COVID-19. At that meeting, Committee members expressed divergent views on whether or not the outbreak constituted a public health emergency of international concern (PHEIC), the highest level of alarm/alert established under the IHR but agreed to reconvene in a matter of days to examine the situation further. The public summary of the meeting confirmed human-to-human transmission of the virus, and provided estimates of the virus' transmissibility, fatality rate, severity rate, and other essential information. On 28 January, the Director-General traveled to China to assess the situation directly.⁵ On 30 January 2020, at the second Emergency Committee meeting, WHO declared the event a PHEIC. The WHO Secretariat issued an Emergency Committee statement⁶ reconfirming human-to-human transmission and further international exportation of cases and recommending comprehensive strategies for country preparedness. The urgency with which Member States took action based on the PHEIC varied both in terms of the timing and the comprehensiveness of public health measures in response to COVID-19. **This raises questions about whether Member States view a PHEIC declaration as a sufficiently clear trigger. The IOAC notes that the design of the PHEIC is very broad, covering everything from a limited regional outbreak such as Ebola in West Africa to a large global pandemic that touches every country. Following the present crisis, it may be useful to review and update the IHR to reflect lessons from the pandemic. The IOAC encourages Member States to consider whether: a stepped level of alerts and galvanization of response measures should be added to the IHR; to enhance the**

⁴ International Health Regulations (2005). World Health Organization: Geneva; 3rd edition, 2016 (<https://www.who.int/ihr/publications/9789241580496/en/>, accessed 14 May 2020).

⁵ WHO newsroom: <https://www.who.int/news-room/detail/28-01-2020-who-china-leaders-discuss-next-steps-in-battle-against-coronavirus-outbreak>, accessed 14 May 2020.

⁶ WHO newsroom: [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)), accessed 25 April 2020.

openness and transparency of the Emergency Committee process; and to review whether the IHR-nominated focal points in governments are able to adequately raise the alarm to ministers within their governments when a PHEIC is declared.

9. Inputs that the IOAC received suggest that the overall level of COVID-19 data reporting by Member States under the IHR needs further improvement in terms of speed, consistency and completeness. The IOAC notes that the quality of country reports varied, making it difficult for the WHO Secretariat to conduct comparable analyses of outbreak and readiness patterns across multiple countries. **Noting the critical role of Member States in data reporting, the IOAC recommends that the WHO Secretariat further streamline the reporting process and support countries in strengthening capacity to report on the information required under the IHR.**

10. The IHR include specific measures to be taken at ports, airports and ground crossings to limit the spread of health risks to neighboring countries, while minimizing interference with world travel and trade. The WHO Secretariat issued its first travel advice on 10 January 2020,⁷ drawing the attention of Member States to IHR provisions. Subsequent recommendations regarding travel under the IHR were issued based on updated guidance.⁸ However, over 100 States Parties reported to WHO that they were taking additional measures, given that each country had different goals depending on the phase of the epidemic, the country's socio-demographic composition and its health system capacity. **The IOAC notes it may be opportune for Member States to reassess WHO Secretariat's role in providing travel advice during a pandemic.**

11. In January 2020, the IOAC was briefed that over 100 countries had undertaken voluntary joint external evaluations (JEEs) and more than 60 countries had developed National Action Plans for Health Security (NAPHSs). The IOAC noted in its previous reports that the voluntary JEE tool was useful for identifying gaps but cautioned that the impact of JEEs and NAPHSs on strengthening IHR core capacities was still unclear. The IOAC sees no clear relation between JEE scores and country preparedness and response to COVID-19, suggesting that existing metrics for public health preparedness and health care capacity do not reflect the full range of variables that affect a country's response during a severe pandemic on a massive scale. The majority of countries appeared ill-prepared and struggled to implement public health measures in response to COVID-19. **In the light of this pandemic, the IOAC recommends that Member States and the WHO Secretariat**

⁷ WHO newsroom: <https://www.who.int/news-room/articles-detail/who-advice-for-international-travel-and-trade-in-relation-to-the-outbreak-of-pneumonia-caused-by-a-new-coronavirus-in-china/>, accessed 14 May 2020.

⁸ WHO newsroom: <https://www.who.int/news-room/articles-detail/updated-who-advice-for-international-traffic-in-relation-to-the-outbreak-of-the-novel-coronavirus-2019-ncov-24-jan>, accessed 14 May 2020;

review the IHR core capacities and existing tools and framework for national and international preparedness, and consider whether they need to be updated.

12. The WHO Secretariat's response to COVID-19 was faster than for either the MERS or SARS epidemics, but this did not prompt similarly rapid action by all Member States; this may indicate a gap between the current IHR and Member State expectations of WHO Secretariat's role. This pandemic has called into question whether the existing roles and responsibilities that the IHR assign to the WHO Secretariat and to Member States are widely understood, fit for purpose and still appropriate for a pandemic. **The IOAC therefore recommends that the International Health Regulations (2005) should be reviewed by Member States in the light of the COVID-19 pandemic to ensure that the attribution of authority and roles outlined under the Regulations are in alignment with Member States' understanding and expectations. This may entail revisiting the roles and responsibilities of the WHO Secretariat and the duties of Member States.**

WHO leadership and capacity for managing a pandemic

13. Evidence collected from the IOAC desk review indicates that the initial process of providing information about the new virus was conducted within the parameters established under the IHR. On 5 January 2020, the WHE Programme published the information that it had available in its first disease outbreak news on the WHO website. On the same day, it alerted all IHR national focal points through a post on the Event Information site. It issued the first situation report on 21 January 2020. Since then, the epidemiological data have been updated on a daily basis. The Director-General has provided media briefings frequently since 4 February 2020. The WHO Secretariat also dispatched a team of 25 national and international experts to conduct a joint WHO-China mission from 16 to 24 February 2020⁹ and conducted COVID-19 technical support missions to the Islamic Republic of Iran on 10 March 2020 and to Egypt on 25 March 2020.
14. The IOAC noted the coordination across the three levels of the organization under the leadership of the Director-General and the Executive Director of the WHE Programme. Internal communication and decision-making processes have been greatly improved through WHO Health Security Council meetings (the Director-General with the Regional Directors), the Senior Leadership Group (composed of Executive Directors, the Assistant Directors-General of different programmes within the Organization and the Chief Scientist), and the incident management system in the context of the COVID-19 pandemic.

⁹ Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19) (https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf?sfvrsn=fce87f4e_2, accessed 14 May 2020).

15. The WHO Secretariat activated its incident management system to coordinate the outbreak response on 1 January 2020. The incident management system has been the core of WHO daily operations and its performance has reaffirmed its potential for acute event management. However, the IOAC observes that the incident management support team is overstretched due to the huge demand generated by the pandemic. Thought needs to be given as to whether it is an adequately resourced and staffed command structure to handle the immediate public health response, produce and communicate sound scientific guidance, develop recommendations for the multiple economic and social consequences of the public health measures, support country preparedness, and equipped with the strategic capacity to manage the challenges of a pandemic of this scale, complexity and impact. **The IOAC recommends that Member States and the WHO Secretariat revisit the size and surge capacity of the WHE Programme to ensure sufficient capacity, resilience and flexibility within and beyond the incident management system to respond adequately to such multidimensional and large-scale emergencies, alongside the increasing number of graded emergencies that it routinely manages.**
16. For the 2018–2019 biennium, WHO allocated US\$ 554 million to implement its core activities in health emergency management and raised 82% of the total requirement. The current pandemic has given rise to questions on the adequacy of the WHE Programme budget, and WHO financing. The IOAC considers that less than US\$ 300 million per year is too modest a budget to implement all the activities needed to support Member States with health emergencies and, at the same time, coordinate a global response to pandemics. The IOAC also notes that a substantial proportion of the funds for WHO are earmarked voluntary contributions. This precarious financial situation has impeded strategic planning and human resources management. An increase in the assessed contributions and improved accountability function would increase the sustainability and funding predictability of WHO. **The IOAC recommends that Member States review WHO financing to ensure the WHE Programme is able to continue to play a key role in global health emergencies with appropriate capacities.**
17. Since the 2019 novel coronavirus strategic preparedness and response plan¹⁰ was launched in early February 2020, WHO has raised US\$ 408.1 million for its work across the three levels of the Organization, with a further US\$ 306.4 million pledged as at 1 May 2020. The second iteration of the strategic response and preparedness plan is expected during the first week of May, and WHO will require an estimated US\$ 1.7 billion through till the end of the year,

¹⁰ 2019 novel coronavirus strategic preparedness and response plan. Geneva: World Health Organization; 2020 (<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/strategies-plans-and-operations>, accessed 14 May 2020).

leaving the Organization with a funding gap of US\$ 1.3 billion. WHO has succeeded in diversifying its donor portfolio and financing mechanisms. It has set up the COVID-19 Solidarity Response Fund¹¹ to promote global solidarity and to secure financial resources in an innovative way. As at 4 May 2020, more than US\$ 200 million had been raised from more than 229 000 individuals and organizations through the Solidarity Response Fund.

18. The IOAC acknowledges that throughout the COVID-19 pandemic, the WHE Programme has engaged closely with numerous existing networks and partnership platforms, including the Strategic and Technical Advisory Group on Infectious Hazards (STAG-IH), the Global Outbreak Alert and Response Network (GOARN), the Inter-Agency Standing Committee for health emergencies, and the global health cluster. These networks have become an important platform for epidemiological update and coordination among implementing partners. The Director-General has also reached out to public health experts to review the situation on a daily basis and seek independent advice in formulating the response strategy. Under WHO's leadership, numerous new initiatives have been put in place with various stakeholders, including from the private sector and faith-based organizations. **The IOAC encourages the WHO Secretariat to continue engaging and working collaboratively with partners and global experts and disseminating best practice.**
19. The leadership role of WHO within the United Nations in global health emergencies has been strengthened through the COVID-19 pandemic. The United Nations Crisis Management Team (UNCMT) was activated on 4 February 2020 to coordinate the entire United Nations system to support countries in responding to COVID-19. The IOAC notes that the UNCMT is being led by the WHO Secretariat for the first time and recognizes the establishment of a United Nations COVID-19 supply chain task force to scale up the supply of essential COVID-19 tools such as personal protective equipment, ventilators, and laboratory equipment.
20. The IOAC welcomes the update, released on 7 May 2020, of the Global Humanitarian Response Plan for COVID-19¹² to avoid the most destabilizing effects of the COVID-19 pandemic. The IOAC was briefed that the plan was updated using a bottom-up approach in close collaboration with NGOs. The humanitarian system is encouraged to continue engaging with local and international NGOs in implementing its response plan, and to obtain community feedback and the perspective of implementing partners on the ground.

¹¹ For information on the fund, see <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/donate>, accessed 14 May 2020.

¹² Global Humanitarian Response Plan for COVID-19. Geneva: United Nations Office for the Coordination of Humanitarian Affairs; 2020 (<https://reliefweb.int/report/world/global-humanitarian-response-plan-covid-19-april-december-2020-ghrp-may-update-abridged>, accessed 14 May 2020).

21. The IOAC recognizes that WHO has published more than 50 technical guidance documents for the public, for health workers and for countries, providing advice on the COVID-19 response. However, the delay between messaging at press briefings and putting out corresponding guidance on some key response elements such as the testing strategy, mask usage and managing personal protective equipment shortages, and the long-term virus suppression strategy, has given rise to uncertainty. The IOAC observes that there is a tension between rapid communication and timely provision of guidance, and between WHO's aspirations to lead technical guidance, and the limits imposed by its workforce capacity to do so in the heat of a crisis. **The IOAC recommends that the WHE Programme make more robust use of WHO collaborating centres around the world, expert networks, such as technical advisory bodies, and public health institutes. These bodies can support WHO in generating technical recommendations, validated by WHO, and thus supplement WHO's capacity in fast-moving crises.**
22. The IOAC observes that some WHO recommendations could be challenging to implement in low-resource settings and for certain populations. The social and economic implications of recommending public health measures such as isolation and social distancing for populations living in overcrowded and insecure settings, with inadequate access to food, safe water and sanitation, or for migrants with temporary or undocumented residential status, must be taken into consideration. Additionally, because of the growing evidence of the disproportionate impact of the virus on certain populations, based on gender, class, race and ethnicity, it is important for public health guidance to take into account the differential medical and socio-economic challenges faced by these populations. The IOAC acknowledges the efforts of other United Nations agencies, under the leadership of the United Nations Deputy Secretary-General, to mitigate the socio-economic impacts of the pandemic. However, mitigating those impacts does not preclude integrating those realities into public health guidance. For this reason, the IOAC also welcomes the Inter-Agency Standing Committee's Interim Guidance,¹³ and the United Nations Sustainable Development Group's Shared Responsibility, Global Solidarity,¹⁴ which both take an integrated approach that tailors public health recommendations for different socio-economic contexts and individual characteristics and empowers communities to find local solutions and mechanisms suited to their own context.

¹³ Interim Guidance on Public Health and Social Measures for COVID-19 Preparedness and Response in Low-Capacity and Humanitarian Settings. Inter-Agency Standing Committee (IASC): May, 2020 (<https://interagencystandingcommittee.org/health/interim-guidance-public-health-and-social-measures-covid-19-preparedness-and-response>, accessed 10 May 2020).

¹⁴ Shared Responsibility, Global Solidarity: Responding to the socio-economic impacts of COVID-19. United Nations Sustainable Development Group (UNSDG): March 2020 (<https://unsdg.un.org/resources/shared-responsibility-global-solidarity-responding-socio-economic-impacts-covid-19>, accessed 10 May 2020).

23. Development of COVID-19 vaccines across the world is progressing rapidly to reduce the impact of the disease on the global population. There are also numerous therapeutic trials underway to find effective clinical management modalities and drugs to treat the disease. The IOAC recognizes the R&D blueprint as a means of coordinating the ongoing efforts of the global research community and that it has facilitated the process of multi-national vaccine and therapeutic drug trials by standardizing protocols and leveraging national capacities. As at 21 April 2020, over 100 countries had joined the Solidarity Trial to evaluate therapeutics for the treatment of COVID-19. The IOAC considers that the future challenge is not purely technical, but that there is a need for a multilateral approach to deal with the global regulation of, and access to, vaccines as they become available, and treatments. **The IOAC recommends that WHO promote the establishment of an appropriate multilateral governance mechanism for ensuring equitable access to therapeutics and vaccines for all countries and effective delivery and stewardship, drawing upon previous experience of epidemics and pandemics.**
24. Without a vaccine or effective treatments, the world will have to live with and manage the virus on the basis of existing public health measures. As countries prepare to lift lockdown measures and move toward sustained suppression, **the IOAC recommends that the WHO Secretariat support Member States to urgently plan the next steps by intensifying basic public health measures at scale, investing in global health architecture for vaccine and drug development, securing the global supply of life-saving tools, strengthening local health care systems, and empowering communities through a calibrated approach, adapted to different individual vulnerabilities and socio-economic contexts.**

Concluding remarks

25. Considering the novel nature of this virus and persistent unknown factors, the IOAC notes that WHO has demonstrated leadership and has made important progress in its COVID-19 response. The IOAC commends the WHE Programme and staff on their dedication and hard work. The IOAC also condemns the credible threats targeted against the Director-General and staff members, which have followed criticism of the Organization in the media. The IOAC commends Member States, the Director-General, the Regional Directors, and the Executive Director of the WHE Programme for their leadership and deep commitment to contain the virus. The IOAC acknowledges the Director-General's engagement of Heads of State of WHO's membership to underscore political commitment and to address the global issues in a coordinated manner. It also notes the growing coordination between United Nations institutions to address some of the wider COVID-19 impacts.
26. The IOAC reiterates that global health is a shared responsibility and Member States must play their part. **It may be useful, at an appropriate time, to independently assess the**

Organization’s performance during this response and identify lessons for the future. The scope of such an assessment should be determined by Member States, and should cover both Member States’ and WHO Secretariat’s actions in response to the COVID-19 pandemic. The IOAC would caution that conducting such a review during the heat of the response, even in a limited manner, could disrupt WHO’s ability to respond effectively. The IOAC reiterates that WHO Secretariat’s actions are grounded in its duties and responsibilities under the IHR, and recommends that reviewing WHO’s performance must be considered in light of the suitability of the IHR, and of Member States’ adherence to the IHR in their own responses to the crisis.

27. The world is at a critical juncture in this unprecedented crisis and will not defeat this virus without greater global solidarity and stronger multilateral cooperation, and the execution of the forward-looking strategy required for the upcoming months of the pandemic. The COVID-19 pandemic is having huge socio-economic impacts across the globe, on health, economies, businesses, and on the workings and interactions of all communities in a way no other emergency has had before. No single Member State can hope to defeat this virus solely with the tools that exist within their own borders. Yet there has been a palpable lack of global solidarity and common purpose. That is a recipe for extending and worsening the global outbreak, leaving all countries less secure. A successful pandemic response hinges on inter-connected global systems and networks: of scientific expertise, medical supply, trade, innovation, and production. The rising politicization of pandemic response is a material impediment to defeating the virus, while it aggravates other health, social and economic impacts. WHO cannot succeed without unified global political support during the next phases of the pandemic.

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