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Public health emergencies: preparedness and response

WHO's work in health emergencies

Report by the Director-General

1. This report is submitted pursuant to the requests contained in resolution EBSS3.R1 (2015) and decision WHA68(10) (2015). It provides information on all WHO Grade 3 emergencies, United Nations Inter-Agency Standing Committee Level 3 emergencies and public health emergencies of international concern that required a response by WHO between 1 January and 30 September 2021. It also responds to the request contained in resolution WHA73.8 (2020) concerning the methodology and the implementation and findings of the Surveillance System for Attacks on Health Care in complex humanitarian emergencies. The response to the request contained in the same resolution for the Director-General to consult and make proposals on possible complementary mechanisms to be used by the Director-General to alert the global community about the severity and/or magnitude of a public health emergency in order to mobilize necessary support and to facilitate international coordination is contained in a separate report.[1]

ACTIVE GRADE 3 EMERGENCIES DURING THE PERIOD FROM 1 JANUARY TO 30 SEPTEMBER 2021

2. During the period under review, WHO responded to 76 emergencies, 59 of which were acute graded emergencies and 17 of which were protracted graded emergencies (see Annex, Tables 1 and 2). Five acute Grade 3 emergencies were active during the reporting period (see Table below), including three United Nations Inter-Agency Standing Committee Level 3 emergencies: the coronavirus disease (COVID-19) pandemic, which was declared a public health emergency of international concern in 2020; the northern Tigray humanitarian response in Ethiopia; and the complex emergency in Afghanistan. Given their scale, complexity and inherent operational challenges, these Grade 3 emergencies required the highest level of Organization-wide support.

[1] Document EB148/17.

Table. Grade 3/Protracted Grade 3 emergencies active between 1 January and 30 September 2021 (in order of initial grading)

Country	WHO region	Date of initial grading	Status as at 30 September 2021
Acute emergencies			
Guinea: Ebola virus disease 2021	African	18 February 2021	Ongoing (Grade 3)
Northern Tigray: humanitarian response	African	18 November 2020	Ongoing (Grade 3)
Global: COVID-19 pandemic	Global	14 January 2020	Ongoing (Grade 3); public health emergency of international concern declared on 30 January 2020
Afghanistan: complex emergencies	Eastern Mediterranean	28 October 2015	Ongoing (Grade 3)
Syrian Arab Republic: complex emergencies	Eastern Mediterranean	3 January 2013	Ongoing (Grade 3)
Protracted emergencies			
Democratic Republic of the Congo: complex emergency 2017–2019	African	29 August 2017	Ongoing (Protracted Grade 3) since 25 September 2020
Somalia: complex emergencies	Eastern Mediterranean	16 February 2017	Ongoing (Protracted Grade 3 since 8 August 2019)
Yemen: complex emergencies	Eastern Mediterranean	2 April 2015	Ongoing (Protracted Grade 3 since 6 May 2020)
Nigeria: humanitarian crises 2016 (north-east)	African	1 April 2015	Ongoing (Protracted Grade 3 since 10 October 2018)
South Sudan: humanitarian crises	African	12 February 2014	Ongoing (Protracted Grade 3 since 1 May 2017)

3. In line with WHO's Emergency Response Framework, all graded emergencies have been managed through WHO's Incident Management System. Where required, initial funds to establish incident management structures were provided from the Contingency Fund for Emergencies, which can release funding within 24 hours. By the end of September 2021, a total of US$ 20.07 million had been released to support WHO's emergency response operations.

4. WHO developed plans for strategic responses and joint operations with national health authorities and partners for all graded and protracted emergencies. The Organization provided support for the efforts of national governments to increase the quality and coverage of health services; strengthen primary health, secondary health and hospital care by deploying mobile teams and reinforcing health facilities; improve surveillance and early warning systems; conduct vaccination campaigns; distribute medicines and supplies; and train health workers. Following revisions to the COVID-19 Global Humanitarian Response Plan, the number of people targeted by health cluster assistance has risen to 160 million across 56 countries, in partnership with more than 900 national and international partners. Although the increase is mainly related to COVID-19 pandemic requirements, WHO is actively strengthening context-specific coordination and multisector collaboration to achieve better health outcomes in collaboration with national authorities, the United Nations Inter-Agency Standing Committee, the United Nations Office for the Coordination of Humanitarian Affairs and other global partner networks.

5. Implementing emergency response operations with health sector partners at the country level has been especially challenging owing to the unprecedented scale and nature of the disruption caused by the COVID-19 pandemic, which has exacerbated pre-existing impediments to implementation, such as limited humanitarian access; lack of sufficient funding to ensure the provision of sustainable and continuous life-saving health services to crisis-affected and vulnerable populations; attacks on health care workers and facilities; and escalating field costs.

PREPAREDNESS, RESPONSE, READINESS AND COORDINATION ACTIVITIES AT GLOBAL, REGIONAL AND COUNTRY LEVELS FOR ACTIVE GRADE 3 EMERGENCIES

COVID-19 pandemic: public health emergency of international concern

6. WHO's response to the COVID-19 pandemic has been rapid, coordinated and sustained on an unprecedented scale. WHO triggered its Incident Management Support System under its Emergency Response Framework on 1 January 2020 and published its first global strategic preparedness and response plan on 4 February 2020. Since then, WHO has been at the centre of the world's response to the COVID-19 pandemic, from convening global expertise to working on the ground with communities in some of the world's most challenging contexts. The Global Strategic Preparedness and Response Plan outlined the essential steps needed at the global, national and local levels to suppress transmission, reduce exposure, protect the vulnerable and save lives. That foundational strategy, which was updated in February 2021, has evolved with our increasing knowledge of the virus and the development of effective tools with which to implement COVID-19 controls. Notably, the most recent update to the Global Strategic Preparedness and Response Plan incorporated vaccination as an additional pillar of the response, fully aligning all relevant pillars of the plan with those of the Access to COVID-19 Tools (ACT) Accelerator. An interim report on WHO support for the implementation of the Global Strategic Preparedness and Response Plan up to September 2021 has been published.[1] Specific information related to the COVID-19 response in the context of other Grade 3 emergencies and in the context of WHO's work in the area of health emergencies is detailed in the relevant sections below.

Democratic Republic of the Congo: protracted complex emergency

7. WHO continued to respond to the graded crises in the Democratic Republic of the Congo, in areas also affected by humanitarian crises arising principally from displaced populations, ensuring delivery of essential medicines and supplies and making available a minimum package of essential health services. The Secretariat also provided technical support and coordination for integrated disease surveillance and response and the prevention of communicable diseases.

Democratic Republic of the Congo: outbreak of Ebola virus disease in North Kivu, South Kivu and Ituri

8. On 7 February 2021, an outbreak of Ebola virus disease was declared in Biena Health Zone in North Kivu Province, which was related to the 2019–2020 outbreak; 12 confirmed and probable cases were reported in four health zones. On 3 May 2021, the Minister of Health of the Democratic Republic of the Congo declared the end of the outbreak of Ebola virus disease, in accordance with WHO recommendations, 42 days after the last confirmed case tested negative for the second time on 21 March 2021. As a result, this outbreak was declared a Grade 2 event. From the beginning of the

[1] 2021 Mid-Year Report: WHO Strategic Action Against COVID-19. Geneva: World Health Organization; 2021.

outbreak, the Secretariat supported the Ministry of Health and provincial health authorities in scaling up and strengthening the capacity of community engagement, surveillance, laboratory testing, vaccinations, infection prevention and control in health facilities, case management, and safe and dignified burials.

9. The Secretariat continues its work with the Government and partners to support survivors of the disease. It supports continuity of the care programme for survivors of Ebola virus disease, providing each survivor with an 18-month medical, biological and psychological care and follow-up. From September 2018 to date, the Secretariat has supported 1267 survivors of Ebola virus disease in the Equateur, Ituri, North Kivu and South Kivu Provinces. This work allows for care of the sequelae of Ebola virus disease and helps to reduce the risk linked to the long-term persistence of the Ebola virus in survivors' body fluids. Building on this, the Secretariat, along with the Government and partners, is updating current knowledge and guidance on care for survivors of Ebola virus disease and proposing a way forward in caring for and mitigating the impacts of long-term viral persistence survivors' body fluids or immune-privileged sites.

10. On 28 September 2020, WHO was alerted to serious reports of alleged sexual exploitation and abuse in the context of the response to Ebola virus disease in the country, despite a zero-tolerance policy regarding such behaviour from any WHO staff, contractors or partners. On 15 October, the Director-General opened an investigation into the claims, establishing a special external Independent Commission with two Co-Chairs: Aïchatou Mindaoudou, Niger's former Minister of Foreign Affairs and Social Development, and Julienne Lusenge, a Congolese human rights activist. The Director-General appointed two senior Secretariat staff to coordinate and facilitate the work of the Commission's Co-Chairs. The Commission was composed of five members covering a broad range of disciplines and experience. The work of the Commission was supported by an external supplier, selected by the Commission through a competitive bidding process, which undertook the fact-finding using a victim/survivor-centered approach. This is the first time in the history of the United Nations system that allegations of misconduct against its personnel have been addressed in such a manner. Alerted to the allegations, the Director-General's Global Policy Group took immediate actions at all levels of the Organization to strengthen the systems for prevention of sexual exploitation and abuse through a zero-tolerance policy supported by rapid and efficient investigation. The Independent Commission's final report and findings were shared in a report and press conference on 28 September 2021.[1] Based on the findings, the report set out several recommendations, including a final recommendation to establish, within two months of publication of the report, an independent monitoring mechanism for the implementation of the Independent Commission's recommendations. The actions being taken by the WHO Secretariat are set out in the WHO management response to the report.[2] In parallel, on 17 October, the Inter-Agency Standing Committee initiated a mission to the Democratic Republic of the Congo, with experts from various organizations in the United Nations system, which assessed the situation and response in North Kivu province and planned implementation of the WHO Management Response Plan. The outcome of the mission was reported during the quarterly briefing for Member States on preventing and responding to sexual exploitation, abuse and harassment on 7 December 2021.

1 Final report of the Independent Commission on the review of sexual abuse and exploitation during the response to the tenth Ebola virus disease epidemic in the provinces of North Kivu and Ituri in the Democratic Republic of the Congo (DRC), 27 September 2021. Geneva: World Health Organization; 2021.

2 Preventing & responding to sexual exploitation and abuse: WHO management response to the Report of the Independent Commission to investigate allegations of sexual abuse and exploitation during the response to the tenth Ebola Virus Disease epidemic in the provinces of North Kivu and Ituri, the Democratic Republic of the Congo, of 28 September 2021 (available at https://cdn.who.int/media/docs/default-source/ethics/who-management-response-20211020-finalv2.pdf?sfvrsn=591a9adf_12&download=true, accessed 27 December 2021).

Ebola virus disease and Marburg virus disease outbreaks in Guinea and Côte d'Ivoire

11. On 14 February 2021, an outbreak of Ebola virus disease was reported in Gouécké sub-prefecture, in N'Zérékoré prefecture. Between 14 February and 19 June 2021, a total of 23 cases (16 confirmed, 7 probable) were identified in four sub-prefectures of N'Zérékoré Prefecture. Of these confirmed and probable cases, 11 survived and 12 died. Investigations into the source of this outbreak using genomic sequencing demonstrated that the identified 2021 virus lineage was very closely related to a virus circulating in Guinea in 2014. On 19 June 2021, the Ministry of Health of Guinea declared the end of the Ebola virus disease outbreak that had affected N'Zérékoré Prefecture, N'Zérékoré Region, Guinea. This outbreak was declared a Grade 3 event. From the beginning of the outbreak, the Secretariat supported the Ministry of Health and provincial health authorities in scaling up and strengthening the capacity of community engagement, surveillance, laboratory testing, vaccinations, infection prevention and control in health facilities, case management, and safe and dignified burials. Similar to the support provided to survivors of Ebola virus disease in the Democratic Republic of the Congo, the Secretariat worked with national health authorities and partners to implement a dedicated survivor care programme. As part of this event, the Secretariat strengthened preparedness activities in neighbouring countries (Côte d'Ivoire, Liberia, Mali, Senegal and Sierra Leone).

12. On 6 August 2021, the Ministry of Health of Guinea informed the Secretariat of a confirmed case of Marburg virus disease in Guéckédou Prefecture, N'Zérékoré Region, south-western Guinea. From 3 August 2021 to the end of the outbreak declaration, only one confirmed case was reported. The patient died on 2 August. On 16 September 2021, the Ministry of Health of Guinea declared the end of the Marburg virus disease outbreak in Guéckédou prefecture, N'Zérékoré Region. In accordance with WHO recommendations, the declaration was made 42 days after the safe and dignified burial of the only confirmed patient reported in this outbreak. This was the first-ever Marburg virus disease case reported in Guinea. This outbreak was declared a Grade 2 event. The Secretariat supported the Ministry of Health and Provincial Health authorities in scaling up and strengthening the capacity of community engagement, surveillance, including ecological investigations, laboratory testing, vaccinations, infection prevention and control in health facilities, case management, and safe and dignified burials.

13. On 14 August, the Ministry of Health of Côte d'Ivoire informed the Secretariat of a suspected case of Ebola virus disease in Abidjan. The case was reported to be confirmed by the Institut Pasteur of Côte d'Ivoire. In accordance with WHO recommendations, the Secretariat requested that the sample be sent to a WHO collaborating centre for laboratory confirmation. While waiting for laboratory confirmation and in line with the no-regrets policy, this event was declared a Grade 3 event. The Secretariat provided immediate support to the Ministry of Health, including sending technical staff and providing vaccine doses, therapeutics, laboratory kits and additional outbreak response equipment. On 27 August 2021, the samples were received at the Jean Mérieux-INSERM and Institut Pasteur laboratory in Lyon, France. On 30 August, results were shared with the Institut Pasteur Côte d'Ivoire and indicated that all tests performed were negative for filoviruses. On 31 August, the Minister of Health of Côte d'Ivoire announced through an official communiqué that this was not a case of Ebola virus disease. Following laboratory results, the Secretariat downgraded the event but continued to work with Côte d'Ivoire, Guinea and their neighbouring countries to improve their capacity to respond to future outbreaks.

Nigeria: complex emergency

14. In north-east Nigeria, across Borno, Adamawa and Yobe states, an estimated 8.7 million people require humanitarian assistance. More than two million people are internally displaced, while 257 000 have sought refuge in neighbouring Cameroon, Chad and Niger. A total of 1 753 484 returnees or 284

389 returnee households were recorded in north-east Nigeria. In addition to the COVID-19 pandemic, ongoing cholera and measles outbreaks pose additional burdens on an already stretched health system.

15. WHO continues to support the Nigerian Government at the federal, state and local levels to meet the needs of vulnerable populations through its strong field presence across the north-east. Through 43 hard-to-reach mobile health teams and 499 community-oriented resource persons, WHO provided integrated health services for 531 722 people during the reporting period of January to August 2021. WHO monitors health resources and services availability, detects and investigates more than 3000 outbreak alerts annually and utilizes health information to provide evidence-informed guidance to partners as co-lead of the health sector. To strengthen recovery and the health system, WHO, in line with the Humanitarian Development Nexus, enhances the capacity of local and national actors through training, the provision of technical cooperation in the areas of health financing and human resources, and the establishment of and support to the Public Health Emergency Operations Centre.

South Sudan: complex emergency

16. In South Sudan, an estimated 8.3 million people need humanitarian assistance, 1.6 million people are internally displaced and 2.3 million people are refugees. To date, 7.2 million people are listed as being acutely food insecure. WHO continues to respond to the health effects of displacement, outbreaks of violence, malnutrition, flooding and communicable diseases. It has strengthened contingency planning against emerging communicable diseases and supported the vaccination of almost one million children in civilian areas under United Nations protection. It has also provided emergency supplies to bridge gaps at the primary care level and donated emergency medical kits to health partners operating in flood-affected areas across the country.

Syrian Arab Republic: complex emergency

17. WHO has maintained a swift and scalable response to meet the health needs of populations affected by conflict in all 14 governorates, continued to fill critical gaps in primary and secondary health care, provided essential medicines and medical supplies, and strengthened the provision of cross-conflict-line and cross-border medical supplies.

18. WHO supported the Ministry of Health in formulating the National Deployment and Vaccination Plan for COVID-19 and provided technical and operational support in rolling out COVID-19 vaccination across the country after the vaccines allocated as part of the Vaccines Global Access (COVAX) mechanism (1 005 920 doses) were delivered to the Syria Arab Republic. Training of 3776 health care workers, 172 school doctors and 13 200 school health staff across 13 of the country's 14 governorates strengthened the understanding of and capacity to work effectively towards preventing and controlling infection. Additional train the trainer sessions on COVID-19 infection prevention and control and triage were conducted by WHO-contracted nongovernmental organizations in 310 health facilities across the north-west, engaging 2657 health workers.

19. The health sector managed in 2020 to deliver assistance to people in need across the Syrian Arab Republic without duplication and ensure the continuity of essential health care during the COVID-19 crisis. Throughout the reporting period, health sector partners in the country administered 5.6 million medical procedures and 6.2 million treatment courses, of which WHO provided 0.52 million and 4.9 million, respectively.

20. WHO has been supporting the provision of the Essential Package of Health Services through integrated service delivery and primary care networks. The Organization delivered life-saving medicines

and medical equipment to fill gaps in primary health care services in 14 governorates, donated 40 ambulances to the Ministry of Health and its health partners and supported 121 hospitals across the country. In response to the COVID-19 pandemic, it continues to bolster supplies of personal protection equipment in the country, focusing on protecting health workers. In total, the health sector distributed about 13 million of such items among health workers from January to August 2021, of which the WHO provided 3.5 million. In the light of the pandemic, WHO also adapted the Health Resource and Services Availability Monitoring System's checklist tool and conducted training in its use at isolation hospitals. Work is ongoing to expand these initiatives.

21. WHO supports psychosocial interventions for the survivors of gender-based violence. Across the country, 834 doctors, health workers and community volunteers have attended online mental health and psychosocial support training sessions to strengthen basic gender-based violence interventions and raise awareness. Through collaboration with local implementing partners, integrated mental health and psychosocial support services are provided at the community level through well-being centres and mobile outreach teams in 248 subdistricts across nine governates. A total of 48 222 beneficiaries have attended awareness-raising sessions and 7337 beneficiaries have received individual support, first-line support, psychological first aid, advanced individual psychological counselling sessions and/or referral to other services where needed.

22. To facilitate trauma and emergency care services for patients in need, WHO provided 318 medical devices to public health facilities and supported the provision of specialized trauma and surgical kits and life-saving medicines. as a result, 1 706 903 treatments were provided for 249 833 trauma cases in 2020. To improve disability and physical rehabilitation services, WHO delivered a range of assistive devices to health partners and public health facilities nationwide, aiding more than 6945 persons with disabilities. WHO-contracted non-governmental organizations in the southern Syrian Arab Republic provided 17 073 advanced surgical interventions in secondary and trauma care to specialized health facilities free of charge in 2020, based on referrals.

23. WHO positioned health emergency kits in seven of 14 governorates. Along with other health sector partners, WHO strengthened COVID-19 laboratory testing capacity from zero capacity by building eight laboratories and providing diagnostic machines and equipment. In the country's north-west, WHO provided life-saving and life-sustaining medicines and medical equipment to 170 health facilities sufficient to cover 2.5 million treatment courses.

24. In the country's north-east, WHO positioned vaccines and trauma and other surgical supplies and supported the country in rolling out COVID-19 vaccination, including in hard-to-reach areas and camps. It supported 19 hospitals and 158 primary health care centres through nine cross-line supplies (sufficient to cover 880 485 treatment courses). WHO also continues to strengthen local capacities in immunization and the treatment of mental health and disability. It similarly continued to expand partnerships with civil society and continued to scale up referral networks and outreach services. WHO continues to lead the health cluster at all levels to improve the collection and analysis of real-time health information for evidence-based planning and response.

Yemen: complex emergency

25. In cooperation with the Ministry of Public Health and Population of Yemen, authorities in the country and other health partners, the Secretariat continued to support the provision of primary and secondary health care services to affected populations in the north and south of the country. Through 45 active health cluster partners during this period, a total of 5331 health facilities were supported (289 hospitals, 956 health centres and 2286 health units).

26. In response to the COVID-19 pandemic, WHO supported the deployment of 670 rapid response teams in 84 districts and supported the functionality of 48 COVID-19 isolation units in 22 governorates across the country by providing medications, medical supplies and life-saving medical equipment, including patient ventilators with monitors. WHO ensured the availability of COVID-19 testing by supporting 14 laboratories with an additional 16 diagnostic machines, 170 000 polymerase chain reaction (PCR) tests and 50 000 testing swabs, in addition to 460 000 rapid diagnostic tests for use in isolation units. The Secretariat supported the training of 572 health workers on COVID-19 case management, the training of 114 laboratory technicians on PCR testing and biosafety and the training of 1250 health workers on infection prevention and control. WHO also provided support for the rehabilitation and maintenance of infection prevention and control, as well as water, sanitation and hygiene services, for 34 COVID-19 isolation units in 20 governorates. A total of 80 280 oxygen cylinders are refilled every month and provided to COVID-19 isolation units by WHO. As a result of WHO's collaborative work with health partners, 59 513 Yemenis were fully vaccinated against COVID-19 during the reporting period.

27. In response to cholera and other communicable diseases, WHO delivered more than 2300 cholera kits and 260 000 doses of intravenous fluid during the reporting period. A total of 379 049 doses of oral cholera vaccine (an estimated 94% of the target) were administered in two rounds of vaccination from December 2020 to February 2021. In addition, WHO donated 4100 vials of diphtheria antitoxin: enough to protect 250 000 people.

28. The United Nations medical air bridge project treated 85% of transferred patients in Amman and Cairo, including more than 20 successful surgeries, in addition to providing imaging and diagnostic services and hormonal, radiotherapy and chemotherapy services. To improve access to diagnostic imaging services, WHO delivered eight computed tomography scanners to major hospitals across Yemen. WHO also provided 700 000 vials of insulin and essential medicines for noncommunicable diseases to 72 major hospitals.

29. During the period January to September 2021, the Health Cluster reached 3.8 million beneficiaries of the targeted 11.6 million (33% of the total target for 2021, with received funding of 15% against the required US$ 438 million). A total of 340 864 consultations were provided to 136 000 internally displaced people over the same period. Health partners also supported noncommunicable disease response for 61 700 hypertensive patients, 46 405 diabetic patients, 9597 cardiac patients, 1548 dialysis patients and 9471 mental health patients. In addition, more than 200 000 children aged under 1 year old received Penta3 vaccination during the same period. Reproductive health efforts included support to conduct 753 629 antenatal visits, 297 454 skilled birth-attended deliveries and 53 541 caesarean sections.

Afghanistan: complex emergency

30. WHO leads the Health Cluster and supports the implementation of humanitarian response and recovery measures to natural and man-made disasters by providing medicines, medical supplies, logistical and technical support. With Health Cluster partners, WHO works to strengthen trauma care and mass casualty management, as well as to provide emergency primary health care to vulnerable, displaced and disaster-affected populations in underserved areas. In areas affected by disasters, WHO supports service provision by establishing temporary and static health facilities. Working to reduce the risks to people and health facilities, WHO supports national and provincial emergency preparedness and response strategies, policies and guidelines along with the Ministry of Public Health. WHO also provides technical assistance to water, sanitation and hygiene and nutrition clusters in humanitarian response.

The WHO-supported Disease Early Warning System surveys, detects and assists in the management of infectious disease outbreaks in all provinces.

31. WHO has been able to maintain static and mobile health teams to support life-saving health service provision. Mobile health teams were crucial for providing services to the 663 969 individuals displaced during the reporting period. WHO supplied 2171 different medical kits to the key Sehatmandi health facilities in a period that covered the needs of 2.9 million people for three months, while also providing 456 trauma and emergency surgery kits to major hospitals in the country.

32. The WHO country office provided technical support to the Ministry of Public Health in developing and revising the national COVID-19 preparedness and response plan in preparation for a third wave of transmission. Support was provided for developing the protocol and tools for a COVID-19 seroepidemiological study for estimating cumulative incidence and related deaths. The WHO country office mobilized resources for COVID-19 preparedness and response activities including those related to: training for 245 rapid response teams, case investigations, contact tracing and isolation, the International Health Regulations (2005), and infection prevention and control at point of entry.

33. An electronic dashboard was established for notifiable diseases under surveillance, including COVID-19, to ensure early reporting and information-sharing at national and subnational levels. The WHO country office established the COVID-19 results notification system through SMS messaging in the country. WHO provided technical and financial support to the investigation and 172 outbreaks were detected and responded to during the first six months of 2021. As of August 2021, surveillance sentinel sites were rationalized to 513 sites, covering almost 92% of Afghanistan districts, including the private health sector (50 facilities). WHO also provided technical inputs in establishing/deploying internet-based surveillance using the Epidemic Intelligence from Open Source tool.

34. WHO also provided technical support for developing standard screening and health education protocols for points of entry in the country and mobilized resources for implementing core capacities required by the International Health Regulations (2005) at points of entry, in coordination with the International Organization for Migration via the Multi-Partner Trust Fund. A total of 32 laboratories in 25 provinces have been established and are actively testing for COVID-19 at major COVID-19 hospitals in the country. More than 1.5 million individuals were fully vaccinated against COVID-19 by the end of the reporting period, with an additional 838 230 partially vaccinated.

Northern Ethiopia: complex emergency

35. The ongoing conflict in northern Ethiopia has led to heightened humanitarian needs, with increased displacement, worsening nutrition and food security, damage to health facilities, severe shortages in essential health services and an increased risk of disease outbreaks. The conflict has mainly affected the Tigray region; however, conflict has recently spilled over into the Amhara and Afar regions. There are currently an estimated 2 629 306 internally displaced people in the affected regions. The influx of internally displaced people into safer accessible areas has exacerbated vulnerabilities and needs in hosting areas, since these communities are exhausting their meagre collective resources as the conflict continues. In Tigray, 5.2 million people are in need of humanitarian support, of whom 3.8 million are in need of health assistance, including 1.3 million for acute malnutrition and 1.5 million for malaria. A total of 4 million cases of COVID-19 are forecast to arise during 2021. About one million of 2.5 million people at risk of cholera are partially protected; 1.8 million people are at risk of measles without the immediate resumption of vaccination. An estimated 400 000 people are acutely food insecure, in addition to the four million people heavily impacted by food insecurity in the Tigray region and the

neighbouring zones of Amhara and Afar regions, indicating potential extreme human suffering and humanitarian needs.

36. The severe shortages of cash due to the closure of the banking system, fuel shortages and the banning of the entry of medical supplies, fuel, generators, seeds, electronics and spare parts into the Tigray region have led to severe disruption of health and nutrition programming. Continued disruption may halt the programme completely, which would result in excess morbidity and mortality. A lack of health supplies is having a devastating impact on the ability of health facilities to provide services and the lack of cash means salaries are not paid to health and other essential workers, leading to a demoralized health workforce.

37. WHO is responding through a scaled-up health response, working with the Federal Ministry of Health, the regional health bureaus, United Nations agencies and nongovernmental organizations to prevent excess mortality and morbidity by providing life-saving and essential health services and strengthening disease surveillance, outbreak prevention and response. WHO also coordinates health sector partners. A total of two million people in the Tigray region and 1.4 million people in the Amhara and Afar regions will be targeted by WHO-supported health services and interventions, including through: the provision of health supplies; immunization; the management of severe acute malnutrition with medical complications; mental health and psychosocial diseases services; services for survivors of gender-based violence; malaria prevention and treatment; maternal, newborn and child health services; and many other services. WHO will support a total of 247 health facilities in affected areas, providing essential health services in the Tigray, Amhara and Afar regions. A total of 1.4 million people who received their first dose of cholera vaccine will be provided with a second dose. Cholera preparedness efforts will also be scaled up. About 100 000 people will be targeted for their second COVID-19 vaccines and 1.6 million people will be targeted for a first dose of COVID-19 vaccine.

38. Recent conflict dynamics have reversed hard-earned gains in epidemiological surveillance coverage across the affected areas. WHO will work with the relevant regional health bureaus to increase the capacity of affected areas to prevent, detect and respond to epidemics by strengthening the surveillance system and early warning, including by providing the necessary surveillance tools. The WHO's Early Warning, Alert and Response System will be established in all 94 districts in Tigray region. Initially, however, 20 districts will be prioritized based on their previous history of disease outbreaks and the presence of internally displaced people sites. The System will be extended to the remaining districts as access to resources improves. WHO will also extend support for the System to affected areas in Amhara and Afar. WHO will support the establishment and strengthening of water quality monitoring in the affected areas and will provide portable water quality monitoring kits, provide expertise to conduct water quality monitoring through deployment of experts and training, and establish a collaboration platform in the water, sanitation and hygiene and other relevant sectors.

39. While rolling out its emergency response to the crisis unfolding in northern Ethiopia, WHO will also identify and leverage entry points to support health systems in stable areas through a systematic approach to support early recovery efforts, so that the health system will be able to respond to the ongoing crisis and be resilient to future threats. WHO will support the re-establishment of selected disrupted health programmes, such as routine immunization, HIV and tuberculosis programmes. WHO will also provide targeted support to initiatives that aim to re-establish the leadership and oversight functions of the system at the regional and district levels, as well as to support disrupted health information systems.

Somalia: complex emergency

40. In cooperation with the Federal Ministry of Health and other partners, the Secretariat continued to provide primary and essential health care services to the crisis-affected populations in Somalia. As a result of a nationwide integrated campaign of polio and measles vaccination, 1.9 million children under 5 years old were vaccinated against poliovirus. More than 1.7 million children aged 6 to 59 months received measles vaccination and vitamin A supplementation throughout the reporting period.

41. In response to an ongoing cholera outbreak, WHO scaled up support for surveillance and oral cholera vaccination campaigns that protected more than 860 000 people in 47 districts, 139 811 of whom are internally displaced people. As a result, between January and August 2021, 192 of 711 suspected cases tested positive for cholera.

42. Since the scaling up of response operations to drought in September 2019, about 450 000 internally displaced people were reached with emergency health services in 15 drought-affected districts of the Hishabelle, Galmudug, Jubaland and South West states.

43. The first COVID-19 case was confirmed in Somalia on 16 March 2020. Since then, the Secretariat has worked closely with the Federal Ministry of Health and Health Cluster partners to provide technical and operational support for operational coordination; surveillance; laboratory testing; patient care and information; and data collection, analysis and sharing. As of mid-August 2020, three WHO-established PCR testing laboratories have ensured uninterrupted testing of samples for COVID-19. WHO is working with the Ministry of Health to establish another four such laboratories at the state level, as well as genome sequencing in three existing laboratories. As of 25 September 2021, a total of 307 225 samples have been tested. In addition, COVID-19 antigen-based rapid diagnostic tests were introduced in areas where PCR laboratory access is limited. The efficient deployment of 1833 community health workers in 71 districts across all states has helped to detect clusters of suspected cases and thereby to identify COVID-19 hotspots. WHO has also supported the establishment and management of seven isolation centres to provide care for patients with COVID-19, provided essential items of personal protection equipment and trained health workers in case management. The installation of three pressure swing absorption oxygen plants and two solar power-based oxygen concentrators is under way. On 15 March 2021, a COVID-19 vaccination campaign was initiated with the arrival of the first shipment of 300 000 doses of vaccine against COVID-19. As of September 2021, 160 048 people have been fully vaccinated.

HEALTH EMERGENCY PREPAREDNESS AND READINESS

44. Throughout the reporting period, the Secretariat continued to expand the monitoring and evaluation of International Health Regulations (2005) capacities in all six WHO regions, obtaining responses from 174 of 196 States parties using the State party self-assessment annual reporting tool through a web-based platform to facilitate online reporting. A 100% submission rate was recorded in the African and South-East Asia Regions. Reported average global capacity scores increased by approximately 2% overall (from 63% to 65%) between the 2019 and 2020 reporting periods. Almost all States parties are performing better than in the previous reporting period in key capacities such as food safety, laboratory testing, surveillance, human resources, the national health emergency framework, health service provision and risk communication. Legislation and financing, International Health Regulations (2005) coordination, and national implementation of International Health Regulations (2005) focal point functions remain at the same level. Areas for improvement include points of entry (ports, airports and ground crossings), despite a small increase, along with zoonotic events and the human–animal interface, chemical safety, and radiation emergency capacities. The improvement of the

core capacities required by the International Health Regulations (2005) through regular monitoring and evaluation has proved to be essential in the context of the COVID-19 pandemic and other health emergencies. Detailed information on annual reporting by States parties is published on the web-based platform of the State party self-assessment annual reporting tool and other WHO websites.

45. As at 7 October 2021, 94 national COVID-19 intra-action reviews had been implemented by 64 countries, 113 joint external evaluations had been completed, 160 simulation exercises undertaken and 66 after-action reviews conducted. WHO also developed intra-action reviews and simulation exercise packages for specific pillars of the Strategic Preparedness and Response Plan, including vaccination to facilitate countries in strengthening functional capacities for critical gaps during the pandemic. In June 2021, WHO supported an after-action review of the response to the ninth, tenth, eleventh and twelfth Ebola virus disease outbreaks in the Democratic Republic of the Congo.

46. A total of 74 countries had developed all-hazards strategic risk assessments by the end of the reporting period using WHO's Strategic Tool for Assessing Risks. This tool supports risk-informed programming that catalyses emergency preparedness action to reduce the level of risk associated with a particular hazard and its consequences. WHO has developed an emergency and disaster risk calendar to complement the tool by mapping the seasonality of hazards, which enables national and subnational authorities to better plan, prioritize and implement timely and appropriate actions to mitigate risk, scale up capabilities and be ready to effectively respond when a health emergency occurs.

47. In March 2021, the Secretariat hosted a global consultation and a series of technical working group meetings to review the International Health Regulations (2005) State party self-assessment annual reporting and joint external evaluation tools and processes in order to incorporate lessons learned from the COVID-19 pandemic in ways that make these national preparedness assessments more predictive of the performance of country capacities in detecting and responding to severe epidemic and pandemic threats. WHO is currently reviewing the recommendations received and integrating them into its tools and processes.

48. During the reporting period, the Secretariat has begun to pilot the Universal Health and Preparedness Review mechanism, and is elaborating a plan in consultation with Member States for the full-scale launch of the peer-review process based on the results of the pilot stage. The aim of the Review is to build mutual trust and accountability for health, by bringing nations together as neighbours to support a whole-of-government approach to strengthening national capacities for pandemic preparedness, universal health coverage and healthier populations.

49. By the end of the reporting period, a total of 71 countries had been supported in developing national action plans for health security; these guide countries on priority actions for building stronger capacities required by the International Health Regulations (2005), including those across the human–animal interface. To improve prevention, detection and response at the human–animal health interface, 35 national bridging workshops and 32 joint risk assessment pilot workshops under the One Health approach have been held. In addition, WHO developed two additional tools to support One Health preparedness capacity-building, including the multisectoral, One Health coordination mechanism and the surveillance and information sharing tool. These have been developed in collaboration with the Tripartite group of partners (Food and Agriculture Organization of the United Nations, World Organisation for Animal Health and WHO). As of 7 October 2021, five multisectoral, One Health coordination pilot workshops and four surveillance and information sharing pilot workshops are under preparation. The Secretariat is also working on One Health response preparedness action, which involves developing a tool to facilitate the coordination of relevant national human health and animal health stakeholders during all phases of a zoonotic disease outbreak.

50. The Secretariat has also further advanced the use of International Health Regulations (2005) data analysis to support the implementation of national COVID-19 strategic preparedness and response plans throughout the pandemic. Such data analysis has also been carried out as part of preparedness costing initiatives, which have facilitated COVID-19 resource mobilization. WHO is currently building on recent progress in implementing International Health Regulations (2005) data analysis to develop a dynamic preparedness metric to allow countries to better understand the real-time changes to their preparedness status and priority gaps that need to be addressed.

51. WHO is continuing to use the WHO Benchmarks for International Health Regulations (2005) Capacities tool to support building core capacity under the International Health Regulations (2005) and map national and health systems components as part of strengthening emergency preparedness. The benchmarks and corresponding actions can be applied to improve countries' emergency preparedness through the development and implementation of national action plans for health security. WHO has also developed a benchmarks reference library to provide Member States, partners and public health stakeholders with direct access to relevant guidance, tools and materials that support the implementation of proposed capacity-building actions.

52. In 2021, WHO published the WHO Health Systems for Health Security Framework to support Member States and partners in bringing together the capacities required for implementing the International Health Regulations (2005), as well as the components of health systems and other sectors for multisectoral, multidisciplinary and effective management of health emergencies. The Framework is an innovative approach that complements existing concepts and tools for global health security capacity-building and covers different types of risks arising from biological and non-biological hazards and events. The Framework facilitates more synergistic working relationships between health security, health systems and other sectors for multisectoral and multidisciplinary health emergency preparedness.

53. Throughout the reporting period, WHO supported the roll-out of the WHO multisectoral preparedness coordination framework, which provides Member States and relevant national sectors with an overview of the key elements required to strengthen overarching, all-hazard, multisectoral coordination for building the core capacities under the International Health Regulations (2005) and emergency preparedness and health security.

54. The Secretariat continued to advance progress towards establishing and piloting the Global Strategic Preparedness Network, in line with World Health Assembly resolution WHA73.8. The aim of the initiative is to facilitate the implementation of national health security plans through a partner network of international experts and stakeholders that are able to provide multisectoral technical assistance for sustainable preparedness capacity-building.

55. Throughout the reporting period, WHO continued to provide resource mapping support to countries through the implementation of WHO's resource mapping tool and process, which facilitate the identification of all available financial and technical resources that are available for implementing International Health Regulations (2005) capacity-building. During the reporting period, resource mapping workshops were conducted in Cameroon, Guinea, Liberia, Mali and Nigeria. Other countries in the African Region and beyond are currently planning resource mapping implementation activities.

56. The WHO Strategic Partnership for Health Security and Emergency Preparedness portal was expanded during the reporting period to better include the tracking and monitoring of national preparedness investments towards relevant capacity-building activities, including those contained in national action plans for health security. The portal was further extended to include links to the COVID-19 Partners Platform in order to support investments and planning for longer-term preparedness and health security.

57. Between January and April 2021, WHO hosted the Safe Hospital webinar series, in collaboration with the International Hospital Federation and the United Nations Office for Disaster Risk Reduction, in order to support hospital preparedness capacity assessments and strengthening. WHO also provided direct support for countries to strengthen the safety and capacity of hospitals and health facilities as a measure of enhancing national preparedness against health emergencies and disasters.

58. A training programme for high-level managers in ministries of health on health emergency disaster risk management was developed by the Secretariat during the reporting period and implemented in a number of countries, including Kazakhstan, Tajikistan and Turkmenistan.

59. WHO has published a series of country case studies[1] to disseminate information and knowledge on best practices, challenges and opportunities for enhancing the implementation of the International Health Regulations (2005) and building sustainable preparedness against health emergency threats. These case studies also facilitate countries in applying lessons learned from country and regional experiences and advancing progress towards long-term preparedness and building back better using whole-of-society approaches.

60. WHO and the Government of Singapore jointly convened the Technical Working Group on Advancing Health Emergency Preparedness in Cities and Urban Settings, which held six meetings between February 2021 and April 2021, during which members shared their experiences of managing COVID-19 in cities and urban settings; discussed challenges faced; and explored potential solutions and approaches, the roles of key stakeholders and the tools and resources necessary for risk assessment, gap analysis and capacity-building for better urban preparedness. A number of recommendations were made and WHO built on them to develop and publish the Framework on Strengthening Health Emergency Preparedness in Cities and Urban Settings. [2] It will be supported by an operational guidance to be published in due course.

61. The Secretariat has also rolled out the World Health Emergencies Programme Gender Working Group to support the development and implementation of a gender mainstreaming strategy across its policies, strategies, operations and capacity-building action as a priority. This also responds to the specific recommendations of resolution WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies.

DETECTING, ASSESSING AND COMMUNICATING POTENTIAL HEALTH EMERGENCIES

62. The Secretariat uses a global event-based surveillance system to detect signals and events through media monitoring. It works 24 hours a day, seven days a week, to detect these signals and identify public health events and potential public health emergencies across the world. From 1 January to 30 September 2021, globally, a monthly average of 79 signals and updates were detected and monitored (excluding COVID-19 pandemic signals). Once an event is identified, the Secretariat analyses, assesses and communicates the level of risk and sounds the alarm to help protect populations from the consequences of outbreaks, disasters, conflict and other hazards. Rapid communication of public health events of potential international concern is shared with designated National IHR Focal Points through

[1] See Case Studies & Publications. Geneva: World Health Organization (https://extranet.who.int/sph/ehs-case-studies).

[2] See https://www.who.int/publications/i/item/9789240037830 (accessed 7 January 2022).

the confidential Event Information Site. During the reporting period, 122 events/announcements were posted on that site.

63. From 1 January to 30 September 2021, 349 public health events were recorded in WHO's event management system for 134 countries: 258 (74%) were attributed to infectious and zoonotic diseases; 34 (10%) were disasters; 20 (6%) were attributed to medical products; and the remaining 37 (10%) were related to chemical, radiological or nuclear products, food safety events, and animal or undetermined events.

64. During the reporting period, a formalized rapid risk assessment was conducted for 28 events in 19 countries. The risk at the national level was assessed as very high or high for 64% of those events. The countries in which the most assessments were conducted were China and the Democratic Republic of the Congo; most assessments were for cholera, COVID-19, yellow fever, hepatitis E virus, the plague and malaria. Three global-level assessments for COVID-19 and one regional-level assessment for an undiagnosed disease event were undertaken. In addition, there have now been 12 rapid risk assessments for COVID-19.

65. It is crucial to strengthen the early detection of all hazards that have the potential to become acute public health events. The Epidemic Intelligence from Open Source initiative is a unique collaboration between WHO and various stakeholders. It brings together new and existing initiatives, networks and systems to create a unified all-hazards, One Health approach to the early detection, verification, assessment and communication of public health threats, using open source information. As of September 2021, the initiative has been adopted by more than 40 national, international and supranational organizations and networks, including 27 Member States across five WHO regions. In Brazil, the Ministry of Health requested the nationwide implementation of Epidemic Intelligence from Open Source in all federal districts and close to 300 users have since been trained on the subject. The growth of individual user accounts almost tripled between January and September 2021 (1501) compared to last year (363). The continued roll-out to additional requesting Member States and organizations has been enabled through specific adaptation of the training modules allowing remote delivery during the COVID-19 pandemic. Epidemic Intelligence from Open Source has been used extensively by the WHO's COVID-19 incident management support team across headquarters and regional offices to monitor the COVID-19 pandemic, including COVID-19 variants. It was also used for mass gathering event monitoring, such as the UEFA EURO 2020 and the Tokyo 2020 Olympic and Paralympics games. The Epidemic Intelligence from Open Source system has been enhanced to respond to additional requirements, including broader source and language coverage and monitoring new priority diseases and topics, such as COVID-19 variants. Machine-learning algorithms for abstractive summarization and credibility assessment have been developed to further support the synthesis and assessment of publicly available information and better cope with the continuous large volume of information, including misinformation.

66. The Secretariat has provided surveillance, epidemiology and health information management for all graded emergencies, including remote support. In the areas of surveillance and the adjustment of public health and social measures for the COVID-19 pandemic, notable developments during the reporting period include:

(a) continued global surveillance of cases and deaths (219 million cases) and global detailed case-based surveillance from 194 countries/territories/areas, including 87 million cases with age and sex disaggregation, as well as 2.4 million forms from cases involving health workers (all data has been made publicly available);

(b) tools developed to support data analysis from surveillance, testing, public health and social measures, including machine-learning tools to predict departures from expected trends and identify hotspots;

(c) several systems automating the collection and collation of data developed to ensure accuracy and alignment with reports from Member States and investigate any discrepancies observed;

(d) variant surveillance interim guidance provided for Member States; and

(e) updated guidance published on the adjustment of public health and social measures.

67. WHO developed working definitions of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) variants of concern, variants of interest and variants that require further monitoring. Signals of SARS-CoV-2 variants are assessed against these definitions and classified accordingly for the appropriate response. A total of 58 signals of SARS-CoV-2 variants have been assessed and as of 1 September 2021, four variants have been classified as variants of concern, five as variants of interest and 11 as alerts for further monitoring. For variants that have been classified as variants of concern, WHO continues to conduct a comparative assessment of characteristics and public health risks, coordinate additional laboratory investigations and monitor their geographical spread.

68. WHO has collected timely and context-specific epidemic intelligence through event-based surveillance to inform COVID-19 pandemic response activities. Event-based surveillance is conducted through the Epidemic Intelligence from Open Source system, together with official reports and targeted online searches. Analysts identify, assess and document signals of interest from around the world based on predefined criteria, including changes in epidemiology, health care capacity, testing and impact on vulnerable populations. As of 1 September 2021, more than 3700 signals from all WHO Member States had been documented from about 39.7 million articles categorized as coronavirus-19-related by the Epidemic Intelligence from Open Source system.

69. WHO has enhanced the global COVID-19 dashboard, which now includes vaccination data and data from the monitoring of public health and social measures. From 1 May 2020 to 22 May 2021, the WHO COVID-19 dashboard received more than 41 million returning users (in excess of 75 million sessions) and continues to receive about 2.6 million users (about four million sessions) each month.

70. WHO has published the *Weekly Epidemiological Update* since August 2020 after revamping its predecessor, the *COVID-19 Weekly Situation Report*. The weekly update provides an overview of the global, regional and country-level COVID-19 cases and deaths, highlighting key data and trends and other pertinent epidemiological information concerning the COVID-19 pandemic. In January 2021, WHO included special focus sections on variants of concern, including vaccine effectiveness, and other areas of the COVID-19 response. Since these sections were introduced, WHO have reported on community readiness, COVID-19 and international trade, travel and points of entry, the COVAX mechanism, risk communications and COVID-19 in prisons, among many other key topics. To date, there have been 59 such weekly updates.

71. In support of the incident management system for the Ebola virus disease outbreaks in the Democratic Republic of the Congo and Guinea, regular situation updates and briefings and advanced epidemiological analysis to guide response activities were provided by teams based in WHO country offices, regional offices, and headquarters, as well as through dedicated epidemiological cells positioned at the emergency operations centre in affected countries, supported by WHO and the Global Outbreak

Alert and Response Network. In Guinea, an analytic cell lead by the Ministry of Health was established that included WHO, the United Nations Children's Fund, the Centre de Recherche et de Formation en Infectiologie de Guinée, the International Federation of the Red Cross and the United States Centers for Disease Control and Prevention. It conducted integrated epidemiological and social science in-field analyses to guide response activities.

72. The Health Resources and Services Availability Monitoring System has provided vital information to decision-makers on health systems capacities, gaps and priorities and has contributed substantially to reinforcing health information systems and management throughout the reporting period. The Monitoring System was reinforced in Burkina Faso, Mali, Nigeria, the Philippines and Yemen and was newly deployed in Ethiopia/Tigray and Somalia to support the ongoing emergency response. Discussions for further deployments in Afghanistan, the Central African Republic, Iraq, Libya and Niger are under way.

73. The "Early Warning, Alert and Response System in a box" tool enables the expansion of disease surveillance coverage to emergency-affected populations living in environments with unreliable or limited internet connections. The tool was updated with improved connectivity during the reporting period and was rolled out to support two acute emergencies.

(a) The volcanic Soufrières eruption in Saint Vincent and the Grenadines. An early warning system for emergency-affected population was housed in the shelters.

(b) The Haiti earthquake in 2021. Early warning systems were located in three departments where emergency-affected populations were hosted in 79 shelters.

74. WHO publishes disease outbreak news to inform the public, public health practitioners, the media and others of new outbreaks and new information related to specific outbreaks. Issues contain an epidemiological summary, the public health actions taken in response to the event, WHO's risk assessment results and WHO's advice. Between 1 January and 30 September 2021, 22 updates on 13 diseases in 13 countries were published in disease outbreak news. One such piece of news was a global update for circulating vaccine-derived poliovirus type 2.

75. Since 1926, WHO has published the *Weekly Epidemiological Record*, a bilingual (English/French) journal that serves as a global vehicle for the provision of updates on technical documents, including those related to standards, tools and the assessment and surveillance of epidemic and pandemic diseases. The results of WHO meetings, consultations and other forums to support and enhance evidence-based public health action are also shared through this publication. A total of 52 issues are published every year, with an average total volume of 600 standard pages. In 2021, the *Weekly Epidemiological Record* published a wide selection of articles on various topics in collaboration with all three levels of the Organization and external partners.

76. The Field Epidemiological Service is coordinating with the Tripartite to develop One Health field epidemiology core competencies, together with curricula guidelines, a guidance for continuing education, a guidance for Field Epidemiology Training Programme mentorship and a guidance for certification and competence evaluation.

DOCUMENTING ATTACKS ON HEALTH CARE

77. WHO continued to collect data on attacks on health care in 2021 using the Surveillance System for Attacks on Health Care, focusing on countries with complex humanitarian emergencies. The System,

launched in December 2017, allows WHO to collect data on the incidence of attacks on health care directly from primary sources and disseminate verified information through its online platform. Verification is done by WHO staff members through triangulation of information and evidence on the occurrence of the incident and the immediate impact in terms of the number of deaths and injuries of health care workers and patients. Each incident is given a certainty level based on the strength of the information used for verification. Information on events with a degree of certainty is then published on the online dashboard, which shows minimal data points to illustrate the incident. WHO neither verifies nor publishes data related to perpetrators or the type and provenance of weapons used in each incident. The reporting aims to ensure safe access to essential health services unhindered by any form of violence or obstruction.

78. The system continues to be implemented in countries with complex humanitarian emergencies that have instances of attacks on health care reported to WHO. The number of countries reporting has increased steadily. In 2021, between 1 January and 30 September, the System received reports from 14 countries and territories of 690 incidents that had resulted in 211 deaths and 328 injuries among health care workers and patients. The use of individual weapons continued to be the most common type of attack reported, closely followed by acts of psychological violence and obstruction. However, the proportion of incidents from the use of heavy weapons was lower compared with previous years, reflecting the change in context dynamics in which attacks have occurred. WHO uses this information to highlight the issue and advocate prevention against attacks and protection of health care. The information is also used so that measures for health care protection against attacks can be better incorporated into emergency operations.

ACTION BY THE EXECUTIVE BOARD

79. The Board is invited to note this report, and to provide further guidance on WHO's response to emergencies including:

- how the Secretariat can further support Member States' access to COVID-19 tools, and ensure achievement of the WHO's strategy to achieve global COVID-19 vaccination by mid-2022 and its plan to vaccinate 70% of the population of all countries against COVID-19 by that date;

- how the Secretariat can support Member States by ensuring that access to essential health services is prioritized and ensured in a context of ever-increasing need precipitated by the climate crisis, conflict, and COVID-19.

ANNEX

TABLE 1. ACTIVE GRADED EMERGENCIES DURING THE REPORTING PERIOD (1 JANUARY–30 SEPTEMBER 2021)

Country/area	Region	Type of crisis	Latest grade
Guinea	African Region	Ebola virus disease outbreak	Closed
Northern Tigray: humanitarian response	African Region	Complex emergency	Grade 3 (L3)
COVID-19	Global	COVID-19 pandemic	Grade 3
Afghanistan	Eastern Mediterranean Region	Complex emergency	Grade 3 (L3)
Syrian Arab Republic	Eastern Mediterranean Region	Complex emergency	Grade 3
Democratic Republic of the Congo	African Region	Meningitis	Grade 2
Madagascar	African Region	Malnutrition	Grade 2
Mali	African Region	Polio outbreak	Grade 2
Guinea: polio 2019	African Region	Polio outbreak	Grade 2
Côte d'Ivoire: polio 2019	African Region	Polio outbreak	Grade 2
Burkina Faso: polio 2019	African Region	Polio outbreak	Closed
Tajikistan, Kyrgyzstan, Uzbekistan	European Region	Circulating vaccine- derived poliovirus outbreak	Grade 2
Benin	African Region	Polio outbreak	Grade 2
Nigeria	African Region	Polio outbreak	Grade 2
Niger	African Region	Polio outbreak	Grade 2
Chad	African Region	Polio outbreak	Grade 2
Central African Republic	African Region	Polio outbreak	Grade 2
Cameroon	African Region	Polio outbreak	Grade 2
Ghana	African Region	Polio outbreak	Grade 2
Kenya	African Region	Polio outbreak	Grade 2
Democratic Republic of the Congo	African Region	Polio outbreak	Grade 2
Myanmar	South-East Asia Region	Humanitarian crisis	Grade 2
Democratic Republic of the Congo	African Region	Ebola virus disease outbreak	Closed
Guinea	African Region	Yellow Fever	Grade 2
Democratic Republic of the Congo	African Region	Ebola virus disease outbreak	Grade 2
Djibouti	Eastern Mediterranean Region	Floods	Grade 2
Central African Republic	African Region	Measles	Grade 2
United Republic of Tanzania: polio 2021	African Region	Polio	Grade 2
Namibia: polio 2021	African Region	Polio	Grade 2
Uganda: polio 2021	African Region	Polio	Grade 2
Senegal: polio 2021	African Region	Polio	Grade 2

Country/area	Region	Type of crisis	Latest grade
Gambia: polio 2021	African Region	Polio	Grade 2
Mauritania: polio 2021	African Region	Polio	Grade 2
Liberia: polio 2021	African Region	Polio	Grade 2
Togo	African Region	Polio outbreak	Grade 2
Zambia	African Region	Polio outbreak	Grade 2
Lake Chad Basin	African Region	Circulating vaccine-derived poliovirus outbreak	Grade 2
Democratic Republic of the Congo	African Region	Measles	Grade 2
Angola	African Region	Polio outbreak	Grade 2
Burkina Faso	African Region	Humanitarian crisis	Grade 2
Pakistan	Eastern Mediterranean Region	HIV outbreak	Grade 2
Measles in the European Region 2019	European Region	Measles outbreak	Grade 2
Djibouti	African Region	Malaria	Grade 2
Mozambique	African Region	Polio outbreak	Grade 2
Horn of Africa 2018–2019	African Region	Polio outbreak	Grade 2
Democratic Republic of the Congo 2018	African Region	Polio outbreak	Grade 2
Sudan	Eastern Mediterranean Region	Complex emergency	Grade 2
Libya	Eastern Mediterranean Region	Complex emergency	Grade 2
West Bank/occupied Palestinian territory operations 2017–2021	Eastern Mediterranean Region	Humanitarian crisis	Grade 2
Multiple locations	Global	Middle East respiratory syndrome outbreak	Grade 2
Burkina Faso	African Region	Hepatitis E	Closed
Niger	African Region	Floods and cholera outbreak	Grade 1
Nigeria	African Region	Cholera outbreak	Grade 1
Madagascar	African Region	Plague	Grade 1
Mauritania	African Region	Rift Valley Fever	Grade 1
Chad	African Region	Chikungunya	Grade 1
Lebanon	Eastern Mediterranean Region	Beirut explosion	Grade 1
Lebanon	Eastern Mediterranean Region	Conflict	Grade 1
Namibia	African Region	Hepatitis E	Grade 1

TABLE 2. ACTIVE PROTRACTED EMERGENCIES DURING THE REPORTING PERIOD (1 JANUARY–3O SEPTEMBER 2021)

Country	Region	Date of initial grading	Type of crisis	Initial grade	Date of latest grading	Latest grade
Democratic Republic of the Congo (2017–2019)	African Region	29/08/2017	Complex emergency	Grade 3	25/09/2020	Protracted 3
Somalia	Eastern Mediterranean Region	16/02/2017	Complex emergency	Grade 2	08/08/2019	Protracted 3
Yemen	Eastern Mediterranean Region	02/04/2015	Complex emergency	Grade 2	07/05/2020	Protracted 3
Nigeria	African Region	01/04/2015	Humanitarian crisis	Grade 2	19/10/2018	Protracted 3
South Sudan	African Region	12/02/2014	Humanitarian crisis	Grade 3	01/05/2017	Protracted 3
Mozambique	African Region	22/10/2020	Humanitarian crises	Grade 2	26/08/2021	Protracted 2
Armenia–Azerbaijan conflict	European Region	31/03/2021	Conflict	Protracted 2	31/03/2021	Protracted 2
Cameroon	African Region	09/11/2018	Humanitarian crisis	Grade 2	26/09/2020	Protracted 2
Myanmar (Rakhine)/Bangladesh	South-East Asia Region	15/09/2017	Conflict	Grade 2	01/05/2019	Protracted 2
Myanmar	South-East Asia Region	12/06/2017	Conflict/civil strife	Protracted 2	12/06/2017	Protracted 2
Iraq	Eastern Mediterranean Region	12/06/2014	Complex emergency	Grade 2	04/02/2019	Protracted 2
Niger	African Region	07/04/2015	Conflict	Grade 2	01/05/2017	Protracted 2
Cameroon	African Region	01/04/2015	Conflict	Grade 2	01/05/2017	Protracted 2
Central African Republic	African Region	28/03/2013	Humanitarian crisis	Grade 2	01/05/2017	Protracted 2
Ukraine	European Region	20/02/2013	Conflict	Grade 1	19/12/2019	Protracted 2
Ethiopia	African Region	18/11/2015	Humanitarian crisis	Grade 2	12/06/2018	Protracted 1
Mali	African Region	04/02/2013	Conflict	Grade 2	20/07/2017	Protracted 1