

Urgent Support for Developing Countries' Responses to the H1N1 Influenza Pandemic

September 17 2009



World Health Organization
Office for the Coordination of Humanitarian Affairs
UN System Influenza Coordination

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Executive Summary

1. The Secretary General of the United Nations and the Director-General of WHO called a meeting on 6 July 2009 to express concern that the H1N1 virus could have a severe impact on low income countries over the coming months. They called on the international community to provide resources to help the least resourced countries to withstand these impacts. At this meeting, donors asked the UN system, WHO and the World Bank to develop a more detailed assessment of what is required.
2. Whilst the future evolution of the H1N1 virus is unpredictable, it is clear that its impacts will be more severe in countries with under-resourced health care systems, lack of access to medicines, populations with a high rates of underlying medical conditions (such as HIV/AIDS, TB or malaria), and insufficient financial, material and human resources to tackle these challenges.
3. A task force comprising WHO, the World Bank, the International Federation of Red Cross and Red Crescent Societies and key UN system agencies was co-ordinated by the UN System Influenza Coordinator to oversee an 'urgent needs identification and prioritization' (UNIP) process.
4. The purpose of the process was to identify interventions that can be completed within the next 12 months that will strengthen the capacity of the most vulnerable countries to mitigate the impact of H1N1, particularly in terms of reducing excess mortality and increasing societal resilience. H1N1 may become more aggressive over the coming months which is why the process focuses on interventions that can be executed rapidly.
5. For strengthening country readiness, the process targets as a first priority the Least Developed Countries and as a second priority the other Global Alliance on Vaccines and Immunisations (GAVI)-eligible countries. These countries have the weakest capacity and resources to withstand an escalation of H1N1, and the most vulnerable populations.
6. WHO, the Office for the Coordination of Humanitarian Affairs and the UN System Influenza Coordinator invited the 77 LDC and GAVI-eligible countries to work with WHO and UN country teams to develop a prioritized assessment of their most urgent needs that could be addressed by rapid interventions that would strengthen their resilience to the current H1N1 virus. 61 of these countries chose to participate in the process.
7. Three categories of support are being requested. The first category of support is to provide antibiotics and antivirals to treat severe illness, and sufficient quantities of vaccine to protect health care workers and other essential service personnel. For vaccines, WHO has identified 85 developing countries who do not currently have the ability to access vaccines from any other source. These are the countries to

whom WHO proposes to provide sufficient vaccine to cover 5% to 10% of the population.

8. The second category of support is to assist countries in strengthening their pandemic readiness. WHO, OCHA and UNSIC, in close collaboration with UNICEF, WFP and IFRC, have developed and costed packages of support that could realistically be delivered to meet the priority needs for strengthened country readiness identified by the 61 participating countries. The support required falls into the 6 broad categories: strengthened health care response, (including operational planning for vaccine campaigns); strengthened communications; strengthened whole of society and humanitarian readiness; strengthened situation assessment and appropriate use of public health interventions; improved laboratory capacity; and regional knowledge sharing and networking.
9. The third category of support is for funding to enable specialist UN and partner agencies to help countries to implement these interventions.
10. A small contingency fund is proposed to enable flexibility lest needs change over time. The option is also left open to support countries with additional vaccines and antivirals, if they wish to cover greater quantities of their populations than the population groups prioritized under this programme and if additional resources become available.

11. The total (rounded) cost for these three categories of urgent intervention is as follows:

	(\$m)
Essential medicines and vaccines	1,140
Strengthening country readiness	240
Agency support costs	80
Contingency	20
Total	1,480

12. The cost of the antivirals that will be needed in the first year of the pandemic can be paid over a three year period. Hence the total funding required for disbursement in year one amounts to \$1,065.
13. The interventions requested by this process build on the important work that has been delivered over the past 3 years to strengthen preparedness for a possible H5N1 pandemic. The capacity that these interventions will create will go a long way toward strengthening the resilience of the world's most vulnerable communities and societies against a range of possible future public health threats.

1. Introduction

1.1. Background

- 1.1.1.** As transmission of a new influenza virus was confirmed in Mexico, the USA and Canada on April 24 2009, WHO raised the pandemic alert level to 4. The alert level was raised to 5 shortly afterwards when community level transmission in these countries was confirmed, and to 6 in June as further global transmission of the virus was detected.
- 1.1.2.** While the majority of people who have become affected suffer a self-limiting illness without complications, the virus can cause severe disease and death particularly in certain vulnerable groups – noticeably the very young, those with underlying medical conditions, and pregnant women. In some locations, indigenous populations seem most likely to be affected.
- 1.1.3.** Most results obtained to date emanate from situations in which attempts have been made to contain the spread of the virus, and where those with severe symptoms have been treated in hospitals with regimes that include antivirals and supportive respiratory care. It should be noted that thus far, many of the countries that have been most affected have high annual health care spending levels.
- 1.1.4.** The impact of the pandemic in least developed countries has yet to be seen as it is only beginning to penetrate very poor communities. It appears likely that in low income countries whose populations are comparatively young, and have high rates of underlying medical conditions and low annual health care spending, the health impact of H1N1 will be considerably higher than has been seen to date.
- 1.1.5.** In all countries, but more so in developing countries, accurate, specific data on H1N1 incidence and death rates are unlikely to be available because asymptomatic and mild cases generally do not seek treatment. In addition only limited diagnostic and reporting capacity is available in some areas. Due to these complexities, WHO is recommending the use of qualitative indicators, namely: geographical spread, trends of respiratory disease, intensity of severe respiratory disease and impact on health services. Unusual absenteeism and increased numbers of burials or cremations could also be considered. It may be some months after the pandemic virus starts to be transmitted within a country before the actual seriousness of the situation becomes evident.
- 1.1.6.** The threats to low income countries are twofold: to human health (excess morbidity and mortality) and to the functioning of society (economic impact on vulnerable sectors, difficulty in maintaining essential services, and civil disruption). These threats are intertwined – an increase in one may lead to knock on effects in the other. In countries with poor health status and limited

resources, the pandemic may divert scarce resources and strain already weak health services. Countries where health services are overburdened by diseases, such as HIV/AIDS, tuberculosis and malaria, will have great difficulty managing the surge of cases seen when pandemic influenza spreads. And if the electricity and water sectors are not able to maintain services, this will have serious implications for the ability of the health sector to function. If suppliers of fuel, food, telecommunications, finance or transport services have not developed plans as to how they will continue to deliver their services in the context of substantial staff absenteeism, the economic, social, humanitarian and governance consequences of the pandemic could be significantly intensified.

1.1.7. Under these circumstances the pandemic may hamper the realization of the Millennium Development Goals and may trigger a humanitarian crisis requiring local, national and international responses. There is a window in which it will be possible to help poor countries get as ready as they can for H1N1, and that window is closing quite rapidly.

1.1.8. The pandemic is liable to impact on the following MDGs in low resource settings:

- **Goal 1: Poverty and Hunger**
Health care costs and absenteeism could result in households who are above the poverty line slipping below it. This is a particular concern for the urban poor who are suffering from the economic downturn and rising unemployment. The potential disruption to critical services could increase the difficulty and costs in maintaining access to food and in moving other humanitarian assistance to vulnerable groups.
- **Goal 4: Child mortality**
Children under five (5) face a high risk of infection and significant risk of serious illness. A widespread outbreak with a high attack rate, particularly in children with pre-existing medical conditions, could result in a significant increase in excess child mortality.
- **Goal 5: Maternal mortality**
Pregnant women are at high risk of developing severe disease and death from H1N1. It is likely that in countries where a high proportion of pregnant women have underlying medical conditions, excess maternal mortality could be observed during the pandemic.
- **Goal 6: Combating HIV/AIDS, Malaria and Other Diseases**
In countries where pandemic H1N1 places a strain on health services, resources could be diverted from HIV, TB and malaria prevention, care and treatment. It is also likely that people with AIDS, TB and malaria will be disproportionately affected by H1N1.

- **Goal 8: Global Partnerships for Development**

Target 17: Essential drugs: It is possible that essential drug supplies could be negatively affected in some countries by the pandemic.

1.1.9. Though the H1N1 influenza continues to spread rapidly throughout the world, the full impact of the pandemic is yet to be realized. The UN system has anticipated three potential scenarios, and is preparing for all of the eventualities:

- The virus continues to spread, though it becomes milder – thus the most serious illnesses and impacts have already passed
- The virus continues to be highly infectious and spreading rapidly, though its severity remains at status quo, causing some disruption and mortality. There would still be a need for support to many developing countries, where various sectors would likely be overwhelmed.
- The H1N1 pandemic influenza virus continues to be highly infectious and spreads rapidly, but also undergoes genetic change to become significantly more severe. Many people become seriously ill and a high fatality rate develops. This has serious implications for developing and developed countries alike, within and beyond the health sector.

1.1.10. One of the concerns of all developing countries is the extent to which they will be able to access financial assistance for pandemic readiness, including for health system support, vaccines, medicines, social protection for households and communities whose income streams are cut, continuity of services, and more substantive backing if the pandemic has a major impact on the national balance of payments.

1.1.11. The UN Secretary General convened a meeting of the UN system Influenza Steering Committee on June 15, shortly after Phase 6 was declared. The committee concluded that the UN system should have a common approach for supporting developing country responses with WHO, the World Bank and UN System Influenza Coordination working in synergy.

1.1.12. On 6 July, the UN Secretary General and the Director-General of WHO held a meeting in Geneva to express concern that the H1N1 virus could have damaging consequences in developing countries over the coming months. Low income countries with restricted implementation capacity are least well-placed to cope with its impact. Ban Ki Moon and Dr Chan invited donors to provide resources to help the least prepared countries to strengthen their capacity to mitigate the consequences of the pandemic. Donors asked the United Nations and WHO to undertake a rapid assessment of gaps and priority needs to help inform their resource allocation decisions.

1.2. Purpose, Goal and Scope of the Urgent Needs Identification and Prioritization (UNIP) Process

- 1.2.1. The **purpose** of the Urgent Needs Identification and Prioritization (UNIP) process is to identify interventions that could be undertaken rapidly in order to help the countries most in need of such help to strengthen their capacities to reduce the health, humanitarian, economic and social impacts of the current pandemic. It is mindful that the impact of the pandemic is likely to be greater in countries with weak health care systems, inadequate access to essential medicines, large numbers of vulnerable citizens with underlying medical conditions, and insufficient resources to address these challenges without international support.
- 1.2.2. The **overarching goal** of the UNIP process is to mobilize financial and technical resources to provide least developed countries with rapid assistance so as to:
- Limit excess mortality associated with pandemic influenza (H1N1)
 - Increase societal resilience so as to reduce the economic, social and humanitarian impact of pandemic influenza (H1N1)
 - Build on the existing capacity that has been developed over the past few years in response to concerns about influenza A/H5N1, and to link any urgent investment to ongoing medium and long term capacity building programmes so as to ensure strengthened global pandemic preparedness and resilience against sudden health related shocks
- 1.2.3. WHO, the Pandemic Influenza Coordination team in OCHA (PIC) and the UN System Influenza Coordinator's Office (UNSIC) developed a tool to help countries **assess** their state of preparedness and to **prioritize** their needs for urgent assistance. For interventions designed to strengthen country readiness to respond to H1N1, it was decided to give priority to the Least Developed Countries and the other GAVI-eligible countries, as these countries have the least capacity and resources, and have populations that are likely to be the most vulnerable to the impact of pandemic influenza (H1N1). The tool was sent to International Health Regulations focal points in Governments in the 77 Least Developed and GAVI-eligible countries (see Annex A for list of countries). WHO Country Representatives and UN Resident Coordinators were asked to help Governments to conduct the assessments and to work with representatives across key government sectors to identify priority needs.
- 1.2.4. With regard to the provision of vaccines, WHO has identified 85 countries who do not currently have the capacity to acquire vaccines. These countries will be targeted for the provision of vaccines under this process.

- 1.2.5.** The process is focused on interventions that can largely be delivered within a **six (6) month time-frame** with follow up support for a further 6 months. It is anticipated that interventions that take more than 6 months to come to fruition run a high risk of arriving too late to be effective against an intensified impact from H1N1 in poor countries.
- 1.2.6.** Participating governments were invited, in collaboration with WHO and UN colleagues, to identify their most urgent needs in the areas of overall management of the response, whole-of-society multi-sector planning, effective communications, reducing transmission, and health sector response. Governments were then invited to select from within these needs the most urgent priorities where rapid donor support would enable strengthened capacity to withstand H1N1 challenges in the coming months, with a view to reducing mortality and sustaining essential services to vulnerable people.
- 1.2.7.** WHO, UNSIC and the Pandemic Influenza Coordination team in OCHA working in conjunction with UNICEF, WFP and IFRC developed a methodology for costing the requests which involved dividing the requests into thematic packages of support that could readily be delivered and then differentiating these packages of support according to the size and relative level of preparedness of the country concerned.
- 1.2.8.** The overall financial needs identified in the report fall into three categories:
- **Category 1:** Meeting the urgent need for essential medicines to treat severe cases and vaccines to protect health care workers and other essential service personnel
 - **Category 2:** Meeting the urgent need for interventions to strengthen country readiness
 - **Category 3:** Funding for relevant agencies and partners to support countries in implementing these interventions.
- 1.2.9.** The interventions that are costed in the UNIP process are restricted to the **highest priority needs** cited by the countries concerned. The countries also cited a number of other gaps that it would be useful to address that are of secondary priority to be addressed in medium and longer term capacity building programmes.
- 1.2.10.** Many countries requested technical assistance as a key component of their priority needs. This is why some funding is being sought for UN and partner agencies, to provide technical and operational support.

1.3. Building on Existing Preparedness

- 1.3.1.** The interventions foreseen in this process build on the important work that has taken place over the past 3 years to prepare for a possible H5N1 pandemic. That work has left countries better-placed to resist the current H1N1 pandemic, and provides an important baseline which the current efforts can supplement.
- 1.3.2.** The UNIP process was developed to highlight the most urgent needs of the least developed and GAVI-eligible countries, to strengthen resilience to H1N1 over the next 12 months. This work comes on top of broader efforts by WHO, the UN System as well as the International Federation of the Red Cross/Red Crescent (IFRC) to assist countries in responding to and preparing for pandemic influenza.
- 1.3.3.** In 1999 WHO issued the first Global Pandemic Preparedness Plan. In 2005 this plan was updated in response to the emergence of highly pathogenic influenza A(H5N1). A series of more detailed guidelines on a range of different health care and public health interventions were subsequently released and significant support to countries to implement these guidelines and to build pandemic preparedness as well as respond to the specific issues related to influenza A(H5N1) was provided by WHO through its headquarters, regional and country offices.
- 1.3.4.** For the past several years, a number of other UN agencies have worked together to assist countries and to help secure long term, global capacity to control avian influenza and prepare for the next pandemic. This work was articulated in the UN System and Partners' Consolidated Action Plan for Avian and Human Influenza. Although much of this work has been focused on avian influenza H5N1, as the current Influenza A(H1N1) outbreak demonstrates, the results of this work are readily applicable when responding to other viruses of pandemic potential.
- 1.3.5.** Evidence suggests that global efforts over the past few years to prepare for an influenza pandemic have enabled a stronger response to the fast spreading outbreak of Influenza A (H1N1). However, while pandemic preparedness efforts have been strengthened, the rapid global spread of pandemic influenza (H1N1) has resulted in the need for additional, urgent action to ready systems, particularly in the least resourced countries.

2. Outcome of the Urgent Needs Identification and Prioritization Process

2.1. State of Readiness

- 2.1.1. For the country readiness component (Category 2), 61 out of 77 LDC and GAVI-eligible countries participated in the process. 16 countries (7 LDCs and 9 other GAVI-eligible countries) chose not to participate. 6 additional non-LDC non-GAVI countries volunteered to submit their needs to the process on an unsolicited basis. All 77 GAVI and LDC countries (except for India) will be supported with antivirals and antibiotics and a separate list of 85 countries (that includes many of the 77 LDC and GAVI countries) has been assessed as needing vaccines.
- 2.1.2. The UNIP tools completed by Governments, in collaboration with WHO country representatives and UN country teams, provide a substantial body of information about the measures that Least Developed and GAVI-eligible countries are taking in response to the H1N1 pandemic and about their assessments of priority areas of need where support from the international community would be welcomed. There is a considerable variety in the levels of preparedness attained thus far, with a tendency on the part of countries that have been seriously affected by avian influenza (H5N1) to have devoted more attention and resources to pandemic preparedness than other countries. The Least Developed Countries have the lowest existing capacity to withstand the impacts of H1N1 and should be the first priority for donor support. A number of the areas of need are already being addressed by WHO and UN agencies without recourse to additional resources, and these will continue to be pursued.
- 2.1.3. Areas globally where much progress is reported include preparation of key public health messages (prepared by 92% of countries), development of national communications plans (developed by 74% of countries), distribution of national clinical care guidelines for pandemic influenza (issued by 56% of countries), establishment of inter-Ministerial or multi-sector coordination mechanisms (established in 85% of countries), collaboration in pandemic preparedness and response with civil society and Red Cross/Crescent partners (in 50% of countries) and strengthened national surveillance systems (strengthened in 77% of countries). Many countries cite encouraging sick people to stay at home as a key strategy used to reduce transmission.
- 2.1.4. In terms of **access to essential pandemic related pharmaceuticals** it was found that:
- None of the countries surveyed as part of the UNIP process have, at this stage, the capacity to produce **pandemic vaccines** and few of the countries currently have guaranteed access to pandemic vaccines.

- None of the countries participating in the UNIP process are able to produce **antivirals** domestically and in the majority of these countries, antiviral stocks are currently small and consist mostly of donations from WHO and other bilateral donors.
- The majority of the UNIP countries are reliant on imports of life-saving **antibiotics** with current holdings thought to be below the levels likely to be needed urgently if the number of pandemic influenza cases were to accelerate.

2.1.5. In terms of **country readiness**, areas where it is reported that progress is very limited and much remains to be done include: implementation of pandemic plans, including communications plans, down to sub-national and local levels (only implemented in 37% of countries), business continuity planning to ensure the continued provision of critical services (not started in 55% of responding countries) and establishment of plans for managing the storage, distribution and delivery of the pandemic vaccine when it becomes available (only started in 44% of countries). These figures were collected in mid-late August. In response to the lack of plans for vaccine storage, distribution and delivery, WHO has subsequently provided urgent support to address this gap.

2.1.6. Due to the specialized nature of laboratory work, a focused, in depth influenza related laboratory assessment was conducted by WHO in parallel with the UNIP survey. This revealed a very wide spectrum of laboratory capacities. A small number of countries in the UNIP have laboratories of such high standard that they are able to provide support to other countries. However many countries have only limited in-country capacity and a small number of countries have no influenza related laboratory capacity and are therefore dependent on shipping samples to other countries for diagnostic purposes. Biosafety standards were assessed to be sub-optimal in many laboratories handling pandemic influenza samples.

2.2. Overview of the Priority Needs

2.2.1. Category 1: Priority Needs for Essential Medicines to Treat Severe Cases and Vaccine to Protect Essential Service Personnel

The majority of countries requested assistance with access to and procurement of essential pandemic related pharmaceuticals for treatment of cases i.e. antivirals and antibiotics and pandemic vaccine for use in vaccinating health care workers and essential service personnel with the aim of ensuring continuity of essential services such as health care.

2.2.2. Category 2: Priority Need to Strengthen Country Readiness

The interventions to strengthen country readiness for which urgent support is sought from the international community most commonly include: assistance with health sector planning, including planning of mass vaccination campaigns (requested by 50% of countries), increased supply of personal protective equipment and other items to improve health facility infection control (82%); training of health care workers in infection control and case management (69%); technical assistance with strengthening of operational communications (72%); assistance with production and dissemination of materials to support community-based communications for behaviour change (69%); strengthening whole of society readiness (69%); training of public health workers in pandemic surveillance (54%); and laboratory support. Technical assistance formed a very significant part of what countries requested, which is why a category of funding for relevant agencies is included in the process.

2.3. Priority Needs – by Region

Africa (33 countries)

2.3.1. Most African countries report having developed inclusive coordination mechanisms incorporating many key actors. The majority of African countries report strong engagement with civil society and the Red Cross on pandemic preparedness. Lack of finance and resources has limited implementation of pandemic plans in Africa. More than half of African countries have not had the resources to implement their pandemic plans down to sub-national and local levels. Very few African countries have developed business continuity planning for key sectors to ensure continuity of essential services. Most African countries have developed a national communications plan – in many cases with support from UNICEF, WHO or CDC. Some are using innovative approaches to communicate pandemic messages, such as theatre and songs. Most African countries have developed key public health messages. However in some cases, poor communications infrastructure, internet and email access, as well as high illiteracy rates, have limited their development and dissemination. In some cases, the messages cover how to prevent infection but not what to do in case people get sick. A majority, though by no means all, of African countries have trained staff in healthcare facilities about how to reduce transmission. But in some cases, this training is still a work in progress. In some cases, it has not reached the local level or remote parts of the country. In some cases, there has not been sufficient funding to enable staff training. Many African countries have developed national clinical care guidelines for pandemic influenza, in many cases strongly based on WHO recommendations. In some cases, these guidelines are still under development – or have reached national and district but not peripheral and community level. Few African countries have developed plans for continuing care for other essential patient groups when there is

increased demand or for alternative care facilities when hospitals cannot meet demand. In some cases these plans are underway but not completed. Very few African countries have plans in place for storage, distribution and delivery of vaccine if it becomes available. Many African countries have made significant efforts to strengthen surveillance, although in some cases these are weak at local level.

2.3.2. In addition to access to essential medicines and vaccines, the interventions most commonly requested by African countries to meet urgent gaps and needs include:

Health sector:

- Training and guidance for health workers in diagnosis, case management, treatment and care;
- Provision of consumables such as gloves, masks, soap, antiseptic, and cleaning agents, as well as personal protective equipment;
- Training, equipment, capacity-building, primers and reagents for laboratories.

Non-health sector:

- Support for effective communications: planning, materials, training, dissemination to community level, protocols and Standard Operating Procedures;
- Training and workshops for government and private sector to develop sectoral business continuity plans.

Latin America and the Caribbean (3 countries)

2.3.3. Latin America and the Caribbean reports limited progress in engaging sectors beyond the health sector in H1N1 preparedness and limited progress in implementing plans at the local level. Countries have not developed business continuity planning (BCP) for continuity of essential services, although some have progressed BCP in the health sector. Countries have elaborated a communications strategy. But sometimes communications have been hampered by lack of media coverage, and by a failure to engage Ministries beyond Health. Countries have trained staff at healthcare facilities about reducing transmission and have developed national clinical care guidelines, drawing on WHO recommendations. But these guidelines have not always reached peripheral/local levels. Countries have developed plans for storing, distributing and delivering vaccines, if it becomes available.

2.3.4. In addition to access to essential medicines and vaccine, the areas commonly requested by Latin America and the Caribbean for international community support are:

Health sector

- Training for health workers in diagnosis, case management, treatment, care and infection control;
- Provision of personal protective equipment;
- Laboratory support – provision of reagents and some biosafety training.

Non-health sector

- Planning and materials for communications;
- Support with business continuity planning.

Asia and Pacific (18 countries)

2.3.5. Many Asian countries report that they have strong, established and operational multi-sector coordination mechanisms. However most countries have not achieved business continuity planning for essential services, although in some cases this is work in progress. Most countries have developed key public health messages, although in a few cases these have not been finalized, or have been disseminated in the capital but not to more remote regions. In many countries, implementation of the pandemic plan has not yet reached sub-national or local levels, or remote communities. There has been significant collaboration with civil society and the Red Cross Movement on H1N1 preparedness and response. Many countries have developed guidelines on clinical care, drawing on WHO and CDC recommendations. In some cases, these guidelines have not reached private sector health facilities, have not reached more remote parts of the country or are still under development. Many countries have trained staff at healthcare facilities in infection control but this training has sometimes not reached peripheral parts of the country or private sector healthcare staff. Limited progress has been made in planning to deliver care to other essential patient groups when there is increased demand, or in making use of alternative care facilities. A lot of countries have made progress in strengthening surveillance.

2.3.6. In addition to access to essential medicines and vaccine, the priority needs most commonly requested by Asian and Pacific countries are:

Health sector:

- Provision of personal protective equipment, medical supplies and medical equipment;
- Training of health care workers at local level in case management and infection control;
- Laboratory support – financial and some training.

Non-health sector

- Financial support for communications equipment, training, media campaigns and outreach activities;
- Training and workshops for government and private sector to develop sector business continuity plans.

Eastern Europe and Central Asia (5 countries)

2.3.7. Eastern Europe and Central Asian countries report relatively stronger progress in implementing pandemic plans at the sub-national and local levels and at developing business continuity planning for key essential services sectors. Many countries in the region have elaborated communications plans and key public health messages. Many countries in the region have elaborated plans for storage, distribution and delivery of vaccines when available, as well as plans to continue delivering essential care when facing increased demand and for alternative care facilities if hospitals cannot meet demand. There has been strong collaboration with civil society and Red Cross partners in a number of countries.

2.3.8. In addition to access to essential medicines and vaccine, the most common requests for assistance in Eastern Europe and Central Asia are:

Health sector:

- Training of health care workers in diagnosis, case management;
- Guidance on community mitigation and support for government decision making in this area.

Non-health sector:

- Financial and technical support with communications;
- Support to develop sector business continuity plans.

Middle East and North Africa (2 countries)

2.3.9. Middle East countries report that they have established clear roles and responsibilities for key actors. They have developed key public health messages. They have developed clinical care guidelines, using WHO guidance. They have developed plans for storage, distribution and delivery of vaccine when available. Collaboration with civil society and the Red Cross has been limited. A lack of epidemiologists is cited as a constraint.

2.3.10. In addition to access to essential medicines and vaccine, the interventions requested by the Middle East and North African countries include:

Health sector:

- Provision of personal protective equipment;
- Training of health care staff in case management.

Non-health sector:

- Support (financial and technical) for communications strategies and training

2.4. Priority Needs – Countries of Humanitarian concern (22 countries)

- 2.4.1.** Conflict-affected zones where many services for vulnerable people are provided through humanitarian assistance are not always well-covered by government-led national preparedness and response plans. Populations in such areas may be at increased risk of infection, due to crowding in camps and dense urban settings - and have higher rates of complications, due to high fertility rates, high prevalence of malnutrition and other illnesses and lack of access to health care and health workers. As noted during Inter-Ministerial conferences on avian and pandemic influenza, one of the challenges countries will face is the provision of critical services and ensuring access to food, medicines and other life-saving assistance.
- 2.4.2.** Humanitarian agencies (including non-governmental organizations) responding to the needs of refugees, migrants, vulnerable people (including pregnant women, those with chronic diseases and disabilities, people with HIV and malnourished women and children) must be prepared for challenges to their existing work, due to breakdowns in logistics and security systems, and a potential increase in demands, due to increased numbers in need. Refugee needs are sometimes accorded lower priority in government planning. The key issues for humanitarian operations include: business continuity planning for humanitarian programmes; prioritizing operations if basic systems are overloaded; and expanding services if new humanitarian needs emerge in areas not currently covered by humanitarian operations. Humanitarian common service support will be required to support national authorities in the maintenance of essential functions such as multi-sector operational continuity and the deployment of humanitarian assistance.
- 2.4.3.** NGOs are often the key implementing partners in humanitarian settings, assisting governments to carry out activities at district, provincial and community level.
- 2.4.4.** The countries of humanitarian concern are amongst the countries who have made the least progress in pandemic readiness to date. As a result, during the UNIP process, they were the group of countries who stipulated the most gaps and needs. Relative to other countries, they have therefore been targeted with a large number of proposed interventions by this process.

3. Addressing Countries' Priority Needs - Categories of Support

3.1. Overview

3.1.1. As described above, a range of needs have been identified and prioritized through the UNIP process. Interventions to address these priority needs are available and have been described in a range of peer reviewed guidelines. These interventions have been collated into a series of 'support packages' that would be provided to requesting countries to assist in addressing the specific priority needs that have been identified. Each 'support package' is described below. Expanded detail on the major activities within each 'support package' and how each support package could be tailored to meet the specific needs of a country is available on request.

3.1.2. There are two categories of support:

- **Category 1: Meeting the urgent need for essential medicines to treat severe cases and vaccines to protect health care workers and essential service personnel**

Three objectives and related support packages have been designed to best meet the priority needs that have been identified:

- A. Increased access to antivirals to treat severe illness
- B. Increased supply of antibiotics to treat bacterial complications
- C. Increased access to pandemic influenza (H1N1) vaccine to protect health care workers and other essential service personnel

- **Category 2: Meeting the urgent needs to strengthen country readiness**

Eight objectives and related support packages have been designed to best meet the priority needs that have been identified:

- A. Strengthened health care response, including operational plans for vaccination campaigns and post-marketing surveillance
- B. Strengthened pandemic related communications
- C. Strengthened whole of society and humanitarian readiness
- D. Strengthened situation assessment and appropriate use of public health interventions
- E. Improved influenza laboratory capacity
- F. Essential pharmaceutical needs in addition to those under Category 1
- G. Enhanced regional knowledge sharing and networking
- H. Flexible response through the creation of contingency fund

4. Category 1: Meeting the urgent need for essential medicines to treat severe cases and vaccines to protect health care workers and essential service personnel

4.1. Background

4.1.1. WHO has stated that the principle of global solidarity should prevail in pandemic times so that all developing countries in need have access to both essential medicines for the treatment of severe cases and vaccines to protect health care workers and other essential service workers to ensure continuity of health care and other critical services. These will be of increasing importance as the pandemic spreads and inequities in access to pharmaceuticals become starker.

4.1.2. Pandemic influenza vaccine has certain characteristics that necessitate a different approach to supply of other vaccines. First, production capacity is limited, and demand for the vaccine will outstrip supply for several months. Several developed countries have pre-existing contracts securing the first supplies of vaccine - initially supplies for developing countries will be extremely limited. Second, limited quantities of vaccine mean countries will need to identify priority groups for vaccination until adequate supplies to reach all populations are available. Third, a variety of formulations are in development - some containing adjuvant – necessitating careful documentation of use, especially if two doses are required. Finally, these vaccines have not been used extensively, so information on effectiveness and safety will be limited.

4.1.3. Three critical pharmaceutical products are needed and have been requested, as a priority, by countries. These are:

- Antivirals to treat patients with severe influenza illness
- Antibiotics to treat patients with bacterial complications
- Vaccines to protect health care workers and other essential service personnel

Note that:

- Additional vaccine may be required to protect high risk groups and/or to control the pandemic – this requirement, that is above the requirement to protect essential services, is discussed under Category 2 F
- H1N1 diagnostic tests are valuable for surveillance, but are not essential for case management. Other elements of patient care for the seriously ill such as oxygen therapy, IV fluid, vasopressors and personal protective equipment and are dealt with under Category 2 A.3.
- WHO has assessed that 85 developing countries have no other capacity or plans to acquire vaccines and therefore will need to be assisted under the vaccine component of this package.

- Antivirals and antibiotics will be provided to the 77 LDC and GAVI-eligible countries

4.1.4. It is recognized that the current volumes of vaccines available to developing countries are grossly inadequate to meet the needs of developing countries. Additional steps, over and above those outlined in this document, are needed to increase the availability of vaccines to developing countries, and substantially reduce the period of inequity in access to vaccines.

4.2. Objective A: Increasing access to antivirals for treatment of serious cases

4.2.1. Although the evidence is still being collected, there are indications that early treatment with antivirals can reduce the severity of illness and complications and may increase survival. Use of antivirals for prophylaxis and containment is not currently recommended. Two antivirals are currently recommended by WHO for treatment of pandemic influenza H1N1: oseltamivir and zanamivir. Oseltamivir is the drug of choice for severe illness due to its ease of administration. Several sporadic cases of oseltamivir resistant H1N1 have been reported but insufficient to justify a change in treatment recommendations at this time.

4.2.2. Based on expected attack rates and rates of serious illness, it has been estimated that between 3 and 6% of the population may require antiviral treatment. For the LDC+GAVI countries covered by the UNIP process (excluding India which has its own antiviral production capacity) it is estimated that around 78 million treatment courses will need to be provided to ensure that those with severe illness can be treated.

4.2.3. Roche has announced a Reserve Programme which allows GAVI eligible countries to order unlimited quantities of Tamiflu® at the reduced cost, with payment spread over a period of up to 6 years.

4.2.4. It is anticipated that support with shipment to each country may be needed. However it is believed that no or very limited assistance will be required by most countries with in-country distribution

4.3. Objective B: Increasing access to essential antibiotics for treatment of patients with bacterial complications

4.3.1. For people who develop bacteria related complications, rapid treatment with antibiotics can be lifesaving during a pandemic. Data from past pandemics show that the majority of secondary bacterial pneumonias were associated with Gram positive cocci.

- 4.3.2.** Most countries already have stocks of antibiotics but it can be assumed that there will be a surge in demand during a pandemic. It is assumed that round 3% of the population will develop complications that may require antibiotic treatment. This implies that upward of 39 million antibiotic treatment courses may be required, though it is likely that the volume that will actually be needed to be supplied through this programme will be somewhat lower as existing domestic stocks can be utilized.
- 4.3.3.** It is anticipated that support with shipment to each country may be required by some countries. However it is believed that no or very limited assistance will be required by most countries with in-country distribution.

4.4. Objective C: Increased access to pandemic influenza H1N1 vaccines for use in protecting health care workers and other essential service personnel

- 4.4.1.** Vaccines against pandemic influenza H1N1 can potentially provide the means of protecting susceptible populations from infection and mitigating the impact of the disease. Several pandemic vaccines are in development, including non-adjuvanted, adjuvanted, live attenuated and recombinant vaccines.
- 4.4.2.** The Strategic Advisory Group of Experts (SAGE) on Immunization has recommended that pandemic influenza vaccines should begin initially with health workers, and then selecting from among the following priority groups; pregnant women; those aged above 6 months with one of several chronic medical conditions; healthy young adults of 15 to 49 years of age; healthy children; healthy adults of 50 to 64 years of age; and healthy adults of 65 years of age and above.
- 4.4.3.** As the current global supply of pandemic influenza H1N1 vaccines is limited, the priority is to provide to countries without access to vaccine and to providing quantities of vaccine to protect health care and other essential service workers.
- 4.4.4.** The Director General of WHO has negotiated with several vaccine manufacturers to make a fixed proportion of their manufacturing capacity available to WHO for developing countries. This is generally in the order of 10%. Vaccines will become available to WHO from the fourth quarter of 2009, but initial supplies will be very limited.
- 4.4.5.** A 10% set aside, based on realistic production projections would amount to around 300 million doses, of which 150 million doses have already been pledged to WHO as donations by manufacturers, but 150 million would need to be procured. 300 million doses is believed to be sufficient to cover up to 10% of the population of the 85 countries currently lacking access to vaccines.

- 4.4.6.** In addition to procuring the vaccine itself, it is anticipated that the following areas of support would be offered to requesting countries on a needs basis as well:
- Assistance with procurement and financing of consumable items required for vaccination (syringes, gloves, sharps boxes etc)
 - Assistance with shipment of vaccine from manufacturer to the countries of concern
 - Assistance with enhanced cold chain for storage and distribution
- 4.4.7.** Countries receiving vaccine through this mechanism would be required by WHO to:
- Have in place a full operational plan to support a vaccination campaign (see Category 2: A1)
 - Put in place an agreement to deal with any liability issues arising from the use of the vaccine
 - Post marketing surveillance (see Category 2:A1)
 - Take note of the recommendation of SAGE on priority groups for vaccine coverage. However final decisions on in-country allocation of vaccine will be an issue for the national authorities.

5. Category 2: Strengthening Country Readiness

5.1. Objective A: Strengthened Health System Response to Pandemic Influenza (H1N1), including operational plan for vaccine campaigns and post-marketing surveillance

5.1.1. As has been witnessed during the first waves of pandemic influenza (H1N1) in the southern hemisphere, health systems can be put under considerable strain for long periods of time. Increased demand, particularly for outpatient and intensive care, can result in resources being diverted from other programmes with possible secondary impact on non influenza services.

5.1.2. Experience thus far has shown that the following interventions have led to a reduction in health care strain and improvement in patient care:

- Robust health sector planning with an emphasis on effective patient triage, provision of specialist influenza services and investment in health sector business continuity
- Training of health care workers and community workers on detection of severe respiratory illness, care of patients with respiratory illness and early identification of respiratory patients in high risk groups
- Training of health care workers and community workers in the detection and treatment of complications and to identify patients who need additional care.
- Consistent application of appropriate infection control measures to reduce health care related transmission – respiratory and oro-faecal routes

5.1.3. Many countries have requested support to strengthen the health system response to pandemic (H1N1). Three packages of support have been developed to assist in implementing the effective interventions described above:

- A.1 Support to review and adapt national plans and guidelines for immediate response to pandemic influenza (H1N1) 2009, including operational planning for vaccination campaigns and post-marketing vaccination surveillance
- A.2 Support for health care worker training to strengthen case management and infection control
- A.3 Support to increased supply of essential pandemic influenza (H1N1) commodities to support case management and infection control

5.2. Objective B: Strengthened Communications for Pandemic Influenza (H1N1)

- 5.2.1.** Effective communication between decision makers, health care workers and with the public is a vital component of an effective response to any major health event. There is a vast body of knowledge and experience on how to enhance effective communications during health events.
- 5.2.2.** Many countries have requested assistance to strengthen their communications and to ensure that all members of the community have the information and understanding they need to protect themselves and their community. Four packages of support have been developed to help countries address specific aspects of effective communications. Although many countries have requested support in all four areas, some have requested specific support in only one or two areas.
 - B.1** Technical assistance to strengthen operational communications (communications within and between decision makers and response agencies)
 - B.2** Training to increase effective use of official spokespeople and the media to disseminate critical public information
 - B.3** Technical assistance on effective planning for communications for behaviour change at community level
 - B.4** Financial and technical assistance to produce, disseminate, evaluate and refine communications materials

5.3. Objective C: Strengthened Whole of Society and Humanitarian Readiness

- 5.3.1.** Whilst the primary concern of most governments has been on the disease itself, lessons learnt during the current pandemic within the southern hemisphere highlight the vulnerability of critical services even with comparatively low absenteeism. This is of particular concern in countries already requiring international assistance to feed and support their vulnerable populations.
- 5.3.2.** There has been limited focus on business continuity during major infectious disease events such as pandemics. As a result a number of countries have requested support to strengthen whole of society readiness and to address possible vulnerabilities across a range of different sectors. To meet these needs, two support packages have been developed:
 - C.1** Assistance with rapid assessment of vulnerabilities in different sectors and technical assistance with urgent planning to reduce vulnerability

C.2 Specific assistance, including if needed material assistance, for LDCs in receipt of humanitarian assistance to assess, plan and reduce sector vulnerabilities.

5.3.3. The assistance provided under this support package is recognized as initial assistance to countries. It is possible that, as the pandemic begins to affect countries, there could be a need for additional humanitarian assistance – both in countries already in receipt of such assistance or in countries where the impact of the pandemic is such that essential supplies and services are placed under significant strain. If this situation were to occur, funds and technical assistance mobilized under this programme might be insufficient and an additional, emergency appeal could be instigated.

5.4. Objective D: Strengthened Situation Assessment and Public Health Decision Making

5.4.1. Continual monitoring of the situation and provision of information to guide risk assessment and decision making is vital if the effective interventions are to be applied appropriately and the impact of the pandemic – health, social, economic and humanitarian – is to be limited.

5.4.2. Surveillance systems, data management and data analysis are limited in some countries, as are country specific guidelines to support the use of this information to guide decision making, particularly about the use of public health interventions to reduce transmission. As a result a number of countries have prioritized these issues and have requested urgent support in these areas. Two support packages have been developed to assist countries in urgently addressing these pandemic influenza (H1N1) needs:

D.1 Technical assistance and training to strengthen situation monitoring and assessment

D.2 Adaptation of guidance to support decision making on the appropriate use of non pharmaceutical interventions to slow transmission

5.5. Objective E: Strengthened Influenza Laboratory Capacity

5.5.1. Laboratory services provide information to support situation assessment as well as provide information on issues such as antiviral resistance that guide clinical management of patients.

5.5.2. However, for laboratory services to function safely, biosafety equipment and training is needed. Pandemic influenza (H1N1) is a high containment agent

meaning that it can be transmitted from a laboratory sample to a worker and can potentially cause disease and death. Strong and effective biosafety procedures and practices are therefore required in all laboratories handling influenza specimens.

5.5.3. WHO has undertaken an exhaustive assessment of the laboratory capacity, including biosafety, in all the laboratories that handle influenza viruses in the 77 LDC and GAVI countries. The findings indicate that considerable support is required in many countries to raise laboratory capacity and to ensure that biosafety standards are adequate. Support packages, tailored to the specific needs of each country have been developed.

5.5.4. Some laboratories in a small number of countries who took part in the process however have laboratories of a high standard. These laboratories are currently providing services (diagnostic, training and mentoring) to neighboring countries. These 'regional' laboratories are currently under considerable strain and require additional support so that they may continue to provide not only their national functions but also regional support services. As a result of this survey, two support packages have been developed:

E.1 Support to strengthening of national influenza laboratory services

E.2 Support to enhance regional laboratories capacity to support other countries

5.6. Objective F: Additional access to pandemic influenza H1N1 vaccine and antivirals

5.6.1. The volume of vaccines made available to countries under support in Category 1: C will only be sufficient to vaccinate health care and other essential services workers in order to maintain continuity of critical services. It is recognized that countries may wish to procure additional supplies so that they can offer vaccination to high risk groups or to try to control the pandemic through the targeted use of vaccine to reduce transmission. Likewise, there may be a need in some countries for additional access to antiviral medication.

5.6.2. As mentioned above, this is an initial appeal for support to provide urgent, prioritized assistance to the countries covered by the process. Should additional resources become available (both financial and additional vaccine and/or antiviral doses), further discussions will be held with countries to develop appropriate mechanisms to assist further in this area.

5.7. Objective G: Enhanced Regional Knowledge Sharing and Networking

- 5.7.1.** In addition to the direct country support packages, regional meetings to share latest information, foster knowledge and support networks and to discuss lessons learnt are thought to be a useful means of supporting countries.
- 5.7.2.** Costs to support the organization of such meetings as well as attendance by experts from countries who took part in the UNIP process have therefore been included.

5.8. Objective H: Contingency Fund

- 5.8.1.** As described at the beginning of this document, the H1N1 pandemic is unpredictable and is affecting countries already in quite different ways. There is therefore a need for continuing monitoring of the impact and corresponding country needs. The costs outlined in this document should therefore be considered to be initial estimates. To ensure flexibility and to ensure that any change in priority needs can be addressed, a contingency fund of 8% of estimated costs for the measures to strengthen readiness is requested. This includes a \$5m contingency sum for the Central Fund for Influenza Action to enable relevant agencies to support any additional needs that may arise.

6. Estimated Cost of Supporting the Priority Needs

6.1. How Initial Costs Were Estimated

- 6.1.1.** As described above, three cost categories are included in this report:
 - **Category 1:** Meeting the urgent need for essential medicines to treat severe cases and vaccines to protect health care and other essential service personnel
 - **Category 2:** Meeting the urgent need for interventions to strengthen country readiness
 - **Category 3:** Funding for relevant agencies and partners to support countries in implementing these interventions.
- 6.1.2.** All costs included in this document are initial estimates to cover support for up to a 12 month period. Costs will be further refined and amended as more

detailed work with countries is undertaken and as the impact of these urgent interventions becomes apparent. In addition, due the unpredictable nature of the current situation, regular review of priority needs and costs will be undertaken.

- 6.1.3.** Costs included in Category 1 and 2 were estimated using best available data and previous costs of similar packages as a benchmark. Costs were moderated to take into account baseline capacity within a country as well as, when appropriate, the geographical and population size of the country.
- 6.1.4.** Vaccine costs relate to the cost of procuring 150 million doses of vaccine as at least 150 million have kindly been donated free of charge by manufacturers. The costs do though cover the administration cost (i.e. cost of syringes, sharps disposal, shipping, distribution and other related costs of administering the vaccine) for the full 300 million doses.
- 6.1.5.** Antiviral costs relate to the cost of 65.4 million doses as 12.6 million doses have been donated by manufacturers.
- 6.1.6.** Agency Costs included under Category III were calculated by:
 - Estimating the costs to the agency over a one year period of providing technical and operational assistance to countries with the implementation of the various support packages.
 - It should be noted that many agencies are already providing support in a number of these areas – though the scale of support identified during the UNIP process is clearly significantly larger than ‘business as usual’ and hence additional financial resources are required to ensure that support can be scaled up and sustained over a one year period.

6.2. Estimated Resource Requirements to Respond the Priorities Identified through UNIP Responding Countries

CATEGORY I: ESSENTIAL MEDICINES AND VACCINES	Cost in USD (‘000)
A. Increased access to antivirals to treat severe illness	525,000*
B. Increased access to essential antibiotics	15,000
C. Increased access to pandemic vaccines for health care workers and other essential service personnel**	600,000
SUB TOTAL: Category 1	1,140,000
CATEGORY II: STRENGTHENING COUNTRY READINESS	Cost in USD (‘000)
A. Strengthening Health Care Response	79,520
A.1 Support for health care planning, including operational plan for vaccination campaigns and post-marketing surveillance	12,400
A.2 Training of health care workers in case management and infection control	52,000
A.3 Increased supply of essential pandemic related commodities to support infection control	15,120
B. Strengthening Communications for Pandemic Influenza	58,500
B.1 Technical assistance with strengthening of operational communications	7,900
B.2 Technical assistance with strengthening communications through the media and spokespeople	8,800
B.3 Effective planning for communications for behaviour change at community level	11,400
B.4 Assistance with the production and dissemination of communications and related materials to support community based behaviour change	30,400
C. Strengthening Whole of Society and Humanitarian Readiness	58,400
C.1 Assistance with rapid assessment of vulnerabilities and technical assistance with urgent planning	23,200
C.2 Specific assistance for LDCs in receipt of humanitarian assistance to assess, plan and reduce sector vulnerabilities.	35,200
D. Strengthening Situation Assessment and Appropriate Use of Public Health Interventions	16,000
D.1 Training of Public Health Workers in Pandemic Related Surveillance	14,600

D.2 Technical assistance to adapt and develop support tools to guide decision making on the use of community level public health interventions	1,400
E. Strengthening of Influenza Laboratory Capacity	25,378
E.1 Country Laboratory Support	22,265
E.2 Enhancing Regional Laboratory Self-Sufficiency	3,113
F. Access to Additional Antivirals and Pandemic Vaccine***	tbc
F.1 Additional antivirals	tbc
F.2 Additional vaccines	tbc
G. Regional Knowledge Sharing and Networking	3,000
H. Ensuring Flexibility – Contingency Fund	19,702
SUB-TOTAL: Category 2	260,500
CATEGORY III: AGENCY SUPPORT COSTS	Cost in USD ('000)
Agency-related support and costs	79,500
SUB-TOTAL: Category 3	79,500
TOTAL COST	1,480,000

* The funding for antivirals will be spread over a three year period for antivirals that will be delivered in the first year, under an agreement between Roche and WHO. This means that the total funds required for disbursement in year 1 will be \$415m less than stated here, ie a total of \$1,065m

** To provide sufficient vaccine for 5 to 10% of the population to protect health care workers and other essential service personnel

*** Individual countries may wish to procure **additional** vaccines and antivirals for high risk groups such as pregnant women, children and people with chronic conditions

Agency Related Support and Costs

Agency	Key areas where support with the implementation of programme would be provided	Amount requested (USD)	How this relates to other funding requests
WHO	<p>Category 1:</p> <ul style="list-style-type: none"> WHO would provide support to all three areas of assistance under this category <p>Category 2:</p> <ul style="list-style-type: none"> WHO would play a lead role in providing support for the implementation of activities under A, B1 and B2, D, E and if required F, and G. WHO would work in conjunction with other agencies in the implementation of B3 and B4 as required 	<p>45 million</p>	<p>At the beginning of the Influenza A (H1N1) pandemic in 2009, WHO requested 127 million to be able to respond to the H1N1 Pandemic. This request was detailed in the WHO Influenza A (H1N1) Global Pandemic Response Plan. This has not yet been fully funded and a large funding gap remains.</p> <p>The 45 million requested here is part of the 127 million requested in the Global Pandemic Response Plan and is required to specifically support the implementation of this programme.</p>
UNICEF	<p>Category 1:</p> <ul style="list-style-type: none"> UNICEF would provide support to the administration of vaccine in-country with the operational plan developed by government and WHO <p>Category 2:</p> <ul style="list-style-type: none"> UNICEF would be the lead agency to provide support on B3 and B4, using technical guidance developed by WHO UNICEF would work with WHO to provide assistance with A.2, particularly at community level UNICEF would work in combination with a range of agencies to assist with 	<p>15 million</p>	<p>Under the Consolidated Action Plan that was agreed to before the start of the Influenza A (H1N1) pandemic, UNICEF estimated that it required 23.2 million dollars to support global pandemic preparedness and avian influenza response during 2009.</p> <p>The 15 million USD requested to support UNIP activities is part of this larger request which at present is not fully funded.</p>

	<p>strengthening of business continuity especially in the education sector</p> <ul style="list-style-type: none"> UNICEF could assist countries with procurement and administration of additional vaccine under F if required/production and resources allow 		
WFP	<p>Category 1:</p> <ul style="list-style-type: none"> WFP, in line with its mandate and as the lead agency of the global Logistics Cluster, could assist with in-country logistics support for deployment and distribution of essential pharmaceuticals <p>Category 2:</p> <ul style="list-style-type: none"> WFP would play a major role in providing assistance with business continuity planning and related training especially with regards to transport and food, and provide input to interagency response to address A.1, C.1, C.2 and D.1. 	10 million	<p>Under the Consolidated Action Plan, WFP estimated that 37.5 million dollars was required to complete a range of logistics, programme, and operational continuity activities for its global pandemic preparedness programme.</p> <p>The 10 million USD requested to specifically support UNIP activities is part of this larger request which at present is not fully funded.</p>
OCHA(PIC) and UNFPA	<p>PIC/OCHA team would provide additional support as needed to Category C (whole of society, multi-sectoral and humanitarian readiness) and UNFPA would provide support in areas related to humanitarian response capacity and reproductive health.</p>	-	<p>4.1 million was requested by OCHA under the Consolidated Action Plan.</p> <p>However it is felt by OCHA and UNFPA that their support to countries to implement the activities outlined in this programme could be accommodated in the funds already requested in the UNIP under country needs and no additional agency support funds are sought at this stage</p>

<p>UNSIIC and OCHA(PIC)</p>	<p>UNSIIC and PIC/OCHA would be responsible for monitoring the implementation of this programme and providing 4 monthly reports on progress. A small amount of funding is requested to support this monitoring and reporting activity</p>	<p>0.5 million</p>	<p>These funds are in addition to the fund requested in the Consolidated Action Plan</p>
<p>IOM and ILO</p>	<p>In conjunction with other agencies, support with Category 2: C. ILO can play a role to train trainers for multi-sectoral business continuity planning.</p>	<p>1.0 million</p>	<p>0.16 and 2.31 million were sought by ILO and IOM respectively under the Consolidated Plan. The 1 million USD requested to support UNIP activities is part of this larger request which at present is not fully funded.</p>
<p>FAO and OIE</p>	<p>It is recognized that influenza A (H1N1) is primarily a human disease and that the focus on the response should on human health and societal resilience. However in view of the need to continually monitor the situation and to ensure adequate vigilance for possible reassortment of the virus, increased attention is needed for surveillance in animals and hence a small amount of money is requested by FAO and OIE to ensure that regional animal surveillance programmes can meet the increase in demand</p>	<p>3 million</p>	<p>Under the Consolidated Action Plan, FAO and OIE estimated that 50.1 million dollars was required during 2009 to support avian influenza programmes and assist with pandemic preparedness. The 3 million USD requested here is to support regional animal surveillance programmes so as to ensure an adequate level of vigilance for possible reassortment or changes in the behaviour of the virus in animals. This 3 million USD is part of the larger request which at present is not fully funded. It is recognized that particularly if there is any change in the behaviour of this virus in animals, additional funding may be urgently required.</p>

IFRC	To support community-based response programmes, aligned with national plans, including support for mass vaccination campaigns	3.5 million	This represents that part of IFRC's existing plan and budget for the next 12 months that is directly relevant to implementation of the UNIP interventions and is currently unfunded.
UNHCR	To support refugee and other displaced populations on surveillance, trainings and programmatic response.	1.5 million	UNHCR's existing plan and budget for the next 12 months is currently underfunded by \$3m. The \$1.5m represents that amount that is required to directly support the priority areas of intervention requested by the 61 target countries.

6.3. Total Costs

Category	Aim	Cost in USD ('000)
I	Meet the urgent needs for essential medicines to treat severe cases and vaccine to protect essential service personnel	1,140,000
II	Meet the urgent needs to strengthen country readiness	262,500
III	Costs of agencies to support implementation of the programme	77,500
TOTAL		1,480,000

Resource Mobilization

6.4. Fund Management

6.4.1. Category 1:

- WHO will manage allocation for the 300 million doses of vaccines expected to be available for developing countries and any additional vaccines donated by governments through WHO
- UNOPS will manage, on behalf of WHO, the funds, procurement and delivery to countries of vaccines for priority countries outside of the PAHO region
- For vaccines for priority countries in the PAHO region, the PAHO Revolving Fund for Vaccines will be utilized to manage pooled funding and distribution.
- For vaccines supplied beyond the 10% population coverage, countries could place their own orders, using their own or donor resources provided through several mechanisms, including the World Bank AHIF and the UNDP CFIA.
- Pooled financing is not required for procurement and allocation of antibiotics and antivirals.

6.4.2. Category II and III:

- Rather than proposing the establishment of a single vertical fund to finance the activities described in this report, a coordinated financing framework which recognizes a variety of funding mechanisms is proposed. This will also facilitate the funding of activities at various levels (country, regional and global). The coordination and tracking of donor spending are essential to such an approach.

As such, funding could be provided through:

Bilateral Support to Governments, where donor governments or development banks provide direct bilateral assistance, either through changes to existing agreements or through the provision of new arrangements.

Bilateral Support to UN Agencies, International Organizations and NGOs, where donor governments or development banks provide support to UN agencies, international organizations and NGOs for specific programs.

WHO Public Health Emergency Fund, the primary purpose of this fund is to enable WHO to directly respond to and mitigate the current outbreak situation in accordance with the WHO Pandemic Influenza A/H1N1 response plan.

Pooled Support to UN Agencies through the multi-donor Central Fund for Influenza Action, which enables donors to pool their resources and support under-funded priority activities within the strategic framework of the Consolidated Action Plan for Avian and Human Influenza, whose objectives include Human Health, Communication, Public Information and Supporting Behaviour Change, and Continuity under Pandemic Conditions.

Pooled Grant Support to Governments through the World Bank's Avian and Human Influenza (AHI) Facility and the World Bank's Global Program for Avian Influenza Control and Human Pandemic Preparedness and Response (GPAI). The grant-based AHI assists countries in implementing integrated country programs to minimize the risk and socioeconomic impacts of pandemic influenza. The loan-based GPAI helps countries finance emergency operations to prevent and control outbreaks of Influenza A(H1N1).

6.5. Mobilization and Coordination of Technical Assistance

- 6.5.1.** A significant part of the needs requested in the UNIP process involves the supply of vaccines, antivirals and antibiotics. But much of the rest of what LDC and GAVI countries have asked for constitutes technical assistance.
- 6.5.2.** There are a variety of ways in which technical assistance will be provided. Some of what has been requested can be and is being supplied immediately without the requirement for additional financial resources, using the staff of UN, Red Cross/Crescent and partner agencies to provide advice to countries, virtually or face-to-face. In some cases, donor governments will wish to provide direct support to developing countries and the technical assistance will be contracted directly by the donor. NGOs and Red Cross/Red Crescent National Societies will have an important role to play in the provision of technical assistance at the community level. A number of UN and partner agencies already have systems for recruiting and deploying technical assistance in their areas of specialist expertise. Relevant partner agencies at regional and country level are being asked to identify and contact relevant consultants in advance, so that we are in a position to rapidly activate as much technical assistance as possible if and when the finance becomes available.

6.6. Tracking and Monitoring

6.6.1. UNSIC, the Pandemic Influenza Coordination (PIC) team in OCHA and WHO will establish systems to track and monitor the support provided to the LDC and GAVI countries under the auspices of the UNIP process. The tracking and monitoring will take place at two levels (i) monitoring of commitment and disbursement of the funds requested, on a country, thematic and donor basis (ii) monitoring of the outcomes in terms of increased readiness of the LDC and GAVI countries. UNSIC and PIC, in close collaboration with WHO, will deploy personnel to establish and run the tracking and monitoring process. Building on the existing PIC/OCHA readiness tracker system, we will record all the data provided by the 61 countries during the UNIP assessment process to establish a baseline against which to monitor progress. This data covers the level of readiness across five broad themes: (i) overall management of the response (ii) whole of society multi-sector planning (iii) effective communications (iv) reducing transmission (v) health sector response. Every 4 months, UN and WHO country teams will be asked to work with Governments to update the UNIP data on the state of readiness based on the expected results listed in Annex B. This will enable UNSIC, PIC and WHO to assess what progress is being made, to identify the most urgent remaining gaps where additional effort is required, and to report to donors on what is being achieved with their investments.

Annexes

Annex A: Countries Invited to Complete a UNIP Survey

Part (i) - Countries invited to complete UNIP survey and eligible for support under this programme

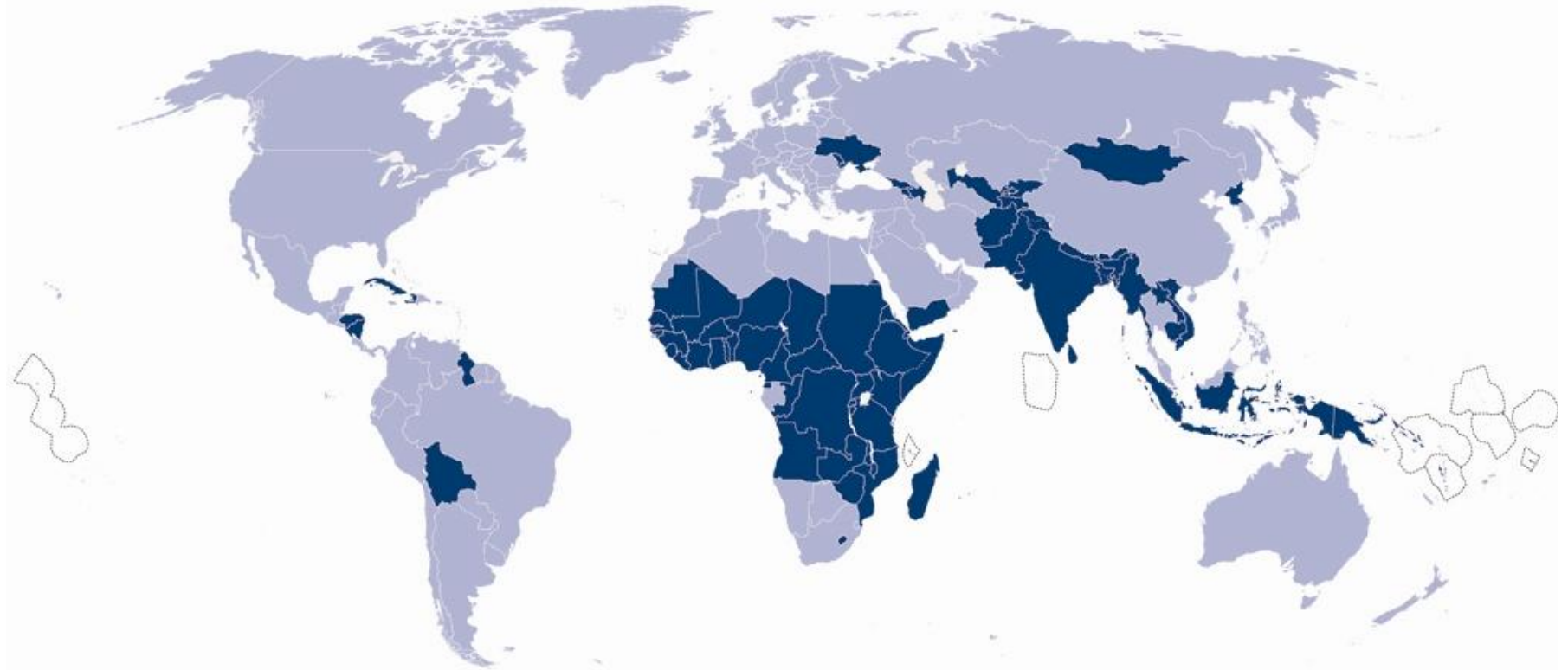
Invited to complete UNIP survey	GAVI-eligible	LDC	IDA	Countries who completed UNIP returns
<i>LATIN AMERICA/CARIBBEAN</i>				
Bolivia	Yes			Yes
Cuba	Yes			
Guyana	Yes		Yes	
Haiti	Yes	Yes	Yes	Yes
Honduras	Yes		Yes	Yes
Nicaragua	Yes		Yes	
<i>ASIA/PACIFIC</i>				
Bangladesh	Yes	Yes	Yes	Yes
Bhutan	Yes	Yes	Yes	Yes
Cambodia	Yes	Yes	Yes	Yes
DPRK	Yes			Yes
India	Yes			
Indonesia	Yes			Yes
Kiribati	Yes	Yes	Yes	Yes
Lao PDR	Yes	Yes	Yes	Yes
Maldives		Yes	Yes	Yes
Mongolia	Yes		Yes	Yes
Myanmar	Yes	Yes	Yes	Yes
Nepal	Yes	Yes	Yes	Yes
Pakistan	Yes			Yes
Papua New Guinea	Yes			Yes
Samoa		Yes	Yes	
Solomon Islands	Yes	Yes	Yes	Yes
Sri Lanka	Yes		Yes	Yes
Timor-Leste	Yes	Yes	Yes	Yes
Tuvalu		Yes		
Vanuatu		Yes	Yes	Yes
Vietnam	Yes		Yes	Yes
<i>CENTRAL/EAST AFRICA</i>				
Burundi	Yes	Yes	Yes	Yes
Cameroon	Yes		Yes	Yes
Central African Republic	Yes	Yes	Yes	Yes
Chad	Yes	Yes	Yes	
Congo Republic	Yes		Yes	Yes
Djibouti	Yes	Yes	Yes	Yes
Equatorial Guinea		Yes		
Eritrea	Yes	Yes	Yes	Yes

Ethiopia	Yes	Yes	Yes	Yes
Kenya	Yes		Yes	
Rwanda	Yes	Yes	Yes	Yes
Sao Tome and Principe	Yes	Yes	Yes	
Somalia	Yes	Yes	Yes	
Sudan	Yes	Yes	Yes	Yes
Uganda	Yes	Yes	Yes	Yes
United Republic of Tanzania	Yes	Yes	Yes	Yes
CENTRAL ASIA/EAST EUROPE				
Armenia	Yes			Yes
Azerbaijan	Yes			Yes
Georgia	Yes			Yes
Kyrgyzstan	Yes		Yes	Yes
Moldova	Yes		Yes	
Tajikistan	Yes		Yes	
Ukraine	Yes			
Uzbekistan	Yes			Yes
MIDDLE EAST/NORTH AFRICA				
Afghanistan	Yes	Yes	Yes	Yes
Yemen	Yes	Yes	Yes	Yes
SOUTHERN AFRICA				
Angola	Yes	Yes	Yes	Yes
Comoros	Yes	Yes	Yes	Yes
Democratic Republic of the Congo	Yes	Yes	Yes	Yes
Lesotho	Yes	Yes	Yes	Yes
Madagascar	Yes	Yes	Yes	Yes
Malawi	Yes	Yes	Yes	Yes
Mozambique	Yes	Yes	Yes	Yes
Zambia	Yes	Yes	Yes	Yes
Zimbabwe	Yes			Yes
WEST AFRICA				
Benin	Yes	Yes	Yes	Yes
Burkina Faso	Yes	Yes	Yes	Yes
Cote d'Ivoire	Yes		Yes	Yes
Gambia	Yes	Yes	Yes	Yes
Ghana	Yes		Yes	
Guinea	Yes	Yes	Yes	Yes
Guinea-Bissau	Yes	Yes	Yes	Yes
Liberia	Yes	Yes	Yes	
Mali	Yes	Yes	Yes	Yes
Mauritania	Yes	Yes	Yes	Yes
Niger	Yes	Yes	Yes	Yes
Nigeria	Yes		Yes	Yes
Senegal	Yes	Yes	Yes	Yes
Sierra Leone	Yes	Yes	Yes	Yes
Togo	Yes	Yes	Yes	Yes

The following non-LDC, non-GAVI countries also voluntarily submitted an unsolicited UNIP needs analysis: Botswana, Colombia, Iran, Kosovo, Libya, Paraguay.

**Part (ii) – World map with the countries invited to complete UNIP survey
H1N1 INFLUENZA**

Countries included in the UNIP process



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties.

Created by UN OCHA VMU, 16 September 2009

ANNEX B: EXPECTED RESULTS

Note that all targets have been set assuming that this programme will be fully funded.

CATEGORY I

AIM: TO MEET THE URGENT NEEDS FOR ESSENTIAL MEDICINES TO TREAT SEVERE CASES AND VACCINE TO PROTECT HEALTH CARE WORKERS AND OTHER ESSENTIAL SERVICE PERSONNEL

Implementation of support packages under each objective	Expected Contribution to Overarching Goals (see 1.2.2)			Target(s)	Monitoring
	1. Reduced excess mortality	2. Increased societal resilience	3. Enhanced ongoing capacity building for health security		
A: Increased access to pandemic influenza (H1N1) antivirals	Current evidence indicates that antivirals, if used early in the course of illness, will have a positive impact on both mortality and reducing complications	A reduction in both morbidity and mortality would reduce absenteeism and help to limit the social and economic impact	Provision of antivirals and antibiotics will be supported by, where needed, assistance with health care worker training on early diagnosis and treatment of respiratory diseases. This is likely to have longer and sustained benefits both in terms of early detection of unusual respiratory events and effective treatment of common respiratory illnesses.	Countries covered by the UNIP process to have received sufficient quantities of antivirals to cover 2% of population by 6 months and 3% by 12 months	Report from WHO Country Office

<p>B: Increased access to essential, pandemic influenza (H1N1) related antibiotics</p>	<p>There is substantial evidence that early treatment of bacterial related complications will have significant positive impact on mortality and reducing complications</p>	<p>A reduction in both morbidity and mortality would reduce absenteeism and help to limit the social and economic impact</p>		<p>Countries covered by the UNIP process to have sufficient quantities of antibiotics to cover 1% of population by 6 months and 1.5% by 12 months</p>	<p>Report from WHO Country Office</p>
<p>C: Increased access to pandemic influenza (H1N1) vaccines to protect essential service personnel</p>	<p>The objective of vaccinating health care workers and other essential service personnel is to ensure continuity of services. Focusing on this group is likely to have only a limited <i>direct</i> impact on mortality. However in maintaining continuity of services, there is likely to be substantial <i>indirect</i>, positive impact on morbidity and mortality</p>	<p>Clinical trial results are not yet available but it is likely that vaccination would reduce infection rates in essential workers and hence reduce absenteeism rates</p>	<p>Supply of pandemic influenza vaccines will, where appropriate, be linked to medium and long term programmes to increase awareness of the effectiveness of seasonal influenza vaccine and programmes to support influenza vaccine production in developing countries</p>	<p>Countries covered by the process to have received sufficient quantities of vaccine to cover at least 2% of population by 6 months and 5% by 12 months</p>	<p>Report from WHO Country Office</p>

CATEGORY II

AIM: TO MEET THE URGENT NEEDS TO STRENGTHEN COUNTRY READINESS

Implementation of support packages under each objective	Expected Contribution to Overarching Goals (see 1.2.2)			Target(s)	Monitoring
	1. Reduced excess mortality	2. Increased societal resilience	3. Enhanced ongoing capacity building for health security		
A: Strengthened health system response to pandemic influenza (H1N1), including operational planning for mass vaccination campaign	Effective health care planning will assist with surge management and strengthen the system's ability to continue to maintain essential non influenza services. Both surge management and business continuity for non influenza services will assist in reducing otherwise avoidable deaths.	A functioning health care system is vital for social stability. Health service planning can also assist other sectors in understanding inter-dependencies and in prioritization and planning. Effective planning is also needed to deliver vaccine to health care workers and other essential workers.	Planning to meet a sudden surge in demand is extremely important for coping with any sudden health shock. It is likely that this urgent work will result in longer term benefits that would be applicable across a range of contingencies	80% of countries requesting assistance in this area to have fully operational health care plan in place by 6 months, 100% by 12 months. All countries to have fully operational pandemic vaccination plan in place by 3 months.	Self reporting surveys
B: Strengthened communications for pandemic influenza (H1N1)	Effective communications about the risks, how to protect yourself and your community and	Effective communications about the risks, resource allocations and addressing stigma	Effective communications are needed for any health shock or emergency. Capacity building in real time and during a crisis is	All countries requesting this assistance to have fully operational communications plan in place by 6 months.	Report from Agency Country Office

	when to seek medical care will be important in ensuring adequate response and in helping to reduce mortality	are vital for social stability	likely to lead to long term strengthening of communications capacity and a 'reusable' system	In all countries requesting assistance, 80% of target population to have received key messages by 6 months.	UNICEF Monitoring and Evaluation plan
C: Strengthened whole of society and humanitarian readiness	<p>Lack of functioning in any critical sector is likely to lead to an increase in excess mortality, socioeconomic damage and potential humanitarian consequences. Effective planning and rapid implementation of contingency measures will reduce the risk of this occurring.</p> <p>Strengthening the readiness of humanitarian actors to deliver humanitarian assistance (should H1N1 escalate to the point where it gives rise to additional humanitarian needs) will enable humanitarian actors to minimise mortality and morbidity.</p>	<p>Capacity building in this area will lead to improvements over the long term in preparedness and response to any sudden shock to a country.</p> <p>Strengthening humanitarian planning will boost the capacity of governments, agencies and partners to tackle a range of possible future emergencies</p>	<p>All countries requesting assistance will have performed multi-sector vulnerability assessment within 3 months</p> <p>All countries requesting assistance will have developed plans to ensure continuity of service in the highest priority/most vulnerable sectors by 6 months</p> <p>Humanitarian needs occasioned by H1N1 effectively addressed</p>	<p>PIC/OCHA tracker</p> <p>OCHA reporting</p>	

<p>D: Strengthened situation assessment and public health decision making</p>	<p>Situation monitoring, if linked to decision making, assists in the early detection of events to ensure that the most appropriate interventions to reduce mortality can be effectively implemented.</p>	<p>Situation monitoring, if linked to decision making, assists in the early detection of events to ensure that the most appropriate interventions to increase societal resilience can be effectively implemented</p>	<p>Capacity building in this area is likely to result in increased ability to detect and respond quickly to events of potential public health concern in the future</p>	<p>All countries requesting assistance to have a functioning system to collect and report critical information by 6 months</p> <p>All countries requesting assistance to have adapted and disseminated decision support tools for public health interventions by 6 months</p>	<p>Self reporting surveys</p>
<p>E: Strengthened influenza laboratory capacity</p>	<p>Rapid detection and accurate diagnosis of unusual events, such as development of antiviral resistance and viral evolution, assists with rapid response and more effective implementation of interventions that could reduce mortality.</p> <p>Biosafety is critical to reduce risks to laboratory workers and prevent laboratory associated transmissions</p>	<p>Indirect impact through improved response and providing information for communications</p>	<p>Capacity building in this area will lead to increased ability to detect a range of organisms that use similar techniques to those used for influenza detection.</p> <p>As the same biosafety procedures are used for a very large range of organisms, capacity building in this area will lead to improved standards for all laboratory services</p>	<p>All countries requesting assistance to have moved one step on the WHO influenza capacity scale within 12 months</p> <p>Regional laboratories able to continue to provide their national and regional activities despite surge in demand</p> <p>All countries requesting assistance to have reached minimum biosafety standards within 6 months</p>	<p>WHO Laboratory Group Monitoring and Evaluation plan</p>

CATEGORY III

AIM: TO MEET THE URGENT NEEDS OF AGENCIES TO PROVIDE SUPPORT TO COUNTRIES IN IMPLEMENTING THE PROGRAMME

A: Effective assistance provided to countries to implement the support packages to address the priority needs identified through the UNIP process	Agencies receiving funds would be required to set specific targets related to the use of those funds. Progress towards meeting these targets would be included in the four monthly activity report produced by PIC/UNSIC
B: Effective tracking and monitoring of activities, finances and outcomes	4 monthly report on activities, finances and outcomes produced by PIC/UNSIC