

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

Four monthly update on resources mobilized and activities undertaken by WHO, UN System and IFRC to support the least resourced countries in strengthening readiness and response to the H1N1 Influenza Pandemic

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FINAL



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

Introduction

Approximately one year ago, on 11 June 2009, WHO declared the first influenza pandemic in over 40 years due to the rapid spread of a novel influenza virus, influenza A (H1N1) 2009. As of 30 May 2010, the virus was reported to be affecting populations in more than 198 countries and territories.

From the outset of the pandemic it was feared that the people in the least resourced countries would be most affected because of the higher prevalence of risk factors, including limited capacities of their health systems and their relative difficulty to access recommended vaccines and antiviral medicines. In light of these concerns, in July 2009, the United Nations System and partners sought to identify and highlight the priority needs of developing countries to support their response to the A(H1N1) influenza pandemic. An “Urgent Needs Identification and Prioritization” (UNIP) process was undertaken and 64 Least Developed Countries and other “GAVI-eligible” developing countries – referred to as the Least Resourced Countries (LRC’s) in this paper – elected to participate in the process. The conclusions of the UNIP process were presented in a September 2009 report entitled “Urgent Support for Developing Countries’ Responses to the H1N1 Influenza Pandemic¹”. This report highlighted USD 1.48 billion in priority needs for medicines, vaccine and supplies, laboratory and surveillance services, communications capacity, investing in pandemic readiness, and needs of entities responsible for supporting regional and international cooperation.

The UN System committed to report on progress made towards addressing the gaps identified through the UNIP process on a regular basis. The first report highlighted the progress that had been made by 1 February 2010², and this next report provides a further update on progress during the reporting period 1 February 2010 to 1 June 2010 on:

- Resources that have been mobilized to assist least resourced countries in meeting the priority, urgent needs that were identified and highlighted during the UNIP process (Section 1)
- Activities undertaken by WHO, UN System and IFRC to assist least resourced countries in meeting the priority, urgent needs to strengthen their readiness and response to pandemic H1N1 (Section 2)

In consolidating this report, it was recognized that a four month reporting period was a somewhat short period in which to show substantial progress in such activities, particularly as the availability of new resources to undertake such activities has declined. Consequently, it has been agreed that the next UNIP report will be produced in June 2011, enabling a consolidated report on the work being done over the course of the next twelve months.

¹ The September 2009 report is available at [http://www.undg.org/docs/10592/UNIP_REPORT_18_\(final\).pdf](http://www.undg.org/docs/10592/UNIP_REPORT_18_(final).pdf)

² The March 2010 UNIP report is available at <http://un-influenza.org/files/FinalUNIPReportMarch2010.pdf>

Section 1: Update on Resources Mobilized to Support Meeting the Urgent Needs of the Least Resourced Countries Identified Through the UNIP Process

1.1 Overview

As noted in the previous report, a flexible financing framework was proposed as the best means of providing financial support to least resourced countries in response to the pandemic. As such, funding to assist least developed countries could be provided through (and is reported according to) five different mechanisms:

- **WHO Public Health Emergency Fund**, which enables WHO to directly respond to and mitigate the current outbreak situation in accordance with the WHO Pandemic Influenza A/H1N1 response plan.
- **Multilateral 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.
- **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.
- **Pooled Support to UN Agencies through the multi-donor Central Fund for Influenza Action (CFIA)**, 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 Facility (AHIF) and the World Bank's Global Program for Avian Influenza Control and Human Pandemic Preparedness and Response (GPAI)**. The grant-based AHIF 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 pandemic H1N1.

Section 1 of this report provides the most up-to-date information on financial contributions and in-kind donations of pharmaceuticals and consumables that have been made to help meet the urgent needs of the least resourced countries through the flexible financing mechanism.

1.2 WHO Public Health Emergency Fund

This fund received in total \$137,126,601 since the beginning of the pandemic, including contributions to WHO country and regional offices, with \$15,353,535 having been contributed since the last report. A description of the activities that have been supported through this funding is given in Section 2³.

³ This information is based on information provided by WHO through their financial accounting system. For further details, please contact Ludy Suryantoro at WHO Headquarters in Geneva.

	Reporting period (1 February to 1 June 2010)	Cumulative (Since the onset of the pandemic)
Total funding raised by WHO for global response plan ⁴	11,154,401	84,927,467
Total funding raised by WHO for vaccines deployment global operations	4,199,134	52,199,134
Grand Total Funding raised by WHO for both global response and vaccines deployment	15,353,535	137,126,601

1.3 Bilateral Support to UN Agencies, International Organizations and NGOs

With the exception of WHO (see Section 1.2) and funds received through the CFIA (see Section 1.5), there were no new contributions for UN agencies or the IFRC specifically for pandemic H1N1 activities during the reporting period.

1.4 Bilateral Support to Governments of UNIP Countries

Details of bilateral support to least resourced countries to support urgent needs in relation to pandemic H1N1 have been collated from information inputted directly by donors onto the web based Financial Tracking System (FTS) that is run by OCHA⁵ and from a poll of major donors conducted by the World Bank in January 2010. It should be noted that although many donors use the FTS, it is unlikely to have captured all bilateral financial contributions or all of the in-kind donations of consumables or technical assistance.

There were no new funds to support urgent needs reported by donors on FTS during the reporting period. All of the contributions displayed in Table 2 were received by governments before 1 February 2010. The table was reprinted to capture recent entries of past donations into FTS.

Recipient country	Donor	Total amount in USD since onset of the pandemic
Ukraine	Austria, Estonia, Greece, Israel, Latvia, Lithuania, Switzerland	622,953
Lao PDR	Asian Development Bank	250,000
Mongolia	Asian Development Bank	350,000
Recipient countries to be determined but likely majority will be least resourced countries	Germany	17,300,000
Variety of Pacific Island Countries	Australia and USA via the	376,516

⁴ A proportion of this money has been used to support countries that did not participate in the Urgent Needs Identification and Prioritization process. However, it is understood that the majority of these funds will have provided either direct or indirect support to least resourced countries. For further details please contact WHO.

⁵ The FTS is a database which records all reported international humanitarian aid (including that for NGOs and the Red Cross / Red Crescent Movement, bilateral aid, in-kind aid, and private donations). All FTS data are provided by donors or recipient organisations. URL: <http://www.reliefweb.int/fts>

⁶ Some original pledges were made in other currencies than USD. The figures in this table were calculated using a 3 month average exchange rate for the period of 1 October – 31 December 2009 provided by the World Bank.

⁷ Information from Ukraine is from OCHA's Financial Tracking System (FTS). Information on the USA's donations obtained from the United States Department of State. All other information is from the World Bank's Donor Polling January 2010.

	Secretariat of the Pacific Community	
Bangladesh	UK	410,000
Afghanistan	USA	166,239
Cote D'Ivoire	USA	350,000
India	USA	1,376,834
Indonesia	USA	416,227
Kenya	USA	2,350,000
Senegal	USA	298,294
Tanzania	USA	740,000
Vietnam	USA	175,000
Countries in the Southern Hemisphere	USA	4,000,000
Afghanistan	Canada	In-kind donation of consumable, non-vaccine supplies
Additional bilateral support to multiple countries via: - TEPHINET - US CDC International Support Programme	USA	500,539 590,000

1.5 Pooled Support to UN Agencies through the multi-donor Central Fund for Influenza Action (CFIA)

Since September 2009, the CFIA has received contributions from United States Agency for International Development (USAID), United Kingdom Department for International Development (DFID) and the Government of Spain (as reflected in Table 3).

Donors	USD (in millions)
DFID	9.8
Spain	0.6
USAID	6.0
TOTAL	16.4

(a) Overall Agency Projects

As described in the March 2010 UNIP report, as of the end of January 2010 the CFIA had allocated approximately USD 6.2 million in funding to eight UN organizations to support least resourced countries in responding to the urgent pandemic-related response and readiness. Some of these projects, such as UNWTO's project for targeted communications for travelers and the travel industry, commenced after 1 February 2010. During the current reporting period, additional funding was provided by the DFID which, subject to the final approval of the CFIA project board, is likely to provide financial assistance amounting to USD 6.8 million for UNICEF to support communications needs identified in the September 2009 UNIP report.

(b) Small Grant Fund

The Pandemic Influenza Coordination team in OCHA manages a small project fund established within the CFIA, which enables UN Resident Coordinators to support multi-sectoral pandemic preparedness and business continuity planning processes. In addition to the USD 1.1 million previously contributed by USAID and DFID (and which was reflected in the March 2010 UNIP report), in May 2010 DFID provided an additional USD 2.2 million in support of this fund, enabling an additional 17 projects to be undertaken in 17 countries. Table 4 includes a list of all projects supporting pandemic H1N1 readiness and response.

Table 4: Central Fund for Influenza Action (CFIA) - Small Project Funding Facility for UN Resident Coordinators⁸ (USD)		
Country	Funds Received as of 1 Feb 2010	During Reporting Period (1 Feb - 1 June 2010)
Bolivia	22,800	
Ghana	100,000	
Guinea-Bissau	100,000	
Indonesia	96,900	
Madagascar	75,000	
Nepal	129,000	
Vietnam	64,200	
Bhutan		130,000
Lao PDR		126,260
Myanmar		130,000
Sri Lanka		119,840
Sudan		130,000
Uganda		130,000
Nicaragua		130,000
Madagascar		119,840
Mozambique		130,000
Benin		129,470
Côte d'Ivoire		130,000
Senegal		129,306
Gambia		130,000
Yemen		126,000
Lesotho		130,000
Honduras		130,000
Niger		120,000

1.6 Pooled Grant Support to Governments through the World Bank's Avian and Human Influenza Facility (AHIF) and the World Bank's Global Program for Avian Influenza Control and Human Pandemic Preparedness and Response (GPAI)

No new money specifically for H1N1 readiness and response was donated to the World Bank-administered trust funds, including notably the AHIF.

1.7 In-kind donations – consumables, equipment and technical assistance

In addition to financial contributions, to date WHO has received 127.4 million doses of H1N1 vaccine (see Table 5) to support least resourced countries.

⁸ Information provided by CFIA. Proportional spend on H1N1-specific activities estimated by OCHA-PIC.

Table 5: In-kind vaccine donations to WHO (in millions of doses)		
Donors	Pledged as of 1 Feb 2010	Pledged During Reporting Period
Australia	2.1	
Belgium	1.26	
Canada	5.0	
CSL	3.0	
France	9.4	
GSK	60.0	
Italy		2.4
MedImmune	3.0	
Norway	0.94	
Sanofi Pasteur	20.0	
Switzerland		1.5
UK		3.8
USA	15.0	
TOTAL	119.7	7.7

In addition to the vaccines, WHO also received in-kind contributions of 45 million syringes and 0.5 million safety boxes from the United States, and 25 million syringes from AmeriCares. The in-kind donations of both vaccines and ancillary products combined amount to USD 335,671,912. Additionally, as noted in the March 2010 report, WHO received from Roche an in-kind donation of antivirals valued at USD 84 million in the previous reporting period.

Section 2: WHO, UN System and IFRC Activities to Support the Least Resourced Countries in Meeting the Urgent, Priority Needs Identified through the UNIP Process

2.1 Overview

The September 2009 “Urgent Support for Developing Countries’ Responses to the H1N1 Influenza Pandemic” report identified nine areas where participating countries were seeking support to enable them to strengthen their readiness and response to H1N1 pandemic influenza. These were divided into two main categories of support:

- **Category One: Essential Medicines**
- **Category Two: Strengthening Country Readiness**

Section 2 of this report provides details of the support that WHO, the UN System and IFRC have provided to developing countries to help address these needs⁹. A summary of activities undertaken between 1 February 2010 and 1 June 2010 to address the nine key areas for support are discussed below. As many of the activities undertaken during this reporting period either extend or augment activities undertaken previously, this section should be read in conjunction with the corresponding section in the March 2010 report.

2.2 **Category One: Urgent need for essential medicines to treat severe cases and vaccine to protect health care workers and other essential service personnel**

2.2.1 ***Objective A: Increase access to antivirals to treat severe illness***

Progress since the last report

Growing international experience in treating pandemic (H1N1) 2009 infections indicates the importance of early treatment with antiviral drugs, especially for patients at increased risk of developing complications and those with severe illness. WHO has revised its guidelines for the clinical use of influenza antivirals (WHO Guidelines for Pharmacological Management of Pandemic (H1N1) 2009 Influenza and other Influenza Viruses¹⁰). These revised guidelines have taken into account new data and experience from the management of pandemic (H1N1) 2009 illness during the course of 2009.

In an effort to support regional preparedness and for rapid deployment to countries, WHO established global stockpiles of influenza antivirals and personnel protective equipment. As noted in the March 2010 UNIP Report, since April 2009, WHO has deployed over 4.7 million treatment courses of Oseltamivir to 128 countries worldwide from combined global and regional stockpiles. In this reporting period, there were no new donations of antiviral drugs, and no further distribution of WHO global or regional stockpiles.

2.2.2 ***Objective B: Increase access to essential antibiotics for treatment of patients with bacterial complications***

Progress since the last report

As of 1 June 2010, WHO had not received any specific requests from Member States regarding access to antibiotics in relation to the pandemic of influenza A (H1N1) and hence no antibiotics have been procured or deployed.

⁹ It should be noted that this section should not be seen as a comprehensive summary of all the support that has been provided by bilateral partners, technical institutions, NGO’s or, very importantly, the activities that countries themselves have instigated.

¹⁰ http://www.who.int/csr/resources/publications/swineflu/h1n1_use_antivirals_20090820/en/index.html

2.2.3 Objective C: Increasing access to pandemic influenza H1N1 vaccine for use in protecting health care workers and other essential service personnel

Progress since the last report

To help countries protect people from developing severe disease from pandemic influenza H1N1 infection, **WHO** is coordinating the distribution of donated pandemic influenza vaccine to eligible countries in need for the vaccination of target populations in line with recommendations from the Strategic Advisory Group of Experts (SAGE) on Immunization.

Before countries receive donated vaccines, they were requested to complete three steps: 1) request donated vaccines, 2) sign an agreement accepting the terms and conditions of support, and 3) develop a national vaccine deployment plan. The national deployment plan (NDP) of each country demonstrates that the country has the financial, logistical and technical resources to appropriately distribute and administer the vaccine to the targeted populations. This NDP requirement has proven to be a great challenge for recipient countries due to several capacity constraints. This criteria was one which WHO has been insistent upon, given the vulnerability of the vaccine and the need to ensure that all target populations were reached.

To date, 99 countries have requested vaccine donations and 86 countries have counter-signed the country letter agreement. Sixty-eight NDP's are complete and final, and WHO expects to have more plans submitted in June, especially from African countries.

In total, 56 countries have received vaccine amounting to 37,871,050 doses. Additionally, another 23 countries will be receiving vaccine in June and July, estimated at 39,092,800 doses. All vaccine deliveries are bundled with matching supplies of AD syringes and safety boxes. Additional details on the status of the vaccine deployment (as of 18 June 2010) are provided in Annex A.

In several countries, **UNICEF** has also worked closely with WHO in providing logistics support and communication interventions for the deployment of the H1N1 vaccine. Furthermore, UNICEF collaborated with WHO/H1N1 Communications Team in the development of an integrated communication strategy for distribution of H1N1 vaccine. **WFP** also continues to work with WHO to plan additional logistic assistance to support in-country vaccine distribution in hard to reach areas.

UNHCR continues to work with WHO to ensure that vaccines reach refugee populations, including health care workers who care for refugees and displaced person. UNHCR is also supporting public health authorities to plan vaccination at district levels. In Kenya during the month of May, vaccination programmes were conducted in three refugee camps. In Bangladesh, UNHCR coordinated with the government to conduct vaccination programmes in the Kutupalong and Nayapara refugee camps, including the surrounding undocumented refugees (makeshift camp).



2.3 Category Two: Strengthening Country Readiness

2.3.1 Overview

While funding for Category Two activities has been extremely limited (particularly for 'non-health' activities), a recent donation from DFID to provide countries with assistance to strengthen

country readiness, in addition to other support that has been provided in this area, will help to strengthen H1N1 response and through this benefit day-to-day capacity to manage pneumonia, improve hand hygiene, strengthen every day communications about health issues and strengthen capacity to deal with major emergencies in the future.

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

Many of the least resourced countries requested support to strengthen the health system response to pandemic (H1N1). Three areas for support were requested:

- **A1:** Review and adapt national plans and guidelines for immediate response to pandemic influenza (H1N1) 2009, including operational planning for vaccine campaigns and post-marketing vaccination surveillance
- **A2:** Health care worker training to strengthen case management and infection control
- **A3:** Increased supply of essential pandemic H1N1 commodities to support case management and infection control

Progress since the last report

A1: Health System Planning

In cooperation with **WHO** and other UN partners, as of 31 May 2010, 67 countries have developed operational plans for vaccine campaigns and community mobilization and communication strategies and tools.

A2: Health Care Worker Training

UNICEF continues to support countries to improve preventative and/or curative services for major causes of child death (pneumonia and diarrhea). Examples of this work include a series of table top and simulation exercises for village health volunteers and migrant health volunteers at the regional, provincial and district levels in Thailand to improve life skills and capacity for community risk management of pandemic influenza. Training for Health Service Providers on H1N1 has been effective in Sudan for improving skills and knowledge on management of the major child killers, and the development of tools for Community IMCI Training of Health Workers in the Philippines has resulted in policies for early detection of H1N1 and heightened advocacy for prepositioning essential antibiotics. **UNICEF** conducted training of 90,000 healthcare workers in Bangladesh who were identified as the vaccinators for the H1N1 Vaccination programme received training and was provided with an information card before the vaccination campaign commenced

IOM held refresher training sessions for migrants and civil society representatives in Egypt and facilitated a health promotion and pandemic preparedness for migrants training in Yemen which included representatives from the Ministry of Health, **WHO**, civil society and community leaders.

Activities by **WHO**, **UNHCR**, **UNFPA** and **IFRC** described in the March 2010 UNIP report continue to be implemented.

A3: Increased supply of essential pandemic H1N1 commodities

Activities described in the March 2010 UNIP report continue to be implemented.

2.3 3 Objective B: Strengthening Communications for Pandemic Influenza (H1N1)

Progress since the last report

Further to what was reported in the March 2010 UNIP report, **WHO's** website continues to be a key vehicle for delivering information to a variety of audiences, including technical guidance to health professionals, personal protection measures to individuals, and general information and updates to journalists and the general public. Assessment of need for local and culturally appropriate adaptations of key health messages for communities has been performed, and reinforces the requirement for further action in this crucial area for effective messaging. WHO has also conducted training workshops with Member States in order to enhance their ability to communicate on issues concerning pandemic (H1N1).

Several agencies are working in collaboration with WHO to specifically support least resourced countries in meeting their urgent needs for strengthening communications for pandemic H1N1.

UNICEF has worked closely with governments, UN organizations and other partners to implement communication interventions and develop resources and materials aimed at building resilience among individuals and communities to reduce the spread of the virus and to lessen its impact on children and their families by adopting behaviours and practices to protect themselves from illness and death caused by the Influenza A (H1N1) virus. UNICEF has actively supported the government of India, Bangladesh, Egypt and Malawi in the update of their National communication strategies to include awareness campaigns and lessons learned from the H1N1 response.

UNICEF and WHO are developing an online survey targeting country level staff involved in external communication, behaviour and social change communication, social mobilization related to the Pandemic (H1N1) 2009 response to assess its effectiveness, utilization and recommended improvements.

The UN Avian and Pandemic Influenza Communication resources web-site¹¹, hosted by UNICEF, has been continuously updated to integrate the latest communication strategies, materials, information, and tools developed around the globe to respond to the Pandemic (H1N1) 2009. The site provides guidance, ready-made prototypes and materials produced by countries, to assist governments to respond to outbreaks of pandemic influenza. UNICEF's Regional Office for South Asia also updated CREATE!¹², an online site offering a core set of tools to prepare, plan, implement and monitor behaviour and social change communication initiatives supporting health, hygiene and child protection efforts in emergencies, to produce communication materials to meet the needs of communities affected by Pandemic (H1N1) 2009 in a matter of hours or days. The new materials include suggested behaviours such as those for rehydrating sick persons and pregnant women.

In Nepal, UNICEF continues to be the lead agency in planning and implementing communication activities to prevent and respond to pandemic influenza. UNICEF has conducted planning workshops for pandemic preparedness for the Department of Education at national level and sub-national levels. In Lao PDR, UNICEF provided support to the government's H1N1 vaccine deployment strategy, including support for conducting orientations for media personnel to assist with promotion, proper reporting and monitoring of the vaccine deployment strategy, as well as the development of and printing of a series of flyers and newspaper inserts.

¹¹ <http://www.influenzaresources.org>

¹² <http://www.createforchildren.org>

Box 1 – UNICEF materials created for audiences. Of the materials created by countries posters were the most common, followed by school materials, songs, videos and PSAs. Materials were targeted at children and schoolchildren primarily, followed by communities and the general public. Some materials were also specifically focused towards groups of people, such as those living in rural areas or health workers. Materials produced were in at least 26 languages, and many contained specific H1N1 messages.

Example Materials for H1N1: Hand washing poster and poster for pregnant women.



ILO continues to work in partnership with governments, workers and employers organizations to assist target countries in their efforts to inform, educate and train workers on animal influenza and pandemic human influenza issues linked to the workplace. In Thailand, approximately 385 small and medium-sized enterprises (SMEs) participated in “training of trainers” programmes, designed to ensure sustainability because of a multiplier effect, for influenza prevention and pandemic preparedness. Good practices and lessons learned on influenza prevention and pandemic preparedness were integrated into regular ILO Occupational Safety and Health (OSH) workshops in Singapore in February 2010 and at a National OSH Workshop for Small Enterprises in Vietnam in March 2010. Additionally, during the first months of 2010, ILO completed the translation, printing and distribution of its latest manual, “*Protecting your health and business from animal influenza: action manual for farmers and workers*”. ILO’s training and information materials are currently available in English, French and Spanish, as well as in a variety of regional languages (Thai, Bahasa Indonesia, Laotian, Khmer, Vietnamese, and Malaysian).¹³

IOM conducted a training of trainers on basic counseling and communication skills in Nigeria, bringing together different stakeholders from multiple sectors of government agencies, representatives from FAO, IFRC and the Nigeria Red Cross. In Cambodia, IOM produced banners with key messages on basic hygiene measures and on the spread of influenza-like illnesses to be used in training and awareness raising activities. In Costa Rica and Panama, IOM also produced information, education and communication materials in local languages for indigenous populations.

¹³ http://www.ilo.org/asia/whatwedo/projects/lang--en/WCMS_099390/index.htm
http://www.ilo.org/employment/Whatwedo/Projects/lang--en/WCMS_114981/index.htm

Case study – IOM Training of trainers on basic counselling and communication skills in Abuja, Nigeria

IOM continues to strengthen pandemic preparedness for migrants by providing counselling and communication skills training to migrant service providers, government officials and other national or international stakeholders who might find themselves in a situation where they engage with migrants, mobile populations as well as host communities in the event of a pandemic or any other crisis.

A training of trainers meeting was conducted in Abuja, Nigeria in April 2010. The training brought together different stakeholders, those who were part of the national pandemic preparedness taskforce and those who provide services for migrant and mobile populations in Nigeria. Participants from different government agencies were represented: the Avian Influenza Control Project (Human Health and Animal health), the Federal Ministry of Health, the Ministry of Information and Communication, the Federal Ministry of Women Affairs & Social Development, the National Agency for the Prohibition of Traffic in Persons (NAPTIP), from the Women Trafficking and Child Labour Eradication Foundation (WOTCLEF). Representatives from FAO, IFRC and the Nigerian Red Cross Society also participated in the training. IOM used this opportunity to include staff from other IOM missions in West Africa, including Ghana, Senegal and Sierra Leone, where similar activities will be conducted later on in the year. Participants were encouraged to conduct similar trainings in their organizations as a follow up action to this training. IOM has already received requests for information, education and communication material and support to facilitate trainings for two agencies in Nigeria. These trainings will be scheduled for later this year.



Teaching session during the training of trainers on basic counselling and communication skills, Abuja, Nigeria 2010.

Activities described in the March 2010 UNIP report for other agencies continue to be implemented.

2.3.4 Objective C: Whole of Society and Humanitarian Readiness

C1. Assistance with rapid assessment of vulnerabilities in different sectors and technical assistance with urgent planning to reduce vulnerabilities

Progress since the last report

OCHA's Pandemic Influenza Coordination (PIC) team continued providing direct technical assistance to a number of countries having requested assistance with multi-sectoral pandemic preparedness through the UNIP process. Working with national disaster management authorities and in close collaboration with UN Country Teams, OCHA/PIC has provided support with

simulation exercises, contingency planning workshops, and training events in twenty-seven countries.

As mentioned in section 1.5, to help UNCTs support governments to develop multi-sectoral “whole of society” pandemic preparedness and response interventions, OCHA/PIC is also overseeing the CFIA approved funding of 17 small, high-value projects to support national governments to strengthen the multi-sectoral pandemic preparedness and response processes in countries lacking adequate capacity and resources.

ILO translated its manual “Business Continuity Planning (BCP) Guidelines for small and medium-sized enterprises” into Thai, for distribution in Thailand. It will be distributed at the National Achievement Workshop which will take place in Bangkok in June 2010, and will be adopted as a training support tool in the next project phase.

As part of UN country teams, **UNICEF** has been working to support national planning to identify critical, life-saving programmes that must be continued under pandemic conditions. It is also working to strengthen links with existing community-based communication networks to inform, protect, and mobilize. UNICEF will continue to act around: 1) identifying key behavior change messages for pandemic response in collaboration with other agencies, and 2) identifying and implementing preparedness actions in sectors critical to the well-being of children and their families during a pandemic.

C2: Specific assistance for LDC’s in receipt of humanitarian assistance to assess, plan and reduce sector vulnerabilities

Progress since the last report

In March OCHA/PIC hosted a meeting of the IASC-based Humanitarians in Pandemic (HiP) network, where discussions focused on how best to sustain the achievements of humanitarian community pandemic readiness work in an era of declining resources. In close coordination with AFRICOM, CMCS/OCHA, ICRC, WFP and WHO, as well as participation from UNICEF and the Core group, PIC/OCHA also produced an advocacy paper on Civil-Military Coordination in a high-impact pandemic. The purpose of this paper is to provide humanitarian actors with key elements of existing civil-military doctrine, and key advocacy messages that the humanitarian community should be familiar with when discussing civil-military pandemic response coordination.



Street drama being performed in Sunsari to raise community awareness on pandemic influenza

The Humanitarian Pandemic Preparedness (H2P) initiative, led by the International Federation of Red Cross and Red Crescent Societies in close partnership with the Core group, Academy for Educational Development, InterAction and the American Red Cross, continued monitoring project implementation progress in more than 90 countries. Through their H2P projects, partnerships with governments and NGOs were reinforced through task forces, workshops, training and planning. More than 50 national societies have developed or are developing comprehensive pandemic preparedness and response plans for inclusion in national government plans, in some countries with the involvement of the private sector.

USAID and the U.S. Department of Defense have partnered in a program under this initiative to enhance Asian and African military capacity to respond to an influenza pandemic. USAFRICOM and USPACOM are leading workshops, training and planning for military leaders in 24 African and Asian countries.

WFP and UNHCR activities described in the March 2010 UNIP report continue to be implemented.

2.3.5 Objective D: Strengthened Situation Assessment and Public Health Decision Making

D1: Strengthened Situation Assessment

Activities described in the March 2010 UNIP report continue to be implemented.

D2: Reduce transmission through appropriate use of transmission reduction

Progress since the last report

(a) School focused transmission reduction measures

UNICEF's efforts have included working with country education sectors to 1) help staff and students prevent local outbreaks and minimise impact, as well as being a conduit of information from child to community, while also 2) addressing social justice and equity issues. At the policy/systems level, UNICEF is working to enhance response capability, as well as sustaining learning opportunities in the event of class suspensions/school closures.

In Nepal, UNICEF provided orientation about H1N1 during the National Summit of people living with HIV, and continues to work with the Department of Education and District Education Offices on the development of an avian and pandemic influenza information module for schools. UNICEF's Community-based School Education Programme (CB-SEP) implemented at the district-level is being expanded to three additional districts. The CB-SEP uses a child-to-child approach for disseminating key messages and encouraging behaviour change. Students are encouraged to disseminate key messages to other students through peer-led interactions and also to family and community members. The implementation modality is extremely child-friendly, using stories, games, songs, and practical hand-washing sessions. The students also receive brochures, danglers and comic books during the group activities for individual learning and for distribution during the peer outreach activities. CB-SEP activities are complemented by mass media activities such as TV and radio messages and street dramas.

In Colombia, UNICEF and the Federal Ministry of Social Protection reached a cooperation agreement for the design of educational material for school children aged 8 to 14 to promote prevention practices and quick identification of H1N1 and other acute respiratory illnesses symptoms. Outcomes will include a comic, school posters and interactive web resources. The Ministry will be in charge of production and dissemination of materials and training resources

(b) Travel based transmission reduction measures

UNWTO continued to test plans and coordination multiple hazard approach mechanisms used during the pandemic (H1N1) 2009 in both regional and global incidents affecting the travel and tourism sector. UNWTO also continued to focus its emphasis on the importance of targeted, two-way communications and systems supporting its Tourism Emergency Response Network (TERN), which is especially important as the package travel directive of the EU is currently under revision.

UNWTO is in close contact with tour operators for an initiative to build an IT system to 'alert' and keep their guests informed, which will have a significant impact on travel and tourism flows when dealing with incidents. Given the importance of social media (i.e. twitter) as technical means to disseminate crisis communications, UNWTO participated in a workshop which took place with the major US players in March. Strong cooperation was also undertaken with the German Travel Association, comprising some of the largest global tour operators, to develop a pilot project which will closely link information systems and will thus not only allow UNWTO and destinations to directly communicate in a targeted two-way communications approach on influenza and other health risks but also to gradually allow for a multi hazard communications network.

The International Civil Aviation Organization (ICAO) has been working with its partners to improve pandemic preparedness planning and response in the aviation sector. A Cooperative Arrangement for the Prevention of Spread of Communicable Disease through Air Travel (CAPSCA) project Steering Committee Meeting was held in Kuala Lumpur, Malaysia, in May and at this meeting a draft template for national preparedness planning in the aviation sector was considered, which will be further developed in coming months. Additionally, in late May ICAO received a CFIA grant, which will enable the CAPSCA project to be extended into the Middle East region, adding to activities already under way in the Asia Pacific, Africa and Americas regions.

After the Malaysia meeting, ICAO conducted a Business Continuity Planning workshop/seminar, to address issues concerning provision of airport, airline and air traffic services during public health (and potentially other) emergencies, incorporating the 'Whole of Society' approach to such planning. A planned CAPSCA airport evaluation and training event in Mongolia had to be rescheduled because of the inability of evaluators to travel, owing to the volcanic ash cloud that disrupted airline operations in Europe during May.



(c) Hygiene Programmes

In Democratic Republic of the Congo, **UNICEF's** efforts have focused in the promotion of hand washing in close collaboration with the Ministries of Education and of Health and five major religious organizations. Activities in primary schools include: production of 100 wall paints on hand washing in 50 Primary schools in Kinshasa; and orientation sessions in 50 Primary schools in Kinshasa on the hand washing and the prevention of the H1N1, through the "theatre forum." UNICEF translated and disseminated messages of the 5 Key Protective Family Practices including Hand Washing. These activities have been reinforced by hand washing spots broadcasted by TV and radio.

IOM's continued outreach on pandemic preparedness included training of focal points for village pandemic preparedness groups in Cambodia on basic hygiene measures for the prevention and mitigation of influenza-like illnesses. IOM also conducted awareness raising activities and trainings in Lao PDR, Costa Rica, Panama and Egypt.

2.3.6 Objective E: Strengthening Influenza Laboratory Capacity

Activities described in the March 2010 UNIP report continue to be implemented.

2.3.7 Objective F: Procurement of additional vaccines

Activities described in the March 2010 UNIP report continue to be implemented.

2.3.8 Objective G: Promote Regional Knowledge Sharing

Progress since the last report to the needs

A number of regional events took place during the reporting period on pandemic preparedness and response, including a pandemic civil-military annex development workshop organized in Honolulu by USPACOM and USAFRICOM for senior representatives of African, Asian and Pacific military forces; an assessment workshop in Jakarta for ASEAN Member States to discuss assessments of national pandemic preparedness; a workshop in Malaysia on pandemic preparedness; and a regional planning meeting on the regional simulation in Mombasa in May 2010, co-sponsored by USAFRICOM and WFP. Additionally, in coordination with PIC, WHO, IOM, FAO and UNICEF, UNSIC organized a workshop in Cairo on preparedness and response of the health and non-health sectors to the current H1N1 pandemic.

2.3.9 Animal Health and Agriculture Sector

Progress since the last report to the needs

FAO and **OIE** have engaged in a number of initiatives since the onset of the pandemic in the following thematic areas:

- Disease monitoring and tracking: daily updates are provided through the web-based animal health information systems EMPRES-i and GLEWS.
- Disease surveillance and diagnostic: FAO developed a specific portfolio on H1N1 to support government efforts in disease surveillance in light of new and ongoing risks associated with influenza viruses in pig and poultry production sectors in high risk areas (Central and South America/Caribbean and South Asia).
- Biosecurity: FAO, OIE and the World Bank produced a paper on the good practices of biosecurity in the pig sector to limit transmission and reduce the impact of infectious swine diseases.
- Information Sharing: Through the OFFLU network of expertise on animal influenza¹⁴, FAO, jointly with OIE, produced strategic papers and technical recommendations for sample collection and shipment. FAO also mounted a global Technical Cooperation Programme to ensure the coordination of activities, information sharing and cross-fertilization of experiences. In addition, FAO is collecting from international laboratories updated information on validated protocols for the diagnosis of pandemic H1N1.

¹⁴ <http://www.offlu.net/>

Section 3: Summary

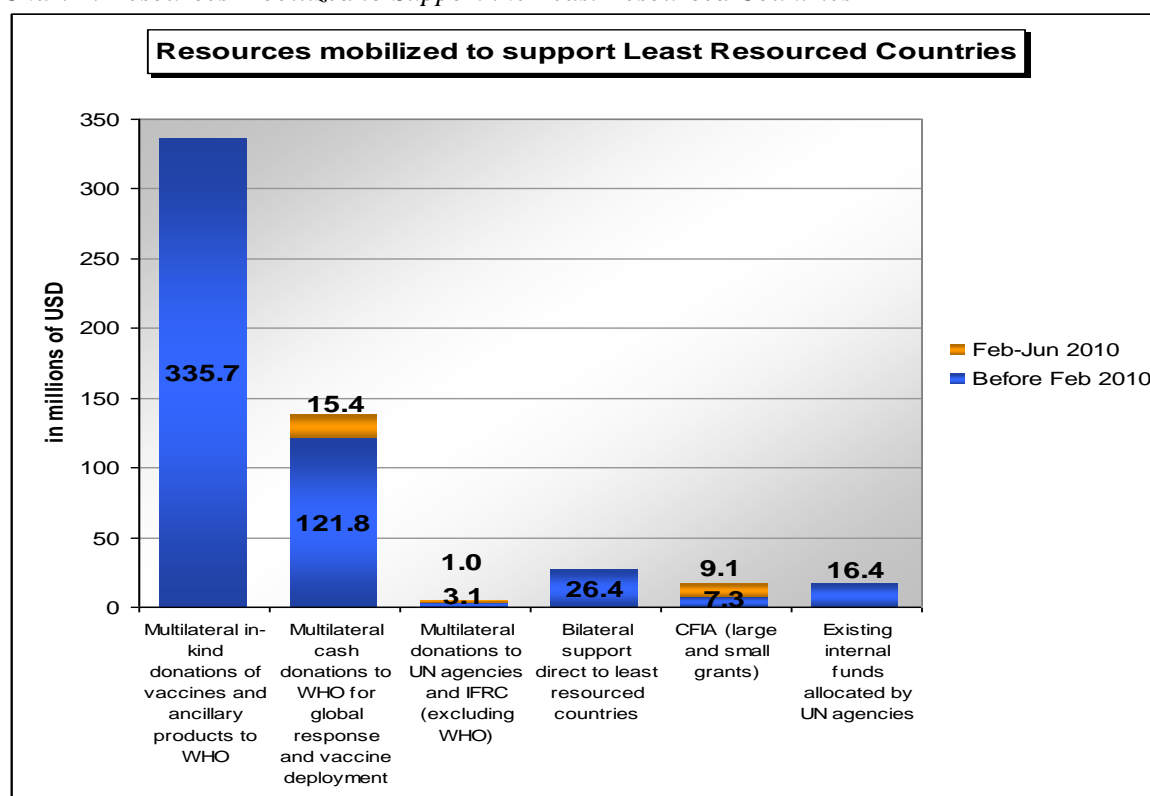
3.1 Funding and activities

As noted in the March 2010 report, it is difficult to calculate in monetary terms the support that has been mobilized to assist the least developed countries in meeting the priority needs identified through the UNIP process, and consequently the figures provided in this section are likely to be an underestimate of the total amount of support as (a) in-kind donations of technical assistance have not been valued and (b) it is likely that only a small proportion of the bilateral assistance provided has been captured in this report. Notwithstanding, this section aims to provide an overview of the types of resources that have been mobilized and how this relates to the needs that were identified through the UNIP process.

The majority of resources mobilized have been provided to WHO to support the global response (Chart 1). This is followed by bilateral donations to least resourced countries which accounts for around 13.2% of all financial support provided (exclusive of in-kind donations). The amount of existing funds allocated by UN agencies (non-WHO) to provide urgent support was similar in total to the amount raised through the CFIA.

It should be noted that the amount of funds originally requested through the September 2009 UNIP report assumed that H1N1 had the capacity to cause significant distress in these countries. Since the virus has proven to be generally mild, it is likely that, in practice, the financial resources needed to respond to the H1N1 influenza pandemic are less than the amount originally requested.

Chart 1: Resources Mobilized to Support the Least Resourced Countries



Category I: Essential Medicines

Objective A: Increased access to antivirals to treat severe illness

There has been no change in donations since the March 2010 UNIP report. Through the UNIP process it was estimated that around 78 million treatment courses would be required. To date 4.7

million courses (6% of requirements) have been donated and distributed to least resourced countries.

Objective B: Increased access to essential antibiotics for treatment of patients with bacterial complications

There has been no change in donations since the March 2010 UNIP report. It was estimated that 39 million treatment courses of antibiotics would be required. To date no donations have been made nor have any specific requests for urgent supplies been received from least resourced countries.

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

Support for essential medicines, through both in-kind and cash donations ensured that 200 million doses of vaccine have been made available (Chart 2). However, there is still a shortfall with regards to ancillary supplies, such as syringes (Charts 3) and safety boxes, as well as distribution costs (Chart 4).

Chart 2: Pandemic Vaccine Donations

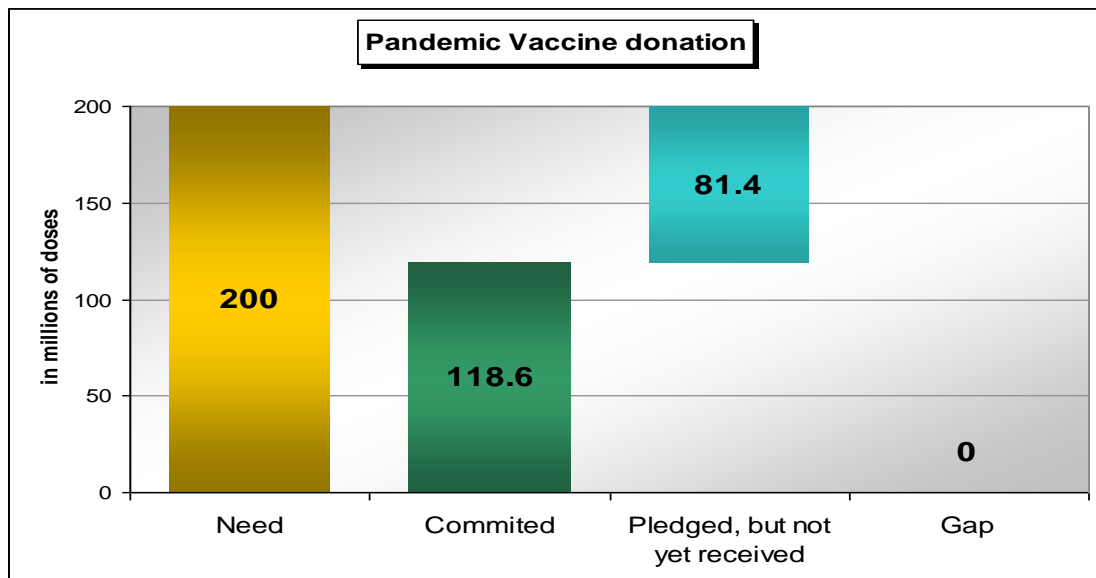


Chart 3: Syringes

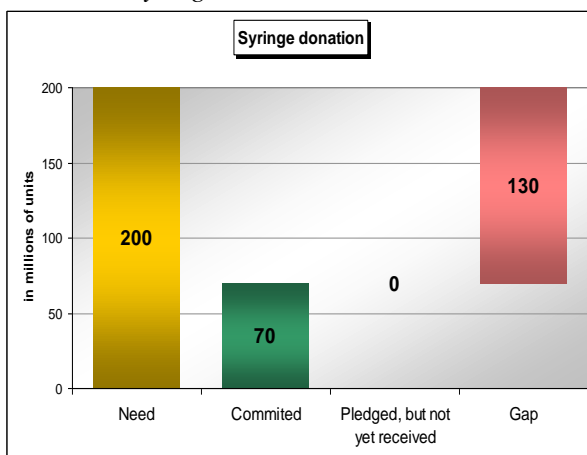
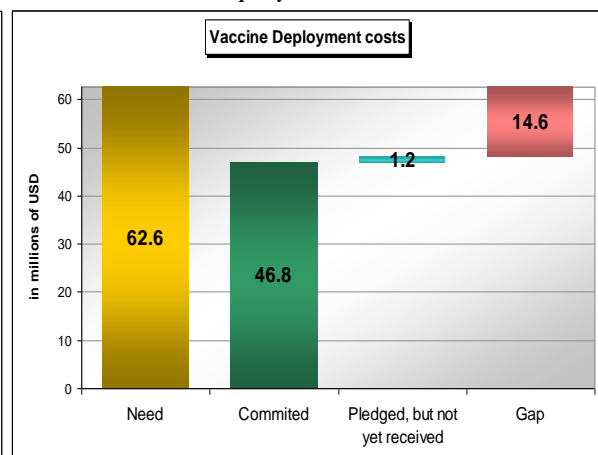


Chart 4: Vaccine deployment costs



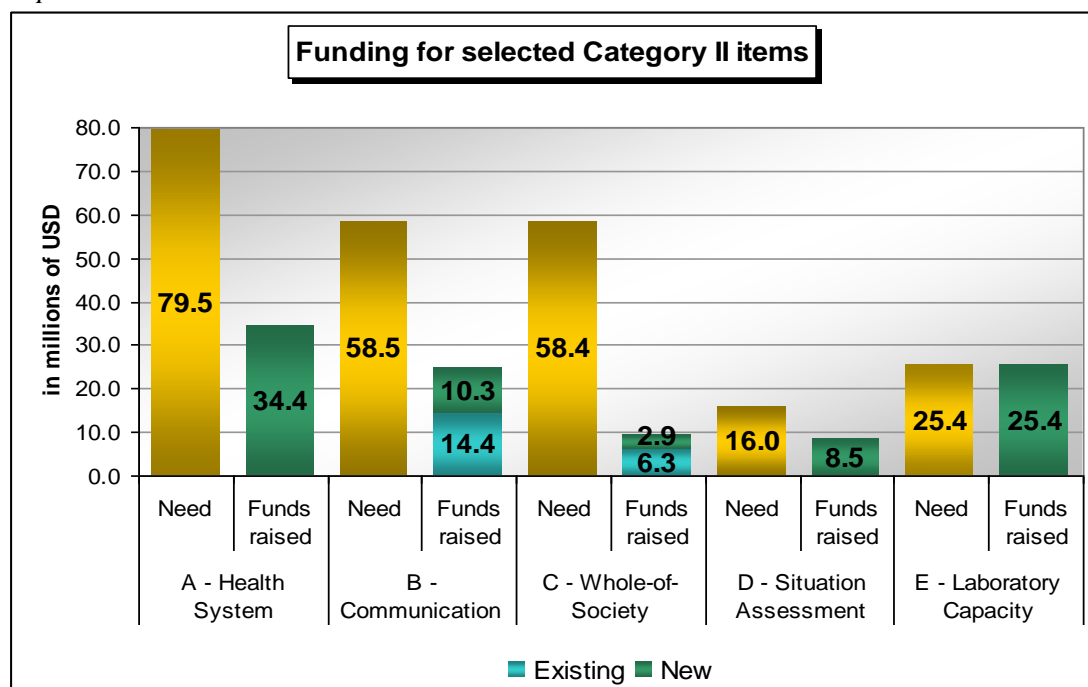
Nearly three quarters of the costs associated with vaccine deployment have been met, whilst the remaining funds have either not been received (2%), or are still outstanding (23%). These funds are critical to the delivery of donated vaccines on the ground and, therefore, are necessary to achieve the successful completion of the vaccine donation programme. There has been no change in donations of safety boxes since the March 2010 UNIP report (thus a shortfall of 1.5 million units persists).

Category II: Country Readiness

Seventy-three countries now have plans in place for in-country planning for vaccine distribution and post marketing surveillance, and additional countries are in the process of finalizing their plans (see annex A for more details).

However, funding for many areas of country readiness, most notably communications and whole-of-society preparedness, continues to be limited. Chart 5 summarises the current status of the main Category II items vis-à-vis the pledged support. The funds that have been raised were classified into new monies and existing cash that has been allocated by UN agencies to address the urgent needs of Least Resourced Countries under Category II. Unlike donations of the pandemic vaccine, which is the main item in Category I, most Category II items remain largely underfunded, with the sole exception of Category II.E ‘Strengthening of Influenza Laboratory Capacity’.

*Chart 5: Funding to support increased country readiness and non-pharmaceutical response**



*The following donors did not specify the type of intervention that their monies, partially or in full, would support. As a result, these following funds could not be assigned to a specific category of support and hence do not appear in the chart above: Germany (\$17.3m), the USA (\$10.07m), Canada (\$5.68m), the Asian Development Bank (\$0.6m) and the UK (\$0.41m).

Annex A

H1N1 Pandemic Vaccine Deployment Update – 18 June 2010



World Health Organization

Background information

To help countries protect people from developing severe disease from pandemic influenza H1N1 infection, the World Health Organization (WHO) is coordinating the distribution of donated pandemic influenza vaccine to eligible countries. This document is an update on efforts to mobilize resources, ensure a sufficient supply of prequalified vaccines, support country readiness and deploy vaccines and ancillary products to countries.

Mobilizing resources

Governments, foundations and manufacturers have offered contributions of vaccines, ancillary products (such as syringes and safety boxes) and finances to support the donation initiative.

Current situation

WHO has received pledges of approximately 200 million doses of vaccine, 70 million syringes and US\$48 million for operations.

Overview of resource mobilization (millions)

Resource ¹	Pledged ²	Committed ³
Vaccines (doses)	200	118.6
AD Syringes	70	70 ⁴
Safety boxes	0.5	0.5 ⁵
US\$ (global)	48	46.8 ⁶

US\$ (in-country) The precise financial needs and available resources for in-country deployment are currently being identified on a case by case basis. Most LICs have large funding gaps.

¹ Australia, Belgium, Becton Dickinson and Co., CSL Ltd., France, Gates Foundation, Germany, GSK Biologicals, Italy, Japan, MedImmune, New Zealand, Norway, Sanofi Pasteur SA, Switzerland, United Kingdom, USA.

² Not all pledged vaccines will be available for the 2010 donation initiative.

³ As per signed agreements with donors.

⁴ Sufficient vaccines have been pledged to meet at least 10% population coverage of all countries that have requested vaccine. Sufficient supplies of syringes to match committed vaccine were obtained by in-kind contribution as well as by procurement using global funds.

⁵ Sufficient supplies of safety boxes to match committed vaccine were obtained by in-kind contribution and by procurement using global funds.

⁶ The pledged resources are sufficient to deploy all pledged vaccines.

Preparing countries to receive vaccines

WHO and partners are assisting all eligible countries to receive and use vaccines. Before countries receive donated vaccines, they complete three steps: 1) request donated vaccines, 2) sign an agreement accepting the terms and conditions of support and 3) develop a national vaccine deployment plan.

Current situation

- 99 countries have requested vaccine donations
- 86 countries have signed agreements with WHO
- Progress of National Deployment Plans:

National Deployment Plans

Stage of preparation	Number of countries
Complete and final	73
Being refined - expected by late June	6

Prequalification of pandemic vaccines

To date 10 pandemic influenza A (H1N1) vaccines from the following manufacturers have been prequalified: GlaxoSmithKline Biologicals SA (2); Sanofi Pasteur SA (2); Novartis AG (3); CSL Ltd. (1); MedImmune USA (1); Green Cross Corp., Korea (1).

More details on prequalification of pandemic vaccines are available at:

http://www.who.int/immunization_standards/vaccine_quality/pq_system/en/

Supplying vaccines to countries

After a country meets the criteria for receiving donated pandemic vaccine, WHO deploys the donated vaccines.

Current situation

WHO with partners has delivered vaccines^a to the following countries and is preparing to supply others:

Completed Vaccine Deliveries (01 January - 18 June)

Country	# of Doses	Arrival	Country	# of Doses	Arrival
Afghanistan	500,000	22 Feb.	Paraguay	600,000	02 May
Lao PDR	600,600	25 Feb.	Cambodia ^a	1,800,000	03 May
PN Guinea	700,000	26 Feb.	Guyana ^a	175,000	06 May
Maldives	31,200	02 Mar.	Chile	1,200,000	06 May
Fiji	88,200	03 Mar.	Lesotho	195,000	07 May
Vanuatu	25,000	03 Mar.	Moldova	380,000	08 May
Kiribati	10,000	04 Mar.	South Africa	3,500,000	12 May
Solomon Is.	55,000	04 Mar.	Nicaragua ^a	750,000	12 May
Kosovo	100,000	09 Mar.	Gambia	31,200	13 May
Cuba	1,124,000	17 Mar.	Ghana	2,300,000	15 May
Kenya	730,000	24 Mar.	Sao Tome	16,000	15 May
Samoa	18,000	24 Mar.	Honduras ^a	1,650,000	17 May
Pakistan	3,100,000	29 Mar.	Tonga ^a	100,000	18 May
Mongolia ^a	270,000	29 Mar.	Namibia	216,000	19 May
Philippines	1,900,000	30 Mar.	Niger	270,000	21 May
Tuvalu	1,000	30 Mar.	Cook Is. ^a	20,000	26 May
Azerbaijan ^a	344,000	01 Apr.	DR Korea	476,500	26 May
Bolivia	900,000	02 Apr.	Guinea-Bissau	160,000	3 June
Myanmar	972,000	04 Apr.	Swaziland	117,000	4 June
Suriname	50,000	15 Apr.	Nauru ^a	8,750	7 June
Seychelles	9,000	21 Apr.	Ethiopia	1,500,000	7 June
Timor-Leste	117,000	21 Apr.	Bhutan	65,000	8 June
Liberia	78,000	23 Apr.	Guatemala ^a	1,300,000	11 June
Niue ^a	1,700	23 Apr.	Togo ^a	663,500	12 June
Bangladesh	3,000,000	27 Apr.	Sierra Leone	577,000	14 June
Sudan	700,000	29 Apr.	Tokelau ^a	1,600	16 June
El Salvador ^a	2,276,000	30 Apr.	Sri Lanka	385,000	17 June
Georgia	100,000	01 May	Botswana	1,612,800	18 June
Total			56 Countries	37,871,050 doses	

^a All donated vaccines are bundled with AD syringes and safety boxes.

^b Multiple deliveries from 07 January to the present.

Planned Vaccine Deliveries (19 June - 30 July)

Country	# of Doses	Country	# of Doses
Angola	2,030,000	Madagascar	2,043,000
Bangladesh ^b	12,600,000	Malawi	1,300,000
Benin ^b	891,800	Mali ^b	1,200,000
Burkina Faso	1,450,000	Mauretania	296,400
Burundi	826,000	Mauritius	127,000
Cameroon	1,825,000	Niger ^b	1,105,000
Congo, Rep.	400,000	Nigeria	2,880,000
Cote d'Ivoire	2,197,000	Philippines ^b	1,500,000
DR Korea ^b	1,899,000	Rwanda ^b	1,000,000
Ethiopia ^b	1,500,000	Senegal	240,000
Gambia ^b	132,600	Zimbabwe	1,250,000
Lao PDR ^b	400,000		
Total		23 Countries^c	39,092,800 doses

^b Second or third delivery.

^c Pending signed agreement or National Deployment Plan.

^d First delivery for 16 countries.