World Health Organization

EXECUTIVE BOARD **EB138/5**
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Overview of reform implementation

Report by the Secretariat

1. This report summarizes the progress of WHO reform since the report to the Sixty-eighth World Health Assembly.[1] It provides an overview of the current status of reform, reviews progress in the three broad reform workstreams (programmes and priority-setting, governance and management), and reports on indicators that have been established to measure achievement of the reform objectives, illustrated with examples from different major offices.

2. The new stream of reform of WHO's work in outbreaks and health emergencies is an important element of the WHO reform programme, and activities are closely aligned with each other. The WHO response in severe, large-scale emergencies is reported on separately.[2]

OVERVIEW

3. In the five years since the Director-General outlined her proposals for the reform of WHO,[3] significant progress has been made towards meeting the objectives of being a more effective, efficient, transparent and accountable organization that leverages its relative strengths and comparative advantages to improve health outcomes. Implementation of the different streams of reform since 2011 has been variable, with the greatest progress made in programmatic reforms, but less in governance and managerial reforms. All reform activities will be mainstreamed into the business processes of the Organization during the next biennium.

4. The majority of reform outputs (84%) have now reached the implementation stage, a proportion that has not changed significantly since May 2015, owing to the postponement of work on several outputs as a result of WHO's response to the outbreak of Ebola virus disease. Work on these outputs has been resumed during the second half of 2015 but has not yet reached the implementation stage. Measurable progress has been made in the completion of implementation, however, where the rate has increased from over 50% to nearly 60%.

5. With the development of a stronger monitoring framework, as recommended by the second stage evaluation of WHO reform,[4] it is now possible to report on the impact of these reforms and

[1] See document A68/4 and the summary record of the Sixty-eighth World Health Assembly, Committee A, first meeting, section 2.

[2] Document EB138/23.

[3] See document EB128/INF.DOC./3.

[4] See document EB134/39.

targeted interventions, where required, based on a set of performance metrics that can be tracked over time and are presented for the first time in this report (see Annex). The indicators show significant achievements in some areas but fewer in others, reflecting to a certain extent the pace of the different reform streams. These indicators will aid the prioritization of reform efforts in the biennium 2016–2017. Although impact appears to be weak in certain areas, this may be a function of the relatively short amount of time between implementation and measurement.

6. The outbreak of Ebola virus disease in West Africa has had a significant impact on WHO reform, with consequences for the pace and delivery of work across the Organization, including reform activities, and has placed enormous strain on WHO's managerial structures and systems. The outbreak reinforced the need to accelerate implementation of key elements of reform, but it also revealed the need for additional reforms to WHO's work in outbreaks and health emergencies, in order to equip the Organization to mount a rapid and massively scaled-up response to a complex health emergency. Reforms of WHO's work in health emergencies, closely linked to the broader reform agenda, have been initiated by the Director-General, guided by an advisory group comprising international experts in disease outbreaks and in health and humanitarian emergencies.[1]

PROGRAMMATIC REFORM

7. Programmatic reform is the most advanced area of reform, with more than 80% of planned activities completed, and the indicators established for programmatic reforms also demonstrate some progress.

8. WHO's contribution to improved health outcomes is achieved by focusing on programmatic priorities that have clear outputs and are supported by adequate financing. Initial steps were taken with the Programme budget 2014–2015 and further developed in the Programme budget 2016–2017. The three levels of the Organization have been systematically involved in the planning process, with a coordinated approach through category and programme area networks. Around two thirds of programme area networks held face-to-face meetings in planning the Programme budget 2016–2017. Through a bottom-up priority-setting and planning process, country offices were requested to work with government counterparts to determine 10 priority areas, to which at least 80% of their budget would be allocated. The majority of country offices were able to follow this guidance, though some larger or more heterogeneous countries found it difficult, and 66% of country offices[2] have allocated at least 80% of their budget to the limited set of priorities for 2016–2017. To further reinforce WHO's presence in countries, the Eastern Mediterranean Region, for example, has increased the budget allocation to country offices, shifting from the regional level. Member States in the Region of the Americas have approved a budget policy[3] that applies a needs-based formula to set budget allocations for country offices. Elements of the formula include health and economic indicators. The policy also defines a minimum presence in each country with a WHO/PAHO representative and allocates 40% of the regional budget for countries, 7% for subregional offices, 18% for intercountry activity and 35% for the Regional Office. The Programme Management Officers network introduced in the Western Pacific Region has strengthened implementation of the programme budget and human resource plan. It

[1] More information on reform of WHO's work in health emergencies and the work of the Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies with Health and Humanitarian Consequences can be found at: http://www.who.int/about/who_reform/emergency-capacities/en/ (accessed 18 December 2015).

[2] This figure excludes country offices in the Region of the Americas.

[3] Document CSP28/7.

has now expanded its mandate to planning and forecasting technical and strategic priorities in each country during the process of elaborating country cooperation strategies.

9. The results chain for the Programme budget 2016–2017 has been strengthened by developing indicators for organizational outputs, linked to measurable health outcomes. The link between results and resources is being enhanced, and the performance assessment and financial reports for the Programme budget 2014–2015 will be merged.

10. Significant improvements have been made in the financing of the programme budget, with the financing dialogue playing an important role.[1] Predictability of financing of the base budget has improved over the last three biennia, from 62% at the beginning of the biennium 2012–2013[2] to 77% for the biennium 2014–2015 and projected to be close to 80% for 2016–2017. There has also been greater alignment of resources with the programme budget at the category level, but several programme areas remain relatively underfunded. The improvements in alignment for 2014–2015 have primarily resulted from more strategic allocation of flexible resources by the Director-General, rather than from a change in donor behaviour. Financial vulnerability continues to be slowly reduced, with the proportion of funds provided by the top 20 donors falling from 82.3% in 2010–2011 to 75.9% for the biennium 2014–2015. Transparency has substantially increased, and the revised web portal[3] now provides detailed information on financial flows down to the country office level. The next iteration of the portal will give more details of results achieved and of the contribution of resources to those results.

11. With these developments in prioritization, articulation of results and financing, it is anticipated that there will be a measurable improvement in the Organization's contribution to health outcomes, which are being tracked through the outcome indicators articulated in the Twelfth General Programme of Work and reflected in biennial programme budgets.

GOVERNANCE REFORM

12. The overarching objective of this area of reform is to ensure greater coherence in global health, with two expected outcomes: improved decision-making in governing bodies, and strengthened engagement with stakeholders. Governance reforms are often the most challenging of organizational reforms, which is reflected in the relatively slow progress in this area, with only 50% of reform activities completed. Despite the limited progress at global level, there are examples of progress at regional level. The South-East Asia Region, for instance, has streamlined the work of the Regional Committee by reducing the number of agenda items, pre-session documents and resolutions and by disseminating documents electronically.

13. In decision EB136(16), the Executive Board decided, inter alia, to establish an inclusive Member States consultative process on governance reform, to complete its work by the Sixty-ninth World Health Assembly in May 2016, providing recommendations through the Executive Board in

[1] See document EB138/42.

[2] Financing for 2012–2013 did not include projected income, whereas this has been included in 2014–2015 and 2016–2017.

[3] See http://extranet.who.int/programmebudget (accessed 18 December 2015).

January 2016 on how to improve WHO governance efficiency. The first open Member State meeting on governance reform was held in May 2015 and the second on 10 and 11 December 2015.[1]

14. Progress continues to be made towards finalizing the framework of engagement with non-State actors.[2] While the Framework is being finalized, the Secretariat continues to conduct due diligence and risk assessments of engagement with non-State actors, and to make information on engagements available on the WHO website.[3]

MANAGEMENT REFORM

15. Although significant progress has been made in the area of management reform, the Ebola outbreak has demonstrated the critical importance of further reforms, notably in the areas of human resources, information management and strategic communications.

Human resources

16. Previous reports to the governing bodies have described the different human resources reforms, based on the human resources strategy, to ensure that staffing is matched to needs at all three levels of the Organization. The annual report on human resources[4] provides a global overview, but regional and country-specific needs are also taken into account: the African Region, for instance, has developed a model to align staffing profiles and numbers with programmatic priorities. Consideration of the disease burden and disability-adjusted life years in the respective countries is an integral part of the model. The European Region decreased its staff expenditure between 2012 and 2014.

17. Human resources planning has improved, with staffing plans available for 62% of the positions becoming vacant through retirement in the current biennium. Recruitment processes are being harmonized, and 65% of all vacancies for internationally recruited staff were filled within 15 weeks in 2014. This has been achieved through the use of generic post descriptions and the creation of rosters of qualified candidates, as initiated for example in the Eastern Mediterranean Region. Efforts are being made to improve gender equity and geographical diversity, but progress has been slow. Only 33% of the incumbents of positions at grades P5–D2 and 36% of the heads of WHO country offices are women (data for 2014 and October 2014 respectively), while 32% of WHO Member States continue to be either unrepresented or under-represented in the category of internationally recruited professional staff.

18. Implementation of the new geographical mobility policy is under way, and the first phase of voluntary mobility will commence in 2016, based on a compendium of rotational positions that is currently being finalized. A plan of action (including specific priority acitivities and timelines) has been drawn up for strengthening the internal justice system, in consultation with the WHO staff associations.

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[1] See document EB138/6.

[2] See document EB138/7.

[3] See http://www.who.int/about/who_reform/partnerships-collaborative-arrangements-with-WHO-involvement.pdf (accessed 18 December 2015).

[4] See documents EB138/51 and EB138/51 Add.1.

Accountability

19. Discussions in the Executive Board and its Programme, Budget and Administration Committee in May 2015 identified accountability as an area requiring significant attention, to address what was described by the Independent Expert Oversight Advisory Committee as "a culture of tolerance for non-compliance" in the Organization.[1] The percentage of operational audits assessed as "satisfactory" or "partially satisfactory", which is the primary measure of accountability, has remained relatively static over the past two years (74% in 2013, 67% in 2014).

20. Several additional steps are being taken to strengthen accountability, transparency and internal controls, further to those described in the report to the Sixty-eighth World Health Assembly:[2]

(a) All budget centres in WHO have established risk registers, with dedicated risk mitigation plans in place for 98% of all identified risks across the Organization.

(b) Steps to encourage adherence to core ethical values have included the publication of an annual report on investigations and an annual update to staff on disciplinary measures taken in response to cases of misconduct.

(c) Particular emphasis is being placed on accountability in country offices: self-assessment checklists have been rolled out there, while development of key performance indicators is ongoing. The European Region, for instance, has implemented an initiative to clearly define in a matrix who is responsible, accountable, consulted and informed, for the different steps of the main business processes down to country level. The African Region has defined key managerial performance indicators for a variety of areas (such as finance, procurement, travel and security), establishing measureable targets and respective data sources for all country offices. Ranges of target achievement have been agreed on and will be used during the performance appraisal of the relevant staff in country offices. The reform implementation network, including representation from all major offices, has served as a platform for learning and exchange of experience in implementing accountability across the Organization.

21. Further steps to promote greater accountability and transparency in 2016–2017 will include implementation of the corporate risk management policy (with escalation of the most critical risks to senior management), and establishment of a whistleblower hotline.

Evaluation

22. An update on progress in the area of evaluation and the proposed evaluation workplan for 2016–2017 are contained in a separate document.[3] A number of evaluations planned for 2015 were delayed or postponed to 2016, in order to provide dedicated resources to support the Ebola Interim Assessment Panel, which concluded its work in July 2015.

[1] See document EBPBAC22/3, paragraph 17.

[2] Document A68/4.

[3] Document EB138/44.

Information management

23. In November 2015, the Director-General announced her commitment to comply with the standards of the International Aid Transparency Initiative. A key element of this commitment will be the development and implementation of an information disclosure policy, which will be finalized in 2016.

Communication

24. Based on lessons learned from the Ebola outbreak, activities in the area of communication have focused on risk and emergency communication and on global and social media presence. A major stakeholder survey was conducted in 2012 and has been repeated in 2015. A WHO communications strategy is being finalized to guide the work of the Organization in this area.

THE WAY FORWARD IN REFORM IMPLEMENTATION

25. Although the reform indicators demonstrate measurable improvement in organizational performance in several areas, further progress is urgently needed in areas such as governance, human resources, accountability, and information management. This is expected to be achieved as the remaining organizational reforms move into the implementation phase. The increasingly widespread practice of conducting independent evaluations of indicators of organizational performance will strengthen the objective assessment of WHO reforms. This is further reinforced in the regions: in the African Region, for instance, the "Transformation agenda"[1] has clearly defined priority strategic actions to accelerate the implementation of reform.

26. In order to sustain the organizational reforms currently under way, steps are being taken to institutionalize organizational learning through a variety of internal mechanisms, including the Global Policy Group, category networks, programme area networks and other regular meetings of senior managers. Recommendations and lessons learned from evaluations, audits and performance assessments are increasingly being shared through these mechanisms. A reform implementation network has been established to coordinate and harmonize the implementation of reforms across the three levels of the Organization.

27. The new stream of reform of the work of WHO in outbreaks and health emergencies will also address several specific areas, such as human resources, information management and communications, and will contribute to strengthening management processes across the Organization, particularly at country level where the need is greatest.

ACTION BY THE EXECUTIVE BOARD

28. The Board is invited to note the report.

[1] See http://www.afro.who.int/en/rdo/transformation-agenda.html (accessed 18 December 2015).

ANNEX

MONITORING WHO REFORM: PERFORMANCE METRICS

	Result (Outcome/Output)	Indicator	Baseline		Actual		Comments
1	**Improved health outcomes**						
1.1	**WHO's priorities defined and addressed in a systematic, transparent and focused manner and financed accordingly**	**Alignment of income and expenditure with approved programme budget, by category and by major office**					**This indicator excludes the budget lines for the Regional Office for the Americas/Pan-American Health Organization (AMRO/PAHO), Oubreak and crisis response (OCR) and Polio.**
		(a) income	**June 2013**	**Lowest award distribution 68% (Strategic objective (SO) 5) and 72% (Regional Office for South-East Asia (SEARO))**	**June 2015**	**Lowest award distribution 87% (Category 2 – noncommunicable diseases) and 88% (Regional Office for the Eastern Mediterranean (EMRO))**	**Award distribution is used as an approximation for income. The lowest award distribution as a percentage of the approved programme budget indicates the lowest level of alignment.**
		(b) expenditure	**June 2013**	**Lowest expenditure 44% (SO2) and 47% (SEARO)**	**June 2015**	**Lowest expenditure 51% (Category 2) and 53% (EMRO)**	**Lowest amount of expenditure as a percentage of the approved programme budget indicates the lowest level of alignment.**
1.1.1	Needs-driven priority-setting, result definition and resource allocation aligned to delivery of results	Percentage of Country Offices allocating at least 80% of budget to their 10 predefined priority programme areas	No baseline, as the concept of predefined priority areas was not followed globally before.		2016–2017	66%	Country Offices were asked to define their priorities (10 programme areas) before the operational planning process. Depending on the size and heterogeneity of a country, sometimes a few more or less priorities were defined. After operational planning, a review indicated the percentage of Country Offices that allocated at least 80% of their budget, i.e. planned costs, to the predefined priorities. The review excludes AMRO/PAHO, OCR and Polio and Category 6 – Corporate services/enabling functions.
1.1.2	Improved delivery model at the three levels of the Organization to better support Member States	Percentage of programme area networks (PANs) with effective coordination mechanism	No baseline, as the concept of PANs was not followed globally before.	2014–2015	64%		The proxy used is the percentage of PANs that met face-to-face for the development or operational planning of the Programme Budget 2016–2017. This indicator excludes Category 6.

	Result (Outcome/Output)	Indicator	Baseline		Actual		Comments
1.1.3	Adequate and aligned financing to support strategic focus	Percentage of programme budget funded at the beginning of biennium	2012–2013	62%	2014–2015	77%	This indicator addresses the predictibility of funding at the global level, but does not take the alignment of funding into consideration. Including projections as of 2014–2015.
1.1.4	Transparent reporting of results delivery and use of resources	Performance measured through a consolidated assessment of delivery of planned outputs	2012–2013	63% fully achieved	2014–2015	Not yet available	While the end-of-biennium performance for 2014–2015 has not yet been assessed, the mid-term report indicates that programme areas are 90% on track. During the next reporting period, the two end-of-biennium assessments will be compared with each other.
2	Greater coherence in global health	Extent to which leadership priorities are reflected in the resolutions and decisions of the governing bodies (World Health Assembly and Executive Board) adopted during the biennium	2013	45%	2015	55%	Of all resolutions and decisions, the vast majority are related to management and administration. Of the technical resolutions and decisions, this indicator measures those reflecting the six leadership priorities.
		Percentage of external stakeholders considering WHO as most effective at influencing policy for improving people's health at the global level	2012	74%	2015	84%	This is an additional indicator for validation purposes only; it is taken from the stakeholder perception surveys conducted in 2012 and 2015.
2.1	Improved strategic decision-making	Member States' perception of the effectiveness of discussions and decisions in Governing Body meetings					Pending outcome of inclusive process of consultation with Member States on governance reform.
		No. of preparatory meetings (1 June 2014–31 May 2015)					
2.1.1	Proactive engagement ahead of Governing Body meetings	Percentage of governing bodies' documentation provided within agreed timeline	2013	52%	2015	48%	WHO is mandated to provide Member States with documents for Governing Body meetings six weeks before the start of the meeting; this is not applicable for "agreed late" documents. This indicator excludes Regional Committee documentation.
2.1.2	Coordination and harmonization of Governing Body practices						Pending outcome of inclusive process of consultation with Member States on governance reform.
2.1.3	Member States work coherently on global health	Number of countries with explicit and effective processes for preparation of and participation in Governing Body meetings, and implementation of governing body decisions					Pending outcome of inclusive process of consultation with Member States on governance reform.

	Result (Outcome/Output)	Indicator	Baseline		Actual		Comments
2.2	Strengthened effective engagement with stakeholders	Number of non-State actors and partnerships for which information on their nature and WHO's engagement is available	early 2014	100	2015	295	Sources: http://www.who.int/about/who_reform/partnerships-collaborative-arrangements-with-WHO-involvement.pdf; http://www.who.int/civilsociety/relations/NGOs-in-Official-Relations-with-WHO.pdf?ua=1
2.2.1	Leverage non-State actors to achieve WHO's results	Percentage of outputs per major office with significant contribution by non-State actors					Pending framework of engagement with non-State actors.
2.2.2	Risk-managed engagement	Number of due diligences conducted	2013	500	October 2015	520	Number of due diligences conducted according to the documentation of the responsible department.
		Percentage of external stakeholders who do not perceive WHO as being inappropriately influenced by industry/private sector	2012	36%	2015	37%	This is an additional indicator for validation purposes only; it is taken from the stakeholder perception surveys conducted in 2012 and 2015.
2.2.3	Maximize convergence with reform of the United Nations system to deliver the United Nations mandate effectively and efficiently	Percentage of United Nations Development Assistance Frameworks containing health-related outcomes (convergent with WHO's leadership priorities)	2012	67%	2015	91%	Data taken from the 2012 and 2015 reports on WHO's presence in countries, territories and areas (http://apps.who.int/iris/bitstream/10665/136487/1/WHOPresence2012Report.pdf?ua=1 and http://apps.who.int/iris/bitstream/10665/171388/1/WHO_Presence_Report_2015.pdf?ua=1).
3	An organization that pursues excellence	Level of performance of WHO management and administration					To measure this indicator it is suggested to use the Multilateral Organisation Performance Assessment Network (MOPAN) reports. The 2103 report would be compared with the results of the next MOPAN report; the exact wording needs to be determined once the 2015 MOPAN report is available.
		Percentage of external stakeholders describing their view of WHO's work over the past 3–5 years as "increasing confidence" or "consistently high confidence"	2012	76%	2015	61%	This is an additional indicator for validation purposes only; it is taken from the stakeholder perception surveys conducted in 2012 and 2015.
3.1	Staffing matched to needs at all levels of the Organization	Percentage of known upcoming vacancies due to retirement with defined staffing plans (e.g. reprofiling, internal talent identification and development, recruitment)	2012–2013	Not available	2014–2015	62%	Proper planning of vacancies is used as a proxy to indicate a staffing matched to the needs of the Organization: retirements are vacancies that are known well in advance and thus allow for proper planning. The figures represent global vacancies.

	Result (Outcome/Output)	Indicator	Baseline		Actual		Comments
3.1.1	Strengthened and more relevant human resources strategy						
3.1.2	Attract talent	Timeliness of recruitment (time between advertisement and selection decision) for full-time, internationally recruited staff	2014	65% within 15 weeks			
3.1.3	Retain and develop talent	Percentage of staff in professional and higher categories who have changed duty station in the last year	2013	9.5%	2014	7.4%	While this indicator is measured already, consideration must be given to the fact that the new mobility policy has not yet been implemented. The indicator excludes AMRO/PAHO.
3.1.4	Enabling environment	Number of appeals or possible appeals resolved by informal means and administrative review (in line with the Internal Justice System review)					The baseline will be taken at the end of 2015, just before the implementation of the revised Internal Justice System.
3.2	Effective managerial accountability, transparency and risk management	Percentage of operational audits issuing a “satisfactory” or “partially satisfactory” assessment during the biennium	2013	74%	2014	67%	Figures as reported by the Office of Internal Oversight to the World Health Assembly in 2014 and 2015.
3.2.1	Effective internal control and risk management processes	Percentage of risks with mitigation plans	No baseline, as no global risk framework available before		November 2015	98%	The number of identified risks globally for which a risk mitigation plan is available.
3.2.2	Effective framework for disclosure and management of conflicts	Proportion of meeting participants completing declarations of interests					While 100% of the declared DOIs are managed today already, this indicator is a proxy for the effective disclosure of DOIs. Measurement will take place after implementation of tool.
3.2.3	Effective promotion and adherence to core ethical values	Transparency and information about action taken in cases of (suspected) wrongdoing	2012	No documentation provided	2015	Regular communication to stakeholders	Annual report on investigations provided, and regular infomation to staff on disciplinary measures taken in response to cases of misconduct.
3.3	Institutionalized corporate culture of evaluation and learning	Number of planned evaluations completed according to the WHO Evaluation policy (compared with the Organization-wide biennial evaluation workplan)					

	Result (Outcome/Output)	Indicator	Baseline	Actual	Comments
3.3.1	Strengthened WHO policy on evaluation				As the new framework for work in the area of evaluation was finalized and agreed early 2015, the indicators will only be measured and show first results from 2016 onwards.
3.3.2	Institutionalization of evaluation function	Structural and functional organization of evaluation across WHO supported by dedicated resources to implement the Framework for Strengthening Evaluation and Organizational Learning workplan			
3.3.3	Staff and programmes plan evaluation and use results of evaluation to improve their work	Implementation rate of recommendations within the specified timeframe from date of evaluation report > 85%			
3.3.4	WHO champions learning from successes and failures	Percentage of evaluations that include identification of lessons learned (WHO Evaluation policy quality assurance requirements)			
3.4	Information managed as a strategic asset				
3.4.1	A strategic framework for streamlined and standardized information management policies, processes, roles and responsibilities and tools	An approved strategic framework for information management covering a high percentage of information management processes			Information management was put on hold owing to resource constraints during the Ebola outbreak response. Work in this area is just being reactivated.
3.4.2	Streamlined national reporting	Number of systems implemented to support the information management framework			
3.4.3	Information and communications technology systems in place to support information management	Percentage of staff thinking they have excellent or good access to information detained by other units			
3.4.4	Promoting a knowledge sharing culture	Percentage of staff thinking they have excellent or good access to information detained by other units			

	Result (Outcome/Output)	Indicator	Baseline		Actual		Comments
3.5	Improved reliability, credibility and relevance of communications	Percentage of stakeholders who view positively (excellent or good) WHO's ability to manage public health threats in the future	2012	79%	2015	67%	These figures are taken from the stakeholder perception surveys conducted in 2012 and 2015.
3.5.1	Clear communications road map						
3.5.2	Showcasing consistent quality and how WHO works to improve health	Percentage of all respondents who have a positive opinion of WHO	2013	63%	2015	68%	These figures are taken from the Gallup International Association's Global NGO Barometer.
3.5.3	Provide accurate, accessible, timely, understandable, useable health information	Percentage of stakeholders who say WHO communicates public health information in timely and accessible ways	2012	66%	2015	66%	These figures are taken from the stakeholder perception surveys conducted in 2012 and 2015.
3.5.4	WHO staff all have access to the programmatic and organizational information they need	Percentage of staff thinking they have excellent or good access to information needed to perform the duties	2012	Not available	2015	71%	These figures are taken from the stakeholder perception surveys conducted in 2012 and 2015.
3.5.5	Quick, accurate and proactive communications in disease outbreaks, public health emergencies and humanitarian crises	Time between WHO being aware of a disease outbreak and publishing the first disease outbreak news	2015	6 days			The median time taken between first information received and first disease outbreak news published.