Global health emergency workforce

Report by the Director-General

1.   The Ebola virus disease outbreak in West Africa has been unprecedented in many ways. In particular, the need for and deployment of many thousands of national and international responders over a sustained period of time has distinguished this outbreak response from others.

2.   Although there have been clear and notable examples of excellence and deep commitment on the part of national and international responders, managing the massive deployment was highly complex. The process of mobilizing the people necessary to tackle the Ebola outbreak exposed gaps in the national and international health workforce infrastructures. At the national level, the numbers of health workers were limited, ill-trained and not properly equipped. Although networks and partnerships exist to deploy international responders, and in many cases performed very well, they faced challenges in terms of scale, quality assurance, training, coordination, financing and opportunities to share lessons learnt between and among deploying partners.

3.   Mindful of these difficulties and of WHO's constitutional mandate as the directing and coordinating authority on international health work with responsibility for furnishing appropriate technical assistance and, in emergencies, necessary aid, the Executive Board in resolution EBSS3.R1 requested the Director-General to develop a plan for a more extensive global health emergency workforce that can be promptly and efficiently deployed, for service in countries that request or accept such assistance, for adequate periods of time, and with adequate resources.

4.   This report contains a conceptual plan for a workforce established in order to respond to acute or protracted risks and emergencies with health consequences and identifies the actions that the Secretariat will be required to take in the coming months.

SCOPE

5.   In order to respond to emergencies with health consequences, caused by the full spectrum of hazards, the required health worker competencies include the following.

(a)   **Public health:** ensuring that the public health aspects of emergency response are taken into consideration requires epidemiologists, laboratory scientists, case finders, contact tracers, infection prevention and control specialists, safe burial experts, event-specific specialists (for example, respiratory specialists in the case of volcanoes) and risk and event assessment specialists.

(b)   **Clinical care:** providing adequate patient care, for affected populations and international responders, requires doctors, nurses, pharmacists, midwives, physiotherapists, community care providers, dentists, psychologists, counsellors, social workers and psychosocial specialists.

(c) **Coordination:** managing complex responses across multiple active sites requires professionals with strategic leadership skills and critical analytic, thinking, planning and management capacity such as programme managers, strategic planners and political analysts.

(d) **Social mobilization:** engaging and motivating a wide range of partners (including community leaders and networks, civic and religious groups, local decision-makers and influencers) at national and local levels to raise awareness of and demand for a particular service requires advocates, communications experts and social and cultural anthropologists.

(e) **Communications:** ensuring that the status of an emergency, WHO's work in response and requests for the assets needed are all communicated effectively, requires strategic communications experts, public relations specialists, graphic designers, web engineers and campaign designers.

(f) **Logistics:** instituting the appropriate structures and systems to guide, organize and support the response requires logisticians, supply chain managers, engineers (for example, water and sanitation), security specialists and fleet management and drivers.

(g) **Information management:** ensuring that information is recorded, organized, available and analysable through the course of the response to an emergency requires computer scientists, data entry and management specialists, and geographic information system specialists, all with the ability to set up, manage and analyse health- and emergency-specific data.

(h) **Core services:** systemic support is essential throughout the response to an emergency with health consequences and requires specialists in human resources, resource mobilization, project management, and budget and finance and grant management, as well as administrative support.

6. In addition, depending on the emergency, competencies may be needed in research and development, in order to develop and deploy new vaccines, therapies, and diagnostics, and to guide the research and development agenda, and in health system strengthening in order to ensure infection prevention and control and safe reactivation of essential services.

7. Leveraging a scaled-up global health emergency workforce effectively requires robust, improved systems for pre-deployment, deployment and decommissioning. This paper considers how a global health emergency workforce can be set up and operated, looking at issues of scale, pre-deployment (establishment of rosters, quality assurance and training), deployment (planning, initiating and deploying and medical evacuation) and decommissioning (repatriation, post-mission support and capturing lessons learnt). It also considers the matter of appropriate governance and financing.

8. Under this plan, WHO – in collaboration with relevant partners and stakeholders – will strengthen the pre-deployment and readiness of existing pools of talent by establishing rosters, by implementing quality assurance measures and by developing and conducting training and simulation exercises. In order to improve the deployment process, WHO will do the following: redesign and, where necessary, create new mechanisms to plan deployment; establish the criteria for initiating deployments; design and implement systems for smooth deployment itself; and institute an effective and accessible medical evacuation process. Regarding decommissioning, the plan aims to ensure that all deployees are appropriately and efficiently repatriated, while incorporating mechanisms to capture lessons learnt and provide post-mission health and psychosocial support.

SCALE

National responders

9.   National health workers, national nongovernmental organizations, faith-based organizations, community and youth groups and other similar entities are the core of the global health emergency workforce and are necessarily the first responders to an emergency with health consequences.

10.   Governments have the primary role and responsibility in developing robust domestic health systems, including a health workforce. WHO's priority is to support countries to develop robust core capacities. The Secretariat will work closely with Member States, and in particular those vulnerable to risks and emergencies with health consequences, to build essential skills by developing and providing training and by developing technical guidelines for establishing: (a) a national health emergency workforce; (b) national alert and response; (c) procedures for country reception of global workforce members; and (d) procedures that uphold national regulations on licensing, customs, accreditation and registration.

International responders from networks and partnerships

11.   There are existing networks and partnerships that are established to provide international responders. These networks need to be expanded and strengthened to provide the scale, diversity of skills and numbers required for a large-scale response.

12.   The Global Outbreak Alert and Response Network supports the coordination of international response, and pools human and technical resources from existing institutions and networks to support international outbreak identification, confirmation and response. WHO will work with partners in the Network in order to strengthen international alert and response capacities, expanding the number of member institutions, strengthening networks of expertise and increasing the number of languages represented in the Network.

13.   The 2005 Inter-Agency Standing Committee's humanitarian reform process resulted in the creation of the cluster approach and the designation of global cluster heads in 11 areas of humanitarian activity. WHO has been designated Cluster Lead Agency for Health.[1] The Global Health Cluster is made up of more than 40 international humanitarian health organizations that work together to build partnerships and mutual understanding and to develop common approaches to humanitarian health action. Under the present plan, the Global Health Cluster will expand its network of affiliated organizations, ensuring predictable deployment of individuals and teams in order to provide emergency health services, health sector coordination, planning, information management and communications during the response to acute or protracted risks and emergencies with health consequences.

14.   Foreign medical teams are trained, self-sufficient groups of health professionals that treat patients affected by an emergency, under the terms of WHO's *Classification and minimum standards*

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[1] See resolution WHA65.20, which supported WHO in fulfilling its role as the Global Health Cluster lead agency.

for foreign medical teams in sudden onset disasters.[1] In response to Member State interest, in 2014 WHO established a dedicated unit to coordinate, manage and assure the quality of foreign medical teams. In order to expand the capacity and effectiveness of foreign medical teams, WHO is now developing a global registration system to verify and classify all teams that meet the WHO minimum standards for deployment. When fully implemented the registry will serve as a deployment and coordination mechanism, allowing a country affected by an emergency with health consequences to call on teams that have been pre-registered and quality-assured and inform those teams of the specific standard operating procedures and requirements for access to their country (including rules on importation of pain relief and registration as a doctor).

15.   With the objective of increasing and complementing the Organization's skilled surge capacity, WHO has signed standby agreements with Canadem, iMMAP, the Norwegian Refugee Council and RedR Australia. Under these agreements, these organizations will provide a variety of trained and experienced staff who can be rapidly deployed for between three and six months in the event of a grade 3 emergency. WHO will increase the number of partners with whom it has signed stand-by agreements, which will help to provide an expanded range of options to support a predictable response for filling human resource gaps in a given response.

16.   The WHO Emerging and Dangerous Pathogens Laboratory Network comprises relevant global and regional networks of high security human and veterinary diagnostic laboratories that collaborate to increase capacity for earlier diagnosis and management of outbreaks and infections in respect of emerging and acute endemic disease threats. Network laboratories are also partners in mounting the response of the Global Outbreak Alert and Response Network. The importance of laboratory capacity was highlighted in the Ebola outbreak in West Africa and WHO is committed to expanding and deepening the Network and building capacities in this area.

17.   WHO's Emergency Communication Network, drawn from people who successfully completed in-depth training sessions, has a pool of 50 communications experts who have completed the pre-deployment training. WHO will expand the network and improve communications across all emergency response operations.

18.   WHO also collaborates with regional and subregional networks, agencies and organizations in responding to emergencies with health consequences. These include intergovernmental organizations like the Association of Southeast Asian Nations, the Secretariat of the Pacific Community, the Caribbean Community Secretariat, the African Union, and the West African Health Organization. In the case of the Ebola outbreak, the African Union and the Economic Community of West African States' West African Health Organization were key parts of the response, training and deploying hundreds of health care workers and public health specialists to the West African countries. WHO worked with these organizations, the World Bank and the United Nations Office for Project Services to create an operational platform for these deployments and the support of the deployees. Governmental agencies including the European Centre for Disease Prevention and Control and the United States of America's Centers for Disease Control and Prevention, many of whom are also partners in the Global Outbreak Alert and Response Network, also work with WHO in emergency response, deploying public health and laboratory experts and conducting research into the pathogens

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[1] Classification and minimum standards for foreign medical teams in sudden onset disasters. Geneva: World Health Organization; 2013. Available at http://www.who.int/hac/global_health_cluster/fmt_guidelines_september2013.pdf, accessed 11 May 2015.

that cause outbreaks, as they did for the Ebola response. WHO will continue and expand these relationships.

WHO standing and surge staff capacity

19.   Standing capacity refers to those human resources dedicated to emergency preparedness and response. WHO has four critical functions in responding to emergencies with health consequences – namely, leadership, information, technical expertise, and core services – and will have a critical mass of standing staff capacity with appropriate skills, across all levels of the Organization to fulfil these at all times.

20.   WHO will increase its dedicated emergency response staff from the current 530 full-time equivalents. Most emergency response staff members will be based at country level, with a significant number at the regional level in order to provide direct support to the country teams. A core team will work at headquarters.

21.   WHO is also committed to increasing its operational capacity, to complement its technical and normative strengths and will engage logisticians at all levels of the Organization, and in particular in high-risk countries. They will be charged with logistic preparedness and readiness, as well as assessment and field support operations, and will be rapidly deployable as part of the first-line responders, responsible for implementing WHO's operational platform in coordination with governments and partners.

22.   WHO's surge capacity is the ability of the Organization to draw on existing, non-emergency specific human resources when unforeseen emergencies or a deteriorating situation require a rapid and effective increase in response. In order to ensure that the response is proportionate to the scale of a given emergency, WHO will also identify a reserve corps of surge-ready staff members, with skill sets, including languages, that complement those of the standing emergency capacity. This capacity should also include the ability to rapidly scale down, when the need has been met. WHO will establish a roster, based on a staff profiling exercise across the Organization, to identify sufficient staff to allow it to rapidly and predictably respond to an event requiring a global response.

United Nations agencies, funds and programmes

23.   As part of the United Nations system, WHO has the advantage of having sister agencies, funds and programmes replete with expertise across all governmental sectors.[1] During the Ebola outbreak, it became clear that the capacities that WHO and the WFP brought to the subnational response would benefit from closer collaboration. A new, formal legal relationship established between the organizations is supporting a joint operations platform across the three countries, leveraging WFP's expertise in large-scale humanitarian logistics and WHO's expertise in outbreak response and health logistics. WHO and WFP will refine their collaboration and explore the full range of emergency response opportunities that this partnership presents. Similar arrangements are being explored with the United Nations Office for the Coordination of Humanitarian Affairs, UNFPA and UNICEF.

24.   WHO is also considering durable agreements with other United Nations entities that would expand the global health emergency workforce. One possibility would be to streamline staff transfer,

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[1] In the case of response to the Ebola outbreak in West Africa, the United Nations Mission for Emergency Ebola Response, the United Nations' first public health mission, harnessed the capacity of the system.

loan and secondment mechanisms. Another would be to partner with the United Nations Volunteers Programme, to allow for the deployment of, among others, retired WHO staff members, thereby capturing a potentially rich source of experience and knowledge that is otherwise difficult to access.

OPERATIONALIZING THE WORKFORCE

Pre-deployment and readiness

Rosters

25.   The first step in managing the global health workforce is identifying, as much as possible, its members. Deployment rosters have proven tremendously effective in partner organizations and modalities for establishing similar databases for the global health emergency workforce will be developed.

26.   The internal WHO rosters will reflect the dedicated standing capacity in emergency response departments across all three levels of the Organization, and those staff members in other departments, and in regional and country offices, who have been identified as being part of the surge capacity. Selecting surge-ready staff members will entail first the staff profiling exercise, as a first filter for finding staff with expertise and experience relevant to emergency response. WHO will then hold follow-up discussions with staff members identified as candidates and their supervisors in order to verify skill sets and map other variables (including type and length of contract and type of post funding). Once identified, surge staff will be assembled into teams with complementary skill sets. The teams will be trained on a regular basis (including through simulations) to ensure their readiness.

27.   The Global Outbreak Alert and Response Network, including the WHO Emerging and Dangerous Pathogens Laboratory Network, works with technical institutions worldwide to maintain inventories of technical response capacity, and ensure the rapid availability of experts and international response teams. The Organization's Emergency Communication Network maintains rosters, and the foreign medical teams unit's registry will serve the same purpose. The Global Health Cluster and standby partners also have databases of available experts, as do those United Nations entities that are involved in emergency response. One valuable contribution of the global health emergency workforce will be to harmonize these systems, making the information more accessible and coherent across platforms.

Quality assurance

28.   It is vitally important that people deployed to work on an emergency response have training and skills at the appropriate level and of the necessary quality in order to enable them to perform their assigned duties and maintain appropriate vigilance for risks and hazards. It is dangerous to individuals and to the collective response work to deploy people with inadequate experience or a lack of expertise with the hazard involved, without training and mentorship. As it is difficult to determine competency based solely on self-reported educational and professional experience, WHO will develop a process to verify training, experience and language proficiencies. In light of the essential need to expand the scope of the workforce, WHO will develop systems for mentorship and training to give people who lack elements of a complete response-ready profile the opportunity to fill in gaps, for instance by pairing epidemiologists with broad response experience with those who are newer and, between emergencies, providing development opportunities for young professionals. One existing example of the development of workforce members through mentorship and training is found in WHO's polio programme, where experts come to WHO for periods of 3–6 months for training and selected job

placements at all levels of the Organization. They then return to their home institution and form a cadre of responders known to WHO and familiar with organizational procedures, who are available for emergency deployments. This complements and supports the strategy of increasing the number of core WHO positions, especially in ensuring adequate numbers of experts for large and protracted events.

29.   In addition to verifying and building individual experts' readiness, WHO is mindful of the need for standardized protocols and information management for the global health emergency workforce as a whole. WHO will work with partners to promote and adapt existing quality assurance standards, understanding that while possibly optimal, global standards can be difficult to adopt. At the same time, WHO will work with partners to maximize the interoperability of elements of the workforce by, for example, agreeing on common terminology and developing generic functional job descriptions.

Training

30.   Three multi hazard pre-deployment training systems are currently in place within WHO. The Global Outbreak Alert and Response Network regional and global training activities are supported by a global faculty that draws on technical expertise, and existing training institutions and networks, and that uses practical application field training and simulation exercises to create rosters of multidisciplinary outbreak response teams pulled from the Network's institutions. WHO's surge capacity training, which replaced the public health pre-deployment training programme, is a classroom-based programme that finishes with a multiday field simulation exercise for WHO staff and Health Cluster and standby partner personnel. WHO's Emergency Communications Network pre-deployment training is an intensive nine-day, operation course with a three-day field simulation for WHO experts, consultants and partner organizations. The focus is on pre-training and selecting a roster of emergency communications, risk communications, social mobilization and/or community engagement personnel for emergency response. The programme includes field support and post-mission debriefing to capture experience and lessons learnt.

31.   In order to support the development of the global health emergency workforce, it is envisaged that a single emergency response training system will be set up for WHO-driven deployments.[1] Training packages that include simulations, that are adaptable to all hazards and suitable for rapid staff turnover and that can be easily replicated and adapted, will be standardized across partners. In order to expand the reach of these training programmes, WHO will explore options for online training modules and other non-traditional training methodologies, where safe and appropriate.

Deployment

Planning for deployment

32.   In line with recently initiated reforms of WHO's emergency capacities, dedicated systems – both administrative and technological – are being developed to support the deployment of dedicated emergency response staff members, surge teams and experts from partners that effect deployment through WHO mechanisms. These systems include databases that facilitate: the matching of needs to rosters; anticipatory strategic and operational planning; and template human resource plans that can be quickly tailored to a given response context.

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[1] Foreign medical teams are pre-trained and pre-qualified for clinical care. Hazard specific training is all that they would require.

33.   If deployment is to be successful, it is essential to have adequate financing in place. Ensuring the deployment capacity of WHO surge teams requires available, adequate funding for the deployment of responders and to compensate departments, regional and country offices that lend their staff members to the response. There is a need for pre-arranged agreements with supervisors or standing policies that prioritize emergency deployment, taking into consideration staff members who are working on projects with earmarked funding and strict deadlines.

Initiating deployment

34.   Following the declaration of an emergency, rapid needs and risk assessments are conducted using standard methodologies and protocols. Based on those outcomes, robust early planning can be undertaken to ensure that the response is commensurate with need, both in size and capacities. In any case when national capacity has been overwhelmed and a Member State requests support, the Director-General will deploy WHO's standing emergency response capacity and, where necessary, its surge capacity. When it is necessary to call on the Organization's network and partnership mechanisms, the Director-General or his or her delegate will consult with the steering committee with a view to rapid, appropriate and scalable deployment.

35.   The assessment processes are constantly reapplied in any specific emergency, including evaluations of national capacity, in view of the fact that the status of emergencies and the circumstances surrounding them can change rapidly. The results of these assessments will be used to make decisions about changes to the required workforce (for example, increasing or decreasing numbers, changing expertise profile or relocating).

Deploying

36.   Deployments include administrative procedures for emergency responders such as those for medical clearance, travel, visas, vaccination, insurance, field-level safety and security, accommodation, in-country transportation, health care needs, evacuation and administrative support. WHO is designing a deployment system that will holistically manage medical clearance, travel arrangements, visas, vaccination and insurance for people that the Organization deploys.

37.   WHO's partnership with the WFP is designed in part to provide standard, safe accommodation and workspaces in those subnational locations where this is not available, as well as transportation to and from accommodation and field sites. WHO's security services are responsible for ensuring safety and security, both at country-level and from regional offices and headquarters, as well as through the overarching United Nations field security systems and programmes.

38.   WHO works with partners and Member State governments to ensure that the health and well-being of responders, including medical care and mental health support, are adequately catered for during deployment.

Medical evacuation

39.   WHO is committed to providing medical evacuation to its international responders, as necessary and appropriate, regardless of hazard, and has traditionally provided evacuation to anyone it has deployed internationally who is in need of medical treatment that goes beyond what is available in the country of deployment. In most circumstances, this requires close communication among WHO offices and with partners which deploy personnel, rapid logistic management, appropriately designed

and triggered financial and insurance mechanisms and strong relationships with governments evacuating and receiving patients.

40.   Some hazards, such as particularly dangerous pathogens, create exceptionally difficult circumstances for medical evacuation. In these cases, the Organization is not able to make all arrangements autonomously and must to look to its partners for assistance.[1] During the response to the Ebola outbreak in West Africa, medical evacuation presented particular challenges in that there are only a limited number of aircraft designed to transport infected patients, and a limited number of hospitals equipped to treat them. In order to ensure that international responders could benefit from evacuation in the case of infection or suspected infection, WHO worked closely with Member States to coordinate evacuation.[2] WHO and the European Union's Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and Directorate-General for Health and Food Safety (SANCO) developed a trilateral evacuation system, coordinated by WHO, to provide the following: patient evaluation and treatment in-country, flight coordination, systematic identification of appropriate hospitals in Europe and dedicated communication lines for requesting governmental agreement to receive patients. In addition, financing mechanisms were put in place to guarantee full payment of transport and treatment costs exceeding the amount covered by a given responder's insurance.

41.   WHO will use the experience gained across its emergency responses during the Ebola outbreak in West Africa to refine and streamline its medical evacuation systems and will expand and build partnerships to best ensure the safety, health and well-being of its international responders.

Decommissioning

42.   The end of a deployment and the period immediately following it are as important as the deployment itself. Current mechanisms for repatriating each deployee will be strengthened, taking into consideration any circumstances unique to their home country (for example, entry screening or isolation requirements). Additionally, participating in emergency response activities often puts people in circumstances that have a physical and mental impact on them. The system must therefore provide adequate follow-up and support in order to facilitate a smooth health transition upon a deployee's return.

43.   Capturing the lessons learnt by experts while on mission is an essential component of monitoring and evaluating response performance. Although WHO has ready access to its own staff and their reports, it is more difficult to ensure that people deployed through one of the partnership mechanisms are fully debriefed and provided with opportunities to provide feedback to WHO on their experiences. WHO will use post-mission reports and deployee evaluations for assessing deployee performance and for improving overall systems.

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[1] The trilateral WHO-ECHO-SANCO partnership for medical evacuation during the West Africa Ebola outbreak provides a good model in this regard.

[2] The policy statement developed for the Ebola response read as follows: "The World Health Organization (WHO) has developed and operationalized comprehensive standard operating procedures for medical care of WHO staff members, consultants and other persons deployed to WHO to perform WHO work ("WHO deployees") who are suspected or confirmed to have been infected with the Ebola virus. If a WHO deployee is suspected or confirmed to have been infected with the Ebola virus, WHO will arrange for his/her transportation to and admission at an appropriate facility designated by WHO within the relevant country of operation. Subject to the outcome of a risk assessment, consultation with the responsible physician and confirmation of available capacity, WHO will arrange for medical evacuation to and hospitalization at an appropriate treatment facility outside the affected country and will pay for the costs that are not covered by the insurance of the concerned WHO deployee."

GOVERNANCE

44.   Effective emergency response requires the appropriate structure, culture and leadership across all levels of the Organization that deliver emergency response; it also requires protocols, processes and systems in place to ensure responsible management of deployments. As part of the reform of WHO's emergency capacities, the Organization is establishing an emergency response programme, which will include a unit dedicated to the direction and coordination of the global health emergency workforce. The unit will be responsible for deploying internal WHO standing and surge capacities. This role will include ensuring physical and mental health and safety and, when necessary, evacuation. The unit will also coordinate with and support networks and partnerships, and engage with the United Nations system and the private sector, as appropriate.

45.   WHO will have similar units dedicated to the global health emergency workforce at all levels of the Organization, supported by appropriately tailored information management systems.

46.   A steering group will be established representing relevant networks, partnerships, United Nations entities and other organizations involved in relevant emergency response deployments. The steering group's role will be to ensure harmonization across the various stages of workforce operationalization, namely: pre-deployment and readiness, deployment and decommissioning. It will conduct an annual review of its emergency response activities.

47.   The Director-General will report, on a regular basis, to the WHO governing bodies on progress made in implementing this plan.

FINANCING

48.   Adequate funding is essential for enabling the global health emergency workforce to be deployed with full effect. Given the diverse sources of the human resources that compose the workforce, funding also will come from a combination of sources.

49.   National responders are part of a national health system and are financed through national mechanisms, drawn on national and, where appropriate, international resources.

50.   As part of WHO's emergency response programme, the global health emergency workforce units will be funded through the existing programme budget, as will standing and surge staff members in times of non-deployment. When a rapid response is required, the WHO contingency fund will provide the necessary resources for the internal WHO staff surge, until appeal funding (or other funding) is received, in accordance with the mechanism proposed.[1]

51.   The salaries of experts who deploy through the Global Outbreak Alert and Response Network mechanisms are supported by their parent organizations, while WHO provides payments for travel and per diem and, where appropriate, hazard pay. The standby partners are funded by their donor organizations. In some cases, Global Health Cluster partners are self-funding and in others they are not. As with the internal surge, at the opening of a response the portion of costs for which WHO is responsible will be drawn from the contingency fund, until contributions tied to the response become available.

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[1] See document A68/26.

52. Partners who deploy as foreign medical teams and who collaborate with WHO through the Global Health Cluster are fully autonomous, and do not require funding from WHO.

TIMELINE

53. The key milestones for this plan are: (a) establishment of the WHO global emergency health workforce unit; (b) development of a detailed plan for operationalizing the global health emergency workforce, in light of ongoing reforms to the Organization's emergency capacities; (c) discussions with relevant partners regarding the structure and function of a steering committee to coordination and rationalize the networks and partnerships; (d) establishment of the steering committee; (e) expansion of internal standing capacity and creation of constant, trained, skilled surge capacity across WHO; (f) development of comprehensive, coherent rosters of responders for WHO and, following discussions, for networks and partners; and (g) development of standardized training packages to help regulate and ensure the quality of responders.

54. A review of WHO's standing and surge capacity will begin in June, and WHO's global health emergency workforce unit will be established by September 2015. Its first task will be to develop the detailed plan for operationalizing the global health emergency workforce. The first discussions with relevant stakeholders will start in June 2015,[1] with a view to establishing the steering committee by the end of the year. Rosters for networks and partnerships will be updated by the end of September 2015, with adjustments and reviews taking place in the last quarter of 2015, as necessary. By the end of 2015, WHO will have developed post descriptions and begin the process of advertising for standing emergency capacity positions and, with partners, will have developed training packages and have a system in place.

55. It is anticipated that the Director-General will report on progress in implementing the plan for a global health emergency workforce to the Executive Board at its 138th session in January 2016.

ACTION BY THE HEALTH ASSEMBLY

56. The Health Assembly is invited to adopt the draft decision in document A68/51, endorsing the Director-General's plan for a global health emergency workforce.

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[1] WHO will take advantage of forthcoming meetings of partnerships and networks, including the Global Health Cluster Partner Meeting, 17–19 June 2015, and the meeting of the GOARN Steering Committee, 24 and 25 June 2015.