Grand Bargain Self-Reporting Explanatory Guidance

1. All signatories to the Grand Bargain are expected to complete the self-report annually.

2. Self-reports must be returned to the Grand Bargain Secretariat [gbsecretariat@un.org] no later than **Thursday 15 March, 2018**. Any submissions after this date may not be considered by the 2018 Independent Grand Bargain Report.

3. Reporting should reflect activities and progress that has taken place between January 2017 and December 2017.

4. The self-report requests information by work stream, however, in order to best track progress, signatories are asked to provide as much specific and relevant detail on progress made against each of the 51 individual commitments as possible. A full list of commitments for each work stream is included in the self-report template for reference.

5. The questions contained in this self-report are the same as in 2017, however some work streams include additional question for signatories, at the request of the work stream co-conveners. If you are unable to provide this information, please note the reasons for this.

6. Signatories who have not previously completed a self-report are asked to answer question one for each work stream, to provide a baseline of where your organisation stood when it became a Grand Bargain signatory. Existing signatories can complete questions two to five for each work stream, as your 2017 self-report will have already provided the baseline information sought by question one.

7. Please type your answers immediately below each question asked.

8. Signatories are encouraged to report both on progress made, and where they may have experienced obstacles or challenges to realising their commitments.

9. Signatories are encouraged, where possible and relevant, to reflect on their contributions to the Grand Bargain both as recipients of humanitarian funds and donors of humanitarian funds. This will allow us to capture the transfer of benefits accrued at higher ends of the value chain down to the frontline.

10. Signatories are asked to limit their responses to a maximum of 500 words per work stream.

11. Self-reports are public documents, and will be published as submitted on the IASC-hosted Grand Bargain website from 3rd June, 2018.

12. Self-reports will be used to inform the 2018 Independent Annual Grand Bargain Report, which will provide a collective analysis of the progress for each work stream, and for the Grand Bargain as a whole. The Independent Annual Grand Bargain report will be published prior to the 2018 Annual Grand Bargain Meeting on 18 June 2018, in New York.

13. The 2018 Independent Annual Grand Bargain Report is being prepared by ODI/HPG. Signatories may be contacted by ODI/HPG as part of their research and preparation of the Independent Report.

14. If you require support or advice to complete your self-report, you may direct enquiries to the Grand Bargain Secretariat [gbsecretariat@un.org].

Gender Inclusion

Signatories are encouraged address to the gender dimensions of their Grand Bargain commitments. For reporting on each work stream, consideration should be given to the guidance provided by the *Aide-Memoire on Gender Mainstreaming in the Grand Bargain* that addresses the gender dimensions of resources, capacity, evidence and data, participation, leadership, accountability and communication within the Grand Bargain. Signatories are also welcome to provide additional detail on how they consider they have, at a macro level, ensured their Grand Bargain follow-up is gender-responsive, and to include any examples of good practice that they wish to share. This data will assist in the preparation of the 2018 Independent Grand Bargain report, which will assess the extent to which gender has been considered by Grand Bargain work streams.

2018 Grand Bargain Annual Self-Reporting – [World Health Organization]

Contents

Work stream 1 - Transparency

Aid organisations and donors commit to:

1. *Publish timely, transparent, harmonised and open high-quality data on humanitarian funding within two years of the World Humanitarian Summit in Istanbul. We consider IATI to provide a basis for the purpose of a common standard.*

2. *Make use of appropriate data analysis, explaining the distinctiveness of activities, organisations, environments and circumstances (for example, protection, conflict-zones).*

3. *Improve the digital platform and engage with the open-data standard community to help ensure:*
   - *accountability of donors and responders with open data for retrieval and analysis;*
   - *improvements in decision-making, based upon the best possible information;*
   - *a reduced workload over time as a result of donors accepting common standard data for some reporting purposes; and*
   - *traceability of donors' funding throughout the transaction chain as far as the final responders and, where feasible, affected people.*

4. *Support the capacity of all partners to access and publish data.*

Transparency work stream co-conveners reporting request: How will you use the data from IATI within your organization including, for example, for monitoring, reporting and vis-à-vis other Grand Bargain commitments?

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1. Baseline (only in year 1)

Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed?

2. Progress to date

Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

Commitment 1: WHO became a member of the International Aid Transparency Initiative (IATI) in November 2016 and issued IATI compliant data in May 2017.

Commitment 3: WHO recently invested in its Programme Budget Portal which now provides detailed public information about humanitarian as well as outbreak response funding flows.

3. Planned next steps

What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

Commitment 2: Through the IATI process, the WHO Programme Budget Portal will be able to report on funding flows down to activity level. WHO is engaging with Development Initiatives and has been included in the beta version of the GB transparency dashboard. Based on scoring in the dashboard, WHO will review areas where progress is required.

: WHO plans to continue to improve its digital platform to further enhance publishing of timely, transparent, harmonised and high-quality data on humanitarian funding.

4. Efficiency gains

Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.

No data analysis on this workstream has been undertaken thus far. Once the Development Initiatives dashboard is approved (and agreed as the methodology to be used for tracking progress on Grand Bargain transparency workstream), WHO will be able to track progress more effectively. More data analysis in general is required to cross-analyse results with circumstances.

5. Good practices and lessons learned

Which concrete action(s) have had the most success (both internally and in cooperation with other signatories) to implement the commitments of the work stream? And why?

The joint UN DFID funding supported cross-UN coordination and cooperation on this workstream. It supported Agencies in critically reviewing the proposed DI dashboard and encouraged dialogue between Agencies and with DFID as important humanitarian donor.

Work stream 2 – Localization

Aid organisations and donors commit to:

1. *Increase and support multi-year investment in the institutional capacities of local and national responders, including preparedness, response and coordination capacities, especially in fragile contexts and where communities are vulnerable to armed conflicts, disasters, recurrent outbreaks and the effects of climate change. We should achieve this through collaboration with development partners and incorporate capacity strengthening in partnership agreements.*

2. *Understand better and work to remove or reduce barriers that prevent organisations and donors from partnering with local and national responders in order to lessen their administrative burden.*

3. *Support and complement national coordination mechanisms where they exist and include local and national responders in international coordination mechanisms as appropriate and in keeping with humanitarian principles.*

4. *Achieve by 2020 a global, aggregated target of at least 25 per cent of humanitarian funding to local and national responders as directly as possible to improve outcomes for affected people and reduce transactional costs.*

5. *Develop, with the Inter-Agency Standing Committee (IASC), and apply a 'localisation' marker to measure direct and indirect funding to local and national responders.*

6. *Make greater use of funding tools which increase and improve assistance delivered by local and national responders, such as UN-led country-based pooled funds (CBPF), IFRC Disaster Relief Emergency Fund (DREF) and NGO- led and other pooled funds.*

Localisation work stream co-conveners reporting request: What percentage of your humanitarian funding in 2017 was provided to local and national responders
(a) directly (b) through pooled funds, or (c) through a single intermediary?[1]

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1. Baseline (only in year 1)
Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed?

2. Progress to date
Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

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[1] The "Identified Categories for Tracking Aid Flows" document agreed through silence procedure (available here) provides relevant definitions. The detailed data collection form (available here) may also assist you in responding to this question. Returning this form with your self report is optional, but encouraged.

Commitment 1:

In 2017, WHO supported the improvement of Ministry of Health Emergency Operations Centres (EOCs) and development of national health emergency plans in Jordan and Nigeria. In addition WHO supported the following countries with the development of a draft national implementation plans for Public Health Emergency Operations Centres: Morocco, Angola, Benin, Burundi, Central African Republic, Comoros, Ghana, Mali and Zambia. The implementation plans for these country contexts will be finalized in 2018.

WHO supported the increase of national and international capacities for health emergency response through the expansion and strengthening of Emergency Medical Teams. 33 countries have received in 2017 EMT capacity building support (Chile, Argentina, Cuba, El Salvador, Mexico, Nicaragua, Venezuela, Paraguay, Dominican Republic, Guatemala, Peru, Colombia, Ecuador, Costa Rica, Panama, Bolivia, Honduras; Kazakhstan, Tajikistan, Turkmenistan, Uzbekistan, Iran, India, Bhutan, Thailand, Indonesia, Fiji, Malaysia, Philippines, Solomon Islands, Tonga, Vanuatu, Republic of Korea) and 14 teams (China-Shanghai, China-Guangdong, Costa Rica, ASB-Germany (NGO), Johanniter-Germany (NGO), Japan-JICA; United Kingdom, New Zealand-NZMAT, Australia-AUSMAT, Ecuador, Russia-EMERCOM, Russia-ZASCHITA, Israel-IDF, Norway) are assessed by WHO as reaching the international EMT standards to be readily deployed internationally with highest standards.

WHO provides a range of activities to support the enhancement of national capacities for risk communication, in support of national Governments. WHO released an evidence-based guidance for emergency risk communication in 2017 and developed a social science interventions network for enhancing community level work to reduce infectious health risks and to promote community engagement.

WHO supported Member States through the implementation of 39 Joint External Evaluations (JEEs) providing Member States with a diagnosis of their capacities under the International Health Regulations (IHR) to prepare, detect and respond to health emergencies. Countries were as follows:
2017 (39 countries): Australia, Belgium, Benin, Bhutan, Botswana, Burkina Faso, Cameroon, Chad, Comoros, Finland, Gambia, Ghana, Guinea, Indonesia, Kenya, Kuwait, Lao People's Democratic Republic, Latvia, Lesotho, Liechtenstein, Madagascar, Maldives, Mali, Mauritania, Mongolia, Myanmar, Nigeria, Oman, Republic of Korea, Saudi Arabia, Slovenia, South Africa, South Sudan , Sri Lanka, Switzerland, Thailand, Uganda , United Arab Emirates, United Republic of Tanzania (Zanzibar), Zambia

National planning for strengthening country capacities for preparedness, detection and response to health emergencies under the IHR was advanced in 16 countries:
2017 (16 countries): Cambodia, Eritrea, Finland, Jordan, Kingdom of Saudi Arabia, Kyrgyzstan, Lao People's Democratic Republic, Liberia, Mongolia, Morocco, Myanmar, Mozambique, Namibia, Senegal, Sierra Leone Uganda.

Commitment 2 and 3:

WHO conducts activities to strengthen the operational readiness of countries, WHO country offices and partners for emergencies. WHO supported strategic health emergency risk assessment and mapping in priority countries to guide risk-informed programming and catalyse action to prevent, prepare for, and reduce the level of risk associated with a particular hazard and its consequences on health.

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2017 (7 workshops): Benin, Cape Verde, Comoros, Guinea, Mozambique, and South Sudan

WHO supported the review and updating of the national health emergency response plans of Madagascar, Tanzania and Togo.

WHO supported the development of risk specific contingency plan in Syria, Sudan, Somalia, Mali, Iran, Ukraine, Mozambique, DRC, Bangladesh, Indonesia, Myanmar, East-Timor, DPRK; Sri Lanka, India, Bhutan, and Nepal

WHO supported or participating in the 31 simulation exercises to test the readiness of countries, WHO COs and partners during 2017 as follows

Cameroon, China, Egypt, Indonesia simulation exercise, Inter-Agency Committee on Radiological and Nuclear Emergencies, Hungary, Inter-Agency exercise in Uzbekistan, G20 countries, GHSA countries, ICMM meeting - Indonesia, Inter-Agency exercise in Georgia, Iraq, Mauritania, Lao PDR, Mongolia, Pakistan, Turkmenistan, Regional exercise in Tunisia, SADC countries in South Africa, Uganda, United Republic of Tanzania, Viet Nam, WHO WPRO Regional Office exercise.

WHO supported IHR-PVS National Bridging Workshops to bring together national representatives of the animal and human health services to share the outcomes of their respective assessment frameworks, conduct a self-evaluation of the coordination between the sectors and develop a road-map of corrective measures to strengthen their collaboration and coordination at the human-animal interface. In 2017, 6 workshops were conducted in Indonesia, Jordan, Pakistan, Senegal, Uganda as well as United Republic of Tanzania.

WHO supports strengthening the safety and emergency management capacities of hospitals to withstand hazards and provide life-saving health services in times of emergencies. 70 countries have been supported to date. In 2017, WHO facilitated the first workshop in Central African Republic for applying WHO's Hospitals Safety Index.

Commitment 5:

WHO participated in the work of the IASC to develop the localisation definitions.

3. **Planned next steps**

What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

Commitments 1, 2, and 3:

In 2018, WHO plans also to continue its support to countries, WHO and interagency activities as follows:

- WHO plans to involve national actors in the country health clusters.
- WHO plans to continue and expand its work on support to national EOCs and national EMTs in strengthening their capacities in 36 additional countries and territories in the next biennium, with more to be confirmed (Haiti, Brazil, Uruguay, Turkey, Georgia, Senegal, South Africa, Nigeria, Uganda, Ivory Coast, Liberia , Egypt, Pakistan, Palestine, Oman, Qatar, Pakistan, UAE, Saudi Arabia, Bahrain, Kuwait, Lebanon, Morocco, Libya, Tunisia, Sudan, Djibouti, Bangladesh , Timor-Leste, Cambodia, Vietnam, Kiribati, Papua New Guinea, Western Samoa, Macao SAR/China).
- Joint External Evaluations: Algeria, Angola, Burundi, DRC, Malawi, Niger, Rwanda, Seychelles, Swaziland, Togo, Zimbabwe, Canada, Djibouti, Egypt, Iraq, Libya, Bosnia and Herzegovina,

Bulgaria, Estonia, Hungary, Lithuania, Republic of Moldova, Serbia, Tajikistan, Uzbekistan, Nepal, Brunei Darussalam, Federated States of Micronesia, Malaysia, New Zealand, Papua New Guinea, Philippines, Singapore

- National action planning: Benin, Chad, Comoros, Côte d'Ivoire, DRC, Ethiopia, Ghana, Guinea, Kenya, Lesotho, Mauritania, Nigeria, United Republic of Tanzania (Zanzibar), Zambia, United States of America, Afghanistan, Tunisia, Sudan, Albania, Belgium, Turkmenistan, Bangladesh, Indonesia, Sri Lanka, Thailand, Papua New Guinea, Viet Nam.

- Development of contingency plans : Ethiopia, Bangladesh (CXB), Nigeria, South Sudan, DRC, Somalia, OPT, Gambia, Ghana, Kenya, Liberia, Mozambique, Namibia, Sierra Leone, South Africa, South Sudan, Tanzania, Uganda and Zimbabwe. Further plans will be supported as risks emerge or evolve.

- Exercises: Mauritania, Nigeria, Senegal, Argentina G20 Health minister Exercise, Inter-Agency exercise in West Bank and Gaza Strip, Jordan, Morocco, Pakistan, Albania, Armenia, Azerbaijan, Bosnia-Herzegovina, Georgia, Kyrgyzstan, Macedonia, Serbia, Tajikistan, Bangladesh (Cox Bazar), Myanmar, Thailand, Cambodia, Malaysia.

- Risk assessments: Chad, Congo , Egypt, Mauritania and Nigeria

- IHR-PVS National Bridging Workshops Sierra Leone, Liberia, Guinea, Morocco Bhutan and Myanmar – about 15 additional candidate countries currently being discussed

- Safe hospitals: roll out of the Hospital Safety Index and strengthening linkages with health systems, sustainable health facilities, security, and hospitals preparedness for epidemics.

Commitment 4:

- WHO plans to map and analyse how the organisation is working with local and national responders in its priority emergency countries towards the development of a coherent localization strategy.

Commitment 5

- WHO plans to continue engaging with the IASC on definition and implementation of localization and to participate in the pilot projects that have been identified.

4. Efficiency gains

Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.

As a result of the Safe Hospitals Initiative, health facilities in Mexico resisted the major earthquakes in Mexico in September 2017, and continued to function and deliver health services. In the Caribbean and the British Virgin Islands in particular, the main hospital not only continued to function, but also provided the coordination centre for the overall national emergency operations centre.

National EMTs deployed effectively to multiple emergencies in 2017 thus reducing the need for international medical support. Examples include 17 national teams (of a total of 68 available) deploying to major flooding in southern Thailand in early 2017, negating the need for international team deployment, and using the EMT coordination architecture completely within their own sub national EOC after training of key Thai officials by WHO in New Delhi.

5. Good practices and lessons learned

Which concrete action(s) have had the most success (both internally and in cooperation with other signatories) to implement the commitments of the work stream? And why?

The EMT initiative exemplifies an emergency related initiative which develops national and local capacities according to a very specific standards level with a view to also develop deployable capacities abroad for certain teams- It works hand-in-hand with the WHO strategy to develop well-functioning Emergency Operating Centres which will position national authorities centrally for coordination functions, rather than imposing an international coordination structure.

WHO's support to countries for assessment and nation planning for accelerating the implementation of the International Health Regulations strengthens to collaboration between sectors and between national and international actors to prevent, prepare and respond to outbreaks. These processes are helping countries identify and cost priorities, including strategic risk assessments, planning for emergency response at country level, and inform Ministries of Finance and international donors on key areas for investment.

Aid organisations and donors commit to:

1. *Increase the routine use of cash alongside other tools, including in-kind assistance, service delivery (such as health and nutrition) and vouchers. Employ markers to measure increase and outcomes.*

2. *Invest in new delivery models which can be increased in scale while identifying best practice and mitigating risks in each context. Employ markers to track their evolution.*

3. *Build an evidence base to assess the costs, benefits, impacts, and risks of cash (including on protection) relative to in-kind assistance, service delivery interventions and vouchers, and combinations thereof.*

4. *Collaborate, share information and develop standards and guidelines for cash programming in order to better understand its risks and benefits.*

5. *Ensure that coordination, delivery, and monitoring and evaluation mechanisms are put in place for cash transfers.*

6. *Aim to increase use of cash programming beyond current low levels, where appropriate. Some organisations and donors may wish to set targets.*

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1. Baseline (only in year 1)
Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed?

2. Progress to date
Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

Commitment 3

- WHO is working closely with partners to improve the evidence base of cash programming for health. A cash task team has been created under the Global Health Cluster, led by WHO.

Commitment 4:

- An initial position paper on cash programming for health has been drafted and is undergoing comments within WHO and with partners.
- A request for a cash-cap adviser was made to support WHO coordination on cash in the health sector.

Commitment 5:

In Ukraine WHO coordinates delivery of international cash and vouchers programmes through the health cluster, looking in particular at ensuring appropriate use of cash and at removing competition and ensuring complementarity with Government's support programmes to the population to access affordable medicines.

3. Planned next steps

What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

Commitment 3

- Continued efforts are planned to gather evidence on the use of cash programming in health service provision.

Commitment 4:

- The finalisation of the position paper on cash programming for health will be followed by the development of standards and guidelines.
- WHO is also working with academic partners to study the efficiency gains of cash programmes in the health sector

Commitment 5:
- WHO plans to support countries and country-based health clusters in defining the best delivery options analysis, including cash where it is an appropriate delivery methodology.

4. Efficiency gains

Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.

Not assessed yet: there is limited evidence available of the operational practice and lessons on the use and efficacy of cash-based programming in the health sector. This is an area that WHO would like to explore but limited available funding has preventing from implementing wide-ranging studies.

5. Good practices and lessons learned

Which concrete action(s) have had the most success (both internally and in cooperation with other signatories) to implement the commitments of the work stream? And why?

The CashCap initiative could have strong potential to mobilize cash expertise to Agencies to review, coordinate and manage cash projects. WHO so far hasn't been able to benefit from this capacity but has made a recent new request, being considered.

Work stream 4 – Management costs

Aid organisations and donors commit to:

1. *Reduce the costs and measure the gained efficiencies of delivering assistance with technology (including green) and innovation. Aid organisations will provide the detailed steps to be taken by the end of 2017.*

Examples where use of technology can be expanded:

- *Mobile technology for needs assessments/post-distribution monitoring;*
- *Digital platforms and mobile devices for financial transactions;*
- *Communication with affected people via call centres and other feedback*
- *mechanisms such as SMS text messaging;*
- *Biometrics; and*
- *Sustainable energy.*

2. *Harmonise partnership agreements and share partner assessment information as well as data about affected people, after data protection safeguards have been met by the end of 2017, in order to save time and avoid duplication in operations.*

Aid organisations commit to:

3. *Provide transparent and comparable cost structures by the end of 2017. We acknowledge that operational management of the Grand Bargain signatories - the United Nations, International Organization for Migration (IOM), the Red Cross and Red Crescent Movement and the NGO sector may require different approaches.*

4. *Reduce duplication of management and other costs through maximising efficiencies in procurement and logistics for commonly required goods and services. Shared procurement should leverage the comparative advantage of the aid organisations and promote innovation.*

Suggested areas for initial focus:
- *Transportation/Travel;*
- *Vehicles and fleet management;*
- *Insurance;*
- *Shipment tracking systems;*
- *Inter-agency/common procurement pipelines (non-food items, shelter, WASH,*
- *food);*
- *IT services and equipment;*
- *Commercial consultancies; and*
- *Common support services.*

Donors commit to:

5. *Make joint regular functional monitoring and performance reviews and reduce individual donor assessments, evaluations, verifications, risk management and oversight processes.*

Management costs work stream co-conveners reporting request: What steps have you taken to reduce the number of individual donor assessments (if a donor) or partner assessments (if an agency) you conduct on humanitarian partners?

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1. Baseline (only in year 1)
Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed? N/A

2. Progress to date
Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

Commitment 1:

   a) WHO Health Emergencies Programme (WHE) has established an internal IT demand management mechanism in 2017. The Deputy Director-General, Emergency Preparedness and Response, has approved IT Guiding Principles, and empowered a cross-departmental IT Task Team to review all existing demand. The review process of all existing IT projects has reduced the 28 IT projects down to the 7-8 priority ones.

   b) The WHO Early Warning Alert and Response System (EWARS) electronic disease surveillance system was deployed to 5 countries in 2017: Bangladesh, Yemen, Chad, Solomon Islands, Vanuatu

   c) MyHealth app was developed in 2017. It is a solution on mobile device to monitor health from field workers deployed in emergencies, collecting health information, alerting and providing doctors with field worker health information

   d) Emergency SOPs Management Platform is under development, which will enable offline solution for mobile device, ensuring field deployees to have access to key documents and provide online feedback.

Commitment 2:

   a) The WHO due diligence system was systematised at corporate level as initial step to performing any partnership agreement in order to comply with the WHO Framework for Engagement of Non-state Actors (FENSA) obligations requested by WHO Member States. FENSA Handbook is now published online (http://www.who.int/about/collaborations/non-state-actors/en/). The emergency provisions for FENSA are being further developed and will be completed in 2018.

   b) WHO Emergency Dashboard was established in 2017 to serve as the online interactive dashboard that provides an overview of all emerging events & incidents to aid decision-making https://extranet.who.int/emergency-bi/

   c) WHE IT Task Team approved "GO Data 2.0" project which will be implemented in 2018. This tool will have quicker and more accurate identification of chains of disease transmission to interrupt these more effectively. It will enable a wider range of users (disconnected field operatives, health clinics, statisticians etc.) to access and work with contact tracing and disease data

   d) WHE rolled out Attack on Health data systems, which generates monthly reports with trends on attacks data by country, region and globally; as well as by type and impact. WHO speaks

with confidence about data on attacks on healthcare in emergency settings and is recognized as a global leader on data collection and sharing on this issue.

Commitment 3:

a) WHO's recent reform process has ensured the alignment of emergency functions and a single cost structure across the three levels of the organisation for the 2018-19 WHO Programme Budget.

b) WHO's Emergency country business model and all WHO Health Emergency Programme's priority country organigram for Health Emergencies Programme were finalized and standardized by end 2017.

Commitment 4:

a) Fleet Management Update: The WHO Fleet Services (WFS) project has drafted several critical documents including WFS SharePoint site with public and internal access, draft WFS fleet management manual, draft WFS pilot satisfaction survey, draft WFS fleet assessment tool, and standard vehicle catalogue updated. A pilot project has been approved for implementation in 2018 with the following objectives: establish a comparative benchmark to measure progress, test WFS "basic" package, demonstrate and prove business case of WFS, and establish an appropriate price for WFS. The list of countries include Republic of Congo (WHO AFRO – Brazzaville), Liberia, Kenya, and Rwanda. Collaboration and information sharing with UNHCR is in progress.

b) WHO and WFP have initiated a broad and comprehensive partnership arrangement for supply chain management capabilities concentrating on acute emergencies, protracted emergencies, and preparedness and readiness initiatives. The basic premise is to leverage the core strengths of each organization – WHO providing health sector leadership via technical guidance and first response capacity while WFP provides downstream logistical capacities.

c) WHO with external partners such as UNICEF, GOARN partners and WFP are collaborating on the development and verification of the Disease Commodity Packages, a technical database that describes the necessary critical supplies of 35 infectious diseases. This technical database will be the basis for numerous partner collaborations such as the Pandemic Supply Chain Network, Member State inventory management tools, and event planning tools for emergency responding partners.

d) The Pandemic Supply Chain Network is an operational platform under development that brings together critical multilateral agencies such as WFP, WHO, technical agencies from donor countries, and the private sector to ensure a fully functional supply chain network capable of responding to large scale epidemics and pandemics. Initial tools being developed are integration of the Disease Commodity Packages (WHO) with the Distribution Visualization Platform (WFP) to provide visibility of available stockpiles cross referenced with required supplies for specific diseases. Additionally, the PSCN is instituting with partners UNGM, WFP, and the World Economic Forum a market assessment and development initiative to ensure visibility and eventual access to critical supplies.

3. Planned next steps

What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

Commitment 1:

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a) WHO will streamline information technology projects within its Health Emergencies Programme.

b) WHE IT Task Team approved "GO Data 2.0" project which will be implemented in 2018. This tool will have quicker and more accurate identification of chains of disease transmission to interrupt these more effectively. It will enable a wider range of users (disconnected field operatives, health clinics, statisticians etc.) to access and work with contact tracing and disease data

Commitment 2:

a) WHO will issue emergency SOPs to FENSA obligations

b) Implementing "Go Data 2.0"

Commitment 3:

a) WHO is establishing a WHO Value for Money Implementation Plan that will be presented for approval by governing bodies in due course and articulated as central to the consultation and implementation of the 13th General Programme of Work (GPW).

Commitment 4:

a) Discussions with UNICEF and WFP will continue on the development of joint medical procurement processes for emergency response.

4. Efficiency gains

Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.

More research will be needed to assess quantitatively the efficiency gains made by all the aforementioned initiatives.

In terms of qualitative improvement, these are making WHO's emergency work more responsive and systematic.

5. Good practices and lessons learned

Which concrete action(s) have had the most success (both internally and in cooperation with other signatories) to implement the commitments of the work stream? And why?

The Pandemic Supply Chain Network is an operational platform under development that brings together critical multilateral agencies such as WFP, WHO, technical agencies from donor countries, and the private sector to ensure a fully functional supply chain network capable of responding to large scale epidemics and pandemics. Initial tools being developed are integration of the Disease Commodity Packages (WHO) with the Distribution Visualization Platform (WFP) to provide visibility of available stockpiles cross referenced with required supplies for specific diseases. Additionally, the PSCN is instituting with partners UNGM, WFP, and the World Economic Forum a market assessment and development initiative to ensure visibility and eventual access to critical supplies.

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Aid organisations and donors commit to:

1. *Provide a single, comprehensive, cross-sectoral, methodologically sound and impartial overall assessment of needs for each crisis to inform strategic decisions on how to respond and fund thereby reducing the number of assessments and appeals produced by individual organisations.*

2. *Coordinate and streamline data collection to ensure compatibility, quality and comparability and minimising intrusion into the lives of affected people. Conduct the overall assessment in a transparent, collaborative process led by the Humanitarian Coordinator/Resident Coordinator with full involvement of the Humanitarian Country Team and the clusters/sectors and in the case of sudden onset disasters, where possible, by the government. Ensure sector-specific assessments for operational planning are undertaken under the umbrella of a coordinated plan of assessments at inter-cluster/sector level.*

3. *Share needs assessment data in a timely manner, with the appropriate mitigation of protection and privacy risks. Jointly decide on assumptions and analytical methods used for projections and estimates.*

4. *Dedicate strengthen data collection and analysis in a fully transparent, collaborative process, which includes a brief summary of the methodological and analytical limitations of the assessment.*

5. *Prioritise humanitarian response across sectors based on evidence established by the analysis. As part of the IASC Humanitarian Response Plan process on the ground, it is the responsibility of the empowered Humanitarian Coordinator/Resident Coordinator to ensure the development of the prioritised, evidence-based response plans.*

6. *Commission independent reviews and evaluations of the quality of needs assessment findings and their use in prioritisation to strengthen the confidence of all stakeholders in the needs assessment.*

7. *Conduct risk and vulnerability analysis with development partners and local authorities, in adherence to humanitarian principles, to ensure the alignment of humanitarian and development programming.*

Needs assessment work stream co-conveners reporting request: What hurdles, if any, might be addressed to allow for more effective implementation of the GB commitment?

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1. Baseline (only in year 1)

Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed?

2. Progress to date

Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

Commitments 1 and 2:

WHO designed, implemented and promoted Public Health Information Services (PHIS) to ensure improved and coordinated data collection tools quality to be used for health need assessment and monitoring at sectoral and intersectoral level. The PHIS is composed by several tools, among these the following are related to need assessment:

1. Public Health Situation Analysis which presents a summary of pre-crisis health status, and expected drivers of excess morbidity and mortality. In 2017, WHO and Global Health Cluster (GHC) contributed to Humanitarian Need Overviews and intersectoral assessments with several PHSA in Nigeria, Bangladesh, Democratic Republic of Congo, Somalia.

2. Rapid Health Assessment for data field collection on health related needs.

3. Health Resources Availability Monitoring System (HeRAMS) that systematically monitors the availability of health resources & services to affected populations. It maps all health delivery points within the crisis-affected area. The HeRAMS approach is a collaborative process that involves all sector actors (incl. Ministry of Health) engaged in the delivery of health services. In 2017 HeRAMS was implemented in 7 countries (Nigeria, Central African Republic, Cameroon, Sudan, Yemen, Syria and Ukraine) in collaboration with health sector actors and in support to strategic decision making, over 400 partners have contributed to the its process.

4. The Early Warning Alert and Response System (EWARS), an information management system that supports generating alerts and enables timely response in an efficient manner to predict, prevent and control outbreaks and national epidemic threats. Aims to reduce the number of cases and deaths that occur during infectious disease outbreaks. In 2017 EWARS has been activated in 5 emergencies: Bangladesh, Chad, Solomon Islands, Vanuatu and Yemen.

WHO and Global Health Cluster are committed to supporting system-wide needs assessments for humanitarian action and continued efforts to achieve this are underway. More specifically sectoral and sub-sectoral (i.e. Gender base violence, Mental health, Vector-borne and WASH related diseases) assessments have contributed to the development of HNO and other intersectoral assessments in several emergencies in 2017.

WHO and Global Health Custer (GHC) are actively participating to the joint Inter-agency Assessment Group (JIAG) coordinated by OCHA and Food Security Cluster. Within the framework of the JIAG WHO and GHC aim to contribute to improve health sector related question within the intersectoral assessment, to provide a wider and deeper understanding of the situation in a graspable way.

Commitment 3:

- WHO's revised Emergency Response Framework formalizes an obligation by WHO to share in 72h the results of the WHO rapid risk assessments of infectious disease events to the IASC Chair and to the UN Secretary General if the risk is assessed as high or very high:

"Informing the United Nations system: Based on the IASC Level 3 Activation Procedures for Infectious Disease Events, the Director-General of WHO will inform the UN Secretary-General, with copy to the Emergency Relief Coordinator, within 72 hours of detection/reporting of an infectious disease event that is assessed as high or very high risk, or when it is assessed as a WHO Grade 2 or Grade 3 emergency." (Chapter 1: Risk Assessments and Situational Analysis, pg. 21)

- At the end of 2017 the afore-mentioned criteria was reviewed when WHO reported to its compliance under the UN Crisis Management Policy to report in 72h to the UN Secretary General events assessed by WHO as high/very high risk at regional and global level (discarding the national level risk since in 2017 there were 46 events assessed as high/very high at national level, which leads to too frequent notifications. This evolution in the reporting criteria was communicated to and agreed by the UN Secretary General's office.

- In 2017 PHIS (PHSA,HeRAMS and EWARS) tools findings have been shared systematically when produced at sectoral and intersectoral level. Some challenges remain in analysing the data on projections and forectast of scenarios as well as in having standardised guidelines in sensitive data sharing.

Commitment 4:

PHIS tools (PHSA, RHA, HeRAMS, EWARS) are built to ensure that data are captured and managed in a fully transparent and collaborative manner.

While PHSA is based on a validated and consultative methodology of Secondary Data Review and validation, HeWARS approach ensures transparency by decentralizing the data management/quality responsibility to each sector actor involved in service delivery and by ensuring findings are regularly shared.

Commitment 5:

Where implemented, PHIS tools (PHSA, HeRAMS, EWARS) have contributed to inter and intra cluster/sector prioritization mechanisms by providing:

- o Basic health need analysis
- o A picture of gaps in the availability of essential health resources and services
- o An Early warning system

The analysis and prioritirization has contributed to the development of Humanitarian Response Plans as well as National Operational Plans in sevreal countries.

WHO is contributing to the development of a Joint Interagency Analysis Framework. The aim is to improve prioritisation through the promotioin of a transparent and consultative methodology to provide evidence-based analysis for response plans.

WHO also tested in a simulation the IASC L3 infectious hazard protocol and drew conclusions on how to improve the prioritization across sectors of the response to these types of events, based on WHO's assessment of the situation.

Commitment 6:

An analysis of PHIS successes and challenges has been run and shared with GHC.

WHO performed 15 After Action Reviews (these cannot be qualified of independent however as performed by WHO) in the context of IHR in 2017: Burkina Faso, Iceland, Benin, Netherlands, Mozambique, Tanzania, Nigeria, Mauritania, Togo, DRC, Angola. CAR. Niger. Cape Verde, Namibia. Common themes that arised frequently include: The need to strengthen operational coordination through systematic incident management; The development of communication

plans and guidance for public health emergency situations; The need for regular refresher training and updating of protocols for infection prevention and control in healthcare settings.

Commitment 7:

Particpating to JIAG and JIAF WHO is commiting to support the process of nexus between humanitarian and development.

WHO performed a joint humanitarian and development analysis with the health authorities in Libya and in Ukraine, using the SARA (developmental) tool for Libya and the HERAMS (humanitarian) tool for Ukraine.

3. **Planned next steps**

What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

Commitments 1 and 2:

- WHO and GHC are working together with IOM for the improvement of the methodology and question's content of the health part of the Displacement Tracking Matrix by the year 2018.

- Within the framework of the Joint Intersectoral Assessment Group WHO and GHC aim to contribute to improve health sector related question within the intersectoral assessment, to provide a wider and deeper understanding of the situation in a graspable way.

- PHIS tools will be maintained in ongoing crises and promoted in other emergencies:

  o An updated version of the Rapid Health Assessment is being designed and will be finalised by mid-2018, to ensure a more detailed approach to field data collection for sectoral and intersectoral need assessment.

  o HeRAMS: as the approach expands, the number of contributing partners is expecting to increase further. Ongoing work on the HeRAMS guidance will ensure tighter links to all relevant inter-cluster/sector processes.

  o EWARS is going to be implemented in further emergencies by expanding the number of trianings and partnerships in affected countries where an alert system is needed

Commitment 3:

WHO will strive to systemize notifications of assessed risks of infectious hazard events to the IASC Chair and to the UN Secretary General, using the protocols agreed in 2017

PHIS: WHO and GHC aim to share PHIS products in a more systematic manner

HeRAMS: the analysis of HeRAMS data will be partly automatized. Cross-sector analysis workshops will be more systematically organized.

Commitment 4:

PHIS: ongoing work on the HeRAMS guidance will ensure methodological and analytical limitations are identified and that mitigation measures are proposed.

Commitment 5:

WHO will work with the IASC to revise the IASC L3 infectious event protocol according to the results of the simulation

Within the UN system, WHO will also work with the UNOCC to do a similar simulation to test the UN Crisis Management Policy for infectious events and draw specific conclusions for the UN system, engaging Departments such as DPKO or DPA not member of the IASC.

PHIS: the contribution of HeRAMS to intra and inter-cluster/sector prioritization mechanisms needs to be further systematized.

Commitment 6:

External evaluations of the HeRAMS approach are planned for the year 2018.

Commitment 7:

WHO will continue to contribute to joint multi-hazard risk assessments and analysis through the Interagency Standing Committee (IASC). It will leverage other agencies' capacities for conflict, hydro-meteorological, and economic forecasts and augment them with an analysis of their potential health impact on affected populations, as well as when these fragile operational environments may lead to potential large scale outbreaks contexts

HeRAMS: development partners will gradually be involved in all steps of the process, from the methodological development to the analysis of the data to ensure the humanitarian/development gap can be bridged

Cooperation with WB work on PDNA/RPBA is also envisioned, workstream to also work on needs monitoring strategies in protracted crises to foster the nexus between humanitarian and development, particularly regarding early recovery and health system strengthening.

6. Efficiency gains

Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.

PHIS (including HeRAMS) roll-out is still not systematized by WHO but the Grand Bargain is pushing the organization towards this direction. The good feedback from partner agencies on the usefulness of the HeRAMS in the countries where it was rolled-out is a qualitative feedback encouraging further efforts

After Action Reviews have also drawn clear conclusions on what needs to be improved in terms of IHR support.

7. Good practices and lessons learned

Which concrete action(s) have had the most success (both internally and in cooperation with other ries) to implement the commitments of the work stream? And why?

In the UN system the initiative by the UNOCC to review the UN Crisis Management policy forced agencies, including WHO, to critically look at what efforts have been made to abide to the agreed protocols on notifications of assessed risks

In the IASC, the IASC L3 infectious events protocol was most useful to test the systems and draw conclusions on what to improve.

The initiative by DFID to support 6 UN agencies through core funding to implement the Grand Bargain, with a specific effort on Needs Assessments is also a strong push for these

Agencies to work together and dedicate investments into more robust, objective, and complementary assessments and to base humanitarian planning on these assessments.

PHIS Good practices

- Excellent support for PHIS from country offices
- PHIS tools have been appreciated and utilised also by other sectors

PHIS Challenges

- More resources needed to improve analysis
- Need strong push from leadership for integrated Information Management
- Simultaneous contract breaks/absence of multiple IM assets
- Secure long term funding and strategic partnership.

Aid organisations and donors commit to:

1. *Improve leadership and governance mechanisms at the level of the humanitarian country team and cluster/sector mechanisms to ensure engagement with and accountability to people and communities affected by crises.*

2. *Develop common standards and a coordinated approach for community engagement and participation, with the emphasis on inclusion of the most vulnerable, supported by a common platform for sharing and analysing data to strengthen decision-making, transparency, accountability and limit duplication.*

3. *Strengthen local dialogue and harness technologies to support more agile, transparent but appropriately secure feedback.*

4. *Build systematic links between feedback and corrective action to adjust programming.*

Donors commit to:

5. *Fund flexibly to facilitate programme adaptation in response to community feedback.*
6. *Invest time and resources to fund these activities.*

Aid organisations commit to:

7. *Ensure that, by the end of 2017, all humanitarian response plans – and strategic monitoring of them - demonstrate analysis and consideration of inputs from affected communities.*

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1. Baseline (only in year 1)

Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed?

8. Progress to date

Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

Commitment 2:

WHO promoted the use of the Humanitarian Emergency Settings Perceived Needs (HESPER) , a method for assessing perceived needs in populations affected by large-scale humanitarian emergencies with trainings offered to all Agencies in using this tool.

Commitment 4:

The Global Health Cluster, led by WHO, has developed an Accountability to Affected Populations (AAP) operational tool.

9. Planned next steps

What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

- WHO plans to continue to utilise the HESPER tool in appropriate settings.

Commitment 4:

- WHO aims to develop and integrate a clear people-centred approach in which AAP, protection, diversity and conflict sensitivity are fully embedded in emergency response guidance, frameworks and trainings.

- WHO will build capacity to better harmonize WHO operational management systems and approaches and how they can involve affected populations in a coordinated manner in priority emergencies is reviewed. The project will also include establishing a list of countries in which WHO implements AAP and review the management of integrating priorities of affected populations in the program cycle, best practice. Lastly, recruited consultant will advise on improvements to current operational practices and on priority countries for implementation of AAP and areas for expansion of AAP involvement.

Commitment 7:

- The AAP operational tool developed by the Global Health Cluster, led by WHO, will be rolled-out to all country clusters.

- WHO will work towards reporting more systematically on feedback received through medical consultations and social mobilization.

10. Efficiency gains

Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.

- In the few countries where the HESPER Scale was used to define needs the results were excellent in terms of better perception of needs. Unfortunately the methodology is not prioritized

11. Good practices and lessons learned

Which concrete action(s) have had the most success (both internally and in cooperation with other signatories) to implement the commitments of the work stream? And why?

- The IASC Task Team on AAP/PSEA is the engine behind coordination in this workstream.

- The prioritization of concrete quantified results for Agencies by DFID on this workstream in the UN core funding support is also an important push factor

Work stream 7 - Multi-year planning and funding

Aid organisations and donors commit to:

1. *Increase multi-year, collaborative and flexible planning and multi-year funding instruments and document the impacts on programme efficiency and effectiveness, ensuring that recipients apply the same funding arrangements with their implementing partners.*

2. *Support in at least five countries by the end of 2017 multi-year collaborative planning and response plans through multi-year funding and monitor and evaluate the outcomes of these responses.*

3. *Strengthen existing coordination efforts to share analysis of needs and risks between the humanitarian and development sectors and to better align humanitarian and development planning tools and interventions while respecting the principles of both.*

Multi-year planning and funding work stream co-conveners reporting request: Please report the percentage and total value of multi-year agreements[2] you have provided (as a donor) or received <u>and</u> provided to humanitarian partners (as an agency) in 2017, and any earmarking conditions.[3] When reporting on efficiency gains, please try to provide quantitative examples.

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2. Baseline (only in year 1)
Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed?

3. Progress to date

Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

<u>Commitment 1:</u>

- WHO is finalising a protracted emergency framework that provides guidance on multi-year humanitarian planning and funding.

- A revised version of the Protracted Emergency Framework (PEF) for Fragile, Conflict-affected and Vulnerable (FCV) countries has been produced and is under internal approval. Sections with predictable deliverables and performance standards will be used in other ongoing work, such as the strategic framework for collaboration with the HIS cluster, and the work on permanent monitoring.

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[2] Multiyear funding is funding provided for two or more years based on a firm commitment at the outset

[3] For the Grand Bargain definitions of earmarking, please see Annex I. Earmarking modalities, as contained with the final agreement, available <u>here</u>.

- WHO is engaging with the World Bank, UNICEF and WFP on the Deliver Accelerated Results, Effectively and Sustainably (DARES) collaboration in priority countries which includes a guiding principle of multi-year programming. Such WHO programming approach is effective in Yemen.

- One of the orientations of the DARES partnership is to build on the Yemen experiences of Yemen and to extend the approach to other countries, most notably Libya (which will soon be initiated). Other priority countries that have been identified for subsequent projects include Somalia, Central African Republic, Democratic Republic of the Congo, Djibouti, Syria and Haiti.

- In Ukraine WHO has also moved towards strategic planning over a multi-year timeframes.

- WHO's Health Emergencies Programme currently has multi-year funding agreements with a number of donors, including UK DFID, US OFDA, Norway, Germany and Luxembourg.

4. Planned next steps

What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

All commitments

- WHO aims to undertake joint analyses in priority countries to increase collaborative humanitarian multi-year planning and funding, bringing together relevant humanitarian and development actors.

- WHO also plans to develop its peace-building programmatic approach which will necessarily be multi-year.

- Efforts will be undertaken to measure the cost-efficiency of such approaches with the support of WHO collaborating centres.

5. Efficiency gains

Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.

- Qualitative assessments of the efficiency in coordinating strategic humanitarian and development planning over multi-year is very good within WHO as reducing duplications and ensuring longer term vision and sustainability of approaches. Moving from a projects and outputs-based approach to a strategic and outcomes-based approach.

6. Good practice and lessons learned

Which concrete action(s) have had the most success (both internally and in cooperation with other signatories) to implement the commitments of the work stream? And why?

- DFID funding to support the Grand Bargain implementation is not only supporting this area of work specifically with indictors, milestones and targets common to all 6 participating UN Agencies, but also working over a 4 years timeframe, which is a relevant timeline to ensure consistent progress and efforts.

Work stream 8 - Earmarking/flexibility

Aid organisations and donors commit to:

1. *Jointly determine, on an annual basis, the most effective and efficient way of reporting on unearmarked and softly earmarked funding and to initiate this reporting by the end of 2017.*

2. *Reduce the degree of earmarking of funds contributed by governments and regional groups who currently provide low levels of flexible finance. Aid organisations in turn commit to do the same with their funding when channelling it through partners.*

Aid organisations commit to:

3. *Be transparent and regularly share information with donors outlining the criteria for how core and unearmarked funding is allocated (for example, urgent needs, emergency preparedness, forgotten contexts, improved management)*

4. *Increase the visibility of unearmarked and softly earmarked funding, thereby recognising the contribution made by donors.*

Donors commit to:

5. *Progressively reduce the earmarking of their humanitarian contributions. The aim is to aspire to achieve a global target of 30 per cent of humanitarian contributions that is non earmarked or softly earmarked by 2020[4].*

Earmarking/flexibility work stream co-conveners reporting request: Please specify if possible the percentages of 2017 vs 2016 of:

- Unearmarked contributions (given/received)
- Softly earmarked contributions (given/received)
- Country earmarked contributions (given/received)
- Tightly earmarked contributions (given/received)

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1. Baseline (only in year 1)
Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed?

12. Progress to date
Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

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[4] For the Grand Bargain definitions of earmarking, please see Annex I. Earmarking modalities, as contained with the final agreement, available here.

- WHO participates in the Inter-Agency Standing Committee (IASC) Financing Task Team (FTT) which provides a clear platform to advocate for flexible funding from donors.

Commitment 3:

- WHO's Contingency Fund for Emergencies (CFE) allows the Organization to rapidly scale up initial, acute response to outbreaks and emergencies with health consequences. Donor contributions are pooled and un-earmarked, allowing WHO the flexibility and speed to address health crises before they escalate.

- The WHO Italy Bilateral Emergency Fund (BEF) is an innovative partnership that allows WHO to quickly mobilize pre-positioned funding contributed by the Government of Italy to respond to health emergencies with minimal bureaucracy.

- WHO has developed a global investment case to explain didactically the global landscape of WHO operations with specific case studies looking at specific cost and cost savings of high visibility operations.

Commitment 4:

- WHO has made efforts to increase the visibility of flexible and softly earmarked funding, and acknowledges flexible donor contributions in donor updates and annual reports.

13. Planned next steps

What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

Commitment 1:
- WHO will continue to invest in coordination with the IASC Financing Task Team

Commitment 3:
- WHO is currently working on a strategy to provide sustainable funding to the CFE

Commitment 4:

- WHO will invest more into communication and visibility to donors providing flexible funding

14. Efficiency gains

Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.
- Unearmarked funding allow WHO to invest into systems that are the backbone of the Grand Bargain's implementation

15. Good practices and lessons learned

Which concrete action(s) have had the most success (both internally and in cooperation with other signatories) to implement the commitments of the work stream? And why?

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The Contingency Fund for Emergencies (CFE) was established by the World Health Assembly in 2015 as part of the wide-ranging reforms of WHO's work in emergencies and exclusively financed by unearmarked contributions by donors to the CFE. The unique benefit of the CFE is that it can be used to rapidly deploy WHO and global health emergency workforce assets for control and containment of a disease outbreak or to strengthen the health response in humanitarian crises before other funding mechanisms can be triggered. During a disease outbreak, for example, an early and robust response allows WHO, national health authorities and health partners to get ahead of the outbreak before it spreads. This was the case in the Democratic Republic of the Congo, where a US$ 2 million rapid grant from the CFE in 2017 enabled WHO to work with the Government to contain an Ebola outbreak. The fast response enabled by the CFE greatly reduced the loss of life and the need to spend many millions of dollars more to deal with the unchecked spread of the disease. The CFE released funding in less than 24 hours to get disease surveillance and control experts on the ground in Madagascar to help the Government stop the plague outbreak in the country and in Uganda to put out the Marburg virus on the border with Kenya. These relatively small outbreaks did not attract immediate donor attention and were not headline news. The CFE responded, saving donor resources, saving lives, and keeping them out of the headlines. The CFE has also been critical in supporting WHO to respond to complex emergencies, permitting WHO to set up humanitarian health operations and respond nimbly to changing circumstances on the ground. In Bangladesh, for example, the CFE has been essential in strengthening WHO's health response to the Rohingya refugee crisis and, later, to control a diphtheria outbreak in the camps, containing an emergency within an emergency. To date, the CFE has made more than 60 emergency allocations to 33 countries, two regional and one global response for a total of $46 million in response to disease outbreaks and humanitarian emergencies. The CFE is financed through voluntary contributions outside of WHO's core budget. The un-earmarked contributions are pooled together, allowing for flexibility in their use. Since the CFE's inception, 11 Member States have contributed nearly US$ 44.5 million to the fund against an original target of $100 million for the last biennium.

Aid organisations and donors commit to:

1. *Simplify and harmonise reporting requirements by the end of 2018 by reducing its volume, jointly deciding on common terminology, identifying core requirements and developing a common report structure.*

2. *Invest in technology and reporting systems to enable better access to information.*

3. *Enhance the quality of reporting to better capture results, enable learning and increase the efficiency of reporting.*

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1. Baseline (only in year 1)

Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed?

2. Progress to date

Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

Commitments 1 and 3

- WHO is taking part in the work stream pilot project to test the common reporting template for funds provided by Germany to support WHO's emergency operations in Iraq.

- In addition, WHO has revised its standard donor reporting template for emergency funding to incorporate elements of the work stream's proposed common reporting template (where appropriate in relation to the signed donor agreement).

3. Planned next steps

What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

Commitment 2:

- WHO has improved its online platform to both ensure better access to information on the use of donor funds and to communicate results more effectively. The portal was revised and now brings even more accessible budget, financing and expenditure data. This re-designed portal version IATI compliant is publishing financial data to the "output" level, which provides a more granular view on WHO activities and how these are funded.

Commitments 1 and 3

- WHO will continue to actively participate in the pilot project in Iraq.

4. Efficiency gains

Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.

- It is still too early to draw conclusions from the Iraq project but generally harmonization of donor requirements is very much requested by WHO field operations.

5. Good practices and lessons learned

Which concrete action(s) have had the most success (both internally and in cooperation with other signatories) to implement the commitments of the work stream? And why?

- The pilot project in Iraq is underway. Lessons learned and good practices will be reviewed when the pilot is completed with a view to implementing recommendations as appropriate.

Work stream 10 – Humanitarian – Development engagement

Aid organisations and donors commit to:

1. *Use existing resources and capabilities better to shrink humanitarian needs over the long term with the view of contributing to the outcomes of the Sustainable Development Goals. Significantly increase prevention, mitigation and preparedness for early action to anticipate and secure resources for recovery. This will need to be the focus not only of aid organisations and donors but also of national governments at all levels, civil society, and the private sector.*

2. *Invest in durable solutions for refugees, internally displaced people and sustainable support to migrants, returnees and host/receiving communities, as well as for other situations of recurring vulnerabilities.*

3. *Increase social protection programmes and strengthen national and local systems and coping mechanisms in order to build resilience in fragile contexts.*

4. *Perform joint multi-hazard risk and vulnerability analysis, and multi-year planning where feasible and relevant, with national, regional and local coordination in order to achieve a shared vision for outcomes. Such a shared vision for outcomes will be developed on the basis of shared risk analysis between humanitarian, development, stabilisation and peacebuilding communities.*

5. *Galvanise new partnerships that bring additional capabilities and resources to crisis affected states through Multilateral Development Banks within their mandate and foster innovative partnerships with the private sector.*

Humanitarian-Development engagement work stream co-conveners reporting request: What has your organisation done to operationalise the humanitarian-development nexus at country level?"

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1. Baseline (only in year 1)
Where did your organisation stand on the work stream and its commitments when the Grand Bargain was signed?

2. Progress to date
Which concrete actions have you taken (both internally and in cooperation with other signatories) to implement the commitments of the work stream?

Commitment 2:

- WHO supported the Member States negotiations to agree an international framework of priorities and guiding principles to promote the health of refugees and migrants (http://www.who.int/migrants/about/framework_refugees-migrants.pdf)

Commitments 1, 4, 5:

- WHO co-chairs (with UNDP) the IASC Task Team on the Humanitarian and Development Nexus. The Task Team shares a joint work plan with the UN Development Group (UNDG).

- WHO mapped the existing initiatives and processes which form the nexus between humanitarian and development work.

- WHO is working towards translating what the humanitarian development nexus means for health through WHO's protracted emergency framework and corporate policy on responding to the health needs of migrants and refugees.

- A peer support mechanism was established under the IASC Task Team to connect practitioners from over 15 countries implementing the Humanitarian, Development and Peace Nexus (HDPN). This allows them to exchange good practices, examples, concrete actions and activities they have established. It also allows them to trouble-shoot issues they see in their countries for implementing HDPN.

- WHO support missions took place to provide support to 4 countries (Sudan, Syria, Uganda, Ukraine) to enhance engagement between humanitarian and development actors in both the health sector and for the UN and Humanitarian Country Teams.

- WHO co-led the organization of a meeting of practitioners from Central and Eastern Africa in Entebbe. This meeting allowed these country colleagues to get together and define strategies to better perform joint analysis and to define collective outcomes.

- In terms of prevention, mitigation and preparedness, WHO is an active participant to the IASC Early-Warning / Early-Action report, which twice a year reviews the highest humanitarian risks towards early action. A dedicated page on infectious events was agreed which WHO populates when relevant, and WHO also informs the report on the potential health consequences of the highest risks identified.

- WHO also is an active participant in all PDNA and RPBA efforts done at global as well as at country level to do harmonized evaluation and costing of recovery requirements.

Commitment 5:

- WHO has agreed with the World Bank the essential elements of the Delivering Accelerated Results Effectively and Sustainably (DARES) programme which is in particular focusing at re-establishing functioning health systems in very fragile contexts. The programme is being piloted in Yemen.

- WHO also supported the World Bank in the development of the Pandemic Emergency Facility, which will be a standing financing instrument readily deployable for future infectious hazard events reaching certain parameters, for earlier and more effective response

3. Planned next steps
What are the specific next steps which you plan to undertake to implement the commitments (with a focus on the next 2 years)?

Commitments 1, 4, 5:

- WHO will continue to co-chair the IASC Task Team on the humanitarian and development Nexus, with increased emphasis in 2018 on country support

- WHO is providing leadership in the IASC and in the UNDG to agree on key messages on implementation of the humanitarian, development and peace nexus

- WHO will lead the production of country snapshots providing systematically organized information on country contexts where HDN/HDPN implementation is ongoing.

- WHO will coordinate with the other 6 UN agencies participating into the DFID UN core funding to implement the Grand Bargain for the reporting on the HDN indicators agreed with DFID .

- WHO will manage a consultancy project to provide definitional elements and process support to country teams for agreeing on "collective outcomes" which is a central component of operationalizing the humanitarian development nxus. The results of this work will be presented to the IASC (Q2 2017=8).

- WHO will continue to participate actively into the IASC EWEA process and into PDNA/RPBA efforts.

Commitment 4:
- WHO is developing an approach to stronger involvement of the health sector into peace-building.

Commitment 5:
- WHO will review the results of the Yemen DARES pilot and work with the World Bank at expansion of the programme to other countries.

4. Efficiency gains
Please indicate, qualitatively, efficiency gains associated with implementation of GB commitments and how they have benefitted your organisation and beneficiaries.

- In all countries where HDN or HDPN is being implemented country teams note strong efficiency gains in terms of coordination of initiatives, more aligned approaches to the Government strategies, and better and more harmonized reporting to donors.

- Some countries however also note a risk of creating a third planning platform to the HRP and the UNDAF and the need to ensure lesser planning more consistently rather than more planning frameworks. Some humanitarian donors by linking humanitarian funding to the existence of a HRP coincidently create disincentives to country teams to come up with innovative solutions to ensure better joint planning and programming frameworks.

5. Good practices and lessons learned
Which concrete action(s) have had the most success (both internally and in cooperation with other signatories) to implement the commitments of the work stream? And why?

- DFID UN core funding funding for the Grand Bargain has 2 indicators focused on HDN, and this supports joined-up approaches by all 6 agencies to invest into this in a coherent manner.

- The IASC HDN Task Team is the place where synergies are created at technical level for practical implementation of HDN with a dynamic group of NGOs, UN and Red Cross partners regularly meeting and advancing the work with direct support provided to countries.

- However the global landscape on HDN is too crowded with a multitude of initiatives working at different levels as well as several bilateral non-coordinated initiatives. Some rationalization is required or at least better harmonization and articulation.

- The dual language on HDN and New Way of Working is also creating confusions in the field. As the New Way of Working wording was met with anxiety and misunderstanding by several UN Member States, a rationalization of wording by calling systematically this work HDN (or HDPN if the peacebuilding element is including) and removing references to "New Way of Working" would also be beneficial to ensure better synergies and avoid confusions.