What's Next?

There is no telling where the next pandemic influenza virus will emerge. All countries must be ready to respond when it does.

PIP supported developing countries to strengthen preparedness capacities in five key areas: laboratory and surveillance, burden of disease estimation, regulatory preparedness, planning for pandemic product deployment, and risk communications. By strengthening capacities, PIP contributed to pandemic influenza preparedness as well as global health security. Significant progress has been made, but more work is needed. This is why PIP will continue to support pandemic influenza preparedness globally.

"The requirements for preparedness are complicated. At a minimum, countries need a solid legal and regulatory foundation, adequately trained and equipped public health workforce, strong surveillance and response framework, functional national public health laboratories, and robust multi-sectoral coordination."[27]

International Working Group on Financing Preparedness

School children learning about influenza prevention, South Africa. © WHO/Isadore Brown

“HLIP I has made the PIP Framework’s performance transparent, visible and measurable to Member States, industry, civil society and other partners. Lessons learnt from HLIP I in terms of achievements and gaps guided the development of HLIP II, which includes process measures to enable better monitoring of progress. It also synergizes with other programmes for strengthening preparedness and response to help countries achieve IHR 2005 core capacities.”

Mahmudur Rahman,
Chair of the PIP Framework
Advisory Group (2017–2019)

Transitioning to HLIP II

A second High-Level Implementation Plan (HLIP II) was developed to guide PIP investment priorities from 2018–2023.[28] Influenza surveillance systems, knowledge and capacities for a timely and appropriate response to pandemic influenza will continue to be established and strengthened. HLIP II will build on each of the five areas of work to fill some of the gaps that remain in global preparedness, and will introduce an additional area of work, Influenza Pandemic Preparedness Planning.[29]

Laboratory & surveillance

Support countries to improve their laboratory and surveillance system capacities, and to actively participate in GISRS.

Burden of disease

Develop national, regional and global influenza burden estimates, and focus on ensuring that they are communicated in an effective manner so that estimates are used by decision-makers.

Regulatory capacity building

Improve regulatory systems and processes that facilitate timely access to pandemic influenza products including antivirals, diagnostics and vaccines.

Risk communications and community engagement

Refine interventions to include social and behavioral science-based risk reduction strategies, while placing a direct focus on exercising capacities for seasonal influenza to improve preparedness for pandemic influenza.

Planning for deployment

Support the development and review of global and national plans for pandemic product deployment, and assist countries in developing and sustaining influenza vaccine procurement and production policies.

Influenza pandemic preparedness planning

A new area of work to support countries to further develop their pandemic influenza preparedness plans. Plans will link progress made under the other HLIP II Outputs.

Endnotes

1 International Working Group on Financing Preparedness. From Panic and Neglect to Investing in Health Security: Financing Pandemic Preparedness at a National Level. 2017 (http://documents.worldbank.org/curated/en/979591495652724770/pdf/115271-REVISED-FINAL-IWG-Report-3-5-18.pdf, accessed 24 August 2018).

2 Past Pandemics [website]. Centers for Disease Control and Prevention. 2017 (https://www.cdc.gov/flu/pandemic-resources/basics/past-pandemics.html, accessed 24 August 2018).

3 Implementation of the International Health Regulations (2005): Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009. Report by the Director-General. Geneva: World Health Organization; 2011 (A64/10; http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf, accessed 24 August 2018).

4 Chan, M. Address to the Executive Board at its 140th session. Geneva: World Health Organization; 2017 (http://www.who.int/dg/speeches/2017/140-executive-board/en/, accessed 24 August 2018).

5 See: Pandemic influenza preparedness framework for the sharing of influenza viruses and access to vaccines and other benefits, sections 6.14.1 and 6.14.2 (http://apps.who.int/iris/bitstream/handle/10665/44796/9789241503082_eng.pdf;jsessionid=B020FE13FC3994BA0CF53C2093774FC5?sequence=1, accessed 24 August 2018).

6 Pandemic Influenza Preparedness Framework Partnership Contribution Implementation Plan 2013 – 2016. Geneva: World Health Organization; 2015 (http://www.who.int/entity/influenza/pip/pip_pcimpplan_update_31jan2015.pdf?ua=1, accessed 24 August 2018).

7 See: Guiding Principles for use of PIP Partnership Contribution "Response" Funds. 23 October 2014 (http://www.who.int/influenza/pip/guiding_principles_pc_response_funds.pdf?ua=1, accessed 24 August 2018).

8 Communicating risk in public health emergencies: a WHO guideline for emergency risk communication (ERC) policy and practice. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

9 Berlin Declaration of the G20 Health Ministers: Together Today for a Healthy Tomorrow. Berlin: G20 Germany; 2017.

10 Participation and performance on EQAP reflects country level laboratory capacities. The results are reported in Output 1 (Detection) to highlight country level progress. The funding for EQAP was under Output 3 (Global Collaboration) as WHO headquarters administered the funding each year.

11 More information about SMTA2 can be found here: http://www.who.int/influenza/pip/smta2/en/.

12 Burden of Disease infographics are available at: http://www.who.int/influenza/surveillance_monitoring/bod/MeasuringBOD_Infographic.pdf?ua=1 and http://www.who.int/influenza/surveillance_monitoring/bod/WHO-INFLUENZA-MortalityEstimate.pdf?ua=1.

13 Iuliano AD, Roguski KM, Chang HH, Muscatello DJ, Palekar R, Tempia S et al. Estimates of global seasonal influenza-associated respiratory mortality: a modelling study. Lancet. 2018;391:1285-1300. doi: 10.1016/S0140-6736(17)33293-2.

14 Coleman BL, Fadel SA, Fitzpatrick T, Thomas SM. Risk factors for serious outcomes associated with influenza illness in high- versus low- and middle-income countries: Systematic literature review and meta-analysis. Influenza Other Respir Viruses. 2018;12:22-29. doi:10.1111/irv.12504.

15 Guidelines on regulatory preparedness for provision of marketing authorization of human pandemic influenza vaccines in non-vaccine-producing countries. WHO Expert Committee on Biological Standardization, Sixty-seventh report; WHO Technical Report Series No.1004, Annex 7. Geneva: World Health Organization; 2017 (http://apps.who.int/medicinedocs/documents/s23326en/s23326en.pdf, accessed 24 August 2018).

16 List of countries participating in WHO's CRP is available at: https://extranet.who.int/prequal/content/collaborative-registration-faster-registration.

17 A checklist for pandemic influenza risk and impact management: building capacity for pandemic response. Geneva: World Health Organization; 2018 (http://apps.who.int/iris/bitstream/handle/10665/259884/9789241513623-eng.pdf;jsessionid=2C4D6737B64718CD80B4F71AC69582D7?sequence=1, accessed 24 August 2018).

18 For more information on country prioritization see: www.who.int/influenza/pip/pip_pc_ga.pdf?ua=1 and www.who.int/influenza/pip/benefit_sharing/PCCountryPrioritizationCriteria.pdf?ua=1.

19 Of the 43 L&S priority countries, country specific reports were not prepared for four countries that received no or minimal PIP funds (Algeria, Burundi, South Africa and Ukraine). However, these countries reported against relevant indicators, which are presented throughout the report.

20 Integrated Diseases Surveillance and Response in the African Region Community-based Surveillance (CBS) Training Manual. Brazzaville: WHO Regional Office for Africa; 2015 (ISBN: 978-929023298; www.afro.who.int/sites/default/files/2017-06/community-based-surveillance_idsr_training-manual.pdf, accessed 24 August 2018).

21 Protocol for national influenza sentinel surveillance. Brazzaville: WHO Regional Office for Africa; 2015 (ISBN: 978- 929023288-9; www.afro.who.int/sites/default/files/2017-06/97892%2090232889.pdf, accessed 24 August 2018).

22 Protocol for the investigation of acute respiratory illness outbreaks of unknown etiology. Brazzaville: WHO Regional Office for Africa; 2016 (ISBN: 978-929023300-8; https://www.afro.who.int/sites/default/files/2017-06/protocol-for-the-investigation-of-acute-respiratory-illness-outbreaks-of....pdf, accessed 24 August 2018).

23 Malik MR, Ul Haq Z, Saeed Q, Riley R and Khan WM. Distressed setting and profound challenges: Pandemic influenza preparedness plans in the Eastern Mediterranean Region. Journal of Infection and Public Health, 11 (2018) 352–356 doi: 10.1016/j.jiph.2017.09.018.

24 Ibrahim E, Sirawan A, El-Bazzal B, El Hage J, Abi Said M, Zaraket H, Kandeil A, Ali MA, Kayali G. 2016. Complete genome sequence of the first H5N1 avian influenza virus isolated from chickens in Lebanon in 2016. Genome Announc 4(5):e01062-16.

25 Farah Z, Khatib O, Hamadeh S, Ahmad K, El-Bazzal B, Zalloua P, Ammar W, Ghosn N. 2018. Containment of Highly Pathogenic Avian Influenza A(H5N1) Virus, Lebanon, 2016. Emerging Infectious Diseases 24(2): 374-376. doi: 10.34201/eid2402.171276.

26 Hamid S, Bell L, Dueger E. Digital dashboards as tools for regional influenza monitoring. Western Pac Surveill Response J. 2017 August;8(3). Doi: 10.5365/wpsar.2017.8.2.003.

27 International Working Group on Financing Preparedness. From Panic and Neglect to Investing in Health Security: Financing Pandemic Preparedness at a National Level. 2017 (http://documents.worldbank.org/curated/en/979591495652724770/pdf/115271-REVISED-FINAL-IWG-Report-3-5-18.pdf, accessed 24 August 2018).

28 Partnership Contribution (PC) Preparedness High-Level Implementation Plan II 2018-2023. Geneva: World Health Organization; 2018 (WHO/WHE/IHM/PIP/2018.1). License: CC BYNC-SA 3.0 IGO.

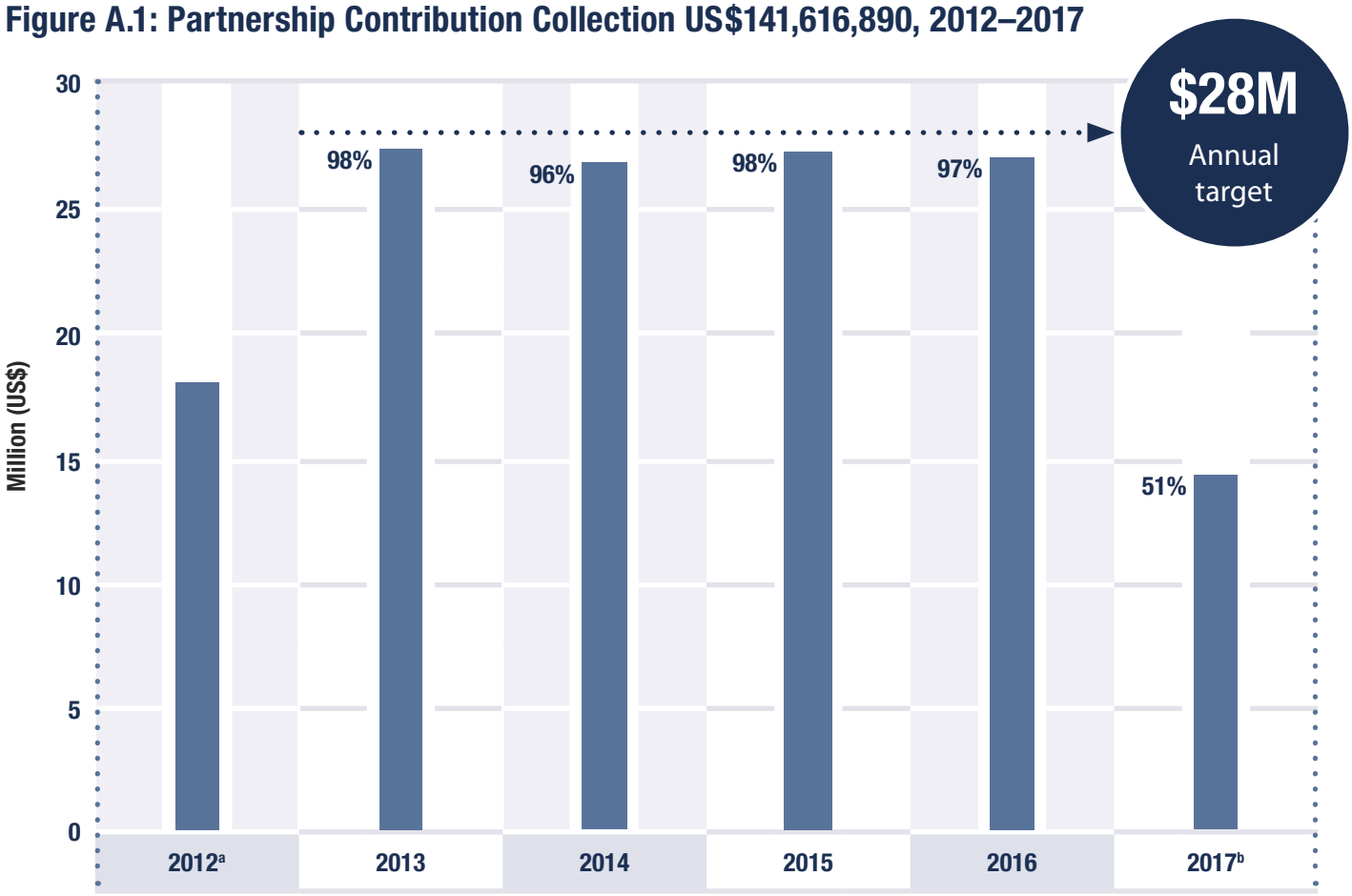
29 Pandemic Influenza Preparedness Framework Partnership Contribution Implementation Plan: Analysis of Gaps and Needs for the PIP PC Implementation. Geneva: World Health Organization; 2017 (http://www.who.int/entity/influenza/pip/benefit_sharing/PIP_GapAnalysis2017.pdf?ua=1, accessed 24 August 2018).

Annexes

Training in specimen collection from patients with severe acute respiratory infection in Armenia. © WHO/Kristine Avetisyan

Annex A: Financial report

Figure A.1: Partnership Contribution Collection US$141,616,890, 2012–2017



a Voluntary contribution made by seven manufactures prior to full implementation of the PC formula in 2013.

b Amount received through 31 December 2017. PC collection for 2017 is in process.

Table A.1: Partnership Contribution received from each manufacturer, 2012–2017

Manufacturer	Total Revenue (US$)
Adimmune Corporation	65,543
Alere Inc.	117,159
Baxter International Inc.	209,205
Becton Dickinson and Company (BD)	311,432
Beijing Tiantan Biological Procucts Co, Ltd .	235,234
Cadila Healthcare Ltd. (R&D Center)	12,716
Cepheid	10,591
Changchun Institute of Biological Products Co., Ltd.	208,231
China National Biotec Group	20,000
CSL Limited	2,667,744
Denka Seiken Co., Ltd.	2,171,983
DiaSorin Molecular LLC	29,692
Fast Track Diagnostics	10,592
Fluart Innovative Vaccines LTD	233,772
Focus Diagnostics, Inc.	83,845
Glaxosmithkline (GSK)	35,511,253
Government Pharmaceutical Organization (GPO)	10,591
Green Cross Corporation	1,642,363
Hoffmann - La Roche and Co., Ltd.	33,335,432
Indevr, Inc.	7,439
Institute of Vaccines and Medical Biologicals (IVAC)	10,592
Kaketsuken	2,997,703
Kitasato Daiichi Sankyo Vaccine Co. Ltd .	1,642,403
Lanzhou Institute of Biological Products	2,173
Medicago Inc.	7,439
Medimmune	5,160,761
Nanosphere Inc.	10,322
NPO Petrovax Pharm	7,792
Novartis	15,292,741
Omninvest Vaccine Manufacturing, Researching & Trading Ltd.	149,442
Princeton Biomeditech Corporation	10,591
Protein Sciences Corporation	4,944
PT Bio Farma (Persero)	4,984
QIAGEN	61,512
Quidel Corporation	8,136
Response Biomedical Corporation	5,417
Research Foundation for Microbial Diseases of Osaka University	1,288,541
Saint-Petersburg Scientific Research Institute of Vaccines & Sera	86,816
Sanofi Pasteur	31,468,521
Serum Institute of India Ltd.	35,623
Seqirus	3,779,042
Shanghai Institute of Biological Products Co., Ltd.	482,969
Sinovac Biotech Ltd.	482,969
Takeda Pharmaceuticals Internatioanl GmbH	10,591
The Research Foundation for Microbial Disease of Osaka University	1,694,489
UMIN Pharm INC.	2,799
Vabiotech	12,761
Total Revenue	**141,616,890**

Table A.2: Fund allocation and expenditure (US$) 1 January 2013 – 31 December 2017 (based on funds received 1 December 2012 – 31 December 2017)[a]

Area of work	Output	Total allocated 2013–2017	Total expenditure 2013–2017[b]	Expenditure 2013	Expenditure 2014–15	Expenditure 2016–17	Implementation (%)	Balance
Laboratory & surveillance	Detection capacity	15,915,313	14,875,150	-	6,010,781	8,864,369	-	1,040,163
	Monitoring capacity	12,072,005	10,128,011	-	4,552,791	5,575,220	-	1,943,994
	Strengthening networks	19,624,963	17,942,936	-	7,315,677	10,627,259	-	1,682,027
	Sub-total	**47,612,281**	**42,946,097**		**17,879,249**	**25,066,848**	**90%**	**4,666,184**
Burden of disease	Regionally representative estimates	1,702,827	1,012,912	-	609,710	403,202	-	689,915
	Global estimates	1,872,132	1,100,713	-	23,396	1,077,317	-	771,419
	Sub-total	**3,574,959**	**2,113,625**	**-**	**633,106**	**1,480,519**	**59%**	**1,461,334**
Regulatory capacity building	Guidelines	317,282	217,466	-	89,481	127,985	-	99,816
	Targeted training	3,803,408	2,916,739	-	1,003,531	1,913,208	-	886,669
	Common approach for accelerated approval	253,556	194,398	-	24,416	169,982	-	59,158
	Sub-total	**4,374,246**	**3,328,603**	**-**	**1,117,428**	**2,211,175**	**76%**	**1,045,643**
Risk communications	Training on risk communication	2,990,037	2,879,453	-	1,720,799	1,158,654	-	110,584
	Support to priority countries	3,048,923	2,249,099	-	1,066,349	1,182,750	-	799,824
	Emergency communications network	843,489	842,578	-	562,822	279,756	-	911
	Sub-total	**6,882,449**	**5,971,130**	**-**	**3,349,970**	**2,621,160**	**87%**	**911,319**
Planning for deployment	Deployment operations	2,468,777	1,887,245	-	473,687	1,413,558	-	581,532
	Country readiness	1,103,856	614,012	-	201,829	412,183	-	489,844
	Sub-total	**3,572,633**	**2,501,257**	**-**	**675,516**	**1,825,741**	**70%**	**1,071,376**
Total for Preparedness (net of PSC for 2014–2017)		**66,016,568**	**56,860,712**	-	**23,655,269**	**33,205,443**	**86%**	**9,155,856**
Unallocated funds for Preparedness[c]		12,937,971	-	-	-	-	-	12,937,971
PSC (13%) on Preparedness funds		10,264,090	7,391,893	-	3,075,185	4,316,708	-	2,872,197
Grand total for Preparedness (including PSC 13%, 2014–2017)		**89,218,629**	**64,252,605**	**-**	**26,730,454**	**37,522,151**	**84%[d]**	**24,966,024**
PIP Secretariat (net of PSC)		10,985,968	9,798,593	929,290	3,277,278	5,592,025	-	1,187,375
Unallocated funds for PIP Secretariat[c]		1,546,510	-	-	-	-	-	1,546,510
PSC (13%) on PIP Secretariat funds		1,629,222	1,273,817	120,808	426,046	726,963	-	355,405
Grand total for Secretariat (including PSC 13%, 2013–2017)		**14,161,700**	**11,072,410**	**1,050,098**	**3,703,324**	**6,318,988**	**88%[e]**	**3,089,290**
Response funds (including PSC 7%, 2012–2017)		**38,236,561**	**-**	**-**	**-**	**-**	**-**	**38,236,561**
Grand total for PIP		**141,616,890[f]**	**75,325,015**	**1,050,098**	**30,433,778**	**43,841,139**	**85%[g]**	**66,291,875[h]**

a Funds unallocated/not implemented as at 31 December 2017 will be carried over to the 2018–2019 biennium.

b Expenditure for the PIP Secretariat is for the period 2013–17 and for Preparedness 2014–17.

c Unallocated funds include Partnership Contribution received after allocations for implementation of 2017 work plans were made.

d Calculated on funds allocated only i.e. US$ 76,280,658 (US$ 89,218,629 minus unallocated funds US$ 12,937,971).

e Calculated on funds allocated only i.e. US$ 12,615,190 (US$ 14,161,700 minus unallocated funds US$ 1,546,510).

f Total Partnership Contribution received (1 December 2012 - 31 December 2017).

g Calculated on funds allocated for Preparedness and PIP Secretariat only i.e. US$ 88,895,848 [(US$ 89,218,629 - US$ 12,937,971) + (US$ 14,161,700 - US$ 1,546,510)].

h This number includes Response Funds (US$ 38,236,561) which will only be used at the time of a pandemic.

Table A.3: Area of work annual expenditures (US$, net of PSC), 2014–2017

Area of work	Output	Expenditure 2014	Expenditure 2015	Expenditure 2016	Expenditure 2017	Total expenditure 2014–17
Laboratory & surveillance	Detection capacity	1,341,714	4,669,067	4,282,318	4,582,051	14,875,150
	Monitoring capacity	1,067,486	3,485,305	1,808,721	3,766,499	10,128,011
	Strengthening networks	1,940,738	5,374,939	5,029,411	5,597,848	17,942,936
	Sub-total	**4,349,938**	**13,529,311**	**11,120,450**	**13,946,398**	**42,946,097**
Burden of disease	Regionally representative estimates	94,254	515,456	289,316	113,886	1,012,912
	Global estimates	-	23,396	436,200	641,117	1,100,713
	Sub-total	**94,254**	**538,852**	**725,516**	**755,003**	**2,113,625**
Regulatory capacity building	Guidelines	29,210	60,271	127,206	779	217,466
	Targeted training	74,779	928,752	1,033,555	879,653	2,916,739
	Common approach for accelerated approval	-	24,416	19,982	150,000	194,398
	Sub-total	**103,989**	**1,013,439**	**1,180,743**	**1,030,432**	**3,328,603**
Risk communications	Training on risk communication	459,913	1,260,886	557,485	601,169	2,879,453
	Support to priority countries	143,549	922,800	460,209	722,541	2,249,099
	Emergency communications network	209,807	353,015	61,482	218,274	842,578
	Sub-total	**813,269**	**2,536,701**	**1,079,176**	**1,541,984**	**5,971,130**
Planning for deployment	Deployment operations	-	473,687	844,778	568,780	1,887,245
	Country readiness	48,861	152,968	148,180	264,003	614,012
	Sub-total	**48,861**	**626,655**	**992,958**	**832,783**	**2,501,257**
Total for Preparedness		**5,410,311**	**18,244,958**	**15,098,843**	**18,106,600**	**56,860,712**

Figure A.2: Expenditures across each area of work by biennium (US$, net of PSC), 2014–2017

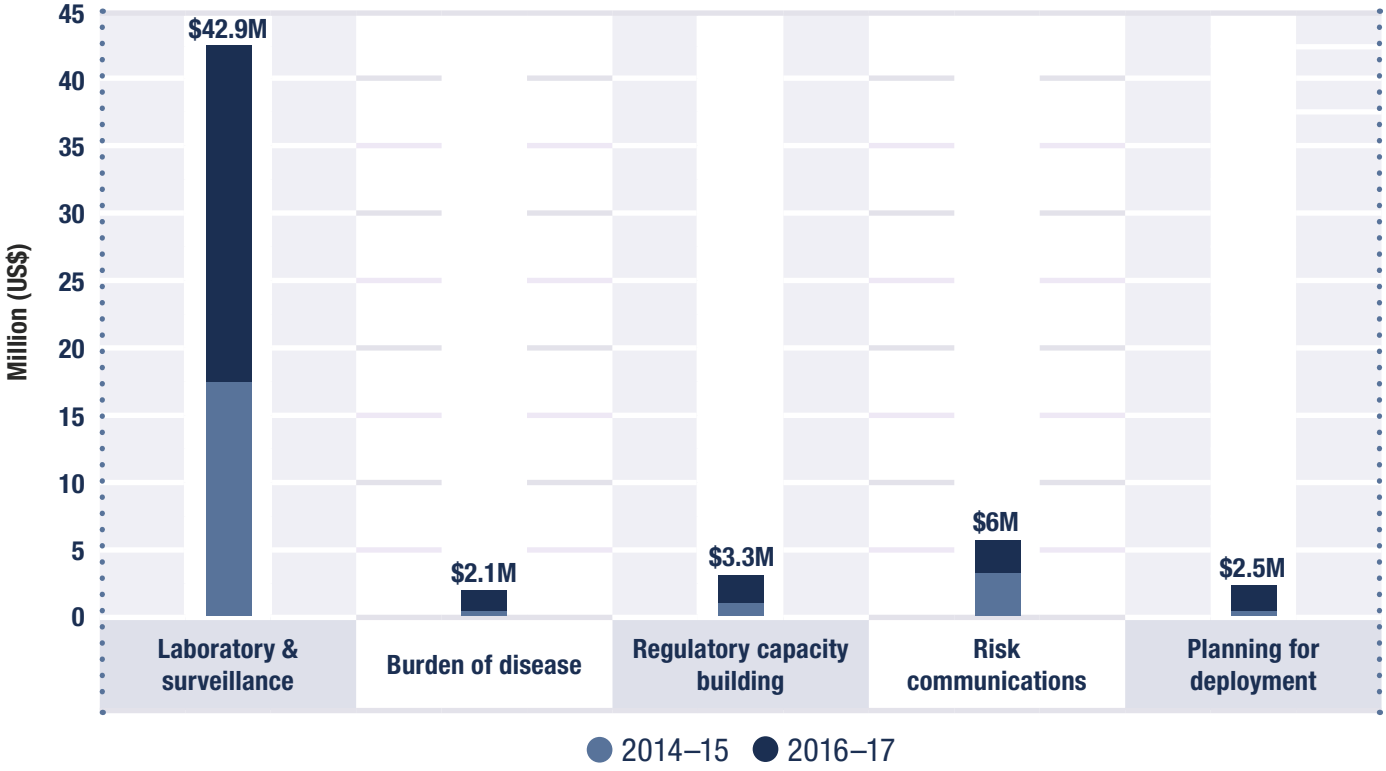
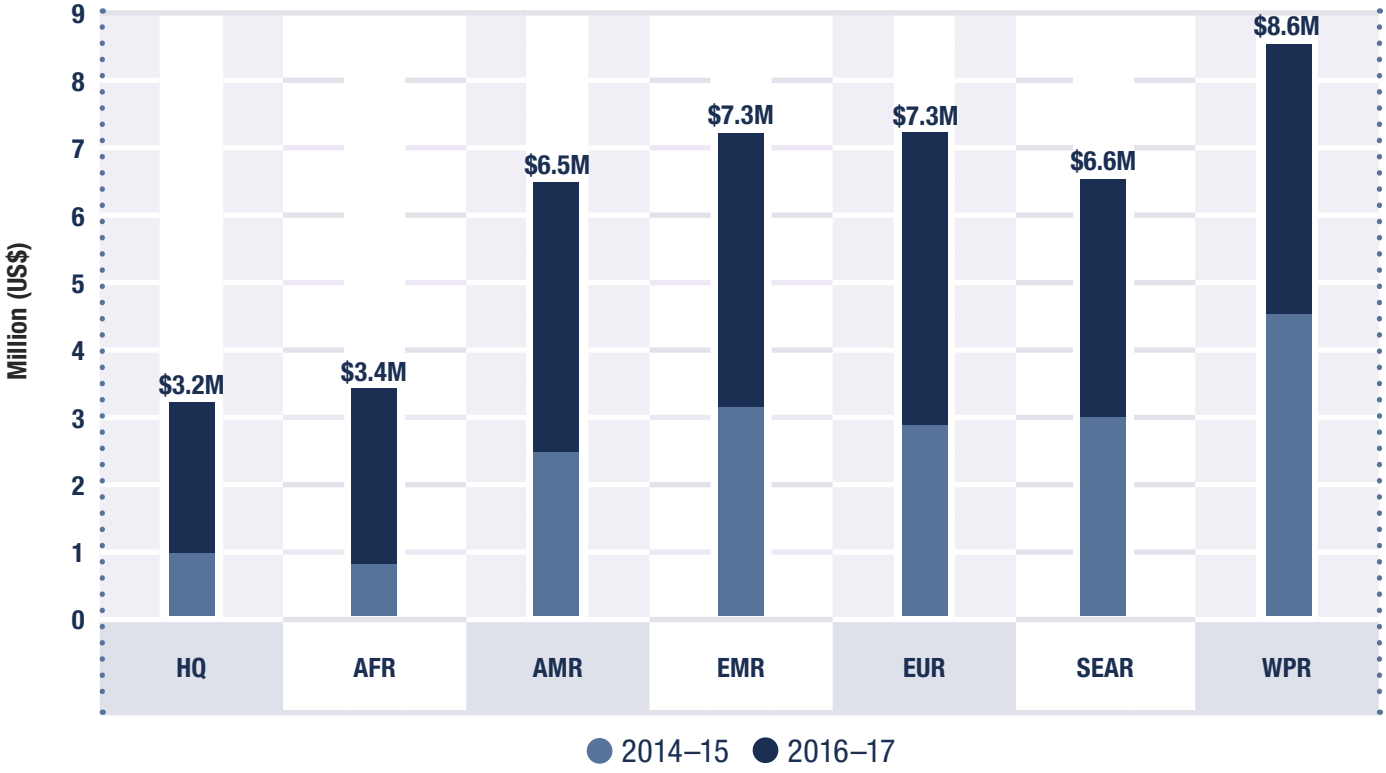


Figure A.3: Lab and surveillance expenditures by major office (US$, net of PSC), 2014–2017



World Health Organization

Pandemic Influenza Preparedness (PIP) – Secretariat, Preparedness and Response
Interim Financial Statement as at 31 December 2015
(expressed in US dollars)

	Secretariat (10%)	Response (30%)	Preparedness (70%)	Total
Revenue				
Receipts from:				
Adimmune Corporation	6,554	17,697	41,292	65,543
Alerre Inc.	7,809	21,083	49,196	78,088
Baxter International Inc.	20,921	56,485	131,799	209,205
Beijing Tiantan Biological Procucts Co. Ltd.	14,952	40,370	94,196	149,518
Cadila Healthcare Ltd. (R&D Center)	492	1,330	3,102	4,924
Cepheid	280	756	1,763	2,799
Changchun Institute of Biological Products Co., Ltd.	14,952	40,370	94,196	149,518
China National Biotec Group	2,000	5,400	12,600	20,000
CSL Limted	174,434	470,974	1,098,940	1,744,348
Denka Seiken Co. Ltd.	129,577	349,859	816,338	1,295,774
Focus Diagnostics, Inc.	8,385	22,639	52,821	83,845
Glaxosmithkline (GSK)	2,417,209	6,526,465	15,228,419	24,172,093
Government Pharmaceutical Organization (GPO)	281	756	1,763	2,800
Green Cross Corporation	102,386	276,443	645,034	1,023,863
Hoffmann - La Roche and Co. Ltd.	1,496,464	4,040,454	9,427,727	14,964,645
Indevr, Inc.	499	1,346	3,139	4,984
Institute of Vaccines and Medical Biologicals (IVAC)	280	756	1,763	2,799
Kaketsuken	190,555	514,498	1,200,497	1,905,550
Kitasato Daiichi Sankyo Vaccine Co. Ltd.	70,731	190,974	445,605	707,310
Lanzhou Institute of Biological Products	217	587	1,369	2,173
Medicago Inc.	498	1,346	3,139	4,983
Medimmune	249,198	672,831	1,569,937	2,491,966
Nanosphere Inc.	499	1,346	3,140	4,985
Novartis	1,529,273	4,129,040	9,634,428	15,292,741
Omninvest Vaccine Manufacturing, Researching & Trading Ltd.	14,943	40,350	94,149	149,442
Princeton Biomeditech Corporation	280	756	1,763	2,799
Protein Sciences Corporation	495	1,334	3,115	4,944
PT Bio Farma (Persero)	499	1,346	3,139	4,984
QIAGEN	280	756	1,763	2,799
Quidel Corporation	281	756	1,763	2,800
Response Biomedical Corporation	542	1,463	3,412	5,417
Saint-Petersburg Scientific Research Institute of Vaccines & Sera	3,079	8,314	19,398	30,791
Sanofi Pasteur	1,705,703	4,605,398	10,745,928	17,057,029
Serum Institute of India Ltd.	2,784	7,515	17,533	27,832
Shanghai Institute of Biological Products Co., Ltd.	24,920	67,283	156,994	249,197
Sinovac Biotech Ltd.	24,920	67,283	156,994	249,197
Takeda Pharmaceuticals Internationl GmbH	545	1,468	3,425	5,438
The Research Foundation for Microbial Disease of Osaka University	169,449	457,512	1,067,528	1,694,489
UMIN Pharm INC.	280	756	1,763	2,799
United States - Becton Dickinson and Company (BD)	28,143	75,987	177,302	281,432
Vabiotech	497	1,342	3,130	4,969
Total Revenue	8,416,088	22,723,424	53,021,302	84,160,814
Expenditure				
2012-2013	1,050,098			1,050,098
2014-2015	3,703,324	-	26,730,454	30,433,778
Total Expenditure	4,753,422	-	26,730,454	31,483,876
Balance as at 31 December 2015	**3,662,666**	**22,723,424**	**26,290,848**	**52,676,938**

I certify that the above statement reflects correctly the revenue and expenditure recorded in the WHO Global Accounting System.

Jane Stewart
Director Accounts
14 February 2018

Statement of Financial Performance-by Donor/Award Entity : 'WHO' , From date : '01-DEC-2012 , To date : '31-DEC-2013' , Award Number : 60478

Sum of Expense	
Expense Type	**Total (USD)**
Staff Costs	806,106
Contractual Service, General	54,904
Travel	64,670
General Operating Costs	3,610
Programme support costs (PSC)	120,808
Total	1,050,098

Statement of Financial Performance-by Donor/Award Entity : 'WHO' , From date : '01-JAN-2014 , To date : '31-DEC-2015' , Award Number : 60478

Sum of Expense	
Expense Type	**Total (USD)**
Staff Costs	2,031,186
Equipment, Vehicles and Furniture	21,133
Contractual Services	648,513
Travel	505,648
General Operating Costs	70,797
Programme support costs (PSC)	426,046
Total	**3,703,324**

Statement of Financial Performance-by Donor/Award Entity : 'WHO' , From date : '01-JAN-2014' , To date : '31-DEC-2015' , Award Number : 61722

Sum of Expense	
Expense Type	**Total (USD)**
Staff Costs	5,441,263
Medical Supplies and Materials	2,259,740
Equipment, Vehicles and Furniture	414,378
Contractual Services	7,960,953
Travel	4,177,045
Transfers and Grants	2,755,967
General Operating Costs	645,924
Programme support costs (PSC)	3,075,185
Total	**26,730,454**

World Health Organization

Pandemic Influenza Preparedness (PIP) – Secretariat, Preparedness and Response

Interim Financial Statement as at 31 December 2017

(expressed in US dollars)

	Secretariat - 10%	Response - 30%	Preparedness - 70%	Total
Opening Balance - 1 January 2016	3,662,666	22,723,424	26,290,848	52,676,938
Revenue				
Receipts from:				
Alere Inc	3,907	10,549	24,615	39,071
Becton Dickinson and Company (BD)	3,000	8,100	18,900	30,000
Beijing Tiantan Biological Products Co.Ltd	8,572	23,144	54,000	85,716
Cadila Healthcare Ltd (R&D Center)	780	2,103	4,909	7,792
Cepheid	780	2,103	4,909	7,792
Changchun Institute Of Biological Products Co., Ltd	5,871	15,853	36,989	58,713
CSL Limited	92,341	249,317	581,739	923,397
Denka Seiken Co. ltd.	87,622	236,576	552,011	876,209
DiaSorin Molecular LLC	2,969	8,017	18,706	29,692
Fast Track Diagnostics	1,060	2,860	6,672	10,592
Fluart Innovative Vaccines LTD	23,378	63,118	147,276	233,772
GlaxoSmithKline (GSK)	1,133,916	3,061,573	7,143,671	11,339,160
Government Pharmaceutical Organization (GPO)	778	2,104	4,909	7,791
Green Cross Corporation	61,850	166,995	389,655	618,500
Hoffmann-La Roche and Co Ltd	1,837,079	4,960,112	11,573,596	18,370,787
Indevr, Inc.	246	662	1,547	2,455
Institute Of Vaccines And Medical Biologicals (IVAC)	779	2,104	4,909	7,792
Kaketsuken	109,215	294,882	688,056	1,092,153
Kitasato Daiichi Sankyo Vaccine Co. ltd.	93,509	252,475	589,109	935,093
Medicago Inc	247	662	1,547	2,456
Medimmune	266,880	720,575	1,681,340	2,668,795
Nanotherapeutics Inc	534	1,441	3,362	5,337
NPO Petrovax Pharm	780	2,103	4,909	7,792
Princeton Biomeditech Corporation	780	2,103	4,909	7,792
Qiagen	5,871	15,853	36,989	58,713
Quidel Corporation	533	1,441	3,362	5,336
Research Foundation for Microbial Diseases of Osaka University	128,854	347,906	811,781	1,288,541
Saint Petersburg Scientific Research Institute of Vaccines and Sera	5,602	15,127	35,296	56,025
Sanofi Pasteur	1,441,149	3,891,102	9,079,241	14,411,492
Seqirus	377,904	1,020,341	2,380,797	3,779,042
Serum Institute of India Ltd.	779	2,103	4,909	7,791
Shanghai Institute Of Biological Products Co., Ltd.	23,378	63,118	147,276	233,772
Sinovac Biotech Ltd	23,378	63,118	147,276	233,772
Takeda Pharmaceuticals International GmbH	514	1,392	3,247	5,153
Vabiotech	779	2,104	4,909	7,792
Total Revenue	5,745,612	15,513,137	36,197,327	57,456,076
Expenditure				
2016-2017	6,318,988	-	37,522,151	43,841,139
Balance as at 31 December 2017	**3,089,290**	**38,236,561**	**24,966,024**	**66,291,875**

I certify that the above statement reflects correctly the revenue and expenditure recorded in the WHO Global Accounting System.

Jane Stewart
Director Accounts

21 May 2018

AN – 60478, 61722 and 60856 – 31.12.2017 – Interim.doc

Statement of Financial Performance-by Donor/Award Entity : 'WHO' , From date : '01-JAN-2016 , To date : '31-DEC-2017' , Award Number : '60478'

Sum of Expense	
Expense Type	**Total (USD)**
Staff Costs	4,281,338
Medical Supplies and Materials	4,738
Equipment, Vehicles and Furniture	14,409
Contractual Services	674,770
Travel	546,085
General Operating Costs	70,685
Programme Support Costs (PSC)	726,963
Total	**6,318,988**

Statement of Financial Performance-by Donor/Award Entity : 'WHO' , From date : '01-JAN-2016' , To date : '31-DEC-2017' , Award Number : '61722'

Sum of Expense	
Expense Type	**Total (USD)**
Staff Costs	8,340,338
Medical Supplies and Materials	2,560,822
Equipment, Vehicles and Furniture	429,441
Contractual Services	10,989,566
Travel	5,129,003
Transfers and Grants	4,108,036
General Operating Costs	1,648,237
Programme Support Costs (PSC)	4,316,708
Total	**37,522,151**

Annex B: Target countries by area of work

Table B.1: Laboratory & surveillance: 43 PIP priority countries

Area of work :	Country		
Laboratory & surveillance	Afghanistan	Egypt	Nicaragua
	Algeria	Fiji	Sierra Leone
	Armenia	Ghana	South Africa
	Bolivia (Plurinational State of)	Haiti	Suriname
	Bangladesh	Indonesia	Tajikistan
	Burundi	Jordan	Timor-Leste
	Cambodia	Kyrgyzstan	Turkmenistan
	Cameroon	Lao People's Democratic Republic	Ukraine
	Chile	Lebanon	United Republic of Tanzania
	Congo	Madagascar	Uzbekistan
	Costa Rica	Mongolia	Viet Nam
	Democratic People's Republic of Korea	Morocco	Yemen
	Djibouti	Mozambique	Zambia
	Dominican Republic	Myanmar	
	Ecuador	Nepal	

Table B.2: Burden of disease: 19 PIP priority countries[a]

Area of work :	Country		
Burden of disease	Albania	Georgia	Oman
	Armenia	Indonesia	Republic of Moldova
	Cambodia	Kyrgyzstan	Senegal
	Chile	Lao People's Democratic Republic	Serbia
	Costa Rica	Madagascar	Ukraine
	Croatia	Mongolia	
	Egypt	Nepal	

a After the baseline was set in 2013, five new PIP target countries were added to receive PC support for BoD estimation

Table B.3: Regulatory capacity building: 16 PIP priority countries

Area of work	Country		
Regulatory capacity building	Armenia	Ghana	Sri Lanka
	Bolivia (Plurinational State of)	Haiti	Sudan
	Cambodia	Kenya	Uganda
	Democratic Republic of the Congo	Lao People's Democratic Republic	United Republic of Tanzania
	Ethiopia	Nepal	
	Georgia	Pakistan	

Table B.4: Risk communications: 38 PIP priority countries

Area of work	Country		
Risk communications	Afghanistan	Kazakhstan	Saint Vincent and the Grenadines
	Bangladesh	Kenya	Senegal
	Barbados	Lao People's Democratic Republic	Seychelles
	Bhutan	Lebanon	Sudan
	Burkina Faso	Mauritania	Suriname
	Cambodia	Mexico	Timor-Leste
	Dominica	Mongolia	Turkey
	Ecuador	Mozambique	Ukraine
	Egypt	Nepal	Uzbekistan
	Fiji	Pakistan	Viet Nam
	Gabon	Panama	Yemen
	Honduras	Republic of Moldova	Zimbabwe
	Indonesia	Saint Lucia	

Table B.5: Planning for deployment: 16 PIP priority countries

Area of work	Country		
Planning for deployment	Armenia	Ghana	Sri Lanka
	Bolivia (Plurinational State of)	Haiti	Sudan
	Cambodia	Kenya	Uganda
	Democratic Republic of the Congo	Lao People's Democratic Republic	United Republic of Tanzania
	Ethiopia	Nepal	
	Georgia	Pakistan	

Annex C: Output indicator results by area of work

Table C.1: Laboratory & surveillance

Outcome: Capacity to detect and monitor influenza epidemics is strengthened in developing countries that have weak or no capacity

Target: At least 35 developing countries will have the capacity to detect and/or monitor influenza outbreaks and to participate in regional and global networks for the sharing of information and viruses

HLIP I - Laboratory & surveillance indicators		Baseline (2014)	Results (2015)	Results (2016)	Results (2017)	Target
Output 1: National capacities to detect respiratory disease outbreaks due to novel virus is strengthened - 43 PIP priority countries						
Indicator 01.1	Number of countries with an established and functioning event based surveillance system	7	12	27	35	43
Output 2: National capacities to monitor trends in circulating viruses is strengthened - 43 PIP priority countries						
Indicator 02.1	Number of countries able to consistently[a] report and analyse virological data[b]	26	29	34	36	35
Indicator 02.2	Number of countries able to consistently[a] report and analyse epidemiological data[c]	5	11	19	24	17
Output 3: Global collaboration through the sharing of information and viruses, is strengthened and the quality of the system is improved (PCR detection quality assurance) - Globally						
Indicator 03.1	Number of countries that participated in EQAP and scored 100%[d]	109	103	117	114	120
Indicator 03.2	Number of countries sharing virus with WHO Collaborating Centres, H5 Reference laboratories and Essential Regulatory Laboratories at least once a year in the past two years (1 January 2016 to 31 December 2017)[e]	90	127	127	132	108
Indicator 03.3	Number of countries that consistently[a] reported epidemiological data to regional or global platforms[c]	55	66	75	91	71
Indicator 03.4	Number of countries that consistently[a] reported virological data to a global platform[b]	108	106	125	130	124

a Consistently means that country reported at least 60% of the weeks during the influenza season.

b Data source: FluNet http://www.who.int/influenza/resources/charts/en

c Data source: FluID http://www.who.int/influenza/resources/charts/en

d Data source: External Quality Assessment Project (EQAP)

e Data source: Vaccine Composition Meetings and Shipping Fund Project. This result does not include areas and territories.

Table C.2. Burden of disease

Outcome: National policy makers will have influenza disease burden data needed for informed decision-making and prioritization of health resources

Target: All 6 WHO regions develop regional representative burden of disease data to guide developing countries' policy making

HLIP I - Burden of disease indicators		Baseline (2014)	Results (2015)	Results (2016)	Results (2017)	Target
Output 1: Derive regionally representative influenza disease burden estimates from selected countries						
Indicator 01.1	Number of PIP priority countries with published burden of disease estimates	0	2	2	3[a]	19
Output 2: Develop a global estimate of influenza disease burden derived from national estimates						
Indicator 02.1	Global estimate of influenza disease burden derived from national estimates published	0	0	0	1[b]	1

a In total, eight PIP priority countries estimated influenza disease burden but only three were published in 2014–2017 (Costa Rica, Egypt and Senegal). The remainder are in the publication process (Albania, Cambodia, Chile, Indonesia and Madagascar). An additional 33 countries estimated influenza disease burden and shared information with WHO.

b Estimate of influenza deaths due to respiratory disease.

Table C.3: Regulatory capacity building

Outcome: Countries with weak or no regulatory capacity will be able to regulate influenza products including vaccines, antivirals and diagnostics, and to accelerate national approval of these commodities in case of an influenza pandemic

Target: At least 16 countries will have improved their regulatory capacity to oversee influenza products including vaccines, antivirals and diagnostics, and to accelerate national approval registration of these commodities in case of an influenza pandemic

HLIP I - Regulatory capacity building indicators		Baseline (2014)	Results (2015)	Results (2016)	Results (2017)	Target
Output 1: Develop guidelines on regulatory preparedness for non-vaccine producing countries that enables them to expedite approval of influenza vaccines used in national immunization programs and/or deployed by United Nations agencies in response to a pandemic emergency						
Indicator 01.1	Regulatory preparedness guidelines endorsed by the WHO Expert Committee on Biologicals Standardization (ECBS)	0	0	1	1[a]	1
Output 2: NRA capacity to regulate influenza products including vaccines, antivirals and diagnostics is strengthened						
Indicator 02.1	Number of countries which developed regulatory capacity to oversee influenza products including vaccines, antivirals and diagnostics in case of a pandemic as per the WHO NRA assessment and IDP elaboration and implementation	0	1	1	1[b]	16
Output 3: Regulatory processes to accelerate approval of influenza vaccines, antivirals and diagnostics during a public health emergency are incorporated into deployment plans for pandemic influenza products						
Indicator 03.1	Number of countries with a common approach for accelerated regulatory approval of influenza products in a public health emergency (WHO Collaborative Registration Procedure)	0	14	14	19[c]	48

a The Guidelines on regulatory preparedness for provision of marketing authorization of human pandemic influenza vaccines in non-vaccine-producing countries were endorsed by WHO ECBS in October 2016.

b Of the 16 PIP priority countries, one country has acceptable capacity in the three areas of assessment specified for this indicator: regulatory systems, marketing authorization and pharmacovigilance. For 14 other PIP priority countries, Institutional Development Plans (IDP) were developed and continue to be implemented noting that enhancing regulatory capacity is a long-term investment.

c All 48 targeted countries have a regulatory approach to facilitate the timely approval of pandemic influenza products during an emergency. Of the 48, 19 selected the WHO Collaborative Registration Procedure specified in this indicator. https://extranet.who.int/prequal/content/collaborative-registration-faster-registration.

Table C.4: Risk communications

Outcome: Global risk communications capacities are strengthened with a special focus on pandemic influenza communications

Target: The number of countries that self-report at least 50% of the IHR risk communications milestones increases from 100 to 120 countries

HLIP I - Risk communications indicators		Baseline (2014)	Results (2015)	Results (2016)	Results (2017)	Target
Output 1: Access to risk communications training and platforms is increased enabling all countries to respond more effectively to a potential influenza pandemic or other Public Health Emergencies of International Concern (PHEIC)						
Indicator 01.1	Tools and web-based risk communications training material accessible to Member States in all language versions and Portuguese	0	0	194	194	194
Indicator 01.2	Number of registered users of online material on IHR/ OpenWHO platform	0	513	858	8,720	500
Indicator 01.3	Number of trainings completed on risk communications IHR/OpenWHO platform	0	96	161	3,667	200
Output 2: Risk communications capacity is established in priority countries with little or no capacity						
Indicator 02.1	Targeted Member States will have benefited from IHR risk communications capacity strengthening	0	17	24	31	30
Output 3: Global Emergency Communications Network (ECN) operationalized to provide support to countries before, during and after public health emergencies						
Indicator 03.1	Proportion of requests for risk communications surge support responded to within 72 hours by WHO	0	100%	100%	100%	80%

Table C.5: Planning for deployment

Outcome: Plans for deployment of pandemic supplies including vaccines, antivirals and diagnostics, will be developed and regularly updated

Target: National plans for 16 countries are developed and updated through simulation exercises every 2 years

HLIP I - Planning for deployment indicators		Baseline (2014)	Results (2015)	Results (2016)	Results (2017)	Target
Output 1: A common approach to manage deployment operations is developed and shared with stakeholders and deployment partners						
Indicator 01.1	A common deployment approach is developed with multiple deployment stakeholder endorsement	0	0	0	1	1
Indicator 01.2	Number of trainings and simulation exercises with deployment stakeholders	0	0	0	15[a]	8
Output 2: Country deployment readiness systems are simplified and updated						
Indicator 02.1	Model country recipient agreement is revised and updated	0	0	1	1	1
Indicator 02.1	Number of countries and partners accessing web-based planning tools	0	0	0	14[b]	16

a Fourteen entities were trained (Afghanistan, Bermuda, Ghana, Jamaica, Jordan, Indonesia, Myanmar, Nigeria, United Republic of Tanzania, two manufacturers, two civil society partners, one donor agency) and one simulation exercise was conducted.

b Fourteen deployment stakeholders accessed web-based planning tools (10 countries, two civil society partners, one freight company and one donor agency).

Annex D: Laboratory & surveillance capacity indicator results

All PIP priority countries

Figure D.1: Output 1 - Detection capacity

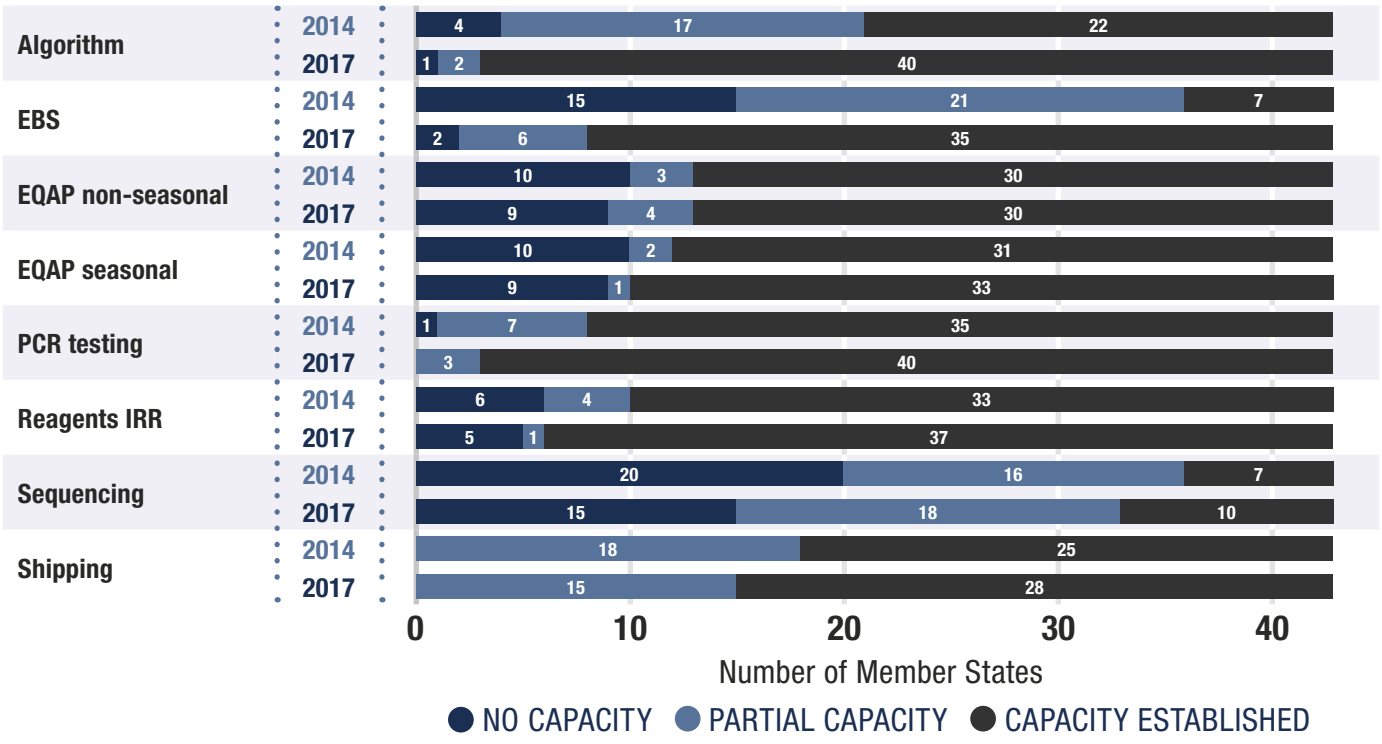


Figure D.2: Output 2 - Monitoring capacity

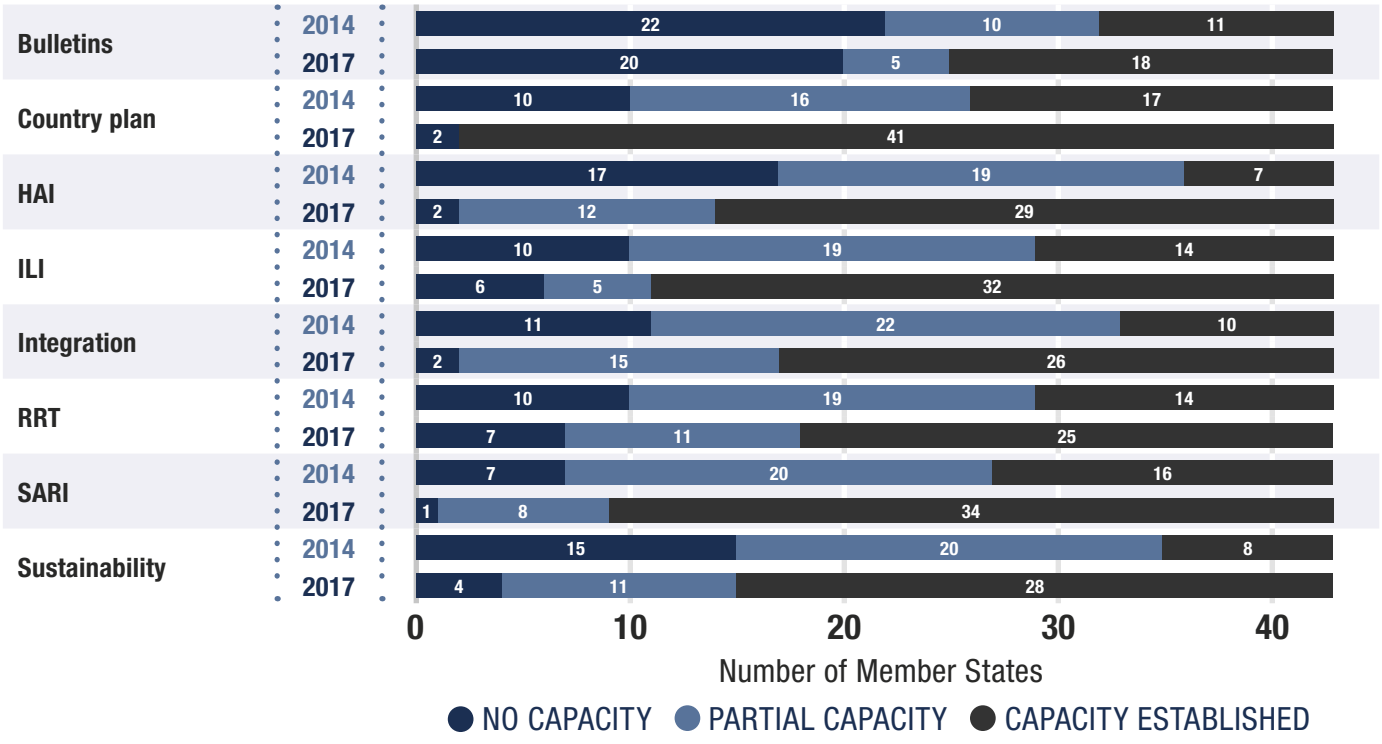
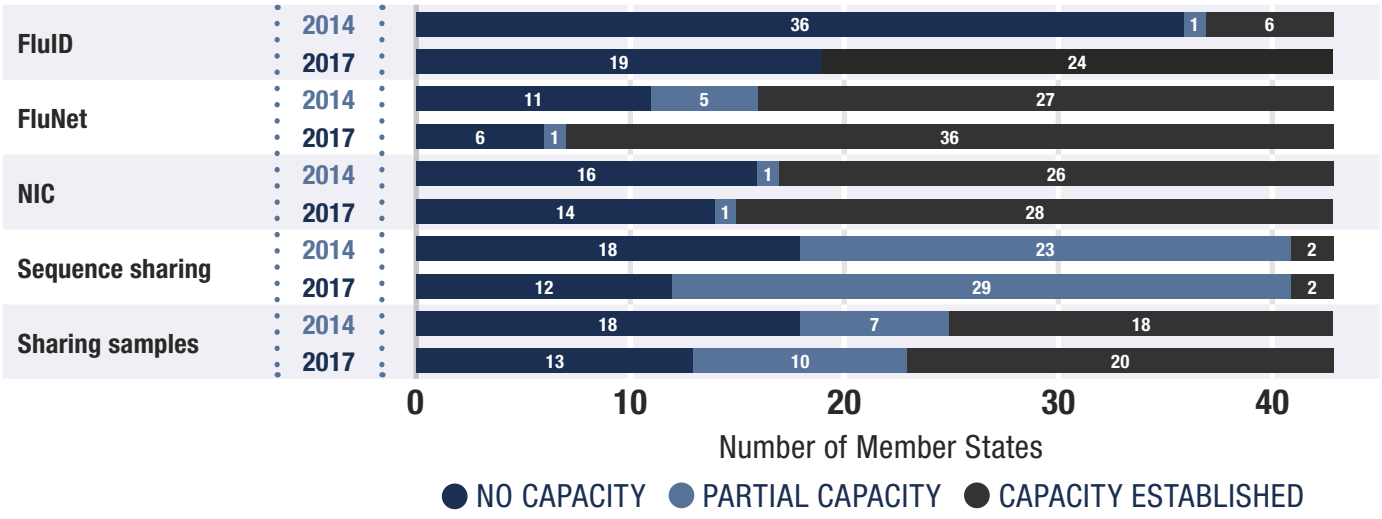


Figure D.3: Output 3 - Sharing capacity & strengthening networks



Annex E: Definitions for the laboratory & surveillance capacity indicators

Capacity indicator	Reporting party	Indicator rationale	No capacity	Partial capacity	Capacity established
Output 1: Detection capacity					
Algorithm for laboratory detection of unusual influenza viruses	RO/CO	This indicator measures laboratory preparedness for detection of influenza viruses with pandemic potential.	No laboratory algorithm established.	Informal laboratory guidance or algorithm existing, but not formally documented and/or not strictly put in use.	Algorithm established, formally documented and strictly put in use.
National "Early Warning" systems or EBS	RO/CO	This indicator measures the status of a national system to identify unusual or unexpected illness events. These systems are often called Event Based Surveillance (EBS) or "early warning" systems and use multiple sources of official and unofficial reports, including media reports.	No national Early Warning System such as EBS.	Planning to establish a national Early Warning System, e.g. relevant definitions, protocols, procedures and targeted training materials etc. under development.	Functional national Early Warning System with relevant definitions, protocols and procedures etc. in place.
PCR testing	RO/CO	This indicator measures the country's status with regards to the ability to perform influenza PCR testing.	No influenza PCR testing ability.	Potential influenza PCR testing ability, e.g. having PCR machine and reagents, but no evidence of functioning.	Influenza PCR testing actively being performed with evidence of reporting.
PCR quality for non-seasonal influenza viruses	HQ	This indicator measures the quality of the PCR testing to detect non-seasonal influenza viruses with pandemic potential based on the performance in the last panel of the WHO Influenza PCR EQAP.	No laboratory participated in the last WHO Influenza PCR EQAP.	At least one national laboratory participated but none achieved a 100% score on non-seasonal viruses in the last WHO influenza PCR EQAP.	At least one national laboratory participated and achieved a score of 100% on non-seasonal viruses in the last WHO influenza PCR EQAP.
PCR quality for seasonal influenza viruses	HQ	This indicator measures the quality of the PCR testing to detect seasonal circulating viruses based on the performance in the last panel of the WHO Influenza PCR EQAP.	No laboratory participated in the last WHO Influenza PCR EQAP.	At least one national laboratory participated but none achieved a 100% score on seasonal viruses in the last WHO influenza PCR EQAP.	At least one national laboratory participated and achieved a score of 100% on seasonal viruses in the last WHO influenza PCR EQAP.
Registration in IRR or receiving kits from WHO CCs	HQ	This indicator measures a country's access to reagents through registration in the IRR or by agreement with a WHO CC, or through using WHO CC established SOPs with in-country capacity to synthesize/order/import primers etc.	Not registered in IRR, and no agreement with WHO CCs, and no other sources available for primers and other reagents.	Registered in IRR or agreement with WHO CCs but no reagents received in the past 18 months, and no other sources available for primers and other reagents in the past 18 months.	Registered user of IRR or agreement with WHO CCs with reagents received in the past 18 months; or reagents received from other sources in the past 18 months.
Sequencing	RO/CO	This indicator measures sequencing capabilities for influenza viruses.	No equipment and no sequencing capacity available.	Sequencing equipment and potential capacity available, but not functioning in the past 12 months.	Influenza virus genes sequenced in the past 12 months.
Shipping capacity	HQ	This indicator measures a country's ability to ship influenza clinical specimens/virus isolates with pandemic potential out of the country to a GISRS-associated WHO CC with appropriate ISST (Infectious Substance Shippers Training) and export permit for such materials.	No ISST in the past 2 years and no valid export permit.	ISST received in the past 2 years or valid export permit in place, but not both.	ISST received in the past 2 years and valid export permit in place.

Capacity indicator	Reporting party	Indicator rationale	No capacity	Partial capacity	Capacity established
Output 2: Monitoring capacity					
Human Animal interface (HAI) coordination	RO/CO	This indicator measures the extent to which animal and human health authorities coordinate activities in response to influenza-related events of potential public health significance.	No evidence of coordination.	Ad-hoc coordination i.e. joint meetings, sharing of information and joint investigation, but no documented functional coordination mechanism in place.	Documented functional coordination mechanism in place.
Bulletins - Regular Influenza surveillance reports	RO/CO	This indicator measures the extent to which the data collected through influenza surveillance is collated into routine bulletins and shared in the public domain.	In the past 12 months no bulletin/report published in the public domain.	In the past 12 months bulletins/reports published in the public domain during the influenza season but less than once a month.	In the past 12 months bulletins/reports published in the public domain at least monthly during the influenza season.
Country implementation plan	RO/CO	This indicator measures the degree to which the country is actively participating in the planning for the work to be accomplished. Ideally this plan would be a MOH Plan or it could be developed by the CO and agreed to by the MOH. It can be simple but should contain activities for targeted improvements, timelines and budgets.	Discussion with MOH not yet started.	The plan being discussed between WHO CO/RO and MOH and is under review.	An implementation plan agreed between MOH and WHO CO/RO in place.
ILI national surveillance	RO/CO	This indicator measures the country's status with regard to the existence of a national surveillance system where patients with non- severe respiratory diseases such as ILI or similar are medically attended at an outpatient or provider setting. As a routine during the flu season, samples should be collected from a subset of patients and sent to a laboratory for diagnosis of influenza. This should be done as defined in the WHO Global Epidemiological Surveillance Standards for Influenza.	No ILI surveillance (no active sites providing data or samples in the past 12 months)	ILI surveillance existing but with gaps in collecting data routinely* and submitting samples regularly** to a laboratory in the past 12 months. *19 or more weeks during the northern hemisphere influenza season (week 40–week 20) or 13 or more weeks during the southern hemisphere season (week 18–week 40), or 32 weeks or more during the whole year for countries with year-round surveillance. **ideally on a weekly basis, however no later than 1 month after collection of samples.	ILI surveillance being carried out, samples being collected routinely* and sent to a laboratory regularly** in the past 12 months. *19 or more weeks during the northern hemisphere influenza season (week 40– week 20) or 13 or more weeks during the southern hemisphere season (week 18–week 40), or 32 weeks or more during the whole year for countries with year-round surveillance. **ideally on a weekly basis, however no later than 1 month after collection of samples.
Integration of laboratory and epidemiologic data	RO/CO	This indicator measures whether laboratory and epidemiologic surveillance data are linked and integrated to produce surveillance updates.	No linkage of laboratory with epidemiologic data.	Laboratory and epidemiologic data shared informally but no reports of integrated laboratory and epidemiologic data.	Surveillance reports with integrated laboratory and epidemiological data published.
Rapid Response Team Training	RO/CO	This indicator measures RRT training delivered through this project. The purpose of the training is to ensure that RRTs are trained and ready to respond to unusual events including human cases/clusters of infection with novel influenza viruses and outbreaks of severe respiratory diseases.	No RRT established.	RRT established, but no training in the past 12 months.	RRT established and trained in the past 12 months.

Capacity indicator	Reporting party	Indicator rationale	No capacity	Partial capacity	Capacity established
SARI national surveillance	RO/CO	This indicator measures the country's status with regard to the existence of a national surveillance system where hospitalized patients with severe respiratory disease such as SARI are medically attended. As a routine, samples should be collected ideally from all or a subset of patients and sent to a laboratory for diagnosis of influenza. This should be done as defined in the WHO Global Epidemiological Surveillance Standards for Influenza.	No SARI surveillance (no active sites providing data or samples in the past 12 months)	SARI surveillance existing but with gaps in collecting data routinely* and submitting samples regularly** to a laboratory in the past 12 months. * 32 weeks or more in a year. **ideally on a weekly basis, however no more than 1 month after collection of samples.	SARI surveillance being carried out, samples being collected routinely* and sent to a laboratory regularly** for diagnosis of influenza in the past 12 months. * 32 weeks or more in a year. **ideally on a weekly basis, however no more than 1 month after collection of samples.
Sustainability (evidence of)	RO/CO	This indicator measures the integration of this project into an overall national plan to increase the chance for long term sustainability of the capacity building efforts. The high-level activities of this project can be part of a national plan for surveillance, preparedness and response, etc.	No integration in a national plan/ national plans.	Agreed to be part of a national plan/national plans with integration under development.	Integrated with a national plan/ national plans.
Output 3: Sharing capacity					
NIC status	HQ	This indicator measures progress towards a country-designated and WHO-recognized NIC.	No NIC designated by country.	NIC designated by country, pending WHO recognition.	NIC recognized by WHO.
Reporting epidemiologic surveillance data to WHO through FluID and/ or regional databases (Epidemiological Data)	HQ	This indicator measures the regularity of reporting epidemiologic data to WHO through FluID and/or RO Databases.	No report in the past 12 months.	Reports submitted for <20 weeks in the northern hemisphere season (week 40-week 20), or for <13 weeks in the southern hemisphere season (week 18-week 40), or for <32 weeks during the whole year for countries with year-round surveillance in the past 12 months.	Reports submitted for 20 or more weeks during the northern hemisphere season (week 40-week 20), or for 13 or more weeks during the southern hemisphere season (week 18-week 40), or for 32 or more weeks during the whole year for countries with year-round surveillance in the past 12 months.
Reporting laboratory surveillance data to WHO through FluNet and/ or regional databases (Virological Data)	HQ	This indicator measures the regularity of reporting virological data to WHO through FluNet and/or RO Databases.	No report in the past 12 months.	Reports submitted for <20 weeks in the northern hemisphere season (week 40-week 20), or for <13 weeks in the southern hemisphere season (week 18-week 40), or for <32 weeks during the whole year for countries with year-round surveillance in the past 12 months.	Reports submitted for 20 or more weeks during the northern hemisphere season (week 40-week 20), or for 13 or more weeks during the southern hemisphere season (week 18-week 40), or for 32 or more weeks during the whole year for countries with year-round surveillance in the past 12 months.
Sharing/using sequence data	HQ	This indicator measures sharing of influenza virus genetic sequences for use globally.	No sequences shared.	Country's sequences being uploaded by a WHO CC to a publicly accessible database in the past 12 months.	Country uploading sequences to a publicly accessible database in the past 12 months.
Sharing samples with WHO CCs	HQ	This indicator measures a country's sharing virus isolates and/or clinical specimens with WHO CCs.	No shipment in the past 12 months.	One shipment in the past 12 months.	At least 2 shipments in the past 12 months.

PIP Framework Secretariat
Infectious Hazard Management
WHO Health Emergencies Programme
email pipframework@who.int

World Health Organization
20 Avenue Appia
1211 Geneva 27
Switzerland

who.int/influenza/pip

World Health Organization