



UNFPA Asia Pacific Regional Office

Coronavirus (2019-nCoV) guidance document

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Key advocacy messages for UNFPA's mandate

- Sexual and reproductive health is a significant public health issue during epidemics
- Safe pregnancies and childbirth depend on functioning health systems and strict adherence to infection precautions
- Pregnant women with respiratory illnesses must be treated with utmost priority due to increased risk of adverse outcomes
- Surveillance and response systems should include sex, gender, and pregnancy status disaggregation
- Neonatal and maternal health units must be segregated from 2019-nCoV cases
- Provision of mental health and psychosocial support (MHPSS) for affected individuals, families, communities and health workers is a critical part of the response
- UNFPA will work closely with governments and WHO to ensure that accurate information is provided to women of reproductive age and pregnant women on infection precautions, potential risks and how to seek timely medical care
- Epidemics compound existing gender inequalities, increasing risks of gender based violence and sexual exploitation and abuse
- The protection needs of women and girls must be at the center of response efforts

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What is 2019-nCoV?

The novel Coronavirus (2019-nCoV) is a **new strain of coronavirus** first reported to WHO on 31 December 2019. Coronaviruses (CoV) are a family of viruses that cause respiratory illness, ranging from the common cold to more severe disease that can result in death, such as SARS-CoV (Severe Acute Respiratory Syndrome) and MERS-CoV (Middle East Respiratory Syndrome).

Coronaviruses are zoonotic, meaning that they are transmitted between animals and people, and can rapidly spread where human to human transmission occurs. The SARS epidemic in November 2002-July 2003, which resulted in 8,098 cases and 774 deaths in 17 countries, was originally transmitted from civet cats to humans in southern China¹. MERS, also known as camel flu, resulting in several outbreaks starting in 2012 with a total of 2,494 cases and 858 deaths as of November 2019, was originally transmitted from dromedary camels to humans².

Initial symptoms from coronavirus infections resemble the common cold or the flu, and may include fever, cough and other respiratory symptoms such as sneezing and nasal congestion. Severe infections can cause shortness of breath and difficulty breathing, and may lead to pneumonia, severe acute respiratory syndrome and kidney failure which require intensive care, and may even lead to death. However, many people with the virus may only exhibit mild symptoms, or no symptoms at all. To date, descriptive studies of patients confirmed to have the 2019-nCoV infection mostly exhibited symptoms of fever, cough and shortness of breath³.

The CDC estimates that 2019-nCoV has an **incubation period** (how long it takes to develop symptoms after exposure) of 2 to 14 days. The estimated range will be narrowed down with further epidemiological data. Understanding the incubation period has implications for determining and enforcing effective quarantine systems in order to control the spread of infection.

Respiratory viruses such as the coronavirus can travel through the air as respiratory droplets that are produced when an infected person talks, breaths, coughs or sneezes, and are transmitted through direct mucous membrane contact (eyes, nose and mouth). However, they can only travel a few meters from the infected person and thus primarily occur in close contact settings and in crowded households. It is not fully known how long the virus survives on surfaces, although preliminary information suggests that it may survive for a few hours. General precautions include **strict handwashing and use of disinfectants** to maintain clean surfaces and to avoid transferring the virus from surfaces to your eyes, nose or mouth, as our hands come into contact with many surfaces.

¹ WHO. Summary of probable SARS cases with onset of illness from 1 November 2002 to 31 July 2003. Geneva: World Health Organization, 2004. http://www.who.int/csr/sars/country/table2004_04_21/en/ (accessed Jan 12, 2020).

² WHO. Middle East respiratory syndrome coronavirus (MERS-CoV). Geneva: World Health Organization, 2020. <http://www.who.int/emergencies/mers-cov/en/> (accessed Jan 12, 2020).

³ Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: a descriptive study, The Lancet (January 29, 2020) [https://doi.org/10.1016/S0140-6736\(20\)30211-7](https://doi.org/10.1016/S0140-6736(20)30211-7)

Other modes of transmission occur in intense exposure settings such as workplaces and modes of mass transportation (eg. airplanes, trains). However, most cases of human to human transmission occur in health care settings in the absence of adequate infection control precautions. During the SARS epidemic, health care workers accounted for 21% of all cases- particularly those involved in medical procedures that generate aerosols (such as intubating and extubating patients)⁴.

There are 2 key factors to understanding and estimating how quickly an epidemic can develop. The first is the **Reproduction number (Ro)**, which measures *how contagious a virus is*; the higher the Ro, the more rapid and extensive the spread. The second is the **Case Fatality Rate (CFR)**, which is the percentage of persons with the virus who die from the viral infection; in other words, *how severe the infection is*. The most updated information on global case rates can be accessed through the [Johns Hopkins website](#).

Early quantification of the basic reproduction number (Ro) of 2019-nCoV in the current phase of the outbreak is **2.2**⁵. The Ro relates to the efficiency of transmission, and represents the average number of people who will catch the disease from a single infected person. Ro of 2.2 means that with no intervention, each case will lead to 2.2 new infections. The Ro of SARS-CoV was quantified at 2.0-5.0⁶, and for MERS-CoV at 2.7-3.9⁷.

The Case Fatality Rate is currently not fully known yet, as there are possible cases with no or mild symptoms that have not been confirmed by laboratory diagnosis and the overall true number of infections is unknown. WHO, in a [press conference on January 29, 2020](#), estimated a CFR of **2%** and a preliminary study in The Lancet provided an estimation of **3%**⁸. This indicates that the fatality rate of 2019-nCoV is lower than that of SARS-CoV (CFR of 9.6%)⁹ or MERS-CoV (CFR of 36%)¹⁰, although the ultimate scope and effects of the outbreak remain to be seen.

Currently, there are **no approved existing therapeutics for 2019-nCoV**. Medical management focuses on early diagnosis of suspected cases, immediate isolation, implementation of strict infection control measures, and supportive/symptomatic care.

Development of effective vaccines are of high importance, as coronaviruses can reemerge and cause additional epidemics. While biotech and research companies are working on a vaccine for 2019-nCoV, **developing, testing and reviewing the safety and efficacy of new vaccines is a long process**; by the time a vaccine was developed for the SARS epidemic one year after the outbreak, the epidemic had been contained.

⁴ Koh D, Occupational health aspects of emerging infections – sars outbreak affecting healthcare workers *Occupational and Environmental Medicine* 2018;**75**:A14.

⁵ Li, Qun et al (2020). 'Early Transmission Dynamics in Wuhan, China, of Novel Coronavirus-Infected Pneumonia' *N Engl J Med*

⁶ Wallinga J, Teunis P (2004) "Different epidemic curves for severe acute respiratory syndrome reveal similar impacts of control measures". *Am. J. Epidemiol.* 160 (6): 509–16. doi:10.1093/aje/kwh255. PMID 15353409. Archived from the original on 2007-10-06.

⁷ Lin, Q.; Chiu, A.P.; Zhao, S.; He, D. Modeling the spread of Middle East respiratory syndrome coronavirus in Saudi Arabia. *Stat. methods Med. Res.* 2018, 27, 1968–1978.

⁸ A novel coronavirus outbreak of global health concern - Chen Wang et al., *The Lancet*. January 24, 2020

⁹ Summary of probable SARS cases with onset of illness from 1 November 2002 to 31 July 2003" World Health Organization (WHO)

¹⁰ de Wit E, van Doremalen N, Falzarano D, Munster VJ. SARS and MERS: recent insights into emerging coronaviruses. *Nat Rev Microbiol.* 2016;14 (8):523-534. doi:10.1038/nrmicro.2016.81

The current epidemic has led to a massive **'infodemic'**- a surge of information, much of which is inaccurate and based on myths and misconceptions. False rumors and unscientific claims can have negative consequences on how this crisis is managed. It is important to ensure accurate information based on trustworthy sources such as the latest WHO guidance and daily sitreps.

Links to daily WHO Sitreps on 2019-nCoV: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>

UNFPA APRO has set up a dedicated page on 2019-nCoV on our agency website to provide updated information:

<https://sites.google.com/unfpa.org/regionalopscop/2019-ncov-updates?pli=1&authuser=1>

A coordinated emergency health system and public health response for the epidemic

Effective and coordinated clinical and public health services, as well as community engagement and mobilization, are key to an epidemic response. Strategic objectives per the [WHO Strategic Preparedness and Response Plan](#) entail:

- Limiting human-to-human transmission, including reducing secondary infections among close contacts and healthcare workers, preventing transmission amplification events, and preventing further international spread from the epicenter in China
- Identify, isolate and care for patients early, including providing optimized care for infected patients
- Identify and reduce transmission from the animal source
- Address crucial unknowns regarding clinical severity, extent of transmission and infection, treatment options, and accelerate the development of diagnostics, therapeutics and vaccines
- Communicate critical risk and event information to all communities, and counter misinformation
- Minimize social and economic impact through multisectoral partnerships

Patients diagnosed with 2019-nCoV must immediately be isolated and examined/treated in a health facility by trained health workers, preferably in negative pressure rooms, with strict adherence to airborne precautions in addition to contact and droplet precautions by using personal protective equipment (PPE)- including gloves, isolation gowns and eye protection- in order to limit the possibility of medical personnel becoming infected. This requires national capacity at all levels of the healthcare system to appropriately triage patients and ensure clear referral pathways for [timely management of positive cases](#) in collaboration with case management and surveillance capacity, and intact supply chain systems to avoid shortage of necessary supplies.

Public health interventions to try to control the spread of disease involve community awareness on accurate preventive measures which include hand washing, disinfection of surfaces, avoiding contact with bodily fluids and avoiding crowded places, in addition to isolation and up to 14 days of quarantine for high-risk individuals travelling from the epicenter of the outbreak. Clear communication is an essential function for effective coordination across the public health sector to prevent and respond to disease outbreaks.

How will 2019-nCoV affect sexual and reproductive health services, including maternal health?

Effect of coronaviruses on maternal health:

Fatality rates from coronavirus infections, and infectious diseases in general, are highest in older people (age 65 or older), newborns, young infants, and other populations considered to be **immunocompromised**. Immunocompromised means not having the ability to respond normally to an infection due to an impaired or weakened immune system. This includes those with chronic health conditions such as diabetes, heart conditions or asthma; HIV or tuberculosis; autoimmune diseases; malnutrition; and cancer patients undergoing chemotherapy or radiation treatment.

Pregnancy also alters a woman's immune system, making them more susceptible to infections. This is why pregnant women are prioritized in receiving annual influenza vaccines during the start of flu season. Historically, pregnant women have been disproportionately affected by respiratory infections. During the 2009 H1N1 pandemic and the 2003 SARS epidemic, respiratory infections in pregnant women led to higher mortality rates, ICU admissions and other co-morbidities compared to non-pregnant women¹¹¹²¹³. There are limited pregnancy specific data available on the 2019-nCoV, but **any febrile respiratory illness in pregnancy should be treated seriously** with immediate diagnosis, appropriate care and infectious precautions.

Pregnant women have more contact than usual with health care settings as they require regular antenatal visits, increasing their risk for contracting infections. In addition, infectious diseases sometimes have atypical presentations during pregnancy, and may be more difficult to diagnose. **Infection control in maternity settings must be prioritized** in order to prevent hospital acquired infections, and a low threshold of suspicion to investigating infections in pregnant women must be exercised.

Coronavirus infections are not believed to cause vertically transmitted infections through **mother-to-child transmission**; in other words, coronaviruses are not believed to cross the placenta directly to the fetus or the baby during pregnancy or childbirth. There were no reported cases of vertical transmission from SARS-CoV¹⁴¹⁵¹⁶ or MERS-CoV¹⁷¹⁸.

¹¹ Eickhoff TC, Sherman IL, Serfling RE. Observations on excess mortality associated with epidemic influenza. JAMA 1961;176:776e82.

¹² Wong SF, Chow KM, de Swiet M. Severe acute respiratory syndrome and pregnancy. BJOG 2003;110:641e2.

¹³ Larsen JW. Influenza and pregnancy. Clin Obstet Gynecol 1982;25:599e603.

¹⁴ Stockman LA, Lowther SA, Coy K, Saw J, Parashar UD. SARS during pregnancy, United States [letter]. Emerg Infect Dis [serial on the Internet]. 2004 Sep

¹⁵ Robertson CA, Lowther SA, Birch T, Tan C, Sorhage F, Stockman L, et al. SARS and pregnancy: a case report. Emerg Infect Dis. 2004;10:345-8

¹⁶ Shek CC, Ng PC, Fung GP, Cheng FW, Chan PK, Peiris MJ, et al. Infants born to mothers with severe acute respiratory syndrome. Pediatrics. 2003;112:254-6 10.1542/peds.112.4.e254

¹⁷ Jeong SY, Sung SI, Sung JH, et al. MERS-CoV Infection in a Pregnant Woman in Korea. J Korean Med Sci. 2017;32(10):1717-1720. doi:10.3346/jkms.2017.32.10.1717

¹⁸ Alserehi, Haleema & Wali, Ghassan & Alshukairi, Abeer & Alraddadi, Basem. (2016). Impact of Middle East Respiratory Syndrome coronavirus (MERS-CoV) on pregnancy and perinatal outcome. BMC Infectious Diseases. 16. 10.1186/s12879-016-1437-y.

Nutritional deficiencies, high fevers, organ failure, mechanical ventilation and medications required for treatment of seriously ill pregnant women may affect pregnancy outcomes for both the mother and the fetus, including premature labor, miscarriage and stillbirth. However, **there is still much that we do not know about the behavior and traits of 2019-nCoV**, and we must remain vigilant and up to date with accurate information from reputable sources.

As with most respiratory viruses transmitted by droplets, transmission of coronaviruses via breast milk is an insignificant mode of transmission, if it occurs at all. Thus, **mothers are encouraged to continue breastfeeding** even if they are diagnosed with the coronavirus; alternatively, expressed or pumped breast milk can be given to an infant until the mother is able to fully recover from the viral infection and breastfeed.

Ensuring universal access to life-saving SRH information and services for women and young people during the outbreak:

Lack of adequate reproductive health services, including contraception and management of gender based violence, including sexual violence, can lead to a range of adverse outcomes including trauma, sexually transmitted infections, unintended pregnancies and maternal and neonatal deaths. Access to life-saving sexual and reproductive health information and services is in line with the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations, and highlights the importance of providing integrated services to women, adolescents and youth. Women of reproductive age who wish to defer getting pregnant during the height of the epidemic should be able to access appropriate family planning counseling and receive a modern method of contraception of their choice, including long acting reversible contraceptives (LARCs) such as implants or IUDs. **Maternal and newborn health services need to be continuously accessible**, particularly access to referral-level facilities capable of providing Basic and Comprehensive Emergency Obstetric and Newborn Care (BEmONC and CEmONC) to manage pregnancy related complications.

During an epidemic, **health systems resources can often be stretched**, negatively affecting availability and access to reproductive and maternal health care, including the capacity to offer safe deliveries. The strain on health services in responding to an epidemic, including diversion of critical resources such as trained health workforce, has the potential to crowd out essential SRH services for women and young people including those not infected with the coronavirus, impacting on access to care and increasing potential risks of SRH related morbidity and mortality. With limitation on people's movement due to high alert, women and young people may not be able to access SRH services, and pregnant women may forego antenatal care and even give birth unattended. Additional considerations to providing essential information and services are to ensure that the needs of vulnerable populations, such as women and girls with disabilities, are met.

Stress from epidemics and heightened emergency situations can create comfort-seeking behaviors, which can lead to unprotected sexual encounters. During an epidemic, schools and

youth centers may shut down, and young people may lose access to social networks and support systems, negatively impacting their ability to cope with stressful situations. Access to contraception and professional psychosocial support mechanisms are an important consideration in such contexts. **Provision of integrated SRH information and services, as an essential service package, should continue in the face of a public health emergency to prevent excess morbidity, mortality and psychological stress among the population.**

Additionally, **provision of mental health and psychosocial support for affected families and communities**, particularly for those who have experienced deaths in the family due to the 2019-nCoV outbreak, will be a critical part of the overall response. This includes provision of psychological first aid (PFA) by front-line health and social workers facing worried and grieving families. A key consideration during this epidemic is that health workers themselves are also experiencing severe stress because of being overstretched, exposed to grief and anxiety, and possibly having their own family members affected by the virus.

Key advocacy messages and considerations:

- Sexual and reproductive health is a significant public health issue, including in epidemics
- Safe pregnancies and childbirth depend on sufficient numbers of trained healthcare workers, adequate facilities for providing essential and emergency care, and strict adherence to infection precautions
- Respiratory illnesses in pregnant women, particularly 2019-nCoV infections, must be treated with utmost priority due to increased risk of adverse outcomes
- Infection control measures include proper segregation of suspected, possible and confirmed cases from neonatal and maternal health units
- Ensure that surveillance and response systems take sex, gender, occupational status and pregnancy status into consideration; the pregnancy status of every female patient of childbearing age should be recorded for epidemiological analysis
- Surveillance and response systems for women of reproductive age and pregnant women should be in place, including in ANC clinics, for screening, early identification and management of possible 2019-nCoV cases
- Provision of mental health and psychosocial support (MHPSS) for affected individuals, families and communities is a critical part of the overall response
- UNFPA supports the leadership role of national and local authorities, communities and beneficiaries in ensuring access to SRH services during the epidemic
- Collaboration and partnership with WHO in supporting the Ministry of Health and relevant line ministries is key to ensuring that accurate information is provided to women of reproductive age and pregnant women on infection precautions, potential risks and how to seek timely medical care



How will 2019-nCoV affect gender-based violence and protection issues?

Women and girls are disproportionately affected by the social and economic consequences of epidemics. Gender is a key factor in affecting health outcomes and patterns of exposure during infectious disease epidemics, often leading to higher infection rates and long-term recovery implications¹⁹. As primary caretakers of the sick and elderly, women are more exposed to diseases, increasing their vulnerability to infection. Feeding and washing persons infected with the virus increase the risk they face of contracting the disease. Gender roles are also such that health care workers and health facility service staff (eg. cleaners, cooks), particularly at community level, tend to be predominantly female, a factor that contributes to higher exposure and infection rates for females than males in most countries.

In addition, **crises compound existing gender inequalities, increasing harm and risks for women, girls and gender diverse people both in the home and in the community.** Previous epidemics such as the Ebola outbreak in 2015 saw an increase in violence, sexual exploitation and abuse of women and girls due to increased financial stress on families, increased demands of household chores in caring for the sick, decreased access to livelihoods, more frequent and longer journeys to obtain food or water which increases exposure to sexual assault, and disintegration of social protection structures as resources are diverted towards responding to the outbreak²⁰. In resource strapped environments, vendors may insist on trading sex with women and girls in exchange for necessary supplies that are scarce. In households where men have fallen ill or died from the epidemic, women and children may be left to fend for themselves, making them vulnerable to violence and sexual exploitation. With schools suspended, young girls and boys can find themselves exposed to heightened risk of exploitation and abuse.

Women and girls who face intersecting inequalities including women and girls with disabilities, adolescent girls, older women, women and girls with diverse sexual orientation and gender identities, those living with HIV and AIDs and those from ethnic and religious minorities or migrant women and girls may be even more vulnerable to various forms of discrimination, violence, exploitation and abuse. Violence against women and girls has significant and long-lasting impacts on the health, and psychosocial and economic well-being of women and girls and their families and communities.

Placing the protection and health needs of women and girls must be at the center of response efforts during epidemics, ensuring equitable access to quality multi-sectoral services, reporting mechanisms and dedicated prevention and outreach efforts.

¹⁹ Addressing sex and gender in epidemic-prone infectious diseases, WHO (2002)
<https://www.who.int/csr/resources/publications/SexGenderInfectDis.pdf>

²⁰ Ebola impact revealed, an assessment of the different impact of the outbreak on women and men in Liberia (2015)
https://www-cdn.oxfam.org/s3fs-public/file_attachments/rr-ebola-impact-women-men-liberia-010715-en.pdf

It is important that targeted information dissemination and programming do not exacerbate potential stigmatization or discrimination due to gender, race, age or any other population differential. Stigmatization of people of Asian descent who are assumed to be more likely to have 2019-nCoV must be countered, as well as stigmatization of individuals who test positive for 2019-nCoV in order to assist in their reintegration into their communities and households. **We must promote a message of solidarity, not stigma.**

Key advocacy messages and considerations:

- Women and girls are disproportionately affected by epidemics. In particular, women and girls with who face multiple forms of inequalities due to disability, sexual orientation, gender identity, age, ethnic minority may be even more vulnerable
- Epidemics compound existing gender inequalities, increasing risks of gender based violence and sexual exploitation and abuse
- The protection needs of women and girls must be at the center of response efforts
- UNFPA can play a key role in sensitizing national partners to understand the intersections of GBV with their mandates and how to safely, ethically and effectively address GBV within their scope of work
- UNFPA can emphasize that given the existing level of gender inequality and prevalence of various forms of violence against women in several countries in the region, the focus should not be on collecting evidence of GBV in virus affected areas but rather to focus on ensuring that adequate support services are in place to address this serious and life-threatening problem regardless of the presence or absence of concrete 'evidence'
- Equal participation of men and women through community engagement and leadership efforts is an important part of the response



What type of support can UNFPA APRO and country offices offer to governments and national partners in the epidemic response?

UNFPA's work at country level should be to **support the leadership of the Ministry of Health** and other relevant line ministries at national and subnational levels to ensure that health services and health workforce are well supported and accountable to the populations they serve. Reaching those that are furthest behind and the most vulnerable to both the immediate and indirect effects of the 2019-nCoV epidemic often require additional funds and supplies to support a nationally led response, and must be approached according to the local context and existing capacities. In addition, any technical or programmatic support provided must be done **in close collaboration with sister UN agencies, particularly WHO, and national partners.**

Immediate actions from the UNFPA country offices would be to engage in interagency and national level fora to ascertain the most updated information on how the coronavirus epidemic is affecting essential health services in the country. The key advocacy points for SRHR and GBV from this document can be raised to ensure continued access to SRH services, particularly maternal health services, and considerations for possible increase in GBV and sexual exploitation and abuse concerning women, adolescents and youth.

In the event that existing primary health services and maternity facilities are overstretched and unable to provide continuity of services, UNFPA can consider various ways of working with WHO, Ministry of Health and national partners on supporting a nationally led response.

Possible support for an SRH response include:

1. Providing technical guidance for service availability and readiness assessments of Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) services
2. Providing technical guidance in developing health system response and recovery strategies
3. Updating ANC consultation guidance
4. Providing guidance in developing 2019-nCoV health education materials for WRA and pregnant women on infectious precautions, danger signs and instructions on how to seek care, for translation into local languages
5. Providing health education information for WRA who wish to delay pregnancy during the height of the epidemic, who may be seeking contraceptive counseling and services
6. Providing training to health workers in disseminating accurate information to WRA and pregnant women through community and facility-level engagement
7. Supporting a nationally led MISP response, from implementation to early transition towards restoration of comprehensive services
8. Procuring interagency reproductive health (IARH) kits that contain essential drugs, equipment and supplies
9. Procuring other requested medical supplies and equipment from the UN catalog

10. Supporting South-South Cooperation through deployment of trained health workers such as midwives

Possible support for prevention and response to gender-based violence include:

1. Providing technical support to integrating GBV risk mitigation into all aspects of the epidemic response, including providing tools and methodologies for conducting safety audits
2. Establishing women friendly spaces
3. Distributing dignity kits as part of a holistic GBV program to provide essential information and services to women and girls
4. Supporting national partners in strengthening multisectoral response services through referral pathways
5. Providing training and/or training materials for MHPSS and PFA
6. Providing and ensuring appropriate administration of IARH kits for clinical management of rape

Resource Mobilization:

Funds to support response activities may be considered through reprogramming of existing country program funds- either core resources or other resources through discussions with donors. Additionally, country offices can explore internal funding mechanisms such as the **UNFPA Emergency Fund**, pending availability of funds.

UNCT's, under the leadership of the RC/HC, may consider applying for the **Central Emergency Response Fund (CERF)** for a Rapid Response where agency response strategies must fulfill [life-saving criteria](#).

Country offices may consider applying for **Fast Track Procedures (FTP's)** to expedite HR, procurement and financial management processes in order to ensure rapid and timely response.

APRO staff will provide technical and programmatic guidance to country offices who may consider supporting nationally led response efforts.

