<table>
<thead>
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<th>Area</th>
<th>Subject of monitoring and assessment</th>
<th>Current status</th>
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</table>
| I. Key elements of the WHE Programme (Legacy from the previous IOAC) | Management and administrative process  
- WHO leadership in global health  
- Delegation of authority, accountability, reporting lines and decision-making processes among Headquarters, Regional Offices and Country Offices | WHO leadership in global health: The thirteenth General Programme of Work (2019-2023) was adopted by Member States at the 71st World Health Assembly in May 2018. The GPW sets out three ambitious strategic priorities that will allow us to achieve the health-related SDGs. These are:  
1. Achieving universal health coverage – 1 billion more people benefitting from universal health coverage  
2. Addressing health emergencies – 1 billion more people better protected from health emergencies  
3. Promoting healthier populations – 1 billion more people enjoying better health and well-being  
The Emergencies Programme has three outcome measures that contribute to delivery of Strategic Priority 2. These are:  
2.1 COUNTRIES PREPARED FOR HEALTH EMERGENCIES  
2.2 EPIDEMICS & PANDEMICS PREVENTED  
2.3 HEALTH EMERGENCIES RAPIDLY DETECTED & RESPONDED TO  
Within each of these are a number of output and indicators that will allow the programme to track whether progress is being made. The WHE leadership team is made up of the Executive Director/WHE, one Assistant Director-General, the Regional Emergency Directors and WHE HQ Directors. The Programme adopt a continuous business improvement approach to continually strengthens and demonstrates its effectiveness in building One Programme and ensure coherent work as a 3-level team. A new HQ structure made of 3 technical divisions and 9 technical departments has been established in 2022 and the organizational charts are pending approval from the Director-General. | All, if relevant |
| Internal and external communication | WHE external communication mechanisms and processes including communication with Member States (grading, risk communication)  
- Effectiveness of communication within the WHE programme across the three levels  
Consistency and coherence of corporate communications in relation to WHO’s Department of Communications and other programmes within WHO | External communication mechanisms and processes: KPIs are attached to the monitoring framework and additional updates will be provided in the session with the IOAC and DCO Director. Communications within WHE across the three levels: Communications across the three levels has been steadily improving. A monthly REDs/HQ management meeting has continued to be organized and regular opportunities for face-to-face meeting are organized once a year and on an ad hoc basis in the margins of Governing Bodies. At HQ level, the WHO HQ Senior Management Team Meeting is being organized every 2 weeks to look at priority issues. The output networks also have regular video/tele conference and network meetings. The HQ senior management team meets weekly for information sharing, problem solving, decision making and accountability. The office of the EXD regularly shares relevant information and documents with all staff in HQ and the regional offices. The EXD holds at least quarterly a town hall with all HQ staff. Technical meetings are regularly held across the three levels, particularly in activated IMSTs. Consistency and coherence of corporate communications: As mentioned above, the emergencies communications has been integrated in to the central department of communications a result of WHO Transformation. | DCO |
| Human resource planning, recruitment and retention of talent | Country business model: The percentage of overall occupied positions at the country level has changed from 37% in October 2017, to 53% in October 2018, 65% in October 2019 and 73% in December 2019 to 66% in 2022. The drop between the years is mainly due to the Ukraine Crisis, which saw an increase of planned positions, thereby increasing the overall number of position. Ukraine and surrounding countries account for 53% of EURO unfilled positions  
For priority 1 countries the overall FTE gap in December 2022 is 36.3%, lower than October 2021. Of this, by region the reduction is at 35.3% for the African Region, 30.2% for the Eastern Mediterranean Region and 61.5% for the European Region. | HRT |
Selection, recruitment, training and deployment of WHO Country Representatives and Incident Managers

Systematic application of fast-track standard operating procedures (SOPs) and contract arrangements for rapid deployment

Mobility, focus on hardship duty stations

Expanded WHE Structure

Centralization and full staffing of HR function

Sixty-five percent of Priority 1 countries positions within the CBM were filled and/or were being performed by a staff at a lower grade, by a non-staff or by another staff also double-hatted. Similarly, in priority 2 countries 59.5% of CBM positions were filled and/or were either being performed by a staff at a lower grade, by a non-staff or by another staff also double-hatted.

Key CBM position still remain vacant in many priority countries. Some of the functions have been temporarily covered by experts on surge for a limited time period, supported by partners or backstopped by headquarters and regional offices.

Next steps will include consultations with the WHO Regional and Country Offices with the aim of determining HR needs for the emergency workforce in priority one and two countries in line with the Incident Management Structure. In addition, WHE will engage in the revision of the CBM to reflect the evolving needs of the countries in fragile, conflict and vulnerable settings.

IM selection, recruitment and training: WHE has a flagship Leadership training programme to identify and train staff with demonstrated or potential leadership abilities in order to perform key leadership roles under the Incident Management System (IMS). The Leadership in Emergencies programme was launched in 2019 and moved online in 2020 to increase access for learners. The programme consists of two phases: Phase 1 is an eight-week online course focused on developing leadership skills, while Phase 2 comprises four weeks of online classes followed by a workshop and training simulation exercise (SIMEX) for nominated individuals. Since the courses started in 2019: 294 WHO staff and Ministry of Health colleagues have completed Phase 1 course and 69 have completed Phase 2. The proportion of women trained through the Leadership programme increased from 29% of participants in 2019 to 49% in 2022. The first fully French cohort was launched in 2022 and will continue in 2023. In 2023 a total of 4 cohorts are planned. The WHE Learning and Capacity Development Unit together with Acute Event Management is designing a curriculum to train up to 30 new Incident Managers in a dedicated programme and providing fast-track SOPs and procedures.

Fast-track SOPs are being applied. Since last year, all outstanding draft e-Manual SOPs have been finalized, including a new section on risk management. WHE has been in the process of an in-depth review of the eManual content to ensure its fit for purpose and to reflect from lessons learned in their implementation during the COVID-19 response and other on-going G3 emergencies with a focus on collaboration across the three levels of the Organization.

An operational toolkit has been launched to ensure the systematic gathering and dissemination of good practices in relation to operational support for emergencies. An online training curriculum, including 11 modules on OpenWHO.org, were launched in 2021 in English and French. An additional 9 modules on OSL SOPs will be finalized in Q2 2022. The Arabic version of the online training is being developed as well to widen the outreach of the SOPs training, and will be launched in February 2022.

Mobility: To ensure a smooth implementation of WHO’s geographic mobility policy a simulation exercise has been conducted throughout 2021. The Director-General has launched a 100 day challenge supported by the Actions for Results Group, a group of dedicated WRs, to issue an updated Global Mobility Policy within 100 days and to publish the compendium of available posts in May 2023 for rotation. This agreed commitment launches WHO’s global mobility programme to ensure staff, and the Organization itself, benefit from increased opportunities for professional growth and development.

New expanded WHE structure: With the creation of the WHO Hub for Pandemic and Epidemic Intelligence in Berlin, (Berlin Hub) in September 2021, WHO now consists of three divisions, WPE, WSE and WRE. Through the creation of a dedicated Division of Alert and Response Coordination (ARC), in Division of Emergency Response (WRE), WHO is managing and strengthening WHE’s capacity to manage all emergency events.

Human Resources: The HR team supporting WHE in both the regular on-going work of WHE, as well as the deployment of personnel under grad exemptions to manage outbreaks and respond to humanitarian disasters, is now fully staffed. One objective is to regularize staff in the HR deployment team that have been on temporary contracts for seven years. The HR Business Partner and Associate position for the WSE Division in Berlin have been filled, with focus of the HR work being on up-scaling the Hub and looking at new collaborative working mechanisms to expand the work of external partners of the Berlin Hub.

The HRT/HRB/HRE Team Lead and the Office of the EXD jointly collaborate on WHE’s strategic objectives, coordinating, managing and monitoring HR support to WHE.

KPIs for the centralized functions have been developed and a monitoring framework is in place. Each centralized function maintain tracking for the key centralized processes and are reported on a 6-monthly period.

WHE has been in the process of an in-depth review of the eManual content, working closely with WHO technical units to generate updated content that 1) streamlines lessons learned from the pandemic response and other emergencies and 2) ensures alignment with the interim update of the ERF (2.1). The eManual format has been restructured to ensure that it is fit-for-purpose. New chapters include Resource Management and Resource Mobilization, Finance in the Field, Procurement, and Partnerships in Emergencies. The eManual review will conclude in Q2 2023.

An operational toolkit has been launched to ensure the systematic gathering and dissemination of good practices in relation to operational support for emergencies. An online training curriculum, including 11 modules on OpenWHO.org, was launched in 2021 in English and French. An additional 9 modules on OSL SOPs were launched in Q2 2022. The Arabic version of the online training was launched in February 2022 to widen the outreach of the SOPs training.

Implementation of the WHO RM Strategy & Financing of the PB: WHE continues to implement the Resource Mobilization Strategy that was presented to the Executive Board at the 146th session held in February 2020. It outlines the strategy for mobilizing the resources needed to deliver on the 13th General Programme of Work (GPW13), covering the period of 2019–2023 (now extended to 2025) and rests on four pillars, namely:

- Established government partners: growing, diversifying or maintaining funding through regular and active engagement and policy alignment, taking a tailored approach;
- Philanthropic partners: building on our most effective partnerships and seeking to grow funds from a wider range of philanthropies;
- Funds, international development banks and multilaterals: maintaining funding from mature partnerships and developing funding streams from new sources and mechanisms;
- Innovative financing and revenue-producing activities: exploring the potential in these areas.
To implement the Resource Mobilization strategy, WHO’s Coordinated Resource Mobilization department, working across the three levels of the Organization, continues to grow and nurture strategic partnerships with donors. This work is underpinned by individual donor profiles and engagement plans developed for top donors on an annual basis, with dedicated profiles and engagement plans, including analyses of key partner institutions, budget cycles, and key opportunities incl. dates/events for engagement.

In 2022, as in previous years, WHO held Strategic dialogues with governments, philanthropic foundations, and international financial institutions including Belgium, the Bloomberg Foundation, the Carter Center, CERF, the European Union, Germany, France, the Netherlands, the United Kingdom, and the United States. All included high-level representation of the health emergencies programme allowing for strategic discussions on key topics including the INB, IHR, HEPR, the criticality of an adequately resourced core budget of WHE, especially in light of the WHA improved increase to the PB 2022-2023, and various emergency response operations. Strategic dialogues are planned for 2023 including with donors, for which dialogues were not possible in 2022 such as Australia and Canada. At the close of 2022, and despite concerted RM efforts and while the overall PB 2022-2023 was well funded, there remains a critical funding gap for which a significant portion is for the base component of WHE.

Furthermore, in line with the Global RM Strategy, work continues to expand and diversify the Organization’s donor base, building on the unprecedented number of non-traditional donors which provided first-time voluntary contributions to WHO during the COVID-19 pandemic (i.e. in 2020 fifteen countries representing new and emerging donors had provided voluntary contributions to WHO ranging from USD 10,000 to USD 10 million). Efforts to engage strategically with this group has continued, shifting from one-off contributions to longer-term partnerships. It is worth noting that several of these countries have since provided further contributions to WHO, including to the Contingency Fund for Emergencies (CFE).

**Resource Mobilization for the Emergency Operations & Appeals Segment of the PB:** People and populations in need of health assistance increased in 2022, and this trend has only continued into 2023, with some 339 million people needing humanitarian assistance, as a result of the convergence of climate change, poverty and conflict coupled with stretched and strained health systems worldwide, particularly in countries and regions dealing with emergencies and humanitarian crises. Alongside the growing population in need of assistance, the financial requirements to deliver this, have increased. At the same time, humanitarian financing environment and ODA trend witnessed sharp decrease following the Ukraine crisis.

To ensure understanding of WHO’s role in emergencies beyond the COVID-19/ACT-A response, in 2022, WHO moved towards a full-fledged annual operational planning process with all 6 regions for the emergency operations and appeal segment of the PB. In March 2022, WHO launched the Organization’s first-ever consolidated Health Emergency Appeal (HEA) seeking US$ 2.7 Billion for its work in responding to ongoing emergencies including for the COVID-19/ACT-A response. The objective of an annual Appeal is to provide stakeholders including donors with a clear overview of WHO’s annual priorities and financial requirements for health emergency/humanitarian response – allowing them to: 1) better understand WHO’s work in emergencies, and 2) to over time, allow donors to better plan their contributions to be transferred early in any given year to maximize time to implement and 3) to encourage donors to give flexibly against the Appeal instead of against donor specific proposals.

By the close of 2022, WHO had recorded some US$ 2.7 billion in income against the Appeal. A significant portion of this income was for the COVID-19/ACT-A response, namely US$ 1.7 billion, while the remaining 1 billion was for other emergency response related activities.

In January 2023, ahead of PBAC and EB157, WHO launched the Organization’s Health Emergency Appeal for 2023 calling for US$ 2.5 million to respond to health emergencies including COVID-19 and other disease outbreaks such as mpox and cholera. WHO held a dedicated launch event led by Dr Tedros, which included several high-level speakers, who spoke to the importance of ensuring that health is a priority in emergencies as well as the partnership with WHO. The event was livestreamed to ensure engagement of the public, media, and other stakeholders, and a concerted visibility effort was made across WHO’s social media platforms with the support of WHO’s Department of Communications (DCO). Dedicated briefings will take place throughout the year, to donors, to provide them with a better understanding of health responses, the priorities, challenges and opportunities, WHO’s role, and the financing situation. As such, in February 2023, CRM and WHE organized a briefing on the global cholera outbreak with focus on Haiti and Malawi. For March, two briefings are planned for, namely on the earthquake response in Syria and Türkiye, and on the Ukraine and neighbouring country response.

Recognizing the important role that communications/advocacy plays in resource mobilization, CRM continues to work closely with DCO to increase the visibility of donor contributions through the development of dedicated webpages (‘Partners in Health’ pages) and via various social media channels.

Efforts to mobilize resources for the CFE continued. In 2022, income reached nearly US$ 80 million. A dedicated donor briefing on the CFE was held on 02 February 2022, looking back at the past biennium and forward to the next biennium and included discussions on more sustainably financing the CFE with a call for more MS to give to the CFE. During this event, participants confirmed the need for the CFE, with existing MS donors together who continued support for the CFE, their continued support of US$ 88 million for 35 emergencies spanning 40 countries/territories. Reporting and information sharing on the CFE was stepped up - monthly updates on income and releases were produced and shared with donors, and quarterly summary updates on income and releases as well as stories from the field, were shared with donors, and published on WHO’s CFE website.

In 2023, the CFE opened with a healthy balance of some US$ 68 million, however, as the scale and number of acute events continue to grow, releases in 2023 are already significant, and concerted efforts are underway to secure the necessary funding for the CFE – the CFE is consistently brought up in meetings with donors including by DG, EXD WHE, and EXD EXT, as well as in other meetings, and a dedicated CFE event is planned for early Q2 2023, ahead of WHA.

**Supporting the 3-levels of the Organization in Resource Mobilization:** Effective RM requires partnership skills at the highest level of WHO, especially at country level, where the role of the WRs is critical to the effective engagement of donors for strengthened partnership and RM. In this regards, CRM continues to support RM across the three levels – examples include:

- The CRM/EHE team continued to support WHO’s work in graded emergencies through the organization of dedicated donor briefings including on the Ukraine response, the Horn of Africa and Sahel responses, the Pakistan flood response, and the Ebola outbreak in Uganda. In these briefings careful consideration is given to ensure representation from country offices, as well as a balanced representation of gender among the speakers.
- Organize the participation of WHO in HL events including pledging conferences e.g. Afghanistan, Ukraine, Yemen.
- CRM/EHE has also in 2022, rolled out virtual ‘brown-bag lunches’, which target RM practitioners across WHO. They are held on a monthly basis with a range of topics related to RM, and on average somewhere between 50-70 staff participate. Topics covered include the CFE and RM for this at country level; engagement with Foundations; the use of CEM, donor visibility including field visits, Donor Reporting; the Health Emergency Appeal 2023 etc.
- The introduction of CEM (Contributor Engagement Management system) – a corporate system for recording of donor related information and intelligence, which provides the three levels of the organization with equal access to contribution/donor related information including donor profiles, contribution templates and more.
CRM/EHE is also part of IMSTs – in 2022 the team were represented in the IMSTs of Afghanistan, the ongoing COVID-19 response, the mpox response, Northern Ethiopia response, the Pakistan flood response, and the Ukraine response.

- Dedicated resource mobilization officers remain in place in a number of graded emergencies including DRC, Ethiopia, Nigeria, Somalia, Yemen, Afghanistan, South Sudan, Ukraine crisis and Syria and the EHE team is in regular contact with colleagues at regional and country level to support and when needed coordinate engagement with donors.

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<tr>
<th>Outcome</th>
<th>AFRO</th>
<th>AMRO</th>
<th>EMRO</th>
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<td>42%</td>
<td>42%</td>
<td>16%</td>
<td>79%</td>
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<td>2.3 EDR</td>
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<td>40%</td>
<td>50%</td>
<td>40%</td>
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### Top 10 Donors Funds Distributed to SP 2 WHE

<table>
<thead>
<tr>
<th>Contributor</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
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<td>INTPA, EC</td>
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<td></td>
<td></td>
<td>22.13</td>
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<tr>
<td>GAV Alliance</td>
<td>15.99</td>
<td></td>
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<td>Gates</td>
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<td>MEAE, France</td>
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<tr>
<td>Ministry of Foreign Affairs and Cooperation, Spain</td>
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<td>Turkey</td>
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### Top 10 Member State Donors Funds Distributed to SP 2 WHE

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<td>Saudi Arabia</td>
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<td>Turkey</td>
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<td>Russian Federation</td>
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<td>Netherlands</td>
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### Top 10 Donors Funds Distributed to SP 13 OCR

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<td>Iran</td>
<td>81.26</td>
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<td>1,430.25</td>
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The table above outlines contributions received by the World Health Organization (WHO) from various donors and member states for different programs. The contributions are categorized into different themes and specified funds, with totals provided for each category.
At the heart of the UHPR process is designed to provide additional incentives to Member States for enacting and monitoring relevant recommendations, while complementing existing voluntary mechanisms such as the State Party Self-Assessment Annual Reporting tool and the voluntary joint external evaluation mechanism. The innovative peer-review mechanism at the heart of the UHPR process is designed to provide additional incentives to Member States for enacting and monitoring relevant recommendations, while complementing existing voluntary mechanisms such as the State Party Self-Assessment Annual Reporting tool and the voluntary joint external evaluation mechanism.

A conceptual zero draft, which was published in December 2022, sets forth many of the principles on which a final accord might be based, including the principles of solidarity and benefit sharing, transparency and accountability, and the sovereignty of Member States.

WHO continues to drive, support and coordinate diverse efforts to strengthen the global architecture for health emergency prevention, preparedness, response, and resilience (HEPR). These efforts can be broken down into three distinct yet complementary areas: governance, financing, and systems.

Leadership, inclusivity, and accountability: strengthening global governance

Effective governance enables governments and national and international partners to achieve the collective goals of HEPR, galvanized by political will, and with the resources to sustain positive changes. WHO continues to support a number of key initiatives to reform the global governance of HEPR, cognizant of the lessons of COVID-19 and the need to build global governance mechanisms that are based on agreed rules and norms, are equitable, inclusive, and coherent, and which are founded on a spirit of solidarity, trust, and mutual accountability.

At the heart of efforts to reform global HEPR governance are two aligned processes driven by WHO Member States. The first of these processes, which is mediated through the Intergovernmental Negotiating Body (INB), seeks to present a so-called pandemic accord, or pandemic treaty, for implementation by the World Health Assembly in May, 2024. To date, the INB has already agreed on a number of key parameters, including that the treaty or accord will be legally binding, and that it will be negotiated under the auspices of WHO’s Constitution Article 19. A conceptual zero draft, which was published in December 2022, sets forth many of the principles on which a final accord might be based, including the principles of solidarity and benefit sharing, transparency and accountability, and the sovereignty of Member States.

In addition to the INB process, WHO Member States are also engaged in the process of considering amendments to the International Health Regulations (IHR; 2005). The second meeting of the Working Group on Amendments to the IHR will take place from 20 February, 2023, and consider a report by the Review Committee regarding the Amendments to the IHR, which will summarize the numerous amendments proposed by Member States to date.

Although both the INB and the Working Group on Amendments to the IHR processes are ongoing, the INB conceptual draft and initial Member State proposals for amendments to the IHR contain several common, cross-cutting themes, such as equity, transparency, trust, sovereignty, collaboration, and solidarity, with the overarching goal of protecting public health.

In the wake of the initial response to the COVID-19 pandemic, several reports and reviews identified the lack of a formal mechanism for Heads of State and Governments to discuss emerging and future global health crises. The question of how to ensure sustained high-level political leadership across the pandemic and health emergency cycle also remains open. WHO continues to work with Member States and partners to propose solutions that balance the need to elevate HEPR to a whole-of-government, whole-of society priority, with the need to avoid duplication of existing governance mechanisms and promote coherence, particularly with respect to the need for any additional governance mechanism to be aligned with WHO’s constitution and mandate. Two UN high-level meetings later this year, on Universal Health Coverage and on Pandemic Preparedness, Prevention and Response, provide crucial opportunities to precipitate the bold solutions required to elevate coordination on HEPR to the level of Heads of State and Government.

The third aspect of governance that requires urgent strengthening relates to the clear need for mechanism for monitoring the implementation of IHR capacities that promote transparency and accountability, and which incentivize Member States to enact recommendations, whilst fully respecting sovereignty and complementing existing voluntary assessment mechanisms. The Universal Health and Preparedness Review (UHPR) process was proposed by the WHO Director-General to increase accountability and transparency among Member States in terms of the identification and remedying of gaps in the core capacities required by the IHR, thereby ultimately leading to better health emergency preparedness. The innovative peer-review mechanism at the heart of the UHPR process is designed to provide additional incentives to Member States for enacting and monitoring relevant recommendations, while complementing existing voluntary mechanisms such as the State Party Self-Assessment Annual Reporting tool and the voluntary joint external evaluation mechanism.

A concept note outlining the UHPR process was submitted to and noted by the Seventy-fifth World Health Assembly in May 2022. Technical and procedural guidance for Member States have been developed to plan and implement the UHPR mechanism, which had been piloted in four countries as of 30 September 2022. The lessons learned from these pilots were incorporated into subsequent UHPR documents and processes. To further guide the technical development of the UHPR process, WHO convened a global group of technical experts to provide inputs on the technical content of the UHPR process, including draft processes for field testing and piloting.
Self-assessment and peer review of national capacities, including through the UHPR process, should continue to be complemented by strengthened independent monitoring at the international level. Such mechanisms should be modelled on best practice in independent monitoring of international instruments, should be evidence-based, transparent and expert-led; and should build on and strengthen existing monitoring mechanisms, such as the Global Preparedness Monitoring Board and the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme. It is crucial that independent monitoring encompass the breadth of the global architecture of HEPR, including financing and governance.

Rebooting the health emergency operating system: realising the world’s potential through collaboration, coordination, and strengthened capacities

Harnessing diversity and promoting coherence through collaboration. The global health landscape has evolved and diversified over the past several decades. The emerging roles of new public–private partnerships, philanthropic donors, and multilateral institutes have combined with the increased participation of civil society and communities in global health initiatives to produce a broad network of actors and stakeholders at national, regional, and global levels. This diversity can be a potent source of strength, but increasing complexity can also pose challenges arising from fragmentation, duplication, and competition.

During COVID-19, new global mechanisms were rapidly developed to address the urgent need to unite often disparate groups of partners around common goals. The ACT-A initiative, and its vaccine arm COVAX, are probably the best-known examples of such multi-partner, time-limited coordination mechanisms developed at the global scale during COVID-19.

The need for these ad-hoc, COVID-19-specific coordination mechanisms at global, regional, and national levels is testament to the fact that the network of stakeholders in health emergency prevention, preparedness and response has outgrown and coordination mechanisms. We need new ways of connecting and collaborating to harness our collective strengths in health emergency preparedness, prevention and response. At the national level this means working more effectively across governments and, more broadly, across societies to prevent, prepare for, detect, and respond to health emergencies. At the regional and global levels this means streamlining and strengthening mechanisms for prevention, preparedness, detection and response built on trust, cooperation, solidarity, and accountability amongst governments and other global health stakeholders, including UN agencies, regional public health institutes, and other international partner organizations.

A renewed focus on One Health for pandemic preparedness and prevention, and on sustainable, multisectoral and integrated solutions to growing humanitarian needs

Within the UN system, an exploration of new ways to connect and coordinate action was already underway prior to COVID-19 in the sphere of One Health, through the Tripartite Alliance of WHO, FAO and WOAH. In 2022 the Tripartite evolved into the Quadripartite through the inclusion of the UN Environment Programme, in recognition of the need to consider the environmental dimensions of One Health.

One Health, as recently defined by the One Health High-Level Expert Panel (OHHLEP), means taking an integrative and systemic approach to health, grounded in the understanding that human health is closely linked to the healthiness of food, animals and the environment, and the healthy balance of their impact on the ecosystems they share, everywhere in the world.

The One Health approach has underpinned zoonotic disease prevention and response strategies for some time, with multidisciplinary and intersectoral efforts focusing on the understanding and investigation of the multiple drivers, patterns and dynamics that lead to the emergence and re-emergence of zoonotic diseases. But as we build on the lessons of COVID-19, we may seek to apply the same coordinated, multi-factorial approach that underpins One Health to health emergencies more broadly.

In December 2022, over 339 million people – almost one in 20 of the world’s population – were predicted to need humanitarian assistance throughout 2023. This is an increase of 25% compared with 2022, and more than double the total of 135 million people who needed humanitarian assistance in 2018. However, in under two months into 2023 these estimates already look conservative, as the aftershocks of the devastating earthquake in Turkey and the Syrian Arab Republic continue to be felt.

The number, scale, and complexity of health emergencies continues to increase year on year, driven by many of the same long-term trends that continue to accelerate the emergence and re-emergence of epidemic-prone diseases: geopolitical conflict, the collapse of trade leading to famine and shortages of essential goods, the intensification of ecological degradation and climate change, weakened health systems, and widening economic and social inequalities. The evidence of the past few decades tells us that these trends are increasingly interacting in complex and unpredictable ways to drive health emergencies. Sustainable solutions, and the attainment of the sustainable development goals, will depend on giving more weight to proactive preventative, readiness and resilience-building measures even as we respond to ongoing crises.

Strengthening capacities at the intersection of health security, primary health care, and health promotion: the “five Cs”

WHO has worked closely with partners to develop a concept of HEPR systems strengthening that brings together the need for new collaborative mechanisms to harness collective strengths and build cohesion, with the concept of One Health, and the principles of equity and inclusivity at its core. This concept depends on accelerating a strategic shift by countries and health emergency stakeholders to focus on the transversal potential of strengthening five core health emergency capacities, or subsystems, that sit at the intersection of health security, primary health care, and health promotion, and which interface with multiple non-health sectors and stakeholders at national, regional, and global levels.

These five interlinked systems, which encompass all IHR core capacities but also expand beyond them, are explicitly multi-stakeholder and whole-of-government, and extend into every area of health emergency preparedness, prevention, readiness and response, from One Health surveillance systems to equitable access to medical technologies. The five Cs are outlined briefly below.

Collaborative surveillance

A truly interconnected global system for public health intelligence has the potential to revolutionize our ability to detect an emerging outbreak, communicate information quickly and rapidly initiate an appropriate response. We should move together towards a collaborative surveillance ecosystem at national, regional and global levels that: (a) puts into the hands of decision-makers accurate, timely information on emergence, transmission, susceptibility, morbidity and mortality; and (b) can combine that information with in-depth contextual insights on risk and vulnerability. Achieving these goals will mean strengthening capacities and combating fragmentation at national, regional, and global levels through enhanced mechanisms for coordination, collaboration and innovation among a range of traditional and new partners across the One Health spectrum.

Community protection
Any effective health emergency response must have communities and their interests at its heart; therefore, communities must be at the centre of efforts to prepare for, prevent and respond to health emergencies. Protecting communities will require partners to come together at subnational, national, regional and global levels to ensure that capacities are in place to provide proactive risk communication and infodemic management functions in order to understand, respond to and inform communities, as well as to build enduring trust in public health authorities.

Population-based and environmental interventions (such as vaccination, vector control, and infection prevention and control measures) form a crucial aspect of protecting communities from infectious disease. However, to be at their most effective these interventions must be co-created and co-designed with affected communities. Such interventions must also be combined with multisectoral actions that ensure that health protection is indivisible from the protection of social and economic welfare, mental health, livelihoods, food security and dignity.

Safe and scalable care
A strong HEPR architecture must be built on a foundation of strong national health systems centred on primary health care. High-quality health services and public health capacities are necessary to detect, prevent and respond to health emergencies. Resilient health systems have the resources to reorganize and redeploy existing resources in response to shocks such as health emergencies, while at the same time maintaining essential health services.

Access to medical countermeasures
Rapid and equitable access to safe, effective medical countermeasures is crucial for responding to outbreaks. Existing partnerships and legal agreements have made important progress in increasing access to medical countermeasures, primarily against specific pathogens such as influenza, smallpox, yellow fever, cholera and meningitis. These partnerships and agreements have largely focused on addressing different points in the medical countermeasures value chain. For example, the International Coordinating Group on Vaccine Provision addresses some of the downstream and delivery challenges related to allocation. It provides a framework for managing and coordinating the provision of emergency vaccine supplies and antibiotics to countries during major outbreaks. The Pandemic Influenza Preparedness Framework focuses on upstream elements, enabling the access of developing countries to vaccines and other pandemic-related supplies by guaranteeing reserved volumes of products for low-income and lower-middle-income countries. More recently, the ACT-Accelerator was established in April 2020 to support the end-to-end process of rapid development and equitable deployment of COVID-19 vaccines, tests, treatments and personal protective equipment. Together, the initiative provides a solid foundation on which to build a global, integrated, end-to-end mechanism for medical countermeasures against known and "disease X" epidemic-prone and pandemic-prone diseases.

Emergency coordination
The ability to rapidly detect health threats and mount a decisive and sustained response requires meticulous and continual strategic planning at subnational to global levels across every stage of the emergency cycle, informed by a constantly evolving and accurate assessment of readiness, threats and vulnerabilities. The benefits of strengthening the other four core HEPR systems can only be realized through systems of leadership and coordination that are able to rapidly leverage capacities, including the key capacity of a multisectoral and professionalized health emergency workforce.

The five Cs must be embedded in strengthened national health systems; enacted by a well-resourced and protected health emergency workforce; underpinned by data, research and innovation; and have strong links to regional and global support, coordination and collaboration structures and mechanisms across all phases of the health emergency cycle of preparing, preventing, detecting, responding and recovering.

Sustainable, coordinated, and innovative financing for HEPR
Agreement on the governance and the systems required to deliver HEPR will be meaningless without the resources to implement them in full on a global scale. WHO Member States have already signaled strong support for the creation of the WHO and World Bank Pandemic Fund, which was officially launched at a high-level event hosted by the G20 Presidency of Indonesia on the margins of the G20 Joint Finance and Health Ministers’ Meeting on November 13, 2022, in Bali, Indonesia. The Fund has already secured more than $US1.6 billion in donations, and these funds will soon be used to strengthen HEPR in low-income and middle-income countries and regions. Over 150 countries have already submitted expressions of interest following the Fund’s first call for proposals, and WHO is working intensively to support countries to develop detailed proposals as part of broader efforts to support the development of national multi-sectoral and multi-hazard health emergency preparedness and response investment cases to drive strengthening of the Five Cs. WHO Chairs the Technical Advisory Group of The Fund.

Despite the rapid progress of The Fund several key questions related to the financing of key HEPR capacities remain to be resolved. Foremost of these is the question of how we expand at-risk financing for the development of medical countermeasures, and how we can ensure the financing is in place to enable equitable access to all available medical countermeasures during large-scale health emergencies. At present, financing requirements for diagnostics, therapeutics and vaccines far exceeds the scope and scale of existing fragmented and often unpredictable emergency funding mechanisms, especially for newly emerging pathogens. WHO is working with and convening multi-sectoral partners at pace to build consensus for an equitable, sustainable solution that will ensure the lessons of the COVID-19 pandemic are learned.

Under the Health Emergency Preparedness and Response (HEPR) architecture, one of the 10 proposals includes the process for amending the International Health Regulations (2005) (see document EB152/12 - https://apps.who.int/gb/ebwha/pdf_files/EB152/EB152_12-en.pdf). As background, the WHO Member States, through the Working Group on Strengthening WHO preparedness and response to health emergencies (WGPR) examined the findings of the multiple reviews of the global response to the COVID-19 pandemic and agreed through decision EB150(3) to begin consideration of potential amendments to the International Health Regulations (2005), with the understanding that this would not lead to reopening the entire instrument for renegotiation. Such amendments should be limited in scope and address specific and clearly identified issues, challenges – including equity, technological or other developments – or gaps that could not effectively be addressed otherwise but are critical to supporting effective implementation and compliance of the International Health Regulations (2005) and their universal application for the protection of all people of the world from the international spread of disease in an equitable manner. Then, in May 2022, Member States of WHO decided to transform the WGPR into the Working Group on amendments to the IHR and invited Member States to propose amendments to the Regulations by no later than 30 September 2022 (Decision WHA75(8)).

Through the same decision, WHO Member States requested the Director-General to convene a Review Committee to provide technical recommendations to the proposed amendments to the IHR, which were supposed to be submitted by Member States by 30 September 2022. The Review Committee was convened in line with provisions of Article 50.1.a of the IHR on 6 October 2022. The IHR Secretariat supported the Review Committee on amendments to the IHR, which met for 6 meetings between October 2022 and January 2023, and submitted its report to the
### Prevention and Response to Sexual Exploitation and Abuse, including Harassment (PRSEAH)

PRSEAH has been incorporated in the updated ERF and is the basis for mainstreaming PRSEAH in WHO emergency operations, with a focus on enhancing SEAH prevention, reporting, referral for victim support services and response. Our efforts are focused on implementing and mainstreaming PRSEAH in graded acute emergencies and in Protracted crisis settings.

Key Minimum interventions for PRSEAH in WHO Emergency Operations have been defined. These interventions are aligned to the IASC PSEA Minimum Operating Standards (MOS) and the recommendations of the OECD Development Assistance Committee (DAC) given that our operations are in both humanitarian and non-humanitarian settings. These standards include:

- i) implementation/contribution to PRSEAH risks and needs assessment.
- ii) deployment of PSEAH Specialist/Technical Officers to priority graded emergencies (grade 2 & 3);
- iii) integrating PSEAH actions in advocacy, funding requests and appeals;
- iv) systematic implementation of PSEAH recruitment safe-guarding measures (systematic screening through the UN Clear-Check database and vetting);
- v) systematic integration of PSEAH actions in emergency specific SRPs and response strategies;
- vi) enhancing PSEAH training and awareness raising of emergency responders (WHO personnel and support to Inter-agency PSEA capacity building needs);
- vii) contributions to joint Inter-Agency PSEAH priority actions at operational level;
- viii) enhancing community awareness on rights and reporting channels;
- ix) enhancing PSEAH capacities and safe-guarding measures of Implementing partners.
- x) strengthening reporting and referral pathways, based on GBV referral pathways or existing national mechanisms.
- xi) enhancing engagement with national governments.

Over the past one year, efforts have been made to systematically implement, and track progress in implementation of these minimum standards in all graded priority emergencies. We have initiated the development of PRSEAH SOPs and tools as part of the Toolkit to facilitate roll out and implementation in WHO emergency operations. The SOPs/Tools are in various stages of development and roll out, and this toolkit will be maintained as a live toolkit to enable continuous updated.

As a Health Cluster Lead, WHO is also working on creating awareness on PRSEAH among health cluster partners where they exist.

As part of the monitoring, evaluation and learning, a comprehensive operational review focused on the PRSEAH mainstreaming in the Ukraine response was conducted and the lessons are being used to strengthen PRSEAH implementation in graded WHE Operations as well as inform the update of the WHO AAR guide to incorporate guidance for PRSEAH after action and operational reviews as part of the broader framework for COVID after action reviews.

WHE HQ and EURO is in the process of finalizing PRSEAH strategy and work plan in emergency operations as an extension of the global WHO PRSEAH 3-year strategy and work plan. This plan focuses on strengthening PRSEAH mainstreaming in acute graded emergencies and in protracted crisis settings. WHE plans to establish an internal technical working on PRSEAH to coordinate and draw on efforts from various units and functions in WHE at the three levels of WHO, and across the organization to ensure we coordinate our efforts.

WHE is also an active member of the global IASC Technical Advisory Group (TAG) and is contributing to the implementation of the IASC Plan of action including the revisions and development of IASC tools and SOPs. This is instrumental in ensuring that the IASC PSEA frameworks, strategies and tools also meet the needs for PRSEAH mainstreaming in emergency operations given the uniqueness of WHO operational models.

To strengthen dedicated capacity for PRSEAH in countries during emergencies, the WHO Health Emergencies Programme (WHE) established a PRSEAH focal points network in May 2021. A scope of work was agreed upon that initially focuses on peer learning, access to the global perspective/resources and trainings. In January 2022, a PRSEAH learning pathway for all personnel and focal points was introduced. A pilot of a Peer-to-Peer learning tool for PRSEAH was conducted from March to October 2022 in priority countries and operations to support expanded informal sharing and exchange between colleagues. A pilot of a learning passport mobile app was also initiated in 2022 to enable focal points to track their learning progress and manage their training records. The focal points network has grown more than 500% since March 2022 to include 326 focal points in 145 country offices across the 6 WHO regions as of December.

The Learning and Capacity Development Unit (LCD) has prioritized the development of PRSEAH learning material, including open online courses:

- A series of 5 online courses on gender-based violence and clinical management of rape and intimate partner violence in humanitarian settings were launched on OpenWHO.org at the end of September 2022. The courses are hosted on OpenWHO’s dedicated PRSEAH learning channel and garnered more than 13,000 total enrolments in 2 months.
- A WHO agency-specific training on PRSEAH was piloted in English on OpenWHO for a dedicated test audience of 400 staff and is under review after the launch of the new WHO Policy on Preventing and Addressing Sexual Misconduct and the WHO Policy on Preventing Retaliation. A learning company was selected to produce the course on both the Learn and OpenWHO learning platforms.
- A pre-deployment induction training on PRSEAH is under development. The course will be available on OpenWHO and iLearn targeting all personnel from community-facing operations.

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MOW/PRSEAH
Partnership and Coordination

- Engagement and support to the Global Health Cluster
- Health cluster coordination in priority countries
- High quality of the Health Cluster Coordinators’ (HCC’s) roster through adequate assessment of candidates, improved performance management of HCCs, training on field-level health cluster coordination prior to deployment, and adequate support on deployment to ensure satisfactory management and coordination.
- Expansion and strengthening of the Global Outbreak Alert and Response Network, Emergency Medical Teams, stand-by partnership, etc.
- Leadership role in outbreaks as per the Inter-Agency Standing Committee L3 protocol.

Partnerships are an essential part of our collective ability to prepare for, prevent, detect and respond to health emergencies. The WHO Health Emergencies Programme works with numerous technical and operational partners to guide longer term preparedness and prevention work, as well as operational response in acute events and delivery of health care in fragile and conflict affected settings (FCAs). Since 2017, WHO has developed and is implementing a series of strategic engagement frameworks with several key partners including US Centers for Disease Control and Prevention, UNICEF, ECHO and the International Association of National Public Health Institutes (IANPHI). Specific MoUs were signed in 2022 with UNICEF and IANPHI and joint action plans are currently under development. In parallel and accelerated by the intense partner engagement on strengthening the global architecture for health emergency preparedness and response, WHO is developing strategic engagement plans on health emergency preparedness and response, aligned with the Inter-agency Health Cluster Coordination (IHCC) and the Bill and Melinda Gates Foundation. Additionally, WHO is engaging proactively with the G7 and G20 as well as other intergovernmental processes such as the UNGA High Level Panel on preparedness and response to support Member States in the agenda setting in this field. The frameworks are aligned with GPW13 strategies to ensure targeted technical, financial and operational support across the scope of WHO’s work in emergencies.

In terms of emergency response, the WHO programme is working to optimize the synergies and complementarity amongst these mechanisms as part of our work towards having a global health emergency corps that allows us to better coordinate across countries and leverage capacity across the world. Below we consider the critical partner networks – the Global Health Cluster, the Global Outbreak, Alert and Response Network (GOARN) and the Emergency Medical Teams through which we are able to maximize our capacity in responding to humanitarian needs, as well as the Stand By Partners Programme and the GSPN.

Global Health Cluster

Since the last report, 2 new partners were approved by the GHC Strategic Advisory Group: Amarceres and Project Hope were both assigned full member status. Project Hope brings strong experience of localization which is a thematic priority for the GHC in 2023.

The GHC has advanced its inter-cluster collaboration with Nutrition, WASH, Food Security and Protection clusters at global and country level through implementation of the USAID/BHA (USD 870k) Full-time Coordinator to lead efforts to advance this work in global and country level. Achievements to date include: establishing a global health sector collaboration around health and food security given evolving global humanitarian context including making substantial contribution to the development and rollout of the new WHO Strategic Framework for Food Insecurity and Health; & representing the GHC in WHO Incident Management Teams for the Greater Horn of Africa & the Sahel. Two support missions (Kenya/WHO Greater Horn of Africa Strategy Workshop & Ethiopia/develop 4-cluster strategy) were undertaken.

In collaborative inter-cluster engagement with other members of the inter-cluster network, the GHC provided inputs for the inter-sector chapeau-paper on principles of inter-cluster engagement and multi-sectoral approach; developed a joint ISP work-plan; drafted and secured consensus on joint statement on averting famine; initiated baseline mapping of existing tools for inter-sectoral action; provided GHC inputs to GNC-led guidance and e-learning for nutrition sensitive programming; contributed to development of inter-sectoral dashboard and developed draft monitoring & evaluation framework.

During the COVID19 pandemic, the Global Health Cluster has continued to participate in the partner coordination pillar of the WHO COVID-19 Incident Management System Team and contributed to the development and implementation of the 2022 Strategic Preparedness and Response Plan. The GHC COVID19 Task Team has continued to support country health clusters and partners integrate the 10 pillars of the COVID19 SPRP through the health component of the 2022 Humanitarian Response Plans. A major focus of the Task Teams’ work has been monitoring the status of COVID19 vaccination delivery among populations of concern (POC) in humanitarian settings. Twelve monthly reports have been compiled and shared with key stakeholders highlighting significant vaccine inequities amongst POC, particularly at sub-national level despite the presence of humanitarian partners with population access and capacity to deliver vaccines. The GHC has persistently advocated on this matter to COVAX, agencies, donors and the IASC through its engagement with the Humanitarian Buffer Working Group. The GHC evidence has informed a key component of the CovDp led Joint Convening on COVID-19 vaccinations in humanitarian settings and the contribution to broader pandemic Preparedness, taking place in Nairobi on 14/15 February 2023. In addition, the Task Team is undertaking a larger in-depth study to examine (i) C19 Vaccination in Humanitarian Settings as well as 3 other studies on (ii) Coordination of the COVID19 Response in Humanitarian Settings; (iii) Multi-sectoral Collaboration for COVID19 in humanitarian settings and (iv) Impact Analysis of COVID19 on Humanitarian Health Response. External providers have been hired to undertake these USAID/BHA funded studies, the results of which will be published in 2023 to inform future epidemic/pandemic readiness and response. More information on GHC COVID19 work can be found here: (https://healthcluster.who.int/our-work/task-teams/covid-19-task-team).

The Global Health Cluster was also part of the partner coordination pillar of the WHO Incident Management System Teams for the response to the crises in Afghanistan, Northern Ethiopia, Mozambique and Ukraine. In country support missions were undertaken to Madagascar and South Sudan.

Global Health Cluster partners met during the Global Health Cluster Partner Meeting, 29-30 June 2022 to (1) understand coordination challenges and opportunities from the Afghanistan, Ethiopia and Ukraine humanitarian responses to improve response action; (2) update on the recent inter-cluster / multi-sector collaboration and share good practices and lessons learned on WASH/Health and Nutrition/Health collaboration to improve health, WASH and nutrition outcomes; (3) update partners on the COVID-19 response, the work of the COVID-19 Task Team, other outbreaks and high-impact epidemics, and the package on High Priority Health Services in Humanitarian settings; (4) update on the following developments and ongoing themes to improve the quality of health cluster action including PRSEAH, Child health in emergencies, Sexual and reproductive health in emergencies, Environment and Climate Change (ECC) and Emergency Health and recent developments on cash-based interventions. https://healthcluster.who.int/newsroom/events/item/2022/06/29/default-calendar/global-health-cluster-partner-meeting-29-30-june-2022
In addition, the Health Cluster Forum, 4-6 July 2022 was held for the first time in 3 years following resolution of funding and COVID19 restrictions. The event was attended by 53 participants representing 31 country Health Clusters, WHO at the global and regional levels and the Global Health Cluster unit. The meeting objectives were (1) to strengthen the understanding of how clusters align with WHO at the global, regional and country level (2) to discuss in-depth selected thematic topics that have a direct impact on the work of the cluster And (3) identify practical solutions to challenges. https://healthcluster.who.int/newsroom/events/item/2022/07/04/default-calendar/health-cluster-forum-4-6-july-2022

At regional level the GHC supported the first EMRO joint WHE Team Leads and Health Cluster Coordinators Retreat in Cairo, 8-12 May 2022 and the AFRO Flagship Initiative through contributing to the development of training materials on humanitarian coordination.

Following the external evaluation of the Global Health Cluster project on Delivering Integrated Sexual and Reproductive Health Rights services in emergencies through the Health Cluster in Bangladesh (Cox’s Bazaar), Yemen, Democratic republic of Congo (Kasai) in May-June 2021, the GHC and UNFPA successfully negotiated and established a new GHC Task Team for Sexual Reproductive Health in Emergencies. Co-chaired by UNFPA and International Rescue Committee the Task Team seeks to ensure SRH priorities are systematically addressed in all phases of humanitarian response and that SRH coordination is consistently included in cluster coordination at both the global and country levels. The workshop addresses 4 key outputs (i) systematize coordination for SRH, (ii) reduce maternal and new-born mortality (iii) prevent unwanted pregnancies and (iv) develop and systematize effective linkages between SRH and GBV. https://healthcluster.who.int/our-work/task-teams/sexual-and-reproductive-health-task-team

During this reporting period, nineteen (61%) of Health Clusters completed the annual IASC Cluster Coordination Performance Monitoring (CCPM) exercise (compared to 24% in 2021). The main areas identified for improvement to date include further development and systematic use of AAP mechanisms; encourage improved multi-sectoral data collection and joint analysis with health partners and other clusters/sectors; deeper examination of localization across all cluster work. The collated annual CCPM report for 2022 is currently being drafted. To address AAP issues the GHC has secured an AAP Technical Advisor through NORCAP to assist the GHC examine current approaches and update guidance where necessary. He will start work in Jan 2023 for 9 months.

As of December 2022, 26 out of 31 (84%) health clusters/sectors have a dedicated Health Cluster Coordinator at national level, which did not meet the 2021 PB target indicator of 100% but is an increase compared to end of December 2021 (77%). The remaining clusters have double hatting HCCs and are all in the Sahel. The number of dedicated HCCs continues to fluctuate depending on available funding and delayed recruitment process; some clusters (e.g.Mozambique) remain overly reliant on the use of SBPs for coordinator positions and it is hoped the ongoing review of the Country Business Model will address these bottlenecks. Interestingly, during 2022, eight serving HCCs have been recruited into WHE Team Lead or Incident Manager positions. Whilst this shift is obviously beneficial to WHE wider operations, the loss of 24% of current HCCs is concerning and requires more exploration regarding underlying reasons (e.g. a genuine desire to move into a new role; or perceived limited opportunity to move to HCC positions in other regions) along with discussion on HR strategy to recruit and retain new HCCs.

During Information Management Officers whilst still challenging. As of December 2022, 22 out 31 (70%) health clusters/sectors have a dedicated Information Management Officer, a slight decrease since the previous reporting period (77%). Most clusters continue to have dedicated IMOs hired on short term contacts linked to event-based funding or deployed through Standby Partners. The strategic partnership with iMMAP has become more challenging during 2022 as they have become less supportive of WHO deployment requests, exercising an intense level of scrutiny on each request and making late decisions to no longer support existing deployments including to priority countries such as Ethiopia. This shift in tactic requires WHE to take more assertive stance in directly hiring IMO capacity for the health cluster.

The GHC continues to support capacity strengthening for cluster coordination through the development and delivery of training packages and materials including:
- E-Learning course for Health Cluster Coordination. The translation of the E-learning content into French was finalized in January 2022, however there is no funding to make the necessary changes to the online pages and soundtrack.
- Simulation-exercise trainings – The first all-women training focused on Health Cluster coordination and leadership from 17 to 21 October in Berlin, Germany, with support from the Center for International Peace Operations (ZIF). 23 women from all six WHO regions and from WHO’s three levels (headquarters, regional offices and country offices) participated, together with eight NGO partners’ representatives. At the request of SEARO, a simulation exercise was delivered in person in Delhi, 20-25 November 2022 with 24 participants from Bangladesh, Nepal and Myanmar. EMRO training planned for December 2022 was deferred until 2023 due to the departure of WHO staff leading this initiative.

The GHC Capacity Development Strategy (2020-2023) offers a competency based, blended learning program to strengthen the skills of HCCs, IMOs and partners. The mid-term review of the Health Cluster Capacity Development Strategy completed in April 2022 found good indications that the HCCDS 2020 - 2023 continues to make progress in achieving effective leadership and coordination capacity at country level, but much remains to be done in order to achieve the ambition of the strategy, particularly with regard to funding and capacity needed to fully implement the strategy. The GHC has prepared a concept note to submit to donors to secure multi-year funding for 2023 and beyond.

The Global Outbreak Alert and Response Network (GOARN)

As of 24 February, there are over 270 partner institutions in the Global Outbreak Alert and Response Network (GOARN).

Steering Committee (SCOM) and GOARN Governance
- Selection process for the GOARN Steering Committee (SCOM) has been completed in November 2022. SCOM with its new composition met for the first time in December 2022.
- During 2022, the GOARN Steering Committee met in June, and December following the usual formal schedule. SCOM meetings 31 and 32 reviewed progress made on the strategy development, progress made in GOARN areas of work, and operations.
- WHO and GOARN SCOM initiated a new strategy development process for the network, based on the IHR, and IPPR reviews and others, global and regional development and operations of the network during the pandemic, and progress and challenges in alert and risk assessment, training, rapid response capacities and research;
- GOARN strategy development process has been finalized, and formal launch took place on 28 February 2023. GOARN strategy document has been published on the WHO web site and is available from the following link https://apps.who.int/iris/handle/10665/366066.

GOARN Projects and areas of work
GOARN Operational support team continued to organize weekly operational call with operational partners. These calls serve as a forum for informal information exchange for ongoing events and have been running continuously since January 2017.

Knowledge management activities continue, including information dissemination to partners including curated research findings, data collection tools and WHO early investigation protocols; identification knowledge gaps with operational partners; conducting systematic reviews and literature queries for operational partners.

New GOARN Knowledge Platform has been launched in January 2023 at https://goarn.who.int. New version of the GOARN Knowledge platform provides a more robust technology stack, improved user experience design, new features and functionalities and easier access to information.

Go.Data continued to be rolled out globally throughout the reporting period and several information products were released, among which:

- Go.Data annual report 2021 https://apps.who.int/iris/handle/10665/352606
- Go.Data implementation photographs https://photos.hq.who.int/search/results?sort_by=&%5Bkeywords%5D=Go.data&%5Bclass%5D=

Risk Communications and Community Engagement (RCCE) / The Collective Service

- GOARN OST continues to provide the coordination platform for IFRC, UNICEF, and WHO as the 3 main international agencies that are shaping the Risk Communications and Community Engagement in outbreak response
- A project with six-month testing of the ‘Operational guide for engaging communities in contact tracing’ resulted in two reports on the perspective impact of engaged communities in contact tracing activities (beyond COVID-19). This work conducted in Northern Macedonia and Sierra Leone.

GOARN Training Programme

- In April 2022, GOARN delivered the virtual “Tier 1.5 Orientation to International Outbreak Response” training workshop which introduces the essentials for pre-deployment in one or two days. This was conducted in partnership with the Training Programmes in Epidemiology and Public Health Intervention Network (TEPHINET). 36 participants from 16 countries and 4 faculties (2 from TEPHINET, 2 GOARN OST) participated.
- In addition, between January and June 2022, GOARN’s Operational Support team organized three virtual facilitated training workshops on Gender and Inclusive Leadership, with 65 participants from over 50 countries. These trainings are conducted in context of GOARN “Tier 3 leadership training.”

GOARN Operations

- GOARN partners continued to mobilize international technical assistance to support preparedness and response missions at country request, and to also support capacity in WHO regions and headquarters in Geneva.
- For continued day-to-day operations, UNICEF has continued to embed staff in the IMST, and GOARN OST.
- In this reporting timeframe (Feb 2022 – Feb 2023) GOARN partners supported response activities for 14 operations with 117 deployments. Expertise provided included epidemiology and surveillance, laboratory, case management, infection prevention and control, risk communication and community engagement, coordination etc.

Emergency Medical Team

The Emergency Medical Team (EMT) Initiative has now definitively expanded from a focus on internationally deployed teams to building national and subnational EMTs and other rapid response capacities, surge planning and coordination. This emphasis also confers benefits in strengthening the resilience of national health systems and workforce, and supports their sustainability.

- The EMT initiative has had engagements, through national focal points, capacity building or operation responses, in the 20 highest risk index countries in the world, and has continued to expand focus on fragile, vulnerable and conflict-affected settings, including with some of the most fragile states.
- Country interest and commitments to establishing EMT capacities have continued to expand with 57% of Member States now having a designated EMT National Focal Point.
- Three multi-country training hubs have been established in line with greater regionalization, conferring proximity to countries for training and simulation opportunities as well as testing new solutions. A MoU between the Indonesian Government and WHO was signed during the G20 meeting in November 2022, recognising the key role of the EMT Initiative in strengthening the health emergency workforce.
- Several trainings, simulation exercises and workshops have been conducted covering all six WHO regions resulting in an increasing number of countries formally adopting the EMT concept and standards.
- WHO continues work to set global standards for EMTs and rapid response capacities through consultation at regional and global level with currently nine active technical working groups in the areas of highly infectious diseases and other clinical areas, medical evacuation and pre-hospital in emergencies, coordination and research.

Increasing national capacities for EMT response and coordination continue to be reflected in recent responses, as exemplified by the Türkiye earthquake nationally-led coordination of over hundred national and international EMTs, the emergency response in Ukraine and neighbouring countries greatly bolstered by the support of 69 entities mobilizing to Ukraine, Moldova and Poland to support clinical work, trauma supply, patient transfers and capacity building efforts necessary for a predictable and reliable response.

Increasingly for infectious disease outbreaks and other health emergencies the same mechanism is providing countries with more bespoke support tailored to the individual health environment and needs of the health system. There is a potential to extend this system to the wider concept of rapid response capacities with consequent possibility to increase interoperability and rationalize existing means when applicable and develop improved joint modalities for rapid response, allowing for surveillance, tracing and treatment to become far more streamlined.

Working more closely with national health systems and national EMTs will provide greater opportunities to improve systems and share knowledge internationally. The benefits of applying the EMT concept and standards have been proven to fit countries of different resources and contexts: for example, the Republic of Palau is now the smallest country in the world by population to have established an EMT.

The biennial EMT Global Meeting was held in Armenia in October 2022. This was the largest Global Meeting to date with over 500 in-person participants from 110 countries representing all
six WHO Regions, and 220 EMTs, partners and organizations. Over three days, participants were engaged in two plenary strategic dialogues, six regional group discussions, and 18 technical sessions across the three thematic streams of standard setting, emergency response and capacity building. As a first, this Global Meeting also featured a research steam with 50 oral and poster abstract presentations, and an exhibition hall showcasing the work and innovations of 20 teams and partners. The Global Meeting culminated in the launch of the EMT 2030 Strategy. This landmark document sets the longer-term strategic objectives and priorities of the EMT Initiative at global, regional and national levels. There are clear directions for emphasis on building national capacities, increased regionalization, expanded standards and quality assurance mechanisms, and enhanced research and information management.

Quality assurance is a central tenet of the EMT methodology. Establishing an appropriate and adaptable mechanism of national validation is a useful facilitator in developing quality assured national EMT and other rapid response capacities. These approaches could also serve as a tool to assess International Health Regulation (IHR) capacities and operational readiness status ensuring longer-term sustainability by building up the expertise within a country combined with the rewarding benefits of the validation itself.

Lastly, all six WHO regions have initiated or fully established their regional EMT governance platforms, which are the main forum at the regional level allowing for Member States, organizations and other stakeholders to shape, guide and drive the implementation of the EMT Initiative in their region.

**Standby Partnerships**

Total value of in-kind contribution through the SBP mechanism in 2022 was valued at USD $7,280,000 - an increase of 62% compared to 2021. This value includes the in-kind contribution through the gratis deployment of 80 Standby Partner personnel for a total of 416 months duration (calculated at a P3 level salary/$USD 15,000 per month), as well as support to hosting of training activities and the gratis deployment of service module (personnel and equipment).

Requests and deployments facilitated through the Standby Partner mechanism:

In 2022, a total of 138 requests were submitted to Standby Partners, out of which 101 requests had funding approved (73%), with 80 Standby Partner experts deployed in 2022 and additional 7 with start dates in early Jan 2023. The remaining 14 funded requests were either cancelled by the Country Offices (5) or suitable candidates could not be identified by partners (9). In addition, 23 requests for extensions have been approved (102 total months).

The 80 Standby Partner personnel deployed in 2022 (a 25% increase compared to 2021) were to support the response to 16 graded emergencies (a 44% increase from 9 emergencies supported in 2021). Over 75% of the total SBP deployments were in response to seven Grade 3 emergencies (81 deployments): Ukraine emergency, Crisis in Northern Ethiopia, Drought and Food Insecurity in the Greater Horn of Africa, COVID-19 response, Afghanistan crisis, SVD Ebola Outbreak in Uganda and the Pakistan Floods.

Standby Partner personnel also supported WHO’s response to five Grade 2 emergencies (9 deployments): the Yellow Fever Outbreak response in the Lake Chad Basin, the Cholera Outbreak in Syria, Flood and Malnutrition emergencies in Madagascar, Sahel Region Humanitarian Emergency as well as other protracted emergencies (6 deployments) in Mozambique, Bangladesh, South Sudan, and Myanmar. In addition, 4 global assignments were in support of the Global Health Cluster (3 Information Management Officers) and 1 deployment hosted for the Standby Partner Network Secretariat (MEAL Coordinator).

Most deployed profiles through Standby Partners in 2022 were: Information Management, Health Cluster Coordination, Prevention of Sexual Exploitation and Abuse (PSEA), Mental Health and Psychosocial Support (MHPSS), Risk Communication and Community Engagement (RCCE), WASH, Nutrition, Logistics, among many others.

The deploying Standby Partner organizations were: IMMAP (24 deployments), Norwegian Refugee Council (23 deployments), CANADEM (17 deployments), RedR Australia (5 deployments), Dutch SURGE Support (4 deployments), ZIF – Berlin Center for International Peace Operations (3), UK-MED (2 deployments) and MSB – Swedish Civil Contingency Agency (2).

The donators that enabled these deployments were: Norway MFA, USAID’s Bureau for Humanitarian Assistance (BHA), and UK Foreign, Commonwealth and Development Office (FCDO), Dutch MFA, Global Affairs Canada, German Foreign Office, Australian Government Department of Foreign Affairs and Trade – DFAT, UK-MED and SIDA.

Forty-three percent (43%) of the 80 SBP deployments (35) were in support of the Health Cluster in 12 countries either on coordination function at sub-national level or Information Management in: Afghanistan, Burkina Faso, Central African Republic, Ethiopia, Madagascar, Mozambique, Myanmar, Pakistan, Somalia, South Sudan, Turkey and Ukraine. The Standby Partners who facilitated these deployments were: IMMAP (24 deployments), NORCAP (5 deployments), CANADEM (funded by UK FCDO – 5 deployments), RedR Australia (1 deployment).

The Standby Partner focal point participates in the HQ Incident Management System Team under the Partner Coordination pillar for all active Grade 3 emergencies. Close collaboration with the Resource Mobilization team for the dedicated Member States portfolios to ensure a comprehensive communication on the collaboration and support from Member States through the various mechanisms.

As part of the HR for Emergencies team, there has been a continuous improvement of the processes and duty of care aspects for the deployment of Standby Partner personnel, with particular attention paid to PSEA.

In term of new initiatives, WHO signed two new SBP agreements in 2022 - with ZIF - Berlin Center for International Peace Operations (June 2022) and MapAction (December 2022), leading to a total of 10 Standby Partnerships agreements which are listed on the website: Standby Partners (who.int). Partnerships were also reinvigorated with UK-Med an DEMA (WHO visited in January 2022 the DEMA’s International Logistics Center in Herning, Denmark).

Several Standby Partner missions were facilitated to WHO Offices (Mozambique, Kenya, Ethiopia, EMRO/Egypt) as well as partnership meetings were held with WHE senior management and major Standby Partners (NORCAP, RedR Australia, UK-MED and MSB).
WHO has continued to enhance its collaboration within the Standby Partner Network. WHO was the Co-Chair of the Duty of Care Working Group and member of the Steering Committee of the Standby Partner Network. WHO actively contributed to the SBP Network Joint Monitoring Mission for the Ukraine response took place in October 2022, with participation from WHO Country Offices in Ukraine, Poland and Moldova. The purpose of this exercise was to assess the overall Standby Partnership contribution to United Nations operations with a focus on: a) assessing the impact and performance of the Standby Partner deployees, b) identifying operational challenges and recommendations, c) identifying emerging needs for future support.

With support from our Standby Partner ZIF, the Global Health Cluster held its first all-women training focused on Health Cluster coordination and leadership on 17-21 October in Berlin, Germany. Through the financial support of the German Federal Foreign Office, ZIF provided organizational support and covered the training venue, as well as the board and accommodation for the duration of this course.

The training brought together participants from WHO and partners. The participants gained the necessary skills to work as Health Cluster coordinators and in other leadership positions linked to the coordination, planning, implementation, and monitoring of effective humanitarian health interventions in acute and protracted emergencies.

Luxembourg, Sweden, and the United Kingdom, through WHO, have provided in-kind contributions of equipment and services worth US$ 995,000 (equivalent to over 3.6 billion Ugandan shillings) to Uganda following the Sudan Virus Disease (SVD) Ebola outbreak. These three Member States provided the assistance as members of the International Humanitarian Partnership, a network of European state actors that supports UN and other agencies as they respond to natural disasters and other complex emergencies.

Luxembourg contributed with eight incinerators and provided air transport of WHO medical supplies. Sweden contributed with two 45KVA generators and tents and has, through WHO provided two staff to support the construction of the Ebola Treatment Unit (ETU) at Mulago and the air transport of the equipment to Uganda. The UK contributed with tents and flooring. The generators, tents, and construction materials were used to equip the ETU at Mulago Hospital and isolation units in the country. An official equipment handover ceremony to the Uganda Ministry of Health was held on 9 December 2022.

Global Strategic Preparedness Network

A Global Strategic Preparedness Network (GSPN) is being developed to coordinate the matching of technical experts that can work with countries to implement NAPHS and other preparedness capacity building plans. The Network is being planned to include stakeholders from national public health institutions, partner organizations, NGOs, the private sector, financial institutions, and other relevant non-traditional actors. GSPN is being developed in line with the lessons from COVID-19 and other recent health emergencies that have underscored the need to support countries with technical assistance required for addressing critical preparedness gaps that are identified through national IHR assessments.

Partners Platform

The WHO Partners Platform was born during the pandemic and provides the first digital space used by governments, partners and donors for two-way information sharing on planning, financing and monitoring their COVID-19 response. The Partners Platform is the only site for countries to apply for and be awarded COVID-19 vaccine delivery support from both GAVI and UNICEF. The Platform tracked over $20B in contributions to countries for the COVID-19 response where over 150 countries shared their plans and needs.

The WHO Partners Platform collaborated with ACT-A partners to develop and now host the GCAT - Global COVID-19 Access Tracker, a dynamic tool to transparently track progress on access to COVID-19 vaccines, treatments, tests, and PPE which is critical for surge planning. The Partners Platform has expanded to include planning, financing, and monitoring for Ebola virus disease, MPox, cholera and measles and will soon expand to include operational readiness for response to imminent threats in countries.

Learning and Capacity Development

Under the WHE Learning Strategy, two concrete strategic directions were pursued: 1. Systematically increase the reach and scope of WHE’s OpenWHO online platform to support preparedness and response and, 2. Strengthen leadership capacity for health emergency response in priority regions (AFRO and EMRO).

OpenWHO.org, an online learning platform, was launched in 2017 to facilitate the transfer of public health knowledge for emergencies on a massive scale in anticipation of the next pandemic. Grounded in the principles of open access and equity, courses are free, self-paced, accessible in low-bandwidth and offline formats, and available in national and local languages. After serving frontline responders in localized outbreaks from Ebola to plague, OpenWHO dramatically scaled up course production for the COVID-19 pandemic, making life-saving information from WHO experts available online at a time when lockdowns and social distancing limited our ability to physically come together to learn.

As of February 2023, OpenWHO has met the following milestones:

- 200 different course topics
- 46 courses related to COVID-19
- 65 languages
- 7.5 million enrolments
- 4.0 million certificates awarded
- 15.7 million words translated

Prioritizing access to learning has enabled OpenWHO to have tremendous reach in line with WHO’s mission to promote health, keep the world safe and serve the vulnerable. Demand has surged during the COVID-19 emergency, with total course enrolments increasing from 160 000 in January 2020 to 7.5 million today. The pandemic expanded OpenWHO learning to previously underrepresented groups, including women, learners age 70+ and learners younger than 20, advancing equity in access to knowledge. Online learning participation has also shifted toward low- and middle-income countries, which make up nearly 2/3 of learners compared to 1/2 before the pandemic, driven by surging demand in middle-income countries. When population is taken into consideration, small island states bring the highest proportion of learners. In addition, OpenWHO has identified a growing multiplier effect beyond the platform as

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multi-use formats are enabled and materials can be adapted to local contexts and offline demands. A study on how the platform is used also revealed that the course completion rate for all courses ranged between 45 and 50% in contrast to the industry experience of 4-15% for online learning platforms.

In 2022, OpenWHO responded to 40 outbreaks through learning in addition to the COVID-19 pandemic. The platform offers courses for 33 different diseases, including all priority disease categories of WHO's R&D Blueprint. OpenWHO also produced courses to strengthen the response to other types of graded emergencies in 2022, including the flooding in Pakistan, food insecurity in the Horn of Africa and the conflict in Ukraine. Other courses that were widely used for health emergency management included the core curriculum for the health emergency response (HER) Tier 1 and Tier 2, WHO Standard Operating Procedures (SOPs) for Emergencies, The Public Health Emergency Operations Centre (PHEOC) and the Incident Management System (IMS) Tier 1 and Tier 2 courses. OpenWHO courses are hosted on 23 topical learning channels, including new channels on health inequality monitoring, digital health and innovation, chemical and biological deliberate events, and harmonized health facility assessment. In collaboration with WHO country offices, OpenWHO also provides 15 countries with one-stop access to public health courses in their official languages through the Serving Countries portal, adding learning channels for Armenia, Myanmar and Poland in 2022, and 15 additional courses in Ukrainian. In February 2023, OpenWHO was recognized as the Learning Platform of the Year at the Learning Awards, which are billed as "the highest accolade you can receive in workplace learning and development."

The Learning and Capacity Development Unit (LCD) in WHE was able to scale up and manage this massive outreach and production because of effective work across WHE teams at headquarters, in regional offices and at countries, and the managerial and administrative systems that were put in place for learning and training (including pre-selected service providers on long-term agreements and the internal service provider mechanism in which LCD operates like an internal service provider using innovative approaches and technologies). Using COVID-19 response resources, the team also quickly scaled up its capacity from 5 staff to a team of 28 at the height of the pandemic (made up of service providers and consultants). It is important to note that the OpenWHO platform was established following the West Africa Ebola outbreak when WHO led the training response and is therefore a concrete example of WHO transformation of its health emergencies work. Secondly, the seed money for the platform was provided by Pandemic Influenza Preparedness Framework, and the team designed the platform to operate in a pandemic. The success story and experiences, such as the one we are currently experiencing, and approaches also means that LCD was able to fully shift into distance work and telework within 4 hours, with not only continuity of production, but a massive and continuing expansion.

For the second key stream of work, LCD, in collaboration with WHE and regional leadership in AFRO and EMRO, has further developed the WHE Leadership in Emergencies Programme. The programme identifies and trains staff with demonstrated or potential leadership abilities to perform key leadership roles under the IMS. The programme was launched in 2019 and moved online in 2020 to increase access for learners. It consists of two phases: Phase 1 is an eight-week online course focused on developing leadership skills, while Phase 2 comprises four weeks of online classes followed by a workshop and training simulation exercise (SIMEX) for nominated individuals.

Since the courses started in 2019, 294 leaders were trained through the flagship Leadership in Emergencies programme, with 363 total course completions after accounting for those who participated in both courses on offer. The programme was significantly upscaled in 2022: LCD trained 153 participants across 5 cohorts in the English Leadership Phase 1 course, and 30 participants in the first French cohort, and trained 48 staff across 2 cohorts in the Phase 2 course. The proportion of women trained through the Leadership programme increased from 29% of participants in 2019 to 49% in 2022. In 2022, 66 staff – 59 WHO personnel and 7 staff from Ministries of Health or non-governmental organizations – received individual coaching from accredited coaches through LCD; 461.5 hours of coaching were delivered cumulatively. A community of learning for those who have enrolled in the Leadership in Emergencies courses was established in 2022 with 142 members. A community of learning for women working in emergencies was also created, which holds monthly virtual coffee events for its 72 members.

The key achievements of the digitalized Leadership programme include:

- Fit for purpose: Learning is accessible in low bandwidth and immediately applicable in emergency settings, with increased psychological safety through coaching and peer learning.
- Efficacy and equity: More than 90% of participants were more confident about applying leadership in emergencies, with inclusivity gains for women, junior staff, and experts from low- and middle-income countries.
- Retention and sustainability: Improved retention and integration of learning into daily work, with an estimated 90% reduction in energy and carbon emissions from digital modalities.

To ensure quality of learning and further support IMS and Leadership training, LCD has also gained key accreditations. In December 2022, LCD received HPass certification for WHE learning activities, verifying that they meet quality standards for humanitarian learning and can be recognized by other humanitarian organizations. LCD also obtained Continuing Professional Development (CPD) accreditation in 2022 for 6 key WHO emergency management courses, including the 2 flagship Leadership in Emergencies courses and 4 OpenWHO.org online courses. Accreditation supports the development of standardized quality learning materials that can form the basis of learning pathways for emergency staff. LCD is working closely with colleagues in regions to support the development and delivery of further response-focused training, as well as colleagues in WHE to develop specialized incident management training.

In addition, LCD provides critical learning support to technical teams to strengthen training and learning across WHE. In 2022, LCD delivered learning and information management support to teams responding to Grade 3 emergencies in Pakistan and Ukraine to strengthen real-time knowledge transfer to emergency responders and affected communities. LCD also provided: instructional design support to optimize WHE learning activities for adult learners, including for an upcoming Ebola vaccine online course; training exercise support to 3 teams through an adapted online platform to enable training participants to practice their health emergency learning; and ongoing capacity development support to the Global Health Cluster, including live support at 3 training events in Germany, India and Togo.

II. Issues requiring corporatetransfer solutions (WTO)

<table>
<thead>
<tr>
<th>Procurement and supply chain management</th>
<th>Operations Support and Logistics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmarking for supply chain process to establish key metrics to gauge the timeliness and effectiveness of the process, and to</td>
<td>Emergency Response Highlights: WHO Operations Support and Logistics (OSL) has played a vital role as a frontline responder supporting emergency response efforts, delivering lifesaving medical supplies and providing critical operational support and technical guidance in emergency response operations in multiple health and humanitarian crises across all WHO regions. In response to the ongoing COVID-19 pandemic, OSL had delivered by the end of 2022, US$ 634 million of essential medical supplies – PPE, diagnostics, therapeutics and clinical care equipment – to support the COVID-19 response in 184 countries. Since the outbreak of war in Ukraine in February 2022, OSL has delivered more than 2,000 metric tons (USD value $59.5 million) of lifesaving medical supplies and equipment to Ukraine. Supplies delivered include: ambulances, trauma and surgery kits, power generators, ECG machines and other essential equipment for hospitals and clinical care. In coordination with</td>
</tr>
</tbody>
</table>

SHO/OSL
Ukraine Ministry of Health and humanitarian partners, OSL has delivered an estimated 1,434 metric tons of essential supplies to beneficiaries in 24 oblasts of Ukraine and the city of Kyiv, providing critical emergency support to hundreds of health facilities across Ukraine.

Responding to the global cholera outbreak in 2021 and 2022, WHO Operations Support and Logistics (OSL) has delivered USD 13.5 million of emergency cholera kits, providing treatment to more than 432,000 people (including 167,000 severe cases) and more than 500,000 cholera rapid tests. WHO also has procured a stockpile of essential cholera supplies to support the rapid response delivery to support emergency treatment for 200,000 people. In response to the growing global demand – and scarcity – of emergency cholera kits, OSL in partnership with UNICEF and MSF, has established a supply coordination mechanism, working with suppliers and partners to aggregate, monitor and coordinate supply requests. This mechanism allows for an equitable distribution of available quantities among affected countries, while ensuring coverage of treatment priorities. OSL has also established a stock of bulk items for case management (infusion, ORS, tests) to ensure these essential supplies are accessible in larger quantities for distribution, in order to expand treatment coverage in the most severely affected countries.

**Dubai Logistics Hub.** The WHO Logistics Hub in Dubai, United Arab Emirates (UAE), was placed at the forefront of WHO’s medical supply response efforts during the COVID-19 pandemic. Managing an initial US$3 million operation since its inception in 2015, the Hub’s operations grew to distributing US$ 70 million worth of medical supplies at the height of the pandemic. This notably included the shipping of personal protective equipment (PPE) and laboratory supplies to 137 countries across all WHO regions.

The Hub’s efficiency in distributing lifesaving medical supplies throughout the pandemic helped popularize its use across Member States, leading to an exponential number of requests for support for all types of emergencies. In 2021, the Hub registered a 61% increase in the number of requests compared to 2020. Of these, only 40% were linked to COVID-19 – the rest linked mainly to response operations for other health emergencies, including cholera, conflict-related humanitarian crises and natural disasters such as floods, drought and earthquakes. In 2022, the Hub processed 578 emergency shipments to 90 countries, delivering health supplies with a total value of approximately US$ 45 million, to support emergency response operations across all WHO regions, including drought in the Greater Horn of Africa, conflict in Northern Ethiopia and floods in Pakistan. This represents a staggering 341% increase in the number of requests for emergency health supply since 2019.

Recognizing the Dubai Hub’s vital role in strengthening global preparedness and response efforts, and in light of the rise in public health threats, WHO and the UAE are currently discussing the Hub’s continued growth and potential to evolve into a Global Logistics Centre for Health Emergencies.

**Health Supplies Procurement.** For the first time since 2020 COVID19 response no longer constitutes the highest portion of support from HQ OSL. OSL HQ support to the Ukraine response has been comprehensive, and included deployments on the ground to facilitate the establishment of an operational footprint that could work to scale, whilst remaining flexible and agile. Clear working modalities and sharing of responsibilities were managed with EURO.

The emergency procurement function continues to benefit from an integrated working approach with BOS/SUP, through the business partnership model that was established in 2021.

<table>
<thead>
<tr>
<th>Emergencies/Activities</th>
<th>Total Requests</th>
<th>Procured (USD)</th>
<th>Donation (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ukraine Conflict</td>
<td>222</td>
<td>74,561,981</td>
<td>$14,615,000</td>
</tr>
<tr>
<td>C19</td>
<td>398</td>
<td>88,009,161</td>
<td>$14,615,000</td>
</tr>
<tr>
<td>HoA Drought &amp; food insecc.</td>
<td>301</td>
<td>5,967,186</td>
<td>$14,615,000</td>
</tr>
<tr>
<td>Pakistan floods</td>
<td>133</td>
<td>7,754,494</td>
<td>$14,615,000</td>
</tr>
<tr>
<td>Cholera</td>
<td>301</td>
<td>1,538,646</td>
<td>$14,615,000</td>
</tr>
<tr>
<td>Ebola</td>
<td>301</td>
<td>1,918,839</td>
<td>$14,615,000</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>301</td>
<td>41,688,402</td>
<td>$14,615,000</td>
</tr>
<tr>
<td>Ethiopia-Tigray</td>
<td>131</td>
<td>107,933</td>
<td>$14,615,000</td>
</tr>
<tr>
<td>Others (MPX, Meningitis, Diphtheria)</td>
<td>119</td>
<td>9,956,172</td>
<td>$14,615,000</td>
</tr>
<tr>
<td>Total</td>
<td>824</td>
<td>160,502,814</td>
<td>$14,615,000</td>
</tr>
</tbody>
</table>

$175,117,814

**Products and Initiatives.** OSL is working with partners to develop key tools and initiatives to improve supply data management and technical guidance to strengthen emergency preparedness and response:
- **Business Management System (BMS)** - OSL is contributing expertise and resources to WHO’s BMS project, designed to shape the new ERP system. This will ensure that system functionality and business processes to support emergency supply response will be embedded within the central operating system of WHO, which is instrumental in managing end-to-end supply chains. Testing has begun on a first version of the Transportation Management System (TMS), which, together with the Transportation Management System (TMS), will be the first BMS module to be launched as part of the end-to-end supply chain management under ERP. This emergency portal module replaces the Covid-19 Supply portal and expands its functionalities and content. The training of testers took place in Geneva and virtually for the Emergency Portal, and in Kuala-Lumpur for Transportation Management System.

The User Acceptance Testing for the Emergency Portal and TMS is underway and expected to be completed by 24 March 2023 and targeted to go live on 17 April 2023. This first version of the portal will be integrated into the new Transportation Management System (TMS) of BMS, which will enable visibility on status of requests and their respective shipments.

- **Market Intelligence Platform** – to create semi-real time and real time insight on market dynamics and surveillance, the platform will enable access to market stakeholders’ datasets and provide analytical tools to determine leading indicators of supply needs and demand, market alert capabilities, demand clarity at the country and global levels, and risk profiles. This will assist governments, WHO, and the private sector to invest, prepare, and respond to emergency supply needs with greater efficiency.

The Data Governance concept note has been completed. The Data Governance will be structured based on the principles, operational needs, and technical requirements detailed in the Concept Note and in compliance with WHO policies. This has been a critical first step to ensuring trusted engagement with data owners across the private sector, multilateral institutions and governments.

- **ESFT/DCP Quant Model** - The architecture and algorithms for the Quant Model have been designed. OSL is currently exploring the necessary funds to develop and launch the model.

**Health Logistics Technical Support.**

- **INITIATE²** - WHO has partnered with the World Food Programme (WFP) to establish INITIATE², a 5-year initiative launched in 2021 to bring together emergency response actors, research and academic institutions to develop and create standardized emergency response facilities and tools to strengthen readiness and response capabilities for prompt action during health emergencies. Hosted by the United Nations Humanitarian Response Depot (UNHRD) in Brindisi, Italy, INITIATE² aims to design and develop standardized technical solutions to logistical challenges and will train logistics and health responders on the installation and use of the products developed. In March 2022, INITIATE² partners began developing a design for the construction of a modular infectious disease treatment unit that can be rapidly deployed in the field or installed in health facilities to offer standardized treatment and response to infectious disease emergencies. Other products to be designed, developed, standardized and deployed, include:

  - Ambulance converter kit
  - Ultra-cold chain mobile infrastructure
  - Mobile base camp

- **Téchne (Technical Science for Health Network)** - a WHO global network of architects, engineers, designers, and public health practitioners collaborating to make health settings and structures safer for health workers and patients to reduce the risk of hospital-acquired infections. Téchne members cooperate with WHO on a diverse range of activities such as sharing specific technical knowhow, supporting State Members on ad-hoc request and developing technical innovation to better respond to infectious diseases outbreaks, complex emergencies and related needs and gaps. Established in early 2020 as part of the response to COVID-19, Téchne has since continued to grow, becoming a key logistical response tool in health emergencies. Some highlights:

  - Country support requests - In collaboration with the Oxygen Scale up Initiative, Téchne has supported 4 countries (Bhutan, Guinea-Bissau, Liberia and Chad) in the design of 5 oxygen (PSA) plant shelters.
  - Téchne supported the design of an infectious diseases ward within an existing health care facility in Tbilisi, Georgia.
  - Support for Uganda response to Ebola outbreak (Nov-Dec 2022) - reviewed the layout of a 64-beds ETC built by Doctors Without Borders (MSF) in Kampala; jointly designed with MSF the layout of a 20-bed treatment center in Masaka, as requested by the Ugandan Ministry of Health and designed and built a screening facility for the Masaka regional hospital; technical support to neighboring countries – Kenya, Rwanda, South Sudan, and United Republic of Tanzania – to design ETC as part of their preparedness efforts. Layouts developed by Téchne are used to develop strategic preparedness and response plans, or as a basis for funds applications.

**Health Emergencies Preparedness, Response and Resilience (HEPR)**

OSL has made substantial contribution towards articulating the access to countermeasures system capabilities. This work provides the building blocks for defining what is needed to be done to respond to large public health emergencies, specifically in ensuring coordinated and equitable supply access and delivery through the 5 subsystems as below:

- Definition of lists, standards, policies, and enablers
- Coordinated demand aggregation to optimize risk sharing
- Coordinated supply and procurement to ensure equitable access
- Equitable & transparent needs-based allocations
- Resilient logistics and distribution

This work will continue, considering, and informing, other ongoing processes such as the INB and the OHR Revision working group.

<table>
<thead>
<tr>
<th>Security and staff protection</th>
<th>Security and staff protection</th>
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</thead>
<tbody>
<tr>
<td>- Corporate strategy and investment level</td>
<td>- Corporate strategy and investment level: A 5-year WHO Security Management Strategy had been completed as of 2021. The implementation is continuing albeit very much dependent on the support on the proposed structure and the corresponding funding requirements. The investment level on security had not changed, except in specific emergency response operations, like Ukraine, where a robust security structure and mechanism had been put in place and continuing. The recruitment of the WHO Director of Global Security remains in progress, but a fit-for-purpose security structure and requirements have been completed through the Security Management Strategic Plan. The recruitment of the Security</td>
</tr>
</tbody>
</table>

SEC/ADGO | BOS | 17 |
2. WHO security function in emergencies in relation to the United Nations Department for Safety and Security (UNDSS): The functional and operational relationship between WHO and other UN entities with UNDSS is clear and provided for in the UN Security Management System (UNSMS) policies, manuals and guidelines. WHO is represented at the UN Inter-Agency Security Management Network (IASMN), the policy and strategic level platform of the UNSMS. IASMN also has an operational arm where WHO is equally represented. The WHO security functions in emergencies are conducted in collaboration with UNDSS. The WHO Security Support Framework for Emergency Response, which is incorporated in the WHO eManual Chapter XVII.7.3 prescribes the security support process for emergencies.

3. Adequacy of procedures and measures for protection of staff and deployed experts, including medical evacuation. Security procedures and measures for the protection of personnel, assets and operations are identified through a security risk management process. These security risk management measures are implemented and complied with as mandatory and critical requirements in WHO operations, including in emergencies.

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**Business processes in the areas of: HR, Administration and Finance**

Procedures for Medical Evacuation for non-staff are being reviewed to incorporate lessons learned from recent emergencies. A key component of the newly published SOPs is to have WHO ensure up-front arrangements and financing is provided and then recover costs to the furthest extent possible afterwards. The detailed SOPs for provision of medevac by WHO for partner agencies is being developed.

HR: New and revised SOPs are being reviewed at WHE/HR to clarify HR principles in emergencies, terms and conditions for Emergency Consultants, and clarification on the use of FT staff are being reviewed to incorporate lessons learned from recent emergencies. A key component of the newly published SOPs is to have WHO ensure up-front arrangements and financing is provided and then recover costs to the furthest extent possible afterwards. The detailed SOPs for provision of medevac by WHO for partner agencies is being developed.

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**ERF tools strengthening –Country Office Readiness Checklist:** With the aim to strengthen operational readiness, WHE programme has updated the WCO Readiness Checklist and digitized it. This initiative is part of the Continuous Business Improvement (CBI) of WHE programme and contributes to operationalize the HEPR at the country office level. The development of the digital Country Office Readiness Checklist builds on a consultative process held with WHE readiness and operations management regional focal points to ensure correct application of FENSA procedures in emergencies, both simplified and standard. The WHE programme has increased the frequency of on-the-job sessions for WHO staff at the divisional level, including WHO Office for Pandemic and Epidemic Intelligence in Berlin; expanded its capacity with an additional FENSA focal point within the Programme at Headquarters. WHO has continued to strengthen collaboration with Non-State Actors, not only during graded emergencies but also in its base operations - this has included a significant expansion in in-kind donations of goods and services in response to graded emergencies, leading to drafting new modalities and processes to fast track acceptance of in-kind donations, while preserving quality standards and requirements. The Programme has also worked to ensure that our work for implementing localization is consistent with FENSA guiding principles, and will continue to report through Grand Bargain mechanisms how we promote harmonization of processes for partnerships.

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**Administrative Services for Emergencies** have been updated to align with the revision of activation of emergency SOPs, including streamlining the authorized officials to request emergency services in GSC. GSC reviewed the existing Emergency on-call list for a variety of administrative services for graded emergencies in January 2023.

Implementation of the WHO Framework for Engagement with non-State Actors (FENSA) in emergencies: to ensure correct application of FENSA procedures in emergencies, both simplified and standard - the WHE programme has increased the frequency of on-the-job sessions for WHO staff at the divisional level, including WHO Office for Pandemic and Epidemic Intelligence. The WHE programme has increased the frequency of on-the-job sessions for WHO staff at the divisional level, including WHO Office for Pandemic and Epidemic Intelligence. The new roles and responsibilities of the programme team include the following:

- **ERF tools strengthening –Country Office Readiness Checklist:** With the aim to strengthen operational readiness, WHE programme has updated the WCO Readiness Checklist and digitized it. This initiative is part of the Continuous Business Improvement (CBI) of WHE programme and contributes to operationalize the HEPR at the country office level. The development of the digital Country Office Readiness Checklist builds on a consultative process held with WHE readiness and operations management regional focal points to ensure correct application of FENSA procedures in emergencies, both simplified and standard. The WHE programme has increased the frequency of on-the-job sessions for WHO staff at the divisional level, including WHO Office for Pandemic and Epidemic Intelligence. The WHE programme has increased the frequency of on-the-job sessions for WHO staff at the divisional level, including WHO Office for Pandemic and Epidemic Intelligence. The Programme has also worked to ensure that our work for implementing localization is consistent with FENSA guiding principles, and will continue to report through Grand Bargain mechanisms how we promote harmonization of processes for partnerships. The programme team includes a new role of FENSA focal point within the Programme at Headquarters.

**Business Continuity and Contingency Planning:** Complementing the development of the new Country Office Readiness Checklist, WHE Programme has started updating the Business Continuity Planning (BCP) and Contingency Planning guidelines. As for BCP, a toolkit is being developed, comprising updated and standardized templates, as well as communication and training material for WHO staff. The revision and update of the BCP toolkit is coordinated with the ADG/BOS. In 2023, the BCP toolkit will be digitalized and integrated with the WCO Readiness Checklist.
Operational risk management for graded emergencies: to complement the WHO corporate risk management policy a process for graded emergencies has been published in the eManual and integrated in the revised ERF. To operationalize this process, a risk catalogue with predefined risks and mitigations has been developed and published in the eManual to help staff identify the risks and mitigate them. This process has been implemented for several emergencies, to expand its application an IT tool to build risk registers has been developed and will be integrated to the new EMS2. This tool is linked to the risk catalogue to facilitated risk import and the planning of the mitigations. To generalize the application of this process and the developed tools, a 2-day training package on operational risk management has been developed and piloted for HQ staff and CRE representatives from the regions in December 2022. These trainings will be rolled out in the regions starting by WPRO in March 2023.

Finance: WHO/EMS team was created as a result of transformation and has since been providing budget and finance support to all grade 3 and other significant events. Lessons learned from COVID response have been integrated into the business processes to strengthen functional alignment between various internal stakeholders.

The financial transactional processes pertaining to management of supply chain procurement has been reviewed thoroughly to generate procedural efficiencies, significant contributions are underway to integrate recommendations into the new ERP package (BMS) and mitigate risks.

Efforts are underway to automate the Financial Reports relating for emergency events. Management, monitoring and reporting of OCR awards (including ECHO and CREF grants) with EXD is being handled efficiently, and in good coordination with SPP, CRM and FMN.

Several guidance notes are being prepared, such as on management of OCR workplans, recording of funding for emergency events, briefings for Staff in the CO who may not be privy to operating emergency environment but have to provide support in case of occurrence of an emergency event. Contributions are also being made to revision of e-manual guidance and SOPs on various interlinked aspects such as grants management, supplies, HR and planning.

Sustainable funding for HQ IMST costs has been a challenge as most of the Humanitarian funding (CERF/ECHO) is specified for implementation at CO level, the cost for enabling functions at HQ is not systematically funded. Option to revise provision of “PMR” charge to grants is being reviewed

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<th>III. WHE Programe areas</th>
<th>Health emergency preparedness in countries, including implementation of IHR</th>
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| 1. Preparedness for health emergencies | WHE is working closely with Member States to assess capacity gaps and the development and implementation of national action plans to strengthen country capacities for managing the range of risks they face in relation to health emergencies. WHE is working across WHO programmes to ensure this work is integrated within an overall approach to health systems strengthening, that best practices are shared and applied, and that community engagement is a component of all national capacity strengthening plans. The States Parties Annual Reporting (SPAR) and other assessments of IHR (2005) capacities including Joint External Evaluations, simulation exercises and after-action reviews are the main components of the IHR Monitoring and Evaluation Framework (IHR MEF). These assessment tools form the basis for the GPW-13 and in the annual reporting to the WHA. The SimEx and AAR are invaluable components of the IHRMEF as they are utilized to stress and assess preparedness and response mechanisms, systems and the functionality of national IHR (2005) capabilities through a simulated or real event. Country COVID-19 intra-action reviews (IARs) have been developed as an additional measure that countries can use to identify practical preparedness, response areas that need immediate remediation or can be targeted for sustained improvement to build capacity to address the risk of the pandemic.

To promote peer learning and sharing of experience amongst countries, the WHE organized a series of 5 Intra-Action Review clinics focusing on lessons learned from the COVID-19 global vaccination roll out in different contexts. The IAR package is available in all UN languages (Arabic, Chinese, English, French, Russian and Spanish) plus one (Portuguese)

WHE has updated the assessment tools in light of the experiences and lessons learnt from Member States and stakeholders. The recommendations and inputs provided by a technical working group that was convened multiple times throughout 2021 helped finalize and launch the second version of the SPAR and the third version of the JEE in 2021. WHE has also developed a JEE IT platform that is currently being tested and will support virtual JEE participation, allow for discussions between experts online pre-mission and serve as a repository for relevant documents from countries. The WHO Benchmarks for IHR capacities are currently being updated to reflect the improved SPAR and JEE through the intensive discussion and collaborative work with relevant teams to align with updated IHR Monitoring & Evaluation tools, foundational elements of health systems and other sectors, latest developments in HEPR, and incorporate recommendations in light of COVID-19 and other recent emergencies of multi-hazard in origin. WHE has developed Benchmark Portal which automates the planning process and has reference library.

The Health Systems for Health Security framework introduced an integrated approach to bring in health systems and other sectors for effective management of health emergencies. WHO Benchmarks for IHR capacities provides guidance and a bank of action to support countries in developing plans based on current IHR capacities and the identification of relevant steps to improve capacity levels across technical areas, accompanied by the costing tool help prioritize the actions in the national plans.

WHE has also advanced progress toward development and application of the Dynamic Preparedness Metric (DPM) and its online dashboard to gauge preparedness capacity dynamically and inform key action plans for improving capacities for each country or region on the basis of identified gaps and risks. at hazards, vulnerabilities and capacities dimensions.

Other tools such as the IHR-PVS One Health National Bridging Workshop (NBW) and its follow up surveys and the Strategic Tool for Assessing Risks (STAR) and disaster risk calendars complement the IHR MEF. Emergency preparedness strengthening is being implemented with MS and in WCOs to establish minimum capacities, as well as operational readiness for imminent threats. WHO is also supporting Member States and key partners to analyze data generated through the International Health Regulations (2005) in order to identify the critical actions that can strengthen national preparedness and response capacities. WHO continues to work with Member States and partners to strengthen the coherence between the implementation of the SDGs, Sendai Framework for Disaster Risk Reduction, IHR, Quadripartite’s One Health Joint Plan of Action (2022-2026) and other global and regional frameworks for health security.

The Strategic Toolkit for Assessing Risks: a comprehensive toolkit for all-hazards health emergency risk assessment (STAR) is a toolkit in line with the IHR (2005) Monitoring and Evaluation Framework and the Sendai Framework for Risk Reduction, that provides countries and partners a comprehensive, easy-to-use approach to rapidly conduct a strategic and evidence-based assessment of public health risks for planning and prioritization of health emergency preparedness and disaster risk management activities. The methodology has been applied in 93 workshops globally to date.

In 2021, WHE developed technical and procedural guidance for Member States to plan and implement the Universal Health and Preparedness Review (UHPR) mechanism which has been
emergency preparedness and disaster risk management established in all countries
  • Countries and WCOs operationally ready to manage identified risks and vulnerabilities
  • Strategy for IHR capacity development in fragile states
  • IHR (2005) data analysis to provide critical actions for countries to strengthen preparedness capacity building
  • Link between WHE and other relevant programmes within WHO, in particular health care systems
  • Scale down of IMS and transition process following major events to build national capacities on lessons learnt in a sustainable way

proposed as a means to increase accountability, solidarity and transparency among Member States in preparedness gap identification and capacity building. The UHPR is based on a voluntary mechanism of peer-to-peer review, led and owned by Member States, to promote greater, more effective international cooperation and global solidarity by bringing nations and stakeholders together toward enhanced preparedness. In December 2021, the first UHPR pilot was conducted in the Central African Republic, facilitated by a WHO mission. As of 14 February 2022, 16 Member States have expressed interest in piloting the UHPR mechanism.

WHE has also rolled-out a WHE Gender Working Group to support the development and implementation of a Gender Mainstreaming Strategy across its policies, strategies, operations and capacity building action as a priority. The Working Group includes representatives of each of the technical departments in the WHE programme as well as representatives from all 6 WHO Regional Offices and some WHO Country Offices.

All-hazards and IHR core capacities assessments and reports:

As of 23 February 2023, 74 countries have reported using the SPAR, 140 Country COVID-19 Intra-Action Reviews (IARs) have been implemented by 80 countries and territories, 117 countries have completed a Joint External Evaluation. Thailand became the first country in 2022 to do a second round of the JEE and use the updated JEE 3.0 version of the tool and test the JEE IT platform. 200 Simulation exercises have been implemented (including country level and regional exercises) and 78 After Action Reviews (AAR) have been conducted. 45 IHR-PVS National Bridging Workshops have been organized in MS countries to encourage the contribution of the veterinary sector in the implementation of the IHR (2005) and define One Health roadmaps for improved coordination at the human-animal interface as of 23 February 2023.

In addition, WHO has developed IAR and simulation exercise packages for specific SPAR pillars including vaccination to facilitate countries in strengthening functional capacities for critical gaps during the COVID-19 pandemic. In June 2021, WHO supported an after-action review of the response to the 9th, 10th, 11th and 12th Ebola Virus Disease outbreaks in the Democratic Republic of Congo and in February 2022, WHO supported an after-action review of the Sudan Ebola Virus Disease (SVD) in Uganda. During the context of COVID-19, WHO supported two mass gathering AARs in March 2022; one following the African Cup of Nations in Cameroon and the second after the FIFA Arab Cup in Qatar. WHE recently published a global analysis of COVID-19 intra-action reviews summarizing 83 IAR reports from 57 countries which were compiled to identify the strategies and solutions that countries used during the pandemic to encourage peer learning and trigger new ideas to advance the pandemic response. This report outlines how governments worldwide used existing systems and resources and developed innovative new solutions and strategies during the pandemic. It also examines countries' views on how the COVID-19 IAR was customized to fit their needs and the value of the IAR process to their COVID-19 response and beyond. Important topics of interest that are rarely or inadequately reviewed during an IAR, such as provision for vulnerable and marginalized populations during the COVID-19 pandemic, are also considered. The report can be accessed at: https://apps.who.intiris/handle/10665/365458

For the 2020 IHR States Parties Annual Reporting period, 174 (89%) State Parties of all Regions submitted SPAR reports as of 14 February 2022, to the Secretariat. All levels of WHO are supporting State Parties to increase high quality reporting to WHO. The information received is being used to track progress against frameworks for public health. This includes the UN’s Sustainable Development Goal 3 and the WHO’s Thirteenth General Programme of Work (GPW 13). As of 14 February 2022, 76 countries developed their all-hazards disaster risk profile (STAR) which support countries to develop specific contingency planning for emergencies and also provides an evidence base for all emergency planning including NAPHS and national emergency response planning.

- Safety assessments of health facilities is underway in all 6 WHO regions. An additional preparedness-readiness checklist has been developed to support countries in preparing effectively for COVID-19. An adapted health facility safety and resilience assessment tool has been developed for humanitarian settings and piloted in Cox’s Bazar, Bangladesh.

- The FAO-DIE-WHO (Tripartite) guidance document “Taking a Multisectoral, One Health Approach: A Tripartite Guide to Addressing Zoonotic Diseases in Countries” (also referred to as the Tripartite Zoonoses Guide) is available online in the 6 UN official languages. The guide aims at supporting national implementation of multisectoral, One Health approaches for a variety of topics and associated TzOG Operational Tools.
  o The Joint Risk Assessment (JRA) Operational Tool has been piloted and used in 38 countries to assist countries in conducting joint qualitative risk assessments for threats at the human-animal-environment interface.
  o The Multisectoral Coordination Mechanism (MCM) Operational Tool has been piloted in 5 countries to assist countries in establishing or strengthening a government-led multisectoral, One Health mechanism for zoonotic diseases and other One Health challenges.
  o The Response Preparedness (RePrep) Workshop has been piloted in 4 countries to support countries in developing an operational framework on jointly responding to zoonotic disease outbreaks. The RePrep materials provide the basis for the development of a coordinated Investigation and Response Operational Tool.
  o The Surveillance and Information Sharing Operational Tool (SIS OT), led by the Food and Agriculture Organization of the United Nations (FAO) in collaboration with WHO, has been piloted in 5 countries to assess and strengthen the capacity for coordinated, multisectoral surveillance and information sharing for zoonotic diseases within the country.
  o The operational tools for One Health Workforce Development and Monitoring and Evaluation are being developed.
  o The roll out of JRA, MCM, and RePrep workshops is ongoing in 2023.

- In 2021, WHE published the WHO Framework for Strengthening Health Emergency Preparedness in Cities and Urban Settings which supports countries to build capacities at the sub-national level with a focus on high population density environments, while also ensuring preparedness strengthening at the national level. The framework is a direct follow up to the outcomes of the Technical Working Group on Advancing Health Emergency Preparedness in Cities and Urban Settings during COVID-19 and Beyond, co-hosted by WHO and the Government of Singapore in early 2021. The framework is online in the 6 UN official languages. The framework is aimed at supporting cities and urban settings to improve their preparedness and response in cases of disease outbreaks and other emergencies. In 2021, WHE published an online training programme to support preparedness strengthening in cities. The training is accessible on the OpenWHO platform. A global webinar was hosted to support this launch which was attended by participants from 138 Member States. A guidance document and other tools are under development to facilitate operationalization of the framework at country level.

- Support was also provided to State Parties to facilitate adequate decision-making and sound planning for mass gatherings in accordance with WHO recommendations. This was done by generating, updating, and disseminating technical guidance, tools and communications products, as well as by providing ad-hoc advice in relationship to specific events. A generic all-hazards risk assessment and planning tool for mass gatherings events has been published to support Member States and mass gathering events organizers. The tool provides a systematic evidence-based approach to identifying and classifying priority risks; a description of the level of national preparedness and readiness to mitigate specific hazards; guidance on the implementation of a comprehensive and strategic risk assessment to inform preparedness and response plans ahead of the mass gathering; and an estimated assessment of the host country capacity to identify and respond to potential negative health impacts.
National Action Plans (NAPs) and National Health Emergency Response Operational Plans (NHEROP):
- Since 2016, 88 NAPHS have been completed by Member States so far, which are aimed to strengthen countries capacity to prepare, detect, respond and recover from health emergencies.
- WHO with all 6 regional offices recently published a new NAPHS Strategy 2022-2026.
- The NAPHS strategy2 defines WHO’s vision and framework to support national stakeholders in accelerating the development, implementation and monitoring of the National Action Plans for Health Security (NAPHS) from 2022-2026.
- A shift from stand-alone five (5) year strategic plans to be complemented with (12-24 months) operational plans that are regularly reviewed and updated by member states.
- Monitoring implementation status through a results framework using existing IHR MEF indicators to ensure course correction and adjustments can be made to national priorities and make it a living operational action plan that can show the progress made to longer-term impact.
- Integration of the NAPHS within the broader national health system planning and budget cycle, as well as alignment to hazards and disease-specific plans, so it does not become a separate isolated plan but fits within existing domestic policies, strategies and priorities.
- The development of a NAPHS online platform/website will enable a flexible, streamlined, pragmatic and simplified planning process that will support country planning practitioners with the initial NAPHS development process but will feature different functionalities, including the planning, monitoring, mobilizing resources implementation, and technical/financial appeal side.
- The NAPHS toolkit is being updated in line with the new strategy and the experiences from COVID. In addition, a NAPHS platform is also being developed to allow for coordination and collaboration with all stakeholders.
- To support countries in establishing and strengthening systems and mechanisms for a coordinated response to any health emergency, WHO published Guidance on Preparing for National Response to Health Emergencies and Disasters. The existence of an updated All-hazard National Health sector emergency response plan, that describes how the health sector structures and organizes itself for emergency response and documents the linkages to other sectors and authorities, is a key preparedness capacity that allows countries to act in a more anticipatory manner, ensuring most effective use of limited resources during the acute response phase. The plan covers all phases of an emergency response including activation, grading, operations and de-escalation and enables response resources to be mobilized and deployed effectively. The implementation of the guidance was recently piloted in South Africa and is currently rolled out in Rwanda, Kenya and Benin.

Multisectoral engagement actions to strengthen country health emergency preparedness
- Continued efforts were made to drive collaboration with its partners to promote the implementation of the International Health Regulations (2005) at Points of Entry, international travel and transport, for both routine times and during health emergencies. A Memorandum of Understanding has been signed between WHO and the International Civil Aviation Organization to support the use of evidence-informed and risk-based approaches to international air travel, both in the context of the COVID-19 pandemic and other potential public health emergencies. The agreement is built on decades’ cooperation with the aim of establishing a closer collaboration on matters related to civil aviation and public health as part of a joint commitment to the United Nations 2030 Agenda for Sustainable Development. In addition, WHO continued participating in other inter-agency wide efforts to foster multisectoral engagement and streamline its public health recommendations, such as in the Joint Action Group to review the impact of the COVID-19 pandemic on the world’s transport workers and the global supply chain (JAG-TSC).
- Support was provided to countries in strengthening the engagement with non-traditional health stakeholders by providing guidance through the WHO Multisectoral Preparedness Coordination (MPC) framework. This includes engagement with key national stakeholders as well as non-traditional actors beyond the health sector such as parliaments, ministries of finance, foreign affairs, defense, transport and defense, and a non-governmental, civil society, and partner efforts to strengthen preparedness for emergencies such as COVID-19, as well as health security investment information to match country needs and to accelerate the implementation of the International Health Regulations (IHR, 2005).
- In addition to the REMAP efforts, over 3,550 different activities for a total of over $7.9 billion of disclosed contributions from 63 donors and partners have been tracked and displayed on the WHO SPH Portal. The partner matching capabilities of the SPH Portal have also enabled donors, partners, and countries to mobilize multisectoral resources to support emergency preparedness for emergencies such as COVID-19, as well as health security investment information to match country needs and to accelerate the implementation of the International Health Regulations (IHR, 2005).
- WHO collaboration with UN system at country, regional and global levels, including the UN Office for Disaster Risk Reduction, underscores the implementation of National Action Plans for Health Security (NAPHS).
- The online Strategic Partnership for Health Security and Emergency Preparedness (SPH) Portal has been updated to further provide data and analysis to support alignment of country and partner efforts to strengthen preparedness for emergencies such as COVID-19, as well as health security investment information to match country needs and to accelerate the implementation of the International Health Regulations (IHR, 2005).
- WHO’s Health Systems for Health Security (HSforHS) framework (first launch in 2021) is supporting WHO, Member States, and partners in bringing in health systems capacities and other sectors to complement the implementation of the International Health Regulations (2005), locate foundational health systems core components for health security, enhance multisectoral and multidisciplinary engagement for effective management of health emergencies. The HSforHS framework is now available in four UN languages (English, French, Russian, and Spanish).
Research and development, advocacy, innovation tools

- WHO has further advanced the outcome analysis and economic analysis to support International Health Regulations (IHR) (2005) and evidence-based national preparedness planning. Analytical and evaluative support has been provided for the development of the GPW13 Prepare indicator and testing of outcomes and impacts related to preparedness interventions. Metrics for the Universal Health and Preparedness Review (UHPR) was developed and tested in the pilot countries CAR, Portugal, Iraq, and Thailand and updated based on the lessons learned. Support on preparedness economics has been provided to assist Member States and partners with improving the size and value for money of investments directly and indirectly in health emergency preparedness and response. Costing and investment case support was provided for the National Action Planning for Health Security (NAPHS) development in the Central African Republic in 2022. A costing toolkit to support the implementation of global architecture for health emergency preparedness, response, and resilience (HEPR) is being developed.

- WHE has provided technical support to the development of the WHO’s Global Research Forum (2021-2023), with 40 partner countries and 120 participants registered, to provide a platform for joint knowledge generation, including research priorities, monitoring and evaluation, and implementation to address global health security challenges. An online course focusing on the implementation of preparedness priority actions is being developed. The WHO is also working on the development of a global Advanced Health Security Framework to support enhanced preparedness and response capacity at all levels.

- WHE has worked with governments to identify potential and anticipated risks using standardization tools such as Strategic Tools for Assessing Risks (STAR), Vulnerability Risk Assessment and Mapping (VRAM), and where necessary, accelerate readiness activities for emerging or anticipated events. Since 2016, 93 risk profiling workshops were conducted with the support of WHO, most of which took place in the African Region. An operational readiness tier one online training is now available on OPENWHO: https://openwho.org/courses/operational-readiness-introduction

- Using information from risk assessments, early warning, the JEEs and other sources, WHO and MS are identifying priority public health risks and the capacities required to manage them. Based on this WHO is supporting countries to develop and implement preparedness plans and business continuity plans for WHO country offices. This was also done in the context of the Ebola outbreak in the Democratic Republic of Congo and in 10 countries neighbouring DRC. WHO and partners have supported these countries to enhance their readiness for the potential spread of EVD across a set of key capacities, including coordination and leadership, epidemiology and surveillance, laboratory support, case management, infection prevention and control, vaccines, points of entry, risk communication, rapid response teams and community engagement. WHO has also mobilized human and financial resources to enable countries, partners and WHO to support country readiness for EVD and other priority hazards including flood, cyclone, volcanic eruption.

Countries and WCOs operationally ready to manage identified risks and vulnerabilities

- WHO works with governments to identify potential and anticipated risks using standardized tools such as Strategic Tools for Assessing Risks (STAR), Vulnerability Risk Assessment and Mapping (VRAM), and where necessary, accelerate readiness activities for emerging or anticipated events. Since 2016, 93 risk profiling workshops were conducted with the support of WHO, most of which took place in the African Region. An operational readiness tier one online training is now available on OPENWHO: https://openwho.org/courses/operational-readiness-introduction

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Research and development, advocacy, innovation tools

- The Global Research Forum deliberations led to an agreement on two main goals: the first was to accelerate innovative research to help contain the spread of the epidemic and facilitate care for those affected; the second was to support research priorities that contribute to global research platforms with the hope of learning from the current pandemic response to better prepare for the next unforeseen epidemic.

- Thereafter, WHO and partners have maintained a network of over 5000 global researchers and experts that has produced a Global Research Roadmap to focus research efforts on...
**COVID-19, debated research priorities, developed methods, and critically appraised emerging evidence via hundreds of virtual scientific consultations with thousands of scientists around the world.**

- Following the development of the Coordinated Global Research Roadmap for COVID-19 in March 2020, a follow up Forum meeting was held in May 2021. Research activities worldwide have been carried out in nine thematic areas and in three cross-cutting areas to support all research endeavours. These have filled many of the key knowledge gaps identified in the roadmap, providing greater clarity on the prevalence of COVID-19, supporting the development of safe and effective COVID-19 vaccines in record time, and evaluating potential COVID-19 therapeutics. Over the past year, multiple activities have been carried out under each theme to support globally coordinated responses to COVID-19. Global collaboration has focused on the emergence of SARS-CoV-2 VOCs and their impact on existing MCMs.

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<th>Community centered health emergency preparedness, readiness and response</th>
<th>WHO has developed and published a guidance document on conducting JEEs and developing and implementation of NAPHS in special context countries, including countries in conflict.</th>
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<td>In addition, WHO works directly and indirectly with countries to build their capacity to meet IHR core readiness requirements.</td>
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<td>One example is WHO’s work to provide support to strengthen public health laboratory systems and networks to provide essential data to inform and monitor disease control strategies, leveraging investments made for COVID-19 testing. This support includes progress efforts towards sustainable biosecurity policies and measures including in collaboration with animal sector to strengthen policy dialogue with financial and technical partners, non-state actors, other international organizations and Member States and provide strategic and technical support to develop national public health laboratory systems.</td>
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<td>The newly established Community Readiness and Resilience unit in WHE is advancing this work through the development of networks, partnerships, and standards at the global and regional levels.</td>
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<td>WHO is working to develop global guide and tools to support countries and communities for mapping emergency risk and assessing the vulnerabilities at community and local level with a strong linkage with PHCs and national EWARS systems.</td>
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<td>WHO has made great strides in defining the strategic direction and framework for WHO work on inclusive, people and community-centered approaches and actions to prevent, detect, respond to, and recover from health emergencies.</td>
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<td>The newly established Community Readiness and Resilience unit in WHE is advancing this work through the development of networks, partnerships, and standards at the global and regional levels.</td>
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<td>WHO is working to support and catalyse production and translation of evidence, including that from the social sciences, into effective community-centred policy and practice for health emergencies. In July 2021, WHO led a global consultation on community-centered approaches across the health emergency cycle to benchmark progress, gaps, and research priorities. The outcome of commissioned evidence reviews for example, on community resilience, is informing strategic and policy documents and research frameworks are being used to guide development of interventions at community level that can enhance quality engagement, for example, Community Conversation Kit intervention packages.</td>
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<td>WHO is working to mainstream community centered health emergency preparedness, readiness and response in IHR monitoring and evaluation framework including JEE and AAR as well as to develop new IHR benchmark on community engagement focusing on community capacity and system building for emergency risk management, integrated health services and community workforce strengthening.</td>
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<td>WHO provides cross cutting technical expertise related to community engagement and good participatory practices (GPP) for public health emergency relevant clinical trials (with the R&amp;D Blueprint team) in order to prepare, plan and deliver community-centred trial implementation and to ready local populations for their participation in clinical and other kinds of research. This work includes generic tools and training packages and bespoke tools for public health emergencies, for example, the COVID-19-relevant Solidarity Trial Vaccine and the “Tokoeka Ebola” Sudan Ebolavirus vaccine trial.</td>
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<td>WHO is working to develop global guide and tools to support countries and communities for mapping emergency risk and assessing the vulnerabilities at community and local level and managing those risks through community readiness planning and actions.</td>
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<td>WHO is initiating the work with partners like IFRC to ensure coordinated actions and efforts are made to detect early, report immediately and respond promptly to outbreaks at community and local level with a strong linkage with PHCs and national settings.</td>
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<td>WHO published a collection of best practices for engaging CSOs for covid-19 response titled “Community Assets and Civil Society outreach in Critical times and convened a WHO internal consultation on engaging CSOs for health emergencies to assess progress in engaging grassroots civil society organizations (CSOs) in response to the COVID-19 pandemic and review opportunities for strengthening systematic partnerships with CSOs in the evolving global architecture for health emergency preparedness, response, support and coordination.”</td>
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and resilience (HEPR), learning from impact-driven covid-19 response in target populations in situation of vulnerability in 40 countries, reaching over 80 million people directly and indirectly.

**Risk Communication and Community Engagement**
- Risk Communication and Community Engagement – RCCE. The RCCE team continues to respond to the COVID-19 pandemic and several emergencies providing evidence based guidance and interventions, with adaptable tools and products supporting community needs and priorities. Over 180 COVID-19 products were developed from the beginning of the pandemic and over 80 sets were produced in 2022.
- Since 2020, the regional RCCE network is meeting on weekly basis, gathering the RCCE focal points from all regions to exchange and share RCCE updates, materials, interventions and technical support.
- Strong internal partnerships are established and strengthened across the WHE with technical teams such as DCO, IPC, Clinical team, mass gathering, surveillance/epi to support readiness and response.
- Since 2020, the RCCE Collective Service partnership continues to deliver tools and mechanisms for a coordinated community-led and data driven approach for COVID-19 and other crisis enabling collaboration between wide range of organisations to support RCCE approach.
- RCCE Capacity building support is provided to regions and countries through on-site training support, remote presentations, learning experience development, competency framework and online available trainings on OpenWHO with over 30,000 learners.

Support was provided to mass gathering host countries and event organizers in preparation for Tokyo 2020 and Beijing 2022 Olympic Games, Qatar World Cup and EURO 2020. WHO scaled up event-based surveillance for COVID-19 and other threats with the goals of detecting and assessing emergent signals of public health concern, monitoring social media & infodemics, and quantifying and analyzing relevant public health information from digital media (e.g., Twitter, Facebook, Instagram, YouTube, blogs, and other forums). Sharing this event-based surveillance with event organizers enabled them to track the spread of misinformation about COVID-19 and address concerns about public safety. Additionally, robust risk communication measures were implemented in conjunction with all three events to earn buy-in and cooperation from spectators, athletes, event staff, the media, and other stakeholders. Constant communication and information-sharing between Member States, event organizers, WHO, and the general public were also essential components of implanting the risk-based approach.

**WSE Division, incorporating WHO Hub for Pandemic and Epidemic Intelligence**
- WSE continues to drive the agenda on Collaborative Surveillance with 25 Projects underway including several strategic large initiatives
  - The Epidemic Intelligence from Open Sources (EIOS) initiative expanded from 30 to 49 Member States. Over 1,400 public health professionals trained on public health intelligence and use of the EIOS system in 2022 further strengthening subnational, national, regional, and global capacity.
  - The EIOS initiative was recognized at the 2022 Paris Peace Forum and showcased as one of the selected projects.
  - WHO drove a Simulation exercise at G7 Health Ministers Meeting; supported the G7 Technical Meetings and contributed to the G7 Pact for Pandemic Readiness: A Roadmap for Practical Cooperation. These engagements led to substantial alignment in pandemic preparedness and response which led into the WHO HEPR framework. Continuing conversations and alignment on priorities moving into the G7 Japan Presidency - raising WHO’s profile across the political ecosystem.
  - Launched the Early Warning Alert and Response in Emergencies, (EWARN) operational guidance. It aims to guide decision-making on when and how to implement and strengthen EWAR in preparation for and response to emergencies.
  - Launched the WHO Open Source Programme Office (OSPO). A center of excellence that supports WHO and its global partners to collaboratively develop and access sustainable and innovative open source solutions for pandemic and epidemic intelligence. WHO the first agency of the United Nations to launch a formal Open Source Programme Office. The OSPO is already the norm for realising value from open source in the technology industry, more and more government organisations are now creating them.
  - Over 500 organizations engaged. Increase WHO’s visibility in building partnerships and cultivating the ecosystem; working with Member States to build a common understanding and trust; expanding capacity development in epidemic intelligence; and engaging in and driving the high-level agenda on collaborative surveillance.
  - The WHO Hub for Pandemic and Epidemic Intelligence in Berlin is fully operational with 55% staff, a division retreat in place to align on mission, vision, and strategic objectives.
  - Growing from 20 to 66 personnel including the appointment of two Directors. Sara Hersy, Director of Collaborative Intelligence and Gerard Krause, Director of Surveillance Systems

**Research agendas, innovative tools and interventions**
- Research agendas have been finalized for influenza, MERS-CoV, Zika virus disease, influenza and smallpox, and in development for Crimean-Congo hemorrhagic fever (CCHF), and Rift Valley fever (RVF), roadmaps developed for Ebola virus disease, Nipah virus infection, Marburg virus disease and Lassa fever.
- The Research and Development Blueprint work is continuing. The work of the Blueprint has allowed the introduction of 4 new therapeutics for case management and large-scale vaccination against Ebola in the Democratic Republic of the Congo (DRC) North Kivu and experimental vaccines have been used in Uganda for the Ebola-Sudan. Some countries are also implementing clinical trials for Mpox drugs and vaccines.
- There have been significant improvements in clinical care during emerging disease outbreaks with a paradigm shift from isolation to care, and implementation of randomized control trials with new drugs during COVID 19, MPox, and Ebola.
- Innovative diagnostic approaches (such as antigenic testing) have been developed under the WHO leadership for the COVID 19 response.
- Development of infodemic management area of work which includes Risk Communication and Community Engagement with a stronger component on social listening, resilience to misinformation with a people centered approach. 1,400 infodemic managers were developed and trained. An online social listening tool has been developed and is being piloted in 30 countries (EARS https://www.who-ears.com/). The risk communication and community engagement (RCCE) Collective Service coordination mechanism between WHO, UNICEF, IFRC supported by GOARN (see more detail in GOARN section, has created a COVID-19 behavioral dashboard https://www.rcce-collective.net/data/ to help inform RCCE response decisions at regional, country and community levels. Rapid transfer of knowledge to front-line responders has been enabled with >7 millions of subscribers to OpenWHO; and the revision of the Managing Epidemics handbook.
- The Strategic & Technical Advisory Group for Infectious Hazards (STAG-IH) has been meeting regularly during the COVID19 pandemic and has provided advice to WHO on the response strategy. In 2023, they published an annual report on Epidemic surveillance of the future.
- New antivirals and vaccines are in the pipeline for many epidemic prone diseases such as Mpox, influenza.
3. Detection and

- Potential health emergencies

<table>
<thead>
<tr>
<th>Public Health Emergencies of International Concern (PHEIC)</th>
<th>Three events are currently determined to constitute a PHEIC under the IHR – ongoing events and context involving transmission and international spread of poliovirus (since 2014).</th>
</tr>
</thead>
</table>

1. Research Roadmaps: R&D roadmaps for 14 priority pathogens have been finalized and/or update for Covid-19, MERS-CoV, Zika, Nipah, Lassa Fever, Zaire Ebolavirus, Sudan Ebolavirus, Marburg, Crimean-Congo Hemorrhagic Fever (CCHF), Rift Valley Fever (RVF), Chikungunya, Plague, Mpxo and Pathogen X. The roadmaps cover research priorities and gaps for each of the three medical countermeasures (vaccines, therapeutics and diagnostics). In addition, for each of the priority pathogens, candidate products for accelerated research have been landscaped and mapped; Target Product Profiles have been developed. The optimal clinical trial designs for clinical research have been determined; and simplified Core protocols have been developed. This constitutes the key package of research preparedness.

2. Disease Prioritization: The R&D Blueprint has launched a global scientific process to update its list of priority pathogens that can cause severe outbreaks or pandemics. To support this effort, over 300 international experts are being convened into 25-27 viral family review groups together with one bacterial expert group. Throughout 2023, these groups will be using a standardize approach developed by the R&D Blueprint to shortlist viruses and bacteria of epidemic and pandemic threat and to make recommendations on pathogen X.

3. Innovative tools: The R&D Blueprint continues to enhance an innovative cloud-based e-data capture system for clinical trials including biometric identification and registration system (iris scanning) and a mobile phone messaging platform to inform and reminded participants of their scheduled visits.

R&D Response

1. Covid-19: Implementation of the COVID-19 R&D Roadmaps is ongoing. The Solidarity Trial Vaccine is continuing to evaluate 2 candidate vaccines and the trial was expanded beyond the initial 3 countries (Colombia, Mal, the Philippines) to include another 2 (Kenya and Sierra Leone). To date, nearly 27,000 participants have been recruited and vaccinated in these 5 countries. The Solidarity Trial Vaccines and Solidarity Trial Therapeutics are expected to be completed in 2023.

2. Sudan Ebolavirus: A research response to the Sudan Ebolavirus outbreak in Uganda was activated at the end of 2022 and will continue in 2023 with a Safety and Immunogenicity study (Phase I / II clinical trial) on 3 candidate vaccines. The study protocols have received regulatory and ethics approval and implementation is beginning. The first participant is expected to be enrolled in May.

3. Marburg: A research response to the Marburg outbreak in Equatorial Guinea was activated in February. Clinical research on candidate Marburg vaccines and treatments is being planned. Simplified core protocols have been developed.

Prevention strategies

The Secretariat develops global strategies for the prevention and control of epidemic-prone diseases, together with partners from a wide range of fields to bring together all globally available resources and scale these strategies to the regional and country levels, protecting billions of people.

- CHOLERA: the “Ending cholera, a global roadmap to 2030” was adopted by the WHA in May and by the Regional Committee for Africa.
- YELLOW FEVER: The global strategy to eliminate yellow fever epidemics
- MENINGITIS: Defeating Meningitis by 2030.

In addition, WHO is also the Secretariat for the governance of global emergency stockpiles, including the International Coordinating Group (ICG) on vaccine provision.

Emerging and re-emerging diseases: support to prevention, risk assessment, preparedness and response

- INFLUENZA: the Global Influenza Surveillance and Response System laboratory has been the backbone of COVID19 laboratory surveillance including the monitoring of variants. In addition to informing influenza vaccine strain selection and supporting influenza risk management. With the increased risk of avian influenza, the influenza platforms for surveillance and response are critical for the world security. Through the implementation of the Pandemic Influenza Preparedness (PIP) Framework, (250 million since 2012) the countries capacities have been and continue to be strengthened in more than 100 geographies.
- COVID 19: WHO has provided the technical coordination and the convening of global expertise for COVID19. Many technical expert groups have been created to address the needs of the pandemic: TAG CO VC, TAG VE, SAGO.

- The trend is to integrate the detection, monitoring prevention preparedness response and recovery for groups of pathogens based on their transmission mode. Hence the grouping of all respiratory pathogens with epidemic and pandemic potential to develop common platforms. The Preparedness and Resilience for Emerging Threats (PRET) approach includes the development of guidance, tools and systems to enhance countries preparedness while leveraging innovation, financing and partnerships. The PRET is aligned with the 5 C’s of the HEPR framework.

- ONE HEALTH: WHO is actively engaged in developing strategies, tools and policies through active partnership with the Quadripartite (FAO, WHOA, UNEP WHO).

- In a nutshell the activities are focusing on preventing the next pandemic while still responding to emergence when it occurs. (i) development of a live mapping of hot spots of emergence, (ii) development of an index to measures the risk of emergence, and (iii) development of a package of interventions to reduce the risk of emergence. It covers a wide range of emerging and re-emerging pathogens MERS CoV, Arbovirus, Hendra, Nipah plague.

- In addition, in order to address the growing risk of vector borne disease, WHO in collaboration with NTD has develop a global strategy for arbovirus diseases.
rhythmically detected, and risks assessed

- Application of Emergency Response Framework (ERF): risk assessment and situation analysis, WHO grading, Incident Management System (IMS), response procedures, roles and responsibilities
- Acute health emergencies rapidly responded to, leveraging relevant national and international capacities
- Effectiveness of field operations
- Rationalization/standardization of production and dissemination of situation reports and risk assessments for each event
- Support affected countries for risk communication and community engagement
- Essential health services and systems maintained in fragile, conflict and vulnerable settings, working jointly between WHE and HIS

COVID-19 pandemic (since 2020), and global outbreak of MPox (since June 2022). IHR secretariat supports the convening the organization of the Emergency Committee related to these events. All three IHR Emergencies Committees discussed during their latest meetings in January/February 2023 about options to continue to manage such events when they will no longer constitute a PHEIC, including among others the issuance of standing recommendations under the IHR.

Performance Standards (PS)
- Between 1 January 2022 and 31 December 2022 – a total of 74 Disease Outbreak News on new and ongoing events published on the external facing website and 109 bulletins for Member States published on the Event Information Site for IHR NFPs.
- There were 1,479 geospatial information products produced by the GIS Team from 1 January 2022 to 31 December 2022. Of these, the majority of the products were related to COVID-19 (36%) and other health emergencies including Mpox, EVD, and Ukraine conflict (18%). Interactive dashboards were also developed for those events, with over 10 million visitors on the COVID-19 public dashboard in 2022.
- From 1 January 2022 to 31 December 2022: 65 rapid risk assessments of acute public health events were undertaken and published including substantial RRAs for new and public health emergencies of international concern, COVID-19 and MPox.
<table>
<thead>
<tr>
<th>Event Description</th>
<th>Initial Grade</th>
<th>Date</th>
<th>Rapid Risk Assessment or Public Health Situation Analysis</th>
<th>Grading memo</th>
<th>IMST activated at country-level within 72 hours</th>
<th>Response plan issued within 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022-G013 Greater Horn of Africa Drought and Food Insecurity</td>
<td>Grade 3</td>
<td>20/05/2022</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>No</td>
</tr>
<tr>
<td>2022-G014 Global Monkeypox</td>
<td>Grade 2</td>
<td>04/06/2022</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>2022-G030 Indonesia VDPV Type 2</td>
<td>Grade 2</td>
<td>28/11/2022</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>2022-G026 Gambia Acute Kidney Injury</td>
<td>Grade 2</td>
<td>23/09/2022</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Yes</td>
</tr>
<tr>
<td>2022-G022 Pakistan Floods</td>
<td>Grade 3</td>
<td>29/08/2022</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>No</td>
</tr>
<tr>
<td>2022-G015 Iraq Congo Crimean Hemorrhagic Fever</td>
<td>Grade 2</td>
<td>06/06/2022</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>No</td>
</tr>
<tr>
<td>2022-G008 Ethiopia Drought Emergency</td>
<td>Grade 2</td>
<td>04/03/2022</td>
<td>N</td>
<td>Y</td>
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</tr>
<tr>
<td>2022-G007 Malawi Tropical Storm Ana</td>
<td>Grade 2</td>
<td>15/02/2022</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>2022-G005 Sahel Region Humanitarian Crisis</td>
<td>Grade 2</td>
<td>10/02/2022</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>2022-G003 Madagascar Flood</td>
<td>Grade 2</td>
<td>28/01/2022</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>No</td>
</tr>
<tr>
<td>2022-G025 SVD Uganda</td>
<td>Grade 2</td>
<td>21/09/2022</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>2022-G021 DRC Beni Ebola</td>
<td>Grade 2</td>
<td>23/08/2022</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>2022-G017 Pakistan Cholera</td>
<td>Grade 3</td>
<td>15/06/2022</td>
<td>N</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>2022-G020 Mozambique Tropical Storm GOMBE</td>
<td>Grade 2</td>
<td>21/03/2022</td>
<td>N</td>
<td>Y</td>
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</tr>
<tr>
<td>2022-G010 DRC Equateur Ebola</td>
<td>Grade 2</td>
<td>28/04/2022</td>
<td>N</td>
<td></td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

- For G1 emergencies the delivery of Performance Standards is not monitored.
Incident management teams were activated within 72 hours for 66% (5/15) of the G2 and G3 events in 2022. Throughout 2022, WHO responded to 54 emergencies, of which 43 were acute graded emergencies and 11 protracted graded emergencies.

COVID-19 Global Response

As of 26 February 2023, there have been over 758 million confirmed cases and 6.8 million deaths reported. In the latest rapid risk assessment (dated 25 January 2023), the risk associated with COVID-19 was assessed as high at the global level. As such the pandemic remains an internal Grade 3 event and a Public Health Emergency of International Concern. Globally, cases surged from mid-Dec 2022 to the start of Jan 2023, due to increases observed in the Western Pacific Region, notably in China. Since the emergence in late 2021, Omicron variant of concern and its descendent lineages remain dominant globally and continue to spread, driving new waves of infections in different parts of the world.

WHO continues to have strong links and coordination mechanisms with regional and country offices, including routine monthly calls between the HQ incident manager and the six regional incident managers. Incident management support teams continue to drive COVID-19 response activities in 149 country offices, six regional offices and headquarters. Discussions with regards to a transition away from an IMST and to a more departmental approach at HQ began in mid-2020, and these discussions remain ongoing.

The Situations of Concern (SOC) project, launched in April 2021, was scaled down in the summer of 2022 in consultation with the regional office incident managers and incident management teams. Over the course of 2021 and early 2022, the SOC project was used to facilitate the early identification of contexts facing a rapid deterioration in the overall COVID-19 situation. The SOC methodology analyzed available information from both indicator and event-based surveillance to identify contexts with potential for a significant increase in COVID-19 morbidity and mortality in the next 2-4 weeks, and for which immediate actions, including technical and operational support, advocacy, or rapid access to funding, may help mitigate the impact of a surge in COVID-19 cases and deaths. The approach supported the release of more than USD 27 million from WHO emergency funding to help expedite response activities, as well as the rapid release of operational and technical support, including over 450,000 RDTs, 6,000 oxygen concentrators, support to deploy and establish COVID-19 treatment centers and deployment of rapid response teams across WHO regions.

With regards to broader UN coordination, WHO continues to chair The United Nations Crisis Management Team (UNCMT), bringing together 23 entities within the UN system for coordinated planning and policy development. The UNCMT met 50 times between 11 February 2020 and 10 February 2022, has nine work streams, and has facilitated strategic coordination and information sharing among UN entities to support member states in the COVID-19 pandemic response.

WHO launched the global SPRP for 2021 in mid-February, along with operational guidance to assist countries with prioritizing, implementing, and tracking activities. The 2021 SPRP covers the period from February 2021 to February 2022 and is an integrated plan which includes WHO’s contribution toward the delivery of COVID-19 tools via the ACT Accelerator. WHO is currently in the process of developing the 2022 SPRP, which will outline the COVID-19 strategy for the year to come.

Key Highlights – WHO Activities:

- WHO continuously monitors global, regional and country COVID-19 situations. WHO continues to collect, compile and analyze COVID-19 epidemiologic data on a daily basis and updating the WHO COVID-19 Dashboard (https://covid19.who.int/), which, as of March 2021, also includes data on global vaccination. Since the start of the pandemic, WHO has provided more than 447 global epi and operational situation reports.
- The Global Outbreak Alert and Response Network continues to provide substantial operational support to countries, with more than 900 individual offers of support received from 83 institutions, 219 deployments, and over 30 areas of technical expertise supporting over 40 countries. WHO and GOARN partners continue to support Go.Data implementation projects worldwide - activities include virtual trainings and briefings, user and technical support for local responders for epidemiology, analytics, reporting, interoperability, and technology.
- Through the Emergency Medical Teams Network WHO has facilitated over 120 international medical support missions and provided technical standards and support for the mobilization of 900+ national medical teams, helping to repurpose and expand hospital bed capacity worldwide.
- WHO continues to supply essential supplies to support the COVID-19 response in countries across all WHO regions. As of 8 February 2022, WHO has shipped to 156 regions more than 400 million PPE items since the start of the COVID-19 pandemic, including: 218.4 million medical masks, 28.2 million respirators, 122.9 million gloves, 12.4 million gowns and 9.8 million face shields. Updates and information on procurement, shipment and delivery of essential supplies for the COVID-19 response by WHO and partners is available on the COVID-19 Supply Chain Dashboard.
- WHO continues to coordinate procurement of biomedical equipment and diagnostics products, regularly receiving supply updates from 11 partners, including UN agencies, Global Fund, MSF, CHAI, FIND, GDF and IMC. To date, WHO and partners have procured (as of 3 February 2022):
  o $280.3 million of biomedical equipment, including oxygen concentrators, pulse oximeters, ventilators and PSA oxygen plants, to support 155 countries
  o $941.6 million of diagnostics products, including PCR tests, antigen RDT tests and sample collection kits, to support 183 countries
- As of 14 February 2022, more than 112 Intra-action Reviews (IARs) have been conducted by 71 countries since the start of the pandemic to understand country capacities and improve response operations in real-time, with an additional 17 IARs are currently in the pipeline. A global meta-analysis of IAR findings is currently ongoing to document the lessons learned, best practices and new capacities instituted by countries during their COVID-19 response for broader dissemination, and to identify the impact and changes triggered by IARs to the country COVID-19 response.
- WHO continues its work in Infodemic Management. WHO published the WHO Public Health research agenda for managing infodemics in February 2021 and launched the first ever WHO social listening tool (WHO EARS tool) in January 2021, with over 30 countries and 9 languages. As of March 2023, the OpenWHO course ‘Infodemic Management 101’ was available in English and Spanish and has had over 21,000 enrolments. In addition, in 2021, WHO trained 500 infodemic managers from 130 countries and held 2 global infodemic manager conferences.

26 January 2023 marked 3 years since WHO launched the first OpenWHO COVID-19 course, which introduced learners across the globe to the then novel coronavirus. That introductory COVID-19 course has been updated 13 times to reflect the latest evidence and has surpassed 1 million enrolments across 45 languages.

https://covid19.who.int/
Pakistan Floods
- Severe monsoon floods began in Pakistan in June 2022. As of 27 August, rainfall in the country was equivalent to 2.9 times the national 30-year average. In response to this escalation in situation and due to the scale and complexity of the event, WHO internally graded the Pakistan floods as grade 3 on 28 August 2022 and activated the incident management system across the three levels on 29 August 2022. The event was managed by the acute events team at HQ.
- The 2022 Pakistan Floods Response Plan was jointly launched by the Government of Pakistan and the United Nations on 30 August 2022 and included a US$ 160 million overall ask, with US$ 22.8 million for health. This joint appeal was updated on 4 October 2022.
- WHO released US$ 10 million from the Contingency Fund for Emergencies (CFE) on 31 August 2022.
- WHO repurposed staff at the country level to support this large-scale response. In addition, HQ and EMRO staff were deployed to support surge response. In addition, a high-level transition coordination of the activities for this event from an incident management structure back to the WHO Global Humanitarian Programme.

Sudan Virus Disease, Uganda
- On 20 September 2022, Uganda health authorities declared an outbreak of Ebola disease, caused by Sudan virus, following laboratory confirmation of a patient from a village in Madudu sub-county, Mubende district, central Uganda.
- On 21 Sept 2022, WHO activated IMS at the three levels, disseminated a Rapid Risk Assessment and graded the event as grade 2. The event was re-graded to grade 3 on 12 Oct 2022.
- WHO released the first DON for this event on 26 Sept 2022 – in total, during the duration of the outbreak, there were six DONs published. WHO released the EIS for this event on 25 Sept 2022, a final EIS was published on 13 Jan 2023 at end of outbreak declaration.
- WHO coordinated response for this event across the three levels of the organization, including the involvement and integration of the R&D Blueprint given that there were no licensed vaccines or therapeutics at the beginning of this SVD outbreak. This included the deployment of HQ and AFRO staff and consultants to Uganda for extended periods of time.
- WHO also mobilized GOARN partners for this event, through a request for assistance. A senior partner coordinator, member of the GOARN SCOM, was also deployed.
- On 11 January 2023, the Ministry of Health (MoH) of Uganda declared the end of the Ebola disease outbreak caused by the Sudan ebolavirus that affected nine districts. A total of 164 cases (142 confirmed, 22 probable) with 77 deaths (65 among confirmed cases and 22 among probable cases) were reported during the outbreak.

Global Cholera
- Since 2021, there has been an increase in cholera cases and their geographical distribution globally. Many of those countries reported higher case numbers and case fatality ratio (CFR) than in previous years. Of particular concern are the outbreaks in 13 countries, which did not report cholera cases in 2021. Of these, some had not reported any cholera outbreaks for many years (between three and 30), and several are not considered cholera-endemic countries. The current situation represents a resurgence of the ongoing seventh pandemic of cholera which began in 1961.
- Given this situation, WHO decided to look at the cholera situation on a global / multi-regional level.
  - HQ IMST established on 13 Jan 2023. Global cholera programme team integrated into HQ IMST, with agreement that response activities support acute response and longer term strengthening of programme.
  - Global cholera event graded G3 on 26 Jan 2023 – subsequently, all existing graded cholera events increased to G3.
  - HQ IMST coordinating with IMSTs and/or focal points in ROs and IMSTs in affected countries.
- Response scaled up in Malawi following concerning epi signals in country – included deployment of multi-disciplinary surge team from HQ and AFRO to capacitate country officer.
- Ongoing response.
In 2022 at least 30 countries have reported cholera outbreaks putting 1.1 billion people at risk from the disease. This represents a shocking 145 per cent increase over the previous five-year average. At least 10 additional countries that share land borders with those currently experiencing outbreaks are also at high risk. The average case fatality rate reported in 2021 was almost triple that of the previous five years. In Africa, for example, the case fatality rate was as high as 3 per cent. The preliminary data for 2022 follows a similar trend. Multiple factors have led to this spike in cases. Cholera is a marker of inequity and poverty, disproportionately impacting communities with limited access to safe water, basic sanitation, hygiene infrastructure and health systems. Cholera is also fueled by conflict, humanitarian emergencies and displacement. In addition, the COVID-19 pandemic has, in many fragile contexts, led to a reduction in resources available for cholera control measures.

At the same time, climate change is increasing the number and severity of floods, droughts, cyclones and amplifying the size and spread of cholera and other infectious disease outbreaks. No lull is expected in 2023 as climatologists are forecasting a strong La Niña climatic phenomenon for the third consecutive year. To further complicate matters, we face a shortfall in oral cholera vaccine (OCV) production and availability. Recently, the International Coordinating Group (ICG) had to take the unprecedented measure of suspending the 2-dose strategy due to limited vaccine availability. The vaccine stockpile has depleted we are unlikely to have sufficient stock to adequately respond to this 7th cholera pandemic. Our response capacity is also being hampered by the global shortage of other medical and non-medical commodities including cholera kits, oral rehydration salt (ORS) and diagnosis tests.

We urgently need to expand our response to save lives (see internal risk assessment). The global cholera crisis has been grade: Grade 3 emergency Both WHO and UNICEF will establish a common incident management system to monitor spread, target the response and ultimately break transmission and significantly reduce mortality. Our primary focus will be on the 11 most impacted countries, while also providing more limited assistance to at least 10 other countries to prevent further spread. In addition, we will support comprehensive preparedness actions in the countries directly at risk of a cholera outbreak.

To save lives, we cannot wait for our traditional fundraising mechanisms. We need to immediately support the following interventions:

- Emergency provision of vaccines, medical and non-medical commodities
- Support to surveillance both epidemiology and laboratory capacity to ensure optimization limited resources and to maximize control effort
- Support to case management and laboratory facilities for case detection
- Provision of emergency community-based water, sanitation hygiene and infection prevention and control (IPC) in communities
- Ensuring Risk Communication and Community Engagement including evidence driven behavior change interventions and accountability to affected populations
- Scale up field based multisectoral response coordination guided by integrated cholera analytics and
- Provision of technical expertise at global, regional and country levels including in country support.

Our organizations are actively engaged with countries to update their cholera preparedness response strategies and we can already see that the total funding gaps can only be addressed through a significant collective effort.

**Yellow Fever**

Despite a pandemic, the global strategy to eliminate yellow fever epidemics 2017-2026 (EYE) is about to reach the initial milestone of number of people protected halfway through its course with more than 233 million people protected against yellow fever for life in Africa through preventive and reactive campaigns to rapidly increase population immunity and control epidemic risk. Under EYE stewardship, the global vaccine supply also more than doubled in 5 years, with > 465.3 million doses procured since EYE inception - a long way from the 2016 global vaccine shortage which led to the creation of EYE. These figures and the engagement of the African Region, the Region of the Americas and the Eastern Mediterranean Region, which are all affected by yellow fever with 40 high-risk countries, are unprecedented in any yellow fever preparedness, prevention and control programme.

However, as evidenced by the independent mid-term evaluation completed in 2022 through the evaluation office of WHO/DGO in collaboration with Gavi and UNICEF, several elements jeopardize this success story and the major investments made thus far:

- **The greatest extent of yellow fever transmission in over 2 decades**, with 16 countries reporting yellow fever cases and outbreaks, predominantly disruptive (7/12), linked to the resurgence of outbreaks in countries of campaigns, affecting high-risk workers, vulnerable and mobile populations, with high concerns of urban outbreaks and international spread
- Changing environmental, climatic and contextual factors
- Competing priorities that derail attention and resources of partners, regions and countries
- **Dire human resources limitations** across the 3 levels, including at the EYE Secretariat and yellow fever team levels, challenging engagement, innovations, sustainability and stressing delivery

**Meningitis**

In 2022, 24 countries reported 20,221 suspected cases and 1182 deaths (CFR: 5.8%). 28 districts crossed the epidemic threshold in Cameroun, DRC, Ethiopia, Niger, Nigeria, and South Sudan. For two meningococcal outbreaks in Niger, ICG released a total of 800,000 ACW PS vaccines and 9,000 vials of ceftriaxone; while 394,083 vaccines (281,543 doses of ACW PS and 112,540 doses of ACYW conjugate) with short shelf-life were successfully repurposed for preemptive campaigns, also in Niger. The team has ensured technical support and coordination across 3 WHO levels and with ICG partners to ensure the effective allocation of vaccines and response in Niger, as well as with WHOCC to strengthen laboratory confirmation in DRC and Ethiopia. The meningitis team lead was deployed twice for country technical support missions.

In November 2020, the World Health Assembly approved the global road map on defeating meningitis by 2030, which is now well on its way to implementation and driving change. The defeating meningitis Road map Secretariat at WHO is led by three Departments: The Department of Immunization, Vaccines and Biologicals, the HEI department within the Health Emergencies Programme, and the Mental Health and Substance Use Department. Member States are encouraged, in close collaboration with WHO at all levels, to develop multiyear meningitis plans and to integrate meningitis prevention and control into Primary Health Care.
The WHE Meningitis Team leads on supporting Member States with meningitis detection and control, including surveillance, outbreak response, and emergency vaccination. Much progress has been made in 2022 in these fundamental technical pillars. Recent multi-country workshops showed a strong commitment to moving the roadmap forward in the Member States in the African region and the Americas. Other regions are stepping up long-term efforts in epidemic prevention and response with an affordable multivalent meningococcal conjugate vaccine available this year for use in the emergency meningitis vaccine stockpile. Work is ongoing to develop effective rapid diagnostic tests for use at the peripheral level to promptly confirm outbreaks and accelerate the response. The team is also leading the organization-wide effort to draft an operational manual for countries to build their multi-year meningitis national plans.

Similarly, to other programs in the organization, the meningitis team is also facing some challenges that pose a risk to effective country implementation:
- Insufficient capacity at the local level for meningitis detection and confirmation, which are essential first steps to start a response (e.g., vaccination against specific serogroups)
- Insufficient capacity for data collection and reporting at the health level to generate timely alerts and guide control measures
- Often, meningitis is not the only outbreak-prone disease affecting the same countries (e.g., Nigeria, Nigeria, DRC, Syria), which tend to experience multiple emergencies at the same time aggravated by changing environmental, climatic and contextual factors, generating competing priorities that derail attention and resources of partners, regions and countries
- The increased scope of work going beyond the African region and beyond controlling meningococcal epidemics is not met by an increased availability of funding
- Dire human resources limitations across the 3 WHO levels pose a challenge to the WHE meningitis program's capacity to deliver technical support to countries sustainably and systematically.

Viral haemorrhagic fever
In 2022, about 50 events of viral haemorrhagic fevers were reported to WHO from about 20 countries. Events included alerts and/or outbreaks of Ebola virus disease (EVD), Sudan virus disease (SVD), Marburg virus disease (MVD), Lassa fever, Crimean-Congo Haemorrhagic fever (CCHF), Rift Valley fever and Nipah virus disease. Among these, five outbreaks were graded 2 or 3: EVD outbreak (April-July 2022) in the Democratic Republic of the Congo (DRC); CCHF in Iraq (peak in April-July 2022); MVD outbreak in Ghana (July -September 2022); EVD outbreak in the DRC (August-September 2022); Sudan virus disease outbreak in Uganda (September 2022-January 2023) (details below and in the IOAC report of Grades 2 and 3). In addition, Lassa fever in Nigeria was graded 1 from early January to end of April 2022. For all these events, WHO provided technical and operational support to national health authorities, in coordination with various partners. Support included strengthening response capacities including surveillance, laboratory, clinical care, infection prevention and control activities, one health activities (when relevant), community engagement and risk communication, safe and dignified burials (when relevant) care for survivors and access to licensed therapeutics and vaccines (when applicable).

In addition to outbreaks activities, WHO is working with countries to better prepare and/or recover. Long-term projects are on-going and include among others, the development of a comprehensive clinical care training package for Lassa fever; the development of a training package for the use of the licensed Ervebo vaccine using a ring vaccination strategy during outbreak response; updating WHO laboratory strategy for filoviruses and finalizing EVD clinical care training package in collaboration with the WHE clinical Team; maintaining strong relationship with health authorities and key partners to share up-to-date and evidence-based guidance; and managing the stockpile of the licensed Ervebo vaccine in close collaboration with the International Coordinating Group vaccine provision secretariat.

The HQ Viral Haemorrhagic Fever (VHF) team works in close coordination with WHO Regional offices and WHO Country Offices to provide technical and operational support at time of outbreaks but also through in-country mission or visit to support joint preparedness efforts. The VHF team works also across the WHE Programme and WHO to tap on specific expertise when needed and provide a comprehensive disease-specific approaches.

VHF events graded 2 and 3 in 2022.

Ebola virus disease
Democratic Republic of the Congo
Equateur Province
- On 23 April 2022, the Ministry of Health of the DRC declared an EVD outbreak in the country after a case was confirmed in Mbandaka, Equateur Province. The outbreak was declared over on 4 July 2022. A total of five cases were reported, including four confirmed cases and one probable case. There were five deaths.
- Full genome sequencing was performed at the INRB in Kinshasa, and the results indicate that this outbreak represents a new spillover from the animal population.
- Overall response: The MoH, together with WHO and other partners, initiated response measures to control the outbreak and prevent further spread. The MoH activated the national and district emergency management committees to coordinate the response. Multidisciplinary teams were deployed to the field to actively search and provide care for cases; identify, reach and follow-up contacts; and sensitize communities on outbreak prevention and control interventions.
- Vaccination: Licensed Ervebo vaccines and matching injection devices were made available through two requests submitted and approved by the International Coordinating Group (ICG) on vaccine provision. Ring vaccination activities started on 27 April targeting contacts, contacts of contacts, and frontline workers. As of 3 July 2104, persons in the affected health zones have been vaccinated against EVD, of which 1307 are frontline health workers.
- Laboratory: A total of 999 samples have been tested for EVD since the onset of the outbreak, including five positive samples collected from four cases. Since 15 April 2022, 2000, Gene Xpert cartridges were made available to the Democratic Republic of the Congo through the global Ebola Xpert stockpile. A total of 935 GeneXpert cartridges remain in stock across the country, with 527 available at the laboratory in Mbandaka City.
- Infection prevention and control: Infection prevention and control (IPC) interventions were implemented in health care facilities and the community to stop the spread of the disease. A total of 70 priority health care facilities were identified for assessment and supervision for improvement for IPC measures and dozens of community sites such as schools, churches and houses were decontaminated. Over 3000 health care workers were briefed on IPC measures and 60 triage centres were set up.
- Clinical management: For case management, one Ebola treatment centre (ETC) was rehabilitated, and seven transit centres, facilities with the capacity to isolate and care for suspected EVD cases before referral to ETC if cases were confirmed, were constructed for the management of suspected and confirmed Ebola cases. Specific EVD monoclonal antibodies were made available to treat confirmed cases in Mbandaka. In addition, standard care guidelines were developed and disseminated to improve care in the affected areas.
North Kivu Province
- On 21 August 2022, the Ministry of Health (MoH) of the DRC announced that a new laboratory-confirmed case of Ebola Virus Disease (EVD) had been detected in the Beni health zone in the province of North Kivu. The outbreak was declared over on 27 September 2022. A single confirmed case was reported and resulted in death. Full genome sequencing indicated that this case is linked to the 2018–2020 outbreak and viral persistence in survivors.

- Overall response: The MoH, together with WHO and other partners, conducted response measures to control the outbreak and prevent further spread. National and district emergency management committees were activated to coordinate the response. Multidisciplinary teams were deployed to actively search and provide care for cases; identify, reach and follow-up contacts; and sensitize communities on outbreak prevention and control interventions.

- Alerts and testing: During this outbreak, from 21 August to 27 September 2022, a total of 9173 alerts were reported from Beni health zone, and all (100%) were investigated, including 607 (7%) validated as suspected cases of EVD. A total of 682 samples were tested for EVD.

- Points of entry: A total of 2390 (92%) of 2608 travellers registered at points of entry were screened for EVD, and no alerts were detected.

- Vaccination: As of 27 September, 550 persons in the affected health zone have been vaccinated against EVD using the ring strategy, targeting contacts and contacts of contact.

- Frontline health care workers made up the majority of those vaccinated (483). Vaccines were made available through the ICG mechanism

Sudan virus disease
Uganda
- Uganda declared an outbreak of Ebola disease caused by Sudan ebolavirus on 20 September 2022, after a case at Mubende Regional Referral Hospital (MRRH) in Mubende district was confirmed by the Uganda Virus Research Institute (UVRI). In total, 164 cases (142 confirmed, 22 probable) with 77 deaths (55 among confirmed cases and 22 among probable cases) and 87 recovered patients, were reported. On 11 January 2023, the Ministry of Health (MoH) of Uganda declared the end of the Ebola disease outbreak caused by the Sudan ebolavirus that affected nine districts. A total of 164 cases (142 confirmed, 22 probable) with 77 deaths (55 among confirmed cases and 22 among probable cases) were reported during the outbreak.

- Coordination: Uganda MoH, together with WHO and other partners, initiated response measures to control the outbreak and prevent further spread. The MoH activated the national and district emergency management committees to coordinate the response.

- Surveillance: WHO supported the MoH in the implementation of enhanced surveillance activities. Multidisciplinary teams were deployed to the field to actively search for cases, identify, list, and follow-up contacts for 21 days.

- Partner support: Following a Global Outbreak Alert and Response Network (GOARN) Request for Assistance, a total of 69 offers of support were received from 23 partner institutions. Eleven experts were deployed to the field and three are still supporting the response in the functions of case management, infection prevention and control (IPC), and Go.Data implementation (Go.Data is the initiative of a group of public health partners and is managed by the GOARN with the aim to provide an outbreak investigation tool for field data collection during public health emergencies).

- Survivor Care Programme: Out of the 142 confirmed cases, 87 survivors were registered. An Ebola Survivors program (ESP) has been established following WHO guidance on clinical care for survivors of Ebola virus disease, with the goal to improve the wellbeing of survivors by integrating survivor health care into the National MoH System. WHO led the ESP planning, supported the needs assessments, and the establishment of three clinics, located in geographical areas where survivors are residing. Two of the three clinics are already operational. All survivors have had at least one clinical evaluation and have received at least one psychosocial support session with the clinic and community teams respectively.

- Laboratory and clinical case management: WHO, GOARN, and partners supported the MoH in the establishment of screening, blage, isolation and care areas at designated reference hospitals in affected districts to identify suspected cases of Ebola virus disease. The MoH supported the establishment of Ebola treatment centres in affected districts, and Ebola testing mobile laboratories. Treatment centres have been equipped with essential medicines and supplies to deliver safe, optimized supportive care, including personal protective equipment (PPE), monitoring devices, point-of-care laboratory testing, intravenous fluids, and supportive oxygen devices. WHO and GOARN deployed clinical experts and organized bio-secured, patient flow circuits that allowed close monitoring of cases. Over time, isolation areas and treatment centres were able to manage both suspected and confirmed patients according to WHO guidelines and standards. For confirmed patients, access to investigational products was provided within the locally approved expanded access protocols under the MEURI ethical framework while the Randomized Clinical Trial (RCT) protocol was under development.

- Risk Communication and Community Engagement (RCCE) activities: WHO supported RCCE activities and awareness campaigns implemented by the MoH, as messages run by local radio stations, social media messages, door to door sensitisation of communities. A festive season RCCE plan was also developed to orient RCCE activities in Uganda and prevention in neighboring countries.

- Vaccination trial: WHO convened an expert meeting to prioritize candidate vaccine candidates. In coordination with Ugandan researchers, health authorities, and regulators, a ring vaccination trial protocol was developed and locally approved. Three candidate vaccines were identified and over 5000 doses of these arrived in the country with the first batch on 8 December and the last two on 17 December.

- Preparedness in neighboring countries: Ministries of Health, WHO, in-country and international partners, supported Sudan Virus Disease (SVD) preparedness and operational readiness activities in neighbouring countries that were identified as at-risk through risk assessments (Burundi, Central African Republic, the Democratic Republic of the Congo, Djibouti, Ethiopia, Kenya, Somalia, South Sudan, Sudan, Rwanda, and Tanzania).

Marburg virus disease
Ghana
- The Ministry of Health of Ghana declared the outbreak on 7 July 2022, after confirmation of Marburg virus on 1 July 2022 in a 26-year-old male (the index case) by reverse transcriptase polymerase chain reaction (RT-PCR) at Noguchi Memorial Institute for Medical Research (NMIMR). Between 28 June and 16 September 2022, the Ministry of Health of
service delivery and health system capacities. PCR machines, GeneXpert machines and oxygen production plants in countries with humanitarian emergencies to respond to urgent needs as well as invest in longer-term strengthening and addressing COVID-19 risks within the local landscape of risks. Moreover, until mid-2022, more than 40 million USD was invested by WHO for critical equipment, including ventilators, measures implementation in humanitarian and low-capacity settings was subsequently published in May 2020, also emphasizing to maintaining essential social, including health services

These figures show the deep inequity that people living in countries with humanitarian emergencies faces in accessing diagnostic services as well as clinical care for severe COVID-19 cases. The population of these 27 countries represents 12% of the global population yet 2% of the total tests performed.

The COVID-19 pandemic has also underscored society’s reliance on women both on the front line and at home. In times of crisis, when resources are strained and capacity is limited, women and children face disproportionate impacts. From the perspective of the global health workforce, women comprise the vast majority of health care workers globally (around 70%, and higher in long-term and social care settings), yet only a small faction is present in positions of authority/decision making. Ungendered public health policies neglect the needs and vulnerabilities of women providers, and during emergencies, studies have demonstrated that women providers face higher risks of exposure due to the nature of their work, more barriers to adequate protective equipment, increased workload including in their personal spheres, even less opportunities to participate in decision making and consequently higher risks for burn-out and mental health problems. This further compromises the quality of health services already disrupted by the pandemic.

In March 2020, WHO published an operational guidance on maintaining essential health services in the context of COVID-19, recommending practical actions that countries can take at national and local levels to reorganize and safely maintain access to high-quality essential health services. In the same month, WHO also coordinated the development of a multi-partner guidance on COVID-19 preparedness and response in camps and camp-like settings under the IASC umbrella. Another IASC guidance on priority actions for public health and social measures implementation in humanitarian and low-potential settings was subsequently published in May 2020, also emphasizing to maintaining essential social, including health services and addressing COVID-19 risks within the local landscape of risks. Moreover, until mid-2022, more than 40 million USD was invested by WHO for critical equipment, including ventilators, POR machines, GeneXpert machines and oxygen production plants in countries with humanitarian emergencies to respond to urgent needs as well as invest in longer-term strengthening of service delivery and health system capacities.

ERF Revision

- In line with the ERF, verified events are risk assessed and graded if necessary, to activate WHO’s operational response and emergency SOPs. Graded emergencies have been managed through WHO’s Incident Management System to fulfill critical functions. Following on from a review process which started in 2019, the ERF was revised in light of recent experiences with acute event response, and recommendations from the IOAC. Further revisions are underway to reflect recent changes and updates.
- The review process included inputs from all major WHO offices and provided critical feedback on all aspects of the ERF – ranging from minor clarifications in the text to substantial additions of new topics. The process was delayed due to COVID, but resumed in late 2020.
- The revised ERF contains updates to the following areas, which will be discussed with the GPG ahead of finalizing the text:
  - Risk assessment and public health situation analysis
  - Grading
  - Accountability clarified

Crimea-Congo Haemorrhagic fever

Iraq

- Between 1 January and 31 December 2022, 380 confirmed cases of CCHF have been reported to the WHO from the Iraqi health authorities of which 74 died [case fatality ratio (CFR) 19%]. The majority of confirmed cases were reported from Southern Iraq with Thi-Qar Governorate being the most affected. 73% of confirmed cases were reported from April to end of July.
- WHO supported the Iraqi health authorities to develop a multidisciplinary outbreak response; strengthen surveillance and diagnostic capacities, enhance clinical management; foster a One Health approach to sensitize most-at-risk populations, especially butchers and animal barns owners, to preventive measures.
- WHO will continue its support to Iraq health authorities to be better prepared for next year epidemic season.

FCVs - maintaining essential services in protracted crises

An analysis of the burden of COVID-19 in 27 countries with a Humanitarian Response Plan in 2022 found that the number of confirmed COVID-19 cases reported from the 27 countries combined represents 3% of the global cases yet 6% of the global deaths. The population of these 27 countries represents 12% of the global population yet 2% of the total tests performed.

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| o IMS functions reviewed and updated  
| o Performance standards updated  
| o New section on Prevention of Sexual Exploitation, Abuse and Harassment in line with WHO’s broader work in this area  
| o New section on Risk management and compliance  
| o New section on responding to vaccine preventable outbreaks  
| o Updated and expanded section on protracted emergency response.  
| o Checklist for accessing the CFE |

**Public Health EOCs**

- WHO continues to support countries in implementing and strengthening EOC capacities for coordination of health emergency preparedness and response. AFRO and EMRO in collaboration with Member States and partners developed a Five year strategic plan for strengthening PHEOC capacities.
- The PHEOC training course on OpenWHO has more than 25,000 learners enrolled across nine language versions.
- WHO is working with partners to develop a PHEOC curriculum to support the Member States in establishing quality work force for PHEOC functions in accordance with best practices.
- The revision of the Framework for a public health operations center is in process to further define the core components and essential requirements for effective PHEOCs.
- The Event Management Suite is an IT platform for Event and Emergency Management that enables rapid adaptation of features and workflows to meet the requirements of new types of Events. It has been developed open source and can be made available to Member States by the end of 2024.