Independent External Evaluation of: The Pandemic Influenza Preparedness (PIP) Framework Partnership Contribution High-level Implementation Plan 2018-2023 (HLIP II)

Prepared for // WHO PIP Framework Secretariat

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Abbreviations

BOD	Burden of Disease
CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organization
DAC	Development Assistance Committee
DCVMN	Developing Country Vaccine Manufacturers Network
DEP	Planning for Deployment
EARS	WHO Early Artificial Intelligence Response and Social Listening System
EQAP	External Quality Assessment Project
GIP	Global Influenza Programme
GISRS	Global Influenza Surveillance and Response System
HEPR	Health Emergency Preparedness, Response and Resilience
HLIP	High-Level Implementation Plan
HQ	Headquarters
IEDCR	Institute of Epidemiology, Disease Control and Research
IFPMA	International Federation of Pharmaceutical Manufacturers & Associations
IHR	International Health Regulations
IPPP	Influenza Pandemic Preparedness Planning
KII	Key Informant Interview
L&S	Laboratory and Surveillance Capacity Building
MAXQDA	Analysis Software for Mixed Methods in Evaluation
M&E	Monitoring and Evaluation
NIC	National Influenza Centre
NPHI	National Public Health Institute
OECD	Organisation for Economic Co-operation and Development
PC	Partnership Contribution
PCITEM	Partnership Contribution Independent Technical Expert Mechanism
PCR	Polymerase Chain Reaction
PIP	Pandemic Influenza Preparedness
PISA	Pandemic Influenza Severity Assessment
PRET	Preparedness and Resilience for Emerging Threats
QA	Quality Assurance
RCCE	Risk Communications and Community Engagement
REG	Regulatory Capacity Building
SDG	Sustainable Development Goals
SMART	Specific, Measurable, Attainable, Relevant and Time-bound
ToR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Programme
VFM	Value for Money
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

Background

An evaluation of the Pandemic Influenza Preparedness (PIP) Framework Partnership Contribution (PC) High-Level Implementation Plan II 2018 - 2023 (HLIP II) was commissioned by the World Health Organization (WHO) PIP Framework Secretariat following on from the Mid-term review of the HLIP II conducted in 2020. The focus of this evaluation is on implementation of the HLIP II across all levels of the Organization over a six-year period, i.e. from 2018 to 2023.

Evaluation Objective, Purpose and Scope

The overall objective of the evaluation was to provide accountability for the use of the PIP PC funds for pandemic influenza preparedness activities, and to serve as an independent assessment to inform learning and provide recommendations for its future implementation. The evaluation was guided by the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) six evaluation criteria (1), to achieve the following Objectives outlined in the Terms of Reference (ToR):

- Document key achievements, best practices, challenges, gaps, and areas for improvement in the design and implementation of HLIP II as well as progress against the 10-year objectives.
- Review effectiveness of resources in meeting the Outcomes of HLIP II.
- Generate a series of findings, conclusions, lessons learned, and recommendations that can inform future activities.

Methodology

The evaluation was conducted between August 2023 - September 2024 by a core team of three senior independent evaluators from IOD PARC, plus supporting research assistance and internal quality assurance. The evaluation was based on consultative and comprehensive data collection and analysis processes within all levels of WHO, as well as stakeholders, beneficiaries, and experts. The evaluation applied a mixed-methods approach combining multiple sources of qualitative and quantitative evidence, including: (i) systematic desk review of 38 documents; (ii) interviews with 61 stakeholders; and (iii) online survey results from 43 respondents. Support was provided by the PIP PC Team with guidance from the WHO evaluation office and input from an external quality assurance expert. An interim presentation of preliminary findings was made to the PIP Advisory Group Meeting in March 2024.

Based on the findings from the various evaluation methods, the following conclusions and recommendations are presented:

Findings

Key Achievements

Key achievements against the intended outcomes for HLIP II include:

- Laboratory virological surveillance and virus sharing mechanisms strengthened.
- High levels of compliance with international quality standards, with more than 90% of WHO Member States meeting WHO External Quality Assessment Project (EQAP) standards.

- Strengthened capacity and skills at country level, helped by predictability of funding streams in an area which requires continuity over several years to make a difference.
- Improved reporting on burden of disease.
- Strengthened risk communications and community engagement, including for example active social digital listening for acute respiratory infections.
- Countries supported to build systems for pandemic preparedness and steadily increasing in planning for deployment and influenza pandemic preparedness planning.

The evaluation found that HLIP II is of high, and continuing, relevance to stakeholder needs and is coherent with other related public health initiatives:

- There was clear and consistent evidence that mechanisms are relevant both for global pandemic preparedness and tailored to country needs. Over time, this relevance was maintained as HLIP II has been able to respond well to changes in the global and local context.
- HLIP II is complementary to and coherent with other related WHO initiatives, those of partners and the health-related SDGs. Most of the key outcomes intended for this second phase of HLIP were met, although the COVID-19 pandemic led to a reduction in implementation and slowed progress on the HLIP II objectives, as national public health capacity and attention was diverted to COVID-19.

One of the most significant achievements was the unanticipated but very important global public health contribution of mechanisms strengthened through the implementation of HLIP II being flexibly redeployed as a starting point for the initial phase of the response to COVID-19. This facilitated rapid progress in adapting planning, surveillance, and testing systems in the early stages of the pandemic. This was also helped by the fact that staff had already been trained on pandemic preparedness and virologic surveillance for acute respiratory illnesses.

Effectiveness of Resources in Meeting the Outcomes

The achievements were possible through highly efficient use of resources and good value for money (VFM). There was strong positive feedback on the role played by the PIP Framework Secretariat and the network of regional and country level focal points. Enabling FactorsTheir work was found to be highly organised and responsive. The evaluation found this, in turn, led to consistent timely disbursement of funds, due to an approach which is based around detailed planning and priority setting for each country receiving PC funding, well developed systems and information sharing, and careful monitoring against plans.

Several enabling factors were key to the successful implementation of the HLIP II.

WHO's convening role and **collaborative approach** in the PC benefit sharing mechanism was seen as important in bringing the different stakeholders together and facilitating links and communications with key decision-makers in the health sector. Over the years, since the initiation of the HLIP and PIP PC, high levels of **trust** have been established, building on well-established partnerships with other organizations such as United States Centers for Disease Control and Prevention (CDC).

As already noted above, the **efficient management** of the PIP PC has been pivotal, both in WHO and through a structured network of PIP focal points at regional and country levels.

Generally, the PIP PC funds are crucial for maintaining pandemic influenza preparedness, and the **predictability of the funds** allows for effective planning and timely implementation at national and sub-national levels.

The **technical support and expertise** provided by WHO at all levels and by the WHO Collaborating Centers has played a key role in building capacity and ensuring quality.

The COVID-19 pandemic has increased recognition of the importance of having a surveillance system in place that facilitates both global and national pandemic preparedness and response. With this increased recognition, the level of **commitment and ownership** from national governments and key stakeholders was a key driver of the successful implementation of the HLIP II.

A final recurring theme was that **effective communication** during the planning and implementation processes for HLIP II has meant that it has been easy to get rapid responses to questions or to receive/provide feedback when needed.

Constraining Factors

Conversely, the following constraints were identified that, while not sufficient to have a large impact on the achievements, do have the potential to become serious challenges in situations with complex needs and relatively weak health systems.

Although the funds received are helpful in supporting certain activities that would not otherwise be addressed, several of the beneficiaries interviewed noted that the **resources were insufficient** compared to their needs.

The context of **high staff attrition and turnover** in some countries means that the building of technical capacity and skills requires continued and consistent funding.

While the COVID-19 pandemic contributed to a greater awareness of the need for pandemic preparedness, **commitment has waned in some countries** and more tangible and immediate threats to public health are often given higher priority than investing in identifying and responding to a potential influenza pandemic.

The overriding priority attached to the COVID-19 response meant that **attention to pandemic influenza preparedness was put on hold** for nearly two years between 2020 - 2021 as public health resources were fully utilized elsewhere.

Challenges, Gaps, and Areas for Improvement

There are relatively few challenges, gaps and areas for improvement identified, as in broad terms the HLIP II is found to have been successfully implemented.

- One challenge is that the progress achieved in the early years of HLIP II was slowed by the reality of the COVID-19 pandemic. This diverted capacity and resources for around two years. While the process of 'catching up' has begun, in some cases activities have changed, and indicators and targets were subsequently revised when met or exceeded.
- Related to this, in terms of sustainability, there has been relatively little space for considering how countries will eventually transition away from dependence on PIP funds. This discussion needs to be restarted within the context of HLIP III, although in countries which are fragile, affected by crisis or that have complex needs, it will not realistically be possible or appropriate to even consider transition yet.
- One area for improvement is that it would be useful to strengthen stakeholder understanding of the M&E Framework, including links between financial implementation and technical progress could be further emphasised through detail already included in existing PIP reporting mechanisms.

Conclusions and Recommendations

Conclusions

Overall, the findings show that the PIP mechanism is **functioning effectively**, with the HLIP II having underpinned progress on pandemic influenza preparedness during a challenging global context. The

funds provided through the PIP PC are reportedly distributed more efficiently than those provided by other health programmes, and the process is seen as **straightforward and reliable** by countries.

Significant progress has been achieved across the six key output areas[1], with PIP also upholding broader public health objectives and, notably, providing key support to pandemic preparedness that in turn helped countries to better respond to COVID-19.

Sustainability

Looking forward, the **picture on sustainability is complicated** and while some countries are on a path to be financially self-sustaining in the medium term, few have graduated from needing external financial support. Challenges exist around **competing priorities** and the **need for a roadmap for transition planning**, which are crucial areas to be considered going forward. One source of additional long-term financing which may play a role here is the new fund for Pandemic Preparedness and Response (2) aimed at low- and middle-income countries, set up in September 2022 and hosted by the World Bank on behalf of 24 countries and philanthropic organisations.

Integration

The PIP mechanism has also had **two broader, unanticipated positive effects**. First, tools and systems built for pandemic influenza surveillance and response were rapidly adapted to respond to the COVID-19 pandemic. Second, the demonstration effect (of showing that a global, collaborative benefit sharing mechanism can help enable pandemic response) is of significant value.

Reporting

To improve stakeholder understanding of the M&E Framework, **links between financial implementation and technical progress** could be strengthened. Emphasising this further through already existing PIP reporting mechanisms would be useful in promoting an understanding of the role of the milestones and indicators in measuring progress towards outcomes over time.

Operations

Staff turnover, particularly within national Ministries of Health, can mean continual refresher training is needed so staff are suitably trained. In order to mitigate this repeated cost and ensure equitable access to tools and resources, in-country training on pandemic preparedness is a potential area which could be digitised. Conducting **a training needs assessment** would be a useful method to identify potential gaps in needs at both country and regional level, which could be alleviated by incorporating digital resources, existing or new.

Value for Money

The evaluation found robust evidence which suggested that the consistent timely disbursement of funds through the PIP mechanism helped to develop systems and information sharing, alongside careful monitoring against plans. To evidence this VFM to relevant stakeholders, including industry stakeholders, it would be useful to explore ways to better **highlight linkages between implementation of funds and progress against high-level objectives**.

Funding Allocation

There are opportunities to build on the progress made and to strengthen key areas further. This includes a ensuring all stakeholders have a good understanding of the rationale for the decision-making leading to the allocation of funds between countries and thematic areas. This was seen as unclear and questioned in interviews, indicating that further efforts to make the process transparent and clearly explained to stakeholders, especially Member States, are required.

[1] These six key output areas are Laboratory and Surveillance, Burden of Disease, Regulatory Capacity Building, Risk communications and community engagement, Planning for Deployment and Influenza Pandemic Preparedness Planning. These are outlined in the Introduction and expanded upon in the Effectiveness section.

Recommendations

The evaluation makes two strategic and four operational recommendations:

Strategic Recommendations:

1) **Sustainability:** Re-initiate, within the next 12-18 months, the discussions on sustainability that were paused during the COVID-19 pandemic and consider what can realistically be done within the PIP framework mandate:

   - Work with countries to identify 'low hanging fruit' that can be financed with government funds and support the Ministry of Health in securing funding for these
   - Explore the feasibility of including a commitment from governments to provide incremental support for influenza pandemic preparedness

   Responsible: PIP Framework Secretariat to initiate the process, working with PIP focal points and Member States. Strong ownership from MS is essential.

2) **Integration**: Build on the awareness of the importance of pandemic preparedness generated by the COVID-19 pandemic to advocate for countries to address overall influenza pandemic preparedness:

   - Compile and share data which demonstrates how strengthening country preparedness for influenza pandemic relates to broader pandemic preparedness

   Responsible: PIP Framework Secretariat and regional focal points

Operational Recommendations:

3) **Reporting:** Further improve stakeholders' understanding (particularly for Member States and industry) of the M&E framework (including the role of milestones and indicators) in measuring progress towards outcomes over time. This is a matter of fully communicating the improvements that have already been made.

   Responsible: PIP Framework Secretariat and regional focal points

4) **Operations:** Improve access to and awareness of digital training tools:

   - In close collaboration with WHO technical leads, share information with beneficiaries, particularly at country level, on the on-line digital training tools for influenza pandemic preparedness that are available
   - Conduct a training needs assessment to identify gaps between available tools and needs at country and regional level; encourage the development of on-line digital training tools to fill the gaps identified

   Responsible: PIP Framework Secretariat and regional focal points

5) **Value for money:** Publicise the evidence of progress made on the 10-year objectives to a wider audience to underpin awareness of value for money of the PIP benefit sharing system:

   - Explore ways to further highlight the correlation between implementation of PIP PC funds and technical progress
   - Highlight the collateral benefits and achievements for the COVID-19 pandemic response, that were due to pandemic influenza surveillance systems. This could include, for

example, case studies that document the achievements in PIP PC countries compared with other countries

Responsible: PIP Framework Secretariat

6) **Funding allocation:** Make the allocation process as transparent as possible and keep it under review to ensure consistency and coherence:

- Explain to stakeholders (particularly Member States) the global and country level factors taken into consideration during the resource allocation process and the roles played by the PIP Framework Secretariat and the respective WHO Regional Offices and Country Offices
- Periodically review the outcomes of the allocations to identify areas where the allocations could be modified to optimise the achievement of outcomes

Responsible: PIP Framework Secretariat and regional focal points

1. Evaluation Purpose, Objectives and Scope

This report presents the findings of the Independent External Evaluation of the Pandemic Influenza Preparedness Framework Partnership Contribution High-Level Implementation Plan II 2018-2023. The terms of reference (ToR) for the evaluation are contained in Annex 1.

The evaluation was commissioned by the WHO PIP Framework Secretariat, with advice and support from the WHO Evaluation Office, under the guidance of an internal Evaluation Reference Group (consisting of technical staff from Headquarters, Regional Offices and Country Offices), and with advice from an external technical adviser appointed from the Evaluation Office's roster.

The purpose of the evaluation is to provide an independent assessment to inform learning and accountability, and it has the following objectives:

- Document key achievements, good practices, challenges, gaps, and areas for improvement in the design and implementation of HLIP II as well as progress against the 10-year objectives for pandemic influenza preparedness established in 2013
- Review effectiveness of resources in meeting the Outcome of HLIP II: influenza surveillance systems, knowledge, and capacities for a timely and appropriate response to pandemic influenza are established and strengthened
- Generate a series of findings, conclusions, lessons learned and recommendations that can inform future activities

The temporal scope of the evaluation was on the second phase of implementation of the PC mechanism, for the six-year period of the HLIP II (2018 - 23). Meanwhile, the next iteration of the High-Level Implementation Plan - HLIP III - has been finalized and implemented from January 2024 and it is hoped that this evaluation serves as a useful resource to help inform decisions during implementation of this third phase. The scope of the evaluation is the OECD DAC criteria of relevance, coherence, effectiveness, efficiency, impact and sustainability.

The primary audience of the evaluation report will be the PIP Framework Secretariat, the PIP Advisory Group, WHO implementing teams, Member States, partnership contributors and other relevant PIP stakeholders.

2. Introduction

2.1 Background to PIP Framework and HLIP II

The PIP Framework was adopted by the World Health Assembly (WHA) in 2011 as a key international agreement focused on the improvement of global pandemic influenza preparedness and response. The PIP Framework is an innovative partnership which brings together WHO Member States, industry, civil society and other stakeholders to implement a global strategy and approach around pandemic preparedness and response. The PIP Framework aims to improve and strengthen the WHO Global Influenza Surveillance and Response System (GISRS), to achieve a fair, transparent, equitable, efficient, effective system which promotes: (i) the sharing of Highly pathogenic avian influenza virus A (H5N1)[2] and other influenza viruses with human pandemic potential; and (ii) access to vaccines and sharing of other benefits.

The PIP Framework establishes a PIP Benefit Sharing System that includes an annual Partnership Contribution (PC) to WHO from influenza vaccine, diagnostic and pharmaceutical manufacturers that use GISRS. This is a voluntary cash contribution, amounting to US$28 million annually, which is used to strengthen pandemic influenza preparedness capacities, provide funds at the time of a pandemic influenza response and support the activities of the PIP Framework Secretariat to implement the PIP Framework.

Of the US$28 million that WHO receives annually, the first 10% is allocated to the PIP Framework Secretariat at WHO HQ level, and of the remaining funds, 70% is allocated to WHO Headquarters, Regional Offices, and Country Offices/Member States to implement influenza pandemic preparedness activities, and the remaining 30% is allocated for influenza pandemic response in the event of a pandemic. Figure 1 shows the allocation and implementation for preparedness activities, by Output Area over the period under evaluation (2018 - 2023).

The overall intended outcome of HLIP II, as described in the Pandemic Influenza Preparedness Framework: Partnership Contribution (PC) Preparedness High-Level Implementation Plan II (3) is that:

"Influenza surveillance systems, knowledge and capacities for a timely and appropriate response to pandemic influenza are established and strengthened."

A series of ten-year objectives in relation to this impact statement are summarised as follows:

- All countries have enhanced capacities for surveillance, risk assessment and response.
- All countries have access to a National Influenza Centre (NIC).
- All countries have a clearer picture of influenza burden on different populations.
- All countries have access to pandemic influenza vaccines and antivirals.
- All countries have improved capacities to carry out risk communications in the time of a pandemic.

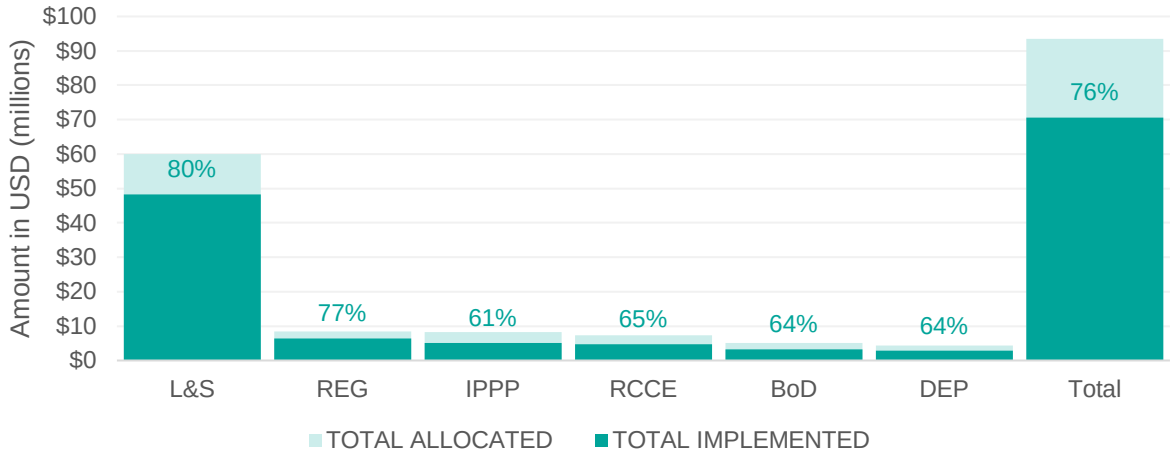
Within that overall aim, HLIP II covered the following six output areas and milestones, indicators and targets were developed for each output area:

- Laboratory and Surveillance (L&S)
- Burden of Disease (BOD)
- Regulatory Capacity Building (REG)
- Risk Communications and Community Engagement (RCCE)

[2] H5N1 is one of several influenza viruses that causes a highly infectious respiratory disease in birds called avian influenza (or "bird flu")

- Planning for Deployment (DEP)
- Influenza Pandemic Preparedness Planning (IPPP)[3]

Figure 1: Allocation and Implementation of PIP PC Funds by Output Area 2018 - 2023



Source: Pandemic Influenza Preparedness Framework: biennial progress reports, 1 January 2018 - 31 December 2019, 1 January 2020 - 31 December 2021 and 1 January 2022 - 31 December 2023. Geneva: World Health Organization; 2020, 2022, 2024

[3] Planning and deployment (DEP) relates to global and national plans for pandemic product deployment, working with global stakeholders to improve deployment systems, vaccine procurement and production practices. Influenza Pandemic Preparedness Planning (IPPP) is broader and supports countries to develop comprehensive plans that are multi-sectoral, engage the whole-of-society and bring together progress made under the other HLIP II Outputs; especially L&S, REG, RCCE and DEP.

3. Methodology

3.1 Evaluation Approach

The design of the evaluation is structured around the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) evaluation criteria. i.e. relevance, coherence, effectiveness, efficiency, impact and sustainability. The evaluation questions and sub-questions, and use of data sources, as agreed at the inception stage, are shown in the Evaluation Matrix at Annex 2 and the high-level evaluation questions from the matrix are set out in Table 1 below.

Table 1: Key Evaluation Questions

Evaluation Criteria	Key Evaluation Question
Relevance	To what extent is the design of the HLIP II relevant to its intended outcomes?
	To what extent has the HLIP II been relevant to WHO needs and priorities and those of other stakeholders?
	To what extent have stakeholders been effectively engaged throughout the HLIP II design and implementation?
	To what extent has the implementation of HLIP II adapted over time/to changes in context?
Coherence	To what extent has HLIP II been complementary to other WHO led frameworks on pandemic preparedness and response (e.g., International Health Regulations (IHR) 2005, regional strategies, etc.)
	To what extent has HLIP II been complementary to the UN's health related SDGs (Sustainable Development Goals)?
	To what extent has HLIP II been complementary to other donor activities/international assistance policies and frameworks?
Effectiveness	To what extent have HLIP II intended outcomes been achieved?
	To what extent have HLIP II activities contributed towards the achievement of PIP Framework objectives?
	To what extent has HLIP II contributed to: • Other WHO led frameworks on pandemic preparedness and response (e.g., International Health Regulations (IHR) 2005)? • The SDGs? • Other donor activities/ international assistance policies and frameworks?
Efficiency	To what extent is there evidence of value for money for each Output area within HLIP II?

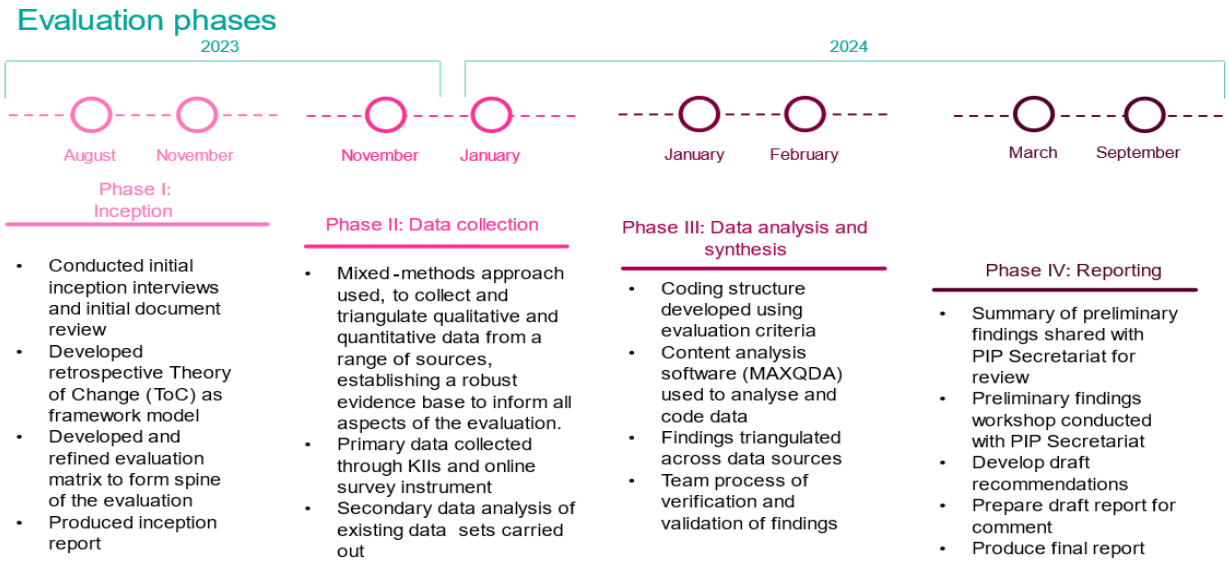
Impact	What has been the overall impact of HLIP II on pandemic influenza preparedness and response? On global pandemic preparedness?
	To what extent has HLIP II contributed to other changes, including "scalable" or "replicable" results?
	To what extent has HLIP II contributed to high-level effects (such as change in norms or systems)?
Sustainability	To what extent has HLIP II built sustainable capacity to improve pandemic influenza preparedness?
	To what extent has HLIP II supported the development and implementation of national policies and institutions to ensure sustainable results?

The findings in the rest of the report are organised according to the OECD DAC evaluation criteria and corresponding evaluation questions. The analysis was also informed by a Theory of Change (ToC) developed retrospectively (see Annex 3). The ToC was used as a framework to understand how change was expected to happen and what that change looks like, and to then unpack the expected mechanisms of change. As an overarching framework, this helped to guide revisions to the evaluation questions contained in the original ToR and inform the development of the evaluation matrix, which represented the 'spine' of the evaluation.

3.2 Evaluation Phases

Our evaluation approach adopted a four phased cycle, as outlined in Figure 2.

Figure 2: Timeline of Evaluation Phases



3.2.1 Inception

This evaluation process began with an inception phase which allowed the evaluation team to:

- Ensure there was a shared and agreed understanding of WHO needs and expectations from this evaluation

- Gain a clear understanding of the quality, availability, completeness, and comparability of available monitoring and reporting data
- Agree and finalise the methodology, data collection tools and evaluation questions with WHO

The evaluation team conducted eight individual and group interviews and reviewed key documentation relevant to the HLIP II. Based on these, the team reviewed the evaluation criteria and questions for the evaluation, proposing a small number of additions and revisions to the sub-questions and developed the Evaluation Matrix (Annex 2). The team also determined the data collection methods and associated tools which would be used in the next phase.

The evaluation matrix enabled systematic data collection and analysis of the HLIP II's performance and set out the selected evaluation criteria, questions, data collection methods, and stakeholder groups the evaluation team considered, allowing the evaluation team to ensure that each question is addressed through multiple evidence sources. The team developed an accompanying data analysis framework (based on the Evaluation Matrix), to organize and record evidence from document reviews and key informant interviews (KIIs), on an on-going basis to systematically capture evidence against the evaluation questions, criteria, and objectives in the evaluation matrix.

Based on the areas of inquiry developed from the evaluation criteria, questions, sub-questions, ToC, and the evaluation matrix, the team completed a systematic review of the existing data sources available for the evaluation, noting data already available to respond to evaluation questions and where primary and secondary data collection efforts should be focused. This ensured triangulation of evidence where data exists, supporting the development of robust findings and clear, meaningful, evidence-based conclusions and recommendations. The qualitative data collection methods for this evaluation, that go beyond the numbers and unpick the how and why results are achieved (or not), were of great value to the analysis and findings derived for this evaluation.

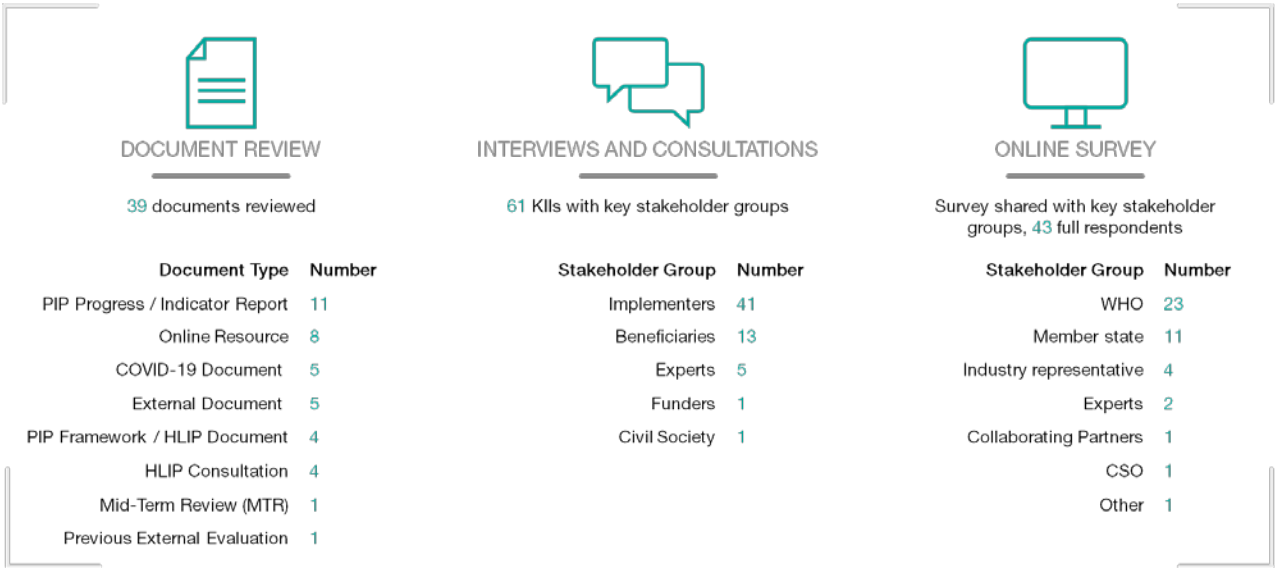
This phase culminated in the development of the inception report, which included the evaluation ToC, the evaluation matrix, data collection methods and associated tools/instruments, data analysis approaches and instruments, a detailed workplan, and evaluation limitations and risks.

3.2.2 Data Collection

The evaluation used a mixed methods approach, i.e., multiple research methods to collect and triangulate qualitative and quantitative data from a range of sources to establish a robust evidence base to inform all aspects of the evaluation. In all data collection and analysis activities, appropriate consideration was paid to ensure approaches, and tools were adapted to context. Primary data was gathered through stakeholder consultations, workshops and an online survey to ensure the inclusion of diverse stakeholder groups. Annex 4 provides a comprehensive list of stakeholders who were interviewed as part of the data collection process. Annex 5 provides secondary data sources used to inform the analysis included documentation and online resources provided by the PIP PC Implementation Team.

The evaluation drew on various sources: a document review (which included the Mid-term Review and PIP framework annual progress reports; HLIP II results indicators (showing data on performance compared against the biennium targets); KIIs with WHO focal points at HQ, regional and country level and national counterparts in PIP PC countries; and the electronic survey conducted for this evaluation. These main data sources, alongside a breakdown of respondent/participant type for each, are shown in Figure 3.

Figure 3: Data Source, Alongside a Breakdown of Respondent/Participant Type



Document Review

A Document Review was carried out during both the inception and core evaluation phase as the main form of secondary data collection. Thirty-nine documents were reviewed including PIP progress and indicator reports, global frameworks and guidance on pandemic preparedness and response and HLIP II architecture documents. A full list of documents reviewed is provided in the Bibliography as Annex 5.

Key Informant Interviews (KII)

Interviews with key stakeholders were the primary sources of data collection and were conducted extensively with WHO staff at global, regional and country level, country governments, industry representatives and experts. Initially, a purposive sampling approach was used, after which a 'snowballing' approach was used i.e., identifying potential key stakeholders during the data collection process through interviewees and referrals.

This approach was used to maximise the number of relevant interviewees for the evaluation. Interviewees were categorised into different stakeholder groupings (see Annex 6).

The purposive sampling approach was used for stakeholder interviews at regional and country levels as follows:

Regional Level: Staff from all six WHO Regional Offices were interviewed, and countries from all of the six WHO Regions were included in the list of interviewees. Countries were selected in a purposive manner to ensure a representative sample across the regions, allowing correlation across common findings or issues during data collection and analysis.

Country Level: The evaluation team sought advice from the Regional PIP focal points on which countries to be interviewed in the respective regions, alongside a representative sample of countries that are both direct and indirect beneficiaries of PIP PC funding (i.e. countries supported from their respective Regional Offices). The evaluation team also interviewed countries performing at differing levels in terms of both technical and financial implementation.

Survey Design

An online survey instrument was designed and implemented to ensure the inclusion of diverse stakeholder groups for the evaluation – particularly at country level - and provide a further basis for data triangulation. Necessary steps to maximise the response rate were taken, including: (a) designing a short, well targeted and easy to complete survey; (b) piloting the survey with the PIP PC Implementation Team and modifying according to relevant feedback; (c) disseminating the survey

as widely as possible, while ensuring the relevance of recipients targeted to receive it; and (d) active follow up and reminders with assistance from the PIP PC Implementation Team to encourage responses. Response rates from the survey have been displayed graphically in text and are included throughout the findings section of the evaluation, where relevant.

Overall, survey results were well aligned with the findings from other data sources. The survey itself (found in full in Annex 7) was translated into French, Spanish and Russian to ensure equal and accessible participation for all stakeholders and evaluation participants, acknowledging the global nature of HLIP II. Data collected from the survey was accessible only to the evaluation team and was not shared with WHO. With a response rate of over 32%, 43 full responses were gathered through the survey instrument. This was a valuable source of data for triangulation and through the process of verifying and validating findings (outlined further below), the general convergence of stakeholder views across different data sources provided sufficient confidence in the evidence base to begin to draw conclusions and develop recommendations as relevant.

3.2.3 Data Analysis and Synthesis

To shape and guide the overall analysis we used a framing that has two key components:

i. Identifying key achievements, best practices, challenges, gaps, and areas for improvement in the programme design, management arrangements and implementation of the HLIP II

ii. Assessing the key factors, both internal and external, responsible for the achievements and gaps observed to date

Using the evaluation matrix to map data from the main data sources and to organise and tabulate it in relation to the evaluation questions, the team utilised systematic analytical tools including Excel tabulation and MAXQDA, a content analysis software tool, to rapidly conduct the data analysis process. To facilitate coding in MAXQDA, the team developed a coding structure based on the evaluation criteria and questions and identified thematic findings, where relevant. To ensure that the analysis and triangulation included a gender, and human rights lens, consideration was given to whether preparedness takes into account the most vulnerable groups and includes gender equity.

Three types of triangulation methods were applied:

- cross referencing of different data sources (interviews with key stakeholders, survey respondent data, and review of secondary documentation),
- triangulation within the evaluation team (to ensure validity, establish common threads and trends, and identify divergent views as a group), and
- the process of verification of findings and information post-data collection (to review data and findings, taking into account feedback from the PIP Framework Secretariat and Evaluation Reference Group on the initial findings).

As part of the process of verification and validation, the evaluation team systematically reviewed the data to verify and identify main findings as a group. This was done through a validation workshop involving the whole evaluation team, leading to preliminary findings which were then reality tested with the PIP team. These triangulation efforts tested the consistency of results, noting that inconsistencies do not necessarily weaken the credibility of results, but reflect the sensitivity of different types of data collection methods and the diverse contexts in which the HLIP II has been implemented. This aids in ensuring validity, establishing common threads and trends, and identifying any divergent views.

3.2.4 Reporting

Reviewing Emerging Findings

A summary of initial findings was shared with WHO at an early stage during a preliminary findings workshop; alongside the Evaluation Reference Group. This helped to build awareness of the

findings and offer an opportunity for the evaluation managers and members of the Evaluation Reference Group to validate or challenge these findings from the varied and valued vantage points that they bring.

Developing Draft Conclusions and Recommendations

Having reflected on the findings and validated them, this provided a solid platform to develop draft conclusions and recommendations and ensure that the recommendations were useful and relevant, as well as to avoid surprises. The discussion of recommendations with the PIP team was important in increasing the quality, utility, and relevance of the evaluation recommendations, and providing a productive space for organizational reflection.

Draft Report

A draft report was prepared for comment, setting out the key findings, conclusions, and recommendations against the evaluation criteria and questions in compliance with the WHO/UNEG quality criteria as set out in the ToR. Comments received from the PIP Framework Secretariat, the Evaluation Reference Group, and the External Quality Adviser were consolidated into one comments matrix and checked for consistency, so that the evaluation team could then clearly address comments and indicate how each point was addressed to produce a second draft (near final) report.

Final Report

The final report was based on the draft report, amended to take into account all comments provided.

Dissemination and Engagement

The evaluation team presented its methodological approach to the Pandemic Influenza Preparedness Framework Advisory Group at their meeting held 5 - 8 March 2024. This offered an opportunity for the Advisory Group to gain insight into the evaluation process and ask questions whilst the team embarked on the reporting stage. Initial findings and draft recommendations were not presented. Dissemination and engagement activities based on the final report and evaluation products will be determined by WHO.

3.3 Limitations

Availability of interviewees and resultant selection bias: This challenge was mitigated through flexibility on the part of the evaluation team in arranging timeslots for interviews, active follow up by the team and the PIP PC Implementation Team to encourage participation, and through the dissemination of the online survey instrument, which offered the opportunity for relevant actors to engage and offer insights to the evaluation through a different method. The team worked in close coordination with WHO colleagues, and their efforts in following up with stakeholders to arrange the maximum number of interviews with representation across all six WHO regions was invaluable. Not all stakeholders identified were interviewed though; in practice, the sample predominantly involved WHO staff more than other groups, with only one civil society representative, a few industry stakeholders and a small number of country representatives involved. As highlighted in Figure 3, the number of beneficiaries and funders interviewed was relatively low, which is important to note here given their significance as stakeholder groups. The evaluation team recognises this sampling could perceivably lead to response bias and result in a more one-sided or positive framing, which is an important limitation to note.

Online survey response rate: The survey response rate was 32%. Measures were taken to maximise uptake of the online survey through the number of questions being kept to a minimum to ensure the survey instrument was succinct and could be easily completed by respondents. This streamlined approach meant there was only a general comments box at the end of the survey, not allowing for a qualitative answer for each question of the survey. Qualitative responses were used to triangulate the evaluation findings. Common trends and correlations relating to interview and documentary data have been elaborated in further detail throughout our Findings in the relevant sections.

Timespan and timing of the evaluation process: Recognising the long timeframe covered by the evaluation, some key figures involved in the early stages of HLIP were no longer available for consultation as they had moved roles. However, given the breadth of interviewees covered during the data collection phase, the evaluation was still able to ensure access to stakeholders who had been involved since the inception of HLIP II. What's more, as HLIP III has already been agreed, this was noted by the team as a limiting factor in terms of the scope of recommendations that the evaluation can provide. The evaluation team were advised that recommendations could be implemented informally prior to the Mid-term review of the HLIP III in 2025-2026, meaning they could still be useful and relevant. The recommendations outlined in this evaluation could also serve as a good starting point for the Mid-term review and are aimed towards smaller-scale changes in the activities within the outputs to mitigate this.

4. Findings

4.1 Relevance

To what extent is the design of the HLIP II relevant to its intended outcomes?

To what extent has the HLIP II been relevant to WHO needs and priorities and those of other stakeholders?

To what extent have stakeholders been effectively engaged throughout the HLIP II design and implementation?

To what extent has the implementation of HLIP II adapted over time/to changes in context?

Overall, the evaluation has found that HLIP II was **well designed with relevant outcome and output areas** which remain pertinent to the needs and priorities of WHO and other stakeholders, including Member States, country/regional implementers, and industry stakeholders. This sense of relevance is further strengthened through the evolution of the HLIP II over time in response to a changing global context. The strengthening of HLIP II over time is a consistent finding confirmed from different evidence sources and across all stakeholder groups. There is a high level of agreement that HLIP II has been relevant in its support to strengthen global pandemic influenza preparedness and response and the evaluators concur with this view.

HLIP II was designed and informed by a number of principles, extensive consultations and lessons learned from HLIP I. Six planning principles underpinned HLIP I and also HLIP II, namely: accountability; sustainability; effectiveness; specific, measurable, attainable, relevant and time-bound (SMART) outputs; transparency; and flexibility (3) as presented in Figure 4.

Figure 4: Planning principles for HLIP II

Source: Pandemic Influenza Preparedness (PIP) framework: partnership contribution (PC) preparedness high-level implementation plan II 2018-2023. Revised version 2021. Geneva: World Health Organization; 2021.

The design was also informed by lessons learned from a 2009 International Health Regulations (2005) (IHR) after-action review, an independent review of the PIP Framework in 2016, a Gaps and Needs analysis conducted in 2016 - 2017 and the recommendations of a previous external evaluation of HLIP I, conducted in Nov 2016 - Feb 2017, which focused on improving the log frame design, increasing the granularity of reporting, providing clarity on the country prioritisation mechanism and speeding up the approval of work plans.

The design of HLIP II has proven relevant and useful for WHO Member States in providing a platform for supporting activities and strengthening capacities. Interview and survey data suggests a strong consensus around the relevance and fit of HLIP II with national public health priorities, in line with the overarching outcome of “influenza surveillance systems, knowledge and capacities for a timely and appropriate response to pandemic influenza are established and strengthened” (3). This has been evidenced in the improvement in virus data collection, both for influenza and COVID-19 during

the pandemic, reported by interviewees as part of broader capacity strengthening. Furthermore, the learnings from HLIP I (2014 - 2017) were seen to be well integrated into this second version of the plan for example adding in the element of Influenza Pandemic Preparedness Planning at the national level, improving the log frame (including indicator revision) and improving monitoring, evaluation and reporting processes (4) (15).

Regarding stakeholder needs, a number of survey respondents quoted the training received by countries for pandemic preparedness as an area which could be evolved using digital tools, which could be a less expensive and more accessible option. To do this effectively, a training needs assessment to identify gaps in knowledge and tools could be first conducted and the relevant on-line digital training tools then be developed. (See Recommendation 4.)

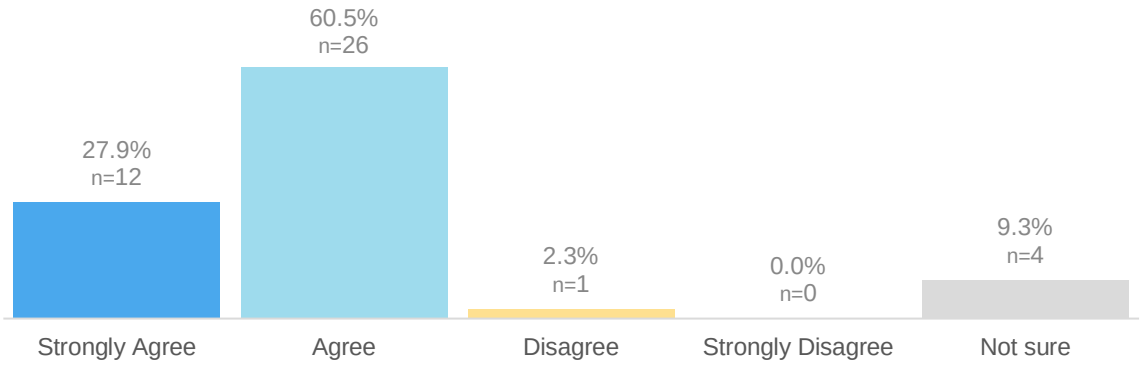
Some interviewees noted that whilst the design of HLIP II remains relevant, the narrow scope focusing solely on influenza increasingly has represented a challenge in today's changing health context. HLIP II was seen by a small number of interviewees as somewhat inflexible when it came to including activities which would have broader implications for other respiratory pathogens and it was often noted that country priorities are extensive in nature, with influenza not necessarily being a top health priority in all areas. Whilst noting these concerns, our overall view is that HLIP II funds were flexible in supporting capacity building for broader pandemic preparedness, whilst retaining a focus on influenza. Indeed, the experience of the COVID-19 pandemic highlighted how existing surveillance systems alongside broader pandemic influenza preparedness systems were of great value in monitoring other respiratory diseases beyond only influenza. This experience has been reflected in the development of HLIP III, which allows greater leeway for countries to strengthen respiratory pathogen pandemic preparedness more broadly through their pandemic preparedness plans, which can include a broader context provided the focus on influenza is retained. (6)

Regarding the consideration of gender and human rights in the design of HLIP II, the data was mixed. The majority of stakeholders felt WHO, as an organisation, prioritises equity, gender and human rights and that these values feed naturally into the PIP PC and HLIP II as WHO initiatives. A small minority commented that some key issues central in addressing equity and vulnerable populations, such as health systems strengthening and training of community health workers, have not been sufficiently addressed to date. Others saw no issues or were not sure how to respond to the question.

These findings are reflected in data taken from the survey shared with representatives from all stakeholder groups, which offers a point of triangulation across data sources. As Figure 5 emphasises, 88% of respondents agreed or strongly agreed that gender, equity, vulnerable populations and human rights had been considered in the design of HLIP II. The stakeholder survey also points to a potential lack of familiarity with these areas among some actors, with 9% of respondents indicating a 'Not Sure' option.

Figure 5: Survey Data on Gender, Vulnerable Populations and Human Rights Consideration

Gender, equity, vulnerable populations and human rights have been considered in the design of HLIP II.

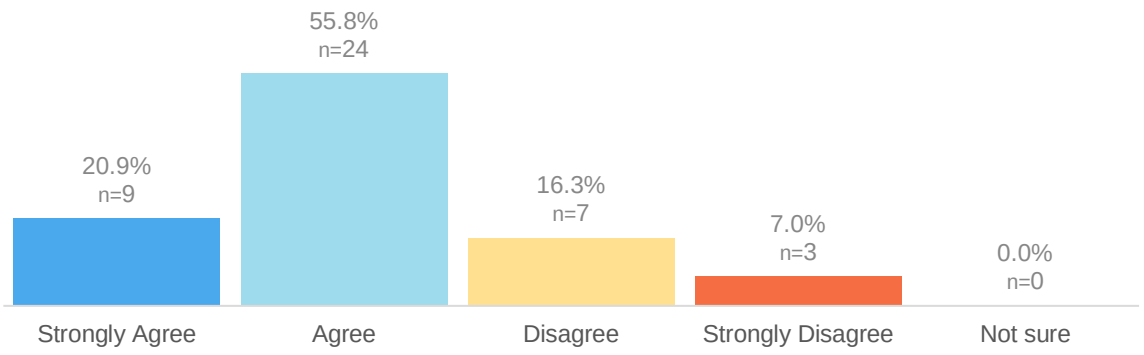


Overall, the consultation of relevant stakeholders and key partners throughout the design and implementation stages of HLIP II was found to be lengthy and robust in nature, involving a wide range of actors including the PIP Advisory Group, GISRS institutions, industry representatives, civil society organisations (CSOs) and other development partners involved in influenza, such as intergovernmental bodies and public/private donor agencies. The consultation process involved multiple rounds of commenting on draft versions of the plan, with extensive meetings and virtual consultations allowing for input and feedback. Invariably, there are limitations involved with these processes, as not every stakeholder was able to attend every meeting and not every person was able to be fully consulted, however the engagement process was noted as being valuable and offered the opportunity for comments and feedback on the development process, which were carefully reviewed and considered in great detail by the PIP Framework Secretariat.[4]

There were a few instances in which high staff turnover in some countries has meant that some individuals who may have been consulted during the design phase are no longer in post and those currently in post, who were interviewed, may not have been consulted as they were not present at the time. This led to some stakeholders, including Member States, stating that they had not been fully consulted on the design of HLIP II whereas the individual responsible for this area at the time had indeed been part of the consultation process. Members of a key stakeholder group expressed frustration that some of their inputs had not been taken into account both during the initial development process of HLIP II and during the Mid-term review stage and asked for greater visibility and transparency of the consultation process. However, it is important to note that as part of the drafting process for HLIP II, extensive feedback was received and considered by the PIP Framework Secretariat as documented in two separate phases. Given the extensive feedback, not all suggestions could be taken on board and justifications for this, where appropriate, were provided by the Secretariat in their response to stakeholder comments.

These mixed findings are reflected in the data collected through the stakeholder survey (see 6), which indicate a general consensus that effective consultation occurred in a meaningful way (over 77% of respondents agreed or strongly agreed), however a significant minority (23% of respondents) either disagreed or strongly disagreed that they had been consulted.

Figure 6: Survey Data on Consultation of Key Stakeholder Groups



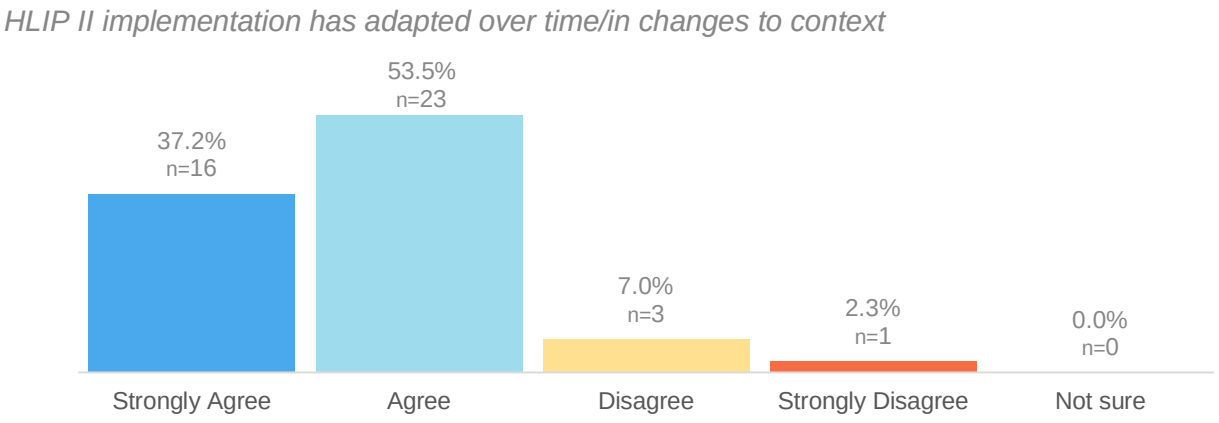
Over time, HLIP II has adapted and was notably modified after the 2021 Mid-term review (5), taking into account lessons learned from the COVID-19 pandemic. The recommendations from the Mid-term review informed mid-course adjustments which aimed to optimise implementation and involved the updating of indicators and milestones no longer fit for purpose. In total, 4 new indicators were added, with 1 removed and 6 revised and 8 new milestones were also added, with 7 removed and 2 revised (3).

[4] The PIP Framework Secretariat shared an internal document outlining detailed responses to each comment received during the development process and justifications around why comments were or were not taken on board. This was shared with all stakeholder groups which participated in the development of the plan in August 2017.

During the COVID-19 pandemic, capacities strengthened using the PIP PC were leveraged to support pandemic response activities. Numerous stakeholders attested to the sense that the value of the support provided through HLIP II was proven during the difficulties of the COVID-19 pandemic, providing a platform to bring together a robust monitoring system for multiple respiratory pathogens, not just influenza. As such, COVID-19 indirectly tested the relevance of influenza pandemic preparedness and response systems by adapting and using the established surveillance networks and pandemic preparedness plans to focus on a different pathogen. Indeed, stakeholders expressed that countries with existing influenza preparedness systems were better placed overall to respond to COVID-19. This sentiment is reflected in stakeholder comments included in Annex 1 of HLIP III, which recognises the collateral benefits for influenza preparedness and COVID-19 response as an overarching lesson from the HLIP II implementation period (6).

These lessons are reflected in 7, with strong agreement (91% of respondents) that HLIP II implementation evolved in response to a changing global context, and only a minority (9%) of respondents disagreed or strongly disagreed with this.

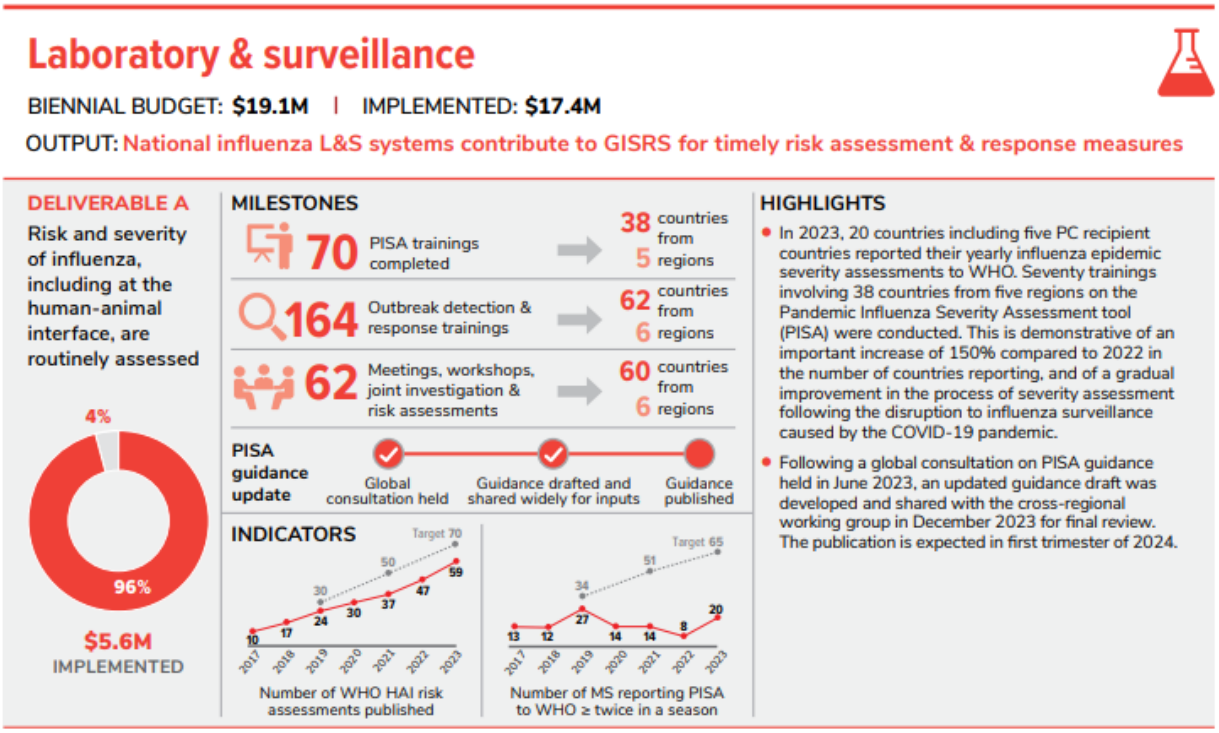
Figure 7: Survey Data on HLIP II Adaptation



Reflecting on the HLIP II implementation period, the relevance of the design of the log frame has improved over the course of HLIP II but perhaps could be improved further. There have been challenges in selecting the most relevant milestones and indicators to measure progress, with interviewees feeling that milestones could be revisited and adapted to better suit the current context. A level of flexibility around this was mentioned by stakeholders to ensure the right milestones are in place and for these to be specific to needs. However, recognising this as a programme which operates on a global scale with global measurements, improving stakeholders' understanding of the reporting through the monitoring and evaluation (M&E) Framework would be a way to address some of the concerns raised. (See Recommendation 3)

In order to improve stakeholder understanding of the M&E Framework, correlations could be further emphasised between financial implementation and technical progress, as whilst some stakeholders felt country data was not readily available, PIP reporting mechanisms (including regular progress reports and the WHO Budget Portal) (7) do provide extensive detail on funding allocations by country, by programmatic area and by region. Further highlighting this correlation between activities and funding would be useful in promoting an understanding of the role of milestones in measuring progress towards outcomes over time. Figure 8 shows an extract from the PIP biennial progress report for 2022-23 which clearly outlines financial implementation, relevant milestones and also includes highlights from the reporting period, using Deliverable A under the L&S output area as an example (8). This reporting, which exists for all six output areas, alongside more detailed regional and country level data contained in the Programme Budget web portal allows stakeholder access to financial and technical data, which could be re-emphasised to increase awareness and understanding. Promoting this existing reporting further (Recommendation 3) would be helpful in visualising where progress is less evident and assessing related funding allocations. This is especially pertinent in the current climate of reduced funding.

Figure 8: Extract from Biennial Progress Report Highlighting Financial Implementation, Relevant Milestones and Reporting Highlights under L&S Deliverable A.



Source: Pandemic Influenza Preparedness Framework: biennial progress report, 1 January 2022-31 December 2023. Geneva: World Health Organization; 2024.

4.2 Coherence

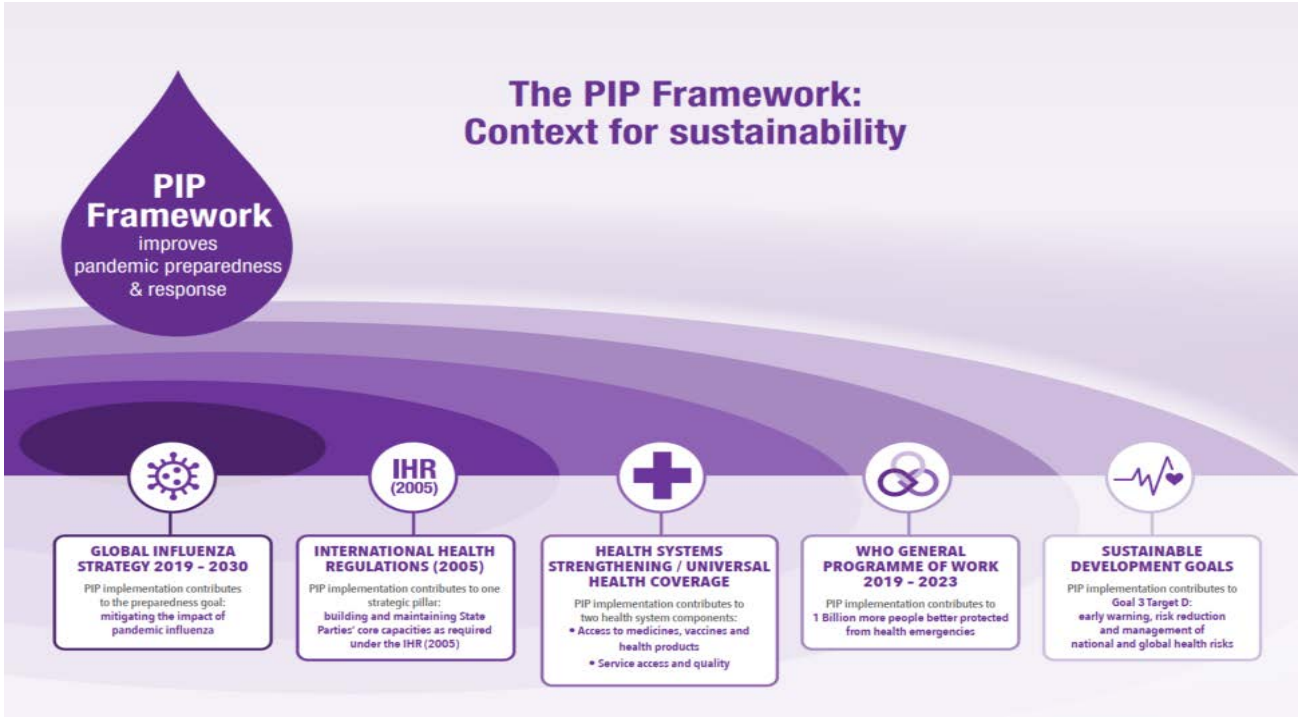
To what extent has HLIP II been complementary to other WHO led frameworks on pandemic preparedness and response?

To what extent has HLIP II been complementary to the UN's health related SDGs (Sustainable Development Goals)?

To what extent has HLIP II been complementary to other donor activities/international assistance policies and frameworks?

The evaluation found the HLIP II to be **highly complementary to various WHO led frameworks on pandemic preparedness and response**. The PIP Framework's preparedness mandate sits within the context of various broader global frameworks and initiatives that address emergency preparedness (such as the Global Influenza Strategy (9), International Health Regulations (IHR)), and PIP PC Implementation aims to align with these frameworks and initiatives in a catalytic manner to build momentum for improving global health (3). This is summarised well in Figure 9, which shows the 'ripple effect' of how different frameworks and initiatives align and complement each other, collectively contributing to SDGs. PIP PC investments focus specifically on strengthening pandemic influenza preparedness whereas some of the other frameworks address more the underlying health systems and capacities augmenting preparedness (6).

Figure 9: The Collateral Benefit and Context for implementation of the PIP Framework



Source: Pandemic Influenza Preparedness Framework: Biennial Progress Report. 1 January 2020-31 December 2021. Geneva: World Health Organization; 2022.

The IHR adopted by the World Health Assembly in 2005 provide an overarching legal framework for countries to prevent, protect against, control and provide a public health response to the international spread of disease (10). Both interviewees and survey respondents felt there was a high degree of coherence between the HLIP II and the IHR, mainly via HLIP II's contribution to strengthening some of the core capacities of IHR, which is also clearly laid out in key documentation, such as the HLIP itself, and summarised in Table 2.

Table 2: Alignment of IHR Core Capacities with HLIP II Outputs

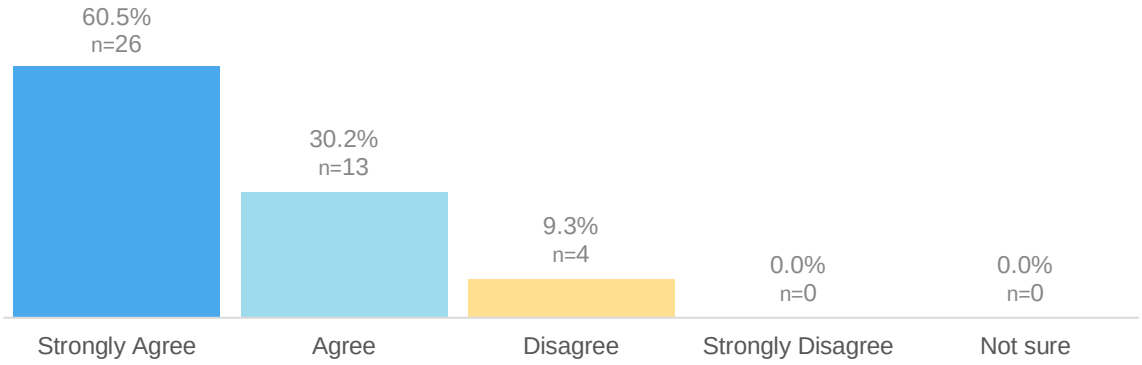
IHR Core Capacity	HLIP II Output
Surveillance	**Output 1** Laboratory & Surveillance Capacity Building – L&S
Laboratory	**Output 1** Laboratory & Surveillance Capacity Building – L&S
Preparedness	**Output 3** Regulatory Capacity Building – REG **Output 5** Planning for Deployment – DEP **Output 6** Influenza Pandemic Preparedness Planning – IPPP
Risk Communication	**Output 4** Risk Communications & Community Engagement – RCCE
Human Resources	**Output 1** Laboratory & Surveillance Capacity Building – L&S **Output 4** Risk Communications & Community Engagement – RCCE
Response	**Output 1** Laboratory & Surveillance Capacity Building – L&S **Output 3** Regulatory Capacity Building – REG

The high alignment with IHR is of particular relevance given a consensus in 2011 from the Review Committee on the Functioning of the IHR that the world was ill prepared to respond to a severe influenza pandemic, noting also that such is the biggest threat to global public health (9). Other interviewees explained how all components of the IHR are covered through PIP PC, especially for L&S for which the IHR acts as a 'parent body' with the IHR covering all events that pose a threat to public health, including pandemics and the PIP PC more narrowly focusing on influenza.

Survey respondents were asked whether they thought there had been complementarity with other WHO frameworks, including the IHR, and 90% either strongly agreed (60%) or agreed (30%), indicating a strong consensus regarding the complementarity of HLIP II (see Figure 10).

Figure 10: Survey Data on HLIP II's Complementarity with Other WHO Led Frameworks

HLIP II has been complementary to other WHO led frameworks on pandemic preparedness and response (e.g., International Health Regulations (IHR), 2005)



The WHO Preparedness and Resilience for Emerging Threats (PRET) initiative (11) demonstrates another aspect of coherence with HLIP II. Launched in 2023 to help ensure countries have systems and capacities in place to respond and recover from issues related to respiratory pathogens, PRET also operates under the IHR and attempts to avoid vertical interventions and interests, promotes coherence and efficiency, and helps streamline actions at the time of a pandemic. Interviews with beneficiaries in countries in three different regions revealed that implementation of HLIP II activities has helped with the establishment of PRET and discussions have been taking place around the integration of HLIP II activities under the PRET umbrella.

The evaluation found the HLIP II to be **highly complementary to the UN's health related SDGs overall, particularly those related to health** i.e. SDG 3 'Ensure healthy lives and promote well-being for all at all ages.'

Specifically, HLIP II has directly or indirectly contributed to the following SDG 3 targets:

- 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all.
- 3b: Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries. Provide access to affordable essential medicines and vaccines in accordance. [indirect]
- 3.d. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

Documentation (12) states that PIP implementation directly relates to target 3d of the SDGs, to strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks. This is done vis-à-vis WHO's facilitation role in bringing together different components of emergency risk management for pandemic influenza, and there was evidence in both documents (such as the biennial progress reports) and interviews of countries in the Western Pacific and African regions being supported through PIP to develop holistic pandemic influenza plans that link with other national strategies for emergency preparedness and response. PIP PC implementation is also recognised as contributing to two main health system components: access to medicines, vaccines and health products and service access and quality (13). This is by improving the distribution system to ensure access to health products at the time of an emergency, and by strengthening evidence-based influenza control programmes. Countries have also been supported to implement a defined regulatory approach and deployment strategies that enables timely approval and use of pandemic influenza products.

Interviewees were generally positive regarding the alignment of PIP and HLIP II to the SDGs, describing them as the driving process' and 'backbone of the work' within HLIP II. HLIP II, like its predecessor and successor (HLIP I and III) complements SDG3 through supporting progress

towards achieving Universal Health Coverage. Interviewees explained their interpretation that the coverage of essential health services includes surveillance for detecting outbreaks of communicable disease, including influenza and how focus on influenza immunization and trying to create awareness of importance of immunization is part of RCCE.

Overall, the evaluation found there to be **good complementarity between HLIP II and other international policies, frameworks and donor activities** in the area of emergency pandemic preparedness and influenza.

The importance of coherence is acknowledged in key documents including the global influenza strategy (9) and in HLIP II and III which explains that it is designed to operate coherently with other country, regional and global initiatives to strengthen pandemic influenza preparedness (3) (6).

Although PIP PC investments through HLIP II are focused specifically on strengthening pandemic influenza preparedness, WHO recognises that there are broad synergies with global frameworks addressing the underlying health systems and capacities that augment preparedness, (6) such that alignment of HLIP should ensure they are complementary and reinforcing.

The most frequently cited example during the interviews of complementarity with other donor activities and international frameworks, both at regional and country level, was that with the CDC; it was described in one interview as 'One team one system'. The CDC's influenza division serves as a WHO Collaborating Centre and plays an important role in year-round surveillance for early detection and identification of both seasonal influenza viruses and novel influenza A viruses that may have pandemic potential (6) and interviews at all levels – global, regional and country – positively noted support received from CDC.

Interviews also emphasised that, at country level, care is taken to avoid duplication of activities between WHO and other donors through joint work planning meetings to ensure complementarity between the agencies providing funding for activities relevant to their respective agendas and priorities. In addition, when countries were originally selected for PIP PC funding, this was done on the basis that they would be able to contribute complementary funding, seeing it as a 'shared responsibility'. There was also anecdotal interview evidence to suggest active efforts are taken to ensure continuous coordination and information exchange through yearly meetings bringing together different stakeholders to discuss different experiences and lessons learnt from seasonal influenza and how these can be used to inform pandemic influenza preparedness. However, in some countries, the degree of coherence with public health priorities at national level is constrained by the fact that influenza is not a top priority compared with other communicable diseases. Following the COVID-19 pandemic though, there is now much greater awareness and stronger interest in pandemic preparedness more broadly.

4.3 Effectiveness

In overall terms, the evidence suggests a high level of effectiveness, both directly in strengthening capacity and skills and ensuring influenza pandemic preparedness, with a major additional achievement that the systems established for influenza were helpful for an informed response to COVID-19. More specifically:

- The predictability of PIP PC funds has allowed capacity to be built at country level, since country stakeholders see PIP as providing a stream of funding which can be relied on from one year to the next and they can therefore plan better, while capacity building is a multi-year endeavor.
- Supported by the PIP PC funding, national virus sharing capacity building has been a key area of improvement under HLIP II with strengthened virology and shipping capacities apparent in many countries.

When discussing the findings related to effectiveness from the evaluation, it is helpful to note that the following key factors played a significant role in either enabling or limiting the achievement of results.

Enabling Factors

When asked about how the intended results were achieved, interviewees highlighted the following key enablers:

- **Commitment, Ownership and Broader Impact**: The level of commitment and ownership as demonstrated in national capacity building, both from national governments and individual staff is appreciated and seen as a key driver. Beyond the national level, there is recognition of the global importance of the system of preparedness and response established for pandemic influenza, particularly when people have seen the effects of the COVID-19 pandemic and, earlier, experienced the threats of zoonotic influenza. Another positive driver is the understanding of the broader public health relevance of pandemic influenza preparedness and the concomitant improvements in surveillance capacity and how these can help detect and monitor different respiratory disease pathogens.
- **Collaborative Approach with High Levels of Trust**: The PC benefit sharing mechanism is a successful example of a public-private partnership in support of global health. It has value in what it delivers but also in demonstrating what is possible as a global partnership to tackle threats to public health. WHO's convening role is seen as important in bringing the different players together and facilitating links and communications with decision-makers in the health sector at the country level, including those in national governments. Over the years since the initiation of PIP PC and the associated high-level implementation plans, high levels of trust have been established, building on existing partnerships with other organizations such as US CDC.
- **Efficient Management**: There was very positive feedback on how the work planning and funding allocation mechanism is organised and run by the PIP Framework Secretariat which follows a structured project management cycle presented in HLIP II, as shown in Figure 11.

Figure 11: Project Management Cycle for Implementation of PC Preparedness Funds

Source: Pandemic Influenza Preparedness (PIP) framework: partnership contribution (PC) preparedness high-level implementation plan II 2018-2023. Revised version 2021. Geneva: World Health Organization; 2021.

Interviewees noted the very structured approach with clarity of roles and expectations. This starts with the leadership provided by a small but highly organised and efficient PIP

Framework Secretariat at WHO Headquarters (HQ) who are responsive, offer clear guidance, are focused on results and work through the details. In turn, they work through a structured network of PIP focal points at regional and country levels, with dedicated technical national staff in the influenza centres and sentinel sites. The role of the WHO Regional Offices is seen as pivotal.

- **Predictable Funding**: For many of the PIP PC recipient countries, the PIP funds are crucial to being able to implement and maintain pandemic influenza preparedness activities and structures. There was particular emphasis on the fact that funding that is predictable in amount and that continues from one year to the next, allows for effective planning and timely disbursement. Without it, progress would be tenuous and even impossible in countries with weaker health systems.[5] Some stakeholders pointed to the fact that although relatively small, the PIP resources can be catalytic and are used strategically to tackle long-standing health system issues which are not otherwise addressed for political or other reasons.
- **Technical Support and Expertise**: At least as important as the financial support provided is the technical expertise that is also part of the support provided through the HLIP II. The tools and technical resources provided by WHO at all levels and from the WHO Collaborating Centres, play a key role in building capacity and ensuring quality.
- **Effective Communication**: A theme from interviews was that messages are clearly and quickly transmitted during the planning and implementation processes for HLIP II, so that the different players know what is expected of them and by when. Having PIP focal points at the regional level, and in some cases at the country level, and the strong leadership of the PIP Framework Secretariat, have meant that it is easy to get rapid responses to questions or to receive/provide feedback when needed.

Constraining Factors

The following constraints came up consistently in interviews. Most of them can also be positive enablers, but become challenges in situations with complex needs and relatively weak health systems:

- **Funding**: While interviewees were appreciative of the PIP funding to recipient countries, filling gaps that could not otherwise be addressed, some countries, especially those in complex and conflict situations, also noted that the resources are simply too small relative to needs. However, PIP PC funding can only ever be a contribution towards addressing needs, and national funding is essential. This is discussed further below in the sections on Efficiency and Sustainability.
- **Staff Turnover**: Due to the challenge of staff attrition and turnover, which can be very high in some countries, building technical capacity and skills was cited by some regions and countries as a 'never-ending task', requiring continued and consistent technical assistance and funding.
- **Lack of Awareness and Ownership from National Authorities**: This was another factor cited in a few countries. While the COVID-19 pandemic had eventually led to much greater awareness of the need for pandemic preparedness, this soon waned and, in some countries, identifying and responding to pandemic influenza is not seen as a high priority for public health, compared with more tangible or immediate threats. In some countries, there can be misinformation around vaccines which prevents uptake, or it is a major challenge of getting politicians and citizens to accept the importance of being vaccinated. It can also be that the influenza vaccine – even if available – is not part of the national immunization strategy at all.

[5] The role that the PIP Framework Secretariat plays in working with industry partners to encourage their contributions is seen as vital, in ensuring that resources are shared as part of benefit sharing. Transparency is also an important enabler in this process, showing how the resources are used and what activities can be funded as part of the PIP PC.

- **Diversion of Attention to the COVID-19 Pandemic:** The overriding priority attached to the COVID-19 response meant that attention to pandemic influenza preparedness was put on hold for nearly two years between 2020 - 2021 as public health resources were fully utilized elsewhere.

To what extent have HLIP II intended outcomes been achieved?

To what extent have HLIP II activities contributed towards the achievement of PIP Framework objectives?

To what extent has HLIP II contributed to: other WHO-led frameworks on pandemic preparedness and response; the SDGs; other donor activities/international assistance policies and frameworks?

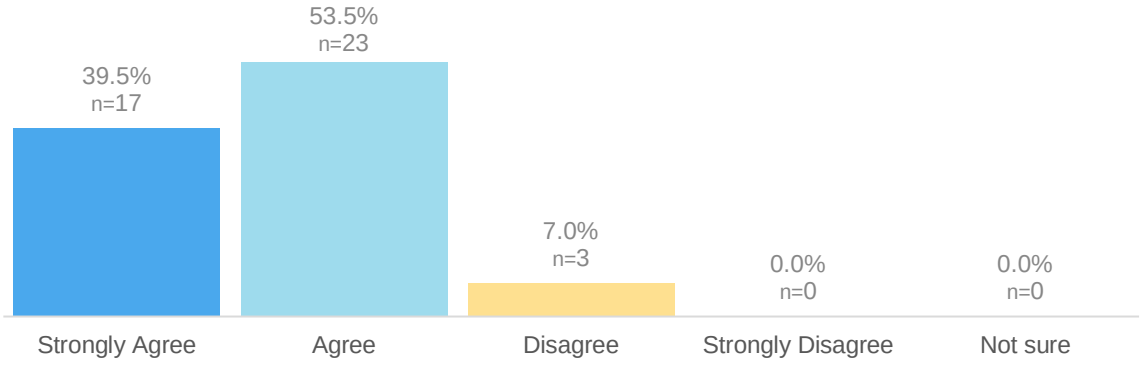
The achievement of outcomes includes two different levels, specific and broad:

- The most specific level is progress towards the intended outcomes of HLIP II, as measured by the indicators in the framework and evidence of contribution to overall PIP results. This type of outcome is the main focus of this section on effectiveness.
- Given progress against output areas, the contribution to intended outcomes then depends on a range of factors and one challenge is that the PIP PC funding is relatively small compared to the public health needs in each country, so measuring the impact of the PC funds can be difficult.
- A broader outcome is that contributions from HLIP II may have improved public health and pandemic preparedness at the country level, such as for the COVID-19 response, and for broader IHR implementation and compliance etc. These types of outcomes are not necessarily intended or foreseen and take us beyond the scope of HLIP II. Nevertheless, they are important benefits that are discussed in the section on impact.

As shown in Figure 12 below, 93% of survey respondents agreed or strongly agreed that HLIP II had achieved its intended objectives outcome. This is an unusually high degree of consensus for a survey of this type. Key informant interviews underlined this view consistently, while also adding very positive comments on how useful the influenza pandemic preparedness systems had been for public health more generally, strengthening capacity and systems, and responding to COVID-19. A small minority of survey respondents (7%) disagreed that the intended outcomes had been achieved. Among this small sample, the common trends which emerged were centered around a limited focus on addressing the challenges faced by pandemic preparedness and response capacities, such as weak health systems, and the low level of influenza vaccination among adults in some countries.

Figure 12: Survey Data on HLIP II's Achievement of Intended Outcomes

HLIP II has achieved its intended outcomes in terms of surveillance systems, knowledge and capacities for response to pandemic influenza being established and strengthened.



There was some variation in performance over time, more specifically indicators from the 2023 Indicator Report: HLIP II Implementation shared by the PIP Framework Secretariat show a dip in performance on the standard indicators during the pandemic itself. Qualitative responses and

interviews confirm that this happened simply because public health resources and skills were – as expected during a pandemic - diverted to prioritize the COVID-19 pandemic response for 2020 and 2021, as well as the impact of the pandemic on health workers themselves in terms of absences from the workplace due to illness, lockdowns, and morbidity and mortality of those around them

While the indicators are useful and relevant, the level of preparedness and therefore the effectiveness of the system cannot be fully assessed, except in the event that there is an influenza pandemic. However, the evidence from this evaluation (particularly from key informant interviews) points to a finding that the system of pandemic preparedness that has been established and strengthened in countries was flexible enough to be used quickly to respond to the COVID-19 pandemic. It was found to be relevant and useful for that purpose. This provides a strong indication that this same system would also be effective in an influenza pandemic, since both are acute respiratory conditions which spread quickly. In that sense the influenza pandemic preparedness and response system was stress tested during COVID-19 and found to work in PC recipient countries, which were then better prepared to respond to the COVID-19 pandemic.

Some stakeholders indicated their concern that there is limited public visibility of the progress achieved during the implementation of HLIP II and limited demonstration of the link between PIP-specific funds and improvements in countries' influenza pandemic preparedness. They noted that being able to demonstrate this link would be crucial to provide evidence supporting the utility of the PIP PC, and to convince national governments of the importance of domestic funding to ensure long term sustainability of the systems established at country level.

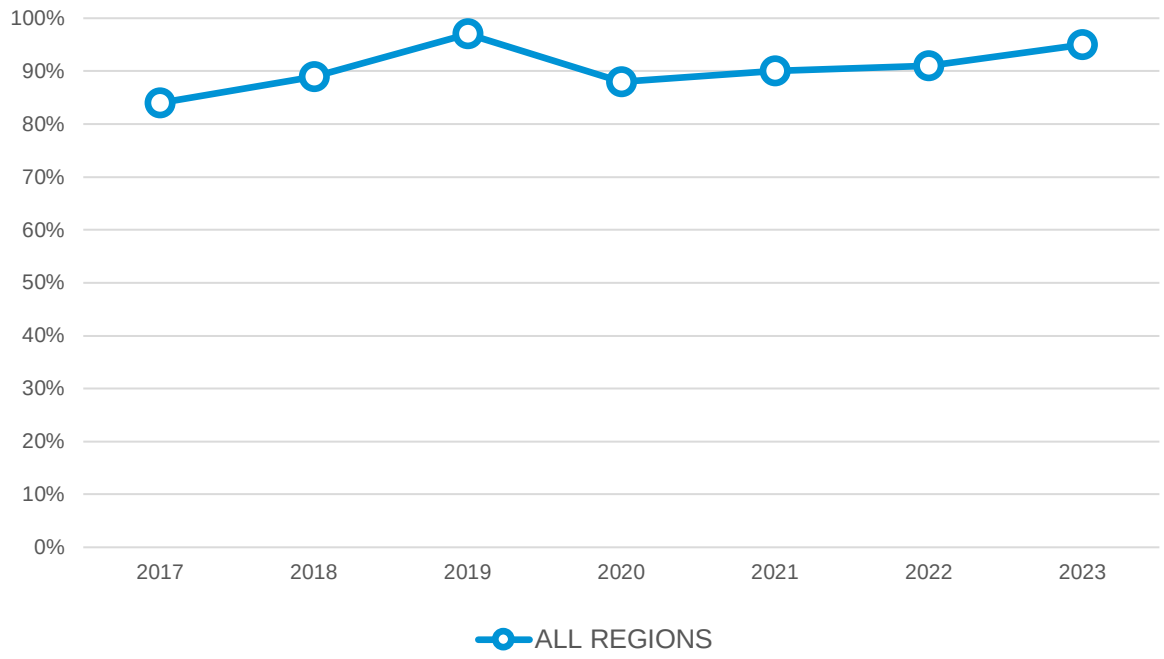
Likewise, some stakeholders commented that the technical reporting as it is currently done does not provide enhanced visibility of the impact of PIP funding. Some thematic areas are able to report on very tangible results, e.g. number of laboratories in which testing and diagnostic capacity has increased, and this achievement can be directly linked to a country's status of influenza pandemic preparedness. However, other thematic areas report, for example, on the number of people trained, but it is not very clear how this contributes to strengthening countries' influenza pandemic preparedness. As this potentially points to false comparisons between milestones and indicators, a measure to mitigate this challenge could be to promote a better understanding of the role of milestones and indicators in measuring progress towards the outcomes over time, as outlined in Recommendation 3.

A comprehensive overview of progress against the HLIP II output indicators can be found in Annex 9, but below the performance of each of the six Output areas is discussed. It should be noted, however, that some of the charts presented reflect cumulative numbers where as others reflect yearly counts. Charts showing cumulative figures offer an indication of how activity slowed during the COVID-19 pandemic.

Laboratory and Surveillance (L&S)

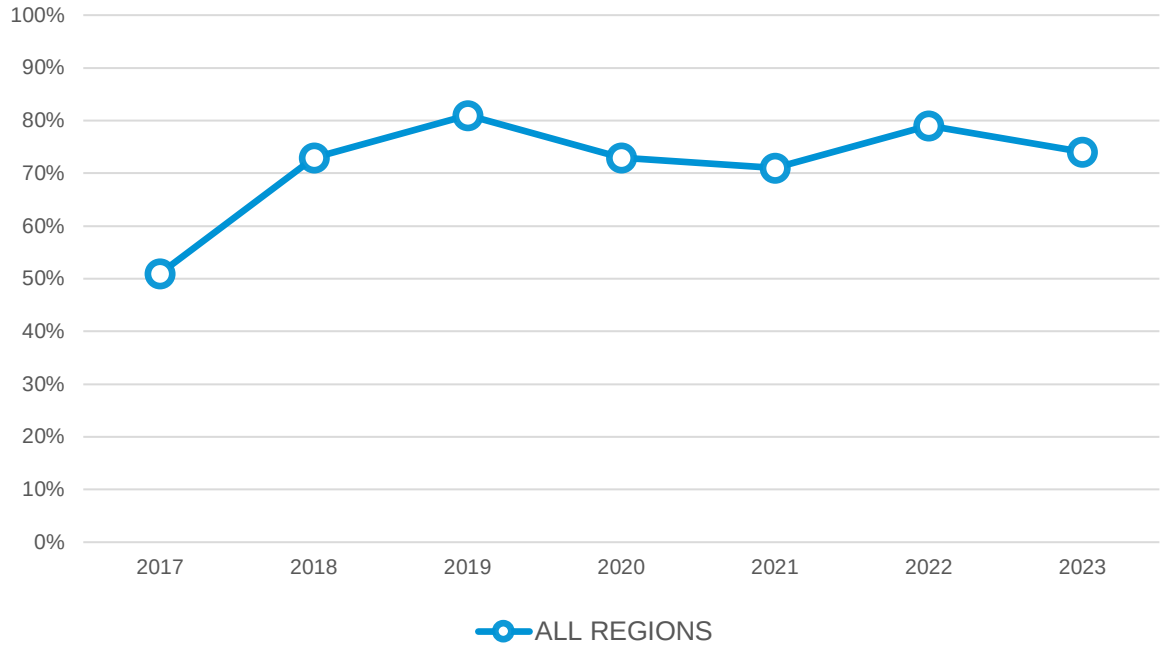
Performance in this area was strong, with targets having been met or exceeded in several of the key areas. Indeed, these targets were met as early as 2019, at the time of the Mid-term Review, before the impact of the COVID-19 pandemic started to be felt. Surveillance was consistently high as shown by reporting to FluNet and FluID. In 2023, 95% of recipient countries reported to FluNet and nearly 75% to FluID (see Figure 13 and Figure 14). The figures were even higher in 2019 but there was a dip in 2020 and 2021 during the COVID-19 pandemic, followed by recovery in the latest year (2023).

Figure 13: HLIP II Results Reporting – Percentage of PC Recipient Countries Reporting to FluNet



Source: 2023 Indicator Report: HLIP II Implementation shared by PIP Framework Secretariat

Figure 14: HLIP II Results Reporting – Percentage of PC Recipient Countries Reporting to FluID



Source: 2023 Indicator Report: HLIP II Implementation shared by PIP Framework Secretariat

Strong progress has been made across the regions regarding reporting to FluNet and FluID. In terms of reporting to FluNet, all regions achieved or came close to achieving the target. As for reporting to FluID, there was significantly more variation in performance across the regions. Overall, this represents a positive development, particularly in light of the impact of the COVID-19 pandemic on reporting.

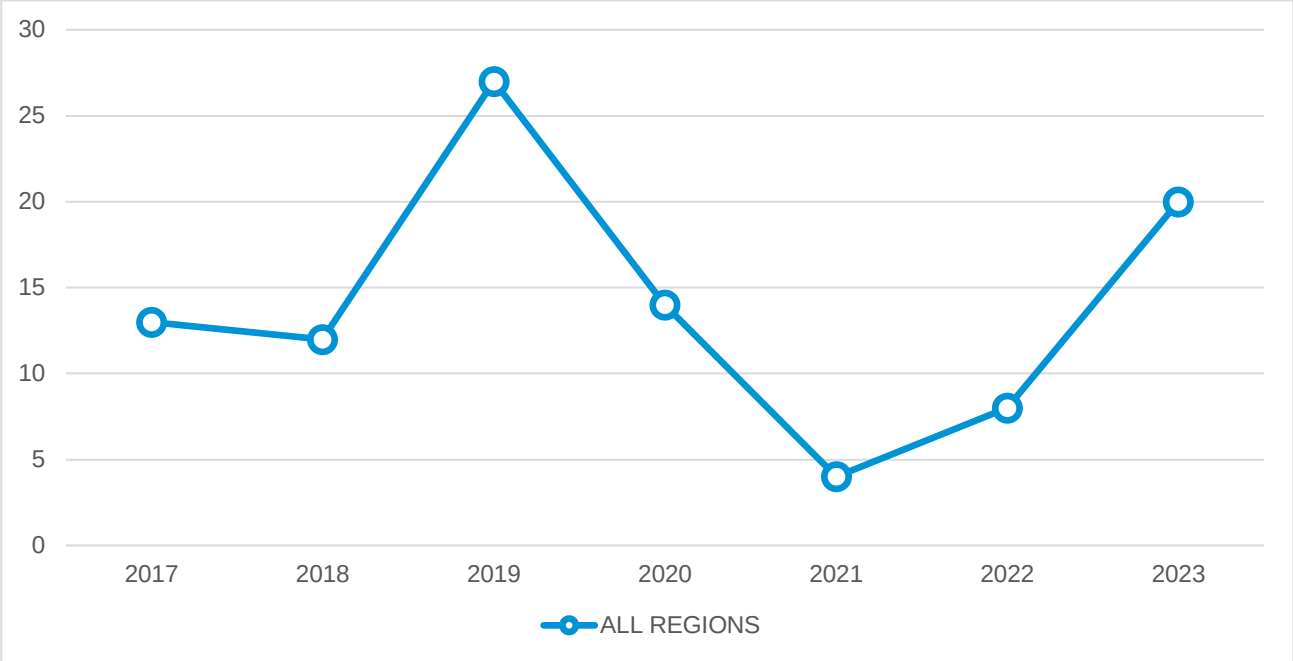
Country participation in WHO's External Quality Assessment Project (EQAP), which was established in 2007 to monitor the quality of GISRS and other national influenza reference laboratories that perform polymerase chain reaction (PCR) diagnosis and to identify gaps of PCR testing in these

laboratories, has also resulted in countries achieving strong results in virus detection capacity. More than 90% of WHO Member States were meeting EQAP standards for most of the period of implementation of HLIP II, i.e. 2018 - 2023.

Further, the number of National Influenza Centres (NIC) has improved over time, and most countries now have a WHO recognized NIC, and this is attributable at least in part due to technical and financial support provided under HLIP II.

Two indicators for L&S were significantly off track: reporting of influenza severity indicators and the number of timely virus shipments. Reporting of Pandemic Influenza Severity Assessment (PISA) severity indicators in 2023 shows only 31% of the 2023 target was achieved, having peaked at 27 WHO Member States in 2019 as shown in Figure 15.

Figure 15: Number of Member States Reporting at least one Influenza Severity Indicator to WHO's PISA Platform



Source: 2023 Indicator Report: HLIP II Implementation shared by PIP Framework Secretariat

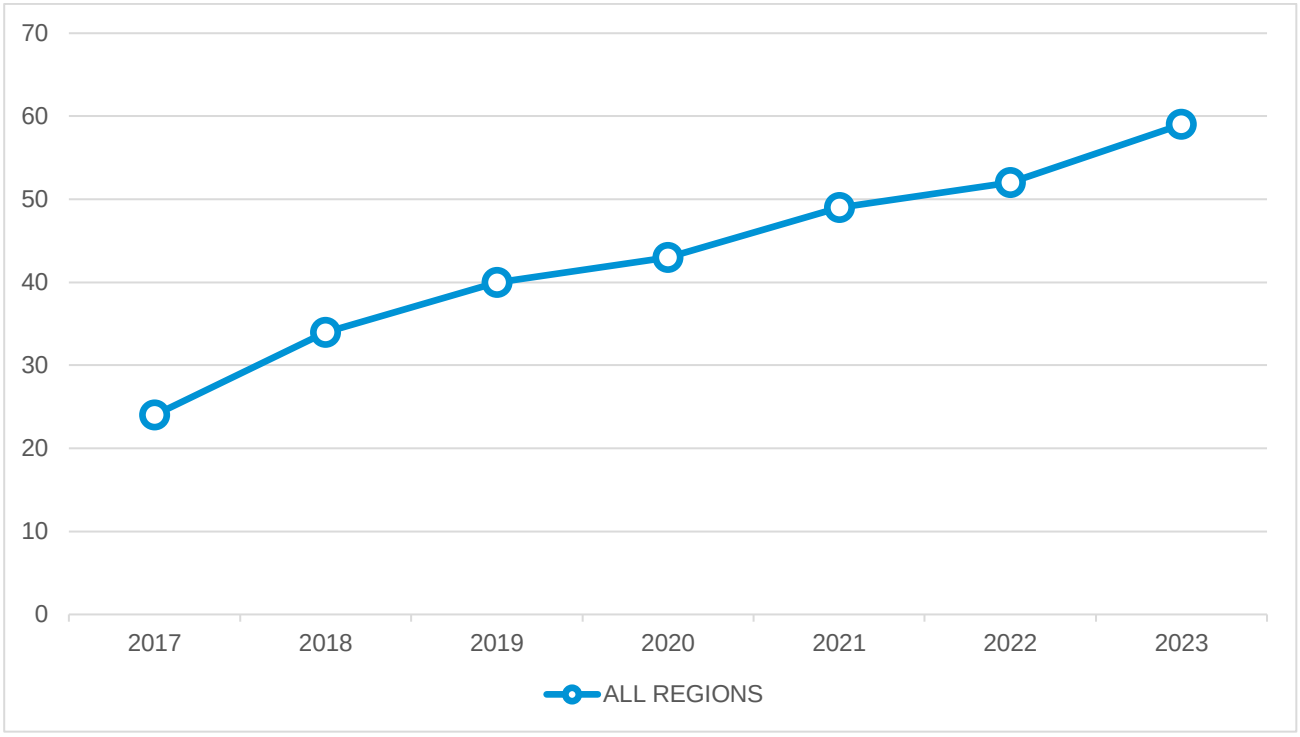
By 2023, 20 Member States had reported at least one PISA indicator to WHO, representing an increase from 8 in 2022. The reporting of PISA indicators to WHO in 2020 and 2021 was affected by the impact the COVID-19 pandemic had on routine influenza surveillance systems, and the sharp decline in influenza activity. As systems have recovered and adapted and PISA methods have been updated, indicator reporting has increased since 2021.

The number of WHO Member States that have sent at least two timely shipments is currently 79, below the target of 50%, and the best performance of 86 was just before the COVID-19 pandemic. For the indicator on timely shipments, disruptions to supply chain systems, severe operational difficulties, and transport disruptions affected the secure transport of shipments.

Burden of Disease (BOD)

Burden of disease studies have been conducted and used to provide a clearer picture of the influenza burden across countries. National authorities use burden estimates to prioritize the allocation of resources, and plan prevention and control measures such as vaccination and clinical management strategies. Performance has steadily improved in this area and both targets were met or exceeded. As highlighted in Figure 16, by 2023, 59 WHO Member States included in this indicator had published burden of disease estimates - more than double the baseline level from 5 years earlier. By 2023, 17 WHO Member States had developed or updated influenza policies, compared with a target of 10 by the end of the period.

Figure 16: Number of Member States with Published Disease Burden Estimates



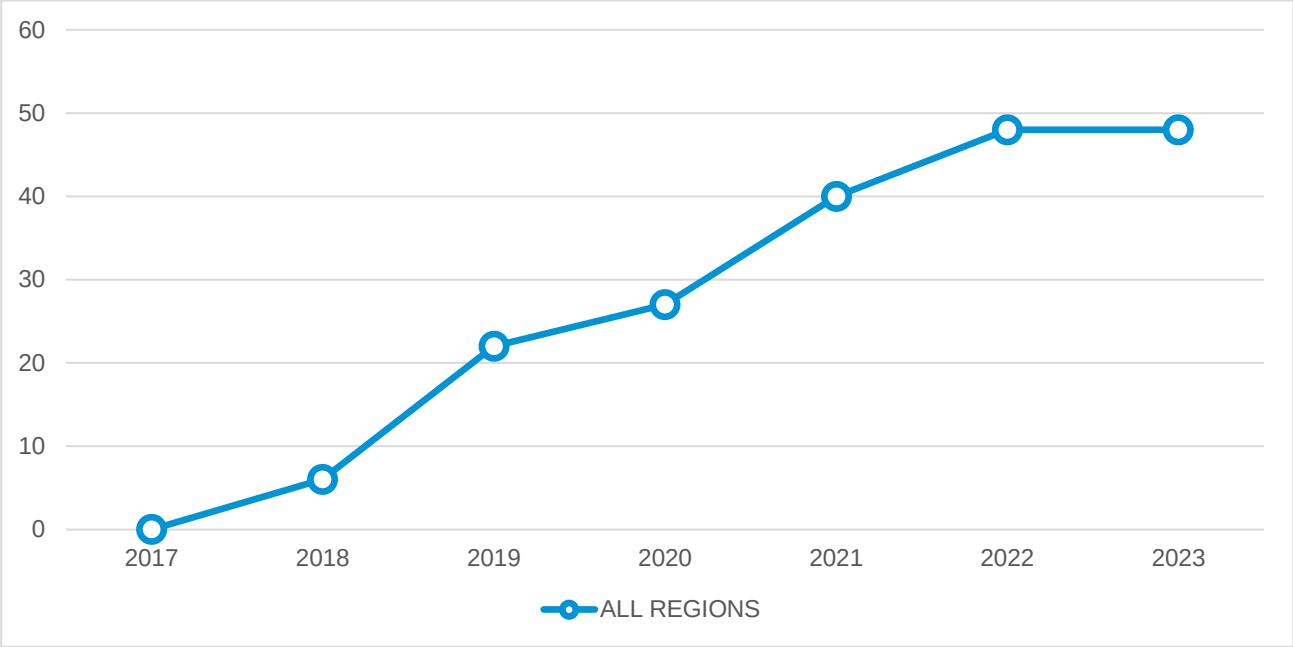
Source: 2023 Indicator Report: HLIP II Implementation shared by PIP Framework Secretariat

Following a finding within the Mid-term review of HLIP II that it is difficult to capture data on use of BOD estimates to inform policy, the indicator was amended in 2022 to track the number of countries that have developed or updated an influenza vaccination policy. Progress reports reveal that since 2018, 11 countries reported sharing their BOD estimates with national decision-making bodies: four of those resulting in policy updates (one country introduced seasonal influenza vaccination policy for risk groups, two updated their list of influenza risk groups, and one utilized the data to plan healthcare capacity during seasonal epidemics and to inform influenza pandemic preparedness planning). Over time, this informs and influences policy not only for vaccination but for pandemic planning overall. It should be noted though, that in at least one country within the WHO Western Pacific Region, the interviewee expressed that no BOD measurements had yet been done and they would be requesting assistance from HQ to initiate this work.

Regulatory Capacity Building (REG)

There was also significant progress in this area, as shown in Figure 17 by the fact that by 2023, 48 countries had implemented a defined regulatory approach to enable timely approval for use of pandemic vaccines, including influenza products. This met the target of 100%. In the baseline year of 2017, no countries had such an approach so this represents a major achievement. There was also progress in eight countries on strengthening regulatory capacity to oversee pandemic vaccines, including influenza products, although this did not meet the target (50% achieved).

Figure 17: Number of Member States with a Defined Regulatory Approach Enabling Timely Approval for use of Pandemic influenza Products



Source: 2023 Indicator Report: HLIP II Implementation shared by PIP Framework Secretariat

A useful comparison on the timely approval of pandemic products is the experience of COVID-19 against the H1N1 pandemic in 2009. A WHO assessment of this showed that investments in regulatory readiness for an influenza pandemic in the years between 2009 - 2019 undeniably improved the regulatory process and contributed to an improved performance of national regulatory authorities during the COVID-19 pandemic.(14) Indeed, during the influenza H1N1 pandemic in 2009, 96 countries were eligible to receive vaccines through the WHO deployment initiative, but only 75 received them. The remaining 21 (22%) did not approve or accept pandemic products because of liability and legal issues, poor regulatory readiness or limited operational capacity to deploy. Whereas, during the COVID-19 pandemic, by 30 June 2021, 47 out of the 48 PIP PC countries had authorised one or more COVID-19 vaccines, with one country not seeking COVID-19 vaccines for non-technical reasons. From the 45 countries with data, 87% provided timely marketing authorisation within 15 days of emergency use listing by WHO, highlighting a marked improvement.(14) The lessons learned from the COVID-19 pandemic have also helped to improve regulatory capacities, with continued support from PIP PC funds key to this ongoing preparedness work.

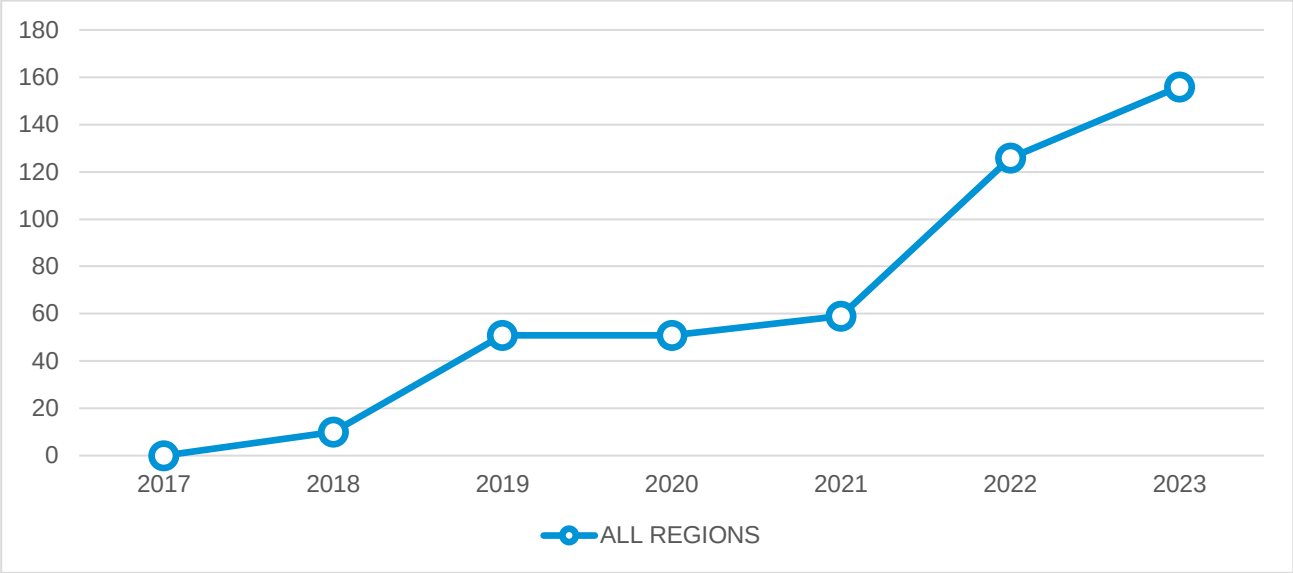
Risk Communications and Community Engagement (RCCE)

This area is somewhat harder to track and the conclusions from the indicator results is mixed. There was a very ambitious target that by 2023, 250 000 users from target audiences would have completed learning modules on influenza and related RCCE content. The indicator reached a peak of nearly 31 000 in 2020 before the pandemic and is now down to just over 8 000 users, or 3% of the target. However, it is important to note that this indicator was adjusted after a surge of users on the OpenWHO platform during the COVID-19 pandemic - both for influenza and COVID-19 courses. The HLIP II Mid-Term Review recommended increasing the 2023 biennial target for indicator 4.1 to 250 000 users having completed influenza courses on OpenWHO. However, upon retrospective analysis of the data received, it was found that previous years' results included not only users that had completed the influenza courses but also those that had enrolled but not fully completed the courses resulting in a higher than achievable target. Taking this into account, together with the natural attrition of users enrolling and completing influenza courses as the pandemic progressed, this resulted in only 3% of the indicator target being met. However, other indicators do show achievements in strengthening risk communications and community engagement, which was also a vital part of the COVID-19 response. As shown in Figure 18, by 2023, 156 WHO Member States

were using RCCE support (compared with zero at baseline in 2017). This represents 98% of the target, set at 160. Furthermore, the WHO Early Artificial Intelligence Response and Social Listening System (EARS) was established during COVID-19 using other funding sources to show real time information about how people were talking about COVID-19 online. This system was established and utilized on behalf of 32 countries for COVID-19, and using PIP PC funds, was adapted for influenza through the development of a respiratory pathogen taxonomy for social listening.

PIP has also been able to support RCCE which according to interviewees tends not to receive funding as readily. Interviewees expressed the view that RCCE is an area with potential for strengthening as highlighted during the COVID-19 pandemic.

Figure 18: Number of Member States that Utilised RCCE Support for Influenza Preparedness or Response

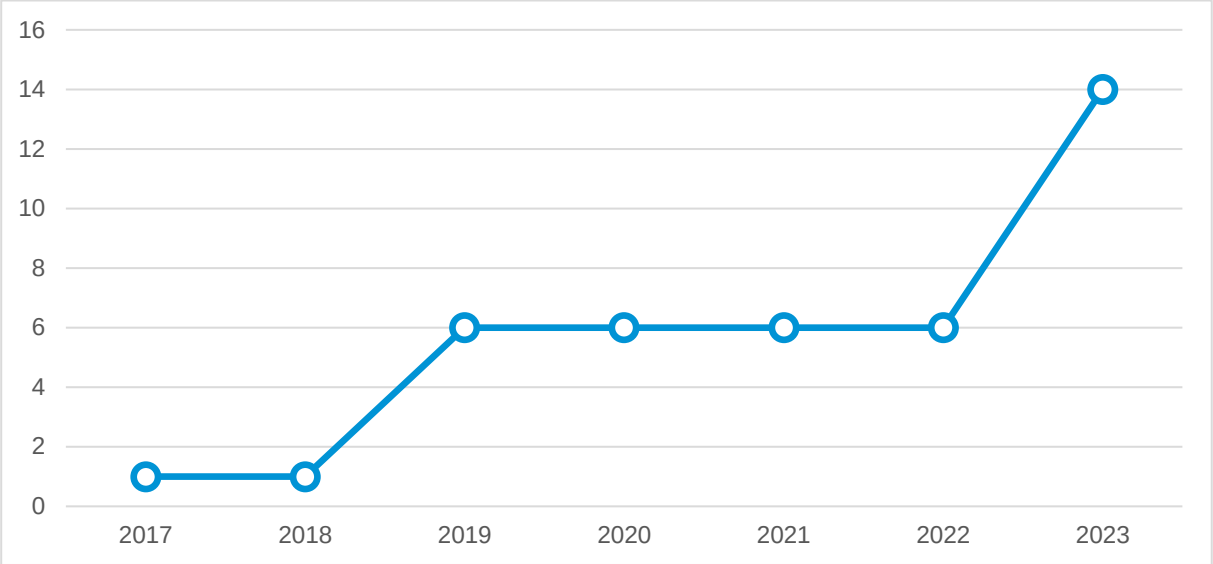


Source: 2023 Indicator Report: HLIP II Implementation shared by PIP Framework Secretariat

Planning for Deployment (DEP)

This was an area which saw progress during the implementation period of HLIP II. Regarding the number of simulation exercises conducted to test global deployment of pandemic influenza vaccines and other products, this indicator saw an uplift to 14 in 2023, exceeding the set target of 10 (see Figure 19). Further progress was seen in the number of Member States that developed or updated a pandemic influenza national deployment and vaccination plan rising to 8 in 2023, from 0 in 2022. The number of Member States that have undergone a national analysis of influenza vaccine procurement or production sustainability has remained stable over the last few years, with 9 Member States since 2020. While this represents progress towards 75% of the 2023 and biennial target, the evaluation team note that the target remains at 12 countries because not all vaccine manufacturers which received seed funding, licenses and technical assistance were successful in establishing seasonal influenza vaccination production capacity.

Figure 19: Number of Simulation Exercises Conducted to Test Global Deployment of Pandemic Influenza Vaccines and Other Products

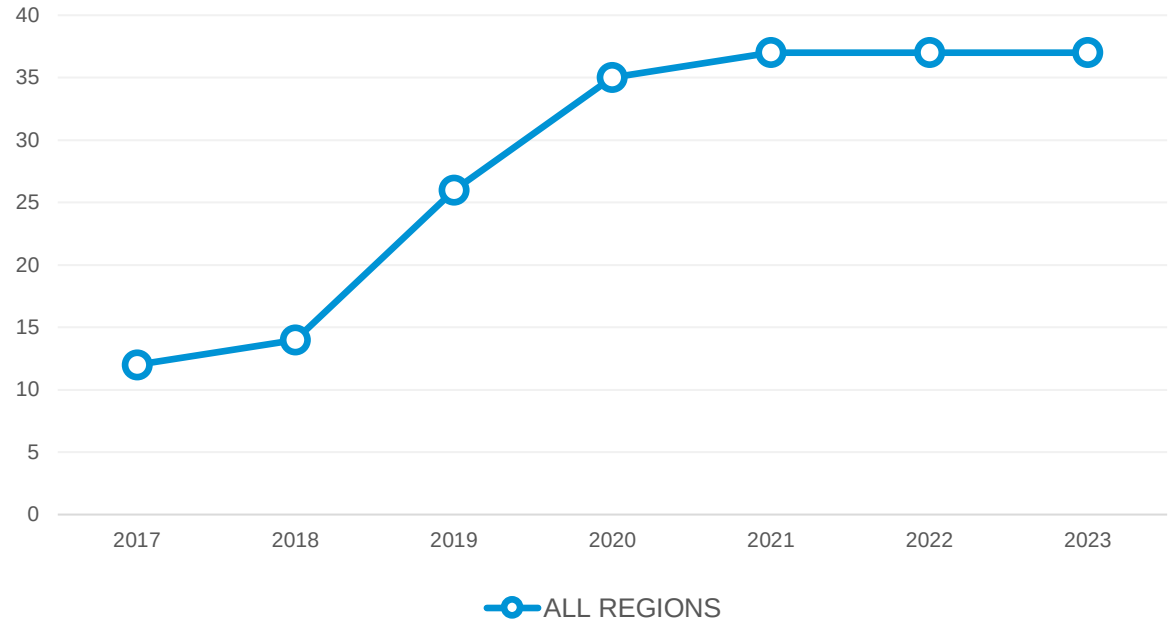


Source: 2023 Indicator Report: HLIP II Implementation shared by PIP Framework Secretariat

Influenza Pandemic Preparedness Planning (IPPP)

This was a key area of progress; it allowed countries to adapt pandemic preparedness plans quickly for use during the COVID-19 pandemic, as noted in the interviews. By 2023, 37 countries had developed or updated an influenza pandemic preparedness plan, i.e. 82% of the biennial target. The overall proportion of PC recipient countries which have developed or updated their influenza pandemic preparedness plan has fallen slightly since 2019. However, it is important to note that this is a reflection of the number of countries supported by the PIP PC increasing over the implementation period. In 2020, the proportion dropped because the denominator increased from 40 to 63 PC countries. In actuality, the number of countries which have created or updated these plans represents a modest uplift from 26 in 2019, to 37 as of 2023, as shown in Figure 20. Stakeholders commented on the development of influenza pandemic preparedness plans as useful in promoting pandemic readiness and that they were adapted in the COVID-19 response, as mentioned above. With the 2023 target of 45 countries in mind, continuing to grow the number of countries with an influenza pandemic preparedness plan is an important step directly for this output.

Figure 20: HLIP II Results Reporting – Number of PC Recipient Countries that Developed or Updated an IPPP since 2014



Source: 2023 Indicator Report: HLIP II Implementation shared by PIP Framework Secretariat

COVID-19 response

The COVID-19 pandemic was a major 'stress testing' of pandemic preparedness for a respiratory pathogen (albeit not of influenza). This highlighted the benefits and importance of the work that has been achieved with PIP funds but also certain challenges.

- During the COVID-19 pandemic, implementation of influenza pandemic preparedness activities was affected, with capacities reduced and human resources redirected to focus on the COVID-19 response.
- Existing influenza surveillance systems facilitated COVID-19 tracking and surveillance due to the human resources and laboratories already in place.
- Influenza Pandemic Preparedness Plans were used as a basis for the COVID-19 response plan, according to feedback from the national level in several of the PIP PC countries. This is likely to have enabled faster response and mobilisation at the beginning of the COVID-19 pandemic.
- On the regulatory side, 47/48 PC beneficiary countries were able to authorize a COVID-19 vaccine within the set timeline. In non-PIP PC countries this timeline was longer due to different reasons, such as the countries' lack of regulatory preparedness and readiness to authorize the vaccine in a timely manner.
- In many countries influenza surveillance waned during the COVID-19 pandemic, as resources normally available for influenza surveillance were re-purposed or more focused on responding to the COVID-19 pandemic. Further, there was less, or in some countries, no influenza virus circulating at the time.
- Both internal and external stakeholders recognised the importance of the infrastructure and networks strengthened through the provision of the PIP PC and the ability to respond quickly to a respiratory pathogen pandemic, including the adaptation of data sharing platforms and increase in PCR testing.
- HLIP II implementation had to adapt during the response to the COVID-19 pandemic. During this period, guidance was shared with countries on using PC funds in a complementary way, benefitting both influenza pandemic preparedness and COVID-19 response. These

complementary activities spanned the six output areas and offered support on the adjustment of workplans and how funds could be used.

4.4 Efficiency

To what extent is there evidence of value for money for each Output area within HLIP II?

Through the interviews, the overall picture is of a funding platform that works more efficiently than other health programmes, due to well organised planning that minimises bottlenecks and facilitates the timely allocation of funds. The objectives, priorities, and activities of the HLIP II are viewed as clear and straightforward and are well understood at country level. Countries are clear on which activities are to be financed using PIP PC funds and are able to build their workplans accordingly.

The PIP Framework Secretariat uses these country workplans for the initial allocation of funding and works to ensure funds are released in a timely manner. The PIP Framework Secretariat undertakes periodic compliance checks to review implementation, follow up on areas of low implementation, and ensure activities align with the objectives of HLIP II and fall within the mandate of the Pandemic Influenza Preparedness Framework.

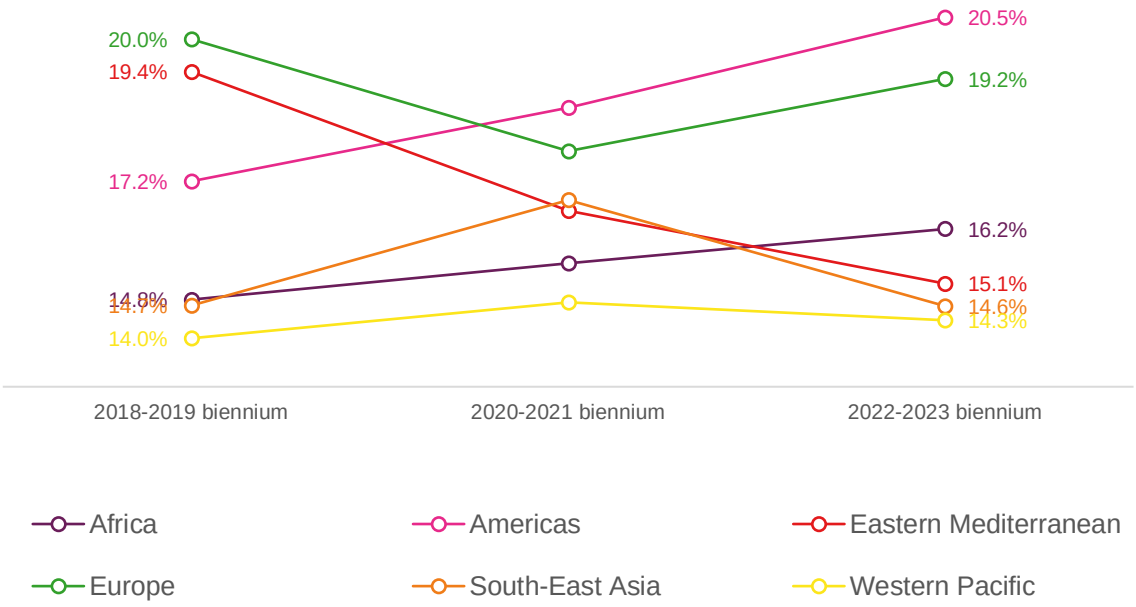
During the process of allocating funds between countries, the PIP Framework Secretariat aims to support as many WHO Member States as possible with the limited resources at their disposal, and to ensure from a global public health perspective that there are no gaps in technical capacities at all levels and that influenza surveillance data is available from as wide a geographic area as possible. During the biennial country prioritization process, the PIP Framework Secretariat, together with the WHO Regional Offices, evaluates the countries to be supported based on the capacity they have to implement the activities, the potential they have to make gains from the investments, the absorption capacity they have for the funding, whether they have received support previously and whether those countries that have not received funding to date could benefit from investment. Table 3 and Figure 21 below highlight changes in and proportionality of funding allocation across the WHO regions over the previous three biennium periods.

Table 3: Changes in Funding Allocation across Regions over the Previous Three Biennium Periods

	Allocation in USD		
WHO Regional Office	**2018 - 2019 biennium**	**2020 - 2021 biennium**	**2022 - 2023 biennium**
Africa	3,112,000 (15%)	3,285,714 (16%)	3,281,738 (16%)
Americas	3,617,672 (17%)	3,954,680 (19%)	4,151,010 (20%)
Eastern Mediterranean	4,085,585 (19%)	3,510,000 (17%)	3,057,430 (15%)
Europe	4,224,950 (20%)	3,767,700 (18%)	3,898,100 (19%)
South-East Asia	3,087,760 (15%)	3,557,150 (17%)	2,965,225 (15%)
Western Pacific	2,946,783 (14%)	3,117,700 (15%)	2,906,600 (14%)
Total	**21,074,750 (100%)**	**21,192,945 (100%)**	**20,260,103 (100%)**

Source: PIP Framework Secretariat

Figure 21: Proportionality of Funding Allocation over the Previous Three Biennium Periods



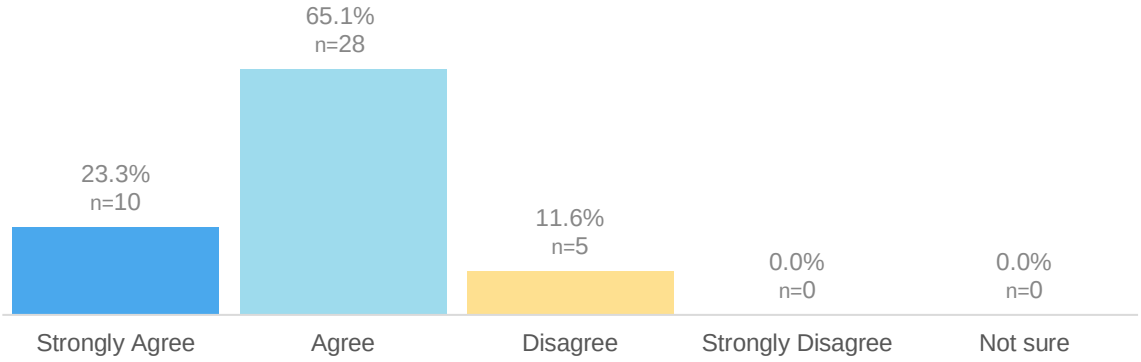
Source: PIP Framework Secretariat

According to the survey data shown in Figure 22 below, the vast majority of survey respondents (88%) agreed or strongly agreed with the statement that resources were allocated adequately across each of the output areas within HLIP II, with a minority (12%) in disagreement. The common trends emerging from the survey data indicated that both Member States and WHO staff at Regional and Country level felt that technical and financial resources were made available on time and planning was appropriate, particularly in relation to L&S areas.

From the minority of respondents who disagreed with the statement that resources had been allocated adequately across each of the output areas, the feedback at country level specifically related to the challenges of retaining human resources, and the inability to provide appropriate compensation, or incentives, to health workers to maximise the collection of influenza samples. At the HQ level, those who disagreed with the statement commented that the current resource allocation seemed to be biased towards the L&S output area leaving areas such as RCCE under-funded.

Figure 22: Survey Data on HLIP II Resource Allocation

Resources were allocated adequately across each of the output areas within HLIP II.



One point made by many interviewees, including country representatives, was that funding was not sufficient to cover their needs. While PIP PC funds typically act as catalytic funding that helps to

leverage broader improvements in respiratory disease surveillance, they do not fully finance pandemic influenza preparedness, and the complementary funding needed is not always secured. This highlights the need for improved alignment with other donors at country level to ensure complementarity between funding streams. Some countries reported that the fact that as PIP PC funding was a small portion of the overall funding received for pandemic influenza preparedness it was sometimes difficult to see the direct impact of the contribution.

The decision-making on the prioritisation of countries for funding also came up repeatedly during the interviews. Balancing the different aspects of need and relative priorities in resource allocation decisions e.g. choosing between putting funds towards countries in crisis versus funding countries with stronger systems where efficient use of resources and impact may be more likely, appears to be an ongoing challenge that was raised by interviewees at both HQ and regional levels. There was one suggestion made that instead of ensuring that as many countries as possible are supported, it may be better value for money to select fewer countries and provide these countries with increased levels of support. (See Recommendation 6.)

Likewise, the decision-making on the prioritisation of thematic areas for funding was also questioned by several interviewees. The continued focus on prioritising allocation of funds for the area of L&S, (between 64% and 65% of the total funding over the last three biennia), was questioned by several stakeholders. It was felt that while all six outputs are relevant to achieving the goals of the PIP Framework, the distribution of funds between the six output areas is disproportional to their objectives and to their costs of operation and would benefit from being reviewed – bearing in mind that L&S has seen an exponential increase in operating costs in recent years without a concomitant increase in funding. (See Recommendation 6.)

For example, slow and hesitant vaccine uptake was highlighted during the COVID-19 pandemic as a key area to address during a pandemic response to achieve maximum protection of a country's population. But investment in BOD and RCCE, the thematic areas that would address this issue, are much lower than for L&S (between 4-6% and between 7-8% of the total funding over the last three biennia respectively). Some interviewees felt that increased investment in burden of disease and vaccine impact studies and RCCE activities that would generate the evidence needed and build capacity to tailor messages to the different target audiences to advocate for vaccine uptake is of highest priority.

While interviewees did not disagree on the thematic areas to be financed, it was felt that more discussion with stakeholders on the strategy for allocating resources between each of the areas to achieve the best outcomes in the broader sense, i.e. pandemic preparedness and response, is needed, especially in light of changing needs at country level such as requirement for improved infodemic management, that have been highlighted during the COVID-19 pandemic .

Understanding the process for developing workplans with countries based on the envelope of available funds would appear to be a topic that warrants attention. Some country representatives expressed their opinion that financial planning and allocation appears to be based on a top-down approach rather than in response to programmatic needs expressed by the countries. The current process consists of extensive discussions with WHO Regional Offices, in the context of the budget envelope available, and made with the knowledge of the financial situation of each country. Countries are then able to decide how to make the best use of the funds they are allocated. Helping in-country government stakeholders to understand this process would help to allay current concerns regarding a top-down approach in this area.

A high level of turnover in Ministry of Health-funded human resources at country level was cited as a potential concern by some interviewees. The backbone of the L&S system is dependent on Ministry of Health staff at country level to identify respiratory disease in patients, collect and send samples for laboratory confirmation and to analyse the data. Several country offices raised concerns over high turnover in Ministry of Health-funded staff resulting in the need for continuous refresher training, to re-establish working relationships with new staff and a downturn in the number of samples collected on a weekly basis. Relatedly, one Regional Office mentioned an ongoing problem in recruiting human resources which negatively impacted on their ability to implement the funds

received effectively and secure engagement at country level. Similarly, many staff were repurposed during the COVID-19 pandemic, which resulted in low implementation in the area of pandemic influenza preparedness, but the situation is returning to normal.

A further issue that came up in several interviews was the provision of incentives. Countries indicated that they would like to be able to provide incentives to the health workers that collect the samples to overcome the bottleneck in obtaining sufficient samples for testing. However, the financial regulations of the PIP PC funds do not allow them to do this, and as a result some countries are losing sentinel sites without additional financial compensation for workers to collect and process samples. In discussion with other countries, support has been alternatively provided to cover overhead and assist surveillance sites with their operational costs including a data communication packages for the mobile phone or to cover transport costs. Such support has resulted in the health workers being able to collect and transport the samples more effectively.

4.5 Impact

What has been the overall impact of HLIP II on pandemic influenza preparedness and response and on global pandemic preparedness?

To what extent has HLIP II contributed to other changes, including "scalable" or "replicable" results?

To what extent has HLIP II contributed to high-level effects (such as change in norms or systems)?

In addition to the positive results achieved for the 6 outputs of HLIP II, as detailed in the earlier section 'Effectiveness', the evaluation found there to be additional broader impacts of HLIP II.

The overall strengthening of surveillance networks has been the most impactful contribution of the HLIP II in terms of pandemic preparedness, going well beyond the intended focus on influenza. Interviews with representatives from various countries specifically highlighted the improvement in surveillance systems. An unintended positive impact has been the capacity /opportunities for using strengthened laboratory and surveillance systems for detecting and monitoring other respiratory pathogens; it has paved the way for surveillance of other diseases to 'follow suit'. The most frequently cited example of this was COVID-19. As noted previously, the impact during the COVID-19 pandemic was almost certainly very significant in allowing rapid mobilisation in the early phase. Interviewees explained that basic laboratory sequencing and other parts of the laboratory and surveillance work were fundamental in allowing existing systems to be leveraged to provide such a rapid and robust response to COVID-19.

Out of 194 Member States, 130 have a NIC and this is attributable at least in part due to technical and financial support provided under HLIP II. Noteworthy as well was anecdotal insight from one country in the South-East Asia region regarding the expansion of NIC type facilities beyond just the capital city; four sub national influenza centres were set up on request across the country, to minimise the challenges for access to the main NIC due to the geography of the country.

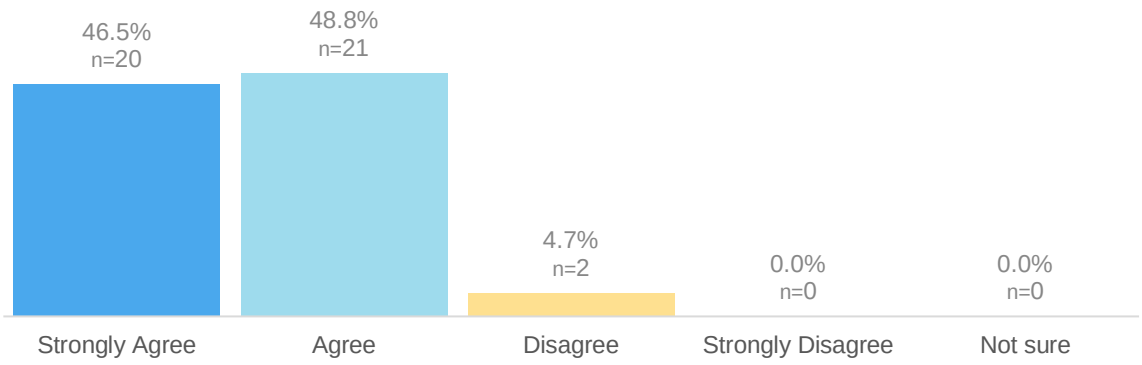
In one country in the African region, interviewees expressed how the expansion of 4 to 10 sentinel surveillance sites was crucial for building additional capacity in line with both the PIP framework and the International Health Regulations. There has also been a positive impact on capacity for data management, sharing information on samples and sequencing, genomic sequencing of influenza viruses as discussed previously under 'Effectiveness' and PIP has also been able to support areas such as Risk Communication and Community Engagement, that, according to interviewees tend not to receive funding as readily.

However, despite this overwhelmingly positive response to the leveraging of HLIP II activities in supporting the COVID-19 pandemic response, some stakeholders did not see it as necessarily representing a test of the established influenza systems. Countries repurposed their use of GISRS to share the COVID-19 samples that played a crucial role in pandemic response, and while influenza systems played an important role in response activities, the extent to which this can be attributed to

support with PIP PC funding remains unclear. This point is linked to Recommendation 5 which suggest highlighting the significant collateral benefits and achievements obtained during the COVID-19 pandemic. Relevant activities could include commissioning a study (or case studies) that document the relative success of countries in their COVID-19 responses comparing countries receiving PIP PC funds with others.

The evaluation found **mixed findings as to the extent to which HLIP II contributed to scalable or replicable results**. When asked about this in the survey though, almost all respondents (95%) indicated that they strongly agreed or agreed with the premise (see Figure 23). Common trends in the survey data suggested that respondents felt the scalability of influenza laboratories alongside the re-purposing of Influenza Pandemic Preparedness Plans as a model or guiding tool, helped to strengthen the response to the COVID-19 pandemic. A very small minority (5%) disagreed with the question, with a trend here indicating respondents felt a state of pandemic readiness had not yet been achieved and, as such, replicating the model may not be an effective use of resources.

Figure 23: Survey Data on HLIP II's Contribution to 'Scalable' or Replicable Results



The most obvious example of contribution to replicability and scalability is, as noted previously, in relation to other infectious diseases, and this was raised numerous times during the interviews. Additionally, there is evidence of replicability/scalability happening in practice as per countries response to COVID-19. Other interviewees expressed different, more negative views, for example that HLIP II has not so far contributed to any scalable results. This is linked to Recommendation 2 which suggests discussions regarding sustainability be renewed and thoughtful consideration given to what can realistically be done within the PIP framework.

The evaluation found other positive examples of scalability and replicability. It was revealed in interviews that a country in the South-East Asia region, through their influenza programme, helped neighbouring countries to set up their own systems for tracking influenza viruses which they consider an important aspect of their work. Also, in one Eastern Mediterranean Region country, WHO played a significant role in convincing the new government (after a regime change) to maintain and sustain the surveillance system, and they are trying now to replicate this lobbying to government in a conflict affected sub-Saharan African country.

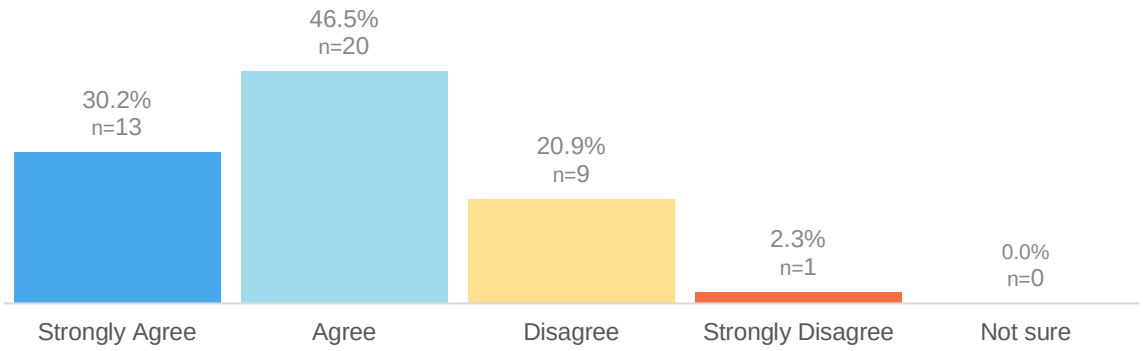
Overall, the evaluation found **that there has been some contribution to high level effects and changes in norms/systems** within the area of influenza and pandemic preparedness response.

HLIP II has elevated awareness of influenza as a public health concern and kickstarted action into addressing this, even for countries which face competing priorities and constrained budgets. A number of PIP PC countries, including a few in the European, South-East Asia and Western Pacific regions, have now integrated influenza activities into their national health and laboratory budgets and have at least basic systems in place to respond to influenza. As outlined in HLIP I, this process began before the outset of the COVID-19 pandemic, however the impact of COVID-19 on increasing

decision-makers' understanding around the need for investment into respiratory pathogens should not be understated.

When asked about HLIP II's contribution to high level effects in the survey, 77% of respondents either strongly agreed or agreed (see Figure 24).

Figure 24: Survey Data on HLIP II's Contribution to High-level Effects



The evaluation found that, at the highest level, HLIP II and the PIP Framework have shown to Member States that access and benefit sharing works and can be an effective and appropriate system. HLIP II has also contributed to helping countries develop guidelines to meet international standards and contributed to human resource strengthening, capacity building and infrastructure as discussed previously.

4.6 Sustainability

To what extent has HLIP II built sustainable capacity to improve pandemic influenza preparedness?

To what extent has HLIP II supported the development and implementation of national policies and institutions to ensure sustainable results?

When evaluating sustainability, the overall picture is somewhat mixed. An overarching key finding is that there is no clear definition of what "sustainability" means in the context of influenza pandemic preparedness, nor what countries are expected to do to achieve sustainability. Discussions and efforts on sustainability began before the COVID-19 pandemic but were paused as a result of the pandemic, and a first step would be to re-initiate these (see Recommendation 1). When countries were originally selected for support with PIP funds, this was done on the understanding that national level influenza pandemic preparedness is a shared responsibility and that countries would be able to contribute in-kind support (primarily staffing) or complementary funding to the funds received from the PIP Framework Secretariat, e.g. staff salaries, premises, etc., to build capacity and eventually sustain the gains made with PIP PC funds.

From the implementation side, there is no clear framework for deciding which countries are ready to transition out of PIP funding, nor what strategies are best for adjusting the funding accordingly. One concern expressed is that with reduction in funding countries may drop the influenza pandemic preparedness activities, which will jeopardise the gains made to date and compromise countries' preparedness for the next influenza pandemic. (See Recommendation 1)

Durable Capacities

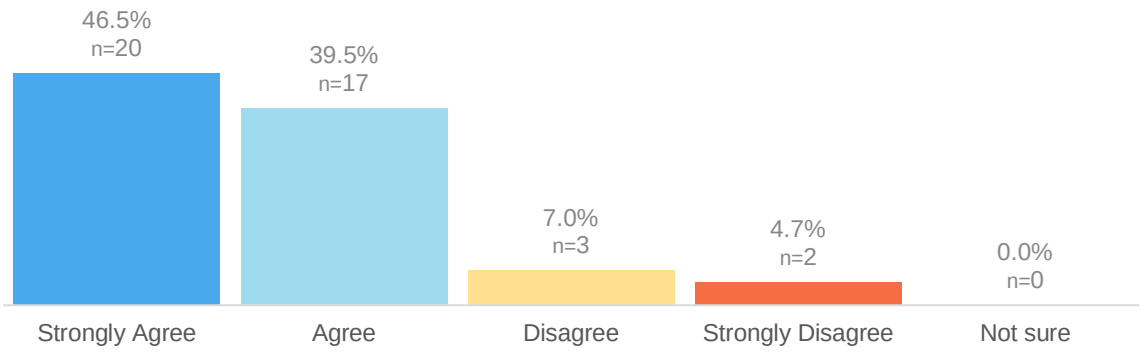
Capacities related to influenza detection, sample collection and laboratory analysis have been strengthened, as highlighted by survey participants and shown in Figure 25 below. However, turnover of trained staff remains an ongoing problem in many countries that requires ongoing

investment in capacity building through training and other technical support to sustain global surveillance capacity at current levels.

The survey data shows that while the majority of respondents (86%) felt sustainable capacity had been built, reflecting on the improvement of surveillance capacities through the development of laboratory networks, sentinel surveillance sites and rapid response team capacities, a minority (14%) did not agree with the statement. Commonalities in the responses gathered indicate a need for continued advocacy for funding and training for core personnel. Respondents also indicated that preparedness efforts sometimes need more support at the local level to be effective.

Understanding sustainability as the removal of dependence from centralized WHO funding, other respondents felt more advocacy is needed to hold Ministries accountable for continuity and sustainability.

Figure 25: Survey Data on Sustainable Capacity Built Through HLIP II



Furthermore, in many countries, the degree of planning for transition beyond PIP PC support is not yet well developed and competing priorities both within the health sector and beyond meant that pandemic influenza preparedness is often not a top national priority. KIIs revealed that i was clear for many countries that in the absence of PIP PC funding it will be extremely difficult to finance the maintenance of sustainable influenza pandemic surveillance systems but progress in this area needs to be made, however small in the initial stages. One option suggested was to see at country level what components of pandemic influenza preparedness could be funded with government funds, e.g. procurement of laboratory supplies, and to work with the Ministries of Health in securing long-term funding for these components. (See Recommendation 1)

It is important to acknowledge that countries are operating at different levels of capacity, even within the same region. Even for those countries that have received 10 years of support, for whom it could be reasonable to assume they have built enough capacity to fund continuing maintenance of the system itself, sustainability is challenged by the changing nature of the capacities needed. For example, although capacity for PCR testing has been built in most countries, countries now need to build capacity for genomic sequencing and efforts to build those capacities will have to be continued.

National Influenza Policies, Strategies and Systems

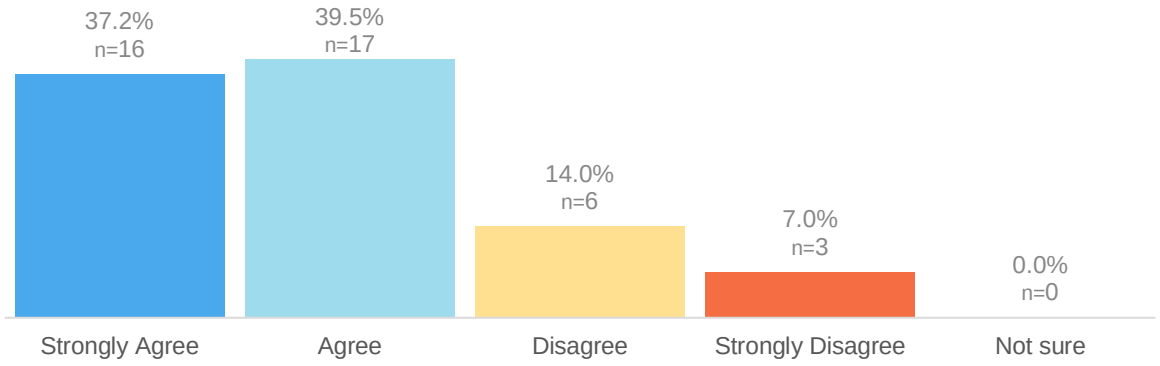
In most regions, progress towards developing national policies and institutions to ensure sustainable results is slow and not necessarily reflected in legal documents yet, but there is ongoing support being provided for the development of policies and frameworks. Some regions acknowledged that work on updating public health legislation is important and this is certainly a focus for several of the countries in the Americas region.

The survey results also show there is a mixed picture regarding sustainability. Figure 26 below shows that 77% of survey respondents agreed/strongly agreed that HLIP II had supported the development and implementation of national policies and institutions to ensure sustainable results. However, a minority (23%) disagreed/strongly disagreed that this was the case. Among respondents who disagreed, capacity to operationalise policy was a common challenge, with weak health systems

affecting effective implementation - especially during a pandemic. Other respondents had limited data on this area, limiting their ability to respond positively and noting that the implementation of national policies was impacted by the COVID-19 pandemic, which invariably affected the extent to which HLIP II could help support national policies to ensure sustainable results.

Figure 26: Survey Data on HLIP II Support to the Development and Implementation of National Policies and Institutions

HLIP II has supported the development and implementation of national policies and institutions to ensure sustainable results.



Financial Sustainability for Influenza

The evaluation heard directly from several countries across a number of regions, who reported high degrees of financial sustainability and ownership as evidenced by national investments in surveillance capacity, surveillance and laboratory personnel, equipment, reagents and facilities. More specifically:

- Countries are already putting in their own funds for their influenza surveillance networks, although the proportion coming from country level compared with external PIP PC funding has been hard to establish.
- Many national governments pay the salaries of the staff working in the laboratories, hospitals and health centres from where the samples are taken.
- Some countries report having achieved and sustained outstanding advances in their influenza surveillance systems, achievements that came to the fore during the COVID-19 pandemic. These could be shared with other countries as examples of best practices.

While some countries, especially the middle-income countries, are on a path to systems that can be financially self-sustaining in the medium term, few have graduated from needing external financial support. In most other countries, and in small and conflict affected states, financial sustainability is not yet a realistic expectation and some PIP PC countries, especially countries in conflict, will continue to need long-term support.

Efforts to obtain information on the different funding sources other than PIP PC funds and respective levels of funding for influenza pandemic preparedness received at country level were unsuccessful. As the focus moves towards sustainability – this information will be useful in understanding the order of magnitude of activities covered by PIP PC funding as countries look to become self-sufficient over time.

5. Conclusions

The evaluation set out to:

- Document key achievements, good practices, challenges, gaps, and areas for improvement in the design and implementation of HLIP II as well as progress against the 10-year objectives for pandemic influenza preparedness established in 2013
- Review effectiveness of resources in meeting the Outcome of HLIP II: influenza surveillance systems, knowledge, and capacities for a timely and appropriate response to pandemic influenza are established and strengthened
- Generate a series of findings, conclusions, lessons learned and recommendations that can inform future activities

Overall, the findings show that the PIP PC funding mechanism is functioning effectively, with the HLIP II having underpinned progress on pandemic influenza preparedness during a challenging global context. The HLIP II was found to have been relevant, in both its design and in relation to the priorities of WHO and other stakeholders and exhibited a strong sense of coherence with other frameworks, the SDGs and ongoing donor activities supporting influenza pandemic preparedness. Significant progress has been achieved across the six key output areas, with PIP PC funding also upholding broader public health objectives and, notably, providing key support to COVID-19 response activities. The funds provided through the PIP PC are distributed more efficiently than those provided by other health programmes, and the process is straightforward and reliable. However, the amounts were not always sufficient to cover needs and there is a need for enhanced clarity on the rationale for the prioritisation of thematic areas for funding, as well as the countries to be funded. HLIP II contributed to replicable impacts, particularly in relation to other respiratory pathogens, and had more high-level effects, including raising broader awareness of influenza as a public health concern.

Sustainability

Looking forward, the picture on sustainability is complicated. Placing a renewed emphasis on sustainability through continuing the discussions and efforts that were curtailed due to the COVID-19 pandemic is of importance, as while some countries are on a path to be financially self-sustaining in the medium term, few have graduated from needing external financial support. Challenges exist around competing priorities and the need for a roadmap for transition planning, which are crucial areas to be considered.

Integration

Importantly, the PIP PC funding mechanism has also had broader positive effects that were not necessarily foreseen but have in fact been globally important. As noted in this report, the main benefit has been in helping with global response to the COVID-19 pandemic, since tools, capacity and systems that had been built for influenza could quickly be adapted to help with speedy response on COVID. In addition, the demonstration effect is important, of showing that a global, collaborative benefit sharing mechanism can build systems and networks that enable pandemic response and make a major contribution to global public health.

Reporting

In order to strengthen stakeholder understanding of the M&E Framework, links between financial implementation and technical progress could be further emphasised through detail already included in existing PIP PC reporting mechanisms. This would be useful in promoting an understanding of the role of the milestones and indicators in measuring progress towards outcomes over time.

Operations

To ensure the ongoing development of staff capacities, continued training programmes are of great importance. As noted in the report, staff turnover, particularly with national Ministries of Health, can mean continual refresher training is needed so staff are suitably trained. In order to mitigate this repeated cost and ensure equitable access to tools and resources, in-country training on pandemic preparedness is a potential area which could be digitised. Conducting a training needs assessment would be a useful method to identify potential gaps in needs at both country and regional level, which could be alleviated by incorporating digital resources, existing or new.

Value for Money

The notable achievements outlined in this report were possible through highly efficient use of resources and a strong sense of value for money (VFM). The evaluation found robust evidence which suggested that the consistent timely disbursement of funds through the PIP PC funding mechanism helped to develop systems and information sharing, alongside careful monitoring against plans. To evidence this VFM to relevant stakeholders, including industry stakeholders, it would be useful to explore ways to better highlight linkages between implementation of funds and progress against high-level objectives, alongside the collateral benefits of PIP PC as a global benefit-sharing mechanism.

Funding Allocation

There are opportunities to build on the progress made and to strengthen this area further through ensuring all stakeholders have a good understanding of the rationale for the decision-making leading to the allocation of funds between countries and thematic areas. This was seen as unclear and questioned in interviews, indicating that further efforts to make the process transparent and clearly explained to stakeholders, especially Member States, are required.

The below recommendations have been developed in response to the evaluation findings at a strategic and operational level.

6. Recommendations

These recommendations are aimed at specifically addressing key issues highlighted in this evaluation report and were developed by the evaluation team to which the PIP Framework Secretariat provided feedback. The below tables briefly outline headline findings, a summary of the issue at hand and the recommended action to undertake, with the responsible party included beneath. The recommendations are in order of importance, with sustainability being the most important to address etc.

6.1 Strategic

Recommendation 1: Sustainability

Finding	Summary	Recommended Action
No clear definition exists of what "sustainability" means in the context of influenza pandemic preparedness. There is no clear framework for deciding which countries are ready to transition out of PIP PC funding, nor what strategies are best for adjusting the funding accordingly	While some countries, are on a path towards being self-sustaining in the medium term, few have graduated from needing external financial support. Competing priorities at country level and the need for a roadmap to support transition planning represent key challenges.	Begin anew the discussions on sustainability that were paused during the COVID-19 pandemic and consider what can realistically be done within the PIP framework mandate: • Work with countries to identify 'low hanging fruit' that can be financed with government funds and support the Ministry of Health in securing funding for these • Explore the feasibility of including a commitment from governments to provide incremental support for influenza pandemic preparedness • Work with WHO Regional and Country Offices to develop a shared approach to, and definition of, "sustainability." This would help to provide a clear vision of objectives, timelines and selection criteria for graduating countries
Responsible: *PIP Framework Secretariat to initiate the process, working with PIP focal points and Member States. Strong ownership from MS is essential.*		

Recommendation 2: Integration

Finding	Summary	Recommended Action
The PIP PC funding mechanism has had an unintended mutual benefit to broader pandemic preparedness. Systems and capacities strengthened through PIP PC funds were adapted to support the global response to the COVID-19 pandemic.	Whilst PIP PC funds are specific to influenza pandemic preparedness, the COVID-19 pandemic highlighted that the PIP Framework, as a global, collaborative benefit sharing mechanism, can enable and support broader pandemic response through its existing systems and tools.	Build on the awareness of the importance of pandemic preparedness generated by the COVID-19 pandemic to advocate for countries to view influenza pandemic preparedness in terms of how it prepares countries for potential pandemics in a broader sense. • Compile and share data to demonstrate how strengthening country preparedness for influenza pandemic relates to broader pandemic preparedness.
Responsible: *PIP Framework Secretariat and regional focal points.*		

6.2 Operational

Recommendation 3: Reporting

Finding	Summary	Recommended Action
Interviewees at country level suggested the design of the log frame could be improved and felt relevant country level data was not available. Small minority of stakeholders felt that milestones could be revisited and adapted to better suit the current context.	Wider understanding of the reporting under the monitoring and evaluation (M&E) Framework can be improved as in-country stakeholders felt some country data was not accessible. Existing reporting mechanisms provide extensive detail on funding allocations by country, programmatic area and region.	Further improve stakeholders' understanding (particularly Member States and industry) of the M&E framework and reporting systems alongside the role of milestones and indicators in measuring progress towards outcomes over time. • Re-emphasise availability of data through PIP reporting mechanisms such as annual and biennial progress reports and the WHO Budget Portal, as these provide detail which some stakeholders felt was not readily available • Further highlight correlation between activities and funding to promote stakeholder understanding of the role of milestones in measuring progress towards outcomes over time
Responsible: *PIP Framework Secretariat and regional focal points.*		

Recommendation 4: Operations

Finding	Summary	Recommended Action
In-country training centred on pandemic preparedness seen by country level stakeholders as potential area which could be digitised to save costs and make more accessible.	Online digital training resources represent an effective learning tool for country stakeholders. Acknowledging high levels of staff turnover within ministries, digital training offers less expensive alternative to repeated in-person refresher training.	Improve access to and awareness of digital training tools: • In close collaboration with technical leads in WHO, share information with beneficiaries, particularly at country level, on the online digital training tools for influenza pandemic preparedness that are available. • Conduct a training needs assessment to identify gaps between the content/focus of available tools and needs at country and regional level; encourage the development of on-line digital training tools to fill the gaps identified.
Responsible: *PIP Framework Secretariat and regional focal points.*		

Recommendation 5: Value for Money

Finding	Summary	Recommended Action
The PIP PC funding mechanism demonstrates good VFM through consistent timely funding for influenza pandemic preparedness, something appreciated by all stakeholder groups.	PIP PC funding is seen as a reliable and timely source of funding for influenza pandemic preparedness, helping to develop systems and information sharing. Links between implementation of funds and technical progress could be made more widely available, to evidence VFM to funders.	Publicise the evidence of progress made on the 10-year objectives to a wider audience to underpin awareness of value for money of the PIP PC benefit sharing system: • Explore ways to further highlight the correlation between implementation of PIP PC funds and technical progress • Highlight the collateral benefits and achievements for the COVID-19 pandemic response, that were due to pandemic influenza surveillance systems. This could include, for example, case studies that document the achievements in PIP PC countries compared with other countries.
Responsible: *PIP Framework Secretariat.*		

Recommendation 6: Funding Allocation

Finding	Summary	Recommended Action
Decision-making underpinning the prioritisation of thematic areas unclear and questioned by several interviewees across stakeholder groups. Funding often not sufficient to cover needs at country-level.	Stakeholders require clear understanding of rationale for decision-making behind the allocation of funds between countries and thematic areas.	Make the allocation process as transparent as possible and keep it under review to ensure consistency and coherence: • Explain to stakeholders (particularly Member States) the global and country level factors taken into consideration during the resource allocation process and the roles played by the PIP Secretariat and the respective WHO Regional Offices and Country Offices • Periodically review the outcomes of the allocations to identify areas where the allocations could be modified to optimise outcomes.
Responsible: *PIP Framework Secretariat and regional focal points.*		

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Annexes

Annex 1: Terms of Reference

1. PURPOSE OF THE APW

These Terms of Reference (TORs) serve as an overall framework for the services to be provided by an evaluation consultancy to conduct an external end of project **Independent External Evaluation of the Pandemic Influenza Preparedness (PIP) Framework Partnership Contribution (PC) Preparedness High-Level Implementation Plan 2018-2023 (HLIP II).**

2. BACKGROUND

The PIP Framework is a partnership to improve global pandemic influenza preparedness and response. The Framework was adopted by WHO's 194 Member States at the World Health Assembly on 24 May 2011. The objective of the PIP Framework is to improve pandemic influenza preparedness and response, and strengthen the protection against pandemic influenza by improving and strengthening the WHO Global Influenza Surveillance and Response System (GISRS), with the objective of a fair, transparent, equitable, efficient, effective system for, on an equal footing: (i) the sharing of H5N1 and other influenza viruses with human pandemic potential; and (ii) access to vaccines and sharing of other benefits.

The PC is one of the PIP Framework's key benefit sharing mechanisms (Section 6.14.3) and is a voluntary annual cash contribution (US$ 28 million), collected by WHO from manufacturers (influenza vaccine, diagnostic and pharmaceutical) who use the WHO GISRS. The PC funds are used by WHO to strengthen pandemic influenza preparedness capacities, support response activities, and support the PIP Secretariat for implementation of the Framework. The PIP high-level implementation plans (HLIP) specify how PC funds will be used to strengthen pandemic influenza preparedness capacities.

In connection with the development of the first HLIP in 2013, the PIP Advisory Group identified five 10-year objectives for improving pandemic influenza preparedness (as described in Section 1.1. of HLIP II). These objectives remained relevant for the development of HLIP II and informed the design of the HLIP II Results Hierarchy. [2] The HLIP II Results Hierarchy has one preparedness Outcome (that summarizes the five 10-year objectives): influenza surveillance systems, knowledge, and capacities for a timely and appropriate response to pandemic influenza, are established and strengthened.

Through the HLIP II, PC preparedness funds have been used to strengthen capacities in six Output areas: 1) Laboratory and Surveillance; 2) Burden of Disease; 3) Regulatory Preparedness; 4) Risk Communications and Community Engagement; 5) Planning for the deployment of pandemic products; and 6) and influenza pandemic preparedness planning. The expected results for each of these six Outputs are detailed in the HLIP II, which was approved by the WHO Director-General for the period 2018-2023. **As part of the HLIP II monitoring and evaluation framework, an independent external evaluation for the Outputs supported by the PC preparedness funds is to be conducted.**

[1] This template is only to be used for APWs granted to Companies, and not for APWs granted to Individuals.
[2] https://www.who.int/publications/i/item/9789240041349

3. PLANNED TIMELINES

Start date: 21 August 2023 **End date:** 24 May 2024
Total Duration: 9 months

4. REQUIREMENTS – WORK TO BE PERFORMED

Scope and Objectives

An independent external evaluation of HLIP II is to be conducted, covering the implementation of the HLIP II across all levels of the WHO from 2018-2023 (six-year period). The evaluation aims to provide accountability for the use of the PIP PC for preparedness activities and also aims to provide recommendations that will improve the implementation of the PIP PC preparedness funds. The WHO Secretariat, Member States, partnership contributors and other PIP stakeholders will be the primary users of the resulting evaluation report.

The evaluation will be guided by considerations of the OECD DAC [3] criteria and will achieve the following Objectives:

- Document key achievements, best practices, challenges, gaps, and areas for improvement in the design and implementation of HLIP II as well as progress against the 10-year objectives for pandemic influenza preparedness established in 2013 (as described in Section 1.1. of HLIP II).
- Review effectiveness of resources in meeting the Outcome of HLIP II: influenza surveillance systems, knowledge, and capacities for a timely and appropriate response to pandemic influenza are established and strengthened.
- Generate a series of findings, conclusions, lessons learned and recommendations that can inform future activities.

Evaluation Questions

The scope of the evaluation could cover the questions listed below and be in alignment with OECD- Development Assistance Committee's six evaluation criteria – relevance, coherence, effectiveness, efficiency, impact, and sustainability.

Relevance

- Is the design of HLIP II relevant to the Outcome set out there in?
- How relevant was HLIP II to stakeholders and WHO priorities?
- How was the HLIP II responsive to the needs and priorities of stakeholders and how were such groups engaged throughout the design and implementation?
- How did the Secretariat adapt to changing circumstances (context and policies) during implementation over time and at critical points such as the Mid-term Review[4]?

Coherence

- Has HLIP II been complementary and/or contributed to other WHO led frameworks on pandemic preparedness and response (e.g., International Health Regulations (IHR) 2005, Pandemic Treaty, etc.) and the UN's health related SDGs (Sustainable Development Goals).

[3] https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm
[4] https://www.who.int/publications/m/item/mid-term-review-of-the-high-level-implementation-plan-ii-of-the-pandemic-influenza-preparedness-framework

- Has HLIP II been complementary and/or contributed to other donor activities/international assistance policies and frameworks?

Effectiveness

- Have the activities undertaken in HLIP II moved us towards achieving the Outcome? Towards achieving the PIP Framework objectives?
- Could PC preparedness funds have been reallocated for enhanced effectiveness in achieving the HLIP II Outcome?

Efficiency

- Is there evidence of value for money for each Output area within HLIP II?
- Was there overlap with other projects funded by other agencies, including other UN Organizations?

Impact

- What has been the overall impact of HLIP II on pandemic influenza preparedness and response? On global pandemic preparedness? Is the project leading to other changes, including "scalable" or "replicable" results?
- Did HLIP II cause high-level effects (such as change in norms or systems)?

Sustainability

- Has HLIP II built sustainable capacity to improve pandemic influenza preparedness?
- Has HLIP II supported the development and implementation of national policies and institutions to ensure sustainable results?

Approach and Methodology

The independent evaluation will be conducted by an external evaluator. The evaluators will develop the evaluation method, conduct the analysis, and deliver a report of the findings, including recommendations. The evaluator(s) will need to meet with the PIP PC team to develop and refine evaluation questions and to agree on the approach and evaluation methodology. Mixed method analyses (quantitative and qualitative) may be utilized including documentation review, key informant interviews, and stakeholder consultations. The overall process and methodological approach will follow the principles set forth in the WHO Evaluation Practice Handbook[5] and related policies.[6,7] The review will also adhere to WHO's cross-cutting evaluation strategies on gender, equity, vulnerable populations, and human rights, and include, to the extent possible, disaggregated data and analysis.[8] The evaluation will follow UNEG norms and standards for evaluations, as well as its ethical guidelines.

Management Arrangement[9]

- Evaluation Commissioner (PIP Framework Secretariat): funds and clears the evaluation
- Evaluation Manager (PIP PC Team): supervises the evaluation team and is responsible for safeguarding the independence of the evaluation, providing the evaluation team necessary documentation and stakeholder contact information.
- Evaluation Team (Selected Vendor), reports to the Evaluation Manager while keeping independence on the contents of the evaluation
- Supporting partners:
  - Quality Assurance Advisor, assists the Evaluation Manager on technical aspects of the evaluation and helps ensure and validate the quality of evaluation products

[5] https://apps.who.int/iris/handle/10665/96311
[6] http://www.unevaluation.org/document/detail/2866
[7] http://www.unevaluation.org/document/detail/2866
[8] https://www.who.int/about/what-we-do/thirteenth-general-programme-of-work-2019--2023

- Reference Group, reviews the contents of key products
- An Advisory Group, provides technical advice to the Evaluation Manager or the Evaluation Team when needed or requested

Key Stakeholders

Key stakeholders include, but are not limited to the following:

Implementers

- WHO Headquarters representatives from the PIP Secretariat, Global Influenza Programme, and Epidemic and Pandemic Preparedness department
- WHO Regional Influenza Programme representatives and PIP PC Output focal points
- WHO Country Office influenza and/or health emergencies focal points, and PIP focal points

Beneficiaries

- Member State Ministry of Health, Public Health, or Centre for Disease Control
- National Influenza Center representatives

Experts

- PIP Independent Technical Expert Mechanism (PCITEM) members
- GISRS members

Funders

- Private sector entities including industry partners who finance the PC preparedness funds

Other

- Civil society organizations

5. REQUIREMENTS - PLANNING

	Deliverables	Due date
1	**Inception Report** which elaborates how the team will conduct the evaluation including: finalized evaluation questions, approach and methodology, data collection tools, the evaluation work plan including stakeholder listing, timeframe, and schedule of delivery of products. The report should also specify how to address gender, equity, vulnerable populations, and human rights.	15 September 2023
2	**Preliminary Findings** presented to the Reference and Advisory Groups. Accompanying PowerPoint presentations, briefing notes and summaries to be provided to WHO.	30 November 2023
3	**First Draft of the Evaluation Report** will be provided to WHO for review and comments	31 January 2024
4	**Second Draft of the Evaluation Report** will be provided to WHO and will be circulated to the Advisory Group and Reference Group for review and comments. It should include an executive summary, have clarity of content, and be of suitable format for industry partners who finance the PC preparedness funds.	1 April 2024
5.1	**Final Evaluation Report,** drafted in alignment with the WHO Evaluation Practice Handbook[10]	24 May 2024

5.2	**Audit Trail of the Final Draft Evaluation Report** will be provided to WHO that captures comments provided by stakeholders to the Second Draft of the report and clearly outlines how the evaluation team addressed the comments.	24 May 2024
5.3	**Presentation to Key Stakeholders** on the progress and findings to the PIP Advisory Group and The Partnership Contribution Independent Technical Expert Mechanism (PCITEM) at the conclusion of the Evaluation (to be confirmed). Accompanying PowerPoint presentations, briefing notes, and summaries to be provided to WHO.	24 May 2024
5.4	**Information Materials** developed including a one-page summary of the Final Report including key messages and focus on elements appropriate for high-level decision makers and key external partners.	24 May 2024

2. *INPUTS

The work will be coordinated by the PIP Framework Secretariat. The technical unit, the PIP PC Implementation team of the PIP Framework Secretariat, will support the contractor by providing an initial briefing on the work and answering any technical questions that may arise. The technical unit will additionally work with the contractor to elaborate the review methodology and to facilitate access to relevant documentation and stakeholders. The technical unit will review and provide comments on deliverables.

3. *ACTIVITY COORDINATION AND REPORTING

Technical Officer:	Jennifer BARRAGAN FROMME
For the purpose of:	Technical supervision and instructions - Reporting
Administrative Officer:	Esther Awit, Secretary, GIH, PIP
For the purpose of:	Contractual and financial management of the contract

4. *CHARACTERISTICS OF THE PROVIDER

Companies with a minimum of seven years of experience in evaluating project implementation including conducting stakeholder consultations, data analysis and synthesis, and document writing. The provider will have knowledge of programme evaluation as well as relevant experience in performing similar evaluations in multilateral or United Nations organizations. Experience in the implementation or the review of public health projects, preferably projects that are WHO-led and/or influenza related. Excellent knowledge of English, both spoken and written. Expertise in health equity, gender equality, disability and human rights issues, or access to such expertise is desirable.

5. PLACE OF ASSIGNMENT

The contractor may work at the place of his/her choosing. No travel will be needed.

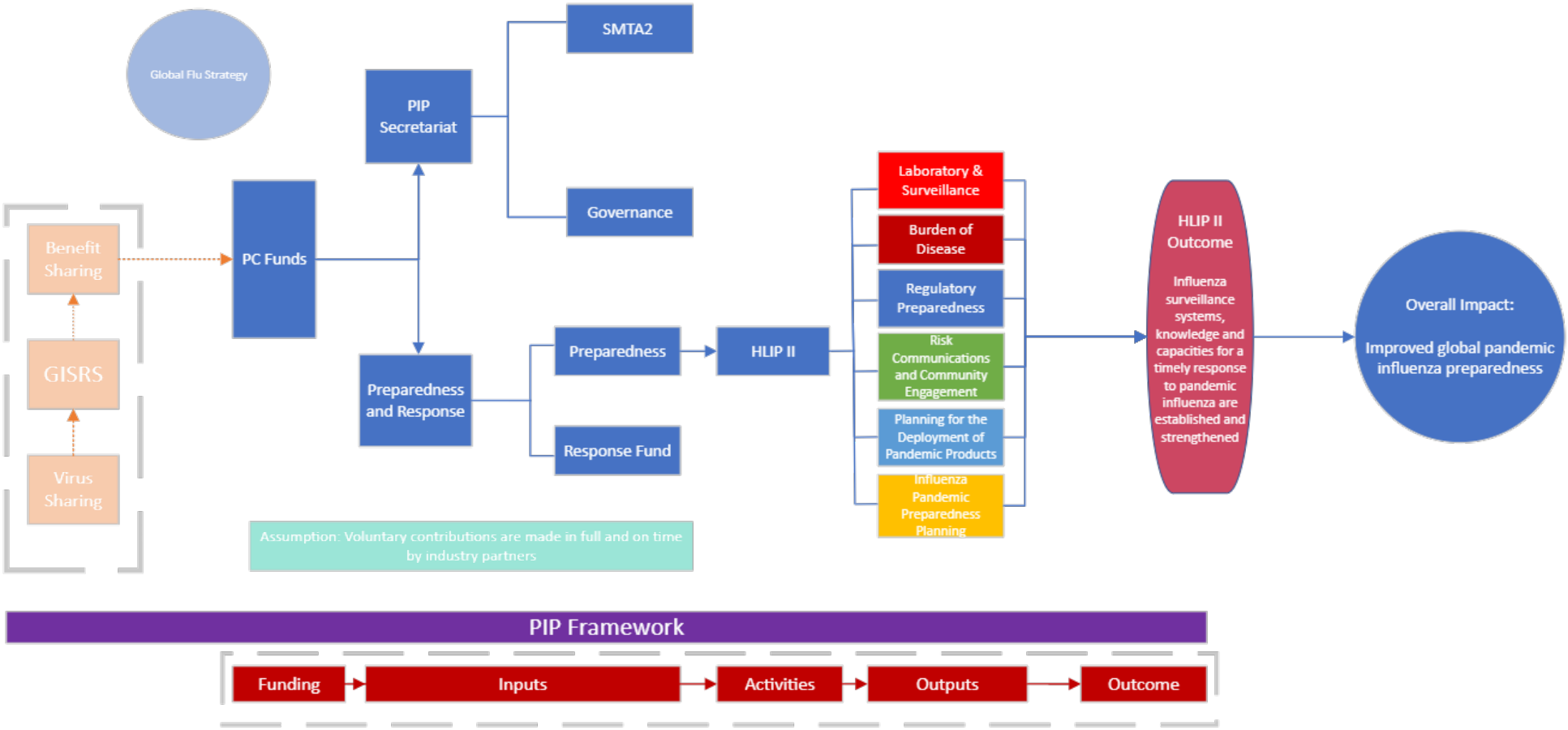
Annex 2: Evaluation Matrix

Evaluation Criteria	Key Evaluation Question	Evaluation Sub-question	Data Collection Method
Relevance	To what extent is the design of the HLIP II relevant to its intended outcomes?	How has HLIP II been designed to ensure maximum impact?	KIIs, Document review
	To what extent has the HLIP II been relevant to WHO needs and priorities and those of other stakeholders?	What needs analyses were undertaken to inform the HLIP II design? How has learning from HLIP I/previous evaluations been integrated into the design of HLIP II? How has countries varying level of capacity/preparedness and need been taken into account in HLIP II design? How have gender and human rights been considered in HLIP II design?	KIIs, Document review, Survey
	To what extent have stakeholders been effectively engaged throughout the HLIP II design and implementation?	What has been the role of different stakeholders in the design and implementation of HLIP II? How have decisions related to HLIP II implementation been made and how has information ben shared?	KIIs, Document review
	To what extent has the implementation of HLIP II adapted over time/to changes in context?	What have been the key adaptations to HLIP II over time and how have contextual changes affected its implementation? How has HLIP II implementation adapted to the Covid-19 context?	KIIs, Document review, Survey
Coherence	To what extent has HLIP II been complementary to other WHO led frameworks on pandemic preparedness and response (e.g., International Health Regulations (IHR) 2005, regional strategies, etc.)	How were other WHO led frameworks on pandemic preparedness and response taken into account in HLIP II design and implementation?	KIIs, Document review
	To what extent has HLIP II been complementary to the UN's health related SDGs (Sustainable Development Goals)?	How were UN's health related SDGs (Sustainable Development Goals) taken into account in HLIP II design and implementation?	KIIs, Document review
	To what extent has HLIP II been complementary to other donor activities/international assistance policies and frameworks?	How were other donor activities/international assistance policies and frameworks taken into account in HLIP II design and implementation?	KIIs, Document review

Evaluation Criteria	Key Evaluation Question	Evaluation Sub-question	Data Collection Method
Effectiveness	To what extent have HLIP II intended outcomes been achieved?	Has HLIP II achieved its intended results? How has the achievement of results varied by context? What are the key factors which have enabled/limited the achievement of results? To what extent have the results frameworks/results reporting for HLIP II been fit for purpose? To what extent have gender and human rights considers been adequately captured in HLIP II's reporting processes? To what extent were PC preparedness funds reallocated for enhanced effectiveness in achieving the HLIP II Outcome?	KIIs, Document review, Survey
	To what extent have HLIP II activities contributed towards the achievement of PIP Framework objectives?	How has the HLIP II supported the achievement of PIP Framework objectives?	KIIs, Document review, Survey
	To what extent has HLIP II contributed to: • Other WHO led frameworks on pandemic preparedness and response (e.g., International Health Regulations (IHR) 2005)? • The SDGs? • Oher donor activities/ international assistance policies and frameworks?	How has the HLIP II supported the achievement of 1. Other WHO led frameworks on pandemic preparedness and response (e.g., International Health Regulations (IHR) 2005)? 2. The SDGs? 3. Oher donor activities/ international assistance policies and frameworks? To what extent have HLIP II funds leveraged/supported broader strengthening of health systems/preparedness for other diseases?	KIIs, Document review, Survey
Efficiency	To what extent is there evidence of value for money for each Output area within HLIP II?	How adequate has the allocation of resources been for each output area in terms of human, financial, technological? What measures have been taken to optimize the use of resources for each output area? Has the HLIP II been implemented according to plan, scope and budgetary requirement?	KIIs, Document review

Evaluation Criteria	Key Evaluation Question	Evaluation Sub-question	Data Collection Method
Impact	What has been the overall impact of HLIP II on pandemic influenza preparedness and response? On global pandemic preparedness?	What have been the unintended/surprising impacts of the HLIP II?	KIIs, Document review
	To what extent has HLIP II contributed to other changes, including “scalable” or “replicable” results		KIIs, Document review
	To what extent has HLIP II contributed to high-level effects (such as change in norms or systems)?		KIIs, Document review, Survey
Sustainability	To what extent has HLIP II built sustainable capacity to improve pandemic influenza preparedness?	To what extent have HLIP II sustainable built capacity in a broader HSS context?	KIIs, Document review, Survey
	To what extent has HLIP II supported the development and implementation of national policies and institutions to ensure sustainable results?		KIIs, Document review, Survey

Annex 3: Theory of Change



Annex 4: List of Interviewees

WHO Headquarters	
Name	**Role**
Implementers	
Alireza Khadem Broojerdi	Team Lead, Regulatory Systems Strengthening (PIP REG Focal Point)
Anne Huvos	Unit Head, PIP Framework Secretariat
Dmitriy Pereyaslov	Team Lead, Laboratory, Global Influenza Programme
Gina Samaan	Unit Head, Pandemic Preparedness Global Platforms
Ioana Ghiga	Technical Officer, High Impact Events Preparedness (PIP DEP Project Manager)
Isabel Bergeri	Technical Officer, Global Influenza Programme (PIP L&S and IPPP Project Manager)
Katelijn Vandermaele	Medical Officer, Global Influenza Programme
Poonam Huria	Technical Officer, PIP Framework Secretariat
Razieh Ostad Dehaghi	Scientist, Regulatory Systems Strengthening (PIP REG Project Manager)
Stefano Tempia	Team Lead, Surveillance, Global Influenza Programme (PIP BOD Project Manager)
Supriya Bezbaruah	Technical Officer, High Impact Events Preparedness (PIP RCCE Project Manager)
Sylvie Briand	Director, Epidemic and Pandemic Preparedness and Prevention
Tim Nguyen	Unit Head, High Impact Events Preparedness (PIP RCCE and DEP Focal Point)
Wenqing Zhang	Unit Head, Global Influenza Programme (PIP L&S Focal Point)
Americas Region	
Implementers	
Andrea Vicari	Unit Chief, Infectious Hazard Management
Angel Rodriguez	Influenza Surveillance Specialist
Angella Smith	Program Management Specialist
Carolina Serrano	Consultant (PIP Regional Project Manager)
Diana Malo	Epidemiologist Expert Consultant, WHO Country Office Colombia
Juliana Barbosa	Laboratory Expert Consultant, WHO Country Office Colombia
Mauricio Cerpa	Advisor WHO Country Office, Colombia

Rainier Escalada	Advisor, WHO Country Office, Guyana
Beneficiaries	
Anand Persaud	Epidemiologist / IHR National Focal Point Coordinator, Focal Point for Influenza Surveillance, Ministry of Health of Guyana
Angelica Maria Rico Turca	Epidemiologist for Influenza and COVID-19, National Institute of Health, Colombia
Paula Estefania Rodriguez Romero	NIC focal point, National Institute of Health, Colombia
Phyllis Pinas	Head of the Central Laboratory, Bureau of Public Health Suriname
Radjesh Ori	Director, Bureau of Public Health, Suriname
Africa Region	
Implementers	
Abraham Abenego	National Public Health Officer, WHO Country Office, South Sudan
Belinda Herring	Technical Officer, Avian Influenza (PIP Regional Project Manager)
Philip Zorto	Coordinator, WHO Country Office, Nigeria
Beneficiaries	
Sikiru Badaru	CDC, Ministry of Health Nigeria
Venusia Zang	Biologist, Ministry of Health, Gabon
Eastern Mediterranean Region	
Implementers	
Abdinasir Abubakar	WHO Representative for Lebanon and Programme Area Manager for the Infectious Hazard Prevention and Preparedness Unit
Amal Barakat	Technical Officer (Regional Laboratory Focal Point)
Amira Ahmed	National Professional Officer, WHO Country Office, Egypt
Moubadda Assi	National Professional Officer, WHO Country Office, Lebanon
Ruba Hikmat	Project Officer (PIP Regional Project Manager)
Wasiq Mehmood Khan	Team Lead, Emergency Operations (former PIP Focal Point)
Europe Region	
Implementers	
Abdulakhad Safarov	National Professional Officer, WHO Country Office, Tajikistan
Liudmyla Slobodianyk	National Professional Officer, WHO Country Office, Ukraine
Lusine Paronyan	National Professional Officer, WHO Country Office, Armenia
Michala Hegermann-Lindencrone	Technical Officer (PIP Regional Project Manager)

Oksana Koshalko	National consultant on Vaccine Preventable Diseases, WHO Country Office, Ukraine
Richard Pebody	Expert (former PIP Focal Point)
Tamanno Safarova	PIP Focal Point, Epidemiologist, Epidemiology Department, State Sanitary and Epidemiological Surveillance Services, Ministry of Health and Social Protection of the Population, Tajikistan
Tatyana Kovalchuk	Ministry of Health of the Republic of Tajikistan
Beneficiaries	
Romella Abovyan	Head of Department, Epidemiological Infections and Non-Communicable Diseases, National CDC, Armenia
South-East Asia Region	
Implementers	
Anthony Eshofonie	Team Lead, WHO Country Office, Bangladesh
ASM Alamgir	Infectious Hazard Management Officer, WHO Country Office, Bangladesh
Dongbao Yu	Team Lead, WHO Country Office, Timor-Leste
Edwin Salvador	Regional Emergency Director
Francis Inbanathan	Technical Officer (Regional L&S Focal Point)
Mahtab Singh	Monitoring & Evaluation Consultant
Maria Angela Varela Niha	National Professional Officer, WHO Country Office, Timor-Leste
Pushpa Wijesinghe	Programme Area Manager (PIP Regional Project Manager)
Saugat Shrestha	National Professional Officer, WHO Country Office, Nepal
Beneficiaries	
Ari Tillman	NIC, Director of PCR Laboratory, National Health Laboratory
Filipe de Neri Machado	National Director of Public Health, Ministry of Health Centers for Disease Control and Prevention, Timor Leste
Mahbubur Rahman	NIC, Assistant Professor, Institute of Epidemiology, Disease Control and Research (IEDCR)
Rubaid Anwar	NIC, Surveillance Consultant, IEDCR
Runa Jha	NIC, Director, National Public Health Laboratory, Ministry of Health, Nepal
Tahmina Shirin	NIC, Director, IEDCR
Western Pacific Region	
Implementers	
Babatunde Olowokure	Regional Emergency Director

May Chiew	Technical Officer, Epidemiologist, WHO Country Office, Lao PDR
Nam Nguyen	Technical Officer, Pandemic Preparedness (PIP Regional Project Manager)
Phetdavanh Leuangvilay	Technical Officer, WHO Country Office, Lao PDR
Sarika Patel	Team Coordinator, WHO Country Office, Cambodia
Satoko Otsu	Team Coordinator WHO Country Office, Lao PDR
Shakila Naidu	National Professional Officer, WHO Country Office, Fiji
Sonesavanh Phimmasine	Technical Officer, WHO Country Office, Lao PDR
Vanra Leng	Technical Officer, WHO Country Office, Cambodia
Beneficiaries	
Seng Heng	Director of Surveillance Bureau, Communicable Disease Control Department, Ministry of Health Cambodia
Experts	
Ann Moen	Former Chief, Influenza Preparedness & Response Unit
Enrique Tayag	PIP Advisory Group Chair, 2022-23
Heidi Meyer	Vice Chair, PIP Advisory Group, 2022-23
Eric Tayag	PIP Advisory Group Member, 2022-23
Kanta Subbarao	Director, WHO Center for Reference and Research of Influenza, Melbourne
Othmar Engelhardt	Essential Reference Laboratory, National Institute for Biological Standards and Control
Silvia Bino	Partnership Contribution Independent Technical Expert Mechanism (PCITEM); Advisory Group
Industry Stakeholders	
Paula Barbosa	Associate Director, Vaccines Policy, International Federation of Pharmaceutical Manufacturers & Associations (IFPMA)
Phyllis Arthur	Senior Vice President for Infectious Diseases, Biotechnology Innovation Organization (BIO)
Rajinder Suri	CEO of Developing Countries Vaccine Manufacturer Network (DCVMN)
Civil Society	
Sangeeta Shashikant	Legal and policy adviser, Third World Network

Annex 5: Bibliography

No.	Document Title
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2	2022 Indicator Report: HLIP II Implementation. Geneva: World Health Organization; 2023. (Internal document)
3	2023 Indicator Report: HLIP II Implementation. Geneva: World Health Organization; 2024. (Internal document)
4	A brief overview of the Preparedness and Resilience for Emerging Threats initiative (PRET). Accessed: A brief overview of the Preparedness and Resilience for Emerging Threats initiative (PRET) (who.int) World Health Organization; 2023.
5	A tale of two pandemics: improvements in regulatory performance between the 2009 influenza A(H1N1) pandemic to the COVID-19 pandemic. Accessed: A tale of two pandemics: improvements in regulatory performance between the 2009 influenza A(H1N1) pandemic to the COVID-19 pandemic (who.int) World Health Organization; 2022.
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8	Gains made in pandemic preparedness through the implementation of the PIP Framework and collateral benefits for COVID-19 pandemic response. Geneva: World Health Organization; 2021. (Internal document)
9	Global Influenza Strategy 2019-2030. Geneva: World Health Organization; 2019.
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12	Mid-term Review of the High-Level Implementation Plan II of the Pandemic Influenza Preparedness Framework. Dr Jayshree Bagaria; 2021.
13	OECD Evaluation Criteria. Accessed: Evaluation Criteria - OECD. Organisation for Economic Co-operation and Development.
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15	Pandemic Influenza Preparedness and COVID-19: Complementary Activities. Geneva: World Health Organization; 2020. (Internal document)
16	Pandemic Influenza Preparedness Framework: progress report, 1 January -30 June 2018. Geneva: World Health Organization; 2018.
17	Pandemic Influenza Preparedness Framework: eighteen-month progress report, 1 January 2018-30 June 2019. Geneva: World Health Organization; 2019.
18	Pandemic Influenza Preparedness Framework: biennial progress report, 1 January 2018-31 December 2019. Geneva: World Health Organization; 2020.

19	Pandemic Influenza Preparedness Framework: eighteen-month progress report, 1 January 2020-30 June 2021. Geneva: World Health Organization; 2021.
20	Pandemic Influenza Preparedness Framework: progress report, 1 January-30 June 2022. Geneva: World Health Organization; 2022.
21	Pandemic Influenza Preparedness Framework: biennial progress report, 1 January 2020-31 December 2021. Geneva: World Health Organization; 2022.
22	Pandemic Influenza Preparedness Framework: eighteen-month progress report, 1 January 2022-30 June 2023. Geneva: World Health Organization; 2023.
23	Pandemic Influenza Preparedness Framework: annual progress report, 1 January-31 December 2022. Geneva: World Health Organization; 2023.
24	Pandemic Influenza Preparedness Framework: biennial progress report, 1 January 2022-31 December 2023. Geneva: World Health Organization; 2024. (pre-publication version)
25	Pandemic Influenza Preparedness Framework: Partnership Contribution (PC) Preparedness High-Level Implementation Plan I Final report 2014-2017. Geneva: World Health Organization; 2018.
26	Pandemic Influenza Preparedness Framework: Partnership Contribution (PC) Preparedness High-Level Implementation Plan II 2018-2023. Revised version 2021. Geneva: World Health Organization; 2021.
27	Pandemic Influenza Preparedness Framework: Partnership Contribution (PC) Preparedness High-Level Implementation Plan III 2024-2030. Geneva: World Health Organization; 2023.
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36	Strategy for assessing and mitigating the risk of COVID-19 on HLIP II implementation. Geneva: World Health Organization; 2021. (Internal document)
37	Strategy for assessing and mitigating the risk of COVID-19 on HLIP II implementation. Geneva: World Health Organization; 2022. (Internal document)
38	Strengthening Health Emergency Prevention, Preparedness, Response and Resilience. Geneva: World Health Organization; 2023.
39	WHO Dashboard of COVID-19 Related Recommendations. World Health Organization; 2023.

Annex 6: Stakeholder Groups

Implementers

- WHO HQ representatives from the PIP Framework Secretariat, Global Influenza Programme, and the Epidemic & Pandemic Preparedness Prevention Department
- WHO HQ Regulatory Systems Strengthening Team, Regulation and Prequalification Department
- WHO HQ Planning, Resource Coordination and Performance Monitoring Department
- WHO Regional Emergency Directors
- WHO Regional Influenza Programme representatives and PIP PC Output focal points
- WHO Country Office influenza and/or health emergencies focal points, and PIP focal points

Beneficiaries

- Member State Ministry of Health, Public Health, or Centre for Disease Control
- GISRS labs

Experts

- PIP Advisory Group members
- PIP Independent Technical Expert Mechanism (PCITEM) members
- GISRS members
- WHO Collaborating Centres

Industry Stakeholders

- Representatives from International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), Biotechnology Innovation Organization (BIO), and the Developing Country Vaccine Manufacturers Network (DCVMN), and individual companies.

Other

- Civil society organizations

Annex 7: Stakeholder Survey

Stakeholder Survey: Evaluation of the Pandemic Influenza Preparedness (PIP) Framework Partnership Contribution (PC) Preparedness High-Level Implementation Plan 2018-2023 (HLIP II)

Introduction

Thank you for agreeing to take part in this short survey, which is being implemented as part of the ongoing evaluation of WHO's PIP PC HLIP II. The purpose of the survey is to gather the perceptions of key stakeholders relating to various dimensions of the HLIP II. We anticipate that the survey should take no more than 15 minutes to complete.

Participation in the survey is entirely voluntary, and your responses are fully confidential and anonymous. No personally identifiable information is captured, and the survey results will be used alongside other lines of evidence to inform our analysis for the evaluation.

Preliminary Questions

The purpose of these questions is to identify which stakeholder category you belong to. Your responses will help us to develop a disaggregated analysis of the survey's results.

* 1. Which of the following group do you belong to?

WHO (HQ, Regional, Country Office)

Member State (MoH, Public Health)

Experts (PIP AG, PCITEM members, GISRS members)

Industry representative

Collaborating Partner (WHO Collaborating Centres)

Civil Society organisation

Other (please specify)

* 2. How familiar are you with the content and objectives of the HLIP II?

Very familiar

Familiar

Unfamiliar

Very unfamiliar

Section 1: Relevance

The following questions ask you for your perceptions relating to the relevance of HLIP II.

* 3. HLIP II implementation has adapted over time/in changes to context

Strongly agree

Agree

Disagree

Strongly disagree

Please provide any examples of adaptations as relevant.

* 4. You were consulted in a meaningful way throughout the HLIP II design and implementation process.

Strongly agree

Agree

Disagree

Strongly disagree

* 5. If you were consulted, were your inputs taken into account? And if so, how?

* 6. Gender, equity, vulnerable populations and human rights have been considered in the design of HLIP II.

Strongly agree

Agree

Disagree

Strongly disagree

Not Sure

Please provide any examples as relevant.

Section 2: Coherence

The following questions ask you for your perceptions relating to the coherence of HLIP II.

* 7. HLIP II has been complementary to other WHO led frameworks on pandemic preparedness and response (e.g., International Health Regulations (IHR), 2005)?

Strongly agree

Agree

Disagree

Strongly disagree

Section 3: Effectiveness

The following questions ask you for your perceptions relating to the effectiveness of HLIP II.

* 8. HLIP II has achieved its intended outcomes in terms of surveillance systems, knowledge and capacities for response to pandemic influenza being established and strengthened

Strongly agree

Agree

Disagree

Strongly disagree

Please provide any examples as relevant.

* 9. What factors (e.g. environmental, political, organisational etc.) have enabled the achievement of results?

* 10. What factors (e.g. environmental, political, organisational etc.) have limited the achievement of results?

Section 4: Efficiency

The following questions ask you for your perceptions relating to the efficiency of HLIP II.

* 11. Resources were allocated adequately across each of the output areas within HLIP II.

Strongly agree

Agree

Disagree

Strongly disagree

Please provide any examples as relevant.

Section 5: Impact

The following questions ask you for your perceptions relating to the impact of HLIP II.

* 12. HLIP II has contributed to changes which have 'scalable' or replicable results.

Strongly agree

Agree

Disagree

Strongly disagree

Please provide any examples as relevant

* 13. Have there been any unintended or surprising impacts, positive or negative, which have come from HLIP II?

* 14. HLIP II has contributed to high-level effects (such as change in norms or systems).

Strongly agree

Agree

Disagree

Strongly disagree

Section 6: Sustainability

Lastly, the following questions ask you for your perceptions relating to the sustainability of HLIP II.

* 15. HLIP II has built sustainable capacity to improve pandemic influenza preparedness

Strongly Agree

Agree

Disagree

Strongly Disagree

Please provide any examples as relevant.

* 16. HLIP II has supported the development and implementation of national policies and institutions to ensure sustainable results

Strongly agree

Agree

Disagree

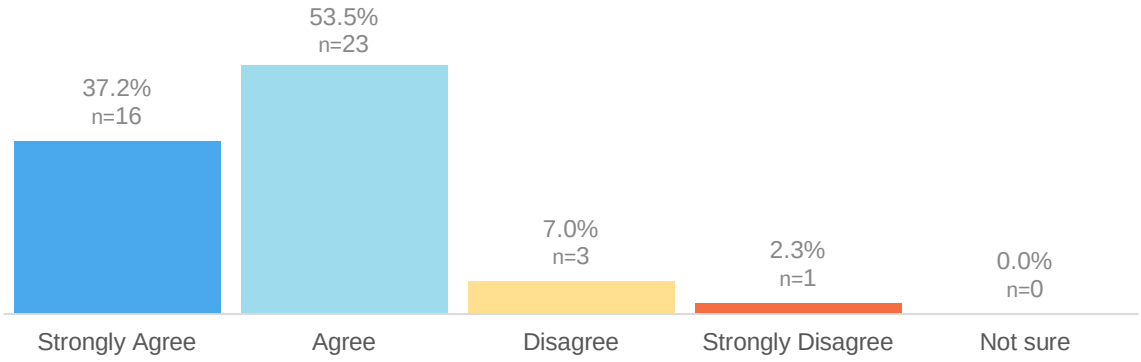
Strongly disagree

Please provide any examples as relevant.

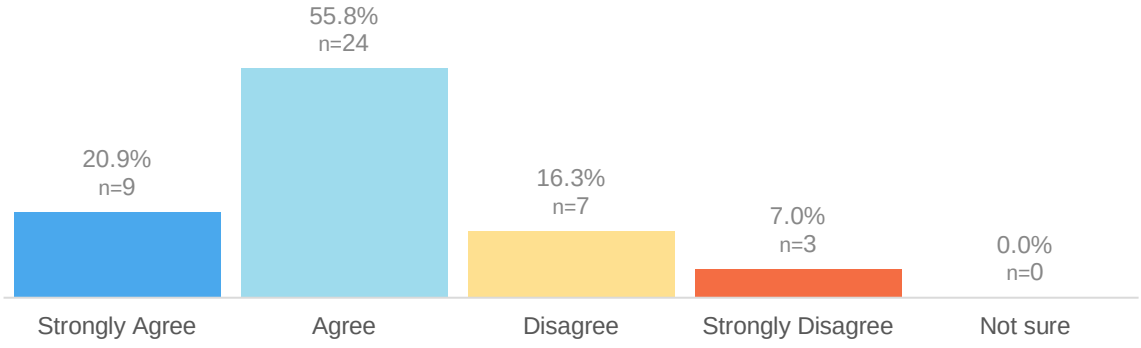
Annex 8: Survey Results

Relevance

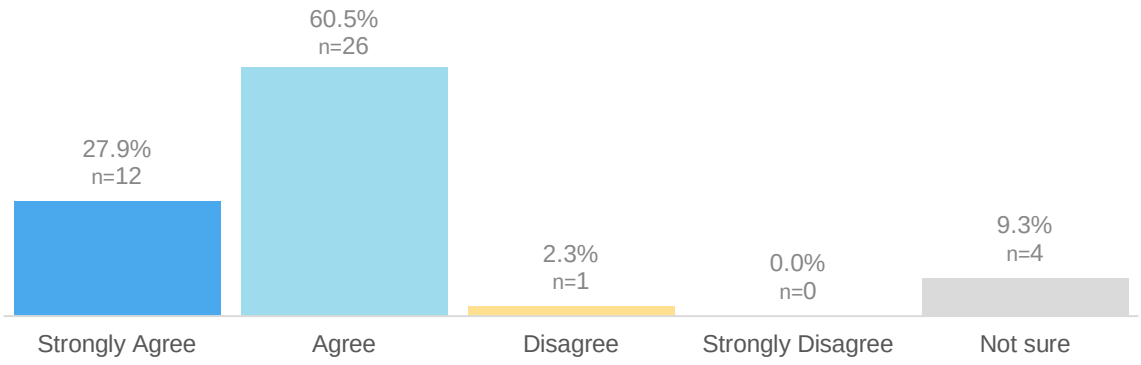
HLIP II implementation has adapted over time/in changes to context



You were consulted in a meaningful way throughout the HLIP II design and implementation process.

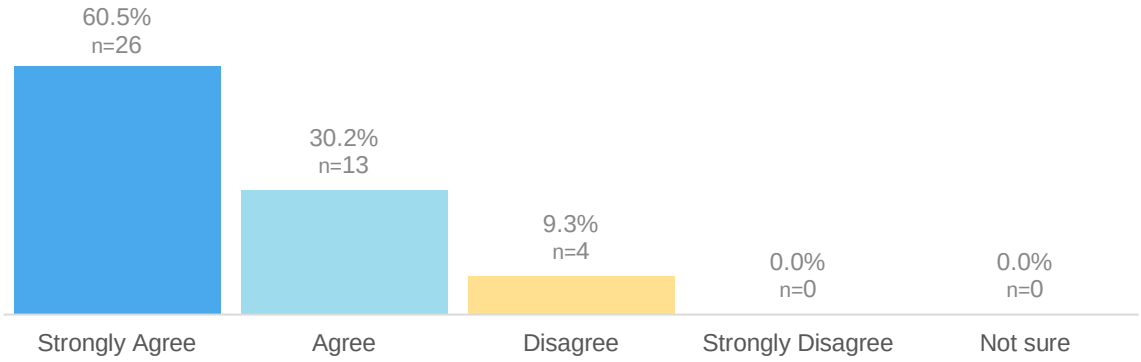


Gender, equity, vulnerable populations and human rights have been considered in the design of HLIP II.



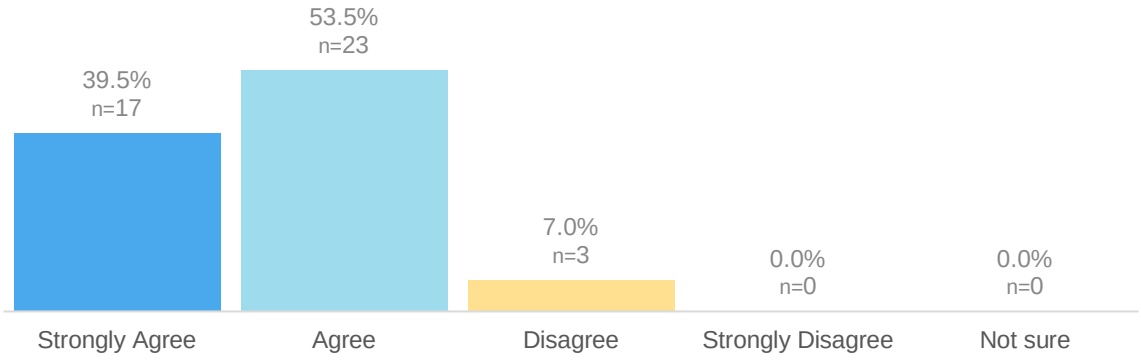
Coherence

HLIP II has been complementary to other WHO led frameworks on pandemic preparedness and response (e.g., International Health Regulations (IHR), 2005)?



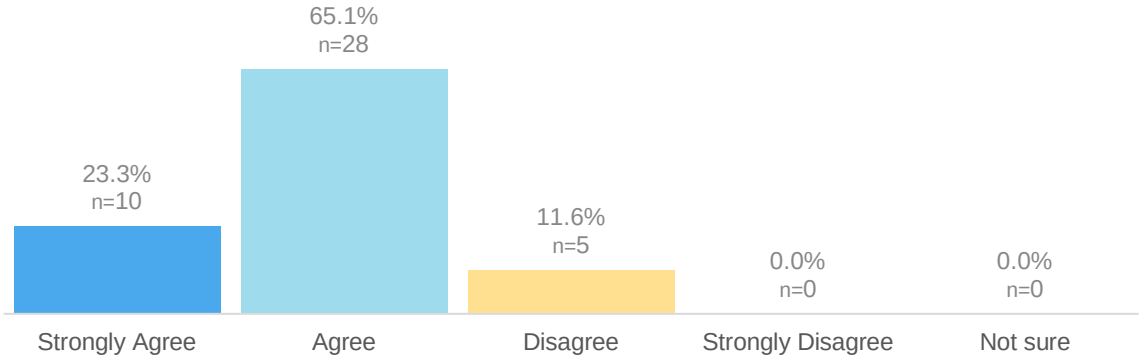
Effectiveness

HLIP II has achieved its intended outcomes in terms of surveillance systems, knowledge and capacities for response to pandemic influenza being established and strengthened.



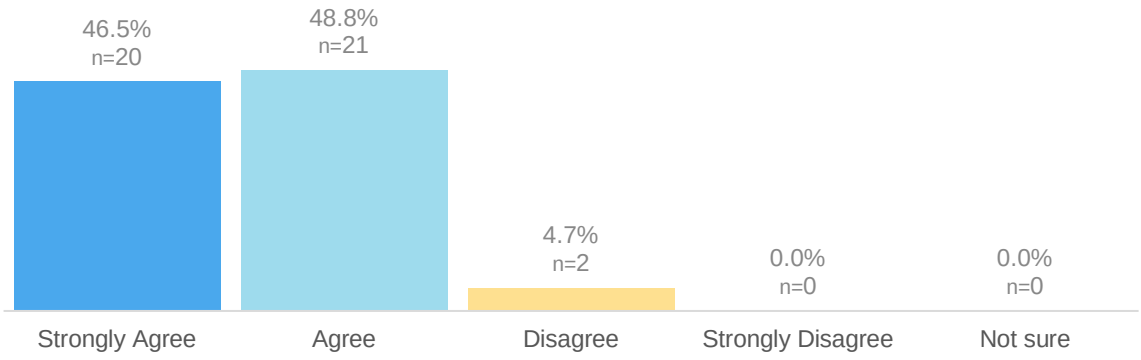
Efficiency

Resources were allocated adequately across each of the output areas within HLIP II.

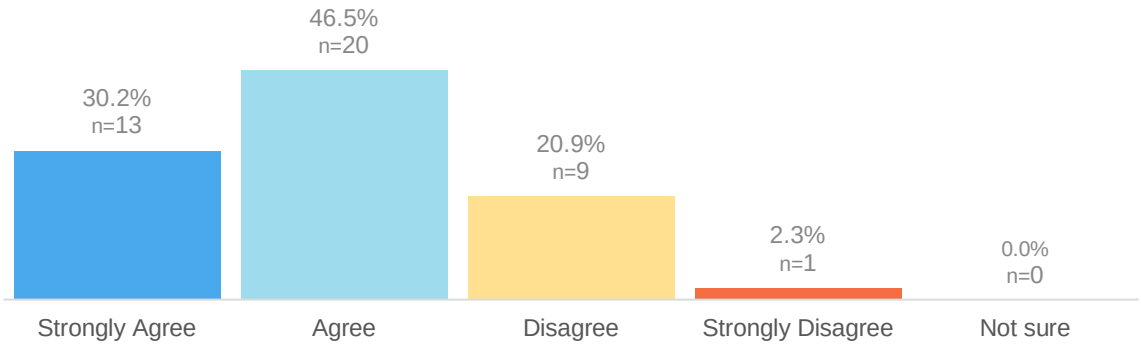


Impact

HLIP II has contributed to changes which have 'scalable' or replicable results.

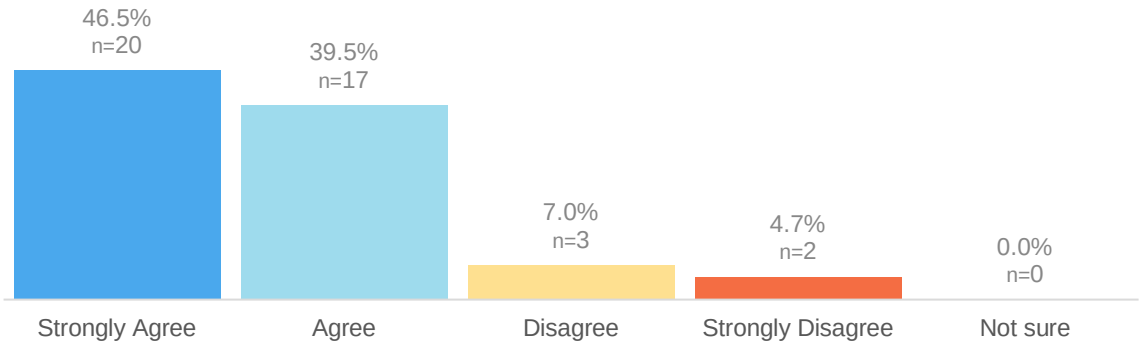


HLIP II has contributed to high-level effects (such as change in norms or systems).

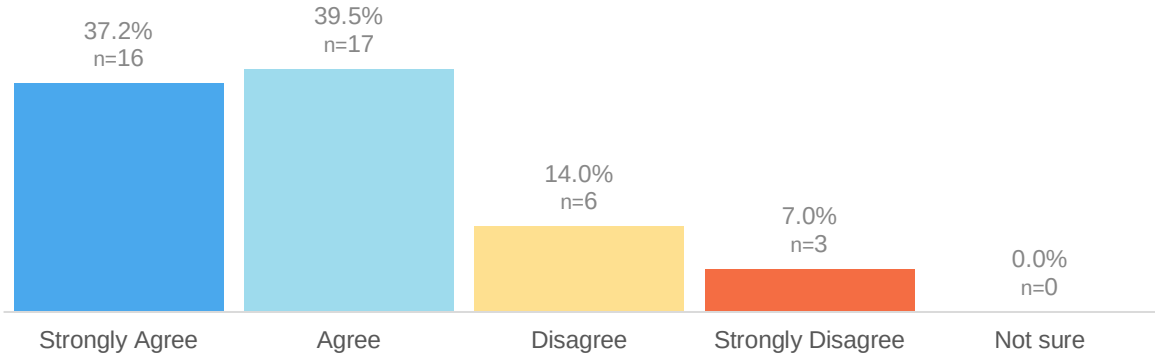


Sustainability

HLIP II has built sustainable capacity to improve pandemic influenza preparedness



HLIP II has supported the development and implementation of national policies and institutions to ensure sustainable results



Annex 9: Progress Against Each of the HLIP II Output Areas

Laboratory and Surveillance

Indicator	Baseline (2017)	Mid-term review Result (2020)	2023 Result	% of biennial target achieved
% of PC recipient countries reporting to FluNet	84%	88%	95%	100%
% of PC recipient countries reporting to FluID	51%	73%	74%	93%
# of HAI risk assessments published	10	30	59	100%
# of Member States reporting at least one influenza severity indicators to WHO's PISA platform	13	14	20	31%
% of Member States that participated and were 100% correct for non-seasonal PCR EQAP	89%	83%	93%	98%
% of Member States that participated and were 100% correct for seasonal PCR EQAP	96%	95%	95%	100%
% of Member States that have sent at least two timely shipments	36%	31%	39%	78%

Burden of Disease

Indicator	Baseline (2017)	Mid-term review Result (2020)	2023 Result	% of biennial target achieved
# of Member States with published (peer reviewed) disease burden estimates based on data collected since 2011	24	43	59	100%
# of Member States that developed or updated an influenza vaccination policy	N/A	33	17	100%

Regulatory Capacity Building

Indicator	Baseline (2017)	Mid-term review Result (2020)	2023 Result	% of biennial target achieved
# of Member States that have implemented a defined regulatory approach that enables timely approval for use of pandemic influenza products	0	27	48	100%
# of Member States which strengthened national regulatory capacity to oversee pandemic influenza products as per WHO benchmarking and IDP implementation	1	7	8	50%

Risk Communications and Community Engagement

Indicator	Baseline (2017)	Mid-term review Result (2020)	2023 Result	% of biennial target achieved
# of users from target audiences who completed learning modules on influenza and related RCCE content on OpenWHO	343	30,897	7,100	3%
# of Member States that utilized RCCE support for influenza preparedness or response	0	51	156	98%
# of pilot countries that have active social digital listening for acute respiratory infections	N/A	N/A	0	0%
# of groups from the EPI-WIN communities engaged in pandemic influenza preparedness initiatives	N/A	N/A	3	30%

Planning for Deployment

Indicator	Baseline (2017)	Mid-term review Result (2020)	2023 Result	% of biennial target achieved
# of simulation exercises conducted to test global deployment of pandemic influenza vaccines and other products	1	6	14	100%
# of Member States that have undergone a national analysis of influenza vaccine procurement or production sustainability	6	9	9	75%
# of Member States that have developed or updated a pandemic influenza national deployment and vaccination plan	N/A	N/A	8	100%

Influenza Pandemic Preparedness Planning

Indicator	Baseline (2017)	Mid-term review Result (2020)	2023 Result	% of biennial target achieved
# of PC recipient countries that developed or updated an IPPP since 2014 *(revised indicator)*	12	35	37	82%
# of PC recipient countries that exercised their IPPP in 2022-23 *(revised indicator)*	2	2	7	35%