2023 ASSESSMENT OF THE STATE OF THE WORLD’S PREPAREDNESS

Appendix to the 2023 Report on the State of the World’s Preparedness
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BACKGROUND: PURPOSE AND METHODS

The Report on the State of the World’s Preparedness is the annual flagship report of the Global Preparedness Monitoring Board (GPMB). It reviews progress over the past year; examines challenges to preparedness for global health crises; and sets out a roadmap for the future. In May 2023 the GPMB launched a comprehensive Monitoring Framework and for its first use in 2023 focused on a subset of key indicators in the areas of leadership and accountability, equity, and coherence. These indicators relate to monitoring and accountability, financing, global governance, research and development (R&D) and access to medical countermeasures, inclusivity and community empowerment, adoption of One Health approaches, and multisectoral coordination.

For each indicator, selected experts provided a preliminary assessment of capacity and trends. In addition, the GPMB consulted with experts and relevant international organizations during the GPMB consultation on the Monitoring Framework. The GPMB then considered these inputs in the light of the overall state of preparedness and made its assessment, which is summarized for each of the indicators below. This appendix provides an overview of key progress, successes, gaps and challenges, and lists priority actions, as identified by the GPMB, based on the expert’s evidence and information.

This appendix should be read alongside the full technical assessment as received from each expert. The GPMB acknowledges the experts and thanks them for their contributions, which have been instrumental in the production of the 2023 Report on the State of the World’s Preparedness (full details of the expert contributions to each indicator are provided in the Compilation of Expert Assessments’).

The Monitoring Framework was designed to evolve over time, as new risks are identified and new knowledge about measures to strengthen prevention, preparedness and resilience emerges, to ensure it continues to capture the most impactful, predictive and actionable indicators. Based on this first experience, the GPMB will revise its Monitoring Framework to integrate lessons learned.
State of the world’s preparedness in 2023

Assessing the status of 30 indicators from the GPMB Monitoring Framework

Figure 1. heatmap

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Capacity scoring
- Excellent/Yes = 3
- Good/Partial = 2
- Insufficient/Incomplete = 1
- Poor/No = 0

Trend scoring
- Improving = +1
- Unchanged = 0
- Declining = -1
1. LEADERSHIP AND ACCOUNTABILITY

Indicator B.1.4.5 (a)
Independent monitoring

Are there global mechanisms to independently monitor and assess progress with preparedness and recommend action?

This assessment was developed based on the work of Clare Wenham from the London School of Economics and Political Science, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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Key points

- The International Health Regulations (IHR) monitoring framework provides the most formal mechanism for monitoring pandemic prevention, preparedness and response (PPPR). The Joint External Evaluations (JEE), part of the framework, are independent; most other elements are self-assessments. While voluntary, at least 116 countries have undertaken at least one JEE.

- The Global Preparedness Monitoring Board was established to independently monitor and assess progress. Five years into its mandate, it would be important to evaluate its functioning and capacity to independently monitor and drive action on PPPR.

Successes and progress

- JEE results are made publicly available, and the new Pandemic Fund has used JEE data as a baseline for assessment of projects.

- The GPMB has published its Monitoring Framework, a multisectoral, whole-of-society framework, using a risk-based approach, which measures the world’s collective capacities and capabilities to address and mitigate health emergencies through prevention, preparedness and resilience measures.

Challenges and gaps

- The World Health Organization (WHO) lacks a mandate to verify scores under the IHR mechanisms.

- Most monitoring mechanisms are not sufficiently multisectoral and are limited in their scope to prevention and containment measures with little consideration given to wider issues, such as governance, leadership or trade-offs in the political, social and structural dimensions. There is also limited monitoring of the determinants of health emergencies.

- There are no monitoring mechanisms linked to accountability for PPPR. The GPMB does not have a formal mandate to report to a governing body or a treaty body.
Monitoring is resource-intensive for countries and there are insufficient resources provided to support them with the process and implementation of the findings.

Monitoring often leads to blaming and shaming, rather than collaboration to improve PPPR.

### Priorities for action

- Independent monitoring should be integrated in the WHO Pandemic Accord and the IHR (2005).
- The mandate of GPMB should be reviewed.
- Positive incentives should be provided for monitoring rather than punitive measures of compliance.
- The conceptual basis and evidence base for independent monitoring should be widened to encompass a full range of social issues, using mixed methods including qualitative approaches.

### Indicator B.1.4.5 (b)

**Independent, universal, periodic review mechanism**

Is there an independent, universal, periodic mechanism to monitor IHR implementation and national action on preparedness and response measures?

This assessment was developed based on the work of Clare Wenham from the London School of Economics and Political Science, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

### Capacity

- Insufficient/Incomplete

### Trend

- Improving

#### Key points

- The Universal Health and Preparedness Review (UHPR) has been developed since 2021 by WHO.³
- The current process involves a national review phase and a peer-review process is in development. There is no independent review component.
- The UHPR is universal, in that it is open to all States. Whether and in what timeframe it will be taken up by all States is not clear.
- The draft Negotiating Text of the WHO Pandemic Agreement establishes a global peer-review mechanism to assess PPPR.⁴

#### Successes and progress

- Five voluntary country pilots of the UHPR national review phase were completed between December 2021 and May 2023. These took place in the Central African Republic, Iraq, Portugal, Thailand and Sierra Leone.
- The UHPR is tasked to provide a process to engage political actors in the process, rather than remaining a technical tool. It intends to generate leadership and commitment from the head of state, mobilizing a whole-of-government and whole-of-society approach beyond the health sector.
Challenges and gaps

- Countries going through the review undertake a self-evaluation, using in large part government data. There is no mandated involvement of civil society or third-party contributions.

- There is yet to be a formal template; countries that have thus far completed the process have not all used the same indicators, making universality and independence more challenging.

- A Global Peer Review Commission is under development, but will likely require considerable resourcing for States to participate equitably. Establishing the Commission to engage representatives from other Member States to provide technical and strategic review and make high-level recommendations, could bring more independence and rigour to the process.

- The periodicity of the UHPR is yet to be determined, and may be constrained by the burden on countries that participation in the process is likely to bring.

- Member State buy-in to the UHPR concept is thus far only partial, so its universality is still in question.

Priorities for action

- The UHPR pilot should be scaled up. A universal health and preparedness review process should be incorporated into the WHO Pandemic Agreement with self-assessment, peer-review and independent review.

- To be effective, the UHPR requires significant resourcing, both for global secretariat functions and to support effective State participation.

- Non-state actors, and in particular civil society, need to be fully integrated into the UHPR process with sufficient attention paid to the independence of their voice.

Indicator B.1.4.4 (a)
Predictability of resources for global health emergency preparedness and response

Is there long-term planning and predictability of sufficient and aligned resources for global health emergency preparedness and response?

This assessment was developed based on the work of Rebecca Katz from Georgetown University, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

Capacity

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Key points

- Planning for emergency preparedness and response occurs on multiple levels, sub-nationally, nationally, regionally, and globally, and is poorly aligned across these levels.

- Financing is becoming more sustainable in certain areas but reliance on official development assistance (ODA) and replenishment cycles is limiting long-term planning capacity.
Successes and progress

✓ The Pandemic Fund and Global Fund to Fight AIDS, TB and Malaria hope to eventually meet some of these resource needs, and provide more alignment.

Challenges and gaps

! Most financing comes from ODA and replenishment mechanisms.

! WHO is moving towards more predictable financing through an increase in the proportion of its funding from Member State-assessed contributions, but the health emergencies programme has traditionally relied very heavily on voluntary donations and the Contingency Fund for Emergencies seems to spend more than it can raise consistently.

Priorities for action

! The Pandemic Fund should be fully financed.

! More sustainable, predictable sources of financing should be identified, especially non-ODA financing.

! WHO and international organizations working on PPPR should be fully funded through predictable financing approaches.

Indicator B.1.3.1

Global financing of global public/common goods

Are global common goods for prevention, preparedness and resilience fully financed?

This assessment was developed based on the work of Sarah England, independent expert, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

Capacity

| Trend |
|-------|-------|
| Poor/No | Declining |

Key points

- While funding for common goods (principally vaccines) was at US $15 billion per year at the height of the COVID-19 pandemic, it has since fallen away rapidly.
- There are worrying signals that common goods funding is decreasing, and that commitment is waning.
Successes and progress

✅ The Pandemic Fund is investing in national strategies, which include common good elements such as surveillance as well as multi-country projects.

✅ Successful COVID-19 initiatives led to the development of key global common goods (vaccines), including the US Operation Warp Speed (US $18 billion), support for the Oxford/Astra Zeneca vaccine designed to be supplied at cost and affordably (GBP 100-225 million), Team Europe’s Initiative on Manufacturing and Access to Vaccines, Medicines and Health Technologies (1 billion Euro).

Challenges and gaps

❗ Demand for countermeasures, including vaccines and diagnostics, has plummeted following the end of the COVID-19 pandemic, markets have collapsed and capacity is following. Investments in global goods outside global health crisis periods has been a challenge.

❗ Financing has fallen away rapidly, notably leading to a shortfall in the Coalition for Epidemic Preparedness Innovation’s (CEPI) replenishment target, and Pandemic Fund oversubscription.

❗ Many common goods, especially vaccines, are not made available as ‘common goods’ to those in need but according to ability to pay.

Priorities for action

→ Strategies are needed to counter the trend of declining common good funding, through multiple channels including innovative financing and more effective domestic resource mobilization.

→ The Pandemic Fund should finance global common goods.

Indicator B.1.3.2

Effectiveness and alignment of spending for preparedness

Is international funding for preparedness adequate, provided efficiently, spent effectively and aligned with agreed priorities and leading to an improvement of global preparedness capacity?

This assessment was developed based on the work of Rebecca Katz from the Georgetown University, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

Capacity

Insufficient/Incomplete

Trend

Declining

Key points

• There are a number of competing global strategies for financing and prioritizing health security efforts, resulting in misalignment and inefficiency.
- Available funds fall far short of needs – the main new funding source for preparedness, the Pandemic Fund, is allocating US $300–350 million this cycle. Yet the needs have been evaluated to be much higher, with estimates ranging from US $75 billion to US $300 billion over the next five years, with another $80 billion needed for global manufacturing and R&D.

- There is a multitude of donors, which contributes to inefficiencies and transaction costs.

**Successes and progress**

- The Pandemic Fund is aiming to improve the efficiency of the allocation process and has aligned its financing with National Action Plans for Health Security.

**Challenges and gaps**

- PPPR financing needs are not clearly defined.
- Analysis has found an inverse relationship between the amount of global financing for a core capacity and sustained capacity over time. This suggests that when external donors set priorities the impact on countries is counterproductive.
- More than one million preparedness financing transactions have been tracked since 2014, from more than 1,000 donors. This suggests major inefficiencies and significant transaction costs to countries, as each donor has different processes.

**Figure 2: Tracking the flow of funds in Global Health Safety**
Priorities for action

→ International funders of preparedness should align and streamline their funding processes, to simplify and unify country applications.

→ The Pandemic Fund should be fully financed, reliance on ODA should be reduced, and new modalities and sources of financing for PPPR should be identified.

Indicator B.1.3.3
Financing of WHO and other key institutions involved in preparedness and response

Are WHO and other key institutions of the global health emergency ecosystem funded adequately, flexibly, and sustainably?

This assessment was developed based on the work of Sarah England, independent consultant, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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Key points

- Member States have agreed to shift more of WHO’s financing to assessed contributions, giving greater flexibility.
- Financing for WHO and other key institutions rely almost entirely on voluntary or earmarked funding, from ODA or replenishment cycles, which are inflexible, unpredictable and unsustainable.
- The level of financing following the COVID-19 pandemic has dropped significantly.

Successes and progress

- WHO Member States have agreed to increase assessed contributions. The gradual increase to assessed contributions will start with WHO’s 2024–25 budget, with a 20% increase over the assessed contributions in the approved 2022–23 base budget. A replenishment mechanism is also planned to start in late 2024.
- As of September 2023, 76% of WHO’s emergencies and appeals budget for the two-year period 2022-2023 is financed.10
- 2022 was a record year for income to the World Fund of the World Organisation for Animal Health (at around 30 million Euro) and members have agreed to increase statutory contributions to 30% in 2025.
- The International Federation of Red Cross and Red Crescent Societies has doubled allocations at country level. (IFRC)11,12
Challenges and gaps

- Funds that went to financing COVID-19 activities are now being redirected by donors to other development priorities.13
- Over 80% of WHO’s budget is from voluntary contributions, of which the great majority are earmarked (close to 95%).14
- The Global Fund 2022 replenishment target of US $18 billion was not met (US $15.7 billion was raised). However, this is the Fund’s biggest replenishment to date.15
- CEPI’s 2022 replenishment fell short of its US $3.5 billion goal by US $2 billion.16

Priorities for action

- Capability should be secured for an early, strong, well resourced, joint resource mobilization campaign with shared branding, using pre-existing tools, such as a pooled fund with allocation mechanism, and front-loading financial mechanisms to spend against pledges for future pandemic threats.
- Organizations should reduce their reliance on ODA and replenishment mechanisms.
- WHO Member States should further progress towards WHO flexible (non-earmarked) funding through assessed contributions, including to the Health Emergencies Programme.

Indicator B.1.3.4
Global surge financing for response

Is there an effective global, adequately financed and sustainably replenished mechanism for rapid funding of the global health emergency response?

This assessment was developed based on the work of Sarah England, independent consultant, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

Capacity

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Key points

- Existing mechanisms are effective, but are not able to provide adequate financing in a sufficiently timely manner. They are continuously but not sustainably replenished. Most importantly, they cannot meet the needs of global surge financing for response.
- The biggest gaps are in substantial funding for global and domestic responses. These are in the order of hundreds of millions for the global Day-Zero response, and tens of billions of financing in the first three months of a major health emergency for R&D, and access to medical countermeasures for use...
by low- and middle-income countries (LMICs) and others that have challenges in accessing markets for these products.

- Surge financing is not always allocated effectively across needs of health emergency response, based on identified priorities.

### Successes and progress

- The WHO Contingency Fund for Emergencies (CFE) and the UN Central Emergency Response Fund (CERF) are highly effective rapid mechanisms to deliver very early response funding.
- Multilateral development banks are taking stock of their financing instruments for PPPR. For example, the World Bank Group is exploring enhancing its financing model and crisis response toolkit. Additionally, the G7 and G20 have committed to addressing governance and financing challenges.
- Reallocation of existing project funds is a fast and effective way to make crisis financing available to countries but leads to funds being diverted from other important priorities.

### Challenges and gaps

- The amounts available through WHO, CFE, the United Nations, and CERF are far too small to cope with multiple concurrent country emergencies that occur in a rapidly evolving pandemic scenario.
- The system for response financing is poorly coordinated due to high fragmentation and suffers from a lack of transparency.
- Significant funding was raised for the COVID-19 response, but there were gaps in the hundreds of millions for Day-Zero rapid response funding. In addition, available funds would have been more effective if they had been available earlier.
- At-risk financing of R&D and manufacturing, as well as for the advance purchase of medical countermeasures, was inadequate in LMICs. The sources and uses of available financing contributed to inequity in eventual access to medical countermeasures in the COVID-19 response.

### Priorities for action

- Surge financing must be substantially increased.
- Predictable replenishment mechanisms must be devised.
- Better coordination of funding partners would create greater opportunities for impact.
Indicator B.1.3.5 (a)
Funding immediate economic and socioeconomic response

Is there a global financing mechanism to rapidly and adequately mitigate the economic and socioeconomic consequences of pandemics and major outbreaks?

This assessment was developed based on the work of Sarah England, independent consultant, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

**Capacity**

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**Key points**

- There is no single global financing mechanism to fund the immediate economic and socioeconomic response. While the COVID-19 pandemic demonstrated that large amounts can be released, these funds are ad hoc, uncoordinated and not all disbursed in a timely manner.

- The International Monetary Fund (IMF), the World Bank Group and regional development banks responded quickly to provide crisis financing and debt service relief within the first three months after the declaration of the COVID-19 public health emergency of international concern (PHEIC).

- Over the course of the COVID-19 pandemic, US $200 billion was made available by more than 10 multilateral development banks, through both pre-arranged contingency and new external financing.

- Uptake was slow, as a result of competing priorities, unpredictability, debt pressure, country capacity for response planning, and proposal processes better suited to development financing than emergencies.

**Successes and progress**

- The World Bank Group, G7 and G20 are exploring how to better provide rapid access to financing at adequate levels and through the right channels for health emergency response.

- The IMF COVID-19 lending tracker shows that from March 2020 to March 2022, the IMF provided financing of approximately US $171 billion to 90 countries.

- The G20 offered debt service relief to 73 countries through the World Bank Group from May 2020 via the Debt Service Suspension Initiative, which resulted in US $12.9 billion in suspended payments in the period to December 2021.

- UNICEF and the Global Fund reprogrammed financing that had already been allocated or used balance sheet flexibility to provide crisis financing rapidly for COVID-19, including needs beyond the health sector.

**Challenges and gaps**

- During COVID-19, resources provided exceeded the US $100 billion prescribed in this indicator. However, these funds were not provided within the timeframe suggested by this indicator, i.e., 90 days following the PHEIC/pandemic declaration. They were often disbursed slowly once allocated.

- Much financing provided during COVID-19 was provided through ad hoc processes developed during the pandemic and for the pandemic only. Several have already expired and therefore might not be in place for future pandemics (e.g., the Debt Service Suspension Initiative).
Challenges with the coordination and predictability of financing affected uptake and effectiveness.

Not all countries qualified for debt service relief through the IMF or the World Bank/G20, or for crisis financing instruments due to conditionalities.

**Priorities for action**

→ A sustained global consensus on funding channels should be established in order to increase the predictability of resourcing and lessen suboptimal uptake.

→ Availability of concessional financing should be increased and access to financing opportunities should be improved by lessening or abolishing conditionalities in health emergency contexts.

→ Debt sustainability should be improved and debt suspension mechanisms should be implemented more broadly.

**Indicator B.3.3.1**

National assessment of financing for preparedness and response

Is national preparedness sufficiently, adequately and sustainably financed? Do countries have government-wide, adequately financed contingency funds to support the national response to health emergencies?

This assessment was developed based on the work of Sarah England, independent consultant, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

**Capacity**

- Insufficient/Incomplete

**Trend**

- Unchanged

**Key points**

- According to the Global Health Security Index, the average country score for financing is 35%. The current funding gap for preparedness at country level is approximately US $6 billion per year. There is insufficient international financing to fill this gap.

- Most funding for national preparedness is based on an unsustainable ODA model.

- A survey conducted for the G20 Joint Finance–Health Task Force indicated that only 40% of countries had domestic contingency funds that could be deployed in a health emergency.

**Successes and progress**

- The Pandemic Fund was created to support countries with PPPR. The Fund was able to raise pledges of approximately US $1.9 billion in 2023 out of its US $10 billion target.

- The Global Fund has facilitated the use of approximately US $800 million from the COVID-19 Response Mechanism that was not implemented during the COVID-19 pandemic, for health systems strengthening including investments in oxygen systems that contribute to health emergency preparedness.
Challenges and gaps

The pendulum of political attention is swinging away from public health towards areas that were relatively neglected during the COVID-19 crisis, such as climate change and migration.

Countries have reduced their PPPR spending and international funding has also decreased following COVID-19. Many capacities are being lost. Infrastructures created during the pandemic will need to be replaced over the next few years. However, it is unlikely that the funds needed to do this will be available on the same scale.

Domestic funding is key to preparedness, but the COVID-19 crisis demonstrated that countries have not chosen to take up all available concessional financing for health emergency response, preferring to use grants.

Many countries are going through a debt crisis and spend more on debt servicing than on health or education. This has increased significantly during the pandemic. Low-income countries pay higher interests than higher income countries, and have to rely on foreign - and often private - creditors which increases their exposure to external shocks and makes credit expensive and debt restructuring complex. Countries have to choose between servicing debt or investing in PPPR.

The Pandemic Fund has struggled to raise sufficient funds to reach its US $10 billion goal. Funds made available in the first funding round are only US $300-350 million, while countries requested approximately US $7 billion.

Only a limited number of World Bank Group contingent instruments could be immediately employed by countries at the crisis onset and so planning and anticipatory activities which could have mitigated much of COVID-19’s impact were not funded.

Figure 3: Several countries are spending more on debt interest payments than health

### Priorities for action

- A development assistance model of preparedness funding is not fit for purpose, and leads to delays, inconsistent use of funds, and a lack of effective prioritization. A model that matches resource strengths to needs and is grounded in domestic ownership needs to guide financing.

- Improving debt sustainability will liberate capital for countries to invest in their own preparedness.

### Indicator B.1.4.1 (a)

#### Global platform to support leadership

Is there a dedicated global platform for the governance of health emergency preparedness and response, which brings cohesion, removes fragmentation and facilitates collective action and where national, regional and global stakeholders can coordinate, plan, and agree on priorities and that can be leveraged in the event of a health emergency?

This assessment was developed based on the work of Adam Kamradt-Scott from Harvard University, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

#### Capacity

| Insufficient/Incomplete |

#### Trend

| Improving |

#### Key points

- There is no global platform to support leadership that can bring together stakeholders across sectors and that allows meaningful involvement of civil society, the private sector, and communities.

- The explosion of different proposals and initiatives for the governance of PPPR threaten to bring further fragmentation.

- Greater clarity is needed on leadership functions, with the form of any proposed institutional reform following the function.

#### Successes and progress

- The World Health Organization is currently the platform that meets the most criteria of the indicator (it is global and facilitates collective action).

- The new WHO Standing committee on health emergency prevention, preparedness and response (WHO SCHEPPR), composed of WHO Member States’ representatives, was created under the WHO Executive Board to provide guidance to the GPMB and the WHO Director-General before and during health emergencies. Its focus is mainly on the work of the WHO Health Emergencies programme.

- The WHO Pandemic Agreement will likely include a Conference of the Parties (COP) that can play a role in facilitating collective action and bringing cohesion.

- The United Nations Secretary-General has made a proposal to establish an Emergency Platform to respond to complex global crises. The platform would bring together leaders from Member States, the
United Nations system, key country groupings, international financial institutions, regional bodies, civil society, the private sector, subject-specific industries or research bodies and other experts. Proposals to create a forum for heads of state/leaders to meet rapidly following identification of an international public health threat/emergency are under consideration, but are yet to be resolved.

**Challenges and gaps**

- WHO as a platform lacks adequate space for meaningful participation of civil society, private industry and other non-state actors. Member States have repeatedly declined proposals to reform WHO to allow for more participatory governance that might derogate from their authority.
- The WHO SCHEPPR is limited in scope and the WHO Pandemic Agreement will likely have a limited multisectoral approach. It is likely that neither of them will be empowered to meaningfully address issues beyond health. The United Nations Secretary-General’s proposal to establish an Emergency Platform is limited to response in relation to health emergencies and does not include prevention and preparedness.

**Priorities for action**

- The needs to be addressed by leadership platforms should be assessed: stronger and inclusive deliberative processes to advise leaders, better programmatic coordination and resource allocation, or empowerment of WHO’s health emergency functioning. They must be designed to meet the specific functions needed.
- Strengthening leadership platforms should include ways to enable non-state actors to participate meaningfully and secure participation at the highest leadership level.
- An effective global leadership platform should be able to address multisectoral PPPR issues such as climate, agriculture, trade, finance, travel, supply chains and transport, security, and others, and prioritize regular and meaningful engagement with key relevant stakeholders and partners across sectors of PPPR, building on good models of inclusive engagement in other areas of United Nations/multilateral system operations.

**Indicator B.1.4.1 (b)**

**Strategic plan**

Is there an agreed global, multisectoral, cross-agency and holistic strategic plan for health emergency preparedness and response?

This assessment was developed based on the work of Adam Kamradt-Scott from Harvard University, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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<tbody>
<tr>
<td>Poor/No</td>
<td>Unchanged</td>
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### Key points

- There is no overall global strategic plan for global, multisectoral, cross-agency health emergency preparedness and response.
- Existing strategic plan elements are represented by the frameworks established in the IHR (2005) and in the guidance from the WHO Emergencies Programme as well through guidance issued by other international organizations involved in PPPR, including the UN Inter-Agency Standing Committee.
- The WHO Pandemic Agreement may provide a key opportunity to strengthen strategic planning coordination and capacity globally.

### Successes and progress

- The IHR (2005) provide a common basis for assessing and strengthening strategic planning and, to that extent, constitutes a global plan. However, its focus is narrowly focused on a public health approach to PPPR.
- The WHO Pandemic Agreement may extend the comprehensive nature of a strategic plan.
- The Political Declaration on PPPR, although limited in its multisectoral focus and commitments, also offers some element of a high-level strategy for PPPR.

### Challenges and gaps

- Existing strategic plan, instruments and tools do not encompass the multisectoral, cross-agency dimensions or do not address the full continuum of PPPR.
- The WHO Pandemic Agreement as it stands does not encompass economic and social dimensions of pandemics.

### Priorities for action

- The scope of the WHO Pandemic Agreement should better encompass multisectoral preparedness as well as social and economic dimensions.
- An approach to better coordinate across sectors and actors is urgently needed.

### Indicator B.1.4.2

**International regulatory instrument**

Is there an international regulatory instrument with clear, enforceable priorities and targets around preparedness and obligations related to data sharing and equity during a health emergency response?

This assessment was developed based on the work of Gian Luca Burci from the Graduate Institute of International and Development Studies, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.
**Capacity**

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<th>Trend</th>
<th>Good/Partial</th>
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**Key points**

- There is not one international regulatory instrument for PPPR. PPPR is regulated through a range of instruments across different sectors and international organizations, such as the IHR and the Pandemic Influenza Preparedness (PIP) Framework under WHO and the TRIPS agreement under the World Trade Organization (WTO), which impact R&D and access to medical countermeasures, and the Nagoya Protocol under the United Nations Environment Programme (UNEP), which governs the sharing of pathogens and the benefits arising from their use.

- The closest the international community is to a clear and enforceable instrument is the current negotiation of a WHO Pandemic Agreement, in parallel with the proposed amendments to the International Health Regulations, but the outcome of these negotiations is as yet uncertain.

**Sector** | **International regulatory framework** | **Elements covered**
---|---|---
Health | International Health Regulations (2005) | Prevention, detection and response to health emergencies, including PPPR core capacities, information sharing and PHEIC Declaration
Health | Pandemic Influenza Preparedness Framework (non-legally binding) | Access to medical countermeasures for pandemic influenza, PPPR core capacities
One Health | WOAH Standards and surveillance framework (non-legally binding) | Outbreak detection in animals
One Health | FAO/WHO Codex Alimentarius Commission (non-legally binding) | Food contamination
One Health | 2022 One Health Joint Plan of Action (non-legally binding) | Quadripartite collaboration between One Health organizations
Environment | Nagoya Protocol/Convention on Biological Diversity | Pathogen-sharing and access to benefits derived from their use
Environment | Multilateral Environmental Agreements (MEA) | Addressing determinants of health emergencies
Intellectual Property | TRIPS Agreement | Access to technologies and medical countermeasures
Global financial system | IMF Articles of Agreement; bilateral investment treaties | Financing of PPPR
Trade | GATT Agreement and other trade agreements | Trade restrictions
Disaster risk reduction | Sendai Framework (non-legally binding) | Pandemic prevention
Human rights | Right to health | Access to healthcare
Successes and progress

✓ WHO Member States have mandated an Intergovernmental Negotiating Body (INB) to begin a global process to draft and negotiate a convention, agreement or other international instrument under the Constitution of the World Health Organization to strengthen PPPR.

✓ The Draft Negotiating Text of the WHO Pandemic Agreement covers many of the areas identified in this indicator. However, it is limited in its multisectoral approach and does not set targets for PPPR.

✓ WHO’s non-binding Pandemic Influenza Preparedness (PIP) Framework, the sole international access and benefit-sharing instrument in the health field, has generated both resources and momentum, albeit only in relation to pandemic influenza.

Challenges and gaps

! There are important regulatory gaps relating to One Health, especially regarding the prevention of spillovers, access and benefit-sharing (beyond influenza), and equitable access to medical countermeasures.

! The IHR lack an institutionalized compliance and accountability mechanism and dedicated provisions on financing.

! Negotiating positions on the WHO Pandemic Agreement as yet seem far apart, with significant North-South and related divides. Despite a commitment to do so, it is unclear whether WHO Member States will be able to adopt the Agreement in time for the May 2024 deadline.

Priorities for action

→ Successful agreement of an ambitious, inclusive and binding WHO Pandemic Agreement will be critical. Failure would be a significant setback.

→ The most important regulatory gap is the One Health approach, in particular primary prevention to reduce the risk of zoonotic spillover. There is no international instrument that covers this area.
2. **EQUITY**

**Indicator B.1.1.2.1**  
**Global R&D coordination and priority setting**

Is there an appropriate and inclusive global governance and coordination system for R&D that supports priority setting, advanced planning, and capacity to rapidly mobilize resources to support end-to-end development, production, procurement, and equitable access to medical countermeasures for health emergencies?

This assessment was developed based on the work of Suerie Moon from the Graduate Institute of International and Development Studies, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

**Capacity**

- Insufficient/Incomplete

**Trend**

- Declining

**Key points**

- There is no appropriate and inclusive global governance and coordination system for R&D that supports priority setting and advance planning.
- Better coordination of R&D will require understanding drivers of different R&D actors, including the private sector, and a more collaborative approach.
- There are very few investments in building capacity to support R&D and access to medical countermeasures.
- While, in principle, resources can be relatively rapidly mobilized during a crisis from governments and philanthropic funders, in reality, such mobilization is uncoordinated and siloed.
- Institutional arrangements to ensure end-to-end development are insufficient, as are arrangements for production, procurement and equitable access to medical countermeasures for health emergencies.

**Successes and progress**

- The WHO R&D Blueprint for emerging infectious diseases, initially developed in response to the 2014-16 West African Ebola crisis, helps set priorities by identifying the pathogens likely to cause international health emergencies and for which existing health technologies are insufficient. The Blueprint team develops an R&D roadmap and target product profiles for each pathogen on the list, providing further guidance to product developers. WHO cannot compel any research funder or research institution to follow these priorities, but there is evidence it has influenced R&D decision-making.
- The WHO Access to COVID-19 Tools Accelerator (ACT-A) facilitated coordination and collaboration between global health agencies, enabling a faster response to COVID-19.
- Negotiations of the WHO Pandemic Agreement indicate an interest by Member States to strengthen global R&D coordination.
During the COVID-19 pandemic, WHO demonstrated capacity to convene upon short notice the international scientific community to discuss and seek to reach agreement on R&D priorities, starting as early as February 2020.

The WHO Global Observatory on Health R&D is an important step forward in making more legible a vast, diverse and global set of R&D activities.

A number of public and philanthropic R&D funders have begun placing conditions on their funding to promote equitable access. While contracts between funders and grantees for health emergency R&D have generally been kept confidential, there have been a growing number of instances of such contracts being made publicly available.

Challenges and gaps

As part of negotiations towards a WHO Pandemic Agreement, Member States are considering whether governments will commit to place equitable access conditions on their R&D funding, but there is opposition from some countries to doing so.

No entity has the authority or mandate to coordinate research institutions or research funders. At best, WHO can monitor progress against the priorities it has identified, but even there, resources are limited. For example, the Global R&D Observatory relies on data collected by other actors and has little capacity to follow-up on identified gaps.

While ACT-A played an important role during COVID-19, it struggled due to its informal governance structure and the lack of inclusion of LMICs and regional bodies. In addition, ACT-A was a time-limited initiative, focused on supporting the COVID-19 response.

Funders are reluctant to give up autonomy in how they set their own priorities.

R&D for emerging infectious diseases is primarily funded with public money, as it is too risky for the private sector. But national governments, who remain the main R&D investors, have been reluctant to tie equitable access conditions to their funding of private firms, universities and other research institutions.

Government research funders prioritize narrowly conceived national self-interest in their R&D investments for health emergencies.

R&D investments for countermeasures are decided by public and philanthropic funders, largely concentrated in the Global North and governance of these investments does not systematically include representatives from LMICs.

Priorities for action

Without a clear commitment to ensuring the fruits of publicly financed R&D are accessible to all, there is unlikely to be equitable access to countermeasures in an end-to-end system.

There is more space for inclusive governance in international funding entities, such as CEPI, the Pandemic Fund or philanthropic funders (e.g., Gates Foundation, Wellcome).

A priority should be to develop a sustainable R&D ecosystem. Its elements need to include bringing together data and mapping the landscape, priority setting, incentives and other mechanisms to shape investment, coordination, advance ‘peacetime’ planning, and long-term sustainable capacity-building.

Funders should agree to include terms of equitable access in funding agreements.
**Indicator B.1.1.2.4**

**R&D capacity-building**

Are there effective global mechanisms supporting technology transfers for vaccines, therapeutics, diagnostics, personal protection equipment (PPE) and medical technologies as well as capacity-building to develop R&D capacities at the regional and national levels?

This assessment was developed based on the work of International Pandemic Preparedness Secretariat (IPPS) and IPPS Science and Technology Expert Group (STEG), as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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<th>Capacity</th>
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<td>Insufficient/Incomplete</td>
<td>Improving</td>
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</table>

**Key points**

- There is insufficient R&D spending on WHO’s R&D Blueprint pathogens and there is a significant lack of funding for research in lower-income settings.
- There are some promising technology transfer programmes (e.g., MPP, C-TAP, DCVMN and the mRNA Technology Transfer Programme), but these could be more widely adopted. The efficient use of resources requires more coordination and alignment of industry, academia and funders.
- Global spending on R&D has reached a record high of almost US $1.7 trillion, but just 10 countries account for 80% of this spending.³²

**Figure 4: R&D spending by country**

The circles show the amounts countries are spending on R&D in PPP$. Countries farther to the right are spending relatively more in terms of their GDP. Those closer to the top have higher numbers of researchers per 1 million inhabitants.
There are 60 times the number of health researchers per million population in high-income countries than in low-income countries.\textsuperscript{33}

Only 3% of the 61,000 products in the development pipeline target R&D Blueprint pathogens.\textsuperscript{34}

While research partnerships hold promise for capacity-building, in 2020, 98% of biomedical research grants resulting in collaborations were to high-income country recipients, and of these, 83% were collaborations among only high-income country partners.\textsuperscript{35}

### Successes and progress

Major global initiatives are the COVID-19 Technology Access Pool (C-TAP), the Pandemic Influenza Preparedness Framework (PIP), the Medicines Patent Pool (MPP), the Developing Countries Vaccine Manufacturing Network (DVCMN) and the mRNA Technology Transfer Programme.

Technology transfer: a variety of technologies are now included in technology transfer programmes including vaccines, diagnostics and therapeutics. These increased LMICs’ access to tools and medicines during COVID-19.

Research capacity: large amounts of research funding was mobilized during the COVID-19 pandemic compared to other disease outbreaks. There is also a growing appreciation for networks and collaborations to build R&D capacity in LMIC settings that proved valuable during the COVID-19 pandemic.

### Mechanism

**C-TAP**
- **Status:** 44 member states (Sept 2022)
- **Milestones:** Nov 2021, Spanish Research Council shares IP rights; May 2022 US NIH shares technology (treatment, early stage vaccine and diagnostics)
- **Advantages:** Transparent; public health oriented; voluntary
- **Disadvantages:** Voluntary; some HICs won’t participate; bilateral agreements have been made outside initiative

**PIP**
- **Status:** WHO member states, industry partners and other stakeholders
- **Milestones:** Partnership contributions from pharma manufactures of $256m since 2012
- **Advantages:** Active state engagement in implementation has led to improvements of preparedness, involvement of private sector
- **Disadvantages:** Time to share surveillance data; competing epidemics and priorities lead to challenges with

**MPP**
- **Status:** 3 COVID-19 antivirals sub-licensed and procured by more than 100 LMICs; 27 billion doses of generic products supplied to 140 countries
- **Milestones:** Recognized as effective model
- **Advantages:** Voluntary licensing increased; Originator companies gain improved compliance and reputation, generic licensees gain access
- **Disadvantages:** Strongest impact on HIV, hepatitis C, tuberculosis. Support for COVID-19 but does not normally prioritize pathogens with pandemic potential

**DVCMN**
- **Status:** Voluntary alliance of 40 developing country manufacturers
- **Milestones:** 60% of global COVID-19 vaccine manufacture from members
- **Advantages:** Accelerated tech transfer from members to 170 countries during COVID-19

**mRNA hub**
- **Status:** Co-convened WHO and MPP
- **Milestones:** Partnerships with 15 governments and organizations
- **Advantages:** Multilateral process to support local and regional manufacture
- **Disadvantages:** Initially just focused on COVID-19
## Challenges and gaps

- Technology transfer: there is limited capacity for LMICs to support technology transfer, even where high-income partners are willing, especially in skilled staff. Data on the progress of, and barriers to, technology transfer is limited. Programmes are often siloed and disease-specific, with limited ability to shift capacity in line with changing needs.

- It can be difficult to incentivize pharmaceutical companies to participate in voluntary patent pools over bilateral agreements.

- Research capacity: There is limited infrastructure and capacity to conduct and produce high-impact research from LMICs, with R&D funding and expenditure dominated by high-income countries.

## Priorities for action

- The limited resources for R&D blueprint pathogens should be well coordinated amongst donors, gaps in our global R&D arsenal should be highlighted and incentives for investment should be created to address the gaps.

- The R&D Blueprint should publish an updated list of priority pathogens to support coordination and prioritization around the R&D agenda.

## Indicator B.1.1.2.7 (a)

### Coordination during health emergencies

Is there a demonstrated capacity for the R&D ecosystem to coordinate and rapidly switch to emergency mode, including for manufacturers to start R&D and switch or scale up their production?

This assessment was developed based on the work of International Pandemic Preparedness Secretariat (IPPS) and IPPS Science and Technology Expert Group (STEG), as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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<th>Capacity</th>
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<tr>
<td>Insufficient/Incomplete</td>
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</table>

### Key points

- A coordinated global system does not exist; if another pandemic were to break out today, countermeasure development would be dominated by market forces, with inequitable outcomes.

- No global actor can develop countermeasures within 48 hours of a PHEIC declaration.
Table. Examples of initiatives to improve R&D coordination during health emergencies

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Aim</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>100 Days Mission</strong></td>
<td>Align countries, industry and global health organizations to be able to develop medical countermeasures within the first 100 days of a pandemic threat</td>
<td>In development. CEPI leads vaccines, FIND leads diagnostics and Unitaid leads therapeutics with an alliance of other partners</td>
</tr>
<tr>
<td><strong>ACT-A, through FIND &amp; Unitaid</strong></td>
<td>Increase manufacturing capacity</td>
<td>Ended. Increased capacity in China and India, committing to supply a minimum volume of product to LMICs at a ceiling price and increasing manufacturing capacity in Senegal and Brazil.</td>
</tr>
<tr>
<td><strong>Trials Coordination Board (Norwegian Institute of Public Health and European Clinical Research Infrastructure Network)</strong></td>
<td>Improve trial coordination across Europe and with WHO.</td>
<td>Began with COVID-19 therapeutics and vaccines, now includes mpox, brings together investigators of large trials internationally, regulatory bodies (EMA), industry partners and experts from across sectors.</td>
</tr>
<tr>
<td><strong>Clinical Trials Information System (European Medicines Agency)</strong></td>
<td>Streamline approach to the registration of clinical trials in Europe.</td>
<td>Came into effect on 31 Jan 2022.</td>
</tr>
</tbody>
</table>

**Successes and progress**

- COVID-19 showed that medical countermeasures can be developed faster with large public investments, joint planning of clinical development, regulation and manufacturing capacity and leveraging innovative platforms, but these benefits were apparent largely in high-income settings.
- WHO R&D Blueprint met in February 2020, approximately one month after the first COVID-19 cases, to map knowledge gaps and define research priorities for COVID-19, although it was not convened again over the course of the pandemic.
- Vaccines have received more emphasis than therapeutics or diagnostics, but rapid diagnostic test production capacity grew from 207 million tests per year in 2020 to 1.866 billion in 2022.
- Diagnostics were developed rapidly in COVID-19 (3–5 days after genome sequence publication) but regulatory steps were much slower (200+ days).
- In the Sudan Ebolavirus outbreak, a partnership led by the Serum Institute of India with Oxford University and CEPI brought a vaccine candidate to trial within 79 days of the outbreak.

**Challenges and gaps**

- Despite increasing coordination during health emergencies, supplies of medical countermeasures are largely secured by high-income countries (for example, inequitable access during COVID-19 and the mpox outbreaks) while LMICs are dependent on donations.
- LMICs often do not have the capacity to develop countermeasures outside of an emergency (due to limited manufacturing capabilities, personnel and cold chain equipment for vaccine distribution).
- An assessment of various outbreak responses in Brazil, Ethiopia, Liberia, Nigeria and Uganda between 2018–22 showed that, in half of cases, an early response (including laboratory diagnosis) was not completed within 7 days.
Priorities for action

→ R&D coordination should start well in advance of a PHEIC and would require an earlier trigger point. There is a need to take the “risk” of starting and then stopping if the emergency does not evolve.

→ WHO could play a more important role in supporting the development of countermeasures at the beginning of an emergency, including by providing the trigger for manufacturers to start R&D and switch or scale up their production. A WHO roadmap could support better coordination.

→ The WHO Pandemic Agreement should enshrine R&D coordination.

→ Investment to fill the gaps in our R&D arsenal should increase, using WHO R&D Blueprint priority pathogens, and emphasizing diagnostics and therapeutics.

→ During inter-pandemic periods more efficient product development and approval pathways should be embedded as learned during COVID-19.

→ Agreements should be established in advance of emergencies on the coordination of product development, approval and manufacture, and with terms for equitable access to medical countermeasures.

→ Knowledge gaps in the R&D coordination ecosystem (e.g., landscaping manufacturing capacity and pipelines) should be addressed.

→ Regional governance and coordination, regulatory barriers (e.g., test validation networks, plans for stockpiling and preparedness funding) should be improved, and developing pan-family diagnostic tests should be developed during inter-pandemic periods.

Indicator B.2.1.2.2
Regional manufacturing capacity

Is there sufficient regional manufacturing capacity for vaccines and therapeutics across WHO regions?

This assessment was developed based on the work of the International Pandemic Preparedness Secretariat (IPPS) and IPPS Science and Technology Expert Group (STEG), as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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<th>Capacity</th>
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<tr>
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Key points

- Global pandemic vaccine manufacturing capacity has increased significantly in recent years, due in large part to the COVID-19 pandemic. However, unless significant resources are invested, this is unlikely to translate to each of the WHO R&D Blueprint pathogens or Disease X.

- No assessment has been made of therapeutics capacity.

- Manufacturing capacity is not uniformly distributed across regions – it is concentrated in Southeast Asia, Europe, and North America. Africa, South America, and the Middle East have relatively low vaccine manufacturing capacity regionally.
For pandemic influenza, the best-case scenario is for the world’s population to be covered within a year. However, this depends highly on the number of doses needed.

Table. Estimated global and regional manufacturing capacity

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Estimated pandemic influenza vaccine production capacity between 8.1 billion doses in 12 months (best case) and 4 billion (moderate-case). In the best case, if two doses are needed, only half of the global population is covered, with a production lead time of 4 to 21 weeks.</th>
<th>No regional estimates.</th>
</tr>
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<tbody>
<tr>
<td>Pandemic influenza vaccines</td>
<td>COVID vaccines production capacity of 14 billion doses by the end of 2021, more than 150 partnerships with contract development and manufacturing organizations.</td>
<td>55% of manufacturing capacity in East Asia, 40% in Europe and North America, and less than 5% in Africa and South America.</td>
</tr>
</tbody>
</table>

Note: Global vaccine capacity is assessed on the basis of production capacity for COVID-19 and influenza vaccines.

Successes and progress

Regional initiatives: The Africa CDC-led Partnership for Africa Vaccine manufacturing involves 10 existing manufacturers and 17 incoming manufacturers, with a majority planning fill-finish as their production entry-point. A World Economic Forum-led Regionalized Vaccine Manufacturing Collaborative is developing a framework. There are also initiative lids by the Association of Southeast Asian Nations (ASEAN) and the Pan American Health Organization (PAHO).

Research Agenda for future pandemic manufacturing capacity: R&D initiatives include the G7 100-day mission; the WHO mRNA network for vaccine development and a technology transfer hub; the G20 Global Vaccine Research Collaborative; and CEPI global vaccine libraries.
Challenges and gaps

- Vaccine manufacturing is concentrated in a few countries, mainly high-income countries, with notable manufacturing capacity in China and India.
- One constraint is the lack of high biocontainment manufacturing facilities in many countries, even if all other elements were available.
- Challenges include:
  - Time taken to switch (from routine vaccines to pandemic vaccines) and to scale up surge;
  - High cost of some vaccines and inequalities of procurement mechanisms;
  - Lack of regulatory capacity;
  - Need to develop sustainable markets.

Priorities for action

- To improve regional manufacturing capacity, a system is needed to establish major technology platforms regionally, as well as create markets for the production of routine vaccines and allied products, so that facilities can be sustainable and agile enough to quickly respond to outbreaks or pandemics.
- A global vaccine manufacturing roadmap should be developed that identifies the specific capacity needs and gaps and defines a research agenda. This roadmap should be used to track progress.
- Invest in more efficient and scalable manufacturing platform processes.
- Sustainable markets for products developed in regional facilities should be developed so that they might have viable business models in between major outbreaks.

Indicator B.3.1.2.1
Assessment of national R&D innovation, development, and access to medical countermeasures

Do countries have adequate national emergency regulatory approval procedures/capacity? Do countries’ health systems have the capacity to deploy medical countermeasures? Do countries ensure equity in R&D and access to countermeasures? Do they involve communities in research and identify/address the needs of different communities? Do countries ensure access to medical countermeasures by vulnerable and marginalized communities?

This assessment was developed based on the work of the International Pandemic Preparedness Secretariat (IPPS) and IPPS Science and Technology Expert Group (STEG), as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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<th>Capacity</th>
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Key points

- While a majority of countries do not have a mature regulatory system, many have the capacity to approve vaccines during a pandemic or health emergency through emergency procedures and via support of the WHO prequalification and Emergency Use Listing (EUL) procedures.

- According to the 2021 Global Health Security Index, 91% of countries do not have a plan, programme, or guidelines in place for dispensing medical countermeasures during a public health emergency, and there has been little progress since 2019 in improving systems.36

- Clinical research inclusiveness has declined over the last 10 years.37

- COVID-19 has disproportionally impacted vulnerable and marginalized communities across the world. Yet, lack of diversity and inclusion in R&D is limiting their access to medical countermeasures.

Successes and progress

- ACT-A delivered 176 million tests to 184 countries, allocated over 300,000 therapeutics to countries globally, and through COVAX, delivered 1.96 billion vaccine doses to 146 countries.38 The Roadmap for Prioritizing Uses of COVID-19 Vaccines issued by the WHO Strategic Advisory Group of Experts on Immunization is a guidance-based approach to prioritization.

- There are examples from HIV responses of effective inclusion of marginalized groups across all stages of R&D innovation and access (e.g., the DolPHIN-2 dolutegravir trial).39

- Research funders and institutions have been making a more active effort to improve R&D diversity by increasing the participation of vulnerable groups and minorities in research and clinical trials, improving representation of research leaders from geographies with the highest burden of disease, and increasing funding for projects that include vulnerable groups.

Exemplar – United Kingdom’s rapid approval of COVID-19 vaccines

During the COVID-19 pandemic the United Kingdom was the first country to approve the Pfizer-BioNTech COVID-19 Vaccine via a temporary authorization for emergency use. The UK Medicines and Healthcare products Regulatory Agency began the evaluation process for the vaccine on 1 October 2020 with an approval granted by 2 December 2020, facilitated through rolling data submission – where the vaccine developer was allowed to submit the data related to product efficacy and safety in batches as it became available.40

Challenges and gaps

- Delivering equitable approaches on the global scale is particularly challenging, as evidenced by universal health coverage gaps in many Sub-Saharan Africa and South-East Asian countries.

- Only 50 of 194 WHO Member States (26%) have national regulatory systems that are classified as ‘mature’.41

- Much data on the use of, and access to, medical countermeasures is not publicly available or is insufficient.

- Criminalization and social exclusion of key populations is preventing their access to medical countermeasures (for example, 66 jurisdictions criminalize private and consensual same-sex sexual activity, impeding mpox vaccination where these populations are most affected).42
Priorities for action

→ There is a need to build on existing and ongoing global and regional approaches to support less developed countries in accessing R&D innovation and countermeasures.

→ Implementing equity approaches for routine immunization will establish a baseline capacity for equity during a health emergency.

→ Useable data sources should be created to set priorities and track improvements in countermeasure innovation, regulation and access.

Indicator B.1.2.2 (a)
Global mechanism to manage misinformation

Is there an effective global mechanism to monitor digital/social information sources on health emergencies and public health issues, to coordinate fact-checking initiatives and to slow the spread of disinformation?

This assessment was developed based on the work of Heidi Larson from the London School of Hygiene & Tropical Medicine, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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Key points

- There is no single global mechanism to identify mis- and disinformation; coordinate fact-checking initiatives; and slow the spread of misinformation and disinformation.

- There has been little progress in improving systems following the COVID-19 pandemic, despite the growing impact of misinformation.

Successes and progress

- There are a number of positive global and regional initiatives, although the degree to which they are used is yet to be established. Examples at the regional level include the Africa Infodemic Response Alliance (AIRA) network, the Global Americans network, the EU strategy to tackle online misinformation and disinformation, and at the global level the UNDP, UNESCO, OHCHR and IFRC platforms.

- Social media companies have implemented policies and tools to tackle health misinformation and disinformation, including specific policies on COVID-19-related misinformation during the pandemic, working in collaboration with WHO.

- WHO has expanded its work on infodemic management, including training of health workers and the development of the Early AI-supported Response with Social Listening (EARS) platform, a social listening platform that aims to provide real-time information about how people are talking about COVID-19 online.
Challenges and gaps

- With growing restrictions on social media, and more people opting to use private messaging services such as WhatsApp, capacity to assess social media trends is becoming more limited.

- Social media platforms are highly susceptible to the spread of disinformation and misinformation, given their reliance on algorithms to target users with specific content and recommendations, but companies are not taking sufficient action or adopting better approaches to prevent the spread or mitigate its impact.

- Some countries have regulated social media and digital platforms; however, in places where regulation does not exist, gaps in international rules and standards are being exploited by some States and non-State actors.

Priorities for action

→ Monitoring, fact-checking and slowing the spread of misinformation and disinformation will need regional and local efforts to supplement global efforts, considering different languages and the proliferation of local platforms for information sharing.

→ There is a need to build social resilience against misinformation and disinformation and promote multi-stakeholder approaches that engage civil society as well as States, companies and international organizations.

→ An independent platform is needed to monitor digital/social information sources on health emergencies and public health issues, to coordinate fact-checking initiatives and to slow the spread of disinformation across mediums and platforms.

Indicator B.1.2.2 (b)
Global spread and impact of misinformation during health emergencies

What is the impact of misinformation and disinformation during health emergencies?

This assessment was developed based on the work of Heidi Larson from the London School of Hygiene & Tropical Medicine, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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Key points

- The spread of misinformation has received a surge of academic attention in recent years, although less on the issue of impact.

- Trials have provided evidence of the impact of misinformation on health behaviours and attitudes (e.g., a 6% reduction in willingness to take a COVID-19 vaccine in the UK). Real life experience may have even higher levels of impact.
• Impact needs to be considered in at least 3 ways: on attitudes, on individual and group behaviours, and more broadly on policy and decision-making.

• A 2022 study found that health misinformation on social media is present in 1–51% of posts associated with vaccines, 0.2–28.8% on posts associated with COVID-19, and 4–60% on posts associated with pandemics. According to the study, “approximately 20–30% of the YouTube videos about emerging infectious diseases contain inaccurate or misleading information”.48

Successes and progress

✓ Attention to this issue is growing, and a number of studies on the spread and impact of misinformation have been conducted.

✓ There are the beginnings of a more rigorous body of literature, including quasi-experimental studies of impacts.

Challenges and gaps

! Much of the spread and impact will be missed unless there is the capacity to track online discussions in local languages.

! Increasingly, the spread of misinformation is highly localized and takes place in more closed settings (e.g., private WhatsApp groups).

! It is difficult to compare the results and methodologies of studies that have been undertaken to date.

Priorities for action

→ There is a need for a globally coordinated effort to assess the impact of misinformation in health emergencies, with the aim of building up an evidence base on ways to minimize harmful impacts.

Indicator B.1.2.2 (c)
Global platform to disseminate information and build knowledge

Is there an effective global platform to measure and build knowledge of relevant communities, including marginalized and vulnerable groups, and to produce and disseminate information on health emergencies, educate the public and build scientific literacy?

This assessment was developed based on the work of Julie Leask from the University of Sydney, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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Key points

- Globally, a number of platforms measure health knowledge and literacy, including the Social Behaviour Dashboard on Public Health Emergency and the COVID Behaviours Dashboard, with a multitude of platforms designed to build health literacy, ranging from WHO sources to Our World in Data to Wikipedia.
- Platforms that measure knowledge are ad hoc in relation to specific emergencies.

Table. Initiatives to measure community knowledge

<table>
<thead>
<tr>
<th>Initiative</th>
<th>From:</th>
<th>Scope:</th>
<th>Status:</th>
</tr>
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<tbody>
<tr>
<td>Social Behaviour Dashboard on Public Health Emergency</td>
<td>Collective service</td>
<td>communication, knowledge, perceptions, practices, social and structural factors</td>
<td>Country specific surveys</td>
</tr>
<tr>
<td>Wellcome Global Monitor</td>
<td>Welcome Trust</td>
<td>people’s interest and trust in science</td>
<td>Data collected from 140 countries since 2018</td>
</tr>
<tr>
<td>World Values Survey</td>
<td></td>
<td>social and religious values, political interest and participation, ethical values and norms, security, trust and corruption</td>
<td>Most recent wave 2017-2022</td>
</tr>
<tr>
<td>COVID-19 Community Rapid Assessment</td>
<td>UNICEF</td>
<td>In-country assessments of social and behavioural trends related to the COVID-19 response</td>
<td>Data collected from 59 countries</td>
</tr>
<tr>
<td>Behavioural and Social Drivers of Vaccination tool</td>
<td>WHO</td>
<td>the main influences on vaccine uptake from the perspective of caregivers and vaccinees. The tools cover domains of thinking/feeling, social processes and practical issues</td>
<td>Fully launched in 2022</td>
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<tr>
<td>Vaccine confidence index</td>
<td>Vaccine confidence</td>
<td>Data from &gt;55 countries, since 2015</td>
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Successes and progress

- The COVID Behaviours Dashboard enabled comparison across countries as the data was collected globally using a unified questionnaire.
- There have been regular (at least weekly) updates of information from trusted sources, especially WHO, during health emergencies.

Challenges and gaps

- It is difficult to compare data from different sources and across different methodologies.
- Information sources are heavily focused on COVID-19.
- One limitation of information-sharing platforms, including WHO, is the lack of availability of information in a wide range of languages.
### Priorities for action

- Shared protocols to enhance the comparability of data should be established to better measure knowledge of communities.
- Ongoing and sustained knowledge measurement and knowledge-building efforts should be ensured.

### Indicator B.3.2.1
**Assessment of communities and people at the national level**

1. Do countries have integrated and implemented minimum standards for community engagement in their preparedness plans, in terms of participation, ownership, inclusion, adaptability and building on local capacity?

2. Do countries have platforms in place that capture the views and experiences of citizens, including the most vulnerable in society, in order that these can be incorporated into preparedness?

3. Do countries have an effective infodemic management plan and established communications channels to share information transparently, including plans to utilize digital and social media?

This assessment was developed based on the work of Julie Leask from the University of Sydney, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

### Capacity  
**Good/Partial**

### Trend  
↓ Declining

### Key points

- Most countries recognize the importance of community engagement in health emergencies and have taken steps to integrate and implement minimum standards in their preparedness plans, but the quality of this implementation varies in practice.

- The global average State Party Self-Assessment Annual Reporting Tool (SPAR) score for risk communication and community engagement is 70%. Regional scores ranged from 60 in EMRO to 81 in WPRO. For specific countries, two scored 0/100, 27 scored 20/100, 15 scored 40/100, 36 scored 60/100, 74 scored 80/100, and 30 scored a full 100/100. 11 countries did not provide data. The WHO Joint External Evaluation global score reported in 2018 was 51% for risk communication and community engagement, based on 124 assessments made between 2016 and 2019. The Global Health Security Initiative (GHSI) score for risk communication is 55% and for access to communications infrastructure is 66%.

- Inclusion of marginalised groups is sub-optimal.

- Most countries have platforms with the potential to incorporate citizens’ views and experiences into pandemic response and have an effective risk communication management plan, including infodemics.
Successes and progress

- Most countries have an effective risk communication management plan.
- There are a number of new surveys, artificial intelligence (AI) listening tools, in-person community and health worker engagement programmes to promote engagement.

Exemplar – Ghana’s management of misinformation

Ghana’s multisectoral National Misinformation Task Force used Talkwalker, an AI-enabled social listening platform, to identify instances of misinformation during COVID-19 and to develop measures to address them. 54

Challenges and gaps

- There is a lack of independent monitoring of the effectiveness of community engagement.
- Few countries collect community-related data for future preparedness in a routine, systematic, rigorous and standardized way.
- Many initiatives have been COVID-19-specific and are not being sustained after the COVID-19 pandemic.
- There is little focus on the accountability of public officials to their communities (‘social accountability’).

Priorities for action

- Bringing together disparate initiatives into a coordinated and sustained global effort would improve their effectiveness.
- Beyond risk communication and community engagement, monitoring initiatives should also measure social accountability.
- Independent monitoring mechanisms (e.g., the WHO Universal Health Preparedness Review) should assess community engagement.
- Building a body of evidence on local and national successes would help to strengthen both community engagement and health emergency literacy.

Indicator B.1.4.7 (a)
Inclusion of low- and middle-income countries (LMICs)

Do global decision-making bodies for preparedness and response effectively include LMICs?

This assessment was developed based on the work of Ngozi Erondu from the O’Neill–Lancet Commission on Racism, Structural Discrimination and Global Health, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.
Capacity Trend

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Key points

- Partly in response to inequitable outcomes of the COVID-19 pandemic, efforts to include LMICs have increased.
- There is anecdotal evidence that meaningful and equitable inclusion of LMICs has already declined in 2023, compared to levels achieved during the COVID-19 pandemic.

Successes and progress

✔ LMIC participation in the WHO Pandemic Agreement and IHR Review processes has been enhanced.

Challenges and gaps

❗ Human resource capacity is a constraint on LMICs’ ability to participate effectively especially in crowded negotiation contexts.
❗ There is a lack of systematic data collection by relevant decision-making bodies on inclusion of LMIC.

Priorities for action

→ Accountability of relevant institutions should be strengthened by routine reporting of LMIC participation.
→ An independent monitoring mechanism should be included in the WHO Pandemic Agreement, with indicators measuring meaningful inclusion of LMICs.

Indicator B.1.4.7 (b)

Involvement of civil society, the private sector, and community representatives

Do decision-making bodies for preparedness and response effectively involve civil society, the private sector, and community representatives?

This assessment was developed based on the work of Ngozi Erondu from the O’Neill-Lancet Commission on Racism, Structural Discrimination and Global Health, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

Capacity Trend

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Key points

- Progress was made in the COVID-19 context in including representation of civil society in ACT-A, the Pandemic Fund Board, the Africa Task Force for Coronavirus (AFTCOR), etc., but this progress is fragile.

- Some new institutionalized structures for engaging civil society have been created, such as the WHO Civil Society Commission.

- There is no central repository for information regarding participation, including on opportunities to participate.

Successes and progress

- Many COVID-19 response mechanisms at global and regional levels included seats for civil society, the private sector, and community representatives.

- Intergovernmental Negotiating Body (INB) processes on the WHO Pandemic Agreement included specific civil society consultations.

Challenges and gaps

- Civil society and the private sector are not meaningfully engaged in several processes, especially in formal state-based negotiation sessions.

- The only systematic involvement of the private sector is for the pharmaceutical industry.

- Involvement can be ad hoc, dependent on the goodwill of individuals, rather than institutionalized.

Priorities for action

- More systems and structures should be put in place for engaging civil society, the private sector, and community representatives.

- A central repository of civil society representation roles (existing and opportunities) should be created.

- Countries and international organizations should resource civil society representation.

- Civil-society led oversight and scrutiny processes should be established (e.g., on the model of PEPFAR-watch and Global Fund Observer processes in the context of HIV).
Indicator B.1.2.1 (a)
Impact of health emergencies on women, youth, vulnerable and marginalized groups

Is there an effective, integrated global strategy to address the impacts of health emergencies on women, youth, and vulnerable and marginalized groups, including a global monitoring mechanism and requirement to report on these impacts?

This assessment was developed based on the work of Clare Wenham from the London School of Economics and Political Science, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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**Key points**

- There is no overarching global strategy to mitigate the gender impacts of pandemics, or the impacts on youth, marginalized and vulnerable groups. Sustainable Development Goal (SDG) 5 offers a strategy for gender equality, but it is not specific to health emergencies.

- The JEE and the GHSI both contain indicators for gender equity and equality in health emergencies. Global monitoring sources which are not health-emergency-specific can be mined for relevant gender and other inclusion data, such as the gender data portal from the World Bank Group and gender indicators from the OECD and the UN Women Data hub.

**Successes and progress**

- A gender working group has been established in the WHO Health Emergencies Programme, and WHO has created a new youth council.

- There are a number of gender and inclusion measures in the latest JEE tool and the WHO Universal Health and Preparedness Review.

- Gender impacts of pandemics, the feminized workforce and gender perspectives are all considered in the UN Political Declaration on PPPR.

- The draft Negotiating Text of the WHO Pandemic Agreement includes consideration of gender impacts.

**Challenges and gaps**

- There is very little systematic attention to youth and vulnerable population inclusion.

**Priorities for action**

- An overarching global strategy to mitigate the gendered impacts of pandemics and in relation to marginalized and vulnerable populations should be established.

- Existing data and monitoring sources should be reviewed to build the evidence base concerning gender and vulnerable group participation.
3. COHERENCE

Indicator B.1.1.1.2 (a)
Global mechanism for early warning and One Health surveillance

Is there an effective global mechanism for early warning, risk assessment and surveillance with data sharing (including standards), data management, analytics, modelling and real-time communication at the human health, animal health, and environment interface to monitor the emergence of potential new threats, with open centralized access to data and rapid pathogen sharing, and grounded in equity?

This assessment was developed based on the work of David Hayman and Marion Koopmans from the One Health High-Level Expert Panel, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

### Capacity

- Insufficient/Incomplete

### Trend

- Improving

### Key points

- There is no global mechanism for early warning, risk assessment, and surveillance across the One Health interface but some components exist through different mechanisms.

### Successes and progress

- Existing elements of the system include the WHO Hub for Pandemic and Epidemic Intelligence\(^{55}\), the Joint FAO–OIE–WHO Global Early Warning System for health threats and emerging risks at the human–animal–ecosystems interface (GLEWS+), the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS), the WHO Global Outbreak And Response Network (GOARN)\(^{\text{56}}\), and FAO’s Global Animal Diseases Surveillance and Early Warning System\(^{57}\).
- There was effective data sharing via the Global Initiative on Sharing All Influenza Data (GISAID) and GenBank during COVID-19.
- The Quadripartite has developed a plan to establish a global One Health intelligence system.\(^{58}\)

### Challenges and gaps

- Most existing systems operate in silos and insufficiently integrate sectors and disciplines.
- There has been insufficient investment in surveillance and monitoring systems, including at the national, sub-national and community level.
- Workforce capacity is not sustainable.
- Countries currently face numerous barriers to accessing and utilizing surveillance data. Data is sometimes centralized away from lower-income countries.
Initiatives overlap or leave gaps and insights are not always effectively shared. Data collected is often incompatible and therefore cannot be analysed to provide the wider insights needed.

**Priorities for action**

- A flexible, but coordinated system, should be developed that can record and share timely and standardized data, and that can accommodate technological advances and big data (e.g., whole genome sequencing, citizen science-based surveillance).
- Governance systems should be established that overcome political, ethical, administrative, regulatory and legal barriers.
- Building workforce capacity will require sufficient investments.
- Sustainable systems should be integrated into everyday systems.
- Benefit-sharing mechanisms are essential for effective surveillance systems, so that lower-income countries that spend scant resources on data sharing will receive fair returns.

**Indicator B.2.1.1.1 (a)**

**Regional laboratory capacity**

Are there sufficiently resourced, globally-coordinated regional laboratories with advanced capacities to support and provide assistance to national laboratories in advance

This assessment was developed based on the work of the Full Board with Lucille Blumberg as Chair, Strategic & Technical Advisory Group on Infectious Hazards with Pandemic and Epidemic Potential (STAG-IH), as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

**Capacity**

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**Key points**

- There are several regional laboratories with some level of capacity to provide assistance to national laboratories and coordination at the global level. However, the capacity of laboratories varies significantly across different regions. Many laboratories are disease-specific (e.g., influenza) and do not necessarily have multi-pathogen or pathogen-agnostic capacities to support national laboratories. In addition, the structure, functions, and collaborations of regional laboratory networks vary extensively. See Figure 1.

- While considerable laboratory strengthening has occurred as a result of the COVID-19 pandemic, a lack of resources remains an obstacle to strengthening laboratory capacity, even though gaps have been identified.
**Successes and progress**

- Laboratory strengthening initiatives are underway in most regions.

**Challenges and gaps**

- The Eastern Mediterranean Regional Office (EMRO), Pan American Health Organization (PAHO), and Western Pacific Regional Office (WPRO) have established and moderately well-resourced multi-function laboratories and associated networks. The South–East Asia Regional Office (SEARO) has some endemic disease-focused laboratories and laboratory networks. EMRO has only MERS–focused and some influenza collaboration centres. The Regional Office for Africa (AFRO) has several strong laboratories, but the number of pathogen-focused laboratories and collaboration centres is small compared to other regions.

- Merely having regional laboratories doesn’t guarantee quality and safety of the laboratories.

- It is uncertain how scalable the capacity of regional laboratories would be during a pandemic, given that many would also be supporting their own national response, although several collaboration cases were made during the COVID–19 pandemic.
Priorities for action

→ Ensuring that the momentum for laboratory strengthening is maintained in the post-COVID period is crucial.
→ High-level buy-in for a set of minimum regional laboratory capabilities should be secured. This will require mobilizing political support around this goal.

Indicator B.3.1.1.1
Assessment of national One Health and health systems preparedness

Do countries have integrated capacity to detect novel and emerging pathogens across the One Health spectrum? Do they conduct comprehensive surveillance and rapidly report zoonotic pathogens in animal populations?

This assessment was developed based on the work of the Strategic Technical and Advisory Group on Infectious Hazards, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

Capacity

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Key points

- Self-reported scores for zoonotic disease capacities and for surveillance have global averages of 67% and 85% respectively. JEE scores are lower: 60% for zoonotic disease and 69% for surveillance.
- However, despite relatively high-self reporting scores, evidence shows that most countries do not have an integrated platform and capacity to detect novel or emerging pathogens across the One Health spectrum.

Successes and progress

✔ Experience has shown that country capacity has significantly improved during COVID-19.
✔ One Health has received considerable policy attention in the wake of COVID-19.

Exemplar - The Brazilian Unified Health System

Since the 1970s Brazil has integrated data from human and animal cases, enabled joint work and collaborations across One health professionals. In the 1990s Brazil established the Unified Health System which relies on interdisciplinary teams that include veterinary doctors.\(^5^9\)
Challenges and gaps

- One Health is not fully integrated into national systems. Relevant sectors often operate in silos with separate facilities and funding across the One Health dimensions.
- Current One Health programmes are primarily disease-specific (e.g., influenza). There is a narrow focus on human health over animal health.

Priorities for action

- One Health programmes should be fully integrated and institutionalized, and resourced adequately across the spectrum of environment, animal health and human health.
- One Health implementation programmes should look into diverse reservoirs to better prepare for future pandemics.
- Regional organizations should play a key role in advocating for national One Health capacity strengthening.

Indicator B.1.4.8
Coherence

Are priorities for preparedness aligned across the main international organizations working on different dimensions of health emergencies?

This assessment was developed based on the work of Rebecca Katz from Georgetown University, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

Capacity

Insufficient/Incomplete

Trend

Improving

Key points

- There are currently some initiatives that are aiming to improve alignment across the work of the main international organizations and to increase coherence, but progress is limited at this time.
- Current governance reforms, including IHR revisions and the WHO Pandemic Agreement, and new initiatives, such as the Pandemic Fund, may help guide priority setting across international organizations.

Successes and progress

- There are efforts at institutional level to align One Health priorities between UNEP, FAO, WOAH and WHO.
- Some organizations have tried to align metrics of success (such as the Global Fund integrating JEE and SPAR metrics when relevant to assess their PPR funding efforts).
- The Pandemic Fund, which currently utilizes 13 Implementing Entities, may serve to force some alignment of priorities.
Challenges and gaps

- Coherence efforts have mainly been around high-level coordination and do not necessarily mean that preparedness priorities and implementation efforts are aligned across all relevant international organizations.
- The differing mandates of organizations will provide an inherent constraint to coherence.
- Different Member State negotiating partners have chosen to emphasize different approaches to preparedness, such as in sharing sequence data (see CBD/Nagoya/GISRS/IHR and INB negotiations/IPSN at WHO).

Priorities for action

- Coherence can be moved forward with a judicious mix of mandated measures (e.g., around funding, or in provisions of the WHO Pandemic Agreement), incentives, and better coherence among respective stakeholders (e.g., Member State consistency).
- It will be important to seize the opportunities provided by the current period of flux and active policy-making.

Indicator B.1.1.4.1 (a)
Trade coordination

Is there an effective global, multisectoral mechanism to support transparent coordination of trade measures in the context of a health emergency?

This assessment was developed based on the work of Joseph François from the World Trade Institute, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

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Key points

- There are institutions, mainly WTO, that provide mechanisms for coordination of trade-related policy during health emergencies and other crises, especially to serve as a framework for meeting and discussion. However, these mechanisms have not been fully effective in preventing trade restrictions and improving trade coordination during the COVID-19 pandemic.
- The Trade Facilitation Agreement (TFA) signed by WTO Members, when fully implemented, could make cross-border flow of goods smoother, whether in normal times or during crisis.
Successes and progress

During COVID-19, there were WTO negotiations to agree on waivers to facilitate access to medical countermeasures. These negotiations led to the adoption of a waiver for vaccines late in the pandemic.

WTO and the World Bank Group have issued proposals to improve trade cooperation and to bolster governance of trade policy in global crises.60

Challenges and gaps

Countries adopted unilateral export bans and trade barriers on critical medical supplies during the COVID-19 pandemic. There was a general lack of coordination of these measures, and many were in violations of WTO and IHR (2005) obligations.

Non-pharmaceutical interventions such as travel bans and lockdowns led to disruption of the cross-border flow of goods, creating shortages for a wide range of medical and non-medical goods. There was little guidance on balancing the risk of disruption to both local and global supply chains against the need to take non-pharmaceutical interventions to prevent the spread of the COVID-19 virus.

Many LMICs lack resources to benefit fully from the Trade Facilitation Agreement (TFA) and have struggled to implement the Agreement.

Figure 6: National Influenza Centres and WHO Collaborating Centres for Epidemic and Pandemic Preparedness and Response

![Bar chart showing progress on implementation commitments under the WTO Trade Facilitation Agreement](http://www.tfadatabase.org)

Priorities for action

- Guidance on balancing non-pharmaceutical interventions and trade should be developed.
- WTO Members should provide support for LMIC implementation of the TFA.
- Independent monitoring of trade and trade-related measures during health emergencies should be established.
- Countries should explore the possibility of adopting a medical goods trade agreement to abolish or lower barriers to trade in medical goods and supporting services, limit restrictions on the export of critical goods during a pandemic, enhance regulatory cooperation, and improve WTO rules that apply to trade of essential medical goods, including an improved intellectual property system.

Indicator B.1.1.4.2
Involvement of relevant actors

Are relevant sectors meaningfully involved in global health emergency preparedness and response?

This assessment was developed based on the work of Adam Kamradt-Scott from Harvard University, as well as contributions from experts during the GPMB consultation on the Monitoring Framework.

Capacity

- Insufficient/Incomplete

Trend

- Declining

Key points

- There is a lack of a clear framework that would specify what actors and sectors need to be involved and normative guidance for their involvement. Therefore, there is little tracking of different sectors’ engagement in PPPR against agreed benchmarks.

- There is no mechanism that provides the opportunity for multiple sectors and actors to engage effectively on PPPR.

Successes and progress

- Multisectoral contributions were made in the COVID-19 response with many countries using or initiating whole-of-government coordination structures.

- Security forces were involved in some way in the COVID-19 response in at least 50%, and possibly up to 95%, of countries, to support civilian efforts or provide leadership. This engagement was supported by normative guidance on engaging security forces in health emergencies at the national level (but there was no relevant global guidance on the issue).
Challenges and gaps

- Existing PPPR processes struggle to engage the animal health sector in a meaningful way, e.g., despite the Quadripartite consultative mechanisms, WOAH has not been central to deliberations concerning a new WHO Pandemic Agreement.
- Views in the public health sector that animal health is only a concern because of its impact on human health remain pervasive.

Priorities for action

- A mechanism should be established to engage sectors meaningfully in the continuum of PPPR.
- The roles, functions and activities of diverse regional and global actors should be considered along a spectrum of legitimacy and appropriateness.
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58 Ibid.


About the GPMB

The Global Preparedness Monitoring Board (GPMB) is an independent monitoring and accountability body to ensure preparedness for global health crises. Co-convened by the World Health Organization (WHO) and the World Bank Group, the GPMB comprises globally recognized leaders and experts from a wide range of sectors, including health, animal health, environment, human rights, economics, law, gender, and development. The GPMB is tasked with providing an independent and comprehensive appraisal for policy-makers and the world about progress towards increased preparedness and response capacity for disease outbreaks and other emergencies with health consequences. In short, the work of the GPMB is to chart a roadmap for a safer world.

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