TECHNICAL CONSIDERATIONS FOR THE UNIVERSAL HEALTH AND PREPAREDNESS REVIEW

DRAFT OF NOVEMBER 2022

WORLD HEALTH ORGANIZATION

World Health Organization

CONTENTS

ACKNOWLEDGMENT 4

EXECUTIVE SUMMARY 5

BACKGROUND 6

INTRODUCTION TO THE UHPR 8

1. Definition 8
2. Purpose and scope 8

Purpose 8

Scope 8

3. Target audience 8
4. Key principles 9
5. Added value 9

At the national level 9

At the global level 10

6. What UHPR is not 10

UHPR AND ITS RELATIONSHIP TO EXISTING TOOLS AND MECHANISMS INCLUDING THE JEE 11

LINKAGE BETWEEN THE UHPR AND STRATEGIC INITIATIVES THAT IMPACT ON THE FUTURE OF THE HEALTH SECURITY AND HEALTH EMERGENCY PREPAREDNESS 12

7. UHPR and the 10 proposals on Health Emergency Preparedness, Response and Resilience 12
8. UHPR and the proposal for amendments to the International Health Regulations (2005) 13
9. UHPR and the pandemic accord currently drafted and negotiated by the Intergovernmental Negotiating Body 13
10. UHPR and the Financial Intermediary Fund 14

OVERVIEW OF THE REVIEW PROCESS 15

1. National review phase 17
2. Global peer review phase 18
3. Post review phase 19

FREQUENCY OF THE OF THE UHPR AND SUPPORT FROM WHO 19

1. Frequency 19
2. Support from WHO 19

SPECIAL CONSIDERATION FOR ENGAGEMENT OF THE WHOLE-OF-SOCIETY IN THE UHPR 20

1. Engagement of social participants in UHPR 20

DRAFT

UHPR METRICS 21
1. UHPR indicators 22
Governance 23
Systems 24
Financing 24
Risk 25
2. Using the UHPR metrics 26
UHPR country profile 27

DRAFT

ACKNOWLEDGMENT

The World Health Organization (WHO) would like to express its sincere gratitude to all those who contributed to the development of the Technical Considerations for the Universal Health and Preparedness Review (UHPR).

The WHO UHPR Secretariat in WHO headquarters developed this document with the support of regional offices, country offices, other departments of WHO headquarters and the UHPR Technical Advisory Group (TAG).

Special thanks to Dr Samira Asma and Dr Jaouad Mahjour for their guidance and leadership.

The document was developed by Dr Stella Chungong, Dr Luc Tsachoua, Dr Rajesh Sreedharan and Dr Marc Ho with contributions from their colleagues, Dr Jun Xing, Dr Liviu Vedrasco, Dr Nirmal Kandel, Miss Cynthia Bell, Miss Bethany-Kate Lewis, Mr Mauricio Reynaud, Mr Benjamin Gutierrez, Mr Elias Mekuria and Miss Maureen Taylor-Smith, of the WHO UHPR secretariat in WHO headquarters.

Special thanks to Dr Dalia Samhouri, Dr Dick Chamla, Dr Marie Rosaline Belizaire, Mr Nicolas Isla, Dr Samuel Reuben and Dr Saidou Kouyate Mohamed for providing inputs from WHO regional and country offices.

Sincere gratitude to all the members of the UHPR TAG: Amanda McCllelland, Alemu Wondimagegnehu, Anne-Catherine Viso, Arthur Reingold, Autilia Newton, Carlos Navarro Colorado, Clare Wenham, Dicky Komar, Gianni Magazzeni, Janneth Maridadi Mghamba, Justin Koonin, Mahmudur Rahman, Mohammed Alkhaldi, Mohamed Moussif, Mona M'Bikay, Nahid Bhadelia, Rakesh Srivastava, Robert Agyarko, Seif Al Abri, Xiaoyun Lin and Zaza Tsereteli.

DRAFT

EXECUTIVE SUMMARY

The rapid emergence and spread of COVID-19 resulted in a significant loss of lives and an unprecedented impact on livelihoods, economies and societies throughout the world. It revealed that no country is fully prepared to deal with a pandemic of such scale, speed of transmission, severity and impact.

The World Health Organization (WHO) is mandated through various resolutions, decisions and reports of the World Health Assembly, and the International Health Regulations (IRH) (2005) to provide technical guidance and support to its Member States for strengthening their health systems including IHR capacities.

In November 2020, the WHO Director-General announced the launch of the Universal Health and Preparedness Review (UHPR). The UHPR is a game changing mechanism that brings together Member States as neighbors to review their preparedness capacities to keep the world safe. This review mechanism is Member State-led whereby countries agree to a voluntary, regular and transparent peer review of their comprehensive national health emergency preparedness capacities. The bold vision of the UHPR is to strengthen health emergency preparedness through a process that integrates available information, engages national leadership at the highest level, catalyses pragmatic, specific actions to improve preparedness, and results in substantial and sustained increases in the attention, focus and financing of preparedness.

This technical considerations document is an overarching framework designed to provide readers with necessary information to understand the UHPR mechanism. It is based on and seeks to operationalize the UHPR concept note. This document targets all stakeholders, who are directly or indirectly involved in the UHPR at the national, regional or global levels. It introduces readers to the UHPR by describing the mechanisms and providing insights on its purpose, scope, target audience, key principles and added value, as well as describing what UHPR is not. It also gives an overview of the review process, including the national-level review and the global peer review. Finally, the document outlines some key considerations, including the UHPR and its relation to existing assessment tools and mechanisms, including Joint External Evaluations, linkage between the UHPR and strategic initiatives that impact on the future of the health security and health emergency preparedness, as well as the importance of some specific stakeholder groups in this review mechanism, such as the social participants.

DRAFT

BACKGROUND

The rapid emergence and spread of COVID-19 resulted in a significant loss of lives and an unprecedented impact on livelihoods, economies and societies throughout the world. COVID-19 revealed that no country is fully prepared to deal with a pandemic of such scale, speed of transmission, severity and impact.

In November 2020, in his opening remarks at the resumed session of the Seventy-third World Health Assembly, the WHO Director-General stated:

"One idea proposed last year by the Central African Republic and Benin as the then-Chair of the African Union, is a system in which countries agree to a regular and transparent process of peer review, similar to the system of universal periodic review used by the Human Rights Council. We're calling it the Universal Health and Preparedness Review.**"**

In January 2021, in his opening remarks at the 148th session of the WHO Executive Board, the WHO Director-General formally launched the Universal Health and Preparedness Review (UHPR), which "is based on a voluntary mechanism of peer-to-peer review, led by Member States, to promote greater, more effective international cooperation by bringing nations and stakeholders together in a spirit of solidarity".

In May 2021, during the Seventy-fourth session of the World Health Assembly, Member States adopted Resolution WHO74.7 Strengthening WHO preparedness for and response to health emergencies[1], including the following operational paragraph "The Seventy-fourth World Health Assembly […] REQUESTS the Director-General, as soon as practicably possible and in consultation with Member States: […] (3) to develop a detailed concept note to be included in the report by the Director-General to the 75th World Health Assembly for the consideration of Member States as they determine next steps on the voluntary pilot phase of the Universal Health and Preparedness Review mechanism, based on the principles of transparency and inclusiveness, and on how it uses existing International Health Regulations (2005) monitoring and evaluation framework components, with the aim to assess, improve and strengthen accountability, cooperation, trust and solidarity around overall preparedness".

As part of ongoing scoping of the mechanism, the WHO UHPR Secretariat has undertaken several voluntary pilots of the review mechanism with four Member States. The lessons learnt from the pilots have been used to update the UHPR process and tools. WHO extends its gratitude to Member States who hosted a UHPR pilot, namely, the Central African Republic (in December 2021), the Republic of Iraq (in February and March 2022), the Kingdom of Thailand (in April 2022) and the Republic of Portugal (in May 2022).

In May 2022, during the Seventy-fifth World Health Assembly, strategic initiatives that impact on the future of the health security and health emergency preparedness were discussed, including:

[1] World Health Organization. 2021. Seventy-Fourth World Health Assembly. Strengthening WO preparedness for and response to health emergencies. https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R7-en.pdf.

- 10 Proposals on Strengthening the global architecture for health emergency preparedness, response and resilience (HEPR) (noted by the World Health Assembly)
- Proposal for amendments to the International Health Regulations (2005)
- Report to strengthen collaboration on One Health (noted by the World Health Assembly)
- Intergovernmental negotiating body (INB) to draft and negotiate a Pandemic Accord (Special session of World Health Assembly in December 2021).
- Concept note on the Universal Health and Preparedness Review (UHPR) (noted by the World Health Assembly)

Since the seventy-fifth World Health Assembly, the WHO UHPR Secretariat has organized meetings that have gathered key stakeholders to review the lessons learnt from the first four UHPR pilots, discuss the UHPR process and tools, and agree on the updates that should be done.

The lessons learnt from the COVID-19 pandemic, enriching UHPR pilots and meetings with stakeholders engaged in the UHPR process, have been incorporated into the updated UHPR process and tools for the coming UHPR pilots.

Although currently voluntary, the goal of the UHPR would be to conduct a review of the maximum number of WHO Member States and share the findings and priority recommendations through existing governing body mechanisms. Thus, once a substantial number of pilots are completed and the concept and results of the pilots are shared during a future World Health Assembly, the possibility of embedding this process within established legal mandates and formalizing the process through a resolution at the assembly will be discussed. In addition, the proposed Pandemic Treaty, which will support international efforts towards global health security, may incorporate a commitment to the UHPR process.

DRAFT

INTRODUCTION TO THE UHPR

1. Definition

The UHPR is a Member State-led review mechanism whereby countries agree to a voluntary, regular and transparent peer review of their comprehensive national health emergency preparedness capacities. It will help to support national public health systems, infrastructures and capacities for health emergency preparedness. Its aim is to promote collective global action for preparedness, by bringing Member States and stakeholders together at national, regional and global levels, in a spirit of solidarity, to make the world safer.

2. Purpose and scope

Purpose

The purpose of the UHPR as stated by the WHO Director-General is to "Build mutual trust and accountability for health, by bringing nations together as neighbours, to support a whole-of-government approach to strengthening national capacities for pandemic preparedness, universal health coverage, and healthier populations".

Scope

The scope of UHPR includes the following:

- health emergency preparedness that takes into account health systems capacities to achieve universal health coverage (UHC) in the context of health security;
- engaging the highest political level to create an enabling environment of governance, sustainable financing and investment towards a resilient national system through:
    - supporting the prioritization and development of national policies, that support multisectoral engagement
    - where WHO uses its technical and convening mandate to put national preparedness priorities on the agenda of national, regional and global leaders to foster collaboration and an investment case to support progress toward national goals.

3. Target audience

To address priority issues identified during the process, and in line with its purpose and scope, the UHPR focuses its attention on the:

- head of government
- prime minister
- council of ministers
- parliamentarians
- regional and global organizations (including the United Nations Country Team (UNCT))
- development partners
- social participants
- private sector

DRAFT

By targeting these audiences, the UHPR gives the opportunity to elevate findings of country assessments to the highest-level authorities with the participation of all sectors of society. This will demonstrate countries' transparency and commitment to improving health and emergency preparedness by promoting national and global dialogues that will foster national and global solidarity, as well as sharing and learning among countries.

4. Key principles

The UHPR is driven by three key principles: solidarity, mutual trust and accountability for health.

- Solidarity: That entails agreements within countries (law and legislation for multisectoral and whole-of-society engagement), agreements between countries (regional and global agreements), sharing of resources (human resources, materials, financing) and sharing of best practices (bilateral cooperation, regional and global sharing and exchange platforms).
- Mutual Trust: That entails transparency with the global community, mutual trust between government and stakeholders within the country and mutual trust between government and civil society.
- Accountability: That entails government accountability to the population (better protected from health emergencies, benefiting from UHC and enjoying better health and well-being), country accountability to global community (implementation of IHR, global health architecture, etc.) and global partners accountability to countries with regard to health matters (global coordination of health matters discussions, shaping the health research and development agenda, setting of norms and standards, articulating evidence-based policy options, providing technical support to countries, monitoring and assessing health trends and public health risks and coordinating the management of health emergencies).

5. Added value

Over the years, countries have made efforts in engaging stakeholders beyond the health sector to identify and address country-level gaps in preparedness, detection and response to public health risks. However, the pandemic has demonstrated the urgent need to create a high level of shared accountability and recognition that countries are only as strong as the weakest link, and the need for sustainable long-term investment in emergency preparedness by countries and stakeholders.

Being a periodic peer-review process engaging high-level authorities and bringing together the whole-of-society, the UHPR adds value in ensuring that health emergency preparedness issues will be considered and acted upon at the highest levels of government and all sectors of society will be engaged in the implementation, follow-up and monitoring of the priority recommendations.

The country reviews conducted under the UHPR will complement existing general monitoring and evaluation (M&E) frameworks in their ability to:

At the national level:

- elevate considerations on health emergency preparedness to the highest level of government;
- prioritize actions and addressing areas that require immediate attention in a sustainable manner;
- establish and sustain improved levels of multisectoral mobilization and dialogue that create and strengthen shared accountability and collective responsibility among government

DRAFT

ministries, civil society, community and non-state actors in terms of health security and pandemic preparedness;
- Promote reliable and sustainable domestic funding to build long-term preparedness capacity, including investments by public and private sectors towards strengthening health systems as a path towards full implementation of IHR and achievement of the Sustainable Development Goals;
- advance partner engagement, using the conclusions of the UHPR national report and the outcome report of the global peer review; and
- provide evidence for countries to track their progress in maintaining and strengthening preparedness capacity and transitioning towards UHC.

At the global level:

- demonstrate to the global community the country's transparency, accountability and commitment to improving health and emergency preparedness;
- identify concrete areas for peer-learning and support between Member States, promoting mutual learning, pooling of best practices, solutions and innovation;
- promote engagement and alignment of national initiatives with sub-regional and regional initiatives and strategies; and
- promote global dialogue on strengthening of health emergency preparedness capacities toward global health security.

For countries to commit to the UHPR, it is imperative that they take ownership of the process, and for that they must see its added value through tangible benefits stemming from countries that have conducted the UHPR. The WHO UHPR Secretariat works with countries that undertake the UHPR process to document their experience (investment case, country case studies, etc.) and demonstrate the added value and benefits of UHPR with concrete examples that will attract and ensure a wider engagement of Member States in the process.

6. What UHPR is not

Based on its purpose, objectives and key principles, UHPR is:

- not an evaluation, an assessment, an audit or an inspection (it is a review)
- not another IHR monitoring and evaluation framework (it doesn't replace any of these tools)
- not a Ministry of Health centric process (it is a whole-of-government and whole-of-society process)
- not only technical (it includes a review at the strategic, political and decision-making levels)
- not a WHO-led process (it is a country-led process). WHO supports countries by funding, accompanying, documenting and promoting the country's work
- not a new tool to collect data (data are extracted from already available sources).

DRAFT

UHPR AND ITS RELATIONSHIP TO EXISTING TOOLS AND MECHANISMS INCLUDING THE JEE

The IHR Monitoring and Evaluation Framework (MEF) was developed in response to the recommendations of the Review Committee on 2nd Extensions for Establishing National Public Health Capacities and on IHR Implementation (WHA68/22 Add.16) in 2014. The four complementary tools in the IHR MEF include the state party annual self-assessment report (SPAR), voluntary joint external evaluation (JEE), simulation exercises (SimEx) and after action review (AAR). As with significant health emergencies in the past, WHO has been working closely with Member States to gather lessons learned from COVID-19 and review the tools currently in place to monitor and evaluate country progress in developing and maintaining the capacities required under the International Health Regulations (2005).

With regard to the relationship between UHPR and existing assessment tools and mechanisms:

- The UHPR does not replace any of the IHR MEF tools and mechanisms; rather, it encourages their implementation, as the reports from these various assessments remain critical in informing the UHPR process and indicators and providing comprehensive preparedness data for the country.
- The UHPR complements findings from these tools and mechanisms by including data on key categories that are not evaluated within existing assessment tools and mechanisms.

The question as to the difference between the UHPR and the JEE is regularly raised. The unique features of the UHPR in comparison with the JEE are as follows:

- The UHPR is a country-owned and country-led process; while JEE is led by WHO.
- The UHPR engages the highest-level authorities which serve as an impetus for raising awareness, multisectoral engagement, commitment and investments both at the national, regional and global levels. The JEE engages mainly technical experts and authorities up to the level of the minister of health.
- The UHPR focus on key categories that are not currently evaluated within existing assessment tools including governance, systems and finance. The UHPR will use available JEE reports among the data and information sources, along with other IHR MEF reports.
- The UHPR review process includes two phases that focus on high-level aspects of preparedness. It includes the national review phase engaging high-level authorities and the global peer review phase engaging representatives from other Member States who will provide technical and strategic review and make high-level recommendations. The JEE process focuses on technical evaluation. It combines a self-evaluation completed by country experts and an external evaluation conducted by international subject matter experts will who provide technical evaluation and recommendations.
- The UHPR has a wide range of activities including core activities (high-level engagement and advocacy meetings, high-level SimEx or AAR/inter-action review (IAR)) and optional activities (risk assessment/profiling, field visits, SimEx, AAR, key informant interviews, etc.) selected as

DRAFT

per country needs. The activities of the JEE include document review, structured site visits and meetings with technical experts.

- The UHPR makes an investment case for the global community, while the JEE investment case is for the country.
- The UHPR aims at fostering national and global solidarity between Member States, while the JEE focuses more on promoting national solidarity.

LINKAGE BETWEEN THE UHPR AND STRATEGIC INITIATIVES THAT IMPACT ON THE FUTURE OF THE HEALTH SECURITY AND HEALTH EMERGENCY PREPAREDNESS

7. UHPR and the 10 proposals on Health Emergency Preparedness, Response and Resilience

The COVID-19 pandemic has highlighted the need for a stronger and more inclusive health emergency preparedness, response and resilience (HEPR) architecture. At the Seventy-fifth World Health Assembly in May 2022, the WHO Director-General presented WHO's proposals, developed in consultation with Member States and other stakeholders, on strengthening the architecture for HEPR.

The UHPR is aligned with the components of the new architecture for HEPR. Indeed, the three key areas reviewed through the UHPR process are the same as the three main pillars of the global HEPR architecture: governance, systems and financing:

- The first area reviews the need for governance structures that are coherent, inclusive and accountable. Here, WHO recommends establishing a global health emergency council at the level of heads of state and government to ensure the sustained political commitment needed to break the cycle of pandemic and neglect, make targeted amendments to the International Health Regulations to increase capacities, information sharing and compliance, and enhance accountability by scaling up the UHPR.
- The second area reviews the need for stronger systems and tools to prevent, detect and respond rapidly to health emergencies.
- The third area of the review is the need for adequate and efficient financing, domestically and internationally.

DRAFT

UHPR is one of the WHO Director-General's 10 proposals for strengthening the global architecture for HEPR. Proposal three recommends to "Scale-up Universal Health and Preparedness Reviews and strengthen independent monitoring"[2].

8. UHPR and the proposal for amendments to the International Health Regulations (2005)

Following major health emergencies, including severe acute respiratory syndrome outbreaks, Ebola outbreaks and more recently the COVID-19 pandemic, consensus emerged on the need to review the IHR (2005). Under Article 55 of the IHR (2005), amendments to the regulations may be proposed by any State Party or by the WHO Director-General. Amending proposals were put forward by State Parties and discussed at the Seventy-fifth World Health Assembly. The International Health Regulations Review Committee is also discussing the UHPR. As one of the key principles of the UHPR is to contribute to improving country accountability in the implementation of the IHR (2005), any amendment in the IHR will take into account the UHPR process and the review mechanism will be immediately aligned to the amended IHR. The UHPR will also take into account potential amendments in the IHR MEF tools that may result from the amendment of IHR.

The aim is for the UHPR to steadily ensure the full review of country preparedness capacities, including capacities for implementation of the updated IHR (2005) toward global health security[3].

9. UHPR and the pandemic accord currently drafted and negotiated by the Intergovernmental Negotiating Body

In light of the impact of the COVID-19 pandemic, the 194 WHO Member States established a process to draft and negotiate a new convention, agreement, or other international instruments "accord" on pandemic preparedness and response. This was driven by the need to ensure communities, governments and all sectors of society – within countries and globally – are better prepared and protected, in order to prevent and respond to future pandemics.

In December 2021, at its second-ever special session, the World Health Assembly established an intergovernmental negotiating body (INB) to draft and negotiate the new accord. The work on the new accord on pandemic prevention, preparedness and response would aim to be coherent with, and complement, the IHR (2005).

The INB is considering the establishment of a global peer review mechanism as part of its current working draft, July 2022 ("a global peer review mechanism to assess national, regional and global preparedness capacities and gaps, by bringing nations together to support a whole-of-government approach, strengthening national capacities for pandemic prevention, preparedness and response mindful of the need to integrate available data, and to engage national leadership at the highest level")[4]. WHO is committed to ensuring alignment between the pandemic accord and UHPR.

[2] White Paper Consultation: Strengthening the Global Architecture for Health Emergency Preparedness, Response and Resilience (who.int)
[3] Amendments to the International Health Regulations (2005) (who.int)
[4] Intergovernmental Negotiating Body (INB) (who.int)

10. UHPR and the Financial Intermediary Fund

The Financial Intermediary Fund (FIF) for pandemic prevention, preparedness and response is a new funding mechanism, which aims to help low and middle-income countries strengthen pandemic prevention, preparedness and response capabilities and fill existing capacity gaps in core domains of the International Health Regulations (2005) at country level, as well as at regional and global levels. Its purpose is in line with the UHPR as both the FIF and UHPR contribute to strengthening countries' capacities to prevent, detect, respond to and recover from health emergencies.

In terms of the procedure from the UHPR to the FIF; the priority recommendations from the UHPR report feed into the national plans for building and strengthening countries' capacities for health security (e.g., the national action plan for health security (NAPHS), national health development plan, humanitarian plan, disaster reduction plan, country cooperation strategy, etc.). These plans will then be used to raise funding domestically and externally, like the new Financial Intermediary Fund.

To summarize, the UHPR, by contributing to the development of investment cases and plans for strengthening health emergency preparedness capacities, taking into account health systems capacities to achieve UHC in the context of health security, will help low- and middle-income countries that undertake the process to access the new FIF in order to implement priority recommendations in line with the scope of this new funding mechanism.

DRAFT

OVERVIEW OF THE REVIEW PROCESS

FIGURE 1: PROCESS AND CHARACTERISTICS OF THE UNIVERSAL HEALTH AND PREPAREDNESS REVIEW

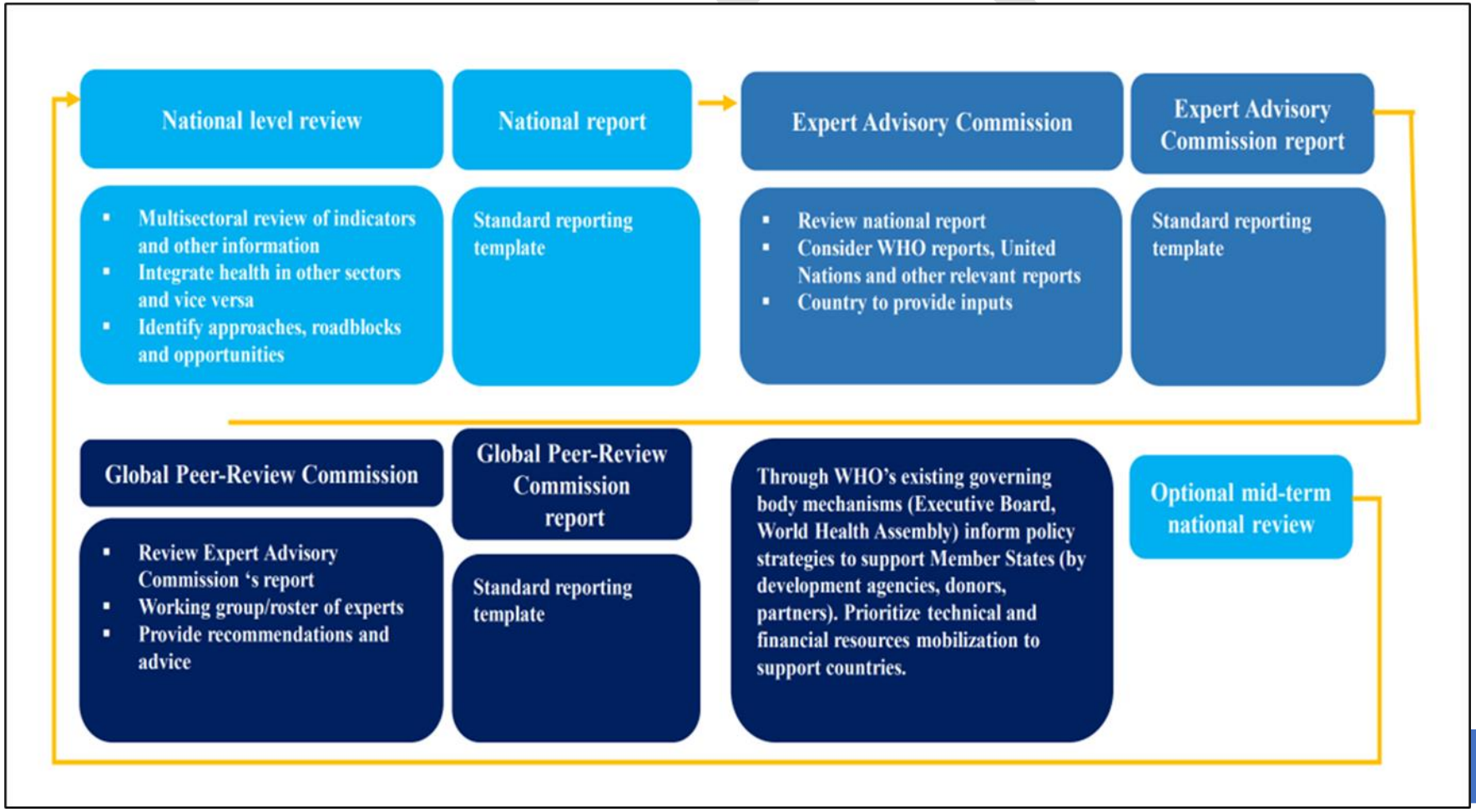
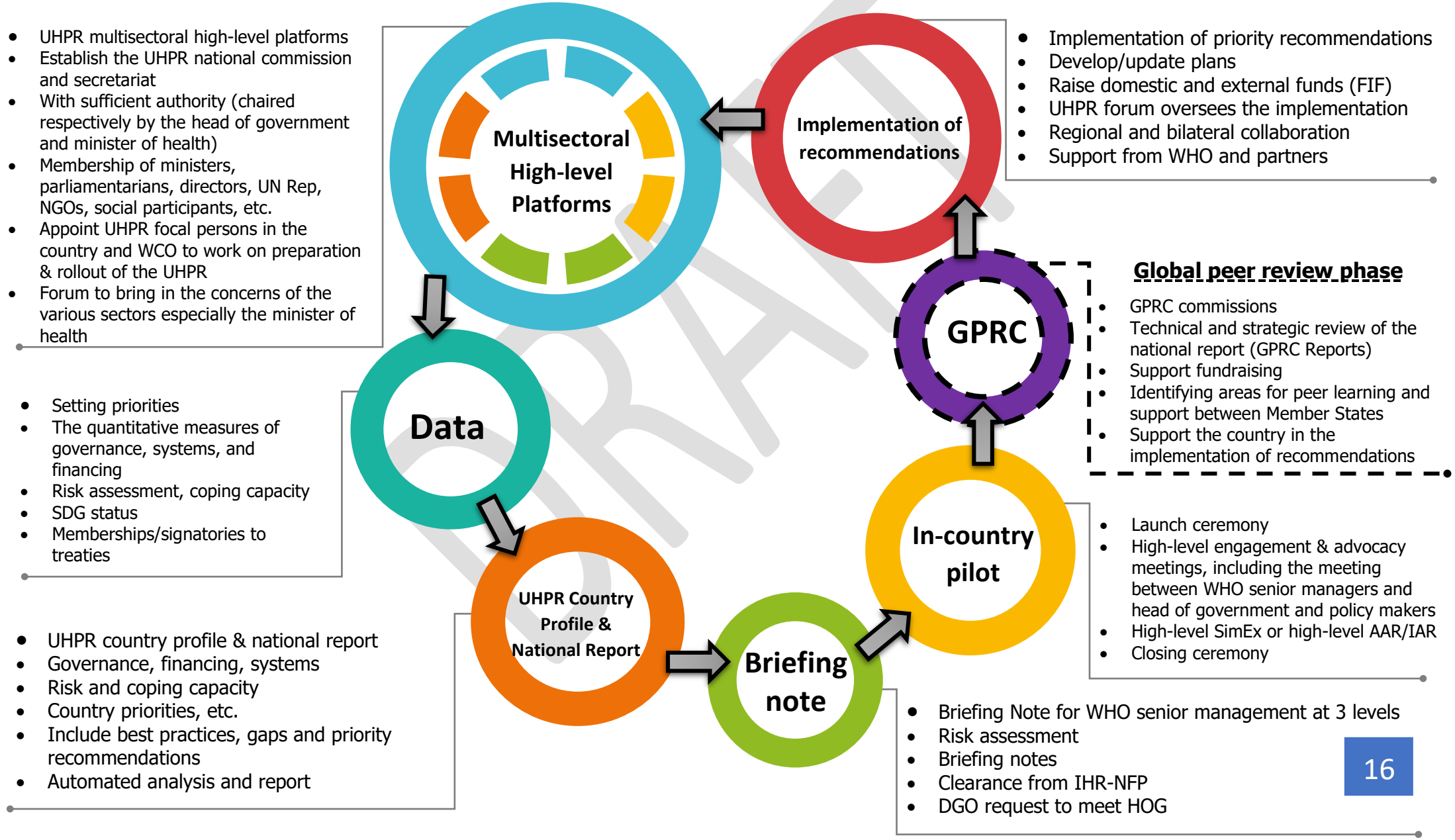


FIGURE 2: STEPS AND ACTIVITIES OF THE UHPR PROCESS



DRAFT

The UHPR review process includes a national review phase and a global peer review phase.

1. National review phase

After the country sends its official letter to engage in the UHPR and the WHO Director-General officially replies, the country is officially engaged in the UHPR process. The national review will be a country-owned and country-led process. As part of this phase, each participating Member State will produce a national report, following a standard template. The national review phase follows these steps:

1. Step 1: The country establishes the UHPR multisectoral high-level forums, including the UHPR National commission and secretariat.

   The national commission should be chaired by the highest level of government (president or prime minister) and comprises high-level representatives from all relevant sectors. With regard to its role and responsibilities, the national commission is in charge of:
   - leading, overseeing and supporting the UHPR process
   - participating in UHPR activities
   - validating the final draft UHPR national report.

   The national secretariat should be chaired by the minister of health and comprises high-level technical experts from all relevant sectors. With regard to its role and responsibilities, the national secretariat is in charge of:
   - planning and coordinating the preparation of the UHPR
   - organizing, facilitating and participating in UHPR activities
   - drafting the UHPR national report

Additionally, both the country and WHO Country Office will appoint UHPR focal persons in charge of the technical and logistical preparation and the rollout of the UHPR process.

2. Step 2: The country sets priorities using UHPR core indicators that span a range of relevant capacities across the UHPR key areas of governance, systems and financing in addition to risk assessment. UHPR data is extracted from existing sources including the IHR MEF, the WHO Global Programme of Work (GPW) Triple Billion targets, the SDGs and other relevant national and international sources.
3. Step 3: WHO develops and shares the UHPR country profile with the country. The country will check and complement (if needed) information in the dashboard/profile. The final version will be used by the country to draft its UHPR national report. The UHPR national report will follow a standard template that will be provided by WHO.

DRAFT

4. Step 4: WHO prepares a briefing note for senior management of WHO (headquarters, regional offices and country offices). The note summarizes the country profile and highlights key elements of best practices, challenges and priority recommendations that will be discussed with the head of government and high-level decision makers and partners in the country. The document is cleared by the country (IHR national focal point) before finalization and sharing with senior management of WHO.
5. Step 5: Consists of meetings between WHO and head of government and policy makers during the in-country pilot mission. Senior managers from the three levels of WHO will meet with the head of state and policy makers, including ministers and parliamentarians, as well as with colleagues from UNCT and development partners to discuss key points from the UHPR country profile and the benefits of the process for the country.

The findings from the country review phase will be summarized in the UHPR national report, which will be developed and validated by the country. The final UHPR national report represents the main output of this phase. The WHO UHPR Secretariat has developed relevant guidance for Member States to accompany the review process and the elaboration of the national report.

2. Global peer review phase

The global commissions of the UHPR constitute one of the most important and distinguishing components of the UHPR process and the organization, functioning, added value and expected outcomes need to be clearly articulated to, and understood by ,the senior policy and decision makers of a country at its highest levels.

The global commissions, in a peer-to-peer modality, will externally review the national report of Member States that have undertaken a UHPR and contextualize the findings amid the regional and global context in supporting the priorities and gaps reported by a country. For this purpose, two commissions are proposed: an expert advisory commission (EAC) and a global peer review commission (GPRC).

Once a Member State completes the UHPR in their country and the national commission has finalized the national report identifying the gaps and national priorities, it submits the national report to the EAC for review. On that basis, the EAC will prepare a report with technical recommendations. The EAC report together with the national report will then be submitted to the GPRC for review.

The GPRC will produce a report containing strategic and technical recommendations for the country undertaking a review. The GPRC will also play a role in following up with the countries which have undergone the UHPR process, to and support the conduct of an optional mid-term review on request by the Member States concerned.

DRAFT

3. Post review phase

The Member States undertaking a review are expected to implement the recommendations contained in the outcome report.

The UHPR seeks to promote cooperation and solidarity, and make countries and stakeholders mutually accountable in ensuring that each country meets its obligations. To this end, WHO will provide support to identify and prioritize recommendations to strengthen national plans for strengthening health emergency preparedness capacities, taking into account health systems and UHC capacities that are required for better health security. These plans include NAPHS, national health development plan, country cooperation strategy, humanitarian plan, etc.

The high-level, multi-sectorial and whole-of-society approach of UHPR fosters the ownership and buy-in of its priority recommendations by the country. This will contribute to promote reliable and sustainable domestic funding for health security capacity building, as well as to foster regional and global support through existing and new funding mechanisms like the FIF for pandemic prevention, preparedness and response.

Following the implementation of the recommendations, a mid-term review may be conducted to monitor the progress of implementation of the recommendations, which is to be conducted upon request by the Member State concerned and as recommended by the GPRC.

FREQUENCY OF THE OF THE UHPR AND SUPPORT FROM WHO

1. Frequency

The UHPR process is envisioned every five years. The UHPR process should be integrated with health emergency planning and budget cycles and must consider other existing assessment tools and mechanisms when establishing the national strategy for capacity review and development. The timing of subsequent reviews will be guided by the global peer review commissions and will be based on the specific needs and contexts of Member States. At the end of the cycle, the Member State undertaking a review will participate in the second review cycle.

2. Support from WHO

Member States will take the lead role and ownership of the UHPR process and are encouraged to commit funding and human resources to support the review. WHO, through its headquarters, regional and country offices, will provide technical support to Member States undertaking the UHPR process, as well as during the post-review process. Specific funding will be allocated through the WHO budget to support the

dispatch of experts and other expenses related to the conduct of the peer review process. WHO will also establish a roster of technical experts from Member States that may be called upon to support the process. These experts will be made available from a global pool hosted in an expert database on a WHO website and will be selected with global representation, expertise and gender balance as key considerations. In addition, WHO will work closely with other relevant United Nations agencies and non-state actors with official relations with WHO in providing support for the peer review and implementation of the recommendations.

Further information on the national review phase, the global peer review phase and the post review process are available in the UHPR pilot protocol.

SPECIAL CONSIDERATION FOR ENGAGEMENT OF THE WHOLE-OF-SOCIETY IN THE UHPR

1. Engagement of social participants in UHPR

Social participation and engagement in multilateral mechanisms has significantly grown in recent years to becoming an expected norm in the establishment of robust multilateral accountability mechanisms. A particular focus of the UHPR is dedicated to the added value of social participation, including engagement by communities, civil society (CSOs), and non-state actors. These stakeholders have not only an important role to play in multilateral peer review processes, but are critical in efforts towards strengthening UHC, which in turn contributes to improving health security, and vice versa. The UHPR on the basis of its whole-of society approach values the engagement of empowered CSO, communities and non-state actors in the review of comprehensive national health emergency preparedness capacities, taking into account health systems capacities to achieve UHC in the context of health security. Building social participation into the concept of the UHPR allows for a holistic view on a countries best practices and gaps, which will contribute to a more inclusive planning and better prioritization of recommendations for improving emergency preparedness capacities for the whole of society, particularly for the most vulnerable groups.

In 2019, the Political Declaration on Universal Health Coverage (UHC) was signed off by 192 UN Member States with several clauses which acknowledge the important role participatory process and the inclusion of all relevant stakeholders, plays in contributing to core components of health system governance achievement of universal health coverage for all. The UHPR approach is also aligned with the WHO Multisectoral Preparedness Coordination Framework (MPC), which emphasizes that a holistic, multisectoral and multidisciplinary approach is needed for addressing gaps and advancing coordination for health emergency preparedness beyond the health sector. The MPC Framework provides States

DRAFT

Parties, ministries, and relevant sectors and stakeholders with an overview of the key elements for overarching, all-hazard, multisectoral coordination for health emergency preparedness, particularly including actors beyond the traditional health sector, such as finance, foreign affairs, interior and defense ministries, local authorities, national parliaments, non-State actors, and the private sector, including travel, trade, transport, and tourism. UHPR seeks to build on the principles already recognized by Member States, and encourages Member States to engage with all relevant social participation stakeholders as part of the UHPR process.

UHPR METRICS

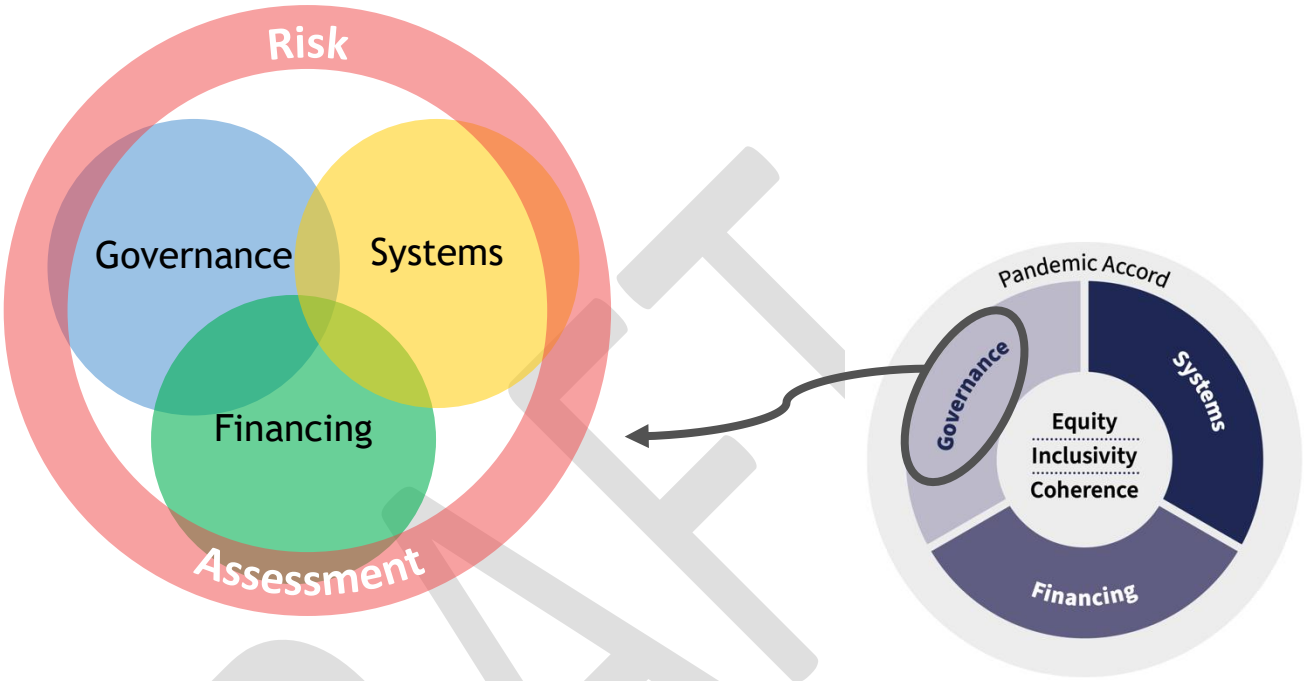
The objective of the UHPH metrics component is to produce a summary view of a country's performance in key areas connected to health and emergency preparedness. This will be used to support the advocacy work of engaging senior policy makers during the UHPR process.

The UHPR metrics component will provide a summary of country level indicators in the key areas of UHPR to be reviewed and discussed by the UHPR national commission. Through these discussions on data and national initiatives, which determine country priorities documented in the UHPR national report, the UHPR process provides platform for countries to show what actions they have done and share with peers in support for high-level advocacy and action.

Three broad categories of health and emergency preparedness capacity are covered in the UHPR process, governance, systems and financing, which are in line with the three pillars of global health emergency preparedness and response (HEPR) architecture (Figure 3). These were identified based on gaps, challenges and priorities from a review of status reports of IHR monitoring and evaluation, reports of various committees (IHR, regional committees, the Independent Oversight and Advisory Committee for the Health Emergencies Programme, the Global Preparedness Monitoring Board and the Independent Panel for Pandemic Preparedness and Response), and a literature review of relevant publications on health emergency preparedness since the onset of the COVID-19 pandemic.

DRAFT

Figure 3. UHPR key areas aligned with HEPR three pillars



Because the UHPR takes a multisectoral and whole-of-government approach, the indicators selected go beyond the traditional domains of IHR core capacities. The UHPR does not replace any of the assessment tools and processes currently in place, rather it uses the existing data and information collected from these sources as primary inputs. Further, the UHPR metrics component includes an additional measure of current risk drivers within the country to aid in interpretation and contextualization of findings in governance, systems and finance as well as to prioritize specific actions to best address the risk profile for a given country.

1. UHPR indicators

In line with the multisectoral and whole-of-society approach to health security, the metrics used as UHPR indicators span a range of relevant capacities across the UHPR key areas of governance, systems and financing in addition to risk assessment. UHPR indicators leverage existing work on vetted metrics from the International Health Regulations (2005): IHR Monitoring and Evaluation Framework, the WHO GPW13 Methods for Impact Measurement, the 2030 Sustainable Development Goals (SDGs), the Strategic Toolkit for Assessing Risk (STAR) or equivalent, and the Dynamic Preparedness Metric (DPM). These indicators are compiled into a country profile to summarise the key areas of UHPR (governance,

DRAFT

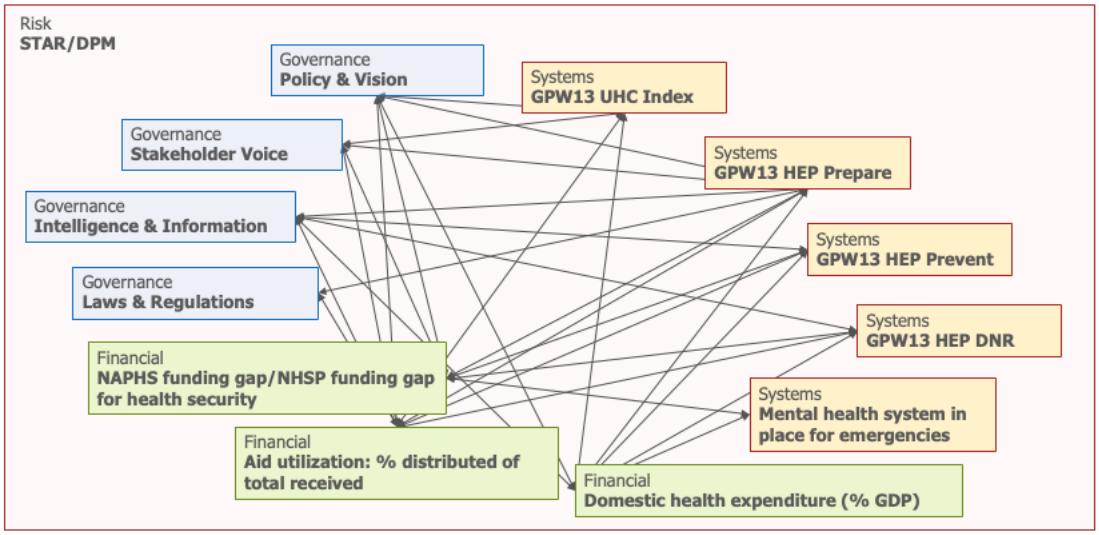
systems and financing) alongside current risk drivers in a country to use data to support the high-level advocacy goals of the UHPR process.

In ongoing consultation with WHO regions and technical working groups, as well as feedback from countries in the initial UHPR pilots, a set of indicators corresponding to the key pillar areas have been identified to serve as consistent inputs into country-level summaries (Figure 4). The indicators for systems, financing and risk comprise of measures already collected at the country-level on a routine basis, to avoid any burden of additional data collection.

The metrics component of the UHPR are based on measures that:

- have a direct contribution to health and emergency preparedness
- are within reasonable control of countries to act upon
- have up-to-date data (including proxies) available for the majority of Member States.

Figure 4. UHPR indicator inter-dependencies



The UHPR indicators were chosen to cover main concepts of the key areas of the UHPR. While these indicators are considered necessary, they may not always be sufficient to adequately describe the governance, systems, financial and risk situation in each country. As a country-led process, high-level and technical experts from each country should supplement these indicators with additional data relevant to the national and sub-national situation. Details on the scope of each key area with links to provided indicators and potential supplemental indicators to best represent each area are provided in the descriptions below.

Governance

The recent COVID-19 pandemic has highlighted the influence of effective leadership, enabling environment, multisectoral coordination and institutional/interpersonal trust as a key factors in

successful health and emergency preparedness (as evidenced in many publications including the Global Preparedness Monitoring Board 2021 Report and peer-reviewed analyses from the COVID-19 National Preparedness Collaborators). However, existing quantitative indicators may not capture the full picture of governance consistently across all countries and do not pinpoint government effectiveness specific to the needs of health and emergency preparedness. Thus, to meet these goals, the WHO UHPR Secretariat has developed a multisectoral, participatory qualitative component in the style of the JEE and based partly on the Health Services Performance Assessment (Annex 4 of the UHPR pilot protocol). As part of the UHPR process, the multi-sectoral UHPR national commission will take part in this qualitative assessment providing input on levels of government effectiveness from all sectors in the following areas:

- policy
- stakeholder voice
- evidence-based decision making
- laws and regulation.

The country-specific assessment of these areas with the UHPR national commission will highlight the presence and functionality of established plans, laws, frameworks, processes and resolutions, etc. Evidence of indicators for each area will be determined through group discussions with the UHPR national commission using provided qualitative assessment questions. If requested, these assessments can be graded on a scale of 1-5 corresponding to the capacity levels from the IHR MEF and displayed on the country profile for reference during in the UHPR process.

Systems

There are numerous existing quantitative indicators available that describe health system access, health security capacities and underlying infrastructure necessary for health and emergency preparedness. UHPR has selected widely respected and well vetted indicators from the GPW13 Triple Billions metrics and the global mental health atlas. From GPW13, the UHC index measures coverage of essential health services as well as financial burden due to health through the combination of the UHC average service coverage index (based on 14 tracer indictors) and the financial hardship indicator (percentage of households with >10% income spent on healthcare). Additionally, from GPW13, the health emergency protection indices for prevent (% of vaccine coverage for at-risk groups from epidemic or pandemic prone diseases), prepare (IHR mean capacity level from SPAR), and detect, notify and respond (% IHR of events detected and responded to in a timely manner) provide the wider view of health emergency preparedness. To determine the level of mental health services available in a country, a key capacity often overlooked in past reviews, the availability of programmes for the promotion and prevention of mental health and psychosocial support was incorporated from the global mental health atlas. Additional supplemental indicators from existing national and sub-national data sources may include recent JEE results, NAPHS report, IAR/AAR findings, evidence of specific health systems infrastructure essential to support health emergency response (such as number of mental health facilities focused on emergency operations), or other national documents including policy, legal and normative instruments related to health and emergency preparedness.

Financing

Sustainable financing for both health and health security has consistently been a key factor for countries in building resilient capacities to quickly respond during a health emergency. To assess the financial factors in a country related to health and emergency preparedness, the UHPR focuses on indicators related to spending gaps and net official aid. Initial indicators come from the domestic health expenditure (in total amount and as % of gross domestic product (GDP)) compared to the availability of funds or the gap in NAPHS/national health security plans (NHSP) estimated for health security preparedness. In addition, the amount of net official development assistance and official aid received will be used to determine a country's dependence on external aid as a measure of sustainable financing as well as commitments to international solidarity to global health. Additional supplemental indicators from existing national and sub-national data sources may include aid utilisation (% distributed of total aid received), as used by the World Bank, to give a quantitative measure of the functional quality of how aid is used in a county or results from recent WHO resource mapping (REMAP) tool results which could aid to identify gaps and mobilize financing.

Risk

Individual health outcome and system measurements alone do not fully capture the preparedness capacity status of a country; they must be examined in conjunction with the current underlying hazards and vulnerabilities. The two tools currently used by WHO to assess risk level and drivers for countries are STAR and DPM.

The Strategic Toolkit for Assessing Risk (STAR) offers a comprehensive, easy to use toolkit to enable national and subnational authorities to conduct a strategic and evidence-based assessment of risks in their settings to support the planning and prioritization of actions to prevent, prepare for, detect, rapidly respond to and recover from a health emergency or disaster. The methodology, aligned to the International Health Regulations (2005) Monitoring and Evaluation Framework, follows an all-hazard, participatory and whole-of-society approach, bolstered with available data in-country. Through the direct participation of multisectoral stakeholders in a multi-day STAR workshop, countries develop and own a risk profile inclusive of a seasonal risk calendar, and reach consensus on priority actions for risk prevention, preparedness, and mitigation. The STAR can be conducted at the national, subnational and district/community level. The methodology can also be adapted to various contexts and settings, including specific focus areas (such as infectious hazards or climate change), the service-delivery level (hospitals to inform hospital risk management and planning) or linked to ongoing event assessments such as mass gatherings.

The Dynamic Preparedness Metric (DPM) is a composite measure with three main conceptual dimensions: hazard, vulnerability and capacity. It makes use of available public-facing data sources. The DPM is dynamic as it is frequently updated with publicly available data and addresses five specific disease syndromes (respiratory, diarrhoeal, neurological, haemorrhagic and acute febrile syndromes) in an initial phase. The DPM is designed to support countries and regions to make evidence-based improvements in emergency preparedness considering the unique contributions of multiple sectors and disciplines. The DPM allows monitoring of the evolution of risks and tracking the effects of actions taken to increase the preparedness capacity.

DRAFT

The STAR and DPM are complementary but different tools. While both tools make use of existing data and analysis, the STAR and DPM serve different purposes and provide different sets of information for review and application by Member States. In summary, the STAR is a country-led and country approved tool that employs both quantitative and qualitative data but is not always available or up-to-date. The DPM tool is a more objective, data-driven approach to risk that is based wholly on openly available quantitative data which is available for all countries and updated on a quarterly basis. Depending on the availability and recentness of STAR in a country, the risk information for UHPR country profile will change according to the following three scenarios:

Scenario 1: STAR (or equivalent) recently completed in country

If STAR (or equivalent) has been recently conducted in the country, the resulting country risk profile (risk prioritization and description, risk calendar, and next steps) and workshop report can be referenced and used as part of the UHPR process and engagement of the country.

In complement, the DPM can provide regional and income-level contextualization, medium and longer-term (3—4 years) trend analysis over time of the parameters for the five syndromes. In addition, risk driver analysis, using the parameters of the DPM, may also be included.

Scenario 2: STAR (or equivalent) completed but not recently updated

If STAR (or equivalent) has been conducted in the country, but not recently updated, the resulting country risk profile (risk prioritization and description, risk calendar, and next steps) and workshop report can be referenced and used as part of the UHPR process and engagement of the country.

In complement, the DPM can provide country overall updates of the risk level across the three dimensions of hazard, vulnerability, and capacity for the five syndromes alongside the regional and income-level contextualization, medium and longer-term (3—4 years) trend analysis over time of the parameters for the five syndromes. In addition, risk driver analysis, using the parameters of the DPM, will also be included.

Scenario 3: No STAR (or equivalent) conducted

If STAR (or equivalent) has not been conducted in the country, the DPM can provide country risk level of the three dimensions of hazard, vulnerability, and capacity for the five syndromes along with the regional and income-level contextualization, medium and longer-term (3—4 years) trend analysis over time of the parameters of the five syndromes. In addition, risk driver analysis, using the parameters of the DPM, will also be included.

Within the UHPR exercise, the technical experts may identify and advocate for the Member State to conduct a strategic risk assessment, engaging whole-of-society and multisectoral experts, to develop the country risk profile as related to multisectoral investment for health security.

2. Using the UHPR metrics

The goal of the UHPR metrics and country profile is to provide a country-specific summary status of key areas of UHPR that sets the stage for further review and consultation with the multi-sectoral UHPR national forum. It is through multisectoral discussions among the UHPR national forum, with evidence based on UHPR metrics and other relevant supplemental national documents and data, that the country

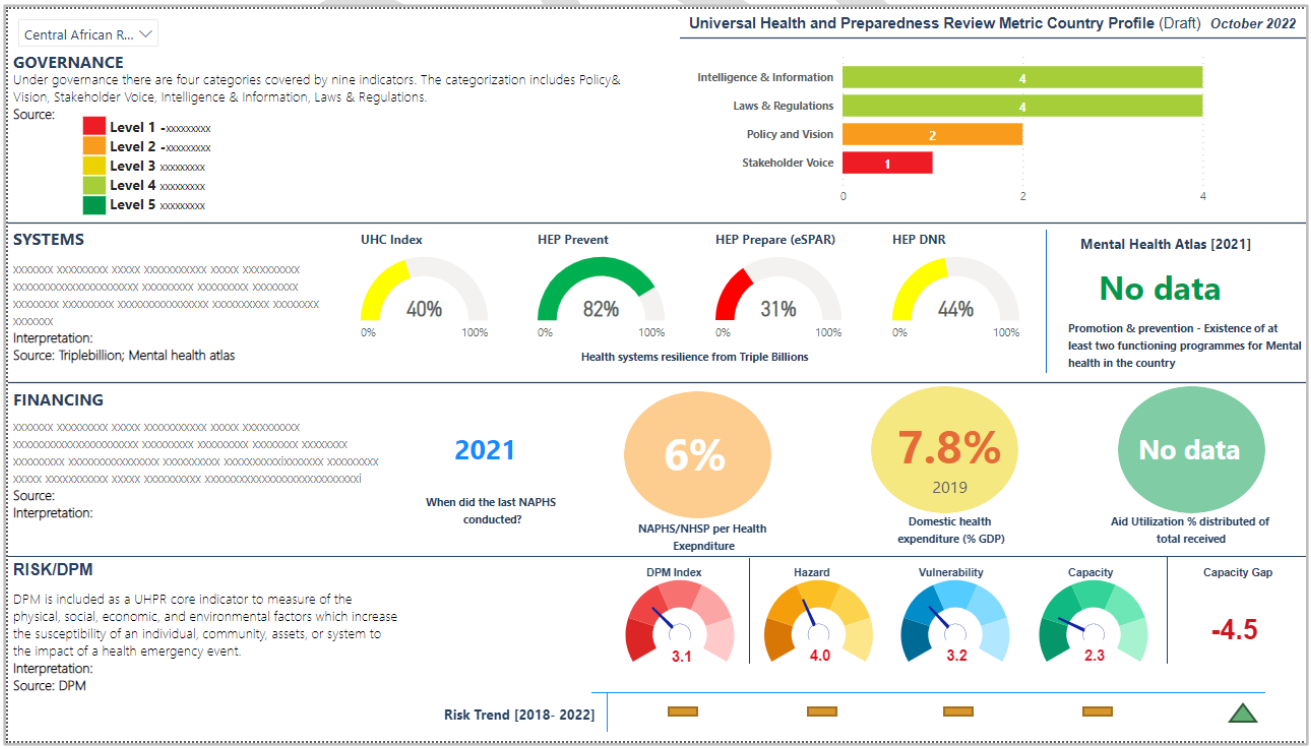
DRAFT

priorities will be determined for high-level advocacy briefings and documentation in the UHPR national report. Annex 3 of the UHPR pilot protocol details each of the indicators, the data source, rationale for inclusion, and the connection to specific areas of governance, systems and financing.

UHPR country profile

All UHPR indicators will be displayed on the UHPR country profile through a semi-automated data processing procedure. The UHPR country profile is a web-based tool that summarizes key data related to health and emergency preparedness for individual countries in a standardised format. Once a country starts the UHPR process with the formation of a UHPR national forum, a private link will be provided for the country profile that can be viewed in any web capable device such as laptop, desktop or mobile. Missing data from NAPHS, NHSP and STAR or equivalent risk assessment reports will be requested to be sent from the UHPR national forum to the WHO UHPR Secretariat in order to update the UHPR country profile accordingly. As part of the UHPR process, scoring from the governance assessment will be added once to the UHPR country profile once complete. The UHPR country profile will display summary findings related to the UHPR key areas of governance, systems and financing alongside a simplified risk profile for contextual interpretation (Figure 5). More detailed risk findings will be displayed separately depending on the three scenarios of data availability (Figure 6). Regional averages or relevant thresholds will be included as a comparison tool. These findings can be used to inform advocacy meetings and UHPR reporting with evidence based on data to ensure key areas of UHPR have been reviewed.

Figure 5. UHPR country profile - UHPR metric menu



Note: *The UHPR country profile page is shown here for an example country. The semi-automated metrics analysis will provide summary of data for governance, systems, financing and risk where available. The*

governance assessment with the UHPR national commission will take part during the UHPR process with data on the UHPR country profile updated accordingly once available (in this example, mock data is used). Systems indicators here show lower levels of UHC and health emergency protection (HEP) prepare but moderately high levels of HEP prevent and HEP detect, notify and respond (DNR) as well as the existence of functioning mental health programmes. Financing data on overall health expenditures is available but additional data from the country's NAPHS/NHSP and aid utilization must be added as part of the initial UHPR process through document sharing. Current risks show improving trends in capacity and vulnerability and a positive capacity gap indicating capacity levels higher than current threats, however details from a current STAR or equivalent risk assessment was not available and should be recommended.

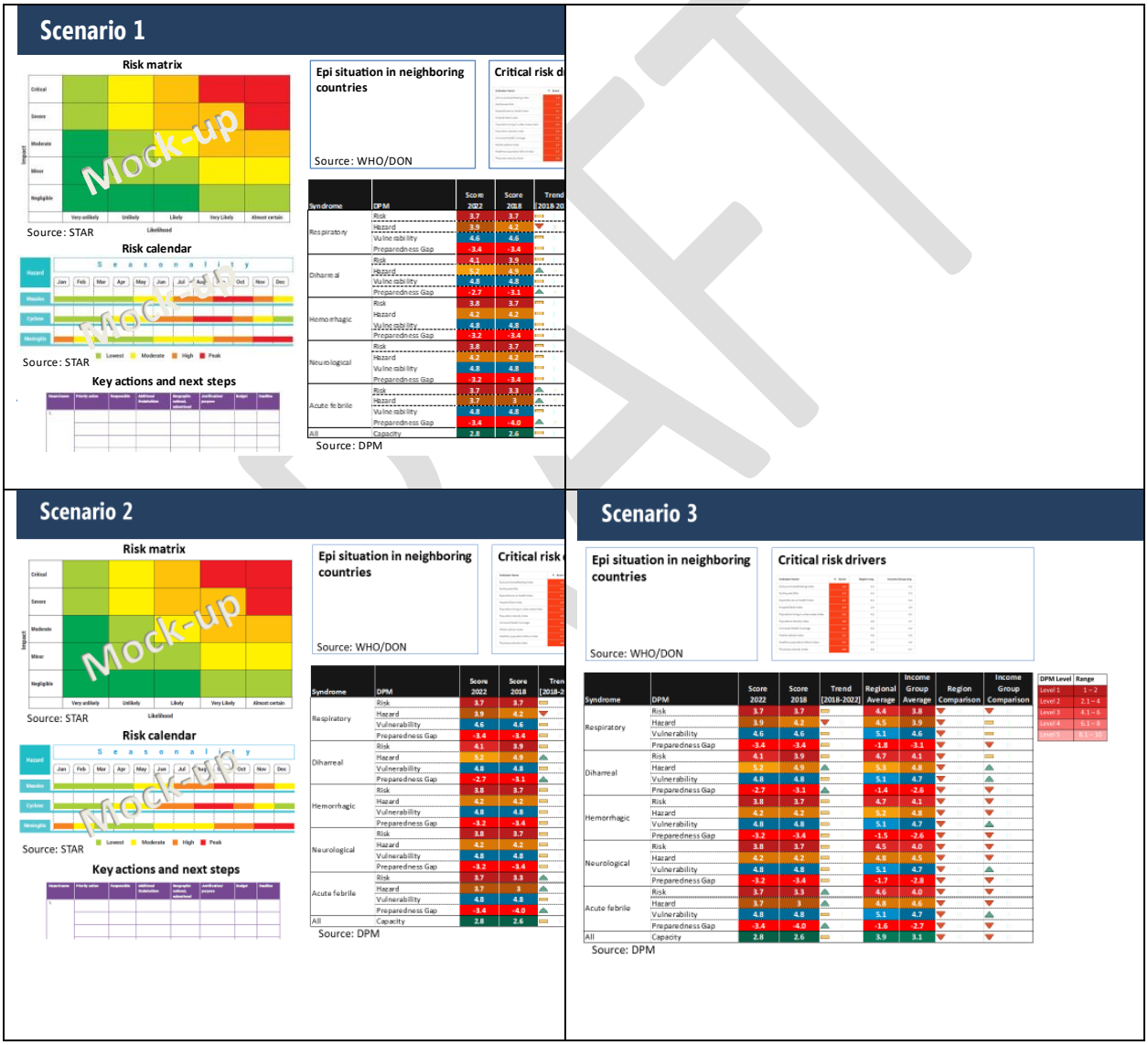



Figure 6. Mock-up of detailed country risk profile under 3 scenarios using STAR and DPM