# The Pandemic Prevention, Preparedness and Response Trust Fund (The Pandemic Fund)

**Key results:**
*The pandemic fund has the following key outcome indicators (Result Framework)*
-Improved capability in holistic disease surveillance and preparedness to respond to health emergencies
- Strengthened coordination among countries globally and regionally and across sectors within countries to foster a coordinated, coherent, and community-led approach to pandemic prevention, preparedness and response (PPR)
- Additional, long-term financing mobilized to bolster pandemic PPR efforts and complement existing mechanisms to address key capacity and capability gaps

Denmark will also have a key focus on
- One-Health and AMR-related indicators
- Gender equality as cross-cutting theme: Indicator 4e/4f

**Justification for support:**
The Pandemic Fund's mandate and work is highly relevant for key Danish priorities and interests within global health. Denmark is committed to take part in efforts to strengthen global health security and pandemic preparedness at the local, national and global level alongside likeminded and multilateral partners.

**Major risks and challenges:**
- The Pandemic Fund could compete with other trust funds, resulting in fundraising competition.
-The Pandemic Fund, as a new entity, needs time to both develop strategic priorities and procedures for calls and will need time to show and deliver results.

| | | | | | | |
|---|---|---|---|---|---|---|
| **File No.** | 23/32652 | | | | | |
| **Country** | Interregional | | | | | |
| **Responsible Unit** | MNS | | | | | |
| **Sector** | 12110 Health | | | | | |
| **Partner** | The World Bank | | | | | |
| *DKK million* | **2023** | **2024** | **2025** | | | **Total** |
| **Commitment** | 25,0 | | | | | 25,0 |
| **Projected disbursement** | 25,0 | | | | | 25,0 |
| **Duration** | 2023-2025 | | | | | |
| **Previous grants** | - | | | | | |
| **Finance Act code** | *§ 06.32.08.75. Internationale sundhedskriser.* | | | | | |
| **Head of unit** | Karen Grønlund Rogne | | | | | |
| **Desk officer** | Simon Feldbæk Peitersen | | | | | |
| **Reviewed by CFO** | YES: Antonio Ugaz-Simonsen | | | | | |

**Relevant SDGs**

| | | | | | |
|---|---|---|---|---|---|
| No Poverty | No Hunger | Good Health, Wellbeing | Quality Education | Gender Equality | Clean Water, Sanitation |
| Affordable Clean Energy | Decent Jobs, Econ. Growth | Industry, Innovation, Infrastructure | Reduced Inequalities | Sustainable Cities, Communities | Responsible Consumption & Production |
| Climate Action | Life below Water | Life on Land | Peace & Justice, strong Inst. | Partnerships for Goals | |

**Objectives**

The Pandemic Fund aims to help Low and Middle Income Countries strengthen PPR 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. The fund will complement existing financing efforts and institutions and will have the flexibility to work through strong implementing institutions, drawing on their comparative strengths. The Pandemic Fund is expected to bring additional, long-term, dedicated resources for PPR, incentivize countries to increase investments in PPR, and enhance coordination among partners.

**Environment and climate targeting - Principal objective (100%); Significant objective (50%)**

| | Climate adaptation | Climate mitigation | Biodiversity | Other green/environment |
|---|---|---|---|---|
| **Indicate 0, 50% or 100%** | | | | |
| **Total green budget (DKK)** | | | | |

**Justification for choice of partner:**

The World Bank is one of the largest sources of funding and knowledge for developing countries. Its five institutions share a commitment to reducing poverty, increasing shared prosperity, and promoting sustainable development. The World Bank Group is the only global multilateral development bank and together with its emphasis on pandemic prevention, preparedness and response, it constitutes an experienced and powerful partner.

**Summary:**

With a contribution to the fund, Denmark will support the (re)building and strengthening of global pandemic preparedness in LMICs, as well as contribute to creating better preparedness and resilience against future international health crises. The foundation focuses its efforts in LMICs on strengthening local and national pandemic preparedness and health security.

**Budget (**engagement as defined in FMI**):**

| | |
|---|---|
| **Total - The Pandemic Fund** | **DKK 25 million** |

# The Pandemic Prevention, Preparedness and Response Trust Fund (The Pandemic Fund)

*(Annex A to Contribution Agreement)*

**Cover page (*)**

See Appropriation Cover Note format.

## 1. Introduction

The present development engagement document outlines the background, rationale and justification, objectives and management arrangements for development cooperation concerning the Pandemic Prevention, Preparedness and Response Trust Fund for the period 2023-2025 as agreed between the parties: The International Bank for Reconstruction (IBRD) and Development and Ministry of Foreign Affairs of Denmark, represented by Team Equal Opportunities. The document is an annex to the legal bilateral agreement with the implementing partner and constitutes an integral part hereof together with the documentation specified below.

"The Documentation" refers to the partner documentation for the supported intervention, which is outlined in the Contribution Agreement (see Annex 10).

## 2. Context, background, strategic considerations, and justification

Population growth, rapid urbanization, environmental degradation, and the misuse of antimicrobials are disrupting the equilibrium of the microbial world. New diseases, like COVID-19, are emerging at unprecedented rates, with the risk of international spread and disrupting people's health and significant social and economic impact.

Increased awareness of the potential hazards and the consequence of climate change for diseases and health, has further underlined the need for action. As the globalization of food production increases, so does the risk of foodborne diseases. As the world's population becomes more mobile, these global health threats increase and national borders cannot protect against the invasion of a disease or vector. Pandemics, health emergencies and weak health systems not only cost lives, but also pose some of the greatest risks to the global economy and security faced today.

Most recently and unparalleled in recent global history, COVID-19 highlighted the urgent need for collective action to augment the existing global health security, including financing system, and the need for mobilizing additional resources for increased investments in pandemic prevention, preparedness, and response (PPR). Avoiding future pandemics requires investing substantially more in PPR. These investments will help avert the much larger costs that the world would have to incur if we were to be caught unprepared for the next global health crisis. Countries must step up domestic investments in the core capacities needed to prevent and contain future pandemics, in accordance with the International Health Regulations (2005). This must be complemented by enhanced external financing, particularly for developing countries. Given the urgent need to step up investments to strengthen the capacity of developing countries to prevent, prepare for, and

respond to future global health threats, and with broad support from the G20 and beyond, the World Bank Board of Directors approved the establishment of a Financial Intermediary Fund (FIF) for PPR (The Pandemic Fund) on June 30, 2022.

As part of the proceedings, the European Union (EU) facilitated a hybrid donor meeting in Brussels on July 19-20, 2022, to help prepare for the establishment of the Pandemic Fund. The meeting allowed for exchanges on the objectives and scope of the Pandemic Fund and its governance and operating framework. Agreement was reached to further engage partner countries, civil society organizations (CSOs), potential implementing entities, and other stakeholders on the Pandemic Fund's design in the coming weeks ahead of its launch.

The Pandemic Fund was officially established by the Governing Board at its inaugural meeting on September 8-9, 2022. The new fund is overseen by a Governing Board, which sets out the overall work program and makes funding decisions. The Pandemic Fund's Governing Board includes equal representation of sovereign donors and potential implementing country governments, as well as representatives from foundations and CSOs. This reflects the Pandemic Fund's commitment to inclusivity and equity, and to operate with efficiency, agility and high standards of transparency and accountability.

Denmark has supported the establishment of the Pandemic Fund under the World Bank due to the need for a long-term sustainable and dedicated financing mechanism for pandemic preparedness and response. To ensure global health security there was, and still is, a significant need for pooling of international resources in a predictable and sustainable manner. Denmark also supported the establishment of the Fund, with a view that it should complement existing multilateral institutions and be a financing *modality* rather than an *implementor*. Hereby it is off course critical, which the fund already shows, that it works in collaboration with existing regional and global financial institutions, implementing agencies and other actors. With no implementing capacity, it is crucial that the fund works in collaboration with implementing institutions, like e.g. WHO, GAVI and the Global Fund on Aids, Tuberculosis and Malaria (GFATM). It is crucial, that the fund is, and continues to be, aligned with efforts for strengthening and financing of the WHO, including its regulatory, normative and standard-setting roles and as a leader in responding to global health security. The fund will also have a crucial role in catalyzing the implementation of the International Health Regulations.

Strong institutions, robust and resilient health systems, a one-health-approach as well as resilient supply chains are critical for global health security globally, regionally and locally. Denmark is committed to take part in efforts to strengthen health security and pandemic preparedness at the local, national and global level alongside likeminded and multilateral partners. The contribution to the Pandemic Fund is also based on the rationale above, assessed as fitting well into the portfolio of Denmark's health partners including WHO, GAVI and the GFATM.

**3. Programme or Project Objective (*)**

The Pandemic Fund aims to help Low- and Middle-income countries strengthen PPR and fill existing capacity gaps in core domains of the International Health Regulations at country level, as well as at regional and global levels. The fund will complement existing financing efforts and institutions and will have the flexibility to work through strong implementing institutions, drawing on their comparative strengths. The Pandemic Fund is expected to bring additional, long-term, dedicated resources for PPR, incentivize countries to increase

investments in PPR, and enhance coordination among partners. While ensuring inclusivity, the design of the Pandemic Fund will be underpinned by simple and agile governance and operating arrangements.

Since the Pandemic Fund is a multi-donor financial intermediary fund it is not possible to attribute specific outputs to the Danish financing. Therefore, it is not possible to develop a results framework or theory of change specifically for the Danish support. Instead the Danish contribution is based on the Pandemic Fund's theory of change, while reporting on the Pandemic Fund's progress will follow the overall results framework (see annex 3). Denmark will in its engagement with the pandemic fund in particular follow the work in the areas of One-Health and Antibiotic resistance (AMR) related indicators and gender equality as a cross-cutting theme.

<u>One-Health and AMR</u>

AMR is a growing global problem that hits Low- and Middle-income countries hardest. A One Health approach is based on a common understanding that the relationship between human and veterinary health and the interaction between people, animals and the environment is crucial to dealing with antibiotic resistance. Investments in Infection Prevention and Control are critical for protecting health workers and patients and preventing the emergence and spread of AMR. Investing in IPC contributes to achieving quality care, patient safety, health security and the reduction of AMR. Strong, effective IPC programs allow safe health care and essential services delivery and prevention and control of outbreaks throughout the health system. A sensitive surveillance system, including at the point of entry, is needed to ensure early warning and provide information for an informed decision-making process during public health events and emergencies. This involves a multisectoral and integrated health system approach and may include sentinel surveillance systems and contact tracing during health emergencies. The system should have the capacity to facilitate cross-sectoral communication in line with the One Health approach and based on international standards, guidance, and best practices, to minimize the transmission of zoonotic diseases to human populations.

<u>Gender equality</u>

Disease outbreaks and pandemics affect women and men differently, and tend to worsen existing gender inequalities, sexual and gender-based violence, and discrimination due to increased tensions in the household, economic stress, including unpaid care work, and disruption or collapse of systems and structures that protect women and girls. Women and girls are often in vulnerable situations, but they continue to hold positions to provide care, services and leadership in their communities. For example, 70% of healthcare workers are women, and women and girls also dominate the social and service sectors globally. This can result in high exposure to viruses and limited access to critical diagnostics, therapeutics, vaccines, and other health interventions.

**4. Inputs/budget (*)**

The total annual financing need for the future PPR systems has been estimated at USD 31.1 billion by the G20 High-Level Panel. During the First Call for Proposals from March to May 2023, the Pandemic Fund aimed to enhance disease surveillance, laboratory capabilities, and the healthcare workforce. It received 179 applications from 133 countries, seeking over USD 2.5 billion. As per 20 November 2023 USD 1,935.59 million has been pledged and contributed as support to the Pandemic Fund (see Budget in Annex 5). An overview over the donors can also be found in the Trustee Update in Annex 5a.

With this document Denmark expresses support to the Pandemic Fund initiative and the intention to provide financial support of DKK 25 million over a three-year period (2023-2025).

**5. Institutional and Management arrangement (*)**

The governing and administrative bodies of The Pandemic Fund are the Governing Board, the Technical Advisory Panel (TAP), the Secretariat, and the Trustee. The Implementing Entities[1] will support implementation of the Pandemic Fund-financed projects and activities. A broad set of stakeholders, including donors, CSOs, potential implementing country governments, and other partners were engaged on the Pandemic Fund's design to ensure it reflected the fund's commitment to inclusivity, equity and to operate with high standards of transparency and accountability.

**The Governing Board**

The Governing Board is the supreme governing body of The Pandemic Fund. The Governing Board, comprising of 21 voting members, reflects an equal balance of sovereign "contributors" (donors) and sovereign "co-investors" (countries that could receive funding); includes a voting seat for non-sovereign contributors (philanthropies/foundations); and two voting seats for CSOs. The Governing Board is led by two co-chairs, currently Dr. Chatib Basri, former Minister for Finance, Indonesia and Sabin Nsanzimana, Minister of Health, Rwanda.

Due to the funding threshold outline in Annex 1 to the Governance Framework of the Pandemic Fund, Denmark will not be able to join as voting constituency on the Governing Board with the contribution made with this agreement. Denmark may be invited by the Governing Board (through the Secretariat) to be an Observer on the Governing Board. As an Observer, Denmark will have access to most of the information shared with the Board.

**Secretariat**

The Secretariat, housed at the World Bank, provides program management and administration services including support to the Governing Board in the delivery of its responsibilities. The Secretariat manages day-to-day operations, prepares policies and procedures, and manages partner relations and stakeholder engagement. It is comprised of a small team of professional and administrative staff employed by the World Bank or seconded to the World Bank from the WHO.

**The Trustee**

The World Bank serves as the Trustee for The Pandemic Fund and carries out its roles and responsibilities in accordance with the World Bank's policies and procedures. The Trustee receives funds from contributors and transfers resources to the implementing partners. The World Bank as Trustee also provides regular reports on The Pandemic Fund's financial status to the Governing Board.

[1] The 13 currently approved implementing entities include: African Development Bank; Asian Development Bank; Asian Infrastructure Investment Bank; European Investment Bank; Inter-American Development Bank; International Finance Corporation; World Bank; Food and Agriculture Organization of the United Nations; UNICEF; World Health Organization; the Coalition for Epidemic Preparedness Innovations; Gavi, the Vaccine Alliance; and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

**The Technical Advisory Panel (TAP)**

The TAP is a pool of up to 20 experts, bringing a diverse range of independent technical and financial expertise relevant to FIF-supported projects and activities. TAP provides independent advice to the Governing Board on critical gaps in pandemic PPR, funding priorities and calls for proposals, as well review of funding proposals submitted to the Fund. In this way, the TAP supports the Pandemic Fund with its goal of financing projects and activities that help strengthen capacity building and implementation of PPR under the International Health Regulations and other internationally endorsed legal frameworks, consistent with a One Health approach. The TAP's roles and responsibilities are set out in paragraph 21 of the Governance Framework and in the Terms and Reference for the TAP.

The Ministry of Foreign Affairs of Denmark shall have the right to carry out any technical or financial supervision mission that is considered necessary to monitor the implementation of the programme.

After the termination of the programme support, the Ministry of Foreign Affairs of Denmark reserves the right to carry out evaluations in accordance with this article.

**6. Financial Management, planning and reporting**

The Contribution agreement as well as the Governance Framework and Operations Manual of the Pandemic Fund defines all the funds' procedures for financial management. As has already been established the Pandemic Fund is organised as a FIF[2] where the IBRD serves as the Trustee. The Trustee carries out its roles and responsibilities in accordance with the World Bank policies and procedures and receives funds from contributors and holds those funds in the FIF pursuant to the terms of contribution agreements or arrangements entered into with donors.

The Pandemic Fund will submit the following annual reports by 31 July:

1. Annual report and audited financial statements, specifying the Danish contribution as income

Within six (6) months following the end of each Bank fiscal year, an annual single audit report shall be made available to the Contributors, comprising: (i) a management assertion together with an attestation from the Bank's external auditors concerning the adequacy of internal control over cash-based financial reporting for all cash-based trust funds as a whole; and (ii) a combined financial statement for all cash-based trust funds together with the Bank's external auditor's opinion thereon.

The disbursement of the full Danish contribution will be made in December 2023 upon signature of the agreement.

Both parties will strive for full alignment of the Danish support to the implementing partner rules and procedures, while respecting sound international principles for financial management and reporting.

**7. Risk Management**

Risk management is handled by each implementing entity who is responsible for the management of risks associated with the respective projects and programs implemented by them. Reporting on risks and

[2] FIF's are financial arrangements that leverage a variety of public and private resources in support of international initiatives, enabling the international community to provide a direct and coordinated response to global priorities.

mitigation measures, as appropriate, form part of their progress and results reporting. The Trustee manages any financial risks associated with administration of the Pandemic Fund and its resources until the time they are transferred to implementing entities or returned to contributors in accordance with the provisions of the Contribution Agreements. The Governing Board maintains oversight of the risk management approach and risk appetite at the portfolio level. The Pandemic fund does not have a Risk Management system as such but has described its risks and mitigation measures as outlined below[3].

**Strategic risk:** The Pandemic Fund is well-aligned with the Bank's strategy, objectives and priorities on PPR. The Pandemic Fund's value proposition for Bank clients is supported by strong diagnostics. The membership of the Pandemic Fund's Governing Board is familiar with the Bank, other MDBs, WHO, and other key global health actors, and is able to leverage on the comparative advantages of these entities. The Bank's participation in the Pandemic Fund's Governing Board (in each of its separate and distinct capacities as trustee, secretariat and implementing entity) provide additional opportunities to ensure alignment with Bank strategy, objectives, and priorities.

**Operational risk:** The Pandemic Fund does not present any known operational risks related to the Bank's ability to carry out its responsibilities as trustee, secretariat and implementing entity, consistent with its operational policies and procedures. The risk of operational issues arising from the Bank's secretariat functions is low, given the mandate and functions of Pandemic Fund secretariat and the Bank's demonstrated capacity and track record in performing this role. Operational risks from the Bank's potential implementing entity role are also likely to be low.

**Stakeholder risk:** This risk relates to how the Pandemic Fund can potentially impact the Bank's relationships and reputation with partners and public opinion. The FIF has broad support from the international community, including the Bank's major shareholders and beyond, the WHO, other global health agencies, philanthropies and CSOs. It is important to continue to broaden and sustain this support.

**Financial risk**: There are no known financial risks associated with this FIF, given the Bank's strong capacity and track record in serving as limited Trustee for FIFs, coupled with the simple financial structure of this FIF (grants in/grants out). The FIF is an off-balance sheet vehicle with no potential impacts on the balance sheets of IBRD or he International Development Association (IDA) or their perceived standing in financial markets. Furthermore, the Bank will recover costs in line with its current cost recovery policy.

**Legal risk:** Legal and governance documents to establish the FIF will be negotiated by the Bank's Legal team such that they do not contain any provisions that could lead to an erosion or loss of privileges and immunities by explicitly or implicitly agreeing to, among others, the application of national law on Bank activity, jurisdiction of local courts over the Bank, contractual or third-party claims against the Bank, or Bank obligation to perform activities that are or may be perceived as outside the Bank's mandate.

**Portfolio risk:** This Pandemic Fund has a clear mandate and objectives, and play a complementarity role within the larger global health financing architecture. With respect to IDA and IBRD, the Pandemic Fund is

[3] 'Establishment of a Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response', PPR, June 2022

expected to play a complementary role by co-financing IDA and IBRD operations or fill gaps, as needed. The FIF could compete with other trust funds, IDA, etc., resulting in fundraising competition. The Pandemic Fund has already mobilized a commitment from a philanthropic institution, and other philanthropies have signaled serious interest. Furthermore, the Bank can play an active role in mitigating portfolio risk, through its involvement in shaping and designing the Pandemic Fund, and participation in the Governing Board.

**Adaptation risk**: It's not a clear identified risk, but as The Pandemic Fund is a fairly new established entity, it would – as most other organizations - need time to adapt and be integrated in the larger global health financing architecture. The global health architecture is quite fragmented, and the adaption of The Pandemic Funds strategic priorities, benefit and clear results to the overall global health agenda and PPPR would probably take time.

### 8. Closure

The formal closure of the project will consist of the following three steps:

(i) Implementing partner's final report
(ii) Responsible unit's final results report (FRR)
(iii) Closure of accounts: final audit, return of unspent funds and accrued interest and administrative closure by reversing remaining provision.

## Annexes:

Annex 1: Context Analysis – Using the partners documentation 'Establishment of a Financial Intermediary Fund for PPR'

Annex 2: Partner Assessment – Based on the recent MOPAN assessment finalized in July 2023[4]

Annex 3: Theory of Change, Scenario and Result Framework

Annex 4: Risk Management

Annex 5: Budget Details

Annex 5 a: Trustee Update

Annex 6: The Pandemic Fund Governing Board

Annex 7: Plan for Communication of Results – This annex is not included. Denmark will follow the communication from the Bank[5] and share internal when relevant. Results will be shared following receipt of the annual report.

Annex 8: Process Action Plan - Have not been developed for this process and therefore not attached.

[4] World Bank Performance at a Glance.pdf (mopanonline.org)
[5] News and Events (worldbank.org)

Annex 9: Quality Assurance Checklist or signed table of appraisal recommendations and follow-up actions taken, depending on whether the appraisal has been conducted by a development specialist

Annex 10: Contribution Agreement

# ESTABLISHMENT OF A FINANCIAL INTERMEDIARY FUND FOR PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE

**June 2022**

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AIDS | Acquired immunodeficiency syndrome |
| AMR | Antimicrobial Resistance |
| CARICOM | Caribbean Community |
| CDC | Center for Disease Control |
| CEPI | Coalition for Epidemic Preparedness Innovations |
| COVID | Coronavirus disease |
| CRW | Crisis Response Window |
| CSO | Civil Society Organization |
| DFAT | Department of Foreign Affairs and Trade |
| DPO | Development Policy Operation |
| FIF | Financial Intermediary Fund |
| G20 | Group of 20 |
| G7 | Group of 7 |
| GAFSP | Global Agriculture and Food Security Program |
| GCFF | Global Concessional Financing Facility |
| GDP | Gross Domestic Product |
| GFF | Global Financing Facility |
| GIF | Global Infrastructure Facility |
| HEPR | Health Emergency Preparedness and Response Fund |
| HLIP | High Level Independent Panel |
| IBRD | International Bank for Reconstruction and Development |
| IDA | International Development Association |
| IFC | International Finance Corporation |
| IHR | International Health Regulations |
| IMF | International Monetary Fund |
| JFHTF | Joint Finance and Health Task Force |
| LIC | Low Income Country |
| MDB | Multilateral Development Bank |
| MDTF | Multi-donor Trust Fund |
| MIC | Middle Income Country |
| MPA | Multi-Phased Approach |
| ODA | Overseas Development Assistance |
| PPR | Prevention, Preparedness and Response |
| SARS, | Severe Acute Respiratory Syndrome |
| TAC | Technical Advisory Committee |
| TB | Tuberculosis |
| UN | United Nations |
| UNDP | United Nations Development Program |
| UNFCCC | United Nations Framework Convention on Climate Change |

| | |
|---|---|
| UNHCR | United Nations High Commissioner for Refugees |
| WBG | World Bank Group |
| WHO | World Health Organization |

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**ESTABLISHMENT OF A FINANCIAL INTERMEDIARY FUND FOR PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE**

# I. Introduction

1. **COVID-19 has highlighted the urgent need for collective action to augment the existing global health security financing system and to mobilize additional resources to build health systems and strengthen capacity for pandemic prevention, preparedness, and response (PPR).** Avoiding future pandemics requires investing substantially more in PPR; these investments will help avert the much larger costs that the world would incur if we were to be caught unprepared for the next global health crisis. Countries must step up *domestic investments* in the core capacities needed to strengthen health preparedness and prevent and contain future pandemics, in accordance with the International Health Regulations. This must be complemented by enhanced *external financing*, particularly for developing countries. The joint World Bank-WHO paper on PPR financing needs and gaps[1], prepared for the G20 Joint Finance and Health Task Force, estimated that external financing amounting to an additional US$10.5 billion per year, over the next five years, is needed for investments at the country, regional and global level to strengthen the capacity of low-income countries (LICs) and middle-income countries (MICs). PPR is a global public good. Mobilizing the needed external financing to strengthen PPR in low- and middle-income countries and regions that are the most fiscally stretched and in need of financial support is the collective responsibility of the international community.

2. **Reinforcing the multiple actors that provide international financing for PPR and enhancing coordination remain critical priorities.** Multilateral Development Banks (MDBs), through their core funding mechanisms, are today the largest source of external financing for PPR in developing countries (Figure 1). Among MDBs, the World Bank Group (WBG) has been the largest provider of PPR financing, and IDA20 includes ambitious commitments to strengthen PPR. Other key actors include: the World Health Organization (WHO) and other specialized UN agencies engaged in PPR activities; global health institutions, like the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), Gavi, the Vaccine Alliance (Gavi), and the Coalition for Epidemic Preparedness Innovations (CEPI), which are supported by FIFs for which the Bank serves as trustee; regional actors, like Africa Centers for Disease Control and Prevention (Africa CDC) and the Pan American Health Organization (PAHO), that have stepped in to perform critical coordinating and operational functions during COVID-19, demonstrating the value and potential of platforms in which countries have a direct stake; bilateral agencies; and philanthropic organizations.

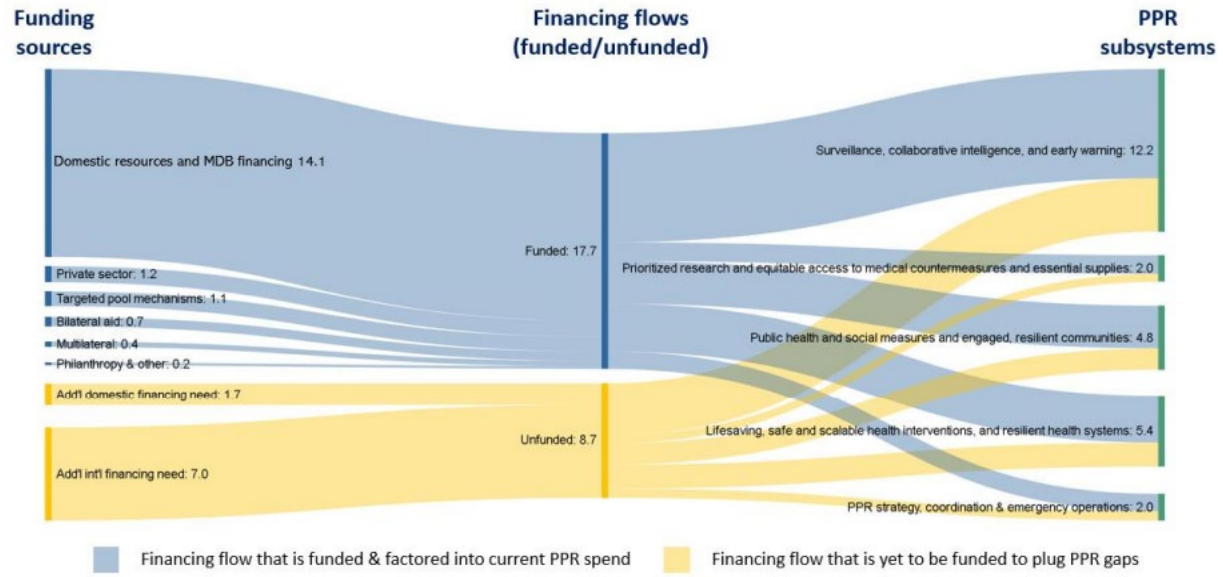
3. **At the same time, there is strong appreciation within the international community of the urgent need for a new multilateral financing mechanism dedicated to PPR financing.** The absence of a dedicated financing mechanism for PPR means that spending on other immediate needs can take priority over critical PPR investments some of whose return may only materialize in the future. A new multilateral financing mechanism would help to focus and sustain much-needed high-level attention on strengthening PPR during "peace time," complementing existing mechanisms. It could mobilize significant additional financing for PPR. With the appropriate structure and design, it could: increase country investments in PPR; promote a more coordinated approach to PPR investments; and by convening key stakeholders, serve as a platform for discussion and advocacy around strengthening PPR (Box 1 clarifies key concepts). A new financing mechanism must however be viewed as one part of the solution to increase financing for PPR.

[1] *"Analysis of Pandemic Preparedness and Response (PPR) architecture, financing needs, gaps and mechanisms",* Paper prepared by the WHO and World Bank for the G20 Joint Finance & Health Task Force, March 22, 2022. The paper estimated that an additional US$31 billion per annum is needed over the next five years to strengthen the PPR capacity of low- and middle-income countries, about two-thirds of which will have to come from domestic financing.

Efforts are needed, in parallel, to enhance the governance of the wider global health security and PPR ecosystem.

**Figure 1**

**Country PPR financing and needs, by source and PPR subsystems (US$ billions)**




*Source: "Analysis of Pandemic Preparedness and Response (PPR) architecture, financing needs, gaps and mechanisms",* Paper prepared by the WHO and World Bank for the G20 Joint Finance & Health Task Force, March 22, 2022.

**Box 1: Clarifying Concepts: Prevention, Preparedness and Response**

**Disease outbreaks, epidemics, and pandemics**

**Disease outbreaks** refer to an increase, often sudden, in the number of cases of a disease in a particular area. Most disease outbreaks with pandemic potential have a zoonotic origin, caused by a pathogen spilling over from animals into humans. **Epidemics** have a similar definition as outbreaks, but the term is generally used for a wider geographic area. A **pandemic** is defined as "an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people".

**Prevention, preparedness, and response (PPR)**

**Prevention** encompasses the systems, policies, and procedures to determine, assess, avoid, mitigate, and reduce public health threats and risks. This definition captures interventions needed to mitigate risk and reduce the likelihood or consequences of spillover events at the human, animal, or ecosystem interfaces. Such interventions frequently reside with agriculture, food, wildlife management, or environmental sectors, highlighting the importance of a multisectoral, "One Health" approach, but also include some health sector interventions (e.g., routine immunization against epidemic-prone diseases).

**Preparedness** refers to *ex-ante* actions that help mitigate losses when a disease outbreak occurs. It includes strengthening the capacities and capabilities at community, country, regional, and global levels to prevent, detect, contain, and respond to the spread of disease, mitigating economic and social impacts.

**Response** refers to *ex-post* actions taken in response to a disease outbreak to reduce its economic, social and health impacts.

4. **Broad support has emerged among major shareholders for a new, multilateral financing mechanism for PPR to be established as a Financial Intermediary Fund (FIF) hosted by the World Bank.**

- The idea of establishing a FIF at the World Bank to support PPR financing was originally put forward at the G20[2] and explored through an informal finance and health working group process under the G20 Italian Presidency. The G20 Leaders in their Rome Declaration (October 31, 2021)[3] noted that *"financing for pandemic prevention, preparedness and response (PPR) has to become more adequate, more sustainable and better coordinated and requires a continuous cooperation between health and finance decision-makers, including to address potential financing gaps, mobilizing an appropriate mix of existing multilateral financing mechanisms and explore setting up new financing mechanisms."* The Declaration called for the establishment of a G20 Joint Finance-Health Task Force (JFHTF) and asked that the Task Force *"report back by early 2022, on modalities to establish a financial facility… to ensure adequate and sustained financing for PPR."*
- The needs and merits for a new multilateral financing mechanism and alternative modalities for the establishment of such a mechanism were discussed extensively within the G20 JFHTF, which is co-chaired by Indonesia and Italy, under the auspices of the G20 Indonesian Presidency. These discussions were supported by World Bank-WHO papers on financing needs and gaps[4] and on PPR financing modalities.[5]
- At the Second Global Covid-19 Summit held on May 12, 2022, co-hosted by the Governments of the United States, Indonesia (holding the G20 Presidency), Germany (holding the G7 Presidency), Senegal (as Chair of the African Union) and Belize (as Chair of CARICOM), the proposal to establish a FIF at the World Bank received broad support.
- The G7 Finance Ministers and Central Bank Governors Communique, May 20, 2022, expressed *"support for the establishment of a Financial Intermediary Fund, housed at the World Bank, to catalyze investments in pandemic prevention, preparedness and response."*[6]

5. ***Financial contributions announced to date towards the FIF.*** The United States Government has announced a contribution of US$450 million towards this proposed FIF for the US fiscal year ending September 30, 2022, and it has signaled its intent to channel additional funds in the coming years; the European Commission has announced a contribution of US$450 million; Germany has announced a contribution of Euros 50 million; Indonesia has announced a US$50 million contribution; and the Wellcome Trust has announced a contribution of GBP10 million. Several other donors have also signaled their interest.

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[2] *"A Global Deal for Our Pandemic Age",* Report of the G20 High Level Independent Panel on Financing the Global Commons for Pandemic Preparedness and Response, June 2021. https://pandemic-financing.org/report/

[3] The G20 Leaders Rome Declaration noted the following: *"We acknowledge that financing for pandemic prevention, preparedness and response (PPR) has to become more adequate, more sustainable and better coordinated and requires a continuous cooperation between health and finance decision-makers, including to address potential financing gaps, mobilizing an appropriate mix of existing multilateral financing mechanisms and explore setting up new financing mechanisms. We establish a G20 Joint Finance-Health Task Force (JFHTF) aimed at enhancing dialogue and global cooperation on issues relating to pandemic PPR, promoting the exchange of experiences and best practices, developing coordination arrangements between Finance and Health Ministries, promoting collective action, assessing and addressing health emergencies with cross-border impact, and encouraging effective stewardship of resources for pandemic PPR, while adopting a One Health approach. Within this context, this Task Force will work, and report back by early 2022, on modalities to establish a financial facility, to be designed inclusively with the central coordination role of the WHO, G20-driven and engaging from the outset low- and middle-income countries, additional non-G20 partners and Multilateral Development Banks, to ensure adequate and sustained financing for pandemic prevention, preparedness and response."*

[4] See footnote 2.

[5] "PPR Financing Modalities", Paper prepared by the World Bank and WHO for the G20 Joint Finance & Health Task Force, March 29, 2022. See also, "WHO White Paper Consultation: Strengthening the Global Architecture for Health Emergency Preparedness, Response and Resilience", May 4, 2022, which specifically highlights the need for a FIF.

[6] https://www.bundesfinanzministerium.de/Content/EN/Standardartikel/Topics/world/G7-G20/G7-Presidency/2022-05-20-g7-communique.html

## II. Sector Context and the WBG's Experience in PPR

6. **The COVID-19 pandemic has demonstrated the disruptive nature of disease outbreaks.** Since the first documented case in December 2019, SARS-CoV-2 has reached every country in the world, resulting in significant mortality, overburdened health systems, and wide-scale economic and social disruptions. As of June 2022, more than 6.2 million COVID-related deaths have been officially recorded, while the excess mortality from COVID is estimated to be approximately three times higher. The combined supply- and demand-side shock resulted in a global recession – the deepest since World War II – with the global economy contracting by 4.4 percent in 2020 and the expected economic losses from the pandemic estimated at nearly US$14 trillion up to 2024.[7] COVID-19 has also disrupted delivery of essential services and exacerbated learning poverty, displacement, hunger, and gender-based violence.

7. **Previous outbreaks have also had far-reaching social and economic consequences.** The 2003 SARS pandemic, which was a modest outbreak relative to COVID-19, led to over 9,000 cases, 700 deaths[8] and an estimated global economic loss of US$52 billion. The Ebola outbreak in West and Central Africa in 2014-2016 was a major outbreak in the region, causing over 11,000 deaths, a GDP loss of US$2.8 billion and a sharp rise in unemployment. The 2015-16 Zika outbreak led to over 17,000 infections[9] and an estimated loss of US$3.5 billion in the Latin American and Caribbean region.[10] At the same time, HIV/AIDS, TB, malaria, and other communicable and non-communicable diseases remain important drivers of mortality that incur vast economic costs, and antimicrobial resistance (AMR) has emerged as a major threat, causing an estimated 5 million deaths per year.[11]

8. **Weaknesses in prevention and preparedness for disease outbreaks and pandemics have been a longstanding concern.** Following the SARS and Ebola outbreaks, several commissions and reports made recommendations to address PPR gaps and much of this dialogue has resurfaced in the context of the COVID-19 pandemic.[12] Some important actions were taken following earlier outbreaks, most notably in 2005 a significant revision of the International Health Regulations (IHR), which requires that all countries are able to detect, assess, report, and respond to public health events and that they report progress on IHR implementation to WHO. The Ebola outbreak also accelerated the establishment of the Africa CDC.

9. **Despite progress, significant capacity gaps remain in key domains of PPR capacity, especially in LICs and some MICs.** Available data on preparedness capacity, such as the Global Health Security Index and the IHR State Party Self-Assessment Annual Reports (SPAR) and Joint External Evaluations (JEE), consistently show critical capacity gaps in key PPR areas, such as laboratory capacity, surveillance and reporting, risk communication, and the management of zoonotic disease risks. The COVID-19 pandemic has also revealed broader gaps in areas such as the development, manufacturing, and deployment of COVID-19 countermeasures, the lack of institutional arrangements for coordinated procurement and pre-positioned financing for countermeasures, the fragility of supply chains and international trade, while also highlighting the far-reaching implications from misinformation and lack of trust in government.

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[7] IMF World Economic Outlook, June 2021; IMF World Economic Outlook, April 2022

[8] https://www.cdc.gov/sars/about/fs-sars.html

[9] https://www3.paho.org/hq/index.php?option=com_content&view=article&id=11599:regional-zika-epidemiological-update-americas&Itemid=41691&lang=en

[10] Yamey, Gavin, et al. "Financing of international collective action for epidemic and pandemic preparedness." The Lancet Global Health 5.8 (2017): e742-e744.

[11] Murray, Christopher JL, et al. "Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis." *The Lancet* (2022).

[12] See, e.g.: International Working Group on Financing Preparedness. 2017. *From Panic and Neglect to Investing in Health Security: Financing Pandemic Preparedness at a National Level*. World Bank, Washington, DC. and Moon, Suerie, et al. "Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola." The Lancet 386.10009 (2015): 2204-2221

10. **While the importance of prevention and preparedness is widely recognized, adequate funding has not followed.** At the domestic level, financing for preparedness has been estimated to account for between one and three percent of total government spending on health, which translates into US$0.10 to US$0.30 per capita in LICs and US$0.40 to US$1.10 per capita in lower middle-income countries. At the international level, development assistance dedicated to strengthening PPR amounted to roughly US$0.5 to 1 billion per year prior to the COVID-19 pandemic, accounting for only one to two percent of total development assistance for health.[13]

11. **PPR is essential to the WBG's twin goals, and financing has increased over time through both PPR-specific and -supportive operations.** Following the Ebola outbreak in West Africa, pandemic preparedness was incorporated as an explicit policy commitment in IDA18. Since then, PPR commitments were expanded in IDA19, and are front and center in IDA20. This sustained commitment to the PPR agenda has been accompanied by a significant scale-up in support of health systems, human capital, and addressing climate change.

12. **The Bank currently has an active portfolio of US$30 billion to support health system strengthening in over 100 countries, with financing supporting core health system capacities that are key to PPR.** Focusing on projects specifically designed to support core PPR functions, the Bank committed US$133 million in IDA financing per year between FY15 and FY19. However, IDA PPR financing more than quadrupled in FY20 and FY21 reaching US$589 million per fiscal year; over the same period IBRD provided US$612 million per fiscal year in PPR financing. These amounts include significant support to PPR through the Global COVID-19 Multi-Phased Approach (MPA), accounting for around 30 percent of committed funds.[14] In addition, the World Bank has also supported the PPR agenda through operations outside the health sector through a "One Health" approach, and currently finances 56 projects in 35 countries that address AMR[15] (Box 2 presents some highlights of the Bank's operational support for PPR).

13. **The WBG has also played a key role in responding to disease outbreaks.** The Bank was a vital member of the global coalition that fought the Ebola outbreak in West Africa (2014–15), committing US$1.62 billion for Guinea, Liberia, and Sierra Leone for emergency response and longer-term preparedness.[16] Similarly, for the 9th and 10th Ebola virus outbreaks in the Democratic Republic of Congo in 2018 and 2019, the IDA Crisis Response Window (CRW) provided US$258 million in financing. The Bank has also provided support in response to other outbreaks, including Avian Flu (covering more than 50 countries), SARS, Swine Flu, and Zika. More recently, the WBG's COVID-19 response package has

[13] Overall Development Assistance for Health (DAH) has been estimated at nearly US$40bn per year in the period prior to COVID. Although DAH is substantial, only a small share, estimated at around 1-2.5% (approx. US$0.5-1 billion) is directed at supporting core PPR functions at global and country level, with the remainder going to disease specific programs (nearly 75%) and broader health system strengthening. For details, see Kraus, Jessica, et al. "Measuring development assistance for health systems strengthening and health security: an analysis using the Creditor Reporting System database." *F1000Research* 9, no. 584 (2020): 584; and Micah, Angela E., et al. "Tracking development assistance for health and for COVID-19: a review of development assistance, government, out-of-pocket, and other private spending on health for 204 countries and territories, 1990–2050." *The Lancet* 398.10308 (2021): 1317-1343.

[14] For example, in Ghana, the US$35 million operation covers support for strengthening national laboratories to provide real time disease surveillance and outbreak reporting systems. Similarly, in Mongolia, the US$26.9 million operation is helping to strengthen capacity for a multi-sectoral response, at the interface of environmental, veterinary, and public health services, to contain the future spread of new viruses of animal origin, at source; while, in Ethiopia, the US$82.6 million project has helped boost laboratory and testing capacity and other preparedness-related infrastructure and supported the development of a Risk Communication and Community Engagement Strategy.

[15] The lending portfolio, which includes current commitments as of February 2021, is estimated to be between 0.62 and 2.32 billion USD with 0.62 billion in financing being specifically allocated for AMR investments and an additional 1.7 billion having been tagged as addressing AMR in operations aimed at strengthening agriculture, health, water, sanitation and hygiene systems.

[16] This included over US$1 billion of commitments from IDA (of which, US$420 million was from the CRW). In addition, US$450 million from the IFC supported continuity of trade, investment, and employment in the three countries.

been the largest and fastest crisis response in our history, reaching clients across the income spectrum with unprecedented speed and scale, while maintaining focus on long-term goals. The Bank's health response alone has included commitments of over US$15 billion through the Global COVID-19 Multi-Phased Approach (MPA). Of this, US$6.5 billion is in IDA financing and around one third of this is on grant terms. Bank financing has helped save lives, including through support to the acquisition and deployment of vaccines; protecting the poor and vulnerable; saving jobs and business; and, building a more resilient recovery. The IFC has been actively helping to expand emerging market vaccine production, especially in Africa, and to make available critically needed equipment and supplies through its US$4 billion Global Health Platform.

14. **The financial models of WBG institutions have the flexibility to provide longer term, sustainable financing for health preparedness as well as surges during crises.** The huge surge in Bank financing for COVID-19 was enabled by several key aspects of its financial structure. These include the recent IBRD and IFC capital increases, the IBRD's crisis buffer – which was explicitly designed to respond to crises – and IDA's ability to front-load its support and accelerate its access to global capital markets. With strong support from members, the Bank moved quickly to bring forward IDA19 resources and accelerate the IDA20 replenishment, which includes funding from the capital markets. For example, in 2022, IDA issued a 20-year euro-denominated Sustainable Development Bond that raised Euros 2 billion and was heavily oversubscribed.

**Box 2. Highlights of World Bank Operational Support for PPR**

**Regional, multi-country projects have been at the heart of World Bank financing for strengthening PPR over the past decade, with a strong focus on Sub-Saharan Africa.** The first large-scale project focused on PPR was the *East Africa Public Health Laboratory Networking Project*, approved in 2010, strengthened regional coordination of laboratory capacity for TB and broader public health challenges. Later, the 2014–2016 Ebola outbreak in West Africa exposed the need for multi-sector engagement and cross-country collaboration to prevent, detect and respond to disease outbreaks. This led to the launch of *the Regional Disease Surveillance Systems Enhancement (REDISSE) Program* in 2016, which initially focused on Guinea, Senegal, and Sierra Leone before expanding to cover 16 countries. REDISSE has established regional coordination structures, built human resource capacities, and strengthened surveillance, testing, border screening, case management and infection prevention and control – all competencies that were tapped during the COVID-19 response. Other regional projects have supported the Africa CDC and other sub-regions to strengthen disease surveillance and response to infectious disease outbreaks in cross-border areas and strengthen laboratories, for example the *Southern Africa TB and Health Systems Support Project*, approved in FY16, and the *Africa CDC Regional Investment Financing Project*, approved in FY20. The experience with regional PPR projects in Africa has stimulated similar approaches elsewhere, including the *Organization of Eastern Caribbean States Regional Health Project*, which was approved in 2019 and focuses on investments in improved health facilities and laboratory capacities, public health surveillance and emergency management, and institutional capacity building for preparedness.

**The World Bank has also supported the PPR agenda through operations outside the health sector as part of "One Health".** In Vietnam, for example, the *Livestock Competitiveness and Food Safety Project* introduced good animal husbandry practices to smallholders of livestock production. As a result of improved biosecurity measures and upgrades to slaughterhouses and sanitation in wet markets, the project has contributed to significant improvements in food safety along the food value chains for pork and poultry, reducing the impact of food-borne zoonoses and risks related to antimicrobial resistance. PPR investments based on a "One Health" approach have important co-benefits related to climate change, biodiversity loss, and transformation of food systems.

**In addition to projects that support PPR directly, the Bank is also financing various projects that seek to address AMR.** The WBG currently finances 57 projects globally that address AMR, which include interventions such as: improving surveillance systems; strengthening laboratory capacity; institution and capacity building; water, sanitation, and hygiene improvements in healthcare facilities; and prevention, detection, and treatment of TB.

**The WBG has supported policy and institutional reforms related to the PPR agenda through a variety of financing instruments, including Development Policy Operations (DPOs) and Catastrophe Deferred**

**Drawdown Options (CAT-DDOs).** Although an explicit focus on disease outbreak preparedness in DPOs remains rare, a growing number of DPOs and CAT-DDOs focus on climate change, deforestation, and crisis and risk management capacity, and hence support PPR by addressing both drivers of disease outbreaks and response capacity. More recently, CAT DDOs have prioritized PPR more explicitly. An example is the recently approved *Colombia - Third Disaster Risk Management Development Policy Loan* (P176650), which includes a broad set of policy actions related to climate and forest policy, fiscal resilience, disaster risk management, housing legislation and public health risks, and the project's results framework includes indicators related to the development of a ten-year public health plan that incorporates health risks and emergencies, as well as the development of public health risks maps (with a focus on dengue and malaria in particular) at the subnational level.

15. **World Bank-managed trust funds have played a key role in building evidence, convening stakeholders, and co-financing projects.** Trust funds supported by the Government of Japan, Resolve to Save Lives, the Bill and Melinda Gates Foundation, Gavi, the Global Fund, the Australian Department of Foreign Affairs and Trade (DFAT), and other partners have supported analytical work, technical assistance, operations, and other engagements at country and regional levels. More recently, the Health Emergency Preparedness and Response Trust Fund Umbrella Program (HEPR Program) was established to provide incentives to countries to increase investments in preparedness.[17] Two years since its approval by the Bank's Board, the HEPR Program has mobilized US$211 million in resources and awarded grants of more than US$106 million to 32 countries with the highest need for health emergency preparedness and response work. The HEPR also supports innovations and learning in the PPR domain, thus complementing the FIF by strengthening the WBG PPR projects.

16. **The Bank has also been instrumental in establishing and supporting several FIFs that are critical for strengthening PPR.** The Bank, in its role as a trustee, manages the contributions, investment management, cash transfer, accounting, and financial reporting for some of the key FIFs in the global health space, including: CEPI, to support vaccine development; the International Finance Facility for Immunization (IFFIm) to support Gavi; the Global Fund; and the Advance Market Commitment for Pneumococcal Vaccines. These initiatives have dramatically reduced the time needed to develop vaccines and make them widely accessible in developing countries.

17. **Analytical work and partnerships have been cornerstones of the Bank's support for pandemic preparedness**. The WBG has an extensive track-record of leading or coordinating studies, research, and dialogue, including to distill lessons, shape policy and reform agendas, and provide data to support decision making.[18] In addition, through its partnerships with WHO, the Global Pandemic Monitoring Board, CEPI, the African Union and Africa CDC, and other institutions, the Bank has contributed to shaping the global PPR agenda. In the context of the COVID-19 pandemic, many of these partnerships have deepened, and others have been formed, including with the International Monetary Fund (IMF), WHO and World Trade Organization (WTO) to convene the *Multilateral Leaders Task Force on COVID-19*. The Bank will also continue to support the G20, G7 and other stakeholders to strengthen global PPR governance and coordination. Going forward, the WBG is committed to work towards aligned and coordinated action, both in the response to COVID-19 and in strengthening PPR for the long term.

18. **The World Bank is part of a broader global health landscape, populated with many different actors, both public and private, that provide international financing for PPR.** The existing set of

[17] The HEPR Program, successor to the Pandemic Emergency Facility (PEF) was approved by the World Bank Board on 17 June 2020 as a multi-donor trust fund umbrella program in response to the short term COVID-19 pandemic and future health emergencies, and to help countries with catalytic, upstream, and incentive financing for future health emergency preparedness.

[18] Key past reports include "Pandemic Preparedness Financing – Status Update" (2019), "Money & Microbes – Strengthening Clinical Research Capacity to Prevent Epidemics" (2018), Lessons Learned in Financing Emergency Response to Epidemics (2018), and "From Panic & Neglect to Investing in Health Security - Financing Pandemic Preparedness at the National Level" (2017).

institutions includes other MDBs; UN agencies, notably the WHO; global health institutions, like the Global Fund, Gavi and CEPI; bilateral partners and organizations; philanthropies; and private sector actors. They are already playing an important role and some of them offer a range of financing mechanisms/modalities that support PPR investments and health systems strengthening, more broadly.

19. ***As noted above, while existing institutions and platforms involved in global health financing efforts must be reinforced and better coordinated to provide the necessary support to strengthen PPR, there is broad consensus that developing countries deserve more and better financial support from the international community that is aligned with their needs. The proposed FIF can be an important part of the solution and add value to the existing PPR landscape.***

## III. The Proposed FIF

### A. Objectives and Value Added

20. **The objective of the FIF is to provide a dedicated stream of additional, long-term funding for critical PPR functions in IDA and IBRD countries, through investments and technical support at the national level, as well as at the regional and global levels.** The FIF is expected to add value, along several dimensions, for contributors, recipients and implementing entities, in the following ways:

- First, the FIF could help bring **additionality** in financial resources for PPR, including through the mobilization of non-ODA resources, for example, from philanthropies. It may be noted in this context that the FIF has already mobilized funding from a philanthropy and other, similar organizations have signaled an interest in contributing.
- Second, financing from the FIF could be used to **incentivize** countries to invest more in PPR, including through blending of MDB resources to further increase concessionality and matching of domestic resources.
- Third, by bringing together key institutions engaged in PPR and health system financing, the FIF will help promote a more **coordinated and coherent approach to PPR** strengthening by linking financing with existing, country-level planning and prioritization processes, thereby strengthening alignment and complementarity of PPR and health system strengthening and reducing transactions costs for client countries. More coordinated support also creates conditions for a more systematic dialogue about domestic financing for PPR.

21. **The following key principles would underpin the FIF's design**: First, it would complement the work of existing institutions that provide international financing for PPR, drawing on their comparative advantages. Second, it would be designed to *catalyse* funding from private, philanthropic, and bilateral sources. Third, it would serve as an integrator rather than become a new silo that only furthers fragmentation. Fourth, it would have the *flexibility* to work through a variety of existing institutions and adjust over time as needs and the institutional landscape evolves. Fifth, its structure would be designed to reflect *inclusivity*, while ensuring *streamlined and efficient governance and operating arrangements.* Sixth, it would operate with high standards of *transparency* and *accountability*.

22. **Given the legitimate concerns that have been raised around fragmentation of the global health finance architecture, it is important to note that a new FIF, hosted by the Bank, would not entail the creation of a new standalone institution that would add to further fragmentation.** The FIF would be designed to draw on existing institutions, building on their respective comparative advantages.

### B. Focus Areas for Financing

23. **The FIF would allocate additional financing where investments are most urgently needed to bolster PPR, plugging key capacity gaps at all levels – as identified by the G20 High Level Independent Panel (HLIP) report as well as by the World Bank-WHO paper prepared for the G20.** Although financing priorities are dynamic, will evolve over time, and will ultimately be determined by the FIF's Governing Board, recent analysis on needs and gaps points to need for financing to support PPR at country, regional and global levels. The FIF could immediately start by providing financing to strengthen and sustain country-level capacity in the areas of prevention and preparedness, with a focus on low- and middle-income countries that are most in need of support; build regional capacity for PPR functions and coordination; strengthen key global PPR functions; and support TA, analytics, learning and convening:

- **Strengthen country-level PPR capacity** by plugging capacity and capability gaps at country and local level in core domains of the International Health Regulations (2005) and the World Organization for Animal Health (OIE) International Standards, including: 1) disease surveillance; 2) laboratory systems; 3) emergency communication, coordination and management; 4) critical health workforce capacities; 5) community engagement. Needs will be contextual and country-specific, and financing priorities would be based on country-driven assessment and coordination efforts and guided by the plans and priorities of beneficiaries and One Health principles. The FIF could also strategically invest in health systems at community and primary health care level to strengthen synergies between the health system and PPR capacity.
- **Build regional and global capacity** by expanding support to regional and global institutions across multiple domains, including surveillance, reporting and information sharing, shared public health assets, regulatory harmonization, capacity to support public health workforce in LICs/MICs, and capacity for coordinated development, procurement, distribution and deployment of countermeasures and essential medical supplies. Progress in these areas will require supporting capacity of existing global/regional institutions and building dedicated PPR entities, such as the one proposed by the African Union in October 2021, modeled on the European Health Emergency Preparedness and Response Authority.
- **Support technical assistance, analytics, learning and convening.** Financial support to countries and regional/global institutions should be complemented by activities to elevate the PPR agenda, support cross-country learning, and promote collective accountability. This could include *inter alia* peer-to-peer learning, learning events, targeted technical assistance, systematic monitoring of PPR capacities and domestic spending on PPR.

### C. Proposed Structure, Governance and Operating Arrangements

24. **The proposed structure, governance and operating arrangements presented below draw on good practices from FIFs, and on the feedback received through stakeholder engagement on a White Paper issued by the Bank on May 17th, 2022.** Details would need to be agreed among the founding donors, the World Bank, WHO and other stakeholders, keeping in mind the key design principles noted above. These details would be endorsed at the first meeting of the FIF's Governing Board, expected to take place in fall 2022. Recognizing that consultations are ongoing, we will update Executive Directors should there be any significant deviations in the final structure or governance.

#### 1. Structure

25. **In line with the organizational structure of other FIFs, the proposed FIF would be organized around the following main elements:**

- An independent **Governing Board** would serve as the FIF's decision-making body, with responsibility for setting the strategic direction, governance and operational modalities, and work program of the FIF, and for making funding decisions. The Governing Board is expected to be informed by a **technical advisory panel**, that would bring in technical expertise from international

organizations, governments, and the private sector, as well as other specialized health expertise, as needed, to advise the FIF's Governing Board on funding priorities, evaluation of funding proposals, recommendations on funding allocations to projects, etc.

- The World Bank would serve as limited **trustee**, as it does for all FIFs**.**[19] The World Bank is already the trustee for all 27 existing FIFs, building on a well-established financial, investment management and accounting platform developed by the World Bank over the past three decades, as well as experienced specialized legal and treasury services. When a FIF is established an initial duration for the trust fund is agreed, the term of which can be subsequently extended with the consent of its governing board and the World Bank.
- Administrative functions, including support to the Governing Board in the delivery of its roles and responsibilities, would be performed by a **secretariat** housed at the World Bank. The Bank currently houses two-thirds of FIF secretariats (18 secretariats). Secretariat staff would be World Bank employees, subject to Bank rules and reporting lines. The secretariat would include expert staff from the WHO on a secondment as per the World Bank's Human Resources policies, to help support and coordinate the technical advisory panel.
- The FIF would transfer resources to a set of agreed **implementing entities,** which are the operational arms of the FIF, to carry out the FIF's work program at country, regional and global level. A core feature of FIFs is that implementing entities carry out FIF-funded activities using their own policies and procedures, including for project preparation, appraisal, supervision, and monitoring.

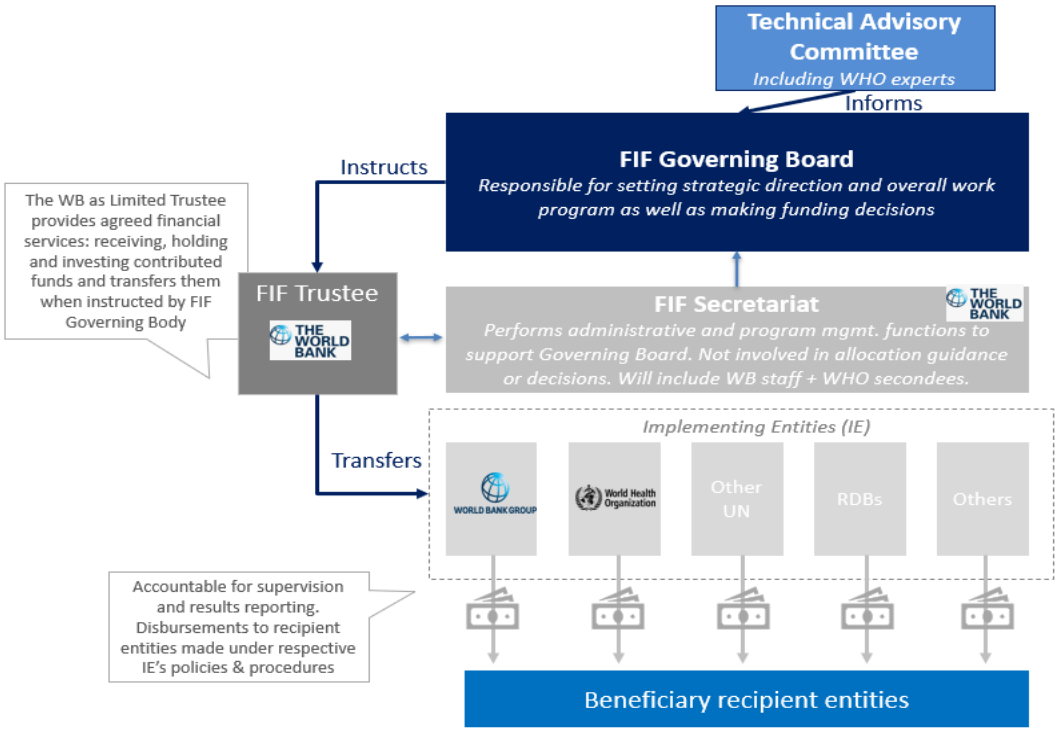
26. **The World Bank is expected to play three roles in the proposed PPR FIF, drawing on its financial and program management, operational and legal expertise and experience in establishing and managing FIFs:** (i) trustee, where the World Bank would hold and transfers donor funds to external entities based on instruction of the FIF governing body; (ii) secretariat, where the World Bank would provide program management and administration services to the FIF and support its governing body; and (iii) implementing entity, where WBG institutions would appraise and provide implementation support for FIF-financed projects. In each of these capacities, and in line with other FIFs, the WBG would be represented as an Observer on the FIF's Governing Board.

27. **Within these standard structural parameters, the proposed FIF would build on the existing global health architecture for PPR, including the IHR (2005) and associated monitoring mechanisms, ensuring a central role for the WHO.** As the international organization with responsibility for pandemic preparedness, it is envisaged that the WHO would support the FIF as follows: (i) member of the technical advisory panel, along with other leading experts; (ii) participation in the secretariat, through seconding staff who would help support and coordinate the work of the technical advisory panel; and (iii) implementing entity. In these capacities, and in line with other FIFs, the WHO would be represented as an Observer on the FIF's Governing Board. Figure 2 below illustrates what the structure of the proposed FIF could look like.

[19] The World Bank's trustee role in FIFs is "limited" from a fiduciary point of view. Its oversight responsibilities end when funds are transferred to eligible implementing entities who then become accountable for the oversight and use of funds in line with their own policies and procedures.

**Figure 2**

**Proposed Organizational Structure**




*Note: Structure is consistent within the broad parameters of the WB's FIF Management Framework (2019) and experience/good practices from other FIFs.*

## 2. Governance

28. **The FIF's governance would be anchored in its Governance Framework.** The framework would be endorsed by the Governing Board at its first meeting. In line with other hosted FIFs, the framework would be guided by two overarching principles: first, the FIF's Governing Board would operate independently from the governance of the host institution (i.e., the World Bank, in this case), and second, it would balance inclusivity with agility.

29. **The FIF's Governing Board would comprise decision-making members and non-decision-making members and carry out its duties based on the agreed Governance Framework.** At a minimum, decision-making members would include the donors to the FIF.[20] In some FIFs, this is limited to donors who make contributions above a specified threshold. In the majority of FIFs for which the World Bank houses the FIF secretariat, representatives of recipient countries/regions are represented on the Governing Board. They could serve either as decision-making members or as non-voting members, depending on a determination on how best to manage real or perceived conflicts of interest between those deciding on funding allocations and those receiving funds as final beneficiaries. The Bank (as trustee, secretariat and one of the implementing entities), WHO, and other FIF implementing entities, would serve as Observers.[21] The FIF's governance would ensure dedicated processes to capture the voices of Civil Society Organizations (CSOs).

[20] Limited exceptions occur in the case of FIFs established as special purpose financial vehicles.
[21] Observers typically have the necessary access and opportunity to contribute to all key discussions in FIF governing boards except final decision-making, particularly around funding allocations and matters pertaining to such allocations.

30. **Depending on the size of the new FIF, a constituency-based approach could be adopted to bring in broad-based representation on the Governing Board, while ensuring efficiency in governance and implementation.** Drawing on practices in some existing FIFs, the FIF's Governing Board could include constituency groupings representing donors and recipients, with the latter organized by regions.

31. **The Governing Board would have a Chair or co-Chairs, either selected from among the decision-making members or appointed as an independent Chair with no organizational affiliation.** In line with governance best-practice, Chairs/co-Chairs typically serve fixed terms, although these can be renewed. Consistent with best practice, Chairs do not have decision-making rights. Where Chairs are selected from among the decision-making members, another representative from that organization or constituency then participates and serves in the decision-making capacity.

32. **Following the practice used by other FIFs, and in keeping with the spirit of FIFs as multilateral partnership programs, decision-making is expected to be by consensus, although unanimity would not be required**. In consensus-based approaches, the Chair(s) seek broad agreement among stakeholders, working together to find mutually acceptable solutions where disagreements surface and/or allowing stakeholders to express descent without blocking decisions. This approach to shared governance is in line with the underlying basis of FIFs as vehicles for collective action and has been a core principle of FIF governance since the first FIF was established in 1992. This is also in line with the consensus approach to multilateral decision-making more generally and is familiar to the sovereign states which sit on FIF governing bodies. In the event consensus is not possible, most FIFs allow for a decision to be made on the basis of a formal vote.

**Box 3. Examples of How Expert Observers Contribute to FIF Governing Bodies**

The governing board of the Global Concessional Finance Facility (GCFF) includes UNHCR as an observer, drawing upon the agency's expertise on refugee issues. The GCFF was established as an outcome of the International Stakeholders Round Table for the Middle East and North Africa Region which convened participants from 50 countries and international organizations to address challenges to countries in the Region impacted by forced displacement driven by the Syrian refugee crisis. GCFF was subsequently expanded to help address the Venezuelan refugee crisis. GCFF provides grant resources that can be blended with MDB lending to support middle-income countries hosting substantial refugee populations. The governing body benefits from UNHCR's participation as an observer. Through its participation, UNHCR provides updates to the governing body on refugee situations, outcomes of needs assessments, and ongoing national and international responses.

The Adaptation Fund (AF) was created as part of efforts to implement the Kyoto Protocol, which sets binding emissions reduction targets and was negotiated as part of the UN Framework Convention on Climate Change (UNFCCC). As such, AF meetings are open to attendance from representatives of UNFCCC Parties, the UNFCCC Secretariat, and other UNFCCC accredited observers. The Board may issue invitations to specific observers from among this broad pool to ensure representation on matters of concern to the body or agency they represent. Similarly, the Board may request observers to make presentations on matters under consideration.[22]

33. **The FIF's Governing Board would be supported by a technical advisory panel.** The boards of many existing FIFs benefit from technical advisory bodies, comprising highly specialized experts. Such bodies can help ensure FIF governing boards are apprised of the latest knowledge and developments related to the issue/topic that the FIF is designed to support, and they can also help with the assessment of funding proposals. Box 4 provides examples of FIF governing boards that are supported by advisory bodies. In the

[22] For example, during a governing board session to allocate program funding, implementing entities appear only to present and/or answer questions about funding proposals they have submitted, but are not present for discussions on proposals submitted by other implementing entities.

case of the proposed FIF, a technical advisory panel comprising leading experts, including from international organizations, specialized health institutions, governments, and the private sector, is expected to play an important role in advising the Governing Board on the status of PPR capacity at country, regional and global levels, emerging lessons and priorities, and significant developments in the areas of broader PPR governance and oversight. In this way, the **technical advisory panel** can help ensure that calls for proposals and their evaluation and assessment as well as results reporting on funded proposals, along with any adjustments needed to the FIF's operational modalities over time, are aligned with the evolving global framework for PPR standards, governance, and good practice. Where there is any overlap between organizations on the technical advisory panel and implementing entities, roles would need to be structured to minimize risks of conflicts of interest (real or perceived) in line with governance best practices.

**Box 4. How Advisory Bodies Support FIF Governing Boards**

The Global Agriculture and Food Security Program (GAFSP) provides grants to support the development of national agricultural and food security investment plans in low-income countries and investment in projects that are part of these plans. End-recipients must demonstrate commitment to a comprehensive approach for increasing agricultural productivity and improvements to food security. The GAFSP Steering Committee (i.e., its governing body) is supported by a Technical Advisory Committee (TAC) of up to 12 members that provides advice to the Steering Committee. TAC members are experts in agriculture and food security and provide advice on project proposals, ensuring consistency with the objectives, modalities and procedures of the GAFSP. TAC members also assess the quality assurance processes used for agriculture and food security plans of the recipient countries and regions, the level of expenditure on agriculture and food security, the conduciveness of policy frameworks and safety nets, and relative magnitude of needs, to help inform Steering Committee decisions. GAFSP Coordination Unit (i.e., secretariat) staff do not participate in the TAC and are not involved in assessing funding proposals.

The Global Infrastructure Facility (GIF) was established to promote investments in sustainable infrastructure and strengthen the pipeline of projects that attract private sector engagement. In addition to capacity and project development the GIF serves as a collaboration platform. The GIF structure includes an Advisory Council, membership in which is voluntary (and unreimbursed); the Advisory Council is comprised of Governing Council members and "Advisory Partners" from institutional investors, commercial and investment banks, infrastructure finance organizations, and developers. The Advisory Council meets bi-annually and serves a convening and collaboration function, sharing experiences, promoting solutions to sustainable infrastructure and innovation and discussing current topics and trends.

35. **Opportunities for the FIF to be guided by the work of the G20 JFHTF or its successor, and for the FIF to inform the coordination work of the JFHTF, would be leveraged.** Though the FIF would be directly accountable to its Governing Body, there are opportunities for the FIF to benefit from the work of the JFHTF or its successor, and for the FIF to inform the finance-health coordination work of the JFHTF.

### 3. Operating Modalities

36. **The World Bank will draw on good practices to ensure a streamlined and efficient operating structure and processes for the FIF as well as transparency and accountability, and with clear results indicators that help inform operations.** Operating modalities would be set out in the FIF's Operations Manual that would be adopted by the Governing Board at its first meeting. These documents would set out, among other things, the FIF's operating principles, including eligibility, resource allocation criteria and processes, and a common approach for implementing entities to submit funding requests, reporting, disclosure, and conflict of interest.

37. **Resources from the FIF will be channeled to programs/projects through a set of accredited implementing entities.** As per the World Bank's FIF Management Framework (2019)[23], in FIFs for which the World Bank houses the secretariat (and thereby provides the FIF its legal personality), eligible implementing entities are MDBs (including Regional Development Banks), the IMF, and UN agencies. These are entities with whom most donors have separate Board-level relationships, ensuring familiarity with applicable policies and procedures and providing additional means for oversight and accountability.

38. **The FIF's founding donors and other stakeholders have recommended that, in addition to MDBs and UN agencies, leading international global health agencies -- CEPI, Gavi and the Global Fund -- be included as implementing entities.** Inclusion of these entities would require a waiver. As such, following approval by the Executive Directors of the FIF's establishment, and prior to the FIF's launch, the Bank will complete the due review processes, including a comprehensive risk assessment of each proposed entity, required for the inclusion of implementing entities in any recommendation for a waiver.[24]

39. **The FIF could allocate funding either through regular (semi-annual or quarterly) calls for proposals to be submitted by the implementing entities or through *ad-hoc* calls for proposals. In both cases, the frequency and size of calls would depend on amounts contributed and when donor funds are paid into the FIF.** Regular calls provide predictability for both implementing entities and the countries in which activities will be undertaken, while *ad hoc* calls allow flexibility but can increase transaction costs (e.g., need for an "always on" Board, proposal development without clear assurances of funding availability at the time).

40. **Decisions on funding allocations would be made and approved by the Governing Board, based on the criteria and process detailed in the FIF's Operations Manual and guided by impact.** In response to the calls for proposals, implementing entities would submit funding proposals, in writing, and in accordance with the template and guidelines set out in the FIF's Operations Manual. The secretariat would screen funding proposals submitted to ensure completeness and overall consistency with the FIF's Governance Framework, Operations Manual, and results framework (as applicable), utilizing a process and timeline agreed upon and endorsed by the Governing Board. Eligible funding proposals would typically be reviewed, in detail, and assessed, by external technical experts (e.g., the technical advisory panel mentioned above), for the Governing Board's final review and decision**.** This process would use a scoring system, or any other means laid out in the Operations Manual. All funding proposals reviewed by the experts, and their accompanying assessments, would be forwarded to the Governing Board for review and decision. The Governing Board would approve and award funding for proposals based on criteria it will establish. These criteria would be subject to periodic review after the first call for proposals. Allocations made by the Governing Board would be committed and transferred by the Trustee to the implementing entity, used by the implementing entity, reported upon by the implementing entity, and returned where applicable to the FIF by the implementing entity.

41. **Reporting and Results Monitoring.** The secretariat would track progress based on reports submitted by the implementing entities, and compile regular reports based on individual progress reports received from implementing entities during the reporting period. In addition, the Trustee would submit to the Governing Board annual reports on the financial status of the FIF. This reporting system would help the Governing Board to oversee allocations and achievement of outputs and outcomes for FIF-financed activities.

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[23] Financial Intermediary Fund Management Framework, World Bank, June 2019.

[24] Inclusion of any additional implementing entities after the FIF is launched would be led by the FIF's Governing Board, with the Bank's "no objection", as laid out in the FIF Management Framework (2019). It may be noted also that the provision of 'direct access' in which sovereign national entities receive funding directly from a FIF is not permitted in World Bank hosted FIFs. In other words, FIFs must channel funds through intermediary entities that must take responsibility, and have the capacity for, project preparation, appraisal, and supervision of projects, using their own policies and procedures.

42. **Each funding proposal submitted by an implementing entity would have a results framework,** which the implementing entity would be responsible for tracking, monitoring, and reporting, based on a format endorsed by the Governing Board. In addition, if the FIF includes an overarching results framework at the partnership level, this would need to be endorsed by the Governing Board. Each funding proposal would then need to link project-level indicators with the overall results framework. Implementing entities would track, monitor, and report on progress.

43. **Risk Management.** Each implementing entity would be responsible for the management of risks associated with the respective projects and programs implemented by them, and reporting on such risks and mitigation measures, as appropriate, as part of its progress and results reporting. The Trustee would manage financial risks associated with administration of the FIF and its resources until such time as they are transferred to implementing entities or returned to contributors in accordance with the provisions of the Contribution Agreements. The Governing Board would have oversight of the risk management approach and risk appetite at the portfolio level.

44. **FIFs naturally evolve in response to new opportunities, lessons learned and other changes in the environment**. When considering significant changes or a restructuring, risks need to be assessed and managed in the same way as they are when a FIF is first set-up. This includes ensuring the proposed approach is in line with risk appetite of the FIF's participants and that all parties agree to continue in their roles in the FIF under the new structure, including donors and the World Bank. In the case of the World Bank, a so-called "lifecycle review" will be undertaken to assess the impact of any proposed restructuring on each of the World Bank's roles within a FIF.

45. **The proposed FIF would incorporate strong transparency and accountability criteria, with full buy-in from implementing entities where much of the monitoring and reporting burden would fall.** In line with good practice, the FIF's governance framework, operations manual, contribution agreements signed with contributors, financial procedures agreements signed with implementing entities, financial and progress reports, and other reviews and evaluations would be made publicly available.

### D. Financing

46. **Contributions to the FIF would be voluntary**. As per the World Bank's FIF Management Framework (2019), setting up the new FIF requires donors to commit to large scale financing (with at least three donors, and a minimum amount totaling US$200 million, at inception) and financial sustainability to meet the criteria set out in the Framework. These criteria have been met. It is imperative that FIF financing be truly additional, and not merely take existing resources from other important development priorities, and that it be sustained. In the near term, the viability of the proposed FIF will depend primarily on ODA and the robust initial pledges from founding donors. Over the longer-term, sustainable financing will be needed to ensure that the FIF and PPR efforts remain financed as a high priority.

47. **The replenishment process would depend, among other things, on the size of the FIF.** Smaller FIFs are typically replenished on an *ad hoc* basis. Regular replenishment cycles become more common in larger, more established FIFs but have been considered in smaller FIFs where "strategy outlook cycles" exist (e.g., five-year strategies), as a means to tie funding to strategy.

48. **For the sake of simplicity and to get the new FIF off the ground as quickly as possible, the FIF will be set up on a grants-in/grants-out basis.** Most FIFs provide concessional financing on a grants-in/grants-out basis, with donor contributions received as grants and funding provided to implementing entities on a grant basis. This includes health-sector FIFs. Grants can provide fully concessional project financing or concessional boosts to other instruments in the implementing entities' toolkits (e.g., core lending in the case of the MDBs). In some cases, grants are also used to encourage complementary funding, in which implementing entities mobilize additional resources from other sources to be used alongside grant

funding from the FIF. More complex financing structures exist in a limited number of FIFs and require a substantial due diligence process before the World Bank agrees to provide trustee services.

## IV. Alternatives Considered

49. As part of the analysis carried out by the Bank and WHO for the G20 JFHTF, various options were examined. The analysis concluded that a FIF hosted by the World Bank would be the most fit-for-purpose vehicle to fill critical PPR financing gaps.[25] The alternatives considered were as follows:

50. UN Multi-Donor and Multi-Partner Trust Funds: Within the UN system, there are *Multi-Donor and Multi-Partner Trust Funds* that are mainly administered by the Multi-Partner Trust Fund (MPTF) Office at the UNDP.[26] The MPTF Office facilitates UN coherence and development effectiveness in addressing multifaceted issues—such as humanitarian crises, peacebuilding, recovery, and development. The MPTF Office assists the UN system and national governments in establishing and administering pooled financing mechanisms, multi-donor trust funds and joint programs.

- *Assessment:* These funds are geared to operate largely through UN agencies and as a result they are not fully complementary to supporting the existing spectrum of entities working in PPR. Such funds have not historically drawn from and worked systematically with non-ODA financing sources and may not be in a strong position to leverage these important potential sources of additional funding. Such funds may not as efficiently incentivize recipient countries to utilize other important domestic financing such as through MDBs, and particularly IDA.

51. World Bank Multi-Donor Trust Funds (MDTF): The option of working through an existing World Bank MDTF or establishing a new one was also considered as an alternative. For example, the HEPR was established as an MDTF to help incentivize investment in preparedness in IDA-eligible countries through co-financing grants and to enable response to major disease outbreaks where access to other sources of financing is limited, such as countries in arrears. HEPR was considered as an alternative to the proposed FIF given its core objective of supporting health systems strengthening and preparedness and its ability to co-finance operations at the country and regional level. HEPR could also accommodate donor contributions earmarked for global health security.

- *Assessment: W*orking through the HEPR or establishing a new MDTF was deemed to be less appropriate in this context, given the objective of facilitating coordination and financing across the range of agencies involved in PPR, leveraging on distinct comparative advantages, and support for global level activities through institutions like the WHO. MDTFs are designed first and foremost to leverage the World Bank's operations platform. Contributors to MDTFs set the strategic directions and parameters for the trust fund but delegate operational decisions to the Bank. MDTFs complement the Bank's core business, providing additional resources for technical assistance and co-financing in support of Bank lending operations, often supporting activities for which recipients are unwilling or unable to borrow. For example, MDTFs have been critical to support the knowledge agenda, capacity building and work in fragile states.

  Due to their design to leverage the Bank's operations platform, MDTFs do not meet the key principle of flexibility to work through all major existing institutions engaged in PPR financing, as an integrator that is able to adjust rapidly to the evolving landscape. While MDTFs do allow for transfers of funds to other organizations (i.e., MDBs and UN agencies), they are not intended where large-scale transfers

[25] "*PPR Financing Modalities*", op.cit.
[26] https://mptf.undp.org/overview/office

to other organizations may be required , and, in principle, cap transfers at 30 percent of total contributions

Other trust funds with complementary activities include the Global Financing Facility (GFF), which is targeted to maternal child health, and Food Systems 2030, which focuses on sustainable food systems through the nexus of improved livelihoods, safety and nutrition. As part of this, the trust fund includes support for prevention of zoonotic diseases. Neither of these would be suitable to accommodate the proposed FIF's objectives, for the reasons noted above; however, it will be important to be aware of potential overlap in some areas and ensure the new FIF remains complementary to minimize any risk of undermining the Umbrella TF programs – especially the HEPR – through fundraising competition.

52. A new FIF at the World Bank: FIFs are an important part of the World Bank's development finance toolkit.[27] FIFs are a type of trust fund for which the World Bank provides tailored administrative, operational, legal, and financial services. As noted above, FIFs mobilize and pool resources from a variety of sources (ODA and non-ODA) and channel those resources through existing institutions (implementing entities). FIFs are intended to provide large-scale financing over a long-term horizon. They are multilateral mechanisms, usually benefiting from broad support over time, to foster collective action through collective governance.

- *Assessment*: i) Through the flexibility of its design, the new FIF can be highly complementary to the work of existing PPR financing institutions, including through their designation as implementing entities. In this context, the World Bank, as an implementing entity, is well placed to implement many of the country and regional activities envisioned by the FIF and benefit from the additional resources that would be made available; ii) FIFs can receive and manage financing from ODA and non-ODA sources; iii) FIFs can act as integrators, bringing together the full experience of existing PPR financing institutions to optimize investments and impact, and help catalyze and incentivize the use of core MDB financing, as well as financing from UN agencies and other actors involved in PPR financing; and iv) a FIF at the World Bank would not require establishing a new institution - not only would this present benefits in terms of cost effectiveness, relative to establishing a new, legally independent institution that would become a permanent part of the health architecture, but it would also safeguard against a further crowding of the global health finance architecture.

53. *In summary, each of the three options above provide a potential capacity to mobilize and deploy additional, long-term resources for PPR, including from non-ODA sources, thereby expanding the pool of funding available for PPR, and to incentivize governments to invest more in PPR. However, a FIF hosted at the World Bank presents some unique benefits, as noted above, to support collective efforts to strengthen PPR with an eye toward the next pandemic.*

## V. Risks and Mitigation Measures

54. **Key risks to be assessed in a FIF-supported partnership include: i) strategic risk; ii) operational risk; iii) stakeholder risk; iv) financial risk; v) legal risk; and vi) portfolio risk.** A summary of the initial risk assessment of the proposed FIF across these six dimensions is provided below.

55. **Strategic risk:** The proposed FIF is well-aligned with the Bank's strategy, objectives and priorities on PPR, most recently articulated in the PPR Position Paper that has just undergone Bank-wide review. PPR is also a key corporate priority with ambitious IDA20 commitments. The FIF is expected to focus attention on this important agenda and complement support provided by IDA and IBRD. The FIF's value proposition for Bank clients is supported by strong diagnostics. It is worth mentioning also that the

[27] See: https://fiftrustee.worldbank.org/en/about/unit/dfi/fiftrustee; https://fiftrustee.worldbank.org/content/dam/fif/documents/fif-framework.pdf

membership of the FIF's Governing Board is expected to be familiar with the Bank, other MDBs, WHO, and other key global health actors, and will be able to leverage on the comparative advantages of these entities. The Bank's participation in the FIF's Governing Board (in each of its separate and distinct capacities as trustee, secretariat and implementing entity) will provide additional opportunities to ensure alignment with Bank strategy, objectives, and priorities.

56. **Operational risk:** The proposed FIF does not present any known operational risks related to the Bank's ability to carry out its responsibilities as trustee, secretariat and implementing entity, consistent with its operational policies and procedures. The Bank's limited trustee and fiduciary responsibility ends when funds are transferred to implementing entities. The design of the FIF is not expected to impede the Bank's ability to fully and consistently carry out its responsibilities as limited trustee, stipulated in its agreements with FIF partners, within the Bank's policies and procedures. Similarly, the risk of operational issues arising from the Bank's secretariat functions is also low, given the mandate and functions of FIF secretariats and the Bank's demonstrated capacity and track record in performing this role. Operational risks from the Bank's potential implementing entity role are also likely to be low. As an implementing entity, if the Bank receives funds from the FIF to prepare and implement projects, those projects would be carried out in accordance with the Bank's operational policies and procedures and would build on the Bank's strong track record of regional and country operations aimed at strengthening PPR. Moreover, any FIF financing to the WBG would be as co-financing to Bank operations in established areas of support.

57. **Stakeholder risk:** This risk relates to how the FIF can potentially impact the Bank's relationships and reputation with partners and public opinion. The FIF has broad support from the international community, including the Bank's major shareholders and beyond, the WHO, other global health agencies, philanthropies and CSOs. It will be important to continue to broaden and sustain this support during the FIF's design phase and once it is launched. The Bank has led an engagement process with a broad set of stakeholders, which will contribute to the proposed FIF's design – a process in which the Bank is actively involved. When the FIF is launched, its Governance Framework and Operations Manual, which will clarify roles and responsibilities of involved parties, will be made public. The Bank, as secretariat, will prepare and implement a communications strategy and will participate actively in the FIF's Governing Board in its various capacities.

58. **Financial risk:** There are no known financial risks associated with this FIF, given the Bank's strong capacity and track record in serving as limited Trustee for FIFs, coupled with the simple financial structure of this FIF (grants in/grants out). The FIF would be an off-balance sheet vehicle with no potential impacts on the balance sheets of IBRD or IDA or their perceived standing in financial markets. Furthermore, the Bank will recover costs in line with its current cost recovery policy.

59. **Legal risk:** Legal and governance documents to establish the FIF will be negotiated by the Bank's Legal team such that they do not contain any provisions that could lead to an erosion or loss of privileges and immunities by explicitly or implicitly agreeing to, among others, the application of national law on Bank activity, jurisdiction of local courts over the Bank, contractual or third-party claims against the Bank, or Bank obligation to perform activities that are or may be perceived as outside the Bank's mandate.

60. **Portfolio risk:** Portfolio risks pertain to how the specific FIF relates to/impacts the overall FIF or trust fund portfolio and the larger aid architecture, including IDA and IBRD. This FIF has a clear mandate and objectives, and it will play a complementarity role within the larger global health financing architecture. With respect to IDA and IBRD, the FIF is expected to play a complementary role by co-financing IDA and IBRD operations or fill gaps, as needed. The FIF could compete with other trust funds, IDA, etc., resulting in fundraising competition. It may be noted in this context that one of the key principles underpinning this FIF is additionality, i.e., it will seek to mobilize additional resources, including from non-ODA sources. The FIF has already mobilized a commitment from [one] philanthropic institution, and other philanthropies have signaled serious interest. Furthermore, the Bank can play an active role in mitigating portfolio risk, through its involvement in shaping and designing the FIF, and participation in the FIF's Governing Board.

## VI. Conclusion and Next Steps

61. **The aim is to launch this FIF by fall 2022, assuming the Bank's Board approval of the establishment of the FIF in June.** The FIF's Governing Board is expected to have its first meeting in September or October 2022, at which time the FIF will be launched and become operational. At that meeting, the Governing Board is expected to endorse the FIF's Governance Framework and Operations Manual. As noted above, should the final structure, governance and operating arrangements deviate significantly from the description provided in this paper, Management will update Executive Directors accordingly.

62. **Executive Directors are hereby requested to approve Management's proposed approach, as described herein, including**: i) the establishment of the proposed Financial Intermediary Fund at the World Bank and ii) World Bank support to the FIF by acting as Secretariat, Trustee, and Implementing Entity.

## ANNEX 2: PARTNER ASSESSMENT

The World Bank comprises the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA). Together with the International Finance Corporation (IFC), the Multilateral Investment Guarantee Agency (MIGA) and the International Centre for Settlement of Investment Disputes (ICSID) they constitute the World Bank Group (WBG). IBRD was established in 1944 to help war-torn Europe rebuild its infrastructure. The creation of IDA in 1960 addressed an important gap by providing resources to low-income countries (LICs) that face issues of creditworthiness, thereby complementing IBRD's activities. IFC and MIGA, which are not covered by this assessment, were created in 1956 and 1988, respectively.

The World Bank operates in 145 countries in all regions of the world and across all major sectors of development. It employs 12.778 full-time staff, 46% of which are based outside of World Bank Headquarters in Washington, DC.1 IBRD and IDA operate under separate financial models: IBRD provide loans from its own equity and capital market borrowings whereas IDA is financed through member contributions that are now also supplemented by market borrowing. IBRD provides lending on market terms to middle-income countries (MICs) and creditworthy LICs, whereas IDA provides concessional lending, often on grant terms, to the poorest countries. These financial products are complemented by guarantees, risk management products, advisory services and analytical work in line with the World Bank's comparative advantage as a solutions bank. At the end of FY22, the World Bank had over 1 978 ongoing projects valued at USD 299 billion in net commitments.

This partner assessment refers to the resent MOPAN assessment finalized in July 2023[1]. The key findings from the MOPHAN assessment is:

**Main strengths**

- Unparalleled strength of the Bank's financial framework, including the Hybrid Financial Model for IDA, the new IBRD Financial Framework and Trust Fund reform. Changes made over the assessment framework have further expanded resources for concessional lending, promoted sustainable lending over the medium-term and reinforced value for shareholders.
- A well-established Country Engagement Model (CEM) promotes the upstream integration of evidence and global themes and downstream adaptation to changing needs and contexts. Corporate measures such as the gender tag and climate co-benefits have promoted extensive integration of global themes into operations downstream.
- Strong safeguards and internal control systems for fraud and corruption, procurement, and environmental and social safeguards, including prevention of and response to Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH). Safeguards are fully integrated throughout the CEM. Increasingly, internal control functions are adopting a proactive approach focused on prevention and outreach.
- Strong performance of operations in contributing to development outcomes. Performance of World Bank operations has improved since the previous assessment period with 85% of

[1] World Bank Performance at a Glance.pdf (mopanonline.org)

operations validated as moderately satisfactory or higher for contribution to project development outcomes.

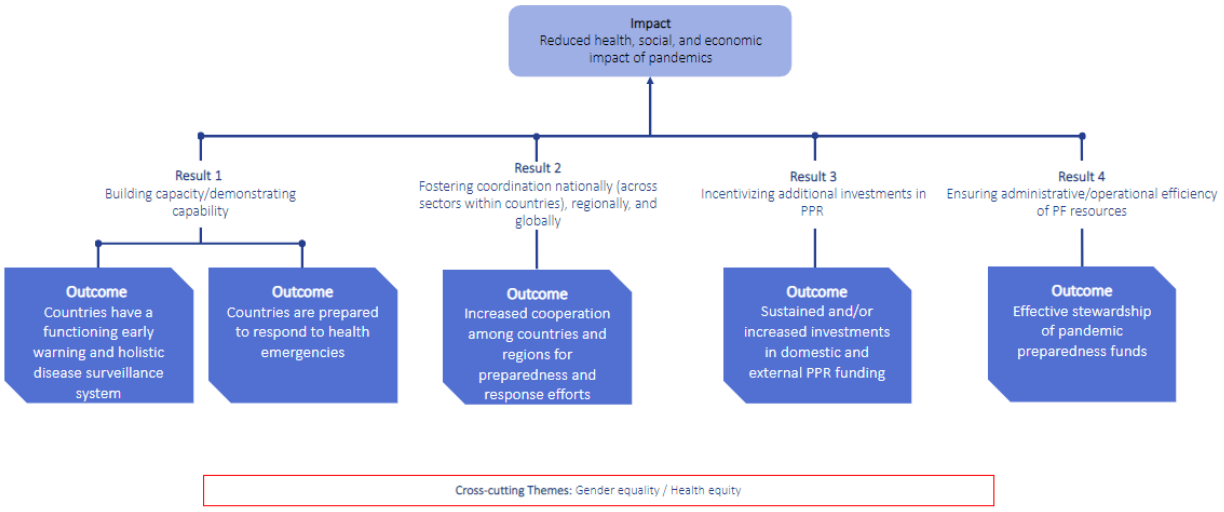
**Areas for attention**

- The "Cascade" process is not being implemented systematically to build upon the World Bank Group comparative advantage in mobilising finance for development. The role of the Bank is facilitating private investment could be better defined and measured.
- The Bank is an active convener globally, regionally and at country level. While the Bank has recently established processes to enhance the selectivity of its global partnerships, there remains no framework to guide and demonstrate the contribution of these partnerships to development results. Other partnerships at the regional and country level are implemented in a decentralised way that is not institutionalised.
- The Bank's regional operations are key to addressing transboundary development challenges and promote regional public goods. There is a need to better demonstrate regional outcomes, streamline instruments for regional operations and enhance incentives for MICs.
- The Bank often does not demonstrate the contribution of its Advisory Services and Analytics (ASA) to the achievement of development outcomes. There is also room to promote more systematic uptake of these resources for operational learning.
- There are opportunities for the Bank to better demonstrate the outcomes of its support in addressing global challenges such as climate change. In addressing this challenge, the Bank may consider strengthening measuring its contribution to global goods at the country and regional level, including through increased evidence from evaluation. This would complement the many positive steps the Bank has taken in addressing global challenges.

**The Pandemic Fund Results Framework**

This Results Framework (Framework) defines the change pathways and qualitative and quantitative metrics that the Pandemic Fund (PF) will use to: (1) help articulate overall impact, areas for improvement, and accountability for the PF and all partners in the PF partnership; (2) guide development of proposals; (3) shape which information will be collected to assess the effectiveness of the PF. The Framework will be used throughout the 8-year lifespan of the PF and will guide project level monitoring, evaluation, and learning and knowledge efforts. The results achieved and information reported from individual projects will be aggregated to articulate the overall impact of the PF. As such, all projects should advance progress against some, or all metrics outlined in the Framework. The Framework will be revised at regular intervals to ensure that it continues to effectively highlight the impact of the PF and reflects the evolution of PF objectives and connections to other components of the global health security and global health architecture.

Figure 1 – Pandemic Fund Theory of Change




Framework and associated metrics and indicators:

1. Building capacity/demonstrating capability:
    a. Sustainment or improvement of capacity as a result of PF projects, as measured by improved or sustained scores for indicators within the Joint External Evaluation (JEE) and Performance of Veterinary Services (PVS), when available, and States Parties' Annual Report (SPAR), or other relevant assessments
    b. Number of after/intra-action reviews or simulation exercises performed utilizing the 7-1-7 approach that identify strengthened capacities, gaps in capacity, and bottlenecks to improve detection, notification, and response
    c. Percentage of the capacities that were improved or maintained by the PF projects (in 1a), that are able to be effectively utilized during an infectious disease outbreak or other public health threat, as measured by an intra/after-action review or simulation exercise

    d. Percentage of PF projects' activities that support gaps identified in countries' National Action Plans for Health Security (NAPHS), or other relevant plans
2. Fostering coordination nationally (across sectors within countries), and among countries regionally and globally:
    a. Inclusion of regional platforms, institutions, networks, and priorities in PF projects
    b. Establishment or improvement of processes/mechanisms that allow for cross sectoral coordination within the country and between countries during a health emergency
    c. Extent to which PF projects are implemented in coordination with multiple ministries, sectors, and stakeholders (including Implementing Entities (IEs), civil society organizations, and others)
3. Incentivizing additional investments in pandemic prevention, preparedness, and response (PPR):
    a. Value of additional financial resources that are secured from stakeholders to support PF projects, including domestic, private and/or philanthropic financing, or as co-financing from IEs
    b. Proportion of funding from PF that is used to complement/strengthen existing health security and health system capacity building projects, including but not limited to those funded by domestic resources, other existing development funds, other partners' global health security, health system, or PPR funds, and philanthropic or other private sector funds
    c. Extent to which the capacities built by PF projects are sustained following completion of the project
4. Ensuring administrative/operational efficiency of PF resources
    a. PF grant amount disbursed for projects as a proportion of total PF grant amount committed to IEs
    b. Time for IEs to fully disburse PF grants committed to them
    c. Of the total amount of PF grants committed to IEs, proportion used by IEs for administrative costs including project preparation, implementation, and supervision
    d. Funds utilized for project-level M&E as a proportion of project funds initially allocated for M&E
    e. Gender equality incoporated in activities implemented through the proposals
    f. Extent to which PF-funded activities advance health equity across underserved populations

<u>Narratives of the metrics and indicators:</u>

1. Building capacity/demonstrating capability

PF projects will help improve JEE, PVS, and SPAR scores and lead to improved capability in holistic disease surveillance and preparedness to respond to health emergencies. SPAR scores (collected annually), PVS scores (collected every 4-5 years), and JEE scores (collected every 4-5 years) will be used to track progress developing critical country capacities. After action reviews, intra-action reviews, and simulation exercises utilizing the 7-1-7 approach[1] will identify bottlenecks that impede countries from achieving optimal performance and enablers to improve performance. After/intra action reviews and simulation exercises will also help validate the capacity scores reported through the SPAR, PVS, and JEE. The results from the JEE, PVS, and SPAR scores and the after/intra action reviews and simulation exercises can inform the NAPHS, or other national and/or regional plans as applicable and help countries prevent and prepare better for the next outbreak. Improvements in capacity measured by the JEE, SPAR,

[1] 7-1-7: an organising principle, target, and accountability metric to make the world safer from pandemics (thelancet.com)

and PVS can be coupled with after/intra-action reviews and simulation exercises to improve pandemic PPR as shown in Figure 2. Links to JEE, SPAR, and PVS assessments as well as example scoring rubrics are included in Annex 1.

2. Fostering coordination among countries globally and regionally and across sectors within countries

The objective of the PF is to provide a dedicated stream of additional, long-term funding for critical capacities through investments and technical support at the sub-national, national, regional (across countries), and global level to foster a coordinated, coherent, and community-led approach to pandemic PPR. PF projects should be developed to reinforce existing regional structures, including regional priorities, platforms, plans, networks, and institutions. The PF may also be used to create new structures of this nature provided there are demonstrated gaps to address and strong country ownership of such structures. To assess the effectiveness of the PF on coordination and collaboration, the Framework incorporates metrics that capture how PF projects complement and build upon regional and global structures. A core component of a coherent approach to pandemic PPR is coordination across sectors and stakeholders including placing community-led organizations and marginalized populations at the center of prevention, preparedness, and response. As such, the Framework also contains metrics to assess the impact of the PF on coordination across sectors/stakeholders within a country.

3. Incentivizing additional investments in PPR

The PF was established to provide a new multilateral financing mechanism to mobilize additional, long-term financing to bolster pandemic PPR efforts and complement existing mechanisms to address key capacity and capability gaps identified through IHR Monitoring and Evaluation Framework (MEF). Additionally, the PF should incentivize policy and financial commitments from countries and IEs as well as attract additional, new funds from other sources. To measure PF effectiveness in these areas, the Framework's metrics capture the extent to which PF resources complement existing pandemic PPR/global health security efforts, the value of new funding sources secured as a result of the PF including sustainable domestic investments, and the extent to which the capacities built by PF projects are sustained following completion of the project.

4. Ensuring administrative/operational efficiency of PF resources

The PF will operate with high standards of transparency and accountability to ensure that resources are used efficiently to address pandemic PPR needs. Each project should state project costs and IE costs related to project preparation and management, including efforts to monitor and evaluate the outputs and impact of the work. The Framework's metrics capture how the costs changed in the implementation of the project including adherence to monitoring and evaluation requirements. People are affected by infectious disease outbreaks differently. To build pandemic PPR capacity effectively and efficiently, projects should be developed with these differences in mind and help promote greater gender equality and broader health equity which affect and are affected by pandemic PPR.

<u>Accountability and Transparency</u>:

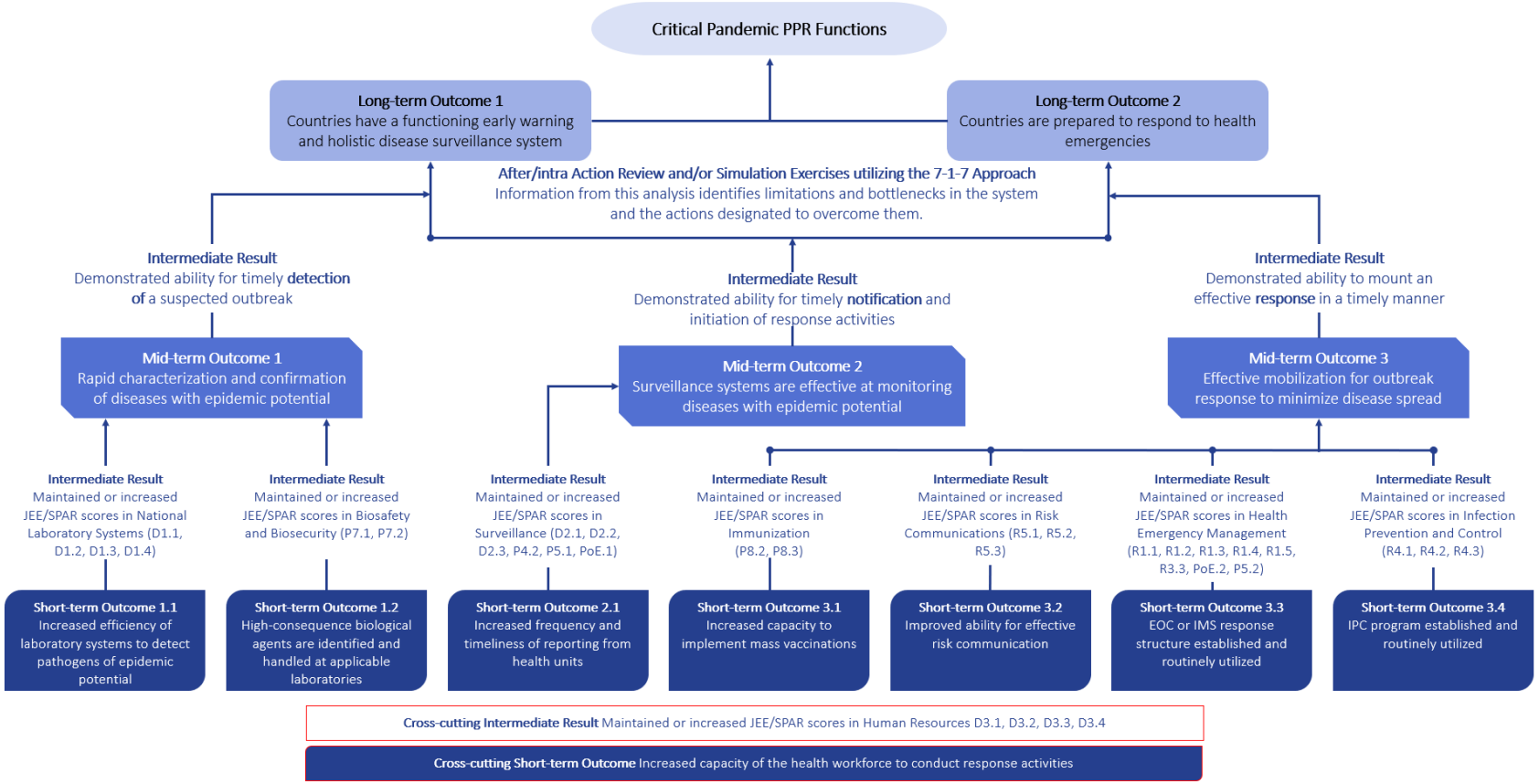
In addition to demonstrating the impact of the PF, the Framework's metrics hold IEs, countries, and the PF accountable to the objectives and principles of the PF outlined in the Operations Manual. Each funding proposal will include project- and/or country- and regional-level indicators expressed in a results

framework against which its performance will be monitored and assessed and will demonstrate alignment with the Framework. Each IE that receives funding from the PF will report annually on progress and results for all activities to the Secretariat, including reporting on all metrics of the Framework. The Secretariat will consolidate reporting into an annual portfolio impact/results report and submit it to the Governing Board. The accuracy of all reporting is the responsibility of the originating IE. The Secretariat will review, consolidate, and analyze individual reports from the IEs, aggregate data on partnership-level metrics, and analyze overall progress of the PF against this Framework. If the IE reports do not include required information, the Secretariat will request the IE to send additional information or a revised report. All projects supported under the PF will have explicit commitments to monitoring and evaluation and learning and knowledge sharing during implementation following the standards, procedures and requirements of the IEs directly concerned. The format and contents to be used for the IE reports will be agreed upon with the Governing Board.

Updating the Framework:

The Framework will be revised throughout the duration of the PF to ensure that it continues to effectively highlight the impact of the PF and remains aligned and responsive to new elements of the global health security architecture, such as the Pandemic Agreement and IHR Amendments. The Framework will be reviewed after annual reports have been collected from the first call for proposals and again every two years. The Secretariat, in consultation with, and based on inputs from, the Technical Advisory Panel (TAP) will share a report with recommended changes and rationale to the Governing Board. The Governing Board may choose to approve the recommended changes and add other changes as it determines appropriate. Revisions should address any deficiencies identified and help the Framework adapt to the global health security architecture but should be done in a way that preserves the ability to compare impact of projects across years, to the extent possible.

## Figure 2: Linking capacity development to improved pandemic PPR functions



Annex 1: Health security assessment technical area, indicator, and level of capacity scoring rubrics from the JEE, SPAR, and PVS

3rd edition of the JEE (https://www.who.int/publications/i/item/9789240051980)

2nd edition of the SPAR (https://www.who.int/publications/i/item/9789240040120)

PVS Pathway (https://www.woah.org/en/what-we-offer/improving-veterinary-services/pvs-pathway/)

# Demonstrated Ability for Timely DETECTION of a Suspected Outbreak

## Mid-term Outcome 1 - Rapid characterization and confirmation of diseases with epidemic potential.

**Maintained or increased JEE/SPAR scores in National Laboratory Systems**

Laboratories are critical to surveillance, preparedness, and response. Strengthening laboratory systems requires investments across several areas, notably in: a) specimen referral and transport systems to ensure that specimens can be shipped in a timely manner to appropriate reference laboratories, as necessary; b) putting in place national biosafety and biosecurity regimes that allow for dangerous pathogens to be identified, held, secured and monitored in a minimal number of facilities according to best practices, as well as biological risk management training and educational outreach and country specific biosafety and biosecurity legislation, laboratory licensing and pathogen control measures, as appropriate; c) strengthening lab quality; d) capacity for reliable and timely testing; and e) modern, safe, secure, affordable, and appropriate diagnostic tests and devices, as well as the establishment of diagnostic networks and the timely sharing of results. These investments are needed at the national level as well as across countries to strengthen existing networks of reference laboratories and specialized centers linked to WHO, FAO UNEP and WOAH.

| JEE D1.1 Specimen Referral and Transport System | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 1: Intermediate Result 1**<br><br>**Associated SPAR indicators: C4.1 Specimen referral and transport system.** | 1 | No system in place for transporting specimens from intermediate levels/districts to national laboratories; only ad hoc transportation is available |
| | 2 | Referral and transport of specimens is organized for some priority diseases but may be restricted within districts or at the intermediate and national level |

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| | 3 | Referral and transport of specimens is organized for diagnostics and/or confirmation of most priority diseases from intermediate to national level |
| | 4 | Referral and transport of specimens is organized systematically for diagnostics and/or confirmation of all priority diseases at all levels |
| | 5 | Sustainable referral and transport systems, that are exercised reviewed, evaluated and updated on a regular basis, are in place for all specimen types and requests for the diagnosis, confirmation, characterization of all specimens with complete coverage at all levels |

| JEE D1.2 Laboratory Quality System | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 1: Intermediate Result 1**<br><br>**Associated SPAR indicators: C4.3. Laboratory quality system.** | 1 | Method, process or mechanisms for verifying and investigating detected events is not available or under development |
| | 2 | National quality standards have been developed but not implemented |
| | 3 | National quality standards have been developed and implemented at the national level. Activities include licensing of laboratories in conformity with national quality standards |
| | 4 | National quality standards have been developed and are being implemented at national and intermediate levels, Activities include mandatory licensing of laboratories in line with basic quality requirements or national laboratory standards |
| | 5 | National quality standards are implemented at all levels including mandatory licensing of all laboratories in conformity with international quality standards and exercised, reviewed, evaluated and updated on a regular basis, as applicable |

## JEE D1.3 Laboratory Testing Capacity Modalities

| Comments | Levels of Advancement | |
|---|---|---|
| **Midterm Outcome 1: Intermediate Result 1**<br><br>**Associated SPAR indicators: C4.4. Laboratory testing capacity modalities.** | 1 | Laboratory system can support one or two testing modalities such as rapid diagnostic testing (antigen and antibody) and microscopy services for pathogen detection |
| | 2 | Laboratory system can support testing modalities including serological tests (i.e., antigen and antibody enzyme immunoassays) and quality assurance process is in place |
| | 3 | Laboratory system can perform nucleic acid amplification testing, bacterial culture with antimicrobial sensitivity testing with quality assurance process in place and have access to (or has) sequencing capacity |
| | 4 | Laboratory system can perform nucleic acid amplification testing, bacterial culture with antimicrobial sensitivity testing with quality assurance process in place and has some basic sequencing capacity and country has ability to test for all its endemic diseases and its priority diseases |
| | 5 | Laboratory system can perform tests described in previous capacities and has access to whole genome sequencing identification of unknown and high-consequence pathogens and has access to viral culture. Laboratory networks configured to support all diagnostic services that are integrated66are sustainable, with maximum population coverage, and exercised, reviewed, evaluated and updated on a regular basis as applicable |

| JEE D1.4 Effective National Diagnostic Network | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 1: Intermediate Result 1**<br><br>**Associated SPAR indicators: C4.5. Effective national diagnostic network.** | 1 | Tier-specific diagnostic testing strategies are not available or under development. |
| | 2 | Tier-specific diagnostic testing strategies are developed. |
| | 3 | Tier-specific diagnostic testing strategies exist, but not fully implemented. |

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| | 4 | Tier-specific diagnostic testing strategies are being implemented at national level. |
| | 5 | Tier-specific diagnostic testing strategies are being implemented at national, intermediate and local levels, and exercised, reviewed, evaluated, and updated on a regular basis, as applicable. |

| PVS II-1. Veterinary Laboratory Diagnostics | | |
|---|---|---|
| **Definition** | **Levels of Advancement** | |
| **The authority and capability of the VS to effectively and efficiently use accurate laboratory diagnosis to support their animal health and veterinary public activities.**<br><br>**A. Access to veterinary laboratory diagnosis**<br><br>The authority and capability of the VS to access laboratory diagnosis in order to identify and report pathogenic and other hazardous agents that can adversely affect animals and animal products, including those relevant to public health. | 1 | Disease diagnosis is almost always conducted by clinical means only, with no access to or little use of a laboratory to obtain a correct diagnosis. |
| | 2 | For major animal diseases and zoonoses of national importance, and for the food safety of animal products, the VS have access to and use a laboratory to obtain a correct diagnosis. |
| | 3 | For animal diseases and zoonoses present in the country, and for animal feed safety and veterinary AMR surveillance, the VS have access to and use a laboratory to obtain a correct diagnosis. |
| | 4 | For animal diseases of zoonotic or economic importance not present in the country, but that exist in the region and/or that could enter the country, the VS have access to and use a laboratory to obtain a correct diagnosis. |
| | 5 | In the case of new and emerging diseases in the region or worldwide, the VS have access to and use a network of national or international reference laboratories (e.g. an OIE or FAO Reference Laboratory) to obtain a correct diagnosis. |
| **B. Suitability of the national laboratory system** | 1 | The national laboratory system does not meet the needs of the VS. |

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| The sustainability, effectiveness, safety and efficiency of the national (public and private) laboratory system (or network), including infrastructure, equipment, maintenance, consumables, personnel and sample throughput, to service the needs of the VS. | 2 | The national laboratory system partially meets the needs of the VS, but it is not sustainable, as the management and maintenance of resources and infrastructure is ineffective and/ or inefficient. Laboratory biosafety and biosecurity measures do not exist or are very limited. |
| | 3 | The national laboratory system generally meets the needs of the VS. Resources and organisation are managed effectively and efficiently, but funding is insufficient for a sustainable system, and limits throughput. Some laboratory biosafety and biosecurity measures are in place. |
| | 4 | The national laboratory system generally meets the needs of the VS, including for laboratory biosafety and biosecurity. There is sufficient sample throughput across the range of laboratory testing requirements. Occasionally, it is limited by delayed investment in certain aspects (e.g. personnel, maintenance or consumables). |
| | 5 | The national laboratory system meets all the needs of the VS, has appropropriate levels of laboratory biosafety and biosecurity, and is efficient and sustainable with a good throughput of samples. The laboratory system is regularly reviewed, audited and updated as necessary. |
| **C. Laboratory quality management systems (QMS)**<br><br>The quality and reliability of veterinary laboratory testing servicing the public sector VS as assessed by the use of formal QMS e.g. having a dedicated quality manager and a quality manual. This includes, but is not limited to, attainment of ISO 17025 accreditation and participation in proficiency testing programmes. | 1 | No laboratories servicing the public sector VS are using formal QMS. |
| | 2 | One or more laboratories servicing the public sector VS, including the major national animal health reference laboratory, are using formal QMS. |
| | 3 | Most major laboratories servicing the public sector VS are using formal QMS. There is occasional use of multi-laboratory proficiency testing programmes. |
| | 4 | Most of the laboratories servicing the public sector VS are using formal QMS, with regular use of multi-laboratory proficiency testing programmes. |

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| | 5 | All the laboratories servicing the public sector VS are using formal QMS which are regularly assessed via national, regional or international proficiency testing programmes. |

**Maintained or increased JEE/SPAR scores in Biosafety and Biosecurity**

| JEE P7.1. Whole-of-Government Biosafety and Biosecurity System is in Place for Human, Animal and Agriculture Facilities | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 1: Intermediate Result 2**<br><br>**Associated SPAR indicators: C4.2. Implementation of a laboratory biosafety and biosecurity regime** | 1 | Elements of a comprehensive risk-based assessment approach in national biosafety and biosecurity system, such as policy instruments and proper financing, are not in place |
| | 2 | Some, but not all, elements of a comprehensive biosafety and biosecurity system are in place. The country is:<br>i. starting the process to monitor and develop an updated record and inventory of pathogens within facilities that store or process dangerous pathogens and toxins and what they house<br>ii. developing, but has not finalized, comprehensive national biosafety and biosecurity regulatory framework to regulate their possession and use |
| | 3 | Comprehensive national biosafety and biosecurity system are in place. The country is:<br>i. finalizing the process to support active monitoring and maintaining an up to date records and inventory of pathogens within facilities that store or process high-consequence biological agents<br>ii. finalizing the development of comprehensive national biosafety and biosecurity framework based on risk assessment to regulate possession and use of high-consequence agents<br>iii. finalizing the development and implementation of risk control measures, operational handling and containment failure reporting systems |

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| | | iv. starting the consolidation of high-consequence agents into a minimum number of facilities<br>v. starting to put into place tools and resources to support diagnostics that do not require culturing high-consequence agents<br>vi. starting to put in place incident and emergency and response programmes. Basic methods are in place for the safe handling, decontamination and disposal of infectious waste |
| | 4 | Biosafety and biosecurity system is developed, but not sustainable. The country is:<br>i. actively monitoring and maintaining an updated record and inventory of pathogens within facilities that store or process dangerous pathogens and toxins<br>ii. implementing enacted comprehensive national biosafety and biosecurity regulatory framework<br>iii. implementing the national framework to regulate possession and use of high-consequence agents<br>iv. implementing risk control measures, operational handling and containment failure reporting systems<br>v. completing the consolidation of high-consequence agents into a minimum number of facilities<br>vi. employing diagnostics that preclude culturing high-consequence biological agents<br>vii. operating incident and emergency and response programmes<br>viii. operating waste management practices which cover sharps, contaminated waste, chemical waste and non-hazardous general waste with full documentation of waste management |
| | 5 | Sustainable multisectoral biosafety and biosecurity system is in place including information security. Ministries have made available adequate funding and political support for a comprehensive national biosafety and biosecurity system, including maintenance of facilities and equipment, as well as review and update the national framework and its effectiveness periodically. Complete disinfection, sterilization and waste management practices are in place |

| P7.2. Biosafety and Biosecurity Training and Practices in All Relevant Sectors (including Human, Animal and Agriculture) | | |
|---|---|---|
| **Definition** | **Levels of Advancement** | |
| **Midterm Outcome 1: Intermediate Result 2**<br><br>**Associated SPAR indicators: C4.2. Implementation of a laboratory biosafety and biosecurity regime** | 1 | No biological biosafety and biosecurity training or plans are in place |
| | 2 | Country has conducted a training needs assessment and identified gaps in biosafety and biosecurity training but has not yet implemented comprehensive training that aligns with the incumbent roles and responsibilities. General lack of awareness among the laboratory workforce of international biosafety and biosecurity best practices for safe, secure and responsible conduct is reported. Country does not yet have sustained academic training in institutions proportionate to the assessed risks, including training those who maintain or work with high-consequence agents |
| | 3 | Country has training programmes in place proportionate to the assessed risks, staff roles and responsibilities, and has begun implementation. Country has specific training programmes in place at most facilities housing or working with high-consequence agents. Training on biosafety and biosecurity has been provided to staff at some, but not all, facilities that maintain or work with high-consequence agents. Country is developing sustained academic training proportionate to the assessed risks, including the one for those who maintain or work with high-consequence agents. All training is aligned with incumbent's role and responsibilities |
| | 4 | Country has training programmes in place at all facilities and staff trained proportionate to the assessed risks, roles and responsibilities, including those that house or work with high-consequence agents. Country has in place academic training proportionate to the assessed risks, including institutions that train those who maintain or work with high-consequence agents |
| | 5 | Country has sustainable training programmes included into university/ college curricula of pre-service training and into continuing education programmes. Staff competence is assessed, and exercises are conducted periodically. Country has funding and capacity to sustain all of the above. A |

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| | | review of training needs assessment is conducted periodically and refresher training on identified needs areas are conducted. Training on emergency response procedures is provided periodically |

## Demonstrated Ability for Timely NOTIFICATION and Initiation of Response Activities

### Mid-term Outcome 2 – Surveillance systems are effective at monitoring diseases with epidemic potential.

**Maintained or increased SPAR/JEE scores in Surveillance**

IHR requires rapid detection of public health risks associated with biological, chemical and radiation events, as well as risk assessment, notification, and response. A sensitive surveillance system, including at the point of entry (PoE), is needed to ensure early warning and provide information for an informed decision-making process during public health events and emergencies. This involves a multisectoral and integrated health system approach and may include sentinel surveillance systems and contact tracing during health emergencies. The system should have the capacity to facilitate cross-sectoral communication in line with the One Health approach and based on international standards, guidance, and best practices, to minimize the transmission of zoonotic diseases to human populations. Investments in this area lead directly to improvements in detection, catalyzing more rapid responses. Stronger surveillance systems require, for example, investments in and access to state of-the-art digital tools to enable public health entities, including local hospitals, laboratories and veterinary services, to generate and share data with national, regional and global public health institutions, including animal and environmental health surveillance; strong and connected national and regional Centers of Expertise for Collaborative Surveillance in IDA and IBRD countries, building on existing, proven systems and being interconnected in a global surveillance network; multi-sectoral genomic sequencing networks and capabilities, including in bioinformatics, to detect new variants and pathogens as they arise in people, animals and the environment, consistent with the WHO's10-year strategy for genomic surveillance of pathogens with pandemic and epidemic potential; and training to empower national /regional public health, animal health and environmental health agencies on data generation and analysis.

| JEE D2.1. Early Warning Surveillance Function | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 2, Intermediate Result: Surveillance systems are effective at monitoring diseases with epidemic potential** | 1 | National strategy, guidelines and/or SOPs for surveillance are not available or under development |
| | 2 | National strategy, guidelines and/or SOPs for surveillance have been developed but not implemented. The surveillance system is functioning but |

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| **Associated SPAR indicators: C5.1. Early warning surveillance function** | | lacks systematic immediate reporting or weekly reporting of events and/or data |
| | 3 | National strategy, guidelines and/or SOPs for surveillance have been developed and are being implemented at the national level. The surveillance system provides immediate and weekly reporting of events and/or data with lab results integrated |
| | 4 | National strategy, guidelines and/or SOPs for surveillance have been developed and are being implemented at the national and intermediate levels. The surveillance system provides immediate and weekly reporting of events and/or data with lab results integrated and integration between IBS and EBS |
| | 5 | National strategy, guidelines and/or SOPs for surveillance for all hazards linking all sectors have been developed and implemented at national, intermediate and primary public health levels; and the system is exercised (as applicable), reviewed, evaluated and updated on a regular basis, with improvement at all levels in the country, with all components linked to one national surveillance system |

| **JEE D2.2. Event Verification and Investigation** | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 2, Intermediate Result: Surveillance systems are effective at monitoring diseases with epidemic potential**<br><br>**Associated SPAR indicators: C5.2. Event management (i.e., verification, investigation, analysis, and dissemination of information)** | 1 | Method, process, or mechanisms for verifying and investigating detected events is not available or under development |
| | 2 | Method, process, or mechanisms for verifying and investigating detected events has been developed but not implemented |
| | 3 | Method, process, or mechanisms for verifying and investigating detected events has been developed and is being implemented at the national and intermediate level |
| | 4 | Method, process or mechanisms for verifying, investigating and risk assessing detected events has been developed and is being implemented at the national and intermediate levels, involving trained personnel from multiple sectors |

| | | |
|---|---|---|
| | 5 | Method, process or mechanisms for verifying, investigating and risk assessing detected events is being implemented at national, intermediate and primary public health levels, involving trained personnel from multiple sectors and exercised (as applicable), reviewed, evaluated and updated on a regular basis |

| JEE D2.3. Analysis and Information Sharing | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 2, Intermediate Result: Surveillance systems are effective at monitoring diseases with epidemic potential**<br><br>**Associated SPAR indicators: C5.2. Event management (i.e., verification, investigation, analysis, and dissemination of information)** | 1 | Surveillance data is received sporadically and analyzed on some priority diseases, or unusual events, often with delay |
| | 2 | Surveillance data is received regularly (i.e., weekly and/or monthly). An ad hoc team does some analysis of data |
| | 3 | Surveillance data is received regularly and analysed on some priority diseases, or unusual events, often with delay. Data is shared across sectors |
| | 4 | Surveillance data is received and analysed regularly. Epidemiological bulletins are generated and disseminated across sectors and internationally on regular basis. Data is shared across sectors and internationally on a regular basis |
| | 5 | Surveillance data analysis is conducted, and epidemiological bulletins are generated and disseminated across sectors and internationally on regular basis. An electronic platform and a dedicated team support data management and generation of epidemiological bulletins. Data is shared across sectors and internationally on a regular basis. Capacity for advanced data analysis is ensured |

| JEE P4.2. Surveillance of AMR | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **No SPAR equivalent** | 1 | No or limited capacity for generating, collating, and reporting data (antibiotic susceptibility testing and accompanying clinical and epidemiological data) |

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| **Midterm Outcome 2, Intermediate Result: Surveillance systems are effective at monitoring diseases with epidemic potential** | 2 | AMR data are collated locally for common pathogens in hospitalized and community patients, but data collection may not use a standard approach and lacks national coordination and/or quality management |
| | 3 | AMR data are collated nationally for common pathogens, but national coordination and standardization are lacking |
| | 4 | There is a standardized national AMR surveillance system collecting data on common pathogens in hospitalized and community patients, with an established network of surveillance sites, designated national reference laboratory for AMR and a national coordinating centre (NCC) producing reports on AMR |
| | 5 | The national AMR surveillance system's data is analysed, interpreted and reported together with antimicrobial consumption and/or use data for human health, and analysis of similar data across sectors (human and animal health and agriculture) is attempted |

| **JEE P5.1. Surveillance of Zoonotic Diseases** | | |
|---|---|---|
| **Definition** | **Levels of Advancement** | |
| **Associated SPAR Indicator C12.1**<br><br>**Midterm Outcome 2, Intermediate Result: Surveillance systems are effective at monitoring diseases with epidemic potential** | 1 | No agreed list of prioritized zoonotic diseases. Capacities for the surveillance of zoonotic diseases do exist but are not coordinated between the animal health, public health and environment sectors and exchange of information is on ad hoc basis |
| | 2 | A list of priority zoonotic diseases has been agreed on between the animal health, public health and environment sectors. Coordination of surveillance activities between animal health, public health, and environmental sectors is informal, and limited to few diseases. Information sharing is not systematic |
| | 3 | Coordination of surveillance activities for listed priority emerging and endemic zoonotic diseases is formalized between the animal health, public health and environment sectors at the national level, ensuring exchange of information, joint assessment of risks, using a One Health approach |
| | 4 | Multisectoral surveillance systems for priority emerging and endemic priority zoonotic diseases are in place at the national level and formal coordination |

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| | | mechanisms between the animal health, public health and environment sectors are also established at intermediate levels, allowing the surveillance of the whole territory |
| | 5 | Coordinated surveillance of priority and emerging zoonotic diseases between animal health, public health and environment sectors is tested/assessed/reviewed and improved on a regular basis (annually) |

| PoE.1. Core capacity Requirements at All Times for PoEs (airports, ports and ground crossings) | | |
|---|---|---|
| **Definition** | **Levels of Advancement** | |
| **Midterm Outcome 2, Intermediate Result: Surveillance systems are effective at monitoring diseases with epidemic potential**<br><br>**Associated SPAR indicators: C11.1. Core capacity requirements at all times for PoEs (airports, ports and ground crossings)** | 1 | A strategic risk assessment for the designation of individual PoEs as an integral part of a national risk assessment has not been completed |
| | 2 | Some designated PoEs are implementing some of the routine core capacities based on a completed associated strategic risk assessment |
| | 3 | Some designated PoEs are implementing all the routine core capacities and these designated PoE are integrated into the national surveillance system for biological hazards/all hazards (e.g., event-based and early warning surveillance) |
| | 4 | All designated PoEs are implementing routine core capacities with an allhazard and multisectoral approach integrated into the national surveillance system. Other non-designated PoEs are integrated into the national surveillance system |
| | 5 | Routine core capacities implemented at all designated PoEs are exercised, reviewed, evaluated, updated and actions are taken to improve capacity on a regular basis |

| PVS II-4. Surveillance and Early Detection | |
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| **Definition** | **Levels of Advancement** |

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| **The authority and capability of the VS to determine, verify and report on the sanitary status of their animal populations, including wildlife, in a timely manner.**<br><br>**A. Passive surveillance, early detection and epidemiological outbreak investigation**<br><br>A surveillance system based on a field animal health network capable of reliably detecting (by clinical or post mortem signs), diagnosing, reporting and investigating legally notifiable diseases (and relevant emerging diseases) in a timely manner. | 1 | The VS have very limited passive surveillance capacity, with no formal disease list, little training/awareness and/or inadequate national coverage. Disease outbreaks are not reported or reporting is delayed. |
| | 2 | The VS have basic passive surveillance authority and capacity. There is a formal disease list with some training/awareness and some national coverage. The speed of detection and level of investigation is variable. Disease outbreak reports are available for some species and diseases. |
| | 3 | The VS have some passive surveillance capacity with some sample collection and laboratory testing. There is a list of notifiable diseases with trained field staff covering most areas. The speed of reporting and investigation is timely in most production systems. Disease outbreak investigation reports are available for most species and diseases. |
| | 4 | The VS have effective passive surveillance with routine laboratory confirmation and epidemiological disease investigation (including tracing and pathogen characterisation) in most animal sectors, and covering producers, markets and slaughterhouses. There are high levels of awareness and compliance with the need for prompt reporting from all animal owners/handlers and the field VS. |
| | 5 | The VS have comprehensive passive surveillance nationwide providing high confidence in the notifiable disease status in real time. The VS routinely report surveillance information to producers, industry and other stakeholders. Full epidemiological disease investigations are undertaken in all relevant cases with tracing and active follow up of at-risk establishments. |

## Demonstrated Ability to Mount an Effective RESPONSE in a Timely Manner

### Mid-term Outcome 3 – Effective mobilization for outbreak response to minimize disease spread.

**Maintained or increased SPAR/JEE scores in Immunization**

This priority includes capacity building for vaccination and treatment access, delivery, and administration; strengthening mass vaccinations capabilities prior to outbreaks of vaccine-preventable diseases; strengthening the clinical trials and regulatory environment ;and promoting legal preparedness to manage liability risk during emergencies, all of which will support health equity.

| JEE P8.2. National Vaccine Access and Delivery | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 1**<br><br>**The SPAR does not contain indicators related to vaccines or medical countermeasures; JEE indicators will be used to assess progress.** | 1 | No plan is in place for nationwide vaccine delivery, nor have plans been drafted to provide vaccines throughout the country to target populations. Inadequate vaccine procurement and forecasting lead to regular stock-outs at the central and district levels |
| | 2 | Implementation has begun to maintain a cold chain for vaccine delivery but is available in fewer than 40% of districts in the country, or vaccine delivery (maintaining cold chain) is available to less than 40% of the target population in the country. Inadequate vaccine procurement and forecasting lead to regular stock-outs at the central and district levels |
| | 3 | Implementation has begun to maintain a cold chain for vaccine delivery but is available in fewer than 40% of districts in the country, or vaccine delivery (maintaining cold chain) is available to less than 40% of the target population in the country. Inadequate vaccine procurement and forecasting lead to occasional stock-outs at central and district levels. Vaccine procurement and forecasting lead to no stock-outs of vaccines at central level and occasional stock-outs at district level |
| | 4 | Vaccine delivery (maintaining cold chain) is available in 60–79% of districts within the country or vaccine delivery (maintaining cold chain) is available in 60–79% of the target population in the country. Functional vaccine procurement and forecasting take into account global stocks, lead to no stock-outs at the central level and rare stock-outs at the district level that are within their control |
| | 5 | Vaccine delivery (maintaining cold chain) is available in greater than 80% of districts within the country or vaccine delivery (maintaining cold chain) is available to more than 80% of the national target population. Systems to reach marginalized populations using culturally appropriate practices are in place. |

| | | |
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| | | Vaccine delivery has been tested through a nationwide vaccine campaign or functional exercise. Functional procurement and vaccine forecasting results in no stock-outs |

| JEE P8.3. Mass vaccination for epidemics of VPDs | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 1**<br><br>**The SPAR does not contain indicators related to vaccines or medical countermeasures; JEE indicators will be used to assess progress.** | 1 | National plan for mass vaccination response to epidemics outbreaks of VPDs, including national guidelines for regulatory approval and acquisition of new and experimental vaccines, is not available or under development |
| | 2 | National plan for mass vaccination response to outbreaks of VPDs, including national guidelines for regulatory approval and acquisition of new and experimental vaccines, has been developed |
| | 3 | National plan for mass vaccination response to outbreaks of VPDs, including national guidelines for regulatory approval and acquisition of new and experimental vaccines, and relevant SOPS are disseminated and implemented at the national level |
| | 4 | National plan for mass vaccination response to outbreaks of VPDs, including national guidelines for regulatory approval and acquisition of new and experimental vaccines, and relevant SOPS are disseminated and implemented at all levels (i.e., national, intermediate and local) |
| | 5 | National plan and relevant SOPs for mass vaccination response have been applied against at least one epidemic of VPD in the country; national guidelines for regulatory approval and acquisition of new and experimental vaccines have been utilized in a real event or SimEx, and the plan and SOPs are assessed, tested and updated regularly |

**Maintained or increased SPAR/JEE scores in Risk Communication**

RCCE have proven to be vital in all public health emergencies. Risk communication refers to real time exchange of information, advice and opinion between experts or officials and people who face a threat. Its ultimate purpose is that all who are at risk are able to take informed decisions to mitigate the effects of the threat and take protective and preventive action. Community engagement is a more focused series of

activities intended to bring communities to the center of preparedness, readiness, and response, providing voices and choices for communities in the decision-making process of community level public health measures. Investments would include developing standard operating procedures for RCCE, training of RCCE personnel, developing public communications platforms, and platforms for community engagement and monitoring.

| JEE R5.1. RCCE System for Emergencies | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 2**<br><br>**Associated SPAR indicators: C10.1 RCCE system for emergencies** | 1 | Mechanisms for RCCE functions and resources including relevant aspects of infodemic management, behavioural and cultural insights, are under development; implementation and coordination of RCCE activities are conducted on an ad hoc basis |
| | 2 | Mechanisms for RCCE functions and resources including relevant aspects of infodemic management, behavioural and cultural insights, are in place and coordination of activities are conducted on a regular basis |
| | 3 | National RCCE functions are established and being implemented, as well as relevant aspects of infodemic management, behavioural and cultural insights. There is dedicated but insufficient human and financial resources; and multisectoral coordination with multiple technical areas is occurring but limited |
| | 4 | National RCCE systems are fully operational; and there is harmonized coordination among all key technical areas. RCCE has adequate number of skilled and/or trained personnel and volunteers, and adequate financial resources. The national multihazard, multisectoral RCCE plans are reviewed at least every 24 months. RCCE has arrangements in place for scale up as evidenced by a SimEx or tested during a real health emergency. Evidence and data gathered from review of RCCE activities are used for measurement, evaluation, learning and continuous improvement on RCCE interventions |
| | 5 | RCCE systems and resources are operational across all levels and relevant sectors, including community-led readiness and response interventions; RCCE systems and resources are fully integrated into emergency response systems. The national level collaborates with and supports intermediate and community levels to use national and local socio-behavioural and epidemiologic data for tailored local risk communication for communities. |

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| | | Evidence and data gathered are systematically used for measurement, evaluation, learning and continuous improvement of RCCE interventions |

| JEE R5.2. Risk Communication | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 2**<br><br>**Associated SPAR indicators: C10.2 Risk communication** | 1 | Mechanisms for public communication, including relevant aspects of infodemic management, are under development or implemented on an ad hoc basis by non-specialist professionals with a near-exclusive focus on conventional media |
| | 2 | Mechanisms for public communication, including infodemic management, are developed but not fully implemented with significant gaps by specialists with minimal online and social media presence |
| | 3 | Risk communication plans, policies and procedures for response and coordination is in place. Risk communication function is included in the emergency response structure and appointed spokespersons are trained in risk communication. Infodemics management and insights analysis are functioning in a routine manner. There is some analysis of target audiences based on language, trusted information resources and preferred communication channels to inform risk communication interventions |
| | 4 | There is planned communication with ongoing proactive outreach through a variety of channels (e.g., hotline, complaint systems, social listening); online and offline media are monitored daily for feedback, and insights and data are used to adjust and improve risk communication strategies. There is strong infodemic management using search mechanisms for online or/and offline sources to shape messages and strategies. There is coordination of risk communication strategies and messages across sectors and levels of government |
| | 5 | Risk communication activities are implemented through a whole-of government approach, with the involvement of all actors including international and national partners, media and influencers. Communication is conducted through online and offline channels in a timely, accessible and understandable way. Evidence and data gathered through |

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| | | measurement and evaluation are used systematically for continuous learning and improvement of RCCE interventions |

| JEE R5.3. Community Engagement | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 2**<br><br>**Associated SPAR indicators: C10.3 Community engagement** | 1 | Mechanisms for community engagement in public health emergencies, including guidelines and/or SOPs, are in development. Community engagement activities are largely one-way information sharing activities and limited to disease control programmes – such as maternal and child health, malaria, tuberculosis, HIV/AIDS, polio, neglected tropical diseases. Community engagement efforts are not systematically linked to the emergency response |
| | 2 | Mechanisms for systematic community engagement in public health emergencies, including guidelines and/or SOPs, have been developed. Community engagement activities involve some community participation, including consulting and gathering their feedback on decisions and actions |
| | 3 | Communities are actively involved in emergency response and co-design emergency response initiatives. Stakeholders, such as community leaders, faith-based organizations and civil society are mapped and but only engaged on ad hoc basis. Formal or informal community feedback mechanisms, such as hotlines and social-behavioural research, are established and used to inform emergency responses. Community engagement coordination mechanisms exist at national and intermediate and community levels |
| | 4 | Communities are actively involved in emergency response and co-design emergency response initiatives. Stakeholders, such as community leaders, faith-based organizations, and civil society are mapped and systematically engaged. Emergency responders are trained and surge capacity mechanisms for community engagement are in place and operational. Collection and analysis of community feedback and socio-behavioural data at national, intermediate and primary public health response level is conducted on an ad hoc basis |

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| | 5 | Communities are active partners in emergency response and participate in planning, design and implementation of interventions. There is systematic collection and analysis of community feedback, socio-behavioural and infodemics insights data at national, intermediate and primary public health response level. Evidence gathered from data analysis are used systematically for continuous improvement of community engagement response to health emergencies |

**Maintained or increased SPAR/JEE scores in Health Emergency Management**

| JEE R1.1. Emergency Risk Assessment and Readiness | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 3**<br><br>**Associated SPAR indicators: C7.1. Planning for health emergencies** | 1 | A national all hazards risk profile based on a multihazard risk assessment is not in place or has not been updated in the past five years and there is no formal mechanism for the readiness assessment for potential public health emergencies |
| | 2 | A national all hazards risk profile developed based on a multihazard risk assessment and capacity/readiness assessment for potential public health emergencies that have been conducted in the past five years is in place with priorities identified |
| | 3 | A capacity/readiness assessment for potential public health emergencies has been conducted in the past two years and a national all hazards risk profile developed based on a multihazard risk assessment that has been conducted in the past two years is in place with priorities identified |
| | 4 | National and intermediate all hazards risk profiles developed based on a multihazard risk assessments that have been conducted in the past two years are in place with priorities identified<br>AND<br>The readiness and/or contingency plan(s) are adequately resourced and implemented in the past two years, including at intermediate levels |
| | 5 | National and intermediate all hazards risk profiles based on multisectoral multihazard risk assessments and readiness plans are annually reviewed and |

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| | | updated to accommodate emerging threats, and are shared regularly among sectors |

| JEE R1.2. Public Health Emergency Operations Centre (PHEOC) | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 3**<br><br>**No associated SPAR indicator.** | 1 | A PHEOC has not been identified at the national level and no PHEOC handbook is in place |
| | 2 | A national PHEOC, occupying a designated permanent or ad hoc facility, has been established<br>AND<br>A national PHEOC handbook86a with basic content is in place<br>AND<br>Staff to conduct core incident management system (IMS) functions within the national PHEOC have been identified |
| | 3 | A national PHEOC, occupying a designated permanent or ad hoc facility, has been established<br>AND<br>A national PHEOC handbook with full content is in place<br>AND<br>Staff identified to conduct core IMS functions within the national PHEOC have been trained against public health emergency management (PHEM) competencies |
| | 4 | A national PHEOC, occupying a designated permanent facility, has been established and an associated PHEOC handbook with full content is in place<br>AND<br>An operating budget exists for the core staffing, daily operations and maintenance of the national PHEOC<br>AND<br>The national PHEOC is capable of activating a coordinated response within 120 minutes of receiving an early warning or other information of an emergency requiring PHEOC activation |

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| | | AND<br>PHEOCs have been established at intermediate levels, their associated PHEOC handbooks with full content are in place, and their staff identified to conduct core IMS functions have been trained against PHEM competencies |
| | 5 | The activation operation, and deactivation of PHEOCs at all levels has been tested and PHEOC handbooks (with their associated plans and SOPs) have been updated annually<br>AND<br>National and intermediate PHEOCs have trained surge staff identified to sustain PHEOC operations across multiple shifts for extended periods |

| JEE R1.3. Management of Health Emergency Response | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 3**<br><br>**Associated SPAR Indicators: C7.2. Management of health emergency response** | 1 | An IMS integrated with a national PHEOC or equivalent structure, is not available or under development |
| | 2 | An IMS integrated with a national PHEOC, or equivalent structure, is developed but not operational |
| | 3 | An IMS integrated with a national PHEOC, or equivalent structure, is in place and operational at the national level |
| | 4 | An IMS integrated with a national PHEOC, or equivalent structure, is in place and operational at the national level and able to support intermediate levels |
| | 5 | An IMS integrated with a national PHEOC, or equivalent structure, is in place and operational at the national level and is able to support Intermediate and primary public health levels and is exercised reviewed, evaluated and updated, with improvements based on SimExs and lessons learned from real-world events, e.g., IARs or AARs |

| JEE R1.4. Activation and coordination of health personnel and teams in a public health emergency | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 3**<br><br>**Associated SPAR Indicator: C6.2 Workforce surge during a public health event** | 1 | No national personnel surge plan has been drafted or is under development |
| | 2 | National plans that outline a system for pre-deployment, deployment and post-deployment of surge personnel and teams, including sending and receiving personnel during public health emergencies have been drafted, including the development of plans for emergency management teams (EMT) and rapid response teams (RRTs) for national response |
| | 3 | National and intermediate level plans have been drafted that outline a system for pre-deployment, deployment and post-deployment of surge personnel, including sending and receiving personnel and teams during public health emergencies have been drafted, including the development of plans for EMTs and RRTs |
| | 4 | Table top exercise(s) has been conducted to test decision-making and protocols for deployment of surge personnel and sending and receiving health personnel and teams from another country during a public health emergency, and training and equipment is available for EMTs and RRTs |
| | 5 | Table top exercise(s) has been conducted to test decision-making and protocols for deployment of surge personnel and sending and receiving health personnel and teams from another country during a public health emergency, and training and equipment is available for EMTs and RRTs. Country participates in a regional/international partnership or has formal agreement with another country or international organization that outlines criteria and procedures for sending and receiving surge personnel and has participated in an exercise or response within the past year to practice |

| JEE R1.5. Emergency Logistic and Supply Chain Management | |
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| **Comments** | **Levels of Advancement** |

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| **Midterm Outcome 3: Intermediate Result 3**<br><br>**Associated SPAR Indicator: C7.3 Emergency logistic and supply chain management** | 1 | Emergency logistics and supply chain management system/mechanism is under development and/or not able to provide adequate support for health emergencies |
| | 2 | Emergency logistics and supply chain management system/mechanism is developed but not able to provide adequate support for health emergencies |
| | 3 | Emergency logistics and supply chain management system/mechanism is developed and is able to provide adequate support for health emergencies at the national level |
| | 4 | Emergency logistics and supply chain management system/mechanism is developed and is able to provide adequate support for health emergencies at national and intermediate levels |
| | 5 | Emergency logistics and supply chain management system/mechanism is implemented at national, intermediate and primary public health levels, and is exercised, reviewed, evaluated and updated on a regular basis |

| **JEE R3.3. Continuity of Essential Health Services (EHS)** | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 3**<br><br>**Associated SPAR Indicator: C8.3 Continuity of essential health services (EHS)** | 1 | A package of EHS is not defined and there are no plans or guidelines for continuity EHS during emergency |
| | 2 | A package of EHS is defined but plans/guidelines on continuity of EHS in emergencies is not developed |
| | 3 | A package of EHS and plans/guidelines on continuity of EHS in emergencies are developed and mechanism for monitoring service continuity during emergency are in place at the national level |

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| | 4 | A package of EHS and plans/guidelines on continuity of EHS in emergencies are developed and mechanism for monitoring service continuity during emergency are in place at national and intermediate levels |
| | 5 | A package of EHS, plans/guidelines on continuity of EHS in emergencies, and mechanisms for monitoring service continuity based on existing guidelines are defined and functional at national, intermediate and primary public health levels and exercised, reviewed, evaluated and updated, with improvements based on simulation exercises and lessons learned from real-world events, e.g., IARs or AARs |

| **JEE PoE.2 Public Health Response at PoEs** | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 3**<br><br>**Associated SPAR Indicators: C11.2. Public health response at points of entry** | 1 | PoEs designated based on a strategic risk assessment are in the process of developing a PoE multisectoral public health emergency contingency plan |
| | 2 | Some designated PoEs have developed a PoE multisectoral public health emergency contingency plan for events caused by biological hazards |
| | 3 | All designated PoEs have developed PoE multisectoral public health emergency contingency plans for events caused by biological hazards and are integrated into national surveillance systems and emergency response plans. Other non-designated PoEs are integrated into the national surveillance system |
| | 4 | All designated PoEs have developed PoE multisectoral public health emergency contingency plans for events caused by all hazards and integrated into national emergency response plans. Contingency planning is conducted at some non-designated PoEs |
| | 5 | All PoE public health emergency contingency plans for events caused by all hazards all designated PoEs are exercised, reviewed, evaluated and updated on a regular basis. Some non-designated PoEs have developed PoE |

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| | | multisectoral public health emergency contingency plans for events caused by all hazards and are integrated into national emergency response plans |

| JEE P5.2. Response to Zoonotic Diseases | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 3**<br><br>**Associated with SPAR C7.2 Management of health emergency response (for the purposes of Pandemic Fund Results Framework) and SPAR C12.1** | 1 | Despite the existence of mechanisms for the response to certain specific diseases or pathogens, no coordination between the animal health, public health and environment sectors is organized for zoonotic diseases |
| | 2 | Multisectoral national policy, strategy and/or plan for response to zoonotic events have been elaborated and are documented. Multisectoral contingency plans following a One Health approach have been developed for the most important endemic and epidemic zoonotic diseases |
| | 3 | A multisectoral operational mechanism for coordinated response to outbreaks of endemic, emerging or re-emerging zoonotic diseases by human health, animal health and environment sectors is in place |
| | 4 | Several experiences of response to zoonotic events confirm timeliness and efficiency of the multisectoral operational mechanism, including clear definition of roles, responsibilities and procedures between sectors in charge of domestic animal, wildlife, human health and other relevant sectors |
| | 5 | The multisectoral operational mechanism for the response to outbreaks of endemic, emerging or re-emerging zoonotic diseases is regularly tested through exercises and/or real events and adjusted accordingly |

| PVS II-2. Risk Analysis and Epidemiology | | |
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| **Definition** | **Levels of Advancement** | |
| **The authority and capability of the VS to base its risk management and risk communication** | 1 | Risk management and risk communication measures are not usually supported by risk assessment. |

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| **measures on risk assessment, incorporating sound epidemiological principles.** | 2 | The VS compile and maintain data but do not have the capability to carry out risk analysis. Some risk management and risk communication measures are based on risk assessment and some epidemiological principles. |
| | 3 | The VS compile and maintain data and have the policy and capability to carry out risk analysis, incorporating epidemiological principles. The majority of risk management and risk communication measures are based on risk assessment. |
| | 4 | The VS conduct risk analysis in compliance with relevant OIE standards and sound epidemiological principles, and base their risk management and risk communication measures on the outcomes of risk assessment. There is a legislative basis that supports the use of risk analysis. |
| | 5 | The VS are consistent and transparent in basing animal health and sanitary measures on risk assessment and best practice epidemiology, and in communicating and/or publishing their scientific procedures and outcomes internationally. |

| PVS II-3. Quarantine and Border Security | | |
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| **Definition** | **Levels of Advancement** | |
| **The authority and capability of the VS to base its risk management and risk communication measures on risk assessment, incorporating sound epidemiological principles.** | 1 | Risk management and risk communication measures are not usually supported by risk assessment. |
| | 2 | The VS compile and maintain data but do not have the capability to carry out risk analysis. Some risk management and risk communication measures are based on risk assessment and some epidemiological principles. |
| | 3 | The VS compile and maintain data and have the policy and capability to carry out risk analysis, incorporating epidemiological principles. The majority of risk management and risk communication measures are based on risk assessment. |

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| | 4 | The VS conduct risk analysis in compliance with relevant OIE standards and sound epidemiological principles, and base their risk management and risk communication measures on the outcomes of risk assessment. There is a legislative basis that supports the use of risk analysis. |
| | 5 | The VS are consistent and transparent in basing animal health and sanitary measures on risk assessment and best practice epidemiology, and in communicating and/or publishing their scientific procedures and outcomes internationally. |

| PVS II-5. Emergency Preparedness and Response | | |
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| **Definition** | **Levels of Advancement** | |
| **The authority and capability of the VS to be prepared and respond rapidly to a sanitary emergency threat (such as a significant disease outbreak or food safety emergency).** | 1 | The VS have no field network or established procedure to determine whether a sanitary emergency threat exists or the authority to declare such an emergency and respond appropriately. |
| | 2 | The VS have a field network and an established procedure to determine whether a sanitary emergency threat exists, but lack the legal and financial support to respond effectively. The VS may have basic emergency management planning, but this usually targets one or a few diseases and may not reflect national capacity to respond. |
| | 3 | The VS have the legal framework and financial support to respond rapidly to sanitary emergency threats, but the response is not well coordinated through an effective chain of command. They have national emergency management plans for some exotic diseases, but they are not updated/tested. |
| | 4 | The VS have the legal framework and financial support to respond rapidly to sanitary emergencies through an effective chain of command (e.g. establishment of a containment zone). The VS have national emergency management plans for major exotic diseases, linked to broader national disaster management arrangements, and these are regularly updated/ tested such as through simulation exercises. |

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| | 5 | The VS have national emergency management plans for all diseases of concern (and possible emerging infectious diseases), incorporating coordination with national disaster agencies, relevant Competent Authorities, producers and other non-government stakeholders. Emergency management planning and response capacity is regularly tested, audited and updated, such as through simulation exercises that test response at all levels. Following emergency events, the VS have a formal 'After Action Review' process as part of continuous improvement. |

**Maintained or increased SPAR/JEE scores in Infection Prevention and Control**

Investments in IPC are critical for protecting health workers and patients and preventing the emergence and spread of AMR. Investing in IPC contributes to achieving quality care, patient safety, health security and the reduction of AMR. Strong, effective IPC programs allow safe health care and essential services delivery and prevention and control of outbreaks throughout the health system. This priority requires investments in IPC minimum requirements, defined as IPC standards, that should be in place at both national and health facility level to provide minimum protection and safety to patients, health care workers and visitors, based on the WHO core components for IPC programs. Key elements include capacity for surveillance of HealthCare Acquired Infections (including pathogens that are antimicrobial resistant and/or prone to outbreaks)in health care facilities and creating a safe environment in healthcare facilities, e.g., WASH, screening, isolation areas and sterilization services. Among other things, this also requires investments in staff training.

| JEE R4.1. IPC Programmes | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 4**<br><br>**Associated SPAR Indicators: C9.1 IPC programmes** | 1 | An active national IPC programme or operational plan according to the WHO minimum requirements is not available or is under development |
| | 2 | An active national IPC programme or operational plan according to WHO minimum requirements exists but is not fully implemented. National IPC guidelines/standards exist but are not fully implemented |
| | 3 | An active national IPC programme exists, and a national IPC operational plan according to the WHO minimum requirements is available including role of IPC in outbreaks and pandemic. National guidelines/standards for IPC in health care are available and disseminated. Selected health facilities are |

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| | | implementing guidelines using multimodal strategies, including health workers' training and monitoring and feedback |
| | 4 | An active national IPC programme is available according to WHO IPC core components guidelines and is leading implementation of the national IPC operational plan and guidelines nationwide using multimodal strategies, including health workers' training and monitoring and feedback in place. National IPC programme is actively engaged in health care outbreaks and pandemic planning. More than 75% of health care facilities meet WHO minimum requirements for IPC programmes, guidelines, training, and monitoring/feedback |
| | 5 | IPC programmes are in place and functioning at national and health facility levels according to the WHO IPC core components and their compliance and effectiveness are exercised (as applicable), reviewed, evaluated and published or available. Plans and guidance are regularly updated in response to monitoring and feedback. National, intermediate and local IPC programmes actively coordinate and are engaged in health care outbreaks and pandemic planning |

| JEE R4.2. Health Care-Associated Infections (HCAI) Surveillance | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 4**<br><br>**Associated SPAR Indicators: C5.2 Healthcare-associated infections (HCAI) surveillance** | 1 | No national HCAI surveillance programme or national strategic plan for HCAIs surveillance, including pathogens that are antimicrobial resistant and/or prone to outbreaks is available or under development |
| | 2 | A national strategic plan for HCAIs surveillance (including pathogens that are antimicrobial resistant and/or prone to outbreaks) is available but not implemented |
| | 3 | A national strategic plan for HCAIs surveillance (including pathogens that are antimicrobial resistant and/or prone to outbreaks) is available and implemented through a national programme and system for data collection, analysis and feedback. Selected secondary and tertiary health care facilities |

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| | | are conducting HCAIs surveillance (as specified above) and provide timely and regular feedback to senior management and health workers |
| | 4 | A national strategic plan for HCAIs surveillance (including pathogens that are antimicrobial resistant and/or prone to outbreaks) is available and implemented nationwide in all secondary and tertiary health care facilities through a national system according to the WHO recommendations on IPC core components. Regular reports are available for providing feedback |
| | 5 | A national strategic plan for HCAIs surveillance (including pathogens that are antimicrobial resistant and/or prone to outbreaks) are available and implemented nationwide in all secondary and tertiary health care facilities through a national programme and system according to the WHO recommendations on IPC core components. Data are shared and being used continuously and in a timely manner to inform prevention efforts. The quality and impact of the system are regularly evaluated, and improvement actions are taken accordingly |

| **JEE R4.3. Safe Environment in Health Facilities** | | |
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| **Comments** | **Levels of Advancement** | |
| **Midterm Outcome 3: Intermediate Result 4**<br><br>**Associated JEE Indicators: C9.3 Safe environment in health facilities** | 1 | National standards and resources for safe built environment e.g., WASH, screening, isolation areas and sterilization services in health care facilities, including appropriate infrastructure, materials and equipment for IPC; as well as standards for reduction of overcrowding and for optimization of staffing levels in health care facilities are not available or under development |
| | 2 | National standards and resources for a safe built environment e.g., WASH, screening, isolation areas and sterilization services in health care facilities, including appropriate infrastructure, materials and equipment for IPC; as well as standards for reduction of overcrowding and optimization of staffing levels in health care facilities, according to WHO minimum requirements, exist but they are not fully implemented through a national plan |
| | 3 | National standards and resources for safe built environment, e.g., WASH, screening, isolation areas and sterilization services in health care facilities, including appropriate infrastructure, materials and equipment fort IPC; as |

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| | | well as standards for reduction of overcrowding and optimization of staffing levels in health care facilities, according to WHO minimum requirements, exist and are implemented in selected health care facilities at a national level according to a national plan |
| | 4 | National standards and resources for safe built environment, e.g., WASH, screening, isolation areas and sterilization services in health care facilities, including appropriate infrastructure, materials and equipment for IPC; as well as standards for reduction of overcrowding and optimization of staffing levels in health care facilities, according to WHO minimum requirements, are implemented at national and intermediate levels according to a national plan |
| | 5 | National standards and resources for safe built environment, e.g., WASH, screening, isolation areas and sterilization services in health care facilities, including appropriate infrastructure, materials and equipment for IPC; as well as standards for reduction of overcrowding and for optimization of staffing levels in health care facilities, according to WHO minimum requirements, are implemented at national and intermediate levels according to a national plan, and are regularly exercised (as applicable) and monitored and improvement actions are taken accordingly |

## Cross-Cutting

### **Cross-Cutting Short-term Outcome –** Increased capacity of the health workforce to conduct response activities.

**Maintained or increased SPAR/JEE scores in Human Resources**

A multisectoral workforce is key to enabling early detection, prevention, preparedness, and response to potential events of international concern at all levels of the health system, as required by the IHR. The availability and accessibility of quality health workforce, surge capacity in emergencies, including workforce for surveillance (e.g., field investigation and contact tracing teams) is critical to building the resilience of communities and for continuity of health services during an emergency. This priority requires investing in a well-educated, trained and paid workforce–with a focus on early warning and disease surveillance and standards around One Health in the context of health security, as well as a public health emergency response workforce, to ensure readiness for surges of workforce across sectors during public health emergencies. Training must be based on up-to-date curricula, common standards, and competencies, reflecting an interdisciplinary approach for pandemic preparedness. Investments in Regional Centers of Expertise that can serve as hubs for education and training, as well as investments in national and regional cadres of primary health care workers can go a long way.

| JEE D3.1. Multisectoral Workforce Strategy | | |
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| **Comments** | **Levels of Advancement** | |
| **Cross-cutting Intermediate Result**<br><br>**No SPAR equivalent.** | 1 | No strategy is in place to develop a multisectoral health workforce. An assessment of the requisite workforce policies, plans, programmes and investment requirements has not yet been completed |
| | 2 | Country has carried out an assessment of health workforce implications and requirements for implementation of health policies, strategies, plans and programmes to ensure sustained support and investment and optimal utilization of workers across public and private sectors. A strategy to develop health workforce exists but does not include all relevant sectors and cadres of public health professionals (e.g., epidemiologists, risk communications specialists, social scientists, IT specialists, legal/policy experts veterinarians/livestock specialists, and community health workers) |
| | 3 | A multisectoral health workforce strategy, which includes all relevant sectors and cadres of public health professionals exists, but is not routinely monitored, updated or implemented consistently |
| | 4 | A multisectoral health workforce strategy, which includes all relevant sectors and cadres of public health professionals is fully implemented and is reviewed, tracked and reported on annually |
| | 5 | Country can measure, monitor and regularly report on the national multisectoral health workforce strategy. The strategy has an adequate and sustainable domestic budget line for appropriate workforce development and to compensate for workforce attrition |

| JEE D3.2. Human Resources for Implementation of IHR | | |
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| **Comments** | **Levels of Advancement** | |
| **Cross-cutting Intermediate Result** | 1 | Country does not have appropriate human resources capacity in relevant sectors required, to detect, assess, notify, report and respond to events according to IHR provisions |

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| **Associated SPAR Indicators: C6.1. Human resources for the implementation of IHR** | 2 | Appropriate human resources are available in some relevant sectors at the national level, to detect, assess, notify, report and respond to events according to IHR provisions |
| | 3 | Appropriate human resources are available in all relevant sectors at national and intermediate levels, to detect, assess, notify, report and respond to events according to IHR provisions |
| | 4 | Human resources are available as required in all relevant sectors at the national, intermediate and primary public health levels, to detect, assess, notify, report and respond to events according to IHR provisions |
| | 5 | Country has documented policies or procedures for sustainable appropriate human resources in all relevant sectors to detect, assess, notify, report and respond to events according to IHR provisions, that are exercised (as applicable), reviewed, evaluated and updated on a regular basis and country may assist other countries in planning and developing human resources for IHR implementation, to the extent possible |

| **JEE D3.3. Workforce Training** | | |
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| **Comments** | **Levels of Advancement** | |
| **Cross-cutting Intermediate Result**<br><br>**No SPAR equivalent.** | 1 | Ad hoc or informal trainings are available in country. No formal multisectoral competency-based training programme(s) is (are) in place |
| | 2 | Required workforce competencies have been mapped, aligning with the health workforce strategy. Ad hoc competency-based training programmes are in place for some professions, cadres or sectors through disease-specific or targeted initiatives |
| | 3 | Regular and routine competency-based training programmes and standards including the One Health approach are available for some professions, cadres or sectors at the national level. In addition, one level of Field epidemiology training programme (FETP) (basic, intermediate, or advanced) or comparable applied epidemiology training programme is in place in the country or in another country through an existing agreement |

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| | 4 | Regular and routine competency-based training programmes and standards including the One Health approach are available for all professions, cadres and sectors at the national and intermediate levels. In addition, two levels of FETP (basic, intermediate and/or advanced) or comparable applied epidemiology training programme(s) are in place in the country or in another country through an existing agreement |
| | 5 | All competency-based training programmes are conducted using a nationally or internationally recognized competency standard, where applicable. The country routinely monitors and evaluates both the required competency and training programme delivery and outcomes and updates as needed |

| JEE D3.4. Workforce Surge During a Public Health Event | | |
|---|---|---|
| **Comments** | **Levels of Advancement** | |
| **Cross-cutting Intermediate Result**<br><br>**Associated SPAR Indicators: C6.2 Workforce surge during a public health event.** | 1 | A national multisectoral workforce surge strategic plan in emergencies is not available or is under development |
| | 2 | Country has conducted a gap analysis of required surge health workforce for emergencies, and a national multisectoral workforce surge strategic plan in emergencies is developed to staff, roster, ready and train the workforce to carry out the functions attributed at the national level, including the government and nongovernmental partners workforce as applicable |
| | 3 | Country has conducted a gap analysis of required surge workforce required in all sectors for emergencies, and a national multisectoral workforce surge strategic plan in emergencies is implemented with procedures to staff, roster, ready and train the workforce to carry out the functions attributed at the national level, including the government and nongovernmental partners workforce as applicable |
| | 4 | A national multisectoral workforce surge strategic plan in emergencies is implemented to carry out the functions at national and intermediate levels, with procedures to staff, roster, ready and train the workforce to and adequate capacity to send and receive multidisciplinary personnel within the |

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| | | country (shifting resources), including the government and nongovernmental partners workforce as applicable |
| | 5 | A national multisectoral workforce surge strategic plan in emergencies is implemented to carry out the functions attributed at national, intermediate and primary public health response levels, with procedures to staff, roster, ready and train the workforce to an adequate capacity to send and receive multidisciplinary personnel within the country (shifting resources), including the government and nongovernmental partners workforce, as applicable, and exercised, reviewed, evaluated and updated annually; and may provide international collaboration for assisting emergency response |

| PVS I-1. Professional and Technical Staffing of the Veterinary Services (VS) | | |
|---|---|---|
| **Definition** | **Levels of Advancement** | |
| **The appropriate level of staffing of the VS to allow for veterinary and technical functions to be undertaken efficiently and effectively.**<br>**A. Veterinary and other professionals (university qualified)**<br><br>The appropriate level of staffing of the VS to allow for veterinary and other professional functions to be undertaken efficiently and effectively. | 1 | The majority of positions requiring veterinary or other professional skills are not occupied by appropriately qualified professionals |
| | 2 | The majority of positions requiring veterinary or other professional skills are occupied by appropriately qualified professionals at central and state/provincial levels. |
| | 3 | The majority of positions requiring veterinary or other professional skills are occupied by appropriately qualified professionals at local (field) levels. |
| | 4 | There is a systematic approach to defining job descriptions and formal, merit-based appointment and promotion procedures for veterinarians and other professionals. |
| | 5 | There are effective procedures for formal performance assessment and performance management of veterinarians and other professionals. |

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| **B. Veterinary paraprofessionals**<br><br>The appropriate level of staffing of the VS to allow for veterinary paraprofessional (according to the OIE definition) functions to be undertaken efficiently and effectively.<br>This covers OIE veterinary paraprofessional categories having trained at dedicated educational institutions with formal qualifications which are recognised by the government or the VSB. | 1 | The majority of positions requiring veterinary paraprofessional skills are not occupied by personnel holding appropriate qualifications. |
| | 2 | Some positions requiring veterinary paraprofessional skills are occupied by personnel holding appropriate qualifications. There is little or no veterinary supervision. |
| | 3 | The majority of positions requiring veterinary paraprofessional skills are occupied by personnel holding appropriate qualifications. There is a variable level of veterinary supervision. |
| | 4 | The majority of veterinary paraprofessional positions are effectively supervised on a regular basis by veterinarians. |
| | 5 | There are effective management procedures for formal appointment and promotion, as well as performance assessment and performance management of veterinary paraprofessionals. |

| **PVS I-2. Competency and Education of Veterinarians and Veterinary Paraprofessionals** | | |
|---|---|---|
| **Definition** | **Levels of Advancement** | |
| **The capability of the VS to effectively carry out their veterinary and technical functions, as indicated by the level and quality of the qualifications of their personnel in veterinary and veterinary paraprofessional positions.**<br><br>**A. Veterinarians** | 1 | The veterinarians' knowledge, skills and practices, are of a variable standard that allow only for elementary clinical and administrative activities of the VS. |
| | 2 | The veterinarians' knowledge, skills and practices are of a uniform standard sufficient for accurate and appropriate clinical and administrative activities of the VS. |
| | 3 | The veterinarians' knowledge, skills and practices are sufficient for all professional/technical activities of the VS (e.g. surveillance, treatment and control of animal disease, including conditions of public health significance). |

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| This references the OIE recommendations on the Competencies of graduating veterinarians ('Day 1 graduates') to assure National Veterinary Services of quality, and OIE guidelines on Veterinary Education Core Curriculum. | 4 | The veterinarians' knowledge, skills and practices are sufficient for specialised technical activities (e.g. higher level epidemiological analysis, disease modelling, animal welfare science) as may be needed by the VS, supported by postgraduate level training. |
| | 5 | The veterinarians' knowledge, skills and practices are subject to regular updating, and are internationally recognised such as through formal evaluation and/or the granting of international equivalence with other recognised veterinary qualifications. |
| **B. Veterinary paraprofessionals**<br><br>This references the OIE Competency Guidelines for Veterinary Paraprofessionals and OIE Curricula Guidelines for Veterinary Paraprofessionals. | 1 | Positions requiring veterinary paraprofessional skills are generally occupied by those having no formal training or qualifications from dedicated educational institutions. |
| | 2 | The training and qualifications of those in positions requiring veterinary paraprofessional skills is of a variable standard and allows for the development of only basic competencies. |
| | 3 | The training and qualifications of veterinary paraprofessionals is of a fairly uniform standard that allows the development of some specific competencies (e.g. vaccination on farms, meat hygiene control, basic laboratory tests). |
| | 4 | The training and qualifications of veterinary paraprofessionals is of a uniform standard that allows the development of more advanced competencies (e.g. blood and tissue sample collection on farms, supervised meat inspection, more complex laboratory testing). |
| | 5 | The training and qualifications of veterinary paraprofessionals is of a uniform standard and is subject to regular evaluation and/ or updating. |

| PVS I-3. Continuing Education (CE) | | |
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| **Definition** | **Levels of Advancement** | |
| **The capability of the VS to maintain, update and improve the knowledge, attitudes and skills of** | 1 | The VS have no access to veterinary or paraprofessional CE. |

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| **their personnel, through an ongoing staff training and development programme assessed on a regular basis for relevance and targeted skills development.** | 2 | The VS have access to CE (internal and/or external training) on an irregular basis but it does not take into account needs, or new information or understanding. |
| | 3 | The VS have access to CE that is reviewed and sometimes updated, but it is implemented only for some categories of veterinary professionals and paraprofessionals. |
| | 4 | The VS have access to a CE programme that is reviewed annually and updated as necessary, and is implemented for all categories of veterinary professionals and paraprofessionals. |
| | 5 | The VS have up-to-date CE that is implemented or is a requirement for all relevant veterinary professionals and paraprofessionals and is subject to dedicated planning and regular evaluation of effectiveness. |

| **PVS I-4. Technical Independence** | | |
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| **Definition** | **Levels of Advancement** | |
| **The capability of the VS to carry out their duties with autonomy and without undue commercial, financial, hierarchical and political influences that may affect technical decisions in a manner contrary to the provisions of the OIE (and of the WTO SPS Agreement where applicable).** | 1 | The technical decisions made by the VS are generally not based on scientific considerations. |
| | 2 | The technical decisions consider scientific evidence, but are routinely modified based on non-scientific considerations. |
| | 3 | The technical decisions are based on scientific evidence but are subject to review and occasional modification based on nonscientific considerations. |
| | 4 | The technical decisions are made and generally implemented in accordance with scientific evidence and the country's OIE obligations (and with the country's WTO SPS Agreement obligations where applicable). |

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| | 5 | The technical decisions are based on a high level of scientific evidence, which is both nationally relevant and internationally respected, and are not unduly changed to meet non-scientific considerations. |

| PVS I-5. Planning, Sustainability and Management of Policies and Programmes | | |
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| **Definition** | **Levels of Advancement** | |
| **The capability of the VS leadership and organisation to develop, document and sustain strategic policies and programmes, and also to report on, review and evolve them, as appropriate over time.** | 1 | Policies and programmes are insufficiently developed and documented. Substantial changes to the organizational structure and/or leadership of the VS frequently occur (e.g. annually) resulting in a lack of sustainability of policies and programmes. |
| | 2 | Some basic policy and programme development and documentation exists, with some reporting on implementation. Sustainability of policies and programmes is negatively impacted by changes in the political leadership or other changes affecting the structure and leadership of the VS. |
| | 3 | There is well developed and stable policy and programme documentation. Reports on programme implementation are available. Sustainability of policies and programmes is generally maintained during changes in the political leadership and/or changes to the structure and leadership of the VS. |
| | 4 | Policies or programmes are sustained, but also reviewed (using data collection and analysis) and updated appropriately over time through formal national strategic planning cycles to improve effectiveness and address emerging concerns. Planning cycles continue despite changes in the political leadership and/or changes to the structure and leadership of the VS. |
| | 5 | Effective policies and programmes are sustained over time and the structure and leadership of the VS is strong and stable. Modification to strategic and operational planning is based on a robust evaluation or audit process using evidence, to support the continual improvement of policies and programmes over time. |

## PVS I-6. Coordination Capability of the Veterinary Services

| Definition | Levels of Advancement | |
|---|---|---|
| **A. Internal coordination (chain of command)**<br><br>The capability of the Veterinary Authority to coordinate their mandated activities with a clear chain of command, from the central level (the Chief Veterinary Officer or equivalent), to the field level of the VS, as relevant to the OIE Codes (e.g. surveillance, disease control, food safety, emergency preparedness and response). | 1 | There is no formal internal coordination and the chain of command is not clear. |
| | 2 | There are internal coordination mechanisms for some activities but the chain of command is not clear. |
| | 3 | There are internal coordination mechanisms and a clear and effective chain of command for some activities, such as for export certification, border control and/or emergency response. |
| | 4 | There are formal, documented internal coordination mechanisms and a clear and effective chain of command for most activities, including surveillance (and reporting) and disease control programmes. |
| | 5 | There are formal and fully documented internal coordination mechanisms and a clear and effective chain of command for all activities, and these are periodically reviewed/audited and updated to re-define roles and optimise efficiency as necessary. |
| **A. External coordination (including the One Health approach)**<br><br>The capability of the Veterinary Authority to coordinate its resources and activities at all levels with other government authorities with responsibilities within the veterinary domain, in order to implement all national activities relevant to the OIE Codes, especially those not under the direct line authority of the Chief Veterinary Officer (or equivalent).<br><br>Relevant authorities include other ministries and Competent Authorities, such as government | 1 | There is no external coordination with other government authorities. |
| | 2 | There are informal external coordination mechanisms for some activities at national level, but the procedures are not clear and/ or external coordination occurs irregularly. |
| | 3 | There are formal external coordination mechanisms with clearly described procedures or agreements (e.g. Memoranda of Understanding) for some activities and/or sectors at the national level. |
| | 4 | There are formal external coordination mechanisms with clearly described procedures or agreements at the national level for most activities (such as for One Health), and these are uniformly implemented throughout the country, including at state/provincial level. |

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| partners in public health (e.g. zoonoses, food safety, drug regulation and anti-microbial resistance), environment (e.g. wildlife health), customs and border police (e.g. border security), defence/intelligence (e.g. bio-threats), or municipalities/local councils (e.g. local slaughterhouses, dog control). | 5 | There are external coordination mechanisms for all activities, from national to field, and these are periodically reviewed and updated to re-clarify roles and optimise efficiency |

**Pandemic Fund Results Framework Indicator Reference Sheets**

Element 1: Building capacity/demonstrating capability

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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|---|---|
| **Element 1:** Building capacity/demonstrating capability | |
| **Indicator 1a**: Sustainment or improvement of capacity as a result of Pandemic Fund (PF) projects, as measured by improved or sustained scores for indicators within the Joint External Evaluation (JEE) and Performance of Veterinary Services (PVS), when available, and States Parties' Annual Report (SPAR), or other relevant assessments | |
| **Rationale/description** | Outputs of PF projects should directly contribute to capacity that can be used to better prepare for, prevent, and promptly respond to infectious disease threats. These capacities are codified in the technical areas included in the WHO's JEE and SPAR assessments. All countries are required to complete a SPAR each year and countries may elect to complete a JEE or PVS (generally on a 4–6-year timeframe). Outputs of PF projects should improve country capacity which will result in progressively higher scores (or maintenance of existing scores) reported in these assessments. The technical areas, indicators, and level of capacity scores and definitions for the JEE, SPAR, and PVS pathway are available online. Relevant sections of each assessment are included in annex 2 of the Results Framework. |
| **Definitions** | Joint External Evaluation (JEE) – a voluntary assessment of health security capacity validated by team of international experts.<br>States Parties Annual Report (SPAR) – a mandatory annual self-report completed by WHO Member States that assesses health security capacity. WHO asks countries to complete by February or March each year.<br>Both the JEE and SPAR are divided into sections called 'technical areas' that focus on specific capacities needed to manage infectious disease outbreaks and other health threats. Technical areas are sub-divided into components called indicators. Indicators are scored on a 1-5 scoring system (1-low, 5-high). Each score has a specific set of capacities that countries need to attain to justify the score. |
| **Data source** | 1) Relevant JEE and SPAR scores and/or PVS indicator scores (posted online);<br>2) PF proposal submission;<br>3) Project annual report |
| **Data Collection Methods** | 1) JEE and SPAR scores can be accessed online. SPAR scores are published annually in May for the previous year. JEE scores are published as reports in an *ad hoc* fashion as countries complete the assessment.<br>2) Pandemic Fund proposals should designate which technical areas and indicators within the SPAR and JEE are improved (or maintained) by the project.<br>3) The annual report should contain a narrative description of how the outputs of the project impacted the JEE, SPAR, and PVS scores for the indicators noted in the proposal. The levels of capacity definitions (included in the Results Framework) should be used as a guide. |
| **Data Type** | Quantitative – JEE and SPAR scores<br>Qualitative – List of deliverables from PF project and narrative capturing impact of activities on JEE, SPAR, and PVS scores |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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| **Analysis** | A country's JEE and/or SPAR scores from before the project is implemented and after the project is completed will be compared to assess improvements in numerical value of the scores for the technical areas and indicators referenced in the PF proposal and annual report. The narrative provided by the IE in the annual report that justifies how the PF project contributed to the score increases (or maintenance) will be used to attribute score improvements, or maintenance of a score to PF projects. The narrative can also capture incremental changes to capacity that may not result in a full score change but may lead to it in the future. By aggregating across projects, the PF can articulate collective impact of PF projects on SPAR/JEE/PVS scores globally, by country, by technical area, or by specific indicator over time. This analysis can be completed annually based on annual reports and posting of SPAR scores.<br>*The JEE and SPAR are updated periodically by the WHO, changes to these assessments may complicate comparison of scores over time. |
| **Responsible** | Secretariat (consolidation of information, pulling JEE and SPAR scores, and analysis), implementing entities (proposal submission and annual report), co-investor countries (submission of SPAR/JEE scores to WHO) |

| **Indicator 1b**: Number of after/intra-action reviews or simulation exercises performed utilizing the 7-1-7 approach that identify strengthened capacities, gaps in capacity, and bottlenecks to improve detection, notification, and response | |
|---|---|
| **Rationale/description** | After/intra action reviews and simulation exercises can help countries identify capacities that are able to be used effectively during a real-life or simulated emergency, those that are not able to be used effectively, and gaps in capacity or bottlenecks/issues that prevent capacity from being used effectively. PF projects should build capacity that is able to be used effectively in a real-life or simulated emergency. Committing to undergo utilize after/intra-action reviews and simulation exercises, if executed effectively, can identify issues to address in future PF projects, or other capacity building efforts, and help validate capacity built in PF projects as measured by increases in JEE, SPAR, and PVS indicator scores. |
| **Definitions** | Capacity: systemic ability level to prevent detect, assess and notify and report events, and to respond promptly and effectively to public health risks.<br>Capability: Ability to utilize capacity effectively when needed – for instance during a disease outbreak or other health threat.<br>Intra action review: periodic reviews conducted during a public health event, project, or intervention that aims to identify aspects that could be improved or need more attention.<br>After action review: qualitative review of actions taken to respond to a public health event, project, intervention at end of the timeline.<br>Simulation exercise: imitation of a situation/process to which a described or similar response is made. |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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| | 7-1-7: performance bottleneck analysis to determine factors which prevent countries' capability to detect, notify, and respond to a disease as rapidly and effectively to new potential major health threats; a timeliness metric. |
| **Data source** | Summary of the after/intra action review or simulation exercise report |
| **Data Collection Methods** | The summary of the after/intra-action review or simulation exercise will include 1) a section to designate which capacities (as identified by JEE, SPAR, or PVS indicator number) were able to be used effectively during a real-life or simulated event, 2) which capacities were not able to be used effectively, 3) gaps in capacity, and issues/bottlenecks that prevented capacity from begin used effectively. |
| **Data Type** | Qualitative |
| **Analysis** | The after/intra action review and/or simulation exercise reports will be reviewed for the four categories listed above, all reports that contains the four elements will be counted toward the total number of reports submitted. |
| **Responsible** | Secretariat (information consolidation and analysis), IEs (annual report), and co-investor country (summary of the after/intra action review report) |

| **Indicator 1c**: Percentage of the capacities that were improved or maintained by the PF projects(in 1a), that are able to be effectively utilized during an infectious disease outbreak or other public health threat, as measured by an intra/after-action review or simulation exercise | |
|---|---|
| **Rationale/description** | Co-investor countries will commit to complete at least one after/intra action review or simulation exercise annually utilizing the 7-1-7 approach to 1) assess if capacities built by PF projects are able to be utilized effectively during a real-life or simulated event, and 2) to identify challenges/hurdles impairing or delaying the ability to detect an outbreak, notify appropriate stakeholders, and mount an effective response. These challenges/hurdles can be used in conjunction with JEE/SPAR/PVS assessment findings and scores to develop a NAPHS and proposals for the PF or as the basis for other health security capacity building projects. |
| **Definitions** | Capacity: components in place needed to prevent, detect, assess, report and notify events, and to respond promptly and effectively to public health risks.<br>Capability: Ability to utilize capacity effectively when needed – for instance during a disease outbreak or other health threat. |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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| | Intra action review: periodic reviews conducted during a public health event, project, or intervention that aims to identify aspects that could be improved or need more attention.<br>After action review: qualitative review of actions taken to respond to a public health event, project, intervention following the event.<br>Simulation exercise: imitation of an outbreak/emergency to which a response is made.<br>7-1-7: performance bottleneck analysis to determine factors which prevent countries' capability to detect, notify, and respond to a disease as rapidly and effectively to new potential major health threats; a timeliness metric. |
| **Data source** | 1) Project annual report;<br>2) Summary of co-investor country after/intra action review report |
| **Data Collection Methods** | 1) The annual report should contain a narrative description of how the outputs of the project impacted the JEE, SPAR, and PVS scores for the indicators noted in the proposal. The levels of capacity definitions (included in the Results Framework) should be used as a guide to justify how the PF project improved or maintained these capacities.<br>2) The summary of the after/intra action review report should include a subsection on how the technical areas and indicators from the PF project fared in the assessment of capability. |
| **Data Type** | Quantitative –Number of JEE, SPAR, and PVS indicators that were improved or maintained as a result of the PF project<br>Qualitative – Narrative from the annual report that captures the impact of the PR project on JEE, SPAR, and PVS indicator scores either to improved them (incrementally or by a full point) or maintain them |
| **Analysis** | A narrative will be provided in the annual report that will describe which indicators from the JEE, SPAR, and/or PVS were improved (or maintained) by the PF project. The narrative will also include how the deliverables of the project specifically improved or maintained these scores.<br><br>The intra/after action review or simulation exercise summary report will include a section to designate which capacities (as identified by JEE, SPAR, or PVS indicator number) were able to be used effectively during a real-life or simulated event.<br><br>The list of indicators improved or maintained the PF project in the annual report will be compared to the list of indicators able to be used effectively from the intra/after action reviews or simulation exercises report.<br><br>The number of indicators where capacity was noted as being able to be effectively utilized from the after/intra action review report or simulation exercise report* will be divided by the total number of indicators improved (or maintained) by PF-funded activities to arrive at a percentage. |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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| | *Not all outbreaks will test all capacities built through PF-funded activities. Some allowances will need to be provided to accommodate this. |
| **Responsible** | Secretariat (information consolidation and analysis), IEs (annual report), and co-investor country (summary of the after/intra action review report) |

| **Indicator 1d**: Percentage of PF projects' activities that support gaps identified in countries' National Action Plans for Health Security (NAPHS), or other relevant plans | |
|---|---|
| **Rationale/description** | PF projects should support existing gaps in PPR, reflect countries' priorities, and reinforce existing elements of the global health security infrastructure.<br><br>Many countries used National Action Plans for Health Security (NAPHS) to articulate key long terms goals for building health security capacity based on the results of health security assessments including but not limited to the JEE, SPAR, and PVS. NAPHS are sometimes complemented by short term operational plans focused on activities that can be implemented in the next 6-12 months that help address gaps in capacity and improve JEE, SPAR, and/or PVS scores. The NAPHS and shorter-term operational plans represent country priorities. All these components – JEE, SPAR, PVS, NAPHS – are codified in the World Health Organization's International Health Regulations Monitoring and Evaluation Framework.<br><br>By supporting activities identified in the NAPHS and shorter-term operational plans, PF projects will reinforce components of the existing global health security architecture, reflect country priorities, and address validated gaps in capacity. |
| **Definitions** | National Action Plans for Health Security (NAPHS): articulate a country's priorities for building capacity to manage infectious disease outbreaks. NAPHS are based on health security assessments like the JEE, SPAR, and PVS and may contain short/long-term objectives and activities for addressing the gaps in capacity identified through assessments. The NAPHS is sometimes accompanied by an operational plan that contains a small number of activities that are meant to be implemented in the next 6-12 months to drive progress toward the objectives outlined in the NAPHS.<br><br>Operational plans can be developed as part of a process to implement a NAPHS, or independently based on the results of a SPAR, JEE, and/or PVS assessment. |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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| **Data source** | 1) Country NAPHS, operational plan, or related plan;<br>2) PF annual report |
| **Data Collection Methods** | The annual report submitted by the IE should contain a list of activities that have been completed and if/how those activities are reflected in the country's NAPHS, operational plan, or similar health security plan. |
| **Data Type** | Qualitative |
| **Analysis** | The total number of activities completed in the PF project that appear in the NAPHS, operational plan, or other relevant health security plan will be divided by the total number of activities completed in the PF project to arrive at a percentage of activities in the PR project that appear in the NAPHS, operational plan, or similar health security plan. |
| **Responsible** | Secretariat (for aggregating data from across projects) and IE (for submitting the annual report with the relevant section referenced above) |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

**Pandemic Fund Results Framework Indicator Reference Sheets**

Element 2: Fostering coordination among countries globally and within countries across sectors

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

| **Pandemic Fund** | |
|---|---|
| **Element 2:** Fostering coordination nationally (across sectors within countries), and among countries regionally and globally | |
| **Indicator 2a**: Inclusion of regional platforms, institutions, networks, and priorities in PF projects | |
| **Rationale/description** | PF projects, including those implemented at a country level(s), should, where relevant, be linked with regional platforms, institutions, and networks to support the goal of promoting a more coordinated approach to PPR. Projects should also be aligned to any relevant regional priorities to support greater coherence with other PPR programmes and health system strengthening programmes. |
| **Definitions** | Regional: relevant to a geographic region of the world.<br>Regional platforms and networks: formal and informal groups of individuals working towards common regional goals.<br>Regional institutions: organization with a membership and/or mandate that spans multiple countries in a region, including small and large institutions. |
| **Data source** | 1) Pandemic Fund proposal submission;<br>2) Project annual report;<br>3) PF final project monitoring and evaluation reports |
| **Data Collection Methods** | 1) PF proposals should outline how regional platforms, institutions, and networks will be included in the activities proposed, and how activities proposed align with regional priorities.<br>2) Project annual reports should summarise how regional platforms, institutions, networks were included in the activities undertaken, and how these activities aligned with regional priorities.<br>3) All final monitoring and evaluation reports for projects should include a qualitative description of how regional platforms, institutions, networks, and priorities were included in the implemented project and any associated outcomes. |
| **Data Type** | Qualitative |
| **Analysis** | A narrative about how regional platforms, institutions, and networks and regional priorities were included in the lifetime of a project, and a comparison of the planned and implemented activities will be generated. This information could encourage including regional priorities by identifying examples of PF projects which have promoted coordination and coherence at the regional level and their associated outcomes. |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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| **Responsible** | Secretariat (information consolidation and analysis,), IEs and co-investor countries (providing information in proposal submission, annual report, and to support monitoring and evaluation of projects) |

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| **Indicator 2b**: Establishment or improvement of processes/mechanisms that allow for cross sectoral coordination within the country and between countries during a public health emergency | |
| **Rationale/description** | PF projects should consider how they contribute to enhancing capacity for cross-sectoral and cross-country coordination with respect to health threats. Projects do not have to be focused on emergency response in order to contribute to improved coordination. |
| **Definitions** | Processes/mechanisms: organized series of actions, procedures or an established system of working towards a specific goal.<br>Public health emergency: any adverse event that compromises the health of the population and has the potential to cause widespread illness. |
| **Data source** | 1) PF proposal submission;<br>2) Project annual report;<br>3) PF final project monitoring and evaluation reports |
| **Data Collection Methods** | 1) PF proposals should outline if projects are intended to establish or improve processes/mechanisms for cross sectoral coordination within and/or between countries during a public health emergency.<br>2) The project annual report should contain a narrative description of how processes/mechanisms for cross sectoral coordination within and/or between countries for public health emergency response were improved and any associated outcomes.<br>3) All final project monitoring and evaluation reports should include an assessment of the degree to which processes/mechanisms for cross sectoral coordination within and/or between countries during a public health emergency were improved. |
| **Data Type** | 1) Qualitative – narratives describing improvements to of establishment of processes/mechanisms for coordination based on improvements in the rating system described below<br>2) Quantitative – 3-level rating as described below |

| **Level** | **Description** |
|---|---|
| No coordination | • Organizations are aware of each other's activities and attempt not to overlap or duplicate |
| Moderate Coordination | • Shared operational goals and objectives<br>• Policy coherence and alignment |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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| | | • Ad hoc communications and structures<br>• Informal networks of stakeholders<br>• Management level support and buy in |
| | Strong coordination<br><br>4) | • Shared strategic goals and objectives<br>• Joint policy setting, planning, and operating<br>• Codified multi sectoral/level/stakeholder coordination structures (ex: MoUs)<br>• Executive level support and buy in |
| **Analysis** | Information collected through narrative descriptions will be aggregated to provide examples of how the PF projects improved or established cross sectoral coordination mechanisms/processes. The narratives may also provide examples of coordination and help encourage proposals which seek to improve in-country and/or between country coordination.<br><br>Project level rating data will be aggregated across all projects. An average of ratings for cross sectoral coordination within and between countries from PF projects can be used to demonstrate the impact of projects as a group. | |
| **Responsible** | Secretariat (information consolidation and analysis,), IEs and co-investor countries (providing information in proposal submission, annual report, and to support monitoring and evaluation of projects) | |

| **Indicator 2c**: Extent to which PF projects are implemented in coordination with multiple ministries, sectors, and stakeholders (including IEs, civil society organizations, and others) | |
|---|---|
| **Rationale/description** | PF projects should support collaboration across sectors and strengthen alignment with national priorities and strategic plans and complementarity of PPR and health system strengthening within countries. This indicator captures the level of coordination across sectors, ministries, and stakeholders for PF projects. |
| **Definitions** | Sectors: one of the areas into which the economic or social activity of a country is divided (examples – human health, animal health, environment, defense/security, etc.).<br>Ministries: department of the government led by a Minister.<br>Relevant stakeholders: organizations or individuals with relevant expertise or interests, including civil society and community organizations, non-governmental organizations, private sector organizations and multilateral organizations. |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

<table>
<tr><td>Data source</td><td>1) Project annual report</td></tr>
<tr><td>Data Collection Methods</td><td>1) Annual report contains a rating and narrative description to justify rating of coordination across sectors, Ministries, and relevant stakeholders during the implementation of the activities and any associated outcomes</td></tr>
<tr><td>Data Type</td><td>Quantitative rating (described below) with qualitative justification<br><br>
<table>
<tr><th>Level</th><th>Description</th></tr>
<tr><td>No coordination</td><td>• Organizations are aware of each other’s activities and attempt not to overlap or duplicate</td></tr>
<tr><td>Moderate Coordination</td><td>• Shared operational goals and objectives<br>• Policy coherence and alignment<br>• Ad hoc communications and structures<br>• Informal networks of stakeholders<br>• Management level support and buy in</td></tr>
<tr><td>Strong coordination<br><br>2)</td><td>• Shared strategic goals and objectives<br>• Joint policy setting, planning and operating<br>• Codified multi sectoral/level/stakeholder coordination structures (ex: MoUs)<br>• Executive level support and buy in</td></tr>
</table></td></tr>
<tr><td>Analysis</td><td>Project level rating data will be aggregated across all projects. An average of ratings for cross sectoral coordination within and between countries from PF projects can be used to demonstrate the impact of projects as a group.</td></tr>
<tr><td>Responsible</td><td>Secretariat (for pooling ratings across projects to generate aggregate average ratings), IEs (for including ratings and descriptive justifications in the annual report)</td></tr>
</table>

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

**Pandemic Fund Results Framework Indicator Reference Sheets**

Element 3: Incentivizing additional investments in PPR

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

| | |
|---|---|
| **Element 3:** Incentivizing additional investments in PPR | |
| **Indicator 3a**: Value of additional financial resources that are secured from stakeholders to support PF projects, including domestic, private and/or philanthropic financing, or as co-financing from IEs | |
| **Rationale/description** | The PF should bring additional in financial resources for pandemic PPR and incentivize countries to invest more in pandemic PPR. This indicator captures the value of additional funds (beyond those provided by the PF) that were successfully secured to support the PF project. |
| **Definitions** | Additional funds – funds used to support the activities in the PF proposal or added after proposal development (beyond those funds provided by the PF) that were secured by the country or implementing partner. These are new funds, not funds redirected from other health work. These funds could include (but aren't limited to) new funds from private or philanthropic partners, co-investment from an IE, or provision of new domestic funds. |
| **Data source** | Project annual report |
| **Data Collection Methods** | The annual report for each project should contain a section dedicated to capturing the value of additional funds recruited including the period of time that those funds will be available (i.e., one year, two years, indefinitely, etc.). |
| **Data Type** | Quantitative |
| **Analysis** | This data (collected by project, by country) will be consolidated to articulate the total value of additional funds that have been secured to support PF projects. This will help articulate the PF's significance in catalyzing investment in pandemic PPR. |
| **Responsible** | IEs and countries (responsible for working together to provide this information by country and project in the annual report) and Secretariat (for data consolidation and analysis) |

| |
|---|
| **Indicator 3b:** Proportion of funding from PF that is used to complement/strengthen existing health security capacity building projects, including but not limited to those funded by domestic resources, other existing development funds, other partners' global health security/PPR funds, and philanthropic or other private sector PPR funds |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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|---|---|
| **Rationale/description** | The PF should serve as an integrator rather than become a new silo that furthers fragmentation in pandemic PPR efforts. PF projects should address gaps in PPR, align with/be informed by country priorities, and complement other health security/PPR efforts ongoing in the country. This indicator captures the extent to which PF funds complement ongoing work in the country. |
| **Definitions** | Complement/strengthen – activities are considered 'complementary to' or 'strengthening' existing work in the country if they support progress toward the objectives of that work, or use the existing work/capacities built and advance it further/augment it. |
| **Data source** | Project annual report |
| **Data Collection Methods** | The annual report should contain a template that allows IEs to indicate what percentage of the PF's project budget was directed toward efforts that are complementary to/build upon existing/ongoing work in the country. The template should include fields for value/percentage of funds (of the total project budget) and a description of the existing/ongoing work that is being complemented/built upon. |
| **Data Type** | Mixed – qualitative/quantitative |
| **Analysis** | The data collected for this indicator will be summarized across projects to articulate the total value of resources that have been complemented/built upon by the PF as a method of articulating the responsiveness of the fund to existing/ongoing work in each country and globally. The PF may use this data to identify types of activities that are well supported by PF funds. |
| **Responsible** | IEs (for provision of data in the annual report, and coordination with other IEs, stakeholders, and the country if necessary) and the Secretariat (for consolidation and analysis of the data from the annual report) |

| **Indicator 3c**: Extent to which the capacities built by PF projects are sustained following completion of the project | |
|---|---|
| **Rationale/description** | The PF should have a lasting impact on country capacity after the project has ended. Therefore, the PF should build capacity that can be sustained by the country or other stakeholders in some fashion following the conclusion of the PF proposal. This includes both the financial and technical resources needed to sustain the capacity developed. This indicator will help demonstrate that sustainment of capacity has been addressed in advance of the end of the PF project. |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

<table>
<tr><td></td><td></td></tr>
<tr><td>Data source</td><td>Project final report</td></tr>
<tr><td>Data Collection Methods</td><td>The final report should contain a rating of the level of sustainment of the capacity/ies developed by the PF project at the time the project concludes. The rating should include text that justifies the rating.</td></tr>
<tr><td>Data Type</td><td>Quantitative/qualitative<br><br>The rating system below will be used to describe the status of sustainability of the capacity/ies developed by the PF project at the conclusion of the project.<br><br>
<table>
<tr><th>Level</th><th>Description</th></tr>
<tr><td>1 – No sustainment</td><td>• There is no plan in place for sustainment of capacity either technical or financial</td></tr>
<tr><td>2 – Options identified for sustainment</td><td>• The country and IE have identified potential options for the financial and technical resources needed to sustain the capacity/ies developed by the PF project (these can be domestic or external)</td></tr>
<tr><td>3 – Sustainment achieved</td><td>• The country and IE secured any financial and technical resources needed to sustain the capacity/ies developed by the PF project for at least one year following conclusion of the project</td></tr>
</table>
</td></tr>
<tr><td>Analysis</td><td>Ratings collected across projects will be aggregated and averaged to articulate the overall sustainability of the capacity/ies developed through PF projects.</td></tr>
<tr><td>Responsible</td><td>IE (for supplying the rating of sustainment and narrative justification) and the Secretariat (for consolidation of the data)</td></tr>
</table>

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

**Pandemic Fund Results Framework Indicator Reference Sheets**

Element 4: Ensuring administrative/operational efficiency of PF resources

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

| | |
|---|---|
| **Element 4:** Ensuring administrative/operational efficiency of PF resources | |
| **Indicator 4a**: PF grant amount disbursed for projects as a proportion of total PF grant amount committed to IEs | |
| **Rationale/description** | This indicator assesses the amount of the funds received from donors with the amount that has been dispersed to grantees in order to measure the efficiency with which the PF is managing its grants. |
| **Definitions**[1] | Grants: transfers made in cash, good or services for which no repayment is required. |
| **Data source** | Trustee |
| **Data Collection Methods** | Annual financial reports from Trustee |
| **Data Type** | Quantitative |
| **Analysis** | Total funds dispersed will be divided by the total funds received from donors by fiscal year. |
| **Responsible** | Secretariat |

| | |
|---|---|
| **Indicator 4b**: Time for IEs to fully disburse PF grants committed to them | |
| **Rationale/description** | This indicator tracks how quickly IEs utilize funds for a given project to ensure activities are undertaken in a reasonable amount of time and are not held up by avoidable delays. This is important to (1) build trust amongst co-investor countries that PF resources are a reliable source of PPR funding, and (2) ensure timely reporting of results to the Board and broader PPR community. |
| **Definitions**[2] | Disbursement: the transaction of providing financial resources, in this case from the IEs to any partners for implementation. |
| **Data source** | IE financial reports |

[1] https://stats.oecd.org/glossary/detail.asp?ID=1143
[2] https://stats.oecd.org/glossary/detail.asp?ID=3798

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

| | |
|---|---|
| **Data Collection Methods** | Project annual report – financial section, project timeline/critical path descriptions. |
| **Data Type** | Quantitative |
| **Analysis** | Total funds disbursed will be divided by the total funds received by fiscal year. |
| **Responsible** | Secretariat (for aggregating the data) and IEs (for providing financial data in annual report) |

| | |
|---|---|
| **Indicator 4c:** Of the total amount of PF grants committed to IEs, proportion used by IEs for administrative costs including project preparation, implementation, and supervision | |
| **Rationale/description** | This indicator tracks the administration costs incurred for preparing, implementing, and supervising a given project as compared to the amount of resources provided by the PF for said project. Each IE has a standard fee for project administration, which should be kept as low as possible. A lower proportion of funds being directed towards project administration would suggest an efficient use of funds by IE. |
| **Definitions** | Administration costs**:** Costs the implementing organization incurs that are not directly tied to specific project activities. Administrative costs include (but aren't limited to) salaries, rent, utilities. |
| **Data source** | Implementing Entities |
| **Data Collection Methods** | Project annual report: financial section |
| **Data Type** | Quantitative |
| **Analysis** | Total administrative expenditures divided by the total grant expenditures by fiscal year. |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

| | |
|---|---|
| **Responsible** | Secretariat (for aggregating the data) and IEs (for providing financial data in annual report) |

| **Indicator 4d**: Funds utilized for project-level M&E as a proportion of project funds initially allocated for M&E | |
|---|---|
| **Rationale/description** | Monitoring and evaluation (M&E) integral components of the project/program life cycle and contribute to learning, accountability, and program improvement. Monitoring assesses stakeholders' understanding of the project as well as implementation progress, helping to minimize the risk of project failure. Evaluation determines the degree to which program objectives have been achieved, the problems associated with program planning and implementation; contributes to better program design and management; and enables improved impact assessment. Despite the integral nature of M&E, it is often the first budget line to be decreased or cut when project implementation costs increase. |
| **Definitions**[3] | Monitoring: a continuous process of collecting and analyzing information to better understand how well a program is operating against expected outputs.<br>Evaluation: an objective assessment of program relevance, effectiveness, efficiency, sustainability and impact; uses specialized methods to determine whether a program meets its objectives, to estimate its net results or impact, and/or to identify whether the benefits the program generates outweigh its costs. |
| **Data source** | Implementing Entities |
| **Data Collection Methods** | 1) Annual project reports<br>2) End of project evaluation reports |
| **Data Type** | Quantitative |
| **Analysis** | Total M&E expenditures divided by the total M&E budget by fiscal year. |
| **Responsible** | Secretariat (for aggregating the data) and IEs (for providing financial data in annual report) |

[3] http://web.worldbank.org/archive/website01506/WEB/IMAGES/10_ME.PDF

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

| Indicator 4e: Gender equality incorporated in activities implemented through the proposals | |
|---|---|
| **Rationale/description**[4] | Disease outbreaks and pandemics affect women and men differently, and tend to worsen existing gender inequalities, sexual and gender-based violence, and discrimination due to increased tensions in the household, economic stress, including unpaid care work, and disruption or collapse of systems and structures that protect women and girls. Girls and women are often in vulnerable situations, but they continue to hold positions to provide care, services and leadership in their communities. For example, 70% of healthcare workers are women, and women and girls also dominate the social and service sectors globally. This can result in high exposure to viruses and limited access to critical diagnostics, therapeutics, vaccines, and other health interventions. |
| **Definitions** | Gender: refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviors and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time.<br><br>Gender Equality: gender equality means that women and men enjoy the same status and have equal opportunity to realize their full human rights and potential to contribute to national, political, economic, social and cultural development, and to benefit from the results. The concept of equality acknowledges that women and men may sometimes require different treatment to achieve similar results, due to different life conditions or to compensate for past discrimination. |
| **Data source** | Implementing Entities |
| **Data Collection Methods** | Project proposals, project reports<br><br>Answers the following questions:<br>• Who is the target (both direct and indirect) of the proposed policy, program or project? Who will benefit? Who will lose?<br>• Have women been consulted on the 'problem' the intervention is to solve? How have they been involved in development of the 'solution'?<br>• Does the intervention challenge the existing gender division of labor, tasks, responsibilities and opportunities? |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

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|---|---|
| | • What is the best way to build on (and strengthen) the government's commitment to the advancement of women?<br>• What is the relationship between the intervention and other actions and organizations — national, regional or international?<br>• Where do opportunities for change or entry points exist? And how can they best be used?<br>• What specific ways can be proposed for encouraging and enabling women to participate in the policy/program/project, despite their traditionally more domestic location and subordinate position?<br>• What is the long-term impact in regard to women's increased ability to take charge of their own lives, and to take collective action to solve problems? |
| **Data Type** | Qualitative |
| **Analysis** | Projects will be qualitatively assessed using a three-level scale:<br><br>Gender sensitive: gender-sensitive approaches include identifying gender gaps. The actions supported by this approach remain at the level of raising people's awareness of gender issues and gender inequalities without questioning and transforming social norms.<br><br>Gender responsive: interventions are developed with the consideration of gender norms, roles and inequalities with measures taken to actively address them; through gender-responsive programing, gender gaps in decision-making, access, control, and rights can be reduced.<br><br>Gender transformative: interventions go beyond gender responsiveness; they aim to transform unequal gender relations to promote shared power, control of resources, decision making, and support for the empowerment of women and girls. |
| **Responsible** | Secretariat |

[4] Make it the Last Pandemic; WHO Gender and Health; Gender Equality Glossary (unwomen.org); Feminist International Assistance Gender Equality - Toolkit for Projects; Policy Brief: The Impact of COVID-19 on Women;

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

| Indicator 4f: Extent to which PF-funded activities advance health equity across underserved populations. | |
|---|---|
| **Rationale/description**[5] | Disease outbreaks and pandemics affect groups of people differently based on demographics, socioeconomic status, and geographics. Often, disease outbreaks worsen the existing inequities within a population through disruption or collapse of systems and structures that protect underserved people. As a consequence of added economic stress and resource constraints, discrimination in allocation of resources is exacerbated. For example, limited access to critical diagnostics, therapeutics, vaccines, and other health interventions can result in high exposure to viruses. During the COVID-19 pandemic, the world witnessed the most suffering endured by groups of underserved people. |
| **Definitions** | Health equity: health equity is the absence of unfair, avoidable and remediable differences in health status among groups of people based on geographic location, rurality, economic status or social standing. Health equity is achieved when everyone can attain their full potential for health and well-being. Allocation of resources. For the Pandemic Fund, we define equity as, communities that are underserved.<br><br>Underserved population: underserved relates to limited access to services that are accessible, acceptable, and affordable, including healthcare. |
| **Data source** | Implementing Entities |
| **Data Collection Methods** | Project proposals, project reports<br>• Answer the question: In what ways has your implementation incorporated equity (as defined)? (500 words or less).<br>• Your description should answer the following questions:<br>  ◦ Describe the specific policy, program, or project that will incorporate communities that are unserved and underserved.<br>  ◦ Describe opportunities for change or entry points that exist. How can they best be used in this policy, program, or project? |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

| | |
|---|---|
| | • Describe the target audience(s) (both direct and indirect) of the proposed policy, program, or project? Who will benefit? Who will lose?<br>• How, if at all, have communities that are normally unserved and underserved been consulted on the 'problem' the intervention is to solve? If yes, how have they been involved in development of the 'solution'?<br>• In what ways does this policy, program, or project challenge the existing inequities of labor, tasks, responsibilities and opportunities between communities that are unserved and underserved, and those who are adequately served?<br>• In what ways does this policy, program, or project build on (and/or strengthen) the government's commitment to the advancement of communities that are unserved and underserved? / or government's commitment to improve health equity<br>• Describe the relationship between the intervention and other actions and organizations working in the health equity space — they can be national, regional or international.<br>• Describe the specific ways the policy, program, or project encourages and enables communities that are unserved and underserved to participate?<br>• In what ways will the policy, program, or project provide long-term impact in regard to unserved and underserved communities' increased ability to take charge of their own lives, and to take collective action to solve problems? |
| **Data Type** | Qualitative |
| **Analysis** | Projects will be qualitatively assessed using a three-level scale:<br><br>1: No evidence provided that IEs PF-funded activities were developed or implemented with health equity and advancing equitable access to capacity as a principle.<br><br>2: Some evidence provided by the IE that the PF-funded activities were developed and implemented with equity and advancing equitable access to capacity as a principle across at least one dimension of equity.<br><br>3: Significant evidence provided by the IE that the PF-funded activities were developed and implemented with equity and advancing equitable access to capacity as a principle across two or more dimensions of equity. |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

| | |
|---|---|
| **Responsible** | Secretariat |

*Note: The WG requests the Secretariat to collaborate with the Results Framework Working Group in the analysis phase for all indicators.

## Annex 4: Risk Management

### Risks and Mitigation Measures

**Key risks to be assessed in a FIF-supported partnership include: i) strategic risk; ii) operational risk; iii) stakeholder risk; iv) financial risk; v) legal risk; and vi) portfolio risk.** A summary of the initial risk assessment of the proposed FIF across these six dimensions is provided below.

**Strategic risk:** The FIF is well-aligned with the Bank's strategy, objectives and priorities on PPR. The FIF's value proposition for Bank clients is supported by strong diagnostics. The membership of the FIF's Governing Board is familiar with the Bank, other MDBs, WHO, and other key global health actors, and is able to leverage on the comparative advantages of these entities. The Bank's participation in the FIF's Governing Board (in each of its separate and distinct capacities as trustee, secretariat and implementing entity) provide additional opportunities to ensure alignment with Bank strategy, objectives, and priorities.

**Operational risk:** The proposed FIF does not present any known operational risks related to the Bank's ability to carry out its responsibilities as trustee, secretariat and implementing entity, consistent with its operational policies and procedures. The Bank's limited trustee and fiduciary responsibility ends when funds are transferred to implementing entities. The design of the FIF is not expected to impede the Bank's ability to fully and consistently carry out its responsibilities as limited trustee, stipulated in its agreements with FIF partners, within the Bank's policies and procedures.

The risk of operational issues arising from the Bank's secretariat functions is low, given the mandate and functions of FIF secretariats and the Bank's demonstrated capacity and track record in performing this role. Operational risks from the Bank's potential implementing entity role are also likely to be low. As an implementing entity, if the Bank receives funds from the FIF to prepare and implement projects, those projects would be carried out in accordance with the Bank's operational policies and procedures and would build on the Bank's strong track record of regional and country operations aimed at strengthening PPR. Moreover, any FIF financing to the WBG would be as co-financing to Bank operations in established areas of support.

**Stakeholder risk:** This risk relates to how the FIF can potentially impact the Bank's relationships and reputation with partners and public opinion. The FIF has broad support from the international community, including the Bank's major shareholders and beyond, the WHO, other global health agencies, philanthropies and CSOs. It is important to continue to broaden and sustain this support. The Governance Framework and Operations Manual, which clarify roles and responsibilities of involved parties, is public. The Bank, as secretariat, will prepare and implement a communications strategy and will participate actively in the FIF's Governing Board in its various capacities.

**Financial risk**: There are no known financial risks associated with this FIF, given the Bank's strong capacity and track record in serving as limited Trustee for FIFs, coupled with the simple financial structure of this FIF (grants in/grants out). The FIF is an off-balance sheet vehicle with no potential impacts on the balance sheets of IBRD or he International Development Association (IDA) or their perceived standing in financial markets. Furthermore, the Bank will recover costs in line with its current cost recovery policy.

**Legal risk:** Legal and governance documents to establish the FIF will be negotiated by the Bank's Legal team such that they do not contain any provisions that could lead to an erosion or loss of privileges and immunities by explicitly or implicitly agreeing to, among others, the application of national law on Bank activity, jurisdiction of local courts over the Bank, contractual or third-party claims against the Bank, or Bank obligation to perform activities that are or may be perceived as outside the Bank's mandate.

**Portfolio risk:** This FIF has a clear mandate and objectives, and play a complementarity role within the larger global health financing architecture. With respect to IDA and IBRD, the FIF is expected to play a complementary role by co-financing IDA and IBRD operations or fill gaps, as needed. The FIF could compete with other trust funds, IDA, etc., resulting in fundraising competition. It may be noted in this context that one of the key principles underpinning this FIF is additionality, i.e., it will seek to mobilize additional resources, including from non-ODA sources. The FIF has already mobilized a commitment from a philanthropic institution, and other philanthropies have signaled serious interest. Furthermore, the Bank can play an active role in mitigating portfolio risk, through its involvement in shaping and designing the FIF, and participation in the FIF's Governing Boa

**PROPOSED TRUSTEE & SECRETARIAT BUDGET FOR FISCAL YEAR 2024**

**July 7, 2023**

## A. OBJECTIVE

This document presents a retrospective analysis of the administrative expenses of the World Bank serving as both Trustee and the Secretariat of the Pandemic Fund over the current fiscal year, FY23 and, for the approval of the Governing Board, the estimated administrative expenses for the coming fiscal year, FY24 (July 1, 2023 – June 30, 2024).

## B. TRUSTEE BUDGET

### I. Background and Overview:

According to the Pandemic Fund Governance Document, the Trustee is required to submit a budget estimate to the Governing Board for approval on an annual basis. The Trustee will present, for Governing Board approval, an estimated budget at the start of each fiscal year, and any adjustments at the end of each fiscal year should there be changes in FIF activities during the year.

The World Bank, in its capacity as Trustee, provides a range of services for the Pandemic Fund FIF. The Trustee's costs for its services are presented in four categories (i.e., Financial and Program Management, Investment Management, Accounting and Reporting, and Legal Services).

***Trustee Budget for services provided in establishing and setting-up the Pandemic Fund FIF***

Retrospective costs incurred by the Trustee in establishing and setting-up the Pandemic Fund FIF are expected to stay within the approved budget.

***Trustee Budget from July 1, 2023, to June 30, 2024 (FY24)***

The Pandemic Fund FIF proposed FY24 Trustee budget estimates are presented based on standardized Trustee services provided under the following components:

- **Financial and program management** fee covers services related to management and execution of financial transactions, including receiving and processing of contributions, recording allocations and commitments, processing cash transfers to Implementing Entities using World Bank financial systems and procedures, and financial reporting for the Pandemic Fund. It also includes collaboration with the Pandemic Fund Governing Board and Secretariat, responding to day-to-day enquiries from the Secretariat, Contributors and other Pandemic Fund constituencies and stakeholders, and ad hoc advisory services to the Secretariat on specific issues, as requested.

- **Investment management** fees are calculated as a flat fee of 4.5 basis points (i.e., 0.045%) of the average annual balance of the undisbursed cash in the Pandemic Fund FIF. The projected average annual balance over FY24 is estimated at USD 750 million. The actual investment management costs may vary depending on the actual average liquidity level during FY24.

- **Accounting and reporting** fees are based on the management of the accounting model for the Pandemic Fund, clearance of agreements and maintenance of appropriate records, accounts, and systems to support financial reporting.

- **Legal services** include drafting, negotiation and finalizing contribution agreements and amendments with Contributors, financial procedures agreements with Implementing Entities, and other legal agreements as needed. It also covers providing policy advice and legal review on issues raised by the Pandemic Fund Governing Board as they impact the Pandemic Fund FIF and the services of the Trustee. In FY24 legal services costs are expected to decrease due to transitioning to stabilization phase of the Fund.

Table 1 reflects the Trustee's estimated actual costs for FY23, including the retrospective costs for establishing and setting up the Pandemic Fund FIF, as well as the Proposed budget for FY24. The Proposed budget for FY24 assumes that the level of trustee activities and cost remains same as FY23, with the exception of investment management fees and legal services costs.

**Table 1: Pandemic Fund Trustee Estimated Actual Costs for FY23 and FY24 proposed budget (in USD)**

| | Approved Budget FY23 | Estimated Actuals FY23 | Proposed Budget FY24 |
|---|---|---|---|
| **Retrospective Costs** | | | |
| Donor and Stakeholder Consultations | 149,000 | 149,000 | - |
| FIF Set-up and Establishment | 291,000 | 291,000 | - |
| *- WB management review and guidance* | *159,000* | *159,000* | - |
| *- Legal counsel, including drafting of legal documentation* | *105,000* | *105,000* | - |
| *- IT systems establishment* | *27,000* | *27,000* | - |
| ***Sub-total*** | ***440,000*** | ***440,000*** | - |
| **Standardized Services** | | | |
| Financial and Program Management | 384,000 | 384,000 | 384,000 |
| Investment Management | 203,000 | 213,000 | 339,000 |
| Accounting and Reporting | 64,000 | 64,000 | 64,000 |
| Legal Services | 180,000 | 140,000 | 100,000 |
| ***Sub-total*** | ***831,000*** | ***801,000*** | ***887,000*** |
| **Total** | **1,271,000** | **1,241,000** | **887,000** |

**The FY23 total estimated actual costs** incurred by the Trustee for its provision of services to the Pandemic Fund are lower than the FY23 total approved budget by USD 30,000 due to decrease in

Legal fees, partially offset by a slight increase in the investment management fee. The investment management fees for FY23 were calculated based on an average annual cash balance of USD 450 million; however, the actual average cash balance over FY23 was USD 473 million. The actual costs for financial and program management, accounting, and reporting in FY23 were in line with expectations.

### II. Recommended Decision:

The Governing Board approves the proposed FY24 Trustee budget of USD 887,000 for the period of July 1, 2023, to June 30, 2024.

## C. SECRETARIAT ADMINISTRATIVE BUDGET

### I. Background:

In accordance with the Pandemic Fund's governance documents, the Secretariat is required to submit a budget estimate to the Governing Board for approval on an annual basis. The Secretariat will present, for Governing Board approval, an estimated budget at the start of each fiscal year, and any adjustments at the end of each fiscal year should there be changes in FIF activities during the year.

### II. Retrospective FY23 Budget Analysis:

The Secretariat's FY23 Budget, which was approved by the Board in September 2022, covered six interconnected categories: i) Overall management and coordination; ii) Operations and portfolio management; iii) Communications and Advocacy; iv) TAP Support; v) Governance / Legal work; and vi) Travel. Table 2 below shows a breakdown of projected costs against actual expenses incurred in each of these categories.

**Table 2: Pandemic Fund Secretariat FY23 Proposed Budget versus Actual Estimated Expenditures**

| Secretariat Services | FY23 Proposed Budget | FY23 Actual Spend |
|---|---|---|
| Retrospective Costs (July 1, 2022 - September 8, 2022) | | |
| Administrative Support | 700 | 700 |
| *Staff cross support to Interim Secretariat* | *700* | *700* |
| Preparation of documents, outreach, communications and meetings | 48,930 | 48,930 |
| Interim Secretariat travel | 7,815 | 7,815 |
| ***Sub-total*** | ***57,445*** | ***57,445*** |
| **Secretariat Services** | **FY23 Proposed Budget** | **FY23 Actual Spend** |
| Estimated Costs (September 9, 2022 - June 30, 2023) | | |
| Overall Management and Coordination | 981,500 | 991,979 |
| *Staff and consultant costs* | *741,500* | *735,347* |
| *Convening Board meetings, Board travel* | *240,000* | *256,632* |
| Operations and Portfolio Management [staff and consultants] | 450,500 | 544,076 |
| Communications and advocacy | 535,055 | 322,458 |
| *Staff and consultant costs for core work* | *330,000* | *201,387* |
| *Creative consultants, website redesign & maintenance, brand identity* | *134,855* | *35,000* |
| *FIF Launch event and other events* | *70,200* | *86,071* |
| TAP Support | 1,435,500 | 893,428 |
| *Staff and consultant costs* | *1,195,500* | *658,585* |
| *Convening TAP meetings, TAP member travel* | *240,000* | *234,843* |
| Governance/legal work [staff and consultants] | 240,000 | 176,181 |
| Staff Travel | 125,000 | 100,000 |
| ***Sub-total*** | ***3,767,555*** | ***3,028,121*** |
| Total | 3,825,000 | 3,085,566 |

- During FY23, *Overall Management and Coordination* entailed ensuring the timely delivery of high-quality outputs to support Governing Board meetings and decision-making, including, but not limited to, the first Call for Proposals and the establishment of the TAP; managing Board and stakeholder relations and building strategic cooperation among the Pandemic Fund partners/stakeholders; high-level coordination with the Trustee and Implementing Entities; ensuring regular interface with the G20; and advocating for the Pandemic Fund and the broader PPR agenda. These functions were led by the Executive Head, with support and inputs from team members. Expenses in this category comprised staff costs (direct and indirect), including those of the Executive Head and the estimated time of other team members to support the Executive Head, consultants (until such time as staff were brought on board), as well as the expenses associated with convening six virtual Board meetings, several optional virtual sessions, and an in-person Board retreat. Total expenses under this category were broadly in line with the budgeted amount.

- *Operations and Portfolio Management* covered staff and consultants' costs related to the Expressions of Interest and first Call for Proposals. For the EOI, Secretariat staff developed the template and associated materials, conducted several dedicated information sessions for prospective applicants, and carried out an extensive review of more than 650 EoIs, working

with applicants and the IEs to identify synergies and opportunities for consolidation. For the design and development of the first Call for Proposals, the Secretariat convened and facilitated working groups, prepared the template and associated materials, engaged intensively with a large number of prospective applicants to provide guidance on the Fund's processes and requirements and establish a feedback loop between the Secretariat and applicants, carried out technical level coordination with IEs, screened all 179 submitted proposals for eligibility, many of which involved going back to applicants for additional information, analyzed the data for presentation to the Board, and supported the TAP by seeking additional information from applicants to fill gaps. A consulting firm was hired to develop a purpose-built electronic portal/dashboard for proposal submission and review, with oversight from the Secretariat. Expenses under this category were slightly higher than projected, owing mainly to the costs associated with the development, maintenance, and support of the portal.

- *Communications and Advocacy:* FY23 included the delivery of high-level events to raise awareness around the Pandemic Fund and to hear from partners and stakeholders, including G20 launch event in Bali in November 2022, a high-level side event during the IMF-World Bank Spring Meetings in Washington, D.C. in April 2023, and a ministerial roundtable on the margins of the World Health Assembly in Geneva in May 2023. Other outputs delivered included developing the Pandemic Fund's branding, maintaining the website (hosted on the World Bank's platform) as well as a new Twitter account, media monitoring, press releases etc. Total expenses under this category were lower than the budgeted amount, mainly because the Senior Communications Officer came on board only towards the end of FY23, Q3 (as opposed to Q2, as originally been projected). In the interim, the Secretariat drew on the services of a short-term consultant with support from the World Bank's central communications team.

- *TAP Support:* The TAP was established and became operational by January 2023. The Secretariat prepared the TAP's ToRs, which were approved by the Board in October. Following this, an open call was issued to solicit applications from experts from which over 300 applications were received. Under the leadership of the TAP Chair and Vice-Chair, and with the Secretariat's support in filtering and organizing the applications, a Board committee worked to assemble a Panel of 20 experts to serve on the TAP. The Secretariat then brought the TAP Experts on board by issuing individual contracts with each expert and provided briefing sessions to the TAP. Further, the Secretariat supported the TAP with the preparation of the evaluation and scoring criteria for the first Call for Proposals, organized the TAP Retreat, and provided dedicated training to TAP experts on using the online platform to evaluate proposals. Total expenses under this category were lower than projected mainly because the two senior WHO secondees to the Secretariat, whose salaries were included in the projected budget numbers, have yet to transfer formally to the Secretariat, given administrative delays in finalizing the agreement. Therefore, their salaries have not been included in the actual expenses for FY23 under this category.

- *Governance and Legal Support:* A Conflict-of-Interest Framework was developed and approved by the Board in March 2023. The Framework was drafted by a senior legal consultant, with support and oversight from the Secretariat, which also facilitated several

rounds of consultations with Board members. A draft Accreditation Framework for accrediting new Implementing Entities was also developed with the help of consultants, and with support and oversight from the Secretariat; the Framework is expected to be finalized shortly. Total expenses under this category were slightly lower than the projected amount, mainly due to the fact that, instead of recruiting an in-house Senior legal advisor, as originally proposed, the Secretariat drew on the services of consultants.

- Expenditures related to *staff travel* were broadly in-line with the proposed costs tabled in the original budget.

Overall, the actual spend in FY23 amounted to USD 3.09 million, or a 80.7% budget utilization rate. Such budget underruns, driven mainly by delays in bringing staff on board for certain workstreams, are not unusual for start-ups in their early stages. However, delivering on the substantial work program for FY24 will require significantly augmenting the Secretariat's capacity along with the associated budget, as described below.

## III. Estimated FY24 Budget:

In accordance with the Governance Framework, the Secretariat has been tasked with a number of roles and responsibilities, including, *inter alia*: supporting Governing Board meetings and decision-making; updating Governance documents; developing Calls for Proposals, screening proposals and supporting the Governing Board in allocation decisions; convening the TAP and supporting its work; reviewing and compiling progress reports based on information from Implementing Entities (IEs) for distribution to the Governing Board, as well as portfolio monitoring and evaluation and commissioning as well as overseeing reviews / evaluations at the request of the Governing Board; relationship management, strategic outreach, communications and broader advocacy designed to promote and advance the interests of the Fund; and supporting the Governing Board in any future resource mobilization efforts, to name a few.

The Secretariat was initially established with an Executive Head and eight specialized staff / consultants (including two secondees from the WHO). The anticipated expansion of the Secretariat's FY24 work program (see attached) will require deepening and building on existing capacity, as well as creating capacity/bringing in new skills to deliver on some new workstreams, such as monitoring, evaluation and reporting related to grant performance, as funds begin to be disbursed to projects under the first Call and supporting the Governing Board on resource mobilization. Specifically, this includes bringing in five additional staff, as follows:

1. A Deputy Secretariat Head/Advisor who will support the Executive Head of Secretariat with overall management and oversight of the Secretariat, including, inter alia:
    - Building up the Secretariat team to support demonstrable results and impact, effectively and efficiently, through staff recruitment, training, and mentoring;
    - Ensuring appropriate internal controls and compliance with policies and procedures, including with respect to the World Bank's fiduciary and safeguard

policies and guidelines, and providing quality control of documents prepared by the Secretariat for submission to the Board;
    - Providing oversight of program and portfolio management;
    - Oversight of various third-party evaluations.
2. Two Senior Partnerships Officers to assist with relationship building and resource mobilization efforts which are expected to move forward over the coming fiscal year; as a first step, their task will be to develop a detailed concept note on resource mobilization options and a proposed approach.
3. One Senior Strategy & Operations Officer to support the workstream on the strategic plan and lead efforts towards the preparation of various Board papers and deliverables.
4. One Monitoring & Evaluation Specialist to lead the Secretariat's work in monitoring and evaluation of projects financed by the Pandemic Fund, overall portfolio monitoring and reporting, updating the Results Framework, etc.

The Secretariat's FY24 budget covers the following categories: i) Overall Management & Coordination; ii) Governance; iii) Stocktaking & Strategic Planning; iv) Calls for Proposals; v) Program Management, Portfolio Monitoring & Evaluation and IE Accreditation; vi) TAP; and vii) Communications & Advocacy; viii) Partnerships; and ix) staff travel. The baseline (core) budget presented in this paper is related to the delivery of critical, time sensitive activities. In response to the Board's feedback on the FY24 budget paper circulated on June 16, 2023, costs related to the engagement of consultants for Resource Mobilization have been removed from the baseline (core) budget, subject to further deliberations by the Board on this topic; the Secretariat will prepare a concept note and supplementary budget request on this for the Board's approval later in the fiscal year.

Table 3 below presents the baseline (core) budget based on the Secretariat's best estimates of costs and expenses, on a full cost-recovery basis for the period July 1, 2023 to June 30, 2024.

1. **Overall Management & Coordination:** This category includes costs related to the overall management and coordination of the Secretariat's work, to ensure the timely delivery of high-quality results. It includes, but is not limited to: support for Governing Board meetings and decision-making; the Calls for Proposals process; the Technical Advisory Panel (TAP); oversight and quality assurance of various reports, reviews/evaluations (including the stocktaking review, strategy paper, resource mobilization strategy etc.); managing Board and stakeholder relations and building strategic cooperation among Pandemic Fund partners/stakeholders; high-level coordination with the Trustee and Implementing Entities; ensuring regular interface with the G20; and advocating for the Pandemic Fund and the broader PPR agenda. Overall management and coordination will continue to be led by the Executive Head, with support from a Deputy Head, the Program Assistant and other team members. The estimated costs in this category include staff costs, including those of the Executive Head, Deputy Head (to be recruited), other Secretariat staff, and short-term consultants (STCs), as needed, until such time as new staff are brought on board.

2. **Governance:** This category includes: i) staff/STC costs (a senior legal advisor/consultant will provide support on the implementation of the Conflicts of Interest Framework and associated Board Committees); preparation of an Options Paper for a Board Standing Committee; constituency building and other support to the Board, including on meetings and Retreats; updating governance documents; ii) costs related to Board meetings (one in-person meeting, one in-person Retreat, and two to three virtual or hybrid meetings), including logistics as well as travel and accommodation for Board members who require such support for in-person meetings.

3. **Stocktaking & Strategic Planning:** This category includes: i) staff/STC costs related to the preparation of the ToRs and RFP for the selection of a consulting firm to undertake the Board-mandated independent Stocktaking Review and provide inputs to the Strategic Plan, which has been requested by the Board, and oversight of these activities; and ii) costs of engaging a consulting firm to carry out these tasks. As described in the paper on this topic circulated to the Board on June 26, 2023, the consulting firm's primary task will be to undertake the Stocktaking Review, for completion before October 2023; at the same time, the firm will provide inputs to the Strategic Plan.

4. **Calls for Proposals:** This category includes: i) staff/STCs to carry out the remaining work related to the first Call for Proposals, including the preparation of scenarios and related analysis for the Board's allocation decision, as well as developing the second Call for Proposals, and associated tasks; the line item on staff/STC costs builds in surge capacity for STCs to help with proposal screening; and ii) IT costs related to the second Call for Proposals, which is expected to require continued technical support from the third-party platform provider, including reconfiguration and improvement of the electronic application portal.

5. **Program Management, Portfolio Monitoring & Evaluation, and IE Accreditation:** This category includes: i) staff/STC costs related to program management, as Pandemic Fund grants begin to be disbursed; portfolio monitoring and results reporting on projects supported under the first Call, including aligning results indicators with the IE reporting form, in consultation with IEs; and updating the Results Framework, to be carried out by the new M&E Specialist, oce recruited, with inputs from other staff, and from STCs, as needed, in the interim; ii) implementation of the IE Accreditation Framework. Given the strong interest amongst IEs in being accredited, the Pandemic Fund expects to receive several applications this year that will need to be reviewed. This task will involve the formation of an external panel of 3 – 5 senior experts who will review each of the interested entities for suitability to serve as IEs.

6. **TAP:** This category includes: i) staff/STC costs related to the technical, operational, logistical, and administrative support for the TAP provided by the Secretariat, including the two WHO secondees who will be aided by a dedicated Assistant/consultant providing administrative and logistical support, and STCs to provide surge capacity around the TAP Retreat related to the second Call for Proposals; ii) honoraria for TAP Experts to cover their work towards reviewing and evaluating proposals under the second Call; iii) logistical costs associated with one TAP Retreat, including charges for hospitality services, AV support, room rentals, and catering; iv)

costs related to the participation of 20 TAP Experts in a TAP Retreat, including the costs of their flights, accommodation and a *per diem*; and v) costs associated with the engagement of a specialized consulting firm to undertake an independent, third party evaluation of the TAP's performance to be completed by October 2023, as required by the TAP ToRs.

7. **Communications and Advocacy:** This category includes: i) staff/STC costs related to a suite of functions pertaining to promoting the efforts and activities of the Fund, such as managing the social media platform, media monitoring and engagement, and keeping the website updated, to be carried out by the Senior External Affairs Officer, with support from other Secretariat staff and consultants, as needed; ii) IT costs related to the development of a new website; iii) delivery of five external events; and iv) miscellaneous expenditures associated with the printing, and design of publications to promote the Fund.

8. **Partnerships:** This category comprises costs related to the Pandemic Fund's development of strategic partnerships, designed to lay the groundwork for resource mobilization. It is proposed that two Partnership Specialists be recruited to support these efforts; their first task would be to prepare a detailed concept note laying out an approach/possible options for resource mobilization for the Board's deliberation and approval. A budget to develop and implement the resource mobilization strategy will be tabled at a future Board Meeting through the submission of a supplementary budget.

**9.** **Staff travel:** These costs, which include staff travel to attend off-site Board meetings, outreach events, field visits for project oversight/M&E, etc., are presented as a separate line item.

## Table 3: Pandemic Fund Estimated Secretariat Budget for FY24 (in USD)

| Estimated Costs (July 1, 2023 - June 30, 2024) | |
|---|---|
| **Overall management and coordination** | **1,029,822** |
| Staff/STCs* | *1,029,822* |
| **Governance** | **1,155,007** |
| Staff/STCs* | *569,407* |
| Board meetings [1] | *219,600* |
| Board Members' Travel [2] | *366,000* |
| **Stocktaking and Strategic Planning** | **1,071,698** |
| Staff/STCs* | *461,698* |
| Third party consulting firm [3] | *610,000* |
| **Calls for Proposals** | **1,027,414** |
| Staff/STCs* | *529,654* |
| IT costs for electronic application portal reconfiguration, development etc. | *497,760* |
| **Program Management, Portfolio M&E and IE Accreditation** | **619,552** |
| Staff/STCs* [4] | *319,552* |
| IE Accreditation Panel [5] | *300,000* |
| **TAP** | **1,924,528** |
| Staff/STCs* | *968,565* |
| TAP experts' honorarium [6] | *318,940* |
| TAP meeting | *50,630* |
| Travel [7] | *220,393* |
| Third party evaluation of the TAP [8] | *366,000* |
| **Communications and Advocacy** | **952,764** |
| Staff/STCs* | *597,704* |
| Website development & management | *83,000* |
| Events [9] | *247,660* |
| Misc. (printing, publications etc.) | *24,440* |
| **Partnerships** | **333,002** |
| Staff/STCs* | *333,002* |
| **Secretariat staff travel** [10] | **195,200** |
| **TOTAL** | **8,308,987** |

*Notes:*

**STC costs in these line items relate to STCs who will fill in for staff as they are hired or provide surge capacity for Secretariat functions at certain times.*

1. This assumes two in-person meetings (one Board meetings and one Board Retreat) and two to three virtual or hybrid meetings. Costs include interpretation and logistical costs which, for in-person meetings, include the venue and event management costs; 2. Includes flights and accommodation for Board members requiring the Secretariat to cover such costs, in line with WBG Travel Policies; 3. Estimate based on prevailing market rates; 4. Excludes consultants who will serve on IE Accreditation Panel; 5. IE Accreditation Panel consultant fees and travel; 6. This covers the honorarium amount for 20 TAP experts and the TAP Vice-Chair; 7. Includes travel and accommodation costs, in line with WBG Travel Policies, for 20 experts plus Vice-Chair, for one in-person retreat with a duration of five days; 8. Estimate based on prevailing market rates; 9. Event management costs for five events; 10. Includes staff travel to attend off-site Board meetings, outreach events, field visits for project oversight/M&E, etc. in line with WBG travel policies.

### IV. Proposed Decision:

The Governing Board approves an estimated budget of core activities for **USD 8,308,987** to cover estimated costs and expenses for the Secretariat services for FY24 for the period from **July 1, 2023 – June 30, 2024**.

## D. NEXT STEPS

Upon Governing Board approval of the FY24 Trustee and Secretariat budgets, the Trustee will transfer the amounts approved from available resources in the PPR Trust Fund.

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# The Pandemic Fund

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## Trustee Update

November 20, 2023

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# STATUS OF CONTRIBUTIONS, RECEIPTS AND RECEIVABLES

| | Contributor | Curr | Signed Contribution Amount in Original Currency | Signed Contribution Amount in USDEq as of Nov 7, 2023 | Amount received (USD) | Amount to be received in the next 3 months (USDEq)* | Additional amount to be received in 2024 (USDEq)* | Additional amount to be received in 2025+ (USDEq)* | Pledges not signed into CAs yet (USDEq) |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Australia | AUD | 50.0 | 32.7 | 6.7 | - | 6.5 | 19.5 | - |
| 2 | B&M Gates Foundation | USD | 15.0 | 15.0 | 15.0 | - | - | - | - |
| 3 | Canada | CAD | 50.0 | 37.0 | 37.0 | - | - | - | - |
| 4 | China | USD | 50.0 | 50.0 | 20.0 | - | 20.0 | 10.0 | - |
| 5 | European Commission | EUR | 427.0 | 464.9 | 247.6 | - | - | 217.3 | - |
| 6 | France | EUR | 50.0 | 54.0 | 21.4 | - | 10.9 | 21.7 | - |
| 7 | Germany | EUR | 119.0 | 121.8 | 121.8 | - | - | - | - |
| 8 | India | USD | 10.0 | 10.0 | 10.0 | - | - | - | - |
| 9 | Indonesia | USD | 50.0 | 50.0 | 9.8 | 0.2 | 10.0 | 30.0 | - |
| 10 | Italy | EUR | 100.0 | 105.6 | 105.6 | - | - | - | - |
| 11 | Japan | USD | 70.0 | 70.0 | 50.0 | - | - | 20.0 | - |
| 12 | Korea | USD | 30.0 | 30.0 | 10.0 | - | 10.0 | 10.0 | - |
| 13 | Netherlands | USD | 10.0 | 10.0 | 10.0 | - | - | - | 10.5 |
| 14 | New Zealand | NZD | 2.0 | 1.3 | 1.3 | - | - | - | - |
| 15 | Norway | NOK | 110.0 | 10.6 | 10.6 | - | - | - | - |
| 16 | Rockefeller Foundation | USD | 10.0 | 10.0 | 5.0 | 1.3 | 1.3 | 2.5 | - |
| 17 | Saudi Arabia | USD | 50.0 | 50.0 | 10.0 | - | 10.0 | 30.0 | - |
| 18 | Singapore | USD | 10.0 | 10.0 | 10.0 | - | - | - | - |
| 19 | South Africa | USD | 2.4 | 2.4 | 2.1 | - | 0.3 | - | 2.60 |
| 20 | Spain | EUR | 20.0 | 21.8 | 10.9 | - | 5.4 | 5.4 | - |
| 21 | Switzerland | CHF | - | - | - | - | - | - | 2.3 |
| 22 | UAE | USD | 20.0 | 20.0 | 20.0 | - | - | - | - |
| 23 | United Kingdom | GBP | 25.0 | 31.0 | 12.3 | - | - | 18.6 | - |
| 24 | United States of America | USD | 450.0 | 450.0 | 450.0 | - | - | - | 250.0 |
| 25 | Wellcome Trust | GBP | 10.0 | 12.1 | 12.1 | - | - | - | - |
| | | | TOTAL | 1,670.21 | 1,209.34 | 1.41 | 74.33 | 385.13 | 265.38 |

** Amounts based on signed contribution agreements, at 11/20/23 FX rates*

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# FUND SUMMARY: INCEPTION → NOV 20, 2023

| | |
|---|---|
| **Donor Pledges and Contributions** | |
| Contributions | 1,670.21 |
| Pledges | 265.38 |
| Total Pledges and Contributions | 1,935.59 |
| **Cumulative Resources** | |
| **Resources received** | |
| Cash Receipts | 1,209.34 |
| Investment Income earned | 44.95 |
| Total Resources Received | 1,254.29 |
| **Resources not yet received** | |
| Contributions not yet paid | 460.87 |
| Pledges | 265.38 |
| Total resources not yet received | 726.25 |
| Total Potential Resources (A) | 1,980.54 |
| **Cumulative Funding Decisions** | |
| Projects | 312.71 |
| IE Fees | 25.69 |
| Administrative Budgets for Secretariat and Trustee | 12.77 |
| Total Funding Decisions Net of Cancellations (B) | 351.16 |
| Total Potential Resources Net of Funding Decisions (A) - (B) | 1,629.38 |
| **Funds Available** | |
| Funds Held in Trust | 1,241.52 |
| Approved Amounts Pending Cash Transfers | 338.39 |
| Unallocated Funds | 903.13 |

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# AVAILABLE RESOURCES IN THE FUND

| Resources | Amount (USD Eq) |
|---|---|
| Currently Available | 903 million |
| Indicative Expected by December 31, 2023 | 905 million |

https://fiftrustee.worldbank.org – ➢ Select a Fund ➢ The Pandemic Fund

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# THE PANDEMIC FUND GOVERNING BOARD
**(Updated as of November 2023)**

## CO-CHAIRS

**Chatib Basri**
Former Minister of Finance, Indonesia

**Sabin Nsanzimana**
Minister of Health, Rwanda

## VOTING MEMBERS

| No. | Member | Principal | Alternate(s) |
|---|---|---|---|
| **Sovereign Contributors (9 seats)** | | | |
| 1 | United States | **John N. Nkengasong**<br>Ambassador-at-Large, U.S. Global Aids Coordinator and Senior Bureau Official for Global Health Security and Diplomacy<br>Bureau of Global Health Security and Diplomacy<br>U.S. Department of State | **Eric O. Meyer**<br>Deputy Assistant Secretary<br>U.S. Department of the Treasury |
| 2 | European Commission | **Martin Seychell**<br>Deputy Director General, Directorate General for International Partnerships | **Roser Domenech Amado**[1]<br>Director of Directorate 'One Health' in DG SANTE |
| 3 | Germany | **Wolfram Morgenroth-Klein**<br>Head of Division, Prevention and Pandemic Preparedness, One Health<br>Federal Ministry for Economic Cooperation and Development (BMZ), Germany | **Alicia Longthorne**<br>Senior Policy Advisor<br>Federal Ministry for Health |
| 4 | Italy | **Francesca Manno**<br>Director, Department of International Finance<br>Ministry of Economy and Finance | **Eleonora Mei**<br>Economic and Financial Analyst<br>Ministry of Economy and Finance |
| 5 | Indonesia-United Arab Emirates-India | **Syarifah Liza Munira**<br>Ministry of Health, Indonesia | **Thuraiya Alhashmi**<br>Ministry of Finance, United Arab Emirates<br><br>**Rajeev Topno**<br>Senior Advisor to the WB Executive Director, India |

[1] Roser Domenach Amado will replace John Ryan as EC Alternate until further notice.

| | | | |
|---|---|---|---|
| 6 | Canada-United Kingdom-Norway | **Kristen Chenier**<br>Director of Policy, Infectious Diseases and Pandemic Preparedness within Global Affairs<br>Health and Nutrition Bureau, Canada | **Kristine Husøy Onarheim**<br>Senior Advisor<br>Norwegian Ministry of Foreign Affairs<br><br>**Niall Fry**<br>Team Leader<br>Foreign, Commonwealth & Development Office, United Kingdom |
| 7 | Japan-Australia-Korea-Singapore[2] | **Daiho Fujii**<br>Deputy Vice Minister for International Affairs<br>Ministry of Finance, Japan | **Fleur Davies**<br>Assistant Secretary, Multilateral Health Branch, Global Health Division<br>Department of Foreign and Trade, Australia<br><br>**Jisung Moon**<br>Deputy Director General, International Finance Bureau,<br>Ministry of Economy and Finance, Korea<br><br>**Derrick Heng**<br>Deputy Director-General of Health, Public Health Group<br>Ministry of Health, Singapore |
| 8 | France-Spain-the Netherlands | **Anne-Claire Amprou**<br>Ambassador for Global Health<br>Ministry of Europe and Foreign Affairs, France | **Blanca Yáñez Minondo**<br>Head of Department for Multilateral Cooperation and European Union<br>Spanish Agency for International Cooperation for Development<br><br>**Johanneke de Hoogh**<br>Head of Section<br>Ministry of Foreign Affairs, The Netherlands |
| 9 | China | **Zhijun Cheng**<br>Director General of the Department of International Economic and Financial Cooperation<br>Ministry of Finance | **Hongxia Li**<br>Deputy Director General, Department of International Economic and Financial Cooperation<br>Ministry of Finance |
| **Non-Sovereign Contributors (1 seat)** | | | |
| 1. | Bill & Melinda Gates | **Kieran Daly**<br>Director, Global Health Agencies and Funds | **Naveen Rao**<br>Vice President, Global Health |

[2] The Principal for this constituency will rotate, with Japan for the first 12 months, followed by Australia and then Korea for six months, each.

| | | | |
|---|---|---|---|
| | Foundation-Rockefeller Foundation-Wellcome Trust | Bill & Melinda Gates Foundation | Rockefeller Foundation |
| **Sovereign Co-Investors (9 seats)** | | | |
| 1. | Bangladesh | **Zahid Maleque**<br>Minister of Health and Family Welfare | **A B M Khurshid Alam**<br>Director General, Directorate General of Health Services<br><br>**Ms. Nargis Khanam**<br>Additional Secretary (Planning), Health Services Division<br>Ministry of Health and Family Welfare |
| 2. | Democratic Republic of Congo | **O'neige Nsele**<br>Deputy Minister of Finance | **Sylvian Yuma Ramazani**<br>Secretary General, Ministry of Public Health, Hygiene and Prevention<br><br>**Christian Diomi Maboti**<br>Alternate Representative, Ministry of Finance |
| 3. | Egypt | **Mai Farid**<br>Assistant Minister & Executive Director, Economic Justice Unit<br>Ministry of Finance | **Mohamed Hassany**<br>Assistant Minister of Health |
| 4. | Guyana | **Frank Anthony**<br>Minister of Health | **Zulfikar Ally**<br>Deputy Chief of Mission, Embassy of Guyana to the United States |
| 5. | Kyrgyz Republic[3] | **Vacant** | **Bakyt Dzhangaziev**<br>Deputy Minister of Health |
| 6. | Pakistan | **Kamran Rehman Khan**<br>Additional Secretary, Ministry of National Health Services, Regulations, and Coordination | **Adil Akbar Khan**<br>Senior Joint Secretary (World Bank), Ministry of Economic Affairs |
| 7. | Philippines | **Benjamin E. Diokno**<br>Secretary of Finance | **Dr. Teodoro J. Herbosa**<br>Secretary of Health<br><br>**Ms. Maria Edita Z. Tan**<br>Undersecretary of Finance |

[3] Names of Principal and Alternate to be confirmed.

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| 8. | Rwanda | **Claude Mambo Muvunyi**<br>Director General, Rwanda Biomedical Center | **Gerald Mugabe**<br>Director General of External Finance, Ministry of Finance and Economic Planning |
| 9. | Senegal | **Mamadou Moustapha Ba**<br>Minister of Finance and Budget | **Marie Khemesse Ngom Ndiaye**<br>Minister of Health & Social Action |
| **Civil Society Organizations (2 seats)** | | | |
| 1. | Global South | **Aida Kurtovic**<br>Executive Director<br>South-Eastern Europe Regional HIV and TB Community Network | **Diah S. Saminarsih**<br>Chief Executive Officer<br>Center for Indonesia's Strategic Development Initiatives (CISDI) |
| 2. | Global North | **Elisha Dunn-Georgiou**<br>President and CEO<br>Global Health Council | **Loretta Wong**<br>Deputy Chief of Global Advocacy and Policy<br>AIDS Healthcare Foundation |

***Saudi Arabia – They have yet to confirm the constituency that they will join.**

| NON-VOTING MEMBERS | |
|---|---|
| **No.** | **Member(s)/Focal Point(s)** |
| **Technical Advisory Panel** | |
| 1. | **Mike Ryan**<br>Executive Director, WHO Health Emergencies Programme<br>TAP Chair<br><br>**Joy St. John**<br>Executive Director, Caribbean Public Health Agency<br>TAP Vice-Chair |
| **G20 Presidency (India)** | |
| 1. | **Shri Lav Agarwal**<br>Additional Secretary<br>Ministry of Health and Family Welfare, India |
| **Country Observers** | |
| 1. | **South Africa**<br>**Anban Pillay**<br>Head of Health Regulation and Compliance<br>National Department of Health |
| 2. | **Switzerland**<br>**Erika Placella**<br>Head of Health<br>Federal Department of Foreign Affairs |
| 3. | **New Zealand**<br>**Rebecca Needham**<br>Senior Policy Officer (Multilateral)<br>Partnerships, Humanitarian and Multilateral Division<br>Ministry of Foreign Affairs & Trade |
| **Implementing Entities** | |
| 1 | **African Development Bank**<br>**Martha Phiri**<br>Director of Human Capital, Youth and Skills Development<br><br>**Patrick Ogwang** |

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| 2 | **Asian Development Bank**<br>**Dinesh Arora**<br>Principal Health Specialist, Sectors Group<br><br>**Bill Parr**<br>Regional COVID-19 Project Implementation Coordinator (Consultant) |
| 3 | **Asian Investment and Infrastructure Bank**<br>**Rodrigo Salvado**<br>Director General, Operational Partnership Department |
| 4 | **European Investment Bank**<br>**Maria Shaw Barragan**<br>Director, Global Partners |
| 5 | **Inter-American Development Bank**<br>**Pablo Ibarrarán**<br>Chief of Social Protection and Health<br><br>**Ramiro Guerrero**<br>Principal Specialist – Social Protection and Health Division |
| 6 | **FAO**<br>**Katrin Taylor**<br>Programme Officer – Partnerships and One Health |
| 7 | **UNICEF**<br>**Douglas James Noble**<br>Associate Director, Public Health Emergencies Preparedness and Response |
| 8 | **WHO**<br>**Scott Pendergast**<br>Director, Health Emergencies Strategy, Programmes and Partnerships |
| 9 | **The World Bank**<br>**Magnus Lindelow**<br>Head of Pandemic PPR and Public Health |
| 10 | **IFC**<br>**Farid Fezoua** |

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| | Global Director, Health and Education |
| 11 | **CEPI**<br>**Neren Rau**<br>Director of Policy |
| 12 | **GAVI The Vaccine Alliance**<br>**Marie-Ange Saraka Yao**<br>Chief Resource Mobilisation & Growth Officer<br><br>**David Kinder**<br>Director of Development Finance |
| 13 | **The Global Fund**<br>**Harley Feldbaum**<br>Head of Strategy and Policy |
| **Other Observers** | |
| 1 | **Africa CDC**<br>**Jean Kaseya**<br>Director General |
| 2 | **WOAH**<br>**Emily Tagliaro**<br>Head, Engagement and Investment Department |
| 3 | **G20 JFHTF**<br>**Serina Ng**<br>Executive Head |
| 4 | **Trustee**<br>**Darius Stangu**<br>Senior Financial Officer |
| 5 | **Legal**<br>**Nneoma Nwogu**<br>Senior Counsel |

## ANNEX 9: QUALITY ASSURANCE CHECKLIST

**Note: Efter aftale med ELK foretages der en intern appraisal, da det blev vurderet tilstrækkeligt i lyset af at bevillingen er til en verdensbank trust fund**

File number/360 reference: 23/32652

Programme/Project name: The Pandemic Prevention, Preparedness and Response Trust Fund (The Pandemic Fund)

Programme/Project period: 2023-2025

Budget: 25 mill. DKK

This Quality Assurance Checklist should be used by the responsible MFA unit to document the quality assurance process of appropriations, where development specialists from either ELK or other units are not involved in the process; i.e.

(i) *internal appraisals* of appropriations up to DKK 10 Million where this checklist constitutes the appraisal.

(ii) *external appraisals* of appropriations between DKK 10 – 43 million and (iii) appraisal in exceptional cases. The checklist aims to help the responsible MFA unit ensure that key questions regarding the quality of the programme/project are asked and that the answers to these questions are properly documented and communicated to the approving authority.

Presentation of quality assurance process:
*The appraisal is an internal appraisal and is based on available documentation received recently from the Pandemic Fund.*

☒ The design of the programme/project has been appraised/appraisal checklist filled out, by someone independent who has not been involved in the development of the programme/project.
*Comments: Yes*

☒The recommendations of the appraisal/comments in the appraisal checklist have been reflected upon in the final design of the programme/project.
*Comments: Yes, comments provided in the document and updated accordingly.*

☒The programme/project complies with Danida policies and Aid Management Guidelines, including the fundamental principles of Doing Development Differently.
*Comments: Yes, though there has been some considerations as to which Guideline should be used, considering that this funding is provision of core-support to the Pandemic Fund. However, ELK has advised that the guidelines to be used are those used for bilateral support.*

☒The programme/project addresses relevant challenges and provides adequate responses.
*Comments: Yes*

☒Issues related to HRBA, LNOB, Gender, Youth, Climate Change, Green Growth and Environment have been addressed sufficiently in relation to content of the project/programme.
*Comments: Gender equality is a cross-cutting theme reflected in the Result Framework however, the mentioned cross-cutting issues should be integrated in the proposals developed by the implementing entities. A point for continues monitoring as we engage with the Pandemic Fund in the future.*

☒Comments from the Danida Programme Committee (if applicable) have been addressed
*Comments: N/A.*

☐ The programme/project outcome(s) are found to be sustainable and in line with the partner's development policies and strategies. Implementation modalities are well described and justified.
*Comments: Yes*

☒The theory of change (if applicable), results framework, indicators and monitoring framework of the programme/project provide an adequate basis for monitoring results and outcome.
*Comments: Yes, the Result Framework is very detailed and provides good insight into the various indicators identified.*

☒The programme/project is found sound budget-wise,

☒The agreed budget and financial reporting procedures provide an adequate basis for financial monitoring of funds.
*Comments: Yes*

☒ The programme/project is found realistic in its time-schedule.
*Comments: Yes, though it is not expected that the outcomes will have been achieved by September 2030 which is when the Pandemic Fund comes to an end. This is mainly due to the fact that the funding needs are significantly higher than what the fund has raised.*

☒ Other donors involved in the same programme/project have been consulted, and possible harmonised common procedures for funding and monitoring have been explored.
*Comments: Yes*

☒Key programme/project stakeholders have been identified, the choice of partner has been justified and criteria for selection have been documented.
*Comments: When proposals are identified for funding by the Pandemic Fund this is managed*

☒ The implementing partner(s) is/are found to have the capacity to properly manage, implement and report on the funds for the programme/project and lines of management responsibility are clear.
*Comments: Yes*

☒ Implementing partner(s) has/have been informed about Denmark's zero-tolerance policies towards (i) Anti-corruption; (ii) Child labour; (iii) Sexual exploitation, abuse and harassment (SEAH); and, (iv) Anti-terrorism.
*Comments*: Yes

☒ Risks involved have been considered and risk management integrated in the programme/project document.
*Comments: Yes*

In conclusion, the programme/project can be recommended for approval: **yes** / no

Date and signature of Desk Officer: 12-12-23 Jacqueline Byld

Date and signature of Management: 21/12/23 Kennedy Rayne