

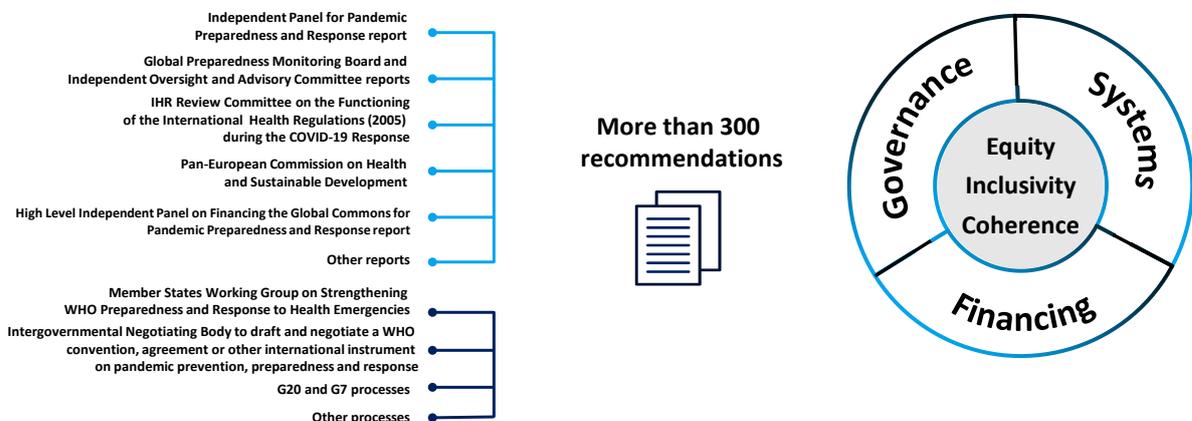
Strengthening the global architecture for health emergency preparedness, response and resilience

Report by the Director-General

1. At the 150th session of the Executive Board, in response to comments from Member States, the Director-General undertook to develop proposals, in consultation with Member States, on strengthening the global architecture for health emergency preparedness, response and resilience (HEPR), and present these to the Seventy-fifth World Health Assembly. Architecture in this context refers to all of the systems and capacities, including mechanisms for financing and governance, at national, regional, and global levels that are crucial to the world's collective ability to prepare for and respond to health emergencies. The proposals presented herein are intended to contribute to the continued deliberations of Member State working groups, and continuing consultations with key stakeholders, including United Nations entities and other multilateral partners.

2. There have been many expert reviews of the HEPR architecture and the global response to the coronavirus disease (COVID-19) pandemic, yielding more than 300 recommendations that have been analysed and discussed through multiple international processes (Fig. 1). The quality of contributions to these reviews reflects the depth of thought, expertise, and engagement of a broad spectrum of stakeholders. Maintaining this engagement, and strengthening the links between stakeholders will be a crucial determinant of the success of an agile, responsive and flexible HEPR architecture in the future.

Fig. 1. Reviews, reports and processes that have informed this report



3. Building on the work done to date, this report outlines the Director-General's 10 proposals to strengthen HEPR under the aegis of a new overarching pandemic instrument, which is currently being developed by the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. The proposals focus on the architecture that will be needed to ensure a significantly more prepared world, and may need to be adapted for specific threats and contexts. The proposals do not attempt to assign roles and responsibilities within that architecture. The capabilities and partnerships developed during the response to COVID-19 will contribute to achieving this ambitious agenda, and WHO will continue to engage with others in determining wider roles and responsibilities.

4. Many of the proposals below are designed to build on, complement and strengthen existing frameworks and capacities established after previous crises, and strengthen the bonds between global health partners. Other proposals build on new and innovative mechanisms put in place during the COVID-19 pandemic to fill critical gaps. In many cases, these initiatives now need to be adapted and refined according to the lessons of the pandemic in consultation with Member States and partners. A small number of proposals call for the establishment of new mechanisms or structures that are currently being discussed in ongoing Member State processes.

5. The proposals are grouped by the three main pillars of the global HEPR architecture: governance, systems and financing, and are based on three key principles.

(i) They must promote **equity**, with no one left behind – equity is both a principle and a goal, to protect the most vulnerable.

(ii) They should promote an HEPR architecture that is **inclusive**, with the engagement and ownership of all countries, communities and stakeholders from across the One Health spectrum. Commitment to diversity, equity and inclusivity is key to effective HEPR at all levels, including equal participation in leadership and decision-making regardless of gender.

(iii) They must promote **coherence**, reducing fragmentation, competition, and duplication; be aligned with existing international instruments such as the International Health Regulations (2005) and the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits; ensure synergy between institutional capabilities for systems strengthening and financing; and promote the integration of HEPR capacities into national health and social systems based on universal health coverage and primary health care.

PROPOSALS FOR STRENGTHENING GLOBAL HEALTH EMERGENCY PREPAREDNESS, RESPONSE AND RESILIENCE

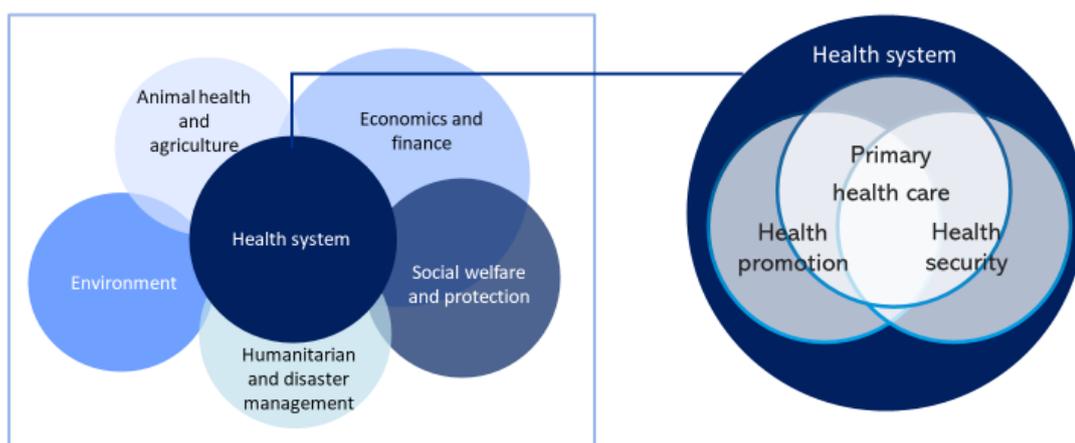
6. Dealing effectively with the multiplying complex and multidimensional threats of the 21st century requires a strengthened and agile approach to the way we prepare for and respond to health emergencies. Where previously there has been chronic neglect and underinvestment in national capacities, we need to make smart, evidence-based investments that deliver the best possible return in terms of lives saved, sustainable development, global economic stability and long-term growth. That means recognizing that strengthening the global HEPR architecture must be part of the broader effort towards the 2030 Sustainable Development Goals.

7. Countries were already off track to meet their commitments under the health-related Sustainable Development Goals before COVID-19, and the pandemic has set back progress even further. Achieving the health-related Goals will therefore require a plan for recovery and renewal based on rapidly accelerating progress in three interdependent priority areas:

- **health promotion:** preventing disease by addressing its root causes;
- **primary health care:** supporting a radical reorientation of health systems towards primary health care, as the foundation of universal health coverage; and
- **health security:** urgently strengthening the global architecture for HEPR at all levels.

8. These priorities stem from the simple principle that there is one health system, encompassing the common functions and structures that are crucial for health security, for primary health care, and for health promotion (Fig. 2). A renewed global architecture for HEPR must be built on a foundation of strong national health systems that are deeply connected with and accountable to the communities they serve, and which advance gender equity and human rights. At national level, a substantial proportion of the capacities required for HEPR, such as risk communication and integrated disease surveillance and immunization, are indivisible from those required for health promotion and the reorientation of systems towards universal health coverage based on primary health care. Targeting these common capacities for investment will accelerate progress towards the health-related Sustainable Development Goals at the same time as boosting national and global health security. Many of these HEPR capacities straddle the boundary of the health system and other governmental and societal sectors and systems, such as education, finance, animal health and agriculture, and the environment.

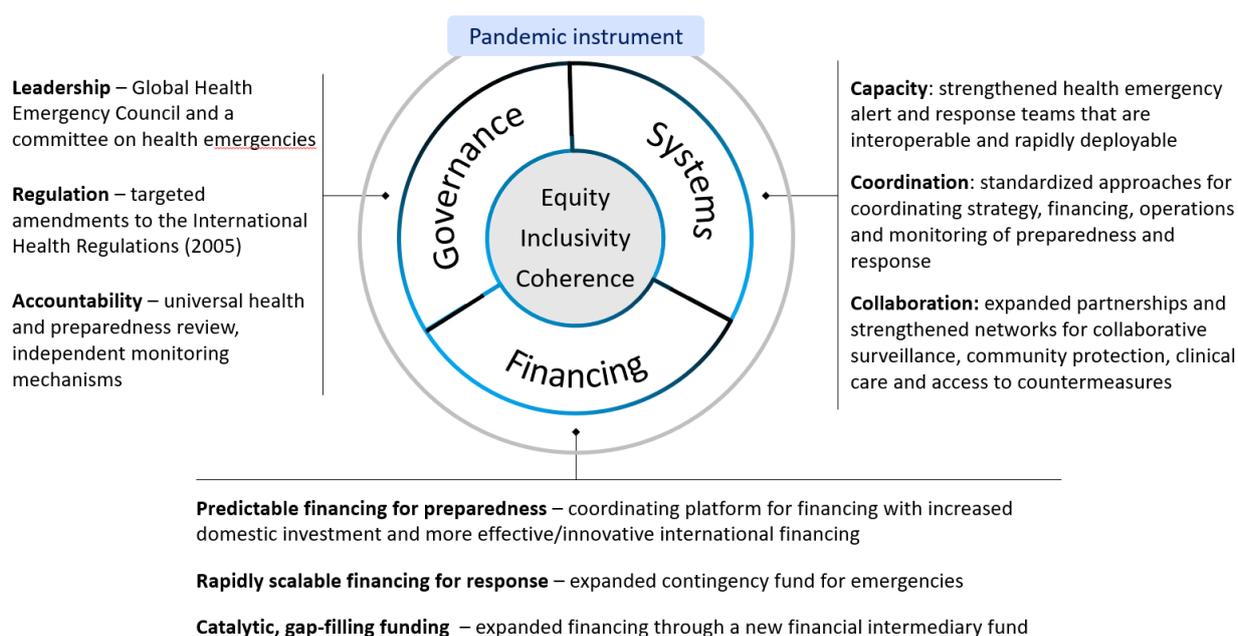
Fig. 2. Investing in health security strengthens primary healthcare and health promotion, and vice versa, within the broader health system



9. The need for greater coherence and coordination of effort and investment extends to the global level. The international community needs ways of working together that deliver collaboration and coordinated, collective action, and that address the fragmentation that weakens the current global architecture for HEPR. That means considering carefully the creation of new mechanisms, and the addition of new organizations or institutes to what is already a crowded landscape.

10. Within the broader context of recovery and renewal for achieving the health-related Sustainable Development Goals, and the need for greater coherence of the global HEPR architecture, 10 proposals for strengthening HEPR are outlined below (Fig. 3).

Fig. 3. Summary of proposed solutions for the strengthening of the global architecture for health emergency preparedness, response and resilience



Governance

11. Effective governance is essential to bring greater equity, inclusivity and coherence to the global architecture of HEPR, enabling Member States and partners to work collectively around a shared plan, galvanized by political will, and with the resources to sustain positive changes.

Proposal 1. Establish a Global Health Emergency Council and a Committee on Health Emergencies of the World Health Assembly

12. HEPR must be elevated to the level of heads of state and government to ensure sustained political commitment, and break the cycle of panic and neglect that has characterized the response to previous global health emergencies.

13. Several panels have proposed the establishment of a high-level body on global health emergencies, comprising heads of state and other international leaders. The Director-General supports this concept, and proposes the establishment of a Global Health Emergency Council, linked to and aligned with the constitution and governance of WHO, rather than creating a parallel structure, which could lead to further fragmentation of the global architecture of HEPR. Head of State participation, especially during health emergencies, would further strengthen WHO's primary constitutional function to act as the directing and coordinating authority on international health work (WHO Constitution, Article 2(a)).

14. The Council would address health emergencies as well as their broader context and social and economic impact. It would have three primary responsibilities:

- (i) address obstacles to equitable and effective HEPR, ensuring collective, whole-of-government and whole-of-society action, aligned with global health emergency goals, priorities and policies;
- (ii) foster compliance with and adherence to global health agreements, norms and policies; and
- (iii) identify needs and gaps, swiftly mobilize resources, and ensure effective deployment and stewardship of these resources for HEPR.

15. The Council would be composed of heads of state and government, attended by the United Nations Secretary General and WHO Director-General, with heads of relevant international organizations and other bodies as observers. The Council would meet annually to review progress in pandemic preparedness and response, and as required in the event of a public health emergency of international concern.

16. The work of the Council would complement and be linked with the work of a Standing Committee on Health Emergency (Pandemic) Prevention, Preparedness and Response, which the Executive Board at its 150th session proposed for consideration as a committee of the Executive Board to which it would report.¹

17. To strengthen integrated governance, the Health Assembly could also establish a new main committee on emergencies: a Committee E. Such a new main committee could be linked with both the Council and the Standing Committee on Health Emergency (Pandemic) Prevention, Preparedness and Response, and as an open-ended committee of all WHO Member States, Committee E would help to ensure global inclusivity. The Officers of Committee E and of the Standing Committee could be invited to attend meetings of the Council to further promote coordination among the three bodies.

18. Further, a Committee on Emergencies (Committee E) could:

- (i) review the work of WHO in health emergency preparedness, response and resilience;
- (ii) act as a “conference of State Parties” to the International Health Regulations (2005);
- (iii) act as a peer review mechanism for the Universal Health and Preparedness Review; and
- (iv) consider any recommendation by the Executive Board based on advice from the Standing Committee on Health Emergencies.

19. Such an interlinked arrangement could strengthen WHO’s constitutional role as the directing and coordinating authority on international health work.

¹ Decision EB150(6) (2022). See also the summary records of the Executive Board at its 150th session, fourth meeting, section 4, fifth meeting, sixth meeting, section 1, and tenth meeting, section 3.

Proposal 2. Make targeted amendments to the International Health Regulations (2005)

20. The International Health Regulations (2005) (IHR) are the international legally binding framework that defines the rights and obligations of its 196 States Parties and of the WHO Secretariat for handling public health emergencies with potential to cross borders. The IHR remains an essential legal instrument for public health emergencies preparedness and response.

21. The COVID-19 pandemic has revealed some weaknesses in the interpretation of, application of and compliance with the IHR. The inherent tension between the aim to protect health and the need to protect economies by avoiding travel and trade restrictions has been noted by the IHR Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response as the most important factor limiting compliance with the IHR.

22. In addition, too many countries still do not have sufficient public health capacities to protect their own populations, and to give timely warnings to WHO. The current reporting mechanism on the implementation of plans of action to ensure that the core capacities required by the IHR are present and functioning lacks incentives for compliance. The absence of a conference of States Parties to the IHR is an overarching limitation in their effective application and compliance.

23. Further strengthening of IHR implementation compliance will require some targeted amendments. Areas of focus may include: improved accountability by establishing the national responsible authority for the overall implementation of the IHR, and a conference of State Parties (see paragraph 18, ii); more specificity in relation to notification, verification and information sharing; capacity-building and technical support for surveillance, laboratories and public health rapid response; and streamlining the process to bring IHR amendments into force.

24. Ensuring that the IHR can be efficiently and effectively strengthened to accommodate evolving global health requirements is key to their continued relevance and effectiveness as a global health legal instrument.

Proposal 3. Scale up Universal Health and Preparedness Reviews and strengthen independent monitoring

25. In response to a proposal from several Member States, the introduction of the Universal Health and Preparedness Review (UHPR) was announced by the WHO Director-General in November 2020, with the goal of building solidarity, mutual trust and accountability for health, through an innovative intergovernmental review process. The UHPR is a Member State-led mechanism in which countries agree to a voluntary, regular and transparent peer review of their comprehensive national health emergency preparedness capacities, incorporating lessons learned from the COVID-19 pandemic on preparedness assessment. It aims to:

- (i) enhance transparency and understanding of a country's comprehensive preparedness capacities among relevant national stakeholders;
- (ii) promote whole-of-government and whole-of-society dialogue on preparedness in countries, including close cooperation with governments, regional organizations and civil society;
- (iii) encourage compliance with commitments made under the IHR and related Health Assembly resolutions in the field of emergency preparedness;

(iv) elevate considerations for preparedness beyond the health sector and ensure the comprehensive implementation of recommendations; and

(v) promote national, regional and global solidarity, dialogue and cooperation.

26. A pilot phase of the UHPR mechanism was completed in 2021. On the basis of lessons learned from the pilot phase, the UHPR should now be scaled up to complement existing assessment tools and processes, and a peer review mechanism should be included as part of the UHPR process, as suggested above (paragraph 18, iii).

27. Self-assessment and peer review of national capacities, including through the UHPR, should be complemented by independent monitoring at the international level. The independent monitoring mechanism should be modelled on best practice in independent monitoring of international instruments, and should build on and strengthen existing monitoring mechanisms, such as the Global Preparedness Monitoring Board and the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme. Together, these accountability tools for governments, international organizations and other stakeholders across all sectors will: identify the risks and determinants of health emergencies; reveal gaps and weaknesses in the capacity and performance of health emergency systems and their financing and governance; develop and implement solutions to ensure equity, effectiveness and efficiency; and promote compliance with obligations under international law, including the IHR and the pandemic accord currently under negotiation.

Systems

28. The ability to prepare for, prevent, detect and respond effectively to health emergencies at national, regional and global levels depends on the operational readiness and capacities of five core subsystems (Fig. 4).

(i) **Collaborative surveillance** and public health intelligence through strengthened multisectoral disease, threat and vulnerability surveillance; increased laboratory capacity for pathogen and genomic surveillance; and collaborative approaches for risk forecasting, event detection and response monitoring.

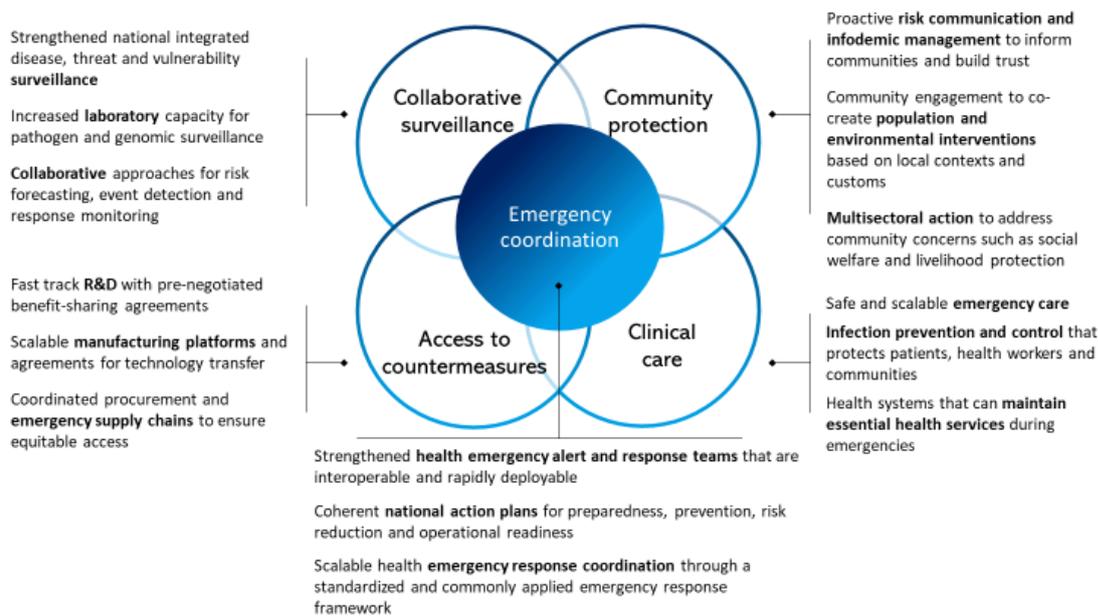
(ii) **Community protection** through two-way information sharing to inform, educate and build trust; community engagement to create public health and social measures based on local contexts and customs; a multisectoral approach to social welfare and livelihood protection to support communities during health emergencies; and mechanisms to ensure the protection of individuals from sexual exploitation, abuse and harassment.

(iii) **Clinical care** that is safe and scalable, with effective infection prevention and control that protects; patients, health workers and communities; and resilient health systems that can maintain essential health services during emergencies.

(iv) **Access to countermeasures** through fast-track research and development, with pre-negotiated benefit sharing agreements and appropriate financing instruments; a seamless link between research and development and scalable manufacturing platforms and agreements for technology transfer; coordinated procurement and emergency supply chains; and strengthened population-based services for immunization and other public health measures.

- (v) **Emergency coordination** with a trained health emergency workforce that is interoperable, scalable; and ready to rapidly deploy; coherent national action plans for health security to drive preparedness and prevention; operational readiness through risk assessment and reduction and prioritization of critical functions; and rapid detection of and scalable response to threats through the application of a standardized emergency response framework.

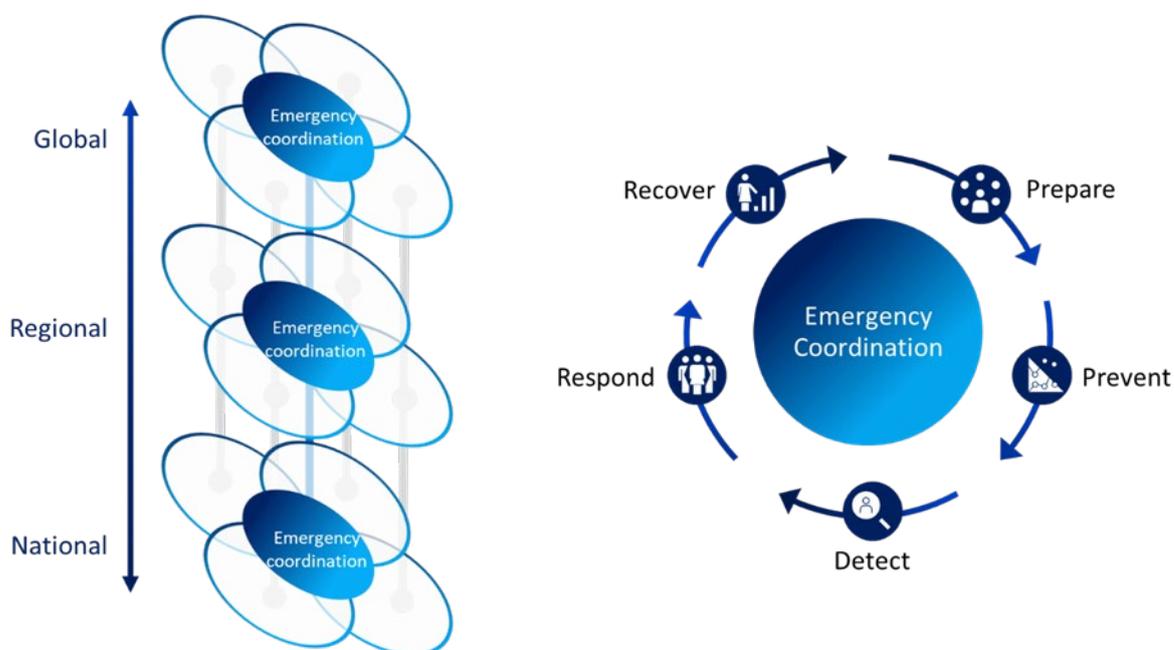
Fig. 4. Interconnected core subsystems for health emergency preparedness, response and resilience



29. These capacities must be embedded in strengthened national health systems, and will require investment in essential public health functions, primary health care and health promotion. Strengthening integrated surveillance, community engagement, health promotion, routine immunization and other essential health services will reduce the risk of health emergencies, and enable communities to be ready for and more resilient to emergencies. Strong primary health and public health systems enable communities to better assess context-specific threats and vulnerabilities to reduce risk through prevention and **readiness**. The link between communities and national health emergency systems is critical to rapidly communicate risk and scale up support once an event has been detected.

30. Given these interdependencies and the breadth of actors involved, it is critical that the five core subsystems are well integrated within countries, and have strong links to structures for support, coordination and collaboration at regional and global levels across all phases of the health emergency cycle of prepare, prevent, detect, respond and recover (Fig. 5).

Fig. 5. Interlinkages between five core subsystems for health emergency preparedness, response and resilience



31. Proposals for strengthening both the subsystems and the linkages between them are outlined below.

Proposal 4. Strengthen global health emergency alert and response teams that are trained to common standards, interoperable, rapidly deployable, scalable and equipped

32. The COVID-19 pandemic continues to expose national-level deficits in the core capacities required for effective HEPR. National capacities are the fundamental building blocks of global health security; therefore, these deficits confer profound systemic risks.

33. Mitigating these risks will require substantial investments in many countries to build and strengthen professionalized multidisciplinary health emergency teams, fully integrated into resilient national health systems and other relevant sectors. The scale and nature of workforce needs depend on national context, but the most substantial and widespread gaps highlighted by COVID-19 are in the areas of epidemiology and surveillance, including laboratories; the health system workforce required to rapidly scale up safe emergency clinical care and maintain essential services during an emergency; the non-clinical aspects of protection, such as working conditions and fair remuneration; and the community engagement and infodemic management resources needed to strengthen trust in health authorities and build community resilience to health emergencies.

34. Smart investments in strengthening national capacities will enable the development of globally deployable health emergency alert and response teams to strengthen regional and global preparedness, detection and response. Combined with mechanisms for emergency coordination (see Proposal 5) to support training, accreditation and deployment, strengthened national alert and response teams can give rise to a country-owned yet internationally deployable global health emergency workforce.

Proposal 5. Strengthen health emergency coordination through standardized approaches to strategic planning, financing, operations and monitoring of health emergency preparedness and response

35. Health emergency subsystems are dependent on each other for operational effectiveness. At national level, COVID-19 demonstrated that overall health emergency preparedness and response management systems were often fragmented. At regional and global levels, the pandemic highlighted a lack of consistency in national approaches, a lack of effective mechanisms to coordinate and communicate action between countries, and challenges in efficiently channeling international support to where it was most needed.

36. Remedying this fragmentation will require further investment in ensuring greater consistency and standardization in emergency coordination at national level, including through a commonly applied emergency response framework. Application of this framework must be enabled by strengthened infrastructure, workforce and leadership that is resourced and empowered to: strengthen operational readiness through assessment of risks and vulnerabilities, and prioritization of critical functions; develop context-specific strategies and plans for preparedness, prevention, readiness and response; mobilize the necessary resources; and monitor and evaluate actions. Health emergency management should be embedded in broader whole-of-government national disaster management systems.

37. A strengthened and redesigned network of public health emergency operations centres can connect international and regional technical, financial and operational support to national emergency management systems, and improve coordination between countries and international partners across the health emergency cycle.

Proposal 6. Expand partnerships and strengthen networks for a whole-of-society approach to collaborative surveillance, community protection, clinical care, and access to countermeasures

38. COVID-19 has shown that resilience to health emergencies can be strengthened in key areas by broader and closer collaboration between organizations and institutions at national, regional and global levels before health emergencies hit. This will require the strengthening and, where required, the establishment of whole-of-society, interdisciplinary, multi-partner networks for collaborative surveillance, clinical care, community protection and access to countermeasures. This will enable the extensive ecosystem of HEPR partners at the global, regional and national levels to fully participate according to their strengths and capabilities to co-create innovative and timely solutions in an agile and collaborative way (see Fig. 6 for a non-exhaustive illustration of the ecosystem of international partners for COVID-19).

Financing

42. Financing an effective health emergency preparedness and response architecture will require approximately an additional US\$10 billion per year, according to WHO–World Bank analyses presented in 2022 to the G20. However, effective financing depends not only on more funds, but also on strengthened and innovative mechanisms to ensure that funds are accessed and delivered in ways that are agile and risk tolerant, to ensure the best possible return on investment and the most effective and timely allocation of resources to fill critical gaps.

Proposal 7. Establish a coordinating platform for financing to promote domestic investment and direct existing and gap-filling international financing to where it is needed most

43. Every country should step up domestic investments to prepare for health emergencies, but low-income countries and some lower middle-income countries need urgent international support to strengthen HEPR.

44. International financial support can come from many different actors, both public and private, with often overlapping and competing priorities. Greater coordination and simplification is needed across this funding landscape to ensure that existing funding flows are coordinated and targeted to the most critical gaps in the global HEPR architecture, such as national-level preparedness gaps, funding for regional and global institutions that support HEPR, investments in upstream and emergency research and development and downstream manufacturing and procurement, and rapidly accessible funding to initiate and scale emergency response operations. Where existing funding flows are insufficient to fill critical gaps in core national and global HEPR capacities, these flows should be augmented by additional catalytic and gap-filling funding through a financial intermediary fund (see below).

45. To bring coherence and efficiency across domestic and international investments, including additional investments through a proposed financial intermediary fund, a new coordination platform is required that unites the technical work of WHO and other HEPR partners as needed, with the financial investments of the World Bank and other international financial institutions. This coordinating platform for finance and health would monitor the performance of HEPR funding flows, improve effective allocation to critical priorities, and help to mobilize and direct catalytic and gap-filling financial support. This new mechanism should strive for worldwide representation, building on the work of the G20's Joint Finance and Health Task Force.

Proposal 8. Establish a financial intermediary fund for pandemic preparedness and response to provide catalytic and gap-filling funding

46. Existing funding flows do not cover gaps in the HEPR architecture. A new pooled fund has been proposed by several reviews and organizations as a potential solution for international financing to better support national preparedness and response, and global public goods. Most recently, WHO and the World Bank recommended to the G20's Joint Finance and Health Task Force the establishment of a Financial Intermediary Fund (FIF), to be hosted by the World Bank.

47. The FIF should avoid duplication and ensure complementarity with existing HEPR financing efforts and institutions. Critical design elements for a FIF should include:

- (i) a central role for WHO to enable direct linkage between national and global HEPR assessment and planning processes and the investments proposed by the FIF;

- (ii) governance mechanisms that include a coalition of participating donors, and that are informed by objective assessments of HEPR needs and the perspectives of beneficiary country governments;
- (iii) links with existing multilateral development banks and implementing partners, who should be eligible for financing; and
- (iv) funding proposals based on national action plans for health security and related financing plans, filling gaps identified through the IHR monitoring framework and UHPR (see above).

Proposal 9. Expand the WHO contingency fund for emergencies to ensure rapidly scalable financing for response

48. At present, funding mechanisms for emergency response are fragmented and unpredictable. The WHO contingency fund for emergencies (CFE) is able to disburse relatively modest amounts rapidly for early response, but it is not designed to directly finance elements of national response, nor the efforts of key partners, often leading to operational gaps when implementing multidisciplinary and multisectoral response plans. In addition, in the event that initial containment efforts fail, WHO's CFE is not designed to support the scale-up and adaptation of response, nor sustain a response over durations longer than the initial few months. In the absence of pre-negotiated draw-down mechanisms to enable access to larger tranches of flexible funding triggered by the escalation of health emergencies, critical windows for scale-up are often missed due to a reliance on unpredictable, often inflexible, and frequently insufficient funding from ad hoc appeals.

49. Addressing the problems above will require two innovations. First, the CFE should be expanded in size and scope to enable the direct financing of national and international partners in the first stages of the response, including deployments through the health emergency workforce and emergency supply chain. This will ensure that multisectoral health emergency response plans can be fully and rapidly implemented. Second, in the event that initial response efforts are unable to contain an infectious threat or sufficiently mitigate the effects of a non-infectious hazard, an additional substantial draw-down facility should be triggered to ensure that the multisectoral response can be scaled up to cover additional geographical areas and populations for an extended duration. The triggers for activation of this draw-down facility should be pre-negotiated, transparent and based on the "no regrets" precautionary principle.

50. An expanded CFE could satisfy both needs, with contingency funds accessed via two transparent mechanisms: a rapid response facility and a sustained scale-up facility, both of which would be linked to a standardized and commonly applied emergency response framework for alert, verification, risk assessment and jointly developed strategic plans and resource requirements for rapid and scalable response.

Equity, inclusivity and coherence

51. In all countries, the burden of risks of and vulnerabilities to health emergencies inevitably falls disproportionately on the most socially and economically disadvantaged and marginalized. As the ongoing experience of COVID-19 shows, the failure of the HEPR architecture to adequately address equity, particularly equitable access to medical countermeasures, has magnified and prolonged the acute phase of the pandemic.

52. An effective, equitable, inclusive, trusted and accountable HEPR architecture must meet the needs of all countries and communities, including the most marginalized and those in fragile, vulnerable and conflict-affected contexts. It is therefore essential that all countries be involved, and all communities be represented, in the translation of the proposals set out here into context-specific solutions, and in the allocation of investments for HEPR, with an equal role for low-income and middle-income countries in the leadership and accountability mechanisms of a new HEPR architecture.

53. Broadening inclusion in global HEPR must go hand in hand with strengthening the links between current stakeholders to: empower coordination; reduce fragmentation, competition and duplication; and accelerate investment in HEPR within the broader context of the drive towards the Sustainable Development Goals.

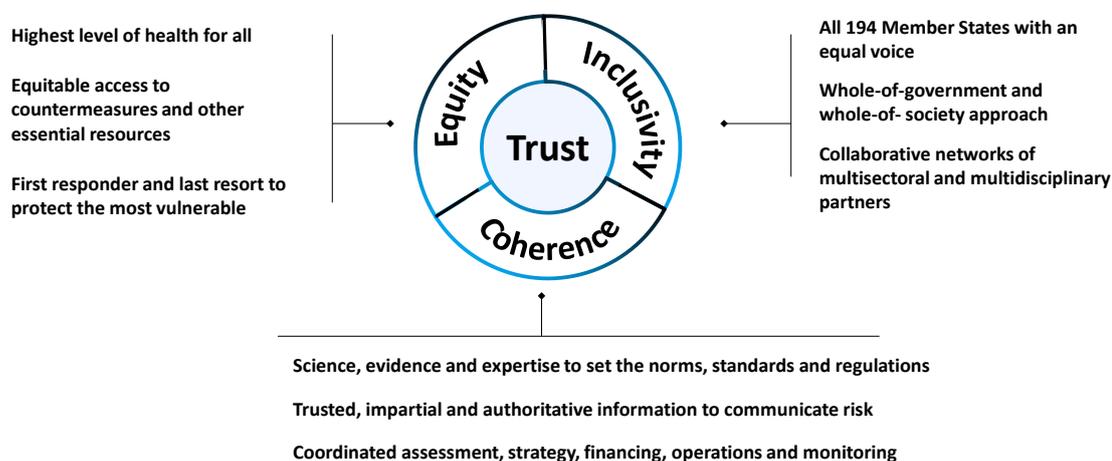
Proposal 10. Strengthen WHO at the centre of the global HEPR architecture

54. Sustained commitment to equity, inclusivity, and coherence will, therefore, be best served by the strengthening of and sustained investment in the only multilateral organization with a mandate that encompasses the systems, finance and governance of HEPR: WHO. To achieve this, the world needs a strengthened WHO, with the authority, financing and accountability to effectively fulfil its unique mandate as the directing and coordinating authority on international health work.

55. The Organization has essential responsibilities: for setting international norms and standards; for promoting and conducting research in the field of health; for providing data and information; for developing evidence-based policy and guidance; for investigating and responding to health emergencies as a first responder and as a provider of last resort, including in the most vulnerable and fragile contexts; and for maintaining strong relationships within the global health ecosystem. Discharging these responsibilities requires adequate and sustainable financing. A pandemic accord, adopted by WHO Member States, would reinforce the legitimacy and authority of WHO and complement steps that Member States are already taking to ensure sustainable financing of the Organization. The accord would also ensure that the technical expertise of WHO, its offices and its various scientific, normative, operational and monitoring bodies and networks, are utilized most effectively and efficiently within an equitable, inclusive and coherent architecture for health emergency preparedness and response.

56. Strengthening WHO at the core of the global HEPR architecture will continue to build and sustain trust in its mission, contributing to a safer world built on equity, inclusivity and coherence (Fig. 7).

Fig. 7: Equity, inclusivity and coherence at the heart of the global architecture for health emergency preparedness, response and resilience



ACTION BY THE HEALTH ASSEMBLY

57. The Health Assembly is invited to note this report.

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