

COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PLAN

Sustaining an effective response to end the acute
phase of the pandemic and transitioning to recovery
in WHO's Eastern Mediterranean Region



2022 EDITION

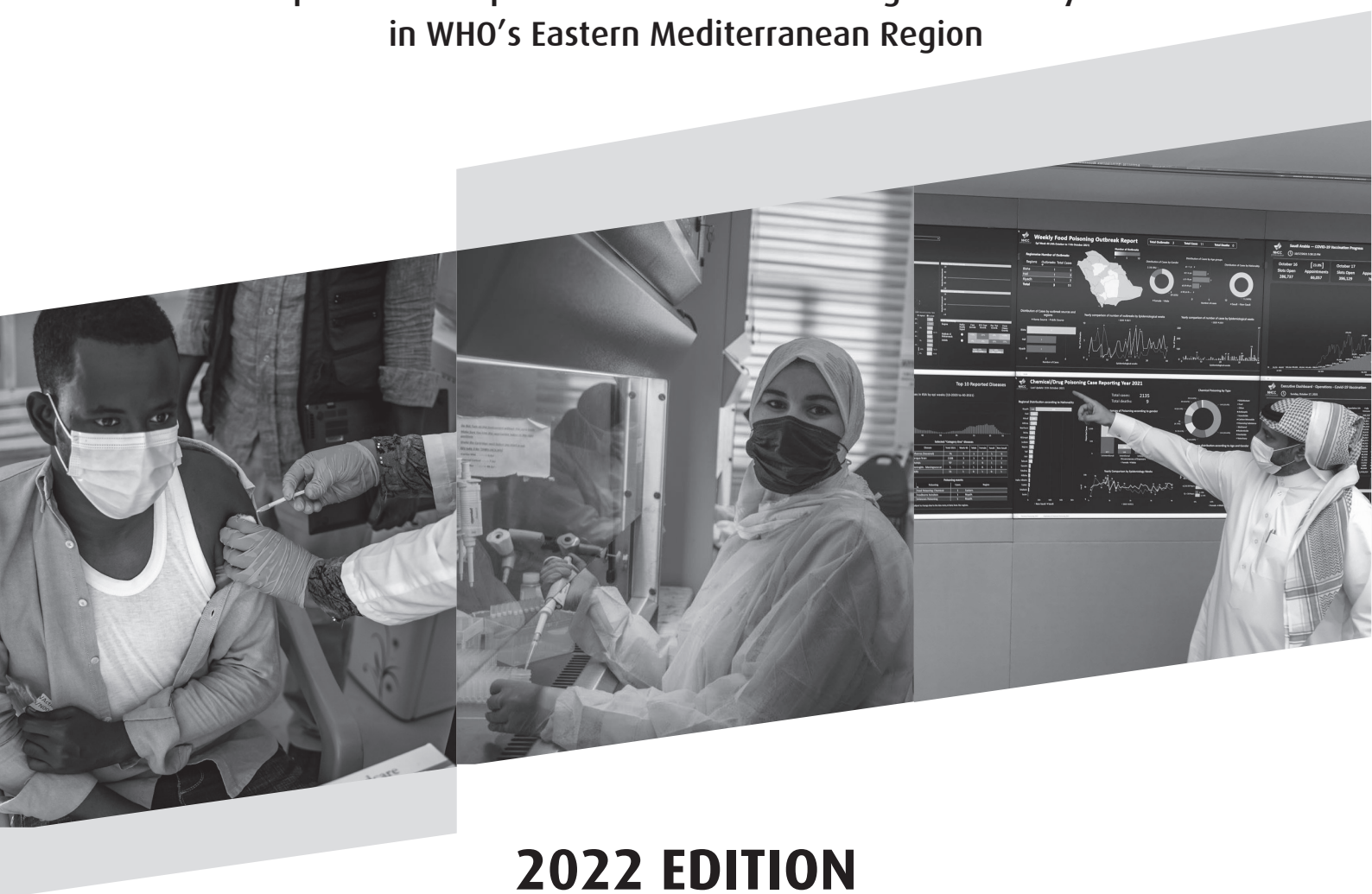
Cover photo 1: COVID-19 vaccination centre in the De Martino Hospital, Mogadishu, Somalia, visited by the WHO mission on 27 September 2021. © WHO Somalia

Cover photo 2: Laboratory technician testing samples for SARS-CoV-2 during the visit of the national Centers for Disease Control and Prevention in Libya by the WHO mission on 28 June 2021. © WHO Libya

Cover photo 3: Dashboards in the National Health Command Center, Riyadh, Saudi Arabia, visited by the WHO mission on 18 October 2021. © WHO EMRO

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FOREWORD FROM THE REGIONAL DIRECTOR



Under the 2021 regional COVID-19 strategic preparedness and response plan, significant progress was made in supporting countries, including airlifting supplies to countries from our logistics hub in Dubai, expanding disease surveillance, building laboratory capacity, sharing technical guidance, supporting the development of national deployment and vaccination plans, and addressing vaccine hesitancy.

Despite the expansion of vaccination efforts, 13 countries in the Eastern Mediterranean Region fell short in reaching WHO's target of vaccinating 40% of all people by the end of 2021. Low levels of coverage, with only 30% of the Region's population fully vaccinated and 8% partially vaccinated by the end of 2021, brought us face to face with the highly transmissible Omicron variant of concern.

In 2022, the Region entered a third year of battling COVID-19, armed with increased knowledge about the virus and effective mitigation measures, but facing the consequences of low vaccination coverage, weak adherence to public health and social measures, and the threat of further SARS-CoV-2 variants of concern emerging. In 2022, the regional Incident Management Support Team for COVID-19 will continue to work with WHO country offices, national counterparts, partners and communities to implement the priority actions set out in this strategic plan.

We continue to encourage countries – especially high-income countries with strong responses – to share resources, lessons learned and best practices with those who have

limited capacities. To overcome the pandemic this year, politics must be put aside for the greater good. In countries facing conflict and political instability, opposing parties must come together and use health as a bridge for peace for the well-being of the people they serve. This includes diverting their power and energy to facilitating our lifesaving work, and improving access for all to essential health care services and COVID-19 vaccination.

The battle against COVID-19 is fought alongside the battle against rumours and misinformation, and further work is needed to inform and empower communities, overcome COVID-19 fatigue, and implement the measures that can prevent transmission and save lives.

Maintaining essential health services remains a key priority. We will continue working with countries on practical actions at subregional, national and local levels to adapt and safely maintain access to these services, despite competing demands to respond to COVID-19.

Special focus will be given to supporting the countries in the Region affected by protracted or acute emergencies to protect and scale up national and local health workforces, strengthen overwhelmed health systems and increase vaccination coverage. Our Region hosts over 32 million refugees and internally displaced persons who need ensured and continued access to essential health services, including services for COVID-19.

Over the coming months, we will be working towards ending the acute phase of the pandemic and transitioning to recovery, while building preparedness for future pandemics. Let us build on the solidarity we saw at the beginning of the pandemic to ensure that all people, everywhere, are protected under our regional Vision 2023 – of health for all, by all.

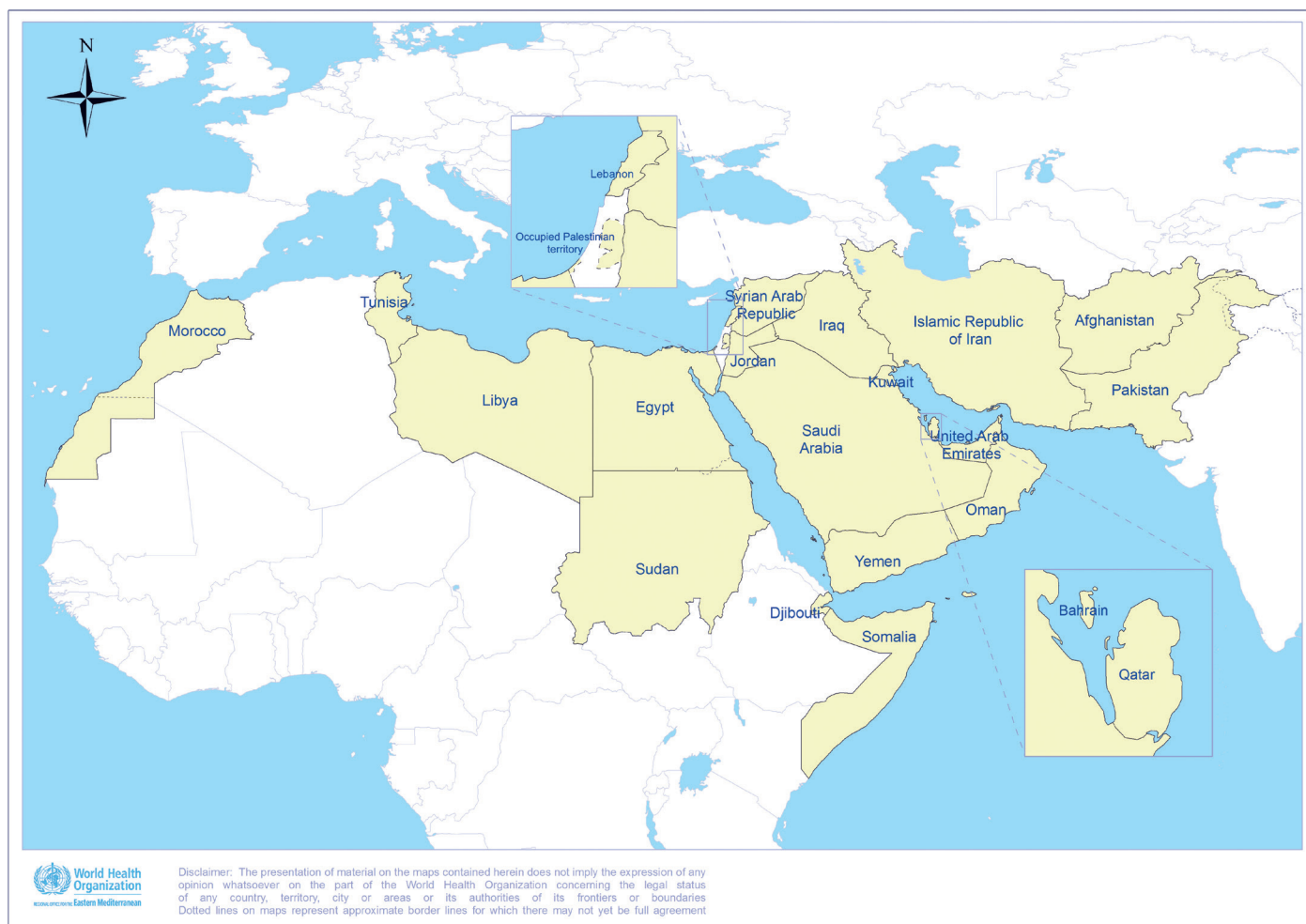
Dr Ahmed Al-Mandhari
WHO Regional Director for the Eastern Mediterranean

1. Overview

The 2022 edition of the COVID-19 strategic preparedness and response plan (SPRP) for the Eastern Mediterranean Region is the fourth regional COVID-19 response plan, serving as an update to the 2021 edition, and aligned with the Region's Vision 2023 and WHO's Thirteenth General Programme of Work 2019–2023. Despite numerous regional challenges, such as vaccination inequity, ongoing health and non-health emergencies, and limited surveillance and testing capacities in many countries, WHO has achieved the objectives set for the Region in the 2021 edition of the SPRP.

With the experience and lessons learned from 2020 and 2021, the WHO Regional Office for the Eastern Mediterranean has developed this 2022 edition of the SPRP. The document serves to continue guiding the regional public health response to end the acute phase of the pandemic and transition to recovery in the Region. It sets the goal and objectives that will guide the response in 2022, and the priority actions that WHO will undertake to sustain, strengthen, adapt and transition the COVID-19 response.

The WHO Eastern Mediterranean Region



WHO's Eastern Mediterranean Region comprises **21 Member States** and **one territory**:

Afghanistan, Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, occupied Palestinian territory, Qatar, Saudi Arabia, Somalia, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen.

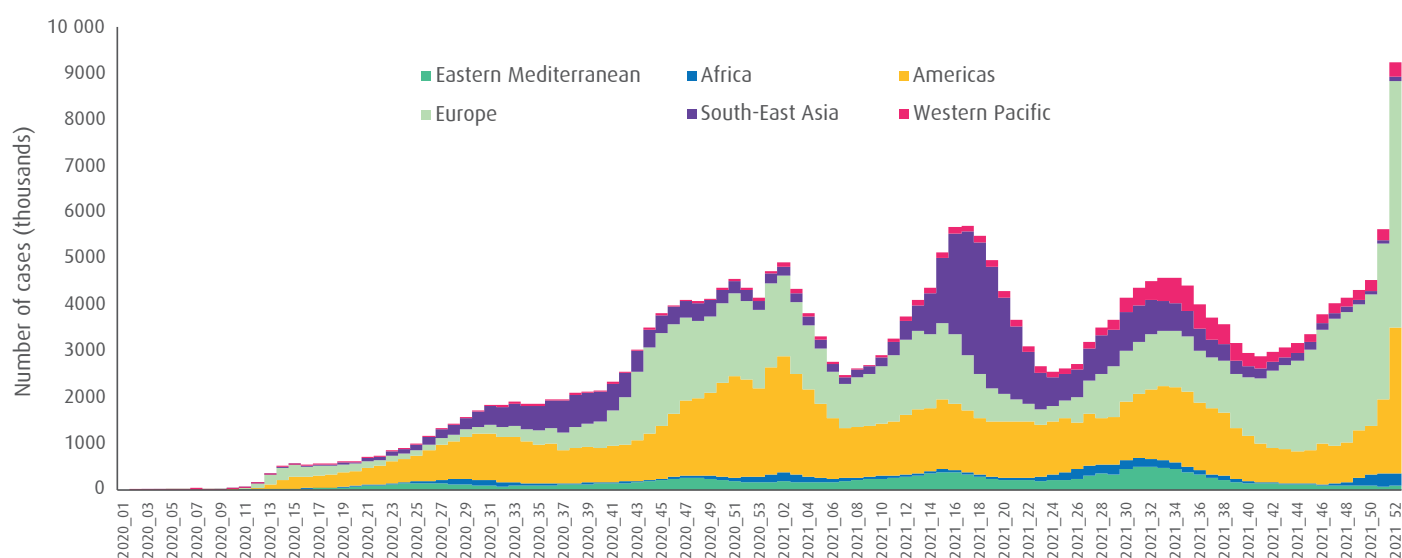
2. Where are we now?

2.1 Global epidemiological situation

On 31 December 2019, WHO was alerted to several cases of pneumonia of unknown origin in Wuhan, China. One week later, on 7 January 2020, Chinese authorities confirmed that they had identified a new type of coronavirus (SARS-CoV-2) as the cause of the pneumonia cluster, causing the illness referred to as coronavirus disease 2019 (COVID-19). COVID-19 spread across the world in 2020, disrupting even

the most resilient health systems and services. Throughout 2021, global incidence rates fluctuated, slowing down after the implementation of public health and social measures, but increasing at the end of the year with premature liftings of some measures and the emergence of variants of concern, despite the increasing COVID-19 vaccination coverage at the global level.

Fig. 1. Weekly distribution of COVID-19 cases globally in 2020 and 2021



As of 31 December 2021, over 291 million COVID-19 cases have been reported globally, with over 5.4 million reported deaths (case fatality ratio (CFR) 1.9%) (Fig. 1). Of these cases, 36.4% were reported from the Region of the Americas, 36.1% from Europe, 15.2% from South-East Asia, 5.9% from the Eastern Mediterranean, 4% from the Western Pacific and 2.5% from Africa. The most affected countries have been the United States of America (53 508 825 cumulative cases and 816 742 associated deaths (CFR 1.5%), India (34 838 804 cases and 481 080 associated deaths (CFR 1.4%) and Brazil (22 263 34 cases and 618 817 associated deaths (CFR 2.8%). The different detection, confirmation and reporting capacities of countries, in terms of case investigation, contact tracing, quarantine, case management and isolation of COVID-19 cases, has led to varying incidence and mortality rates among and within WHO regions, countries and territories, and to observed trends that are not always accurately representative of the actual evolving epidemiological situations.



Over
291 million cases
reported globally



Over
5.4 million deaths
reported globally

Global COVID-19 incidence increased from mid-October 2021 with widespread circulation of the Delta variant of concern (VOC), particularly in the European Region, and from late November 2021 with the Omicron VOC. First identified by South Africa, the Omicron VOC had spread to over 149 countries in all six WHO regions as of 5 January 2022, with the largest relative increases of COVID-19 incidence reported by the African Region, the Region of the Americas and some of the countries of the European Region. Early evidence suggests it has a substantial epidemiological growth advantage compared to the Delta VOC, due to a higher level of immune escape (ability to evade acquired immunity), increased intrinsic transmissibility, and efficient replication in the upper respiratory tract. Early data suggest that disease severity associated with the Omicron VOC is lower than with the Delta VOC. However, with increasing transmission, WHO expects many individuals will develop severe disease based on the sheer volume of cases being reported, further straining health systems. Despite expanded SARS-CoV-2 genomic surveillance and improved phenotypic characterization of variants, genomic surveillance capacities remain suboptimal in many countries, limiting the availability of timely and representative evidence on variant circulation, and hampering the use of such data to understand the related risks to global public health.

Globally, 9.3 billion COVID-19 vaccine doses have been administered as of 31 December 2021. Although over half (59%) of the world's population has received at least one vaccine dose, and 50% is fully vaccinated, the global vaccine distribution remains unequal. Only 9% of people in low-income countries have received at least one dose as of 15 December 2021, compared to 66% in high-income countries. In view of the continued vaccine inequity and supply uncertainties, individual countries' vaccine booster dose policies need to balance the public health benefits to their populations while supporting global equity in vaccine access. Although vaccine supply to low-income countries through the COVID-19 Vaccines Global Access "COVAX" mechanism and African Vaccine Acquisition Trust (AVAT) has increased in the fourth quarter of 2021, unpredictable supply visibility, short vaccine shelf life and vaccine hesitancy have hampered effective roll-out in many countries globally.



149 countries
reported detecting the
Omicron VOC



9.3 billion
COVID-19 vaccines
administered globally

50%
of the world's population
is fully vaccinated



© WHO / Zeinab Ismail

WHO Djibouti organized COVID-19 vaccination in the vaccinodrome in downtown Djibouti, Djibouti, in June 2021, allowing community members and United Nations staff to get vaccinated.

2.2 Current epidemiological situation in the Eastern Mediterranean Region

The first cases of COVID-19 in the Eastern Mediterranean Region were reported by the United Arab Emirates on 29 January 2020 among travellers coming from Wuhan, China. By the end of February 2020, 11 countries in the Region had reported cases of COVID-19, and by 10 April 2020 all 22 countries and territories of the Region had reported COVID-19 cases.

Nearly two years later, as of 31 December 2021, countries and territories of the Region have reported a total of 17 203 559 cases, about 5.9% of the global count, and 316 176 associated deaths (CFR of 1.8%). Since the beginning of the pandemic, the countries reporting the highest numbers of total cases have been the Islamic Republic of Iran (6 195 403 cases; 36% of the Region's total), Iraq (2 093 891; 12.2%) and Pakistan (1 296 527; 7.5%). The Islamic Republic of Iran has also reported the highest number of total associated deaths (131 639; CFR of 2.1%), followed by Pakistan (28 941; CFR of 2.2%) and Tunisia (25 586; CFR of 3.5%). The highest CFRs were reported by Yemen (19.6%) and Sudan (7.1%), while the lowest CFRs were reported by Qatar (0.25%), the United Arab Emirates (0.28%) and Bahrain (0.49%).

Countries and territories in the Eastern Mediterranean Region have shown mixed patterns of resurgence, decreases, increases or stabilization of reported COVID-19 cases throughout 2021. Two waves of the pandemic were observed in 2021 across the Region: the first reaching a peak in week 15 (starting on 11 April) with 387 375 new confirmed cases and 5553 deaths, followed by a gradual decrease in reported cases and deaths, and the second

starting in week 24 (13 June) with a significant increase in the number of confirmed cases and deaths observed across the Region (Fig. 2). COVID-19 cases increased sharply from the last week of July 2021 and reached a peak (501 055 cases and 6998 deaths) in week 32 (starting on 8 August). A gradual decrease in the number of confirmed cases was subsequently observed until week 51, but was followed by a sharp increase observed since week 52.



Over

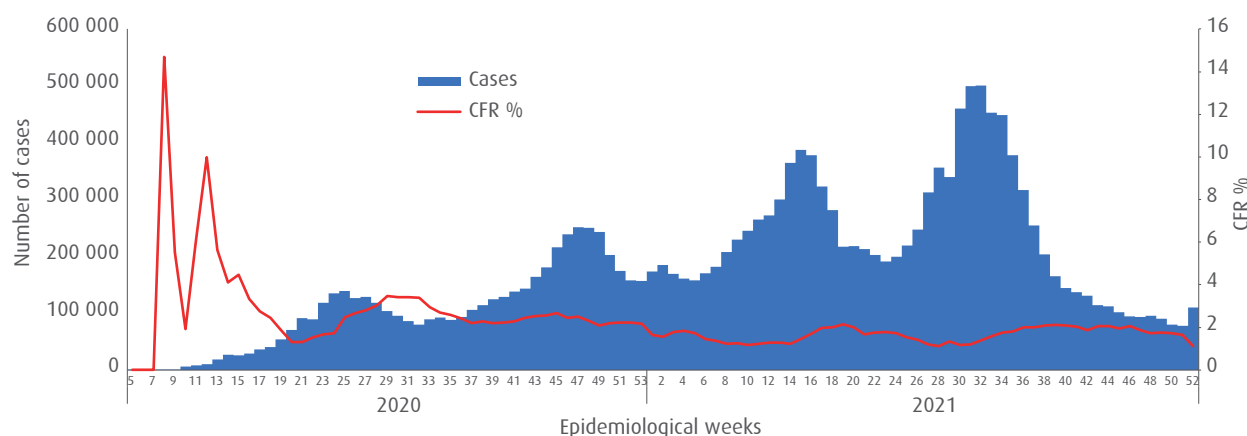
17 million cases
reported in the Region



Over

316 thousand deaths
reported in the Region

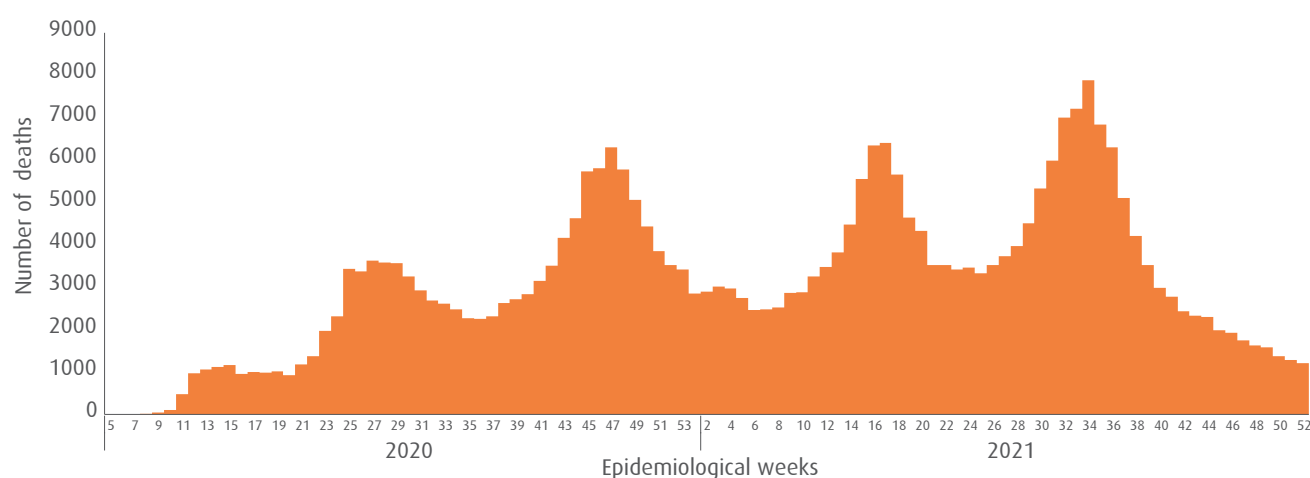
Fig. 2. Weekly distribution of COVID-19 cases in the Eastern Mediterranean Region from week 5 of 2020 to week 52 of 2021



A similar pattern was observed in the trend of COVID-19 deaths: an increase was observed starting in the last week of June 2021, reaching a peak in week 34 with a record 448 165 reported deaths, and followed by a continuous

decline until the end of the year (Fig. 3). The Islamic Republic of Iran, Pakistan, Tunisia, Iraq and Egypt have reported the highest numbers of deaths in 2021.

Fig. 3. Weekly distribution of COVID-19 associated deaths in the Eastern Mediterranean Region from week 5 of 2020 to week 52 of 2021



Over
294 million PCR tests
conducted in the Region



538 million
COVID-19 vaccines
administered in the Region

30%
of the Region's population
is fully vaccinated

In terms of testing, a total of 294 992 406 laboratory polymerase chain reaction (PCR) tests have been conducted in the Region since the start of the pandemic. The highest numbers of PCR tests were reported by the United Arab Emirates (111.2 million), the Islamic Republic of Iran (42.1 million) and Saudi Arabia (33.3 million). The United Arab Emirates and Bahrain have reported the highest rates of testing per capita (11 192/1000 and 4604/1000, respectively). The average test positivity rate in the Region is 5.8%.

COVID-19 vaccination started in December 2020 in the Region and, as of 31 December 2021, 538 million doses have been administered. As of 31 December 2021, 38% of the Region's population have received at least one dose of the COVID-19 vaccine with 30% fully vaccinated and 8% partially vaccinated. However, coverage in low-income countries in the Region (Afghanistan, Somalia, Sudan, Syrian Arab Republic and Yemen) is 7% on average, while it averages at 76% for the Region's high-income countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates). Six countries in the Region have not yet reached 10% of coverage (fully vaccinated): Afghanistan, Djibouti, Somalia, Sudan, Syrian Arab Republic and Yemen.

3. What can we expect?

3.1 Predicting the evolution of the Omicron wave

As of January 2022, countries in the WHO Eastern Mediterranean Region are experiencing an upsurge of COVID-19 cases, with the Omicron variant having been detected in 15 of the 22 countries and territories in the Region. Not all countries in the Region have confirmed the circulation of the Omicron VOC, mainly due to varying genomic sequencing capacities across countries; however, the Omicron VOC is likely responsible for the observed upsurge of cases in all countries. In Europe, Omicron cases make up a large proportion of the total cases reported since the beginning of the pandemic. Although the “Omicron wave” started later in the Eastern Mediterranean Region than in Europe, a decrease in cases is already being observed in some countries, suggesting that the wave’s duration may be shorter than in Europe.

In most countries, the proportions of severe cases and deaths among reported cases are lower than during previous waves. This is likely due to the decreased disease severity associated with the Omicron VOC, and the immunity acquired through previous infection and vaccination. In January 2022, a new sub-lineage of the Omicron VOC, sub-lineage BA.2, was identified and reported by 57 countries globally, including three in the Eastern Mediterranean Region (Jordan, Pakistan and Qatar). The transmissibility of sub-lineage BA.2 is reportedly higher than that of sub-lineage BA.1, the Omicron VOC originally circulating most widely.

3.2 Planning response priorities based on possible scenarios

Future trends of the pandemic will be driven by the levels of immunity within the population from natural infection and vaccination, disease severity, access to health care, the emergence of new VOCs, and the implementation of and

adherence to public health and social measures. Given the considerations provided above, WHO anticipates three main interim scenarios of the evolution of the COVID-19 pandemic in 2022 in the Region, as described below.

Scenario 1:
Continuous SARS-CoV-2 circulation with predominance of the Omicron VOC and without the emergence of new VOCs

Under this scenario, circulation of SARS-CoV-2 is moderate after a rapid and high increase in cases in most countries in early 2022, and levels of severe disease including deaths are low to moderate.

Scenario 2:
Emergence of a new SARS-CoV-2 VOC with high transmissibility, moderate immune escape and decreased disease severity

Under this scenario, new waves of cases of moderate-to-high intensity occur. The height of the first wave and the duration of the pandemic depend on the new VOC’s level of immune escape, or ability to evade acquired immunity.

Scenario 3:
Emergence of a new SARS-CoV-2 VOC with high transmissibility, moderate immune-escape and increased disease severity

Under this scenario, new waves of cases of moderate-to-high intensity and moderate-to-high disease severity occur. Moderate-to-high disease severity is particularly expected in countries with low levels of naturally acquired or vaccine-induced immunity and in settings with poor health system capacities.

Irrespective of the scenarios, response priorities will be:



Accelerating vaccine coverage, with a focus on reaching the WHO target of 70% of the population of all countries fully vaccinated by mid-2022



Increasing adherence to public health and social measures, such as mask-wearing and limiting social gatherings



Recommending a booster dose for high-risk groups



Enhancing genomic sequencing and surveillance capacity, nationally and subnationally, including monitoring variant circulation



Supporting case management (e.g. access to therapeutics, availability of medical oxygen, and intensive care unit capacity) including prioritizing the most vulnerable groups, especially those living in fragile, conflict-affected and vulnerable (FCV) countries

Special attention will be given to populations living in FCV countries where COVID-19 data are limited and response capacity is low.



Hanano Hospital, Dhusamareb, Somalia, visited by the WHO mission on 28 September 2021.

Integration of surveillance for influenza and other emerging respiratory pathogens

The COVID-19 pandemic has exposed weaknesses in responding effectively to the emergence of a new health threat, including in the Eastern Mediterranean Region, thus highlighting the need to improve surveillance, preparedness and response for emerging respiratory viruses with epidemic and pandemic potential beyond influenza. One of the lessons learned from the COVID-19 pandemic is the importance of leveraging existing influenza surveillance systems and associated networks to improve the response. In the early phase of the pandemic, existing influenza surveillance assets were repurposed to support the COVID-19 response, including sentinel sites, national influenza centres and laboratories, reporting platforms and staff. Many countries adapted their strategy to integrate SARS-CoV-2 surveillance and testing into existing influenza surveillance to enable a more effective COVID-19 response. WHO developed interim guidance for operational considerations for COVID-19 surveillance using the Global Influenza Surveillance and Response System (GISRS) for efficient and cost-effective implementation of COVID-19 surveillance.

The integration of emerging respiratory disease surveillance within existing or developing influenza sentinel surveillance systems is in line with the WHO strategy to enhance and expand the GISRS for respiratory viruses with epidemic and pandemic potential (GISRS+). The WHO Regional Office for the Eastern Mediterranean has developed an operational framework for integrated surveillance of influenza and other respiratory viruses with epidemic and pandemic potential. The goal of this framework is to promote an efficient system built from existing influenza foundations to achieve integrated surveillance of a range of respiratory viruses with epidemic or pandemic potential in the Region. The influenza sentinel surveillance system provides a ready-to-use platform for the integrated surveillance of multiple pathogens with epidemic and pandemic potential. Integrating the surveillance of multiple respiratory viruses under one surveillance platform has many advantages and will likely increase system efficiency, including cost efficiency and sustainability.

The prevention of disease caused by emerging respiratory pathogens will be given the highest priority by the Regional Office. Irrespective of the planning scenarios in 2022, WHO will promote and provide technical support for integrated preparedness and response to respiratory viruses with epidemic and pandemic potential through three main actions, described below.

1. Integrated respiratory disease surveillance



Supporting the establishment of an efficient system built from existing/developing influenza foundations to achieve integrated surveillance for a range of respiratory viruses with epidemic or pandemic potential (in line with the GIRS+ concept and the regional strategy for integrated disease surveillance¹, adopted during the 68th session of the Regional Committee in October 2021 through resolution EM/RC68/R.3).

2. Genomic sequencing



Supporting the establishment/strengthening of genomic sequencing capacities for influenza and other respiratory viruses with epidemic and pandemic potential (this will include systems for metadata collection and sharing, and mechanisms for the rapid assessment of transmissibility and severity of emerging viruses/viral variants).

3. Pandemic preparedness plans



Supporting the development/revision of integrated epidemic and pandemic preparedness plans for influenza and other respiratory viruses with epidemic and pandemic potential, building on the COVID-19 pandemic experience and lessons learned.

¹ A regional strategy for integrated disease surveillance – overcoming data fragmentation in the Eastern Mediterranean Region (EM/RC68.5). Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (<https://applications.emro.who.int/docs/EMRC685-eng.pdf>, accessed 27 March 2022).

4. What have we learned?

4.1 Achieving key SPRP priorities in 2021

In 2021, WHO continued “supporting countries in the Region to leverage and sustain an effective response to suppress transmission, reduce exposure and minimize the impact of the COVID-19 pandemic, while exploring options to build resilient health systems for improved preparedness and response,” which was the main goal of the 2021 edition of the SPRP. The 2021 edition of the COVID-19 SPRP is available at:

<https://applications.emro.who.int/docs/WHOEMCSR383E-eng.pdf?ua=1&ua=1&ua=1>.

Despite the increased number of cases and deaths recorded in 2021, WHO and Member States of the Region have made significant progress in implementing the priority activities under the SPRP 2021 and minimizing the overall impact of the pandemic. As set out in the 2021 regional strategic objectives, WHO maintained partnerships for strong and well-coordinated pandemic planning, strengthened country capacities to prevent and suppress transmission through public health and social measures, minimized the risk of exposure and supported the community to adapt to the pandemic through risk communication and community engagement (RCCE), ensured equitable, timely and affordable access to vaccines and other lifesaving COVID-19 tools and interventions, and reduced mortality and morbidity through strengthened clinical care and essential health services continuity.

Maintain strong and well-coordinated pandemic planning and response

The COVID-19 pandemic is the most significant global political and health leadership crisis in recent history, and successful pandemic control depends on decisive leadership at all levels. WHO continued to advocate for maintaining a whole-of-government and whole-of-society approach with strong commitment of the highest levels of government, and religious and community leaders, to fully engage and reinforce response efforts at national and subnational levels. The WHO Regional Office brought together 43 partners as a network for continued alignment of the regional response. The Regional Director and other senior WHO leaders maintained constant engagement and communication with ministers of health and other government officials to provide guidance in building public trust and making the right decisions to better respond to the pandemic and minimize its impact on all sectors. In 2021, the Regional Director convened special meetings with ministers of health and United Nations heads in the Region for regular briefings and consultations related to the COVID-19 pandemic. Many of the Region’s political leaders have demonstrated decisive leadership and a firm commitment to the implementation of effective public health and social measures to limit the spread of the virus and minimize the impact of the pandemic.



US\$149 million

received from donors for
the COVID-19 response



**43 regional
partners**

brought together
as a regional network

Strengthen country capacities to prevent or suppress community transmission

Many countries in the Region accelerated the adaptation of digital tools and techniques to improve detection and management of COVID-19 and to provide solutions to other pressing issues related to the pandemic. WHO has taken steps to promote the use of applications for next-generation sequencing and extended technical and financial support to priority countries in the Region to strengthen their sequencing capacities, including training, provision of MinION sequencer machines and supplies, and transfer of specimens to reference laboratories.



Laboratory technician testing samples for SARS-CoV-2 in the Syrian Arab Republic.

Minimize the risk of exposure through intensive community awareness campaigns

Globally and in the Region, the effective engagement and empowerment of communities has been central in defining the evolution of the pandemic in countries. WHO strengthened its collaboration and partnership with community-based partners and networks across various sectors at regional and country levels to assist them in responding to COVID-19. This included guiding and supporting them to design and implement interventions to address COVID-19 risks and needs, and adapting measures given the socioeconomic impacts experienced by communities. Joining forces to ensure harmonized guidance and support to countries, WHO and other regional agencies developed and implemented the Regional guiding framework for risk communication and community engagement for the COVID-19 response.¹ Helping to better understand community knowledge, attitudes and behaviours to COVID-19 and COVID-19 vaccines, regional studies were conducted to build evidence for intervention, enabling WHO to support targeted interventions to build public confidence and increase access to and acceptance of COVID-19 vaccines.

¹ Regional guiding framework for risk communication and community engagement for the COVID-19 response in the Eastern Mediterranean Region/Middle East and North Africa, December 2020. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (<https://applications.emro.who.int/docs/WHOEMIHR015E-eng.pdf>, accessed 27 March 2022).



14 national laboratory technicians

trained on SARS-CoV-2 next-generation sequencing in

7 complex-emergency countries

without sequencing capacity



10 regional webinars

held on risk communication and community engagement



Tunisia receiving 1 million COVID-19 Moderna vaccines from the United States of America through the COVAX mechanism on 30 July 2021.

Ensure equitable, timely and affordable access to vaccines

COVID-19 vaccination was first introduced in the Region in December 2020 and all 22 countries and territories had started vaccination by April 2021. Although COVAX was intended to ensure fair and equitable access to vaccines for every country, many low- and middle-income countries in the Region failed to receive enough doses to vaccinate their target populations in the first half of 2021. With strong WHO support and advocacy, COVAX increased vaccine allocation to meet countries' demands in the second half of 2021, allowing many countries to vaccinate their target populations. Vaccination coverage in the Region reached 30% (fully vaccinated population) by 31 December 2021, but with significant variations between countries; and six countries failed to reach the 40% WHO coverage target. It is critical to ensure the availability of adequate vaccine supplies, operational support, strong political commitment and community engagement to reach the current WHO target of vaccinating 70% of the population of each country by mid-2022.



**180 million
COVID-19 vaccine
doses**

shipped to countries in the
Region through COVAX

Reduce mortality and morbidity through quality clinical care

WHO supported countries in the Region to enhance their national capacities for critical care through trainings, mentorships, and provision of medical oxygen and other biomedical supplies. WHO and Member States have taken concrete steps to ensure the availability of new drugs for COVID-19 patients. WHO supported countries in the Region to actively participate in the global effort to generate evidence through research and innovation, and many countries conducted Solidarity trials to evaluate potential drugs and other research studies. WHO continued to negotiate with drug manufacturers to lower prices for new COVID-19 drugs and improve access to these therapeutics in low- and middle-income countries. With WHO's support, Member States of the Region procured lifesaving medical oxygen and biomedical equipment.



16 countries
supported by WHO in
receiving medical oxygen
and biomedical equipment
and supplies

4.2 Key lessons learned to leverage the COVID-19 response in 2022



Partnership and coordination

- Ensuring regular information sharing with partners is crucial to identify opportunities and any gaps in the regional COVID-19 response.
- Strong commitment from the highest levels of political leadership, recognizing the COVID-19 response as a national priority, is a key success factor in the coordination of a whole-of-government and whole-of-society response.



Operations support and logistics

- Facilitating the consolidation, prioritization and scheduling of deliveries through solid demand and distribution planning can enable increased precision of the health emergency response.
- Pre-positioning health supplies in a timely manner is critical to mitigate potential stockouts of essential supplies for the COVID-19 response.



Infection prevention and control (IPC)

- An effective IPC response to COVID 19 requires leadership commitment and true partnership by bringing together different agencies, experts, donors and national authorities to plan and operationalize the IPC programme.
- Protecting the health workforce requires the implementation of sound national surveillance systems for detection, management and optimal treatment of infected health care workers.



Communications (external and internal)

- Aligning high-level advocacy goals with communications efforts at the Regional Office, WHO country offices and ministry of health levels, with the collaboration of the highest levels of WHO and national management, is vital for an effective response.
- Training country communications officers plays a central role in advancing the COVID-19 response at country and community levels.



International Health Regulations and social measures

- Developing national policies and legislation is essential to guide and enforce the implementation of public health and social measures and enhance compliance to the International Health Regulations (IHR, 2005) at the country level.
- Institutionalized multisectoral coordination is key in the implementation of well-coordinated public health and social measures.



Risk communication and community engagement (RCCE)

- Increasing community participation in the response through community engagement and social mobilization campaigns has been key in almost all countries.
- Accommodating social media in public communications strategies for listening, information-sharing and addressing rumours is crucial given the impact of misinformation, disinformation and rumours on people's behaviours and overall responses.



Laboratory diagnostics

- Leveraging molecular testing for SARS-CoV-2 to diagnose other high-threat pathogens is required in countries with complex emergencies.
- Integrating, digitalizing and aligning testing strategies with surveillance systems, nationally and subnationally, has contributed to the success of the COVID-19 response in many countries.



Essential health systems and services

- The universal health coverage priority benefits package (UHC-PBP) has not been widely accepted and implemented in the Region due to weak health systems and the lack of involvement of key partners.
- The COVID-19 response has provided the opportunity to fast-track “building back better” and building more resilient health systems in the Region.



Case management and clinical operations

- Investing in and building critical care capacity in priority countries can save lives.
- Tackling the inequity in access to medical drugs, oxygen and biomedical supplies has contributed to minimizing the burden on health systems.



Resource mobilization

- Countries should continue to highlight the urgent funding needs for the COVID-19 response, while also showcasing the importance of preparedness, health systems strengthening and the continuity of essential health service delivery.



Research and knowledge management

- Ensuring the use of appropriate evidence from research and available data is essential during the emergency response for timely decision-making.
- Countries investing in research and innovation in support of the COVID-19 response has resulted in the conduct of large-scale trials and vaccine-effectiveness studies in the Region.



COVID-19 vaccine

- Improving vaccine delivery systems, especially for those most at risk such as refugees, migrants and people living in FCV settings, using integrated people-centred approaches, will maximize the impact of vaccination.
- Despite challenges, COVAX has achieved its intended goal of fair and timely vaccine distribution to priority countries.



Health information management and surveillance

- There is a need to invest in solid national health information management and integrated disease surveillance systems that are flexible enough to detect new events to allow for timely decision-making.
- Political willingness to share data is crucial for sustaining the monitoring of diseases and response activities, and to feed into global knowledge on new diseases.



Programme management

- Increasing and sustaining adequate capacity in programme management for emergencies, including dedicated and trained staff, is critical both at regional and country levels.

5. STRATEGIC PREPAREDNESS AND RESPONSE PLAN FOR COVID-19 IN THE EASTERN MEDITERRANEAN REGION IN 2022

5.1 Goal

Accelerate efforts to end the acute phase of the COVID-19 pandemic with an integrated, sustained and comprehensive response, while building the foundations for better preparedness and health systems recovery and resilience.

5.2 Regional strategic objectives

1. Leadership, coordination and political investment



Increase or maintain strong political commitment, leadership, coordination and partnership within and among Member States and partners to sustain an effective and integrated whole-of-government and whole-of-society COVID-19 response and minimize the impact of the pandemic.

2. Surveillance and laboratory diagnostics



Expand, enhance and integrate surveillance, testing and genome sequencing capacities to detect emerging SARS-CoV-2 variants early, monitor variant circulation, and generate reliable and comprehensive data analyses for decision-making. Fully integrate SARS-CoV-2 surveillance into existing influenza and other respiratory disease surveillance, such as GISRS+, to better contribute to the regional strategy for integrated disease surveillance.

3. Vaccination



Accelerate COVID-19 vaccination to reach coverage targets set to reduce the impact of the pandemic in terms of severe disease, hospitalization, death and the emergence of new variants, by prioritizing the most vulnerable, especially in countries with low coverage. Leverage efforts and investments into COVID-19 vaccination to strengthen routine immunization programmes and immunization systems overall.

4. Public health and social measures



Implement feasible and effective public health and social measures informed by regular situational assessments to mitigate transmission of SARS-CoV-2, prevent clusters among vulnerable populations and reduce the risk of new SARS-CoV-2 VOCs emerging.

5. Risk communication and community engagement



Renew efforts to strengthen risk communication and community engagement and empowerment, and address misinformation, through consistent social listening and community feedback.

6. Clinical care and the protection of health workers



Reduce severe disease and mortality by ensuring quality COVID-19 care (especially for at-risk groups), improving critical care and intensive care unit capacities, strengthening, protecting and supporting the health workforce, ensuring the availability of medical oxygen and other essential supplies, and continuing research on COVID-19 therapeutics.

7. Health systems and essential services



Strengthen health systems resilience, including through the Health Systems and Response Connector (HSRC) to improve access to COVID-19 tools, sustain an effective COVID-19 response, enhance countries' readiness, strengthen workforce capacities and primary health care, and build stronger and resilient systems, while ensuring the continuity of all essential health services.

8. Access to essential tools



Accelerate and promote equitable access to and distribution of new COVID-19 diagnostics, therapeutics and vaccines, and explore opportunities to expand the regional production of these tools.

6. What do we need to succeed in 2022?

6.1 Ending the acute phase of the pandemic

The acute phase of the pandemic is still ongoing as more cases and deaths were reported in the last few months, and some countries are currently suffering from record rates of hospitalization and death, due to the Omicron VOC. High levels of infection continue to be observed globally, large proportions of populations remain unvaccinated, and the risk of new VOCs emerging is high.

Ending the acute phase of pandemic means suppressing transmission and reducing morbidity and mortality across the world; protecting individuals (especially the vulnerable) from exposure; reducing the risk of future VOCs emerging;

enhancing surveillance and sequencing capacity to detect and monitor the circulation of new variants; accelerating access to vaccines and vaccination coverage to achieve the 70% target; and, empowering and enabling communities to adopt COVID-19 protective behaviours and adapt to living with COVID-19, including building resilience to the ongoing infodemic of misinformation and disinformation. It is imperative for all countries of the Eastern Mediterranean Region to adopt and implement these critical strategies and tools to end the acute phase of the pandemic and save more lives.

7%
of population of low-income countries
is fully vaccinated

versus

76%
of population of high-income countries



Less than **10%**
vaccination coverage (fully vaccinated)
in 6 countries

WHO has continued to advocate that the world can end the acute phase of the pandemic if 70% of the population of every country is vaccinated by mid-2022, with a focus on ensuring that those most at risk are protected, and by using the strategies and approaches proven to effectively respond to COVID-19. Disparity in vaccination access and coverage between higher and lower income countries is a major challenge. Six countries in the Region have not yet reached 10% of vaccination coverage (fully vaccinated) (Afghanistan, Djibouti, Somalia, Sudan, Syrian Arab Republic and Yemen) as of 31 December 2021. Inadequate vaccine supplies, limited access due to practical barriers, ongoing vaccine hesitancy, and limited operational capacity are all key factors preventing these six countries from achieving the set targets. Therefore, governments should commit to prioritizing COVID-19 vaccination, and partners should step up their support to enhance the operational capacity for vaccination. Furthermore, WHO and partners should maximize global vaccine manufacturing capacity through technology transfer, waiver of the vaccine patents, and public-private partnerships to expand vaccine production capacity.



Joint mass vaccination campaign by WHO and the Ministry of Health in Baghdad, Iraq, on 7 November 2021.

In 2021, WHO published strategic action and resources requirements to end the acute phase of the COVID-19 pandemic,¹ encouraging all countries to implement these strategic actions. The 68th Regional Committee for the Eastern Mediterranean Region adopted an action plan and resolutions to end the pandemic and prevent future pandemics.² Key actions to end the acute phase of the pandemic are described below.

1. Reaching vaccination coverage targets:

As COVID-19 vaccination has been identified as one of the key tools to end the acute phase of the pandemic, supporting vaccination is necessary in 2022 to ensure high coverage in every country following the Strategic Advisory Group of Experts on Immunization (SAGE) prioritization roadmap.³ To achieve this, equitable access to and delivery of COVID-19 vaccines should be ensured, research should be expanded to develop more effective vaccines for interrupting transmission, and community confidence and acceptance of the vaccines should be ensured.

2. Enhancing surveillance, testing and sequencing capacities:

Ensuring the rapid identification, characterization, tracking and evaluation of new variants through effective surveillance at all levels is a priority. This should be sustained nationally and regionally, without exhausting the system and while integrating testing within surveillance, as well as through monitoring and evaluation. Due to the risk of new VOCs emerging, expanding and improving regional and national sequencing capacities is urgent to rapidly detect new variants and monitor their circulation. Integrating SARS-CoV-2 surveillance into the existing system with surveillance of other respiratory diseases should be prioritized in order to monitor the virus circulation and evolution and to identify ways to transition systems into sentinel surveillance.

3. Reducing disease morbidity, mortality and long-term consequences of infection:

Integrating the COVID-19 CARE pathway⁴ into existing health services should be prioritized, at all levels, while ensuring sustainable capacity development of health care professionals in the management of critically ill patients to reduce mortality. In parallel, the procurement of oxygen, drugs and medical supplies should be scaled up. Adequate management of post-COVID-19 conditions and an enhanced understanding of risk factors and possible therapeutic options are also needed to reduce the long-term consequences of infection.

4. Supporting public health and social measures:

Public health and social measures should be adapted and calibrated utilizing a systematic risk-based approach consistent with a multisectoral lens, and kept agile via periodic revision. Implementation and further adjustment of such measures must be effectively communicated with the public and involve community engagement. Continuing to uphold a series of measures will effectively work towards curbing COVID-19 transmission and prevent significant surges in cases; no single measure will stand effective alone. Understanding pandemic fatigue, continued efforts for communication and transparency, novel approaches to shield vulnerable cohorts, and efforts to ensure compliance need to be calculated.

5. Travel measures and points of entry (PoE):

Ensuring healthy borders while maintaining the continuous movement of travel and trade remains a priority to prevent harmful economic collateral consequences and ensure an efficient global response. Additional measures concerning travel should adopt a risk-based approach and should be tied to larger national strategic efforts. These measures must be continuously communicated to the wider public as well as to WHO, as per Article 43 of the IHR (2005) obligations.⁵ Capacities and resources at PoE should be repurposed in accordance to volume and risk. Contingency planning, professionalized training, and cross-border collaboration working towards the exchange of information and joint surveillance and response among countries would serve as highly beneficial investments for COVID-19 and beyond.

6. Empowering communities and promoting behaviour change:

There is a need to strengthen community participation and leadership in COVID-19 response, including support to communities to adapt and implement community-led and adapted interventions. Doing so will help to build relationships of trust with health authorities and ensure COVID-19 guidance and interventions are accepted, accessible and sustained. Building upon this, there is a need to strengthen collaboration with community-based networks and partners for generating access and demand to COVID-19 vaccines, including ensuring easy and equitable access to those most at risk. There is a need to continue risk communication efforts in order to address ongoing COVID-19 risks and emerging issues, including rapid response to harmful rumours and misinformation.

¹ WHO strategic action and resource requirements to end the acute phase of the COVID-19 pandemic 2021. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/who-strategic-action-and-resource-requirements-to-end-the-acute-phase-of-the-covid-19-pandemic-2021>, accessed 27 March 2022).

² Accelerating health emergency preparedness and response – a plan of action (EM/RC68/4). Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (<https://applications.emro.who.int/docs/EMRC684-eng.pdf?ua=1>, accessed 27 March 2022).

³ WHO SAGE Roadmap for prioritizing uses of COVID-19 vaccines. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/who-sage-roadmap-for-prioritizing-uses-of-covid-19-vaccines>, accessed 27 March 2022).

⁴ COVID-19 clinical care pathway (CARE): confirm, assess, respond, evaluate. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/WHO-2019-nCoV-Clinical-CARE_Pathway-Poster_A-2022.1, accessed 27 March 2022).

⁵ International Health Regulations (2005) – second edition. Geneva: World Health Organization; 2008 (<https://www.who.int/publications/i/item/9789241580410>, accessed 27 March 2022).

6.2 Health systems recovery and resilience

In 2020 and 2021, the COVID-19 pandemic took a toll on economies and health systems globally, and challenged local, national, regional and global capacities to prepare and respond to public health threats. With nine major humanitarian emergencies, 102 million people needing humanitarian assistance (37% of the global total) and 32.3 million people forcibly displaced, the impact on Member States and populations in the Eastern Mediterranean Region was pronounced. In the early stages of the pandemic, many countries struggled with maintaining essential health services, while enforcing public health and social measures to control the spread of the virus, and adequately treating COVID-19 cases in often overwhelmed health facilities. Later, countries had to adapt their health systems to ensure the continuity of essential health services alongside an adequate COVID-19 response. Despite the extraordinary challenges in the health care systems, there were many opportunities to take steps to innovate and drive positive health system changes and meet the growing demands. Now, a successful transition into the next stage of the COVID-19 response relies on resilient and strong health systems. During a pandemic, a resilient health system is one able to effectively adapt and ensure health service continuity, deliver high-quality care, engage local communities, sustain public health functions and reduce vulnerabilities across the system.

It currently also entails the fair and continued supply of services, therapeutics and diagnostics, and equitable access to COVID-19 vaccines, through well-established, efficient and effective delivery mechanisms. This requires global and regional solidarity, for which the collaboration of Member States of the Region is needed.

In addition, the COVID-19 pandemic has demonstrated that improving service delivery is a priority. Not only should primary care be strengthened as the core of service delivery, but efficient human and financial resources should be integrated strategically across services and levels of the health system. Furthermore, many of the initiatives and progress by Member States and WHO during the COVID-19 pandemic were shown to address other public health concerns, such as scaling up laboratory networks, improving supply chain mechanisms and strengthening IPC. Integrating these initiatives into health systems, for long-term system-building, will strengthen the health system as a whole. Additionally, an overarching lesson learned during the COVID-19 pandemic is the value of utilizing existing systems (such as influenza surveillance, for example). In the same way, systems and processes implemented and enhanced during the COVID-19 pandemic should be integrated and utilized for future pandemic preparedness and response.



Visit to intensive care units and isolation facilities near the Salmaniya Medical Complex in Manama, Bahrain, established to ensure essential health services continuity in the main hospital, on 7 November 2021 during the WHO mission to Bahrain.

Health Systems and Response Connector (HSRC)

The HSRC aims to help countries to: turn vaccines into well-prioritized vaccination campaigns; turn tests into effective test-and-treat approaches; pursue community-based testing strategies to support public health measures and the platform for disease surveillance; and turn therapeutics into lifesaving clinical pathways. This means strengthening national response mechanisms, overcoming health system bottlenecks and barriers – including gender barriers – and putting communities and users at the centre, while maintaining essential health services and supporting integrated service delivery platforms.

The HSRC also ensures that all countries have the necessary technical, operational and financial resources to translate new COVID-19 tools into national response interventions to stop transmission and save lives. To that end, the HSRC will provide coordinated support to countries in planning, financing and tracking delivery against targets, and provide coordinated technical, operational and financial support to ensure the translation of tools into effective health interventions. It will complement the work of the product pillars to enable the delivery of national SPRPs, and protect the health system and health workforce.

In addition to providing support to achieve the product-specific targets of the pillars, the HSRC has one specific target of its own: to cover personal protective equipment (PPE) needs to protect all essential health and care workers.

The HSRC targets the following milestones for 2022:

- countries to conduct regular needs and gaps analysis based on epidemiological and essential supplies forecasts to inform national planning and response activities, while also identifying potential situations of concern;
- countries have integrated and “up-to-date” plans, resource requirements and financing allocations for vaccination, testing and clinical management on the COVID-19 partners platform;
- countries have at least 80% of their financing gaps for delivery met, primarily through domestic funding and, where required, are supported through concessional and/or grant financing;
- countries have “real-time” monitoring of availability and absorption of new COVID-19 tools and tracking against delivery targets;
- product pillars are supported to meet their targets by aligning with and leveraging national response capabilities, engaging communities and addressing immediate health system bottlenecks;
- countries reach pre-pandemic essential health service delivery levels and are supported to minimize COVID-19 knock-on effects and strengthen community resilience;
- essential health and community care workers are kept safe through provision of PPE and strengthening of IPC measures.

6.3 Health workforce development for a stronger response and lasting impact

In 2020 and 2021, WHO prioritized support to health care workers given their frontline role in the COVID-19 response. All countries of the Region have implemented activities to protect health workers, strengthen and optimize the health workforce, increase capacity and strategic health worker deployment, and address the pandemic's short- and long-term impact, including through mental health and psychosocial support. WHO built capacity for enhanced health worker preparedness to national public health emergencies.

Two years into the COVID-19 pandemic, health care workers remain a central component of the pandemic response and among the most at risk of infection. The prolonged emergency context has impacted their mental health, availability and capacity to deliver essential services and meet surge needs. Therefore, the health workforce response in 2022 will follow a two-pronged approach, as described below.

#1 Addressing health workforce requirements and challenges due to the COVID-19 pandemic

Protecting health care workers remains the priority. Their protection will be ensured through: IPC, including use of and access to personal protective equipment; decent working conditions, including occupational health and safety; mental health and psychosocial support; and remuneration and incentives. Protecting health care workers through vaccination is also critical. Although a high proportion of health care workers have been vaccinated in the Region, reaching those who have not yet been fully vaccinated is an urgent priority. Furthermore, building health care workers' capacities for an adequate response to COVID-19 is continuously needed and can be addressed through on-site or virtual training.

#2 Building emergency preparedness and response capacities, including surge capacities

As the response is ongoing, emergency preparedness and response capacities will be enhanced to build, mobilize and monitor surge capacities and mechanisms, and public health professionals' capacities will be scaled up. The COVID-19 pandemic has further illustrated the importance of essential public health functions and a well-trained public health workforce in preparing and responding to emergencies. The Regional Office has already taken steps to identify the skills and knowledge required to fulfil essential public health functions; incorporating these competencies within the programmes of the health professional education institutions is essential.



Health worker providing care to a COVID-19 patient in the De Martino Hospital isolation facility in Mogadishu, Somalia, on 27 September 2021.

7. How can we prepare for the next pandemic?

Despite the availability of effective and lifesaving medical countermeasures against COVID-19, many countries are still suffering from their highest rates of new cases, hospitalization and deaths due to the inaccessibility of these tools. The risk of another new variant emerging, with potentially increased transmissibility, disease severity and immune escape, persists.

As the COVID-19 pandemic has highlighted weaknesses in health emergency preparedness globally, successful strategies and lessons learned were identified throughout 2020 and 2021 to end the current pandemic and to prevent and prepare for the next possible pandemic. Translating these lessons learned into concrete actions, reconceptualizing current thinking around governance, leadership and the tools and systems required to strengthen health system resilience, and revising existing health emergency preparedness approaches, are essential for

moving forward. The availability of effective vaccines and therapeutics will likely reduce the risk of severe disease and death from COVID-19, but availability and access to these tools are major challenges in many low- and low-middle-income countries. Therefore, it is imperative to take collective action now to end the acute phase of the pandemic and prevent future public health emergencies by strengthening the international architecture of prevention, preparedness, detection and response to build resilience to this and future threats.¹ Strengthening national, regional and global capacities to prevent, prepare for, detect and respond to pandemics requires stronger political commitment, better national and global governance, increased investment in health systems and IHR (2005) core capacities, improved tools and systems, full engagement of communities, strengthened collaboration with other sectors especially those related to One Health, and equitable access to global public goods.

In May 2021, the Seventy-fourth **World Health Assembly** adopted resolution WHA74.7 on Strengthening WHO preparedness for and response to health emergencies,² and decided to establish a Member States Working Group on strengthening WHO preparedness and response to health emergencies. The Working Group was requested to consider the findings and recommendations of the three main independent review committees of the pandemic response,³ while taking into consideration the work of WHO and other relevant bodies, and to submit a report with proposed actions to the Seventy-fifth World Health Assembly in May 2022. Through decision WHA74.7, the Working Group was also tasked to review the benefits of developing a new WHO convention, agreement or other international instrument on pandemic preparedness and response and to provide a report at a special session of the World Health Assembly in

November 2022. The subsequent special session decided to establish an intergovernmental negotiating body to draft and negotiate the new convention/agreement/international instrument and to submit its outcome for consideration by the Seventy-seventh World Health Assembly in May 2024, with a progress report to the Seventy-sixth World Health Assembly in May 2023.

Furthermore, the 68th **Regional Committee** for the Eastern Mediterranean in October 2021 adopted resolution EM/RC68/R2 on Accelerating health emergency preparedness and response – a plan of action,⁴ which describes short-, medium- and long-term priorities to accelerate efforts to end the current COVID-19 pandemic and to prevent future health emergencies across the Region.

¹ Clark H, Johnson Sirleaf E. Ending this pandemic and securing the future. *BMJ* 2021;375:n2914. <http://dx.doi.org/10.1136/bmj.n2914>.

² Resolution WHA74.7. Strengthening WHO preparedness for and response to health emergencies. In: Seventy-fourth World Health Assembly, Geneva, 24–31 May 2021. Geneva: World Health Organization; 2021 (https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R7-en.pdf, accessed 17 April 2022).

³ Independent Panel for Pandemic Preparedness and Response (IPPPR), the IHR Review Committee and the Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies Programme

⁴ WHO Regional Committee for the Eastern Mediterranean resolution EM/RC68/R2 on accelerating health emergency preparedness and response – a plan of action. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021 (<https://applications.emro.who.int/docs/EMRC68R2-eng.pdf?ua=1>, accessed 27 March 2022).

8. How will we reach our objectives?

8.1 Priority activities for COVID-19 preparedness and response in 2022 by pillar

Pillar	Priority activities
Partnership and coordination	<ol style="list-style-type: none">1. Continue to support multisectoral, multi-partner coordination mechanisms with international and regional health partners, stakeholders and donors to ensure a whole-of-government approach to country preparedness and response to COVID-19.2. Establish effective monitoring of the progress of COVID-19 response by regional partners and identification of gaps/needs among the partners.3. In collaboration with other pillars, conduct an in depth-analysis of the difficulties in collecting the necessary data for the health cluster indicators, including variables that are not being collected and identification of and suggestions for necessary improvements.4. Conduct field missions to the country offices and strengthen the linkage between the regional partnership and coordination pillar with the country offices' health cluster coordination.5. Facilitate advocacy and technical discussions with ministers, United Nations officials and other key partners on the COVID-19 situation in the Region.6. Support countries to adapt/develop and implement their national SPRPs for COVID-19, incorporated in either the Country Preparedness and Response Plan for 2021 or the Humanitarian Response Plan for 2021, as applicable, with estimated resource requirements (human, financial, supplies, etc.).7. Facilitate capacity assessment and risk analysis, including proper mapping and inclusion of populations in FCV settings, gender analysis, and mapping of vulnerable populations, for the implementation of the national plan.8. Sustain the regional partner network to ensure coordination of COVID-19 preparedness and response at regional and country levels.
Communications (external and internal)	<ol style="list-style-type: none">1. Develop the regional emergency communications strategy to cover all health emergencies including COVID-19.2. Organize and undertake capacity-building for country communications officers on emergency communications and best practices including writing for the web, feature stories, press releases, social media and talking to the media.3. Develop an emergency communications toolkit and materials on COVID-19 and other health emergencies to share with regional and country partners, in alignment with the goal of strengthening external communications to make WHO more visible, responsive and interactive.4. Roll-out of regional media training for journalists, with a focus on building their capacity on reporting on COVID-19 and COVID-19 vaccines via online training package and webinars.5. Developing a COVID-19 communications toolkit for regional and country focal points to ensure streamlined, quality, accurate and relevant communications.6. Monitor, evaluate, analyse and promote the lessons learned, country success stories and trends in efforts to enhance best practices and observe the effect of communications on targeted audience behaviour.

Pillar

Priority activities

Operations support and logistics

1. Forecast and identify the demand for therapeutics, diagnostics and other COVID-19 critical health supplies to establish a cost-effective pre-positioned supply of health commodities available for rapid dispatch to address gaps and respond to evolving epidemiology and operating environments, particularly in FCV contexts.
2. Establish a full quality management system at the global hub inclusive of infrastructure and human resources to ensure the quality of pharmaceutical products distributed globally.
3. Establish supply planning and tracking capabilities to support country programmes by improving the visibility of supplies and the status of the supply chain response.
4. Build the capacity of staff working in the global hub on innovative supply chain management and ways to support country capability to manage humanitarian supplies.

Laboratory diagnostics

1. Support Member States to establish and enhance capacity for genome surveillance and sequencing of SARS-CoV-2 and other high-threat pathogens to support early detection of unusual events.
2. Support Member States to develop, update and implement their SARS-CoV-2 genomic surveillance strategies in line with the updated WHO global strategy document.
3. Support Member States to review and optimize their national laboratory testing strategies for SARS-CoV-2 based on transmission dynamics and available resources.
4. Conduct virtual and on-site training for the use of antigen rapid diagnostic test (RDT) kits and develop a system of training for non-laboratory health care workers (nurses, doctors) on antigen RDT use, including fit-testing, waste disposal, etc.
5. Organize a quality assurance mechanism through participation in the WHO External Quality Assessment scheme and facilitate rechecking of positive and negative specimens by national laboratories.
6. Support technology transfer and troubleshooting through mentoring and supervision visits of peripheral laboratories by national reference laboratories.
7. Organize regional training on sequencing and bioinformatics and uploading of sequencing data in international databases.
8. Support countries to develop a procurement and distribution plan to ensure timely and sustained access to testing kits, reagents and other laboratory supplies.
9. Procure and pre-position stocks of essential supplies in the Dubai hub to enable a faster, more efficient regional response.

Infection prevention and control

1. Enhance IPC capacities and implementation of priority IPC practices for COVID-19 within hospitals in vulnerable countries through instituting a multimodal intervention/quality improvement programme.
2. Support countries to review, update and disseminate national IPC guidance in the context of COVID-19 for health and community care settings.
3. Support countries to develop and endorse national IPC training plans and curricula and conduct regular IPC training courses targeting the health care workforce.
4. Conduct tailored IPC trainings for high-vulnerability settings that favour the spread of COVID-19 (camps, migrant dormitories, etc.) to reduce the risk of outbreaks.
5. Conduct regional IPC webinars, in collaboration with the WHO Collaborating Centre in Saudi Arabia, on updates in IPC in the context of COVID-19.
6. Advocate for development and implementation of clear national protocols for prevention and management of COVID-19 infection among health care workers.
7. Support countries to institute national monitoring programmes for IPC priority indicators including hand hygiene in selected health care facilities.

Pillar	Priority activities
Case management and clinical operations	<ol style="list-style-type: none"> 1. Ensure frontline health workers have access to the necessary quality assured therapies, training, equipment and supplies to provide safe and quality care. 2. Enhance critical care/intensive care unit capacities and lifesaving skills among frontline health care workers in priority countries. 3. Continue to monitor and identify oxygen and mechanical ventilation capacities in priority countries and address the gaps. 4. Ensure equitable access to medical oxygen, supplies/equipment and therapeutics for priority countries. 5. Continue updating and disseminating WHO guidelines and evidence-based information to all countries in the Region. 6. Facilitate implementation of international/WHO protocols for research and clinical trials at the country level, where opportunities exist.
Health information management and surveillance	<ol style="list-style-type: none"> 1. Strengthen detection capacity at the regional and country level by cascading the available procedures and tools. 2. Pursue dialogue with WHO country offices and ministries of health for improving data collection and sharing in a timely manner. 3. Support countries to enhance capacities in data collection, analysis and information generation, as well as data sharing in a timely manner; and specifically monitor health system capacities including hospitalization rates and hospital occupancy. 4. Encourage countries to strengthen their influenza surveillance systems (SARI and ILI sentinel sites) and integrate the surveillance of other respiratory diseases. 5. Support the integration of SARS-CoV-2 into the existing influenza surveillance, while promoting integrated surveillance of emerging respiratory diseases. 6. Enhance detection and monitoring of SARS-CoV-2 VOCs and develop a mechanism for related information management processes. 7. Develop/build new indicators to better understand the evolution and impact of the pandemic and implement mechanisms to collect and monitor the indicators. 8. Continue to update the regional COVID-19 SPRP monitoring and evaluation framework, in coordination with WHO headquarters and country offices. 9. Streamline the use of information technology platforms for COVID-19 data management and dashboards at the regional and country level and support adaptation and deployment of the DHIS2 digital data package for COVID-19 surveillance. 10. Conduct in-depth epidemiological analysis of possible risk factors contributing to COVID-19 morbidity and mortality, particularly in countries with high case fatality rates. 11. Strengthen the modelling capacities at regional and country level and support countries in running statistical modelling at national and subnational levels. 12. Support continuing training and capacity-building of national and subnational rapid response teams/integrated public health teams for COVID-19 outbreak and case investigation and management, laboratory sample collection, contact tracing, RCCE and IPC. 13. Develop and disseminate protocols to enable rapid response teams/integrated public health teams to collect and analyse subnational data for assessing levels of local transmission and health system response capacity, so as to assign a "situation level" and to inform implementation of public health and social measures. 14. Conduct landscape analysis and needs assessment to identify rapid response team capacities in the Region and identify gaps, challenges and strengths for improved COVID-19 response.

**International
Health
Regulations and
social measures**

Points of entry and international travel

1. Enhance operational capacities at PoE by supporting country assessments of PoE premises and operations and the modification/restructuring of physical premises to mitigate transmission risks.
2. Strengthen PoE surveillance and screening systems through enhanced multisectoral coordination between national authorities and PoE stakeholders.
3. Foster collaboration among PoE stakeholders by harmonizing existent PoE partners across the Region to synergize a body of practice, including expanding the Regional Interagency PoE working group to coordinate technical support to countries.
4. Support countries to conduct risk assessment of international travel and public health measures, and provide training on WHO's guidance for risk assessment related to international travel.
5. Foster cross-border collaboration on COVID-19 and other public health threats of mutual concern or in the light of mass gatherings of mutual attendance, and provide technical and strategic support to enhance information sharing between countries.
6. Maintain and coordinate the regional Travel Measures platform and follow up with countries on weekly entering of data.

Mass gatherings

1. Encourage documentation of best practices and lessons learned on mass gatherings for use in scientific studies and case-studies.
2. Scale up capacities for mass gathering events in the context of COVID-19 by providing technical trainings and support countries to conduct risk assessments and preparedness evaluations to inform contingency plans and operational SOPs, perform joint exercises/drills, and develop and communicate travel requirements for specific events.
3. Assist countries in developing effective communication materials and methodologies to convey risk, protective public health measures, and additional health measures concerning mass gatherings, and public health and social measures.

Social measures

1. Ensure daily data collection and monitoring of social measures implemented in countries, including mobility and epidemiology data, maintain the Social Measures dashboard and produce a weekly summary report on social measures implemented in the Region.
2. Monitor, collect and conduct in-depth analysis (such as time series analysis) to understand the impact of social measures on the epi curve in each country and develop policy briefs guided by the findings to inform decision-making at country level.

Pillar	Priority activities
Risk communication and community engagement	<ol style="list-style-type: none"> 1. Support countries with review of the national COVID-19 RCCE response plans, including updating, to consider longer term impacts of COVID-19 and priority issues. 2. Support countries to assess and strengthen their COVID-19 RCCE response through intra-action reviews and simulation exercises. 3. Strengthen regional and country-level coordination mechanisms for RCCE, facilitate stakeholder mapping and, where necessary, establish an RCCE coordination mechanism with multisectoral partners for COVID-19 and COVID-19 vaccine roll-out. 4. Maintain regional interagency coordination with core partners (IFRC and UNICEF) for COVID-19 and COVID-19 vaccine demand generation activities. 5. Establish a regional social listening dashboard for systematic collection of and reporting on social listening and behavioural insights to inform COVID-19 and COVID-19 vaccine demand generation response. 6. Strengthen capacity of ministries of health in establishing social listening and community feedback mechanisms, including infodemic management. 7. Support the roll-out of community resilience projects in countries, aimed at strengthening community resilience and adaption to COVID-19 and other public health threats. 8. In close coordination with the vaccine pillar, support countries in COVID-19 vaccine demand generation including support with reviewing demand generation plans, workshops and training for trusted partners and social influencers, and designing social mobilization interventions and community engagement strategies with a focus on vulnerable groups. 9. Continue roll-out of the community health worker training package to priority countries, strengthening the capacity of community health workers in generating demand for vaccines and addressing hesitancy.
Research and knowledge management	<ol style="list-style-type: none"> 1. Conduct or support priority research on assessing COVID-19 vaccines effectiveness (priority countries are Egypt, Islamic Republic of Iran, Jordan, Morocco, Pakistan and Tunisia). 2. Conduct or support COVID-19 sero-epidemiology studies in countries of the Region. 3. Provide operational and technical support to conduct WHO Unity Studies in countries. 4. Assess and support national COVID-19 evidence-informed policy-making processes and national decision-making processes, and how these were affected by the pandemic. 5. Identify and support COVID-19-related innovation (including digital health innovations) in response to country needs, in collaboration with relevant teams at all levels of WHO. 6. Support priority research on COVID-19 in countries through open calls for research proposals linked to the announced global or regional priority topics. 7. Support sharing and dissemination of peer-reviewed knowledge and evidence with the WHO community, partners involved in the COVID-19 response, and wider academic and policy-making circles.
Essential health services and systems (through HSRC)	<p>Health systems strengthening through the HSRC to improve access to COVID-19 tools</p> <ol style="list-style-type: none"> 1. Support country planning and tracking against delivery targets of COVID-19 tools, through gap assessments of needs and capacities, the development of national deployment strategies of COVID-19 tools, and by monitoring the availability and absorption capacities of COVID-19 tools in the Region. 2. Coordinate technical, operational and financial support to countries to ensure the translation of COVID-19 tools into effective health interventions by supporting the effective deployment of vaccines, therapeutics and diagnostics, building capacity, and providing operational support and technical assistance.

Sustain effective health system response to COVID-19

1. Integrate service delivery pathways into the health system by supporting countries to devise context-specific models of care and move toward their implementation, including developing guidelines and documenting success stories.
2. Ensure adequate supply, uptake and use of PPE by the health workforce by conducting situation analyses and improving regional capacity for the production and distribution of PPE and other essential medical supplies.
3. Advocate for digital health and innovation supported by national and international collaboration through data collection, deployment of international consultants and advisory meetings.
4. Engage in policy dialogue with ministries of finance to allocate more public money for health, through country missions, consultant deployment and system-building.
5. Strengthen health governance and improve the role of the private sector and institutional arrangements towards coordinating and maintaining essential health services, through regional meetings, regional guidance and networking.

Building a resilient health system

1. Leverage the current response to strengthen pandemic preparedness and response through a health systems approach by conducting country assessment missions, amplifying technical cooperation and utilizing One Health.
2. Invest in essential public health functions, including those needed for all-hazards emergency risk management, through policy dialogues, capacity assessments and capacity-building.
3. Build a strong primary health care foundation to advance universal health coverage and health security, through country missions, advocacy, regional forums and model-of-care implementation.
4. Invest in institutionalized mechanisms for whole-of-society engagement as part of health systems strengthening by reviewing documents, enhancing advocacy, assessing the regional workforce capacity, empowering populations and increasing technical cooperation.
5. Create and promote enabling environments for research, innovation and learning for continuous health systems strengthening through policy guidance documents, advocacy and networking.
6. Increase domestic and global investment in health system foundations and all-hazards emergency risk management through capacity assessments, legislative and policy coordination, and by leveraging non-health investments to support public health.
7. Address pre-existing inequities and the disproportionate impact of COVID-19 on marginalized and vulnerable populations by engaging vulnerable groups, promoting social protection policies, and fostering strategic and operational connections between development and humanitarian programmes.

Ensuring the continuity of essential health services

1. Minimize the knock-on effects of COVID-19 on other essential health services (such as reduced access to health facilities, reduced ability to pay for services, reduced staffing available to provide care, disrupted supply chain systems and lack of essential medical supplies) by monitoring the continuity of care, putting in place policy dialogues and recommendations, and documenting success stories.
2. Support system-building to improve access to integrated quality essential health services amid COVID-19 and beyond through technical cooperation, cross-departmental initiatives, guidance documents on the implementation of the UHC-PBP, assessments of the UHC-PBP in Member States, country missions and regional meetings.

COVID-19 vaccine

1. Secure access to sufficient quantities of COVID-19 vaccine of ensured quality.
2. Promote demand for COVID-19 vaccines in the population.
3. Increase COVID-19 vaccine coverage towards the WHO target through provision of client-friendly vaccination services.
4. Ensure vaccine equity across and within countries, with a focus on refugees, migrants and people living in FCV settings and vulnerable situations.
5. Support evaluation of the effectiveness of COVID-19 vaccination in the field.
6. Support and facilitate the COVID-19 vaccine intra-action review (Mini-cPIE) in priority countries.

8.2 Budget summary by pillar for 2022

The budget covers all COVID-19 needs at regional and country levels, with over 95% of the budget designated for countries. The priority activities mentioned above are covered by WHO's Regional Office for the Eastern Mediterranean.

Pillars	WHO country office (US\$)	WHO Regional Office (US\$)	Grand total (US\$)
Pillar 1. Leadership, coordination, planning and monitoring	7 504 194	988 814	8 493 007
Pillar 2. Risk communication and community engagement	10 562 880	428 000	10 990 880
Pillar 3. Surveillance, case investigation and contact tracing	19 601 487	888 100	20 489 587
Pillar 4. Travel, trade and points of entry	8 728 525	673 030	9 401 555
Pillar 5. Diagnostics and testing	59 079 709	963 000	60 042 709
Pillar 6. Infection prevention and control	22 615 912	315 383	22 931 294
Pillar 7. Case management and therapeutics	57 808 456	642 000	58 450 456
Pillar 8. Operational support and logistics	24 180 048	214 000	24 394 048
Pillar 9. Essential health systems and services	24 780 577	116 067	24 896 644
Pillar 10. Vaccination	105 261 010	732 950	105 993 960
Pillar 11. Research, innovation and evidence	1 718 420	1 967 730	3 686 150
Grand total (US\$)	341 841 217	7 929 073	349 770 290

9. How will we measure our impact?

9.1 Monitoring and evaluation

The SPRP's regional monitoring and evaluation (M&E) framework for 2021, including a comprehensive indicator compendium and analysis plan, allowed the identification of lessons learned and the development of recommendations, leading to improved WHO support to the implementation of country preparedness and response plans for COVID-19. Throughout 2021, regular meetings were held with WHO's global COVID-19 M&E network, as well as with WHO country offices, to follow up on data entry, quality and analysis. COVID-19 M&E training materials were developed and virtual trainings were provided to COVID-19 M&E focal points in country offices. In late 2021, an end-of-year review with WHO country office focal points was conducted to review the

indicators, assess the challenges encountered in reporting and M&E, and determine the way forward for 2022.

Aligned with the global M&E framework, the SPRP's regional M&E framework for 2022 (see below) is a collaborative initiative of WHO teams at country, regional and global levels, built on the nine pillars of the regional IMST. The framework aims to assess the regional and national performance and progress towards the SPRP goals and strategic objectives for 2022, through a set of regional indicators to monitor countries' COVID-19 response activities. The pillar-based indicators provide a periodic situational snapshot of the regional and national operations.

COVID-19 SPRP M&E framework for 2022

No.	Indicator	Type	Target	Source	Frequency
Partnership and coordination					
1	Proportion (%) of countries with an active multisectoral, multi-partner coordination mechanism to support preparedness and response	Process	100%	Country offices/ activated Emergency Operations Centre or IMST	Quarterly
2	Proportion (%) of countries that have modified at least one planned event due to COVID-19 (cancelled, postponed)	Output	50%	Country offices	Quarterly
Communications (external and internal)					
3	Number of country press releases issued	Output	NA	Country offices	Monthly
Operations support and logistics					
4	Proportion (%) of countries requesting PPE from the regional and global system that have received stockpiles within 6 weeks	Output	85%	WHO regional OSL/ WHO SPRP M&E team	Monthly
5	Proportion (%) of requested supply volume disaggregated by type (PPE, biomedical equipment and diagnostics) that has been shipped to countries	Output	85%	WHO regional OSL/ WHO SPRP M&E team	Monthly
6	Percentage (%) of countries experiencing stock out of critical items	Output	0	Country offices	Monthly

No.	Indicator	Type	Target	Source	Frequency
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Health operations and technical expertise

Laboratory diagnostics

7	Proportion (%) of laboratories with COVID-19 testing capacity in the country	Outcome	NA	Country offices/Regional Office laboratory focal point	Monthly
8	Proportion (%) of laboratories in the country performing SARS-CoV-2 molecular testing that are participating in external quality assessment (EQA) for SARS-CoV-2	Process	100%	WHO headquarters (influenza programme) and COVID-19 laboratory team	Twice a year if EQA is organized
9	Percentage (%) of laboratories with 80% performance in WHO's COVID-19 EQA	Outcome	75%	WHO headquarters (influenza programme) and COVID-19 laboratory team	Twice a year if EQA is organized

Infection prevention and control

10	Percentage (%) of countries with a designated national IPC COVID-19 response committee/group/focal person to lead the IPC response to COVID-19	Output	100%	Country offices	Monthly
11	Percentage (%) of countries that developed and disseminated national IPC guidance for COVID-19	Outcome	100%	Country offices	Annually
12	Number or percentage (%) of health workforce trained on IPC in the context of COVID-19 (percentage of the total number of health workforce, if data are available)	Output	NA	Country offices	Monthly

Case management and clinical operations

13	Proportion (%) of hospitals designated to treat COVID-19 cases	Output	NA	Country offices/List of designated hospitals from Member States	Monthly
14	Number of health workers trained on COVID-19 case management	Output	NA	Country offices	Monthly

Rapid response teams

15	Proportion (%) of countries with trained multidisciplinary rapid response teams at a subnational level	Input	100%	Country offices/training records	Monthly
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Health information management and surveillance

16	Inpatient bed (designated for COVID-19) occupancy rate (%), nationwide	Output	NA	Country offices/country surveillance report, HeRAMS	Monthly
17	ICU bed (designated for COVID-19) occupancy rate (%), nationwide	Output	NA	Country offices/country surveillance report, HeRAMS	Monthly
18	Number and percentage (%) of cases who are health care workers	Outcome	NA	Country offices/country surveillance report, HeRAMS	Monthly

No.	Indicator	Type	Target	Source	Frequency
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International Health Regulations and social measures

Points of entry

19	Proportion (%) of PoE with public health emergency contingency plans inclusive of a risk communication strategy (i.e. travellers, media/public)	Input	100%	Country offices	Biannually
20	Percentage (%) of PoE with public health emergency contingency plans and SOPs for managing respiratory illnesses at specific PoE	Input	100%	Country offices	Biannually
21	Percentage (%) of PoE equipped to generate real-time electronic data on suspect passengers	Process	100%	Country offices	Quarterly

Risk communication and community engagement

22	Percentage (%) of countries where an RCCE coordination mechanism is formally activated (e.g., multisectoral RCCE team, working group, task force)	Process	100%	Country offices	Quarterly
23	Percentage (%) of countries that have an active mechanism in place to capture community feedback (e.g. community meetings, hotlines, health volunteer networks, social listening, surveys, etc.)	Outcome	100%	Country Offices	Quarterly
24	Percentage (%) of countries that monitor disinformation, misinformation and rumours deemed harmful to public health and implement related response measures	Outcome	50%	Country offices/WHO headquarters infodemic management team	Quarterly

Research and knowledge management

25	Percentage (%) of countries funding research proposals for COVID-19-related topics that were completed according to plan	Output	75%	Regional office IMST	Annually
26	Percentage (%) of COVID-19-related RCTs conducted by the countries that have a minimum of 1000 participants	Output	20%	Regional office IMST	Annually
27	Proportion (%) of vaccine effectiveness studies completed according to plan	Output	20%	Regional office IMST	Annually
28	Proportion of countries that received technical and financial support to implement at least one sero-epidemiological investigation using WHO Unity Studies protocols	Outcome	60%	Regional office/global bi-weekly bibliography	Quarterly
29	Number of countries that received technical and financial support to implement at least one WHO Unity Study	Process	18	Regional office/global bi-weekly bibliography	Quarterly
30	Percentage (%) of countries submitting all-causes mortality on weekly basis	Process	40%	Country offices	Monthly

No.	Indicator	Type	Target	Source	Frequency
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Essential health services and systems

31	DTP3 vaccination coverage in children under 12 months of age	Outcome	NA	Regional IMST	Monthly
32	Institutional delivery	Outcome	NA	Regional IMST	Monthly
33	Percentage (%) of countries where at least one VPD immunization campaign was affected (suspended or postponed, partially or fully) by COVID-19	Outcome	NA	WHO/IVB headquarters team	Monthly
34	Outpatient attendance (number)	Outcome	NA	Country offices	Monthly
35	Hospital admissions OR discharges (number)	Outcome	NA	Country offices	Monthly
36	Stockouts of essential medicines or supplies (%)	Output	NA	Country offices	Monthly
37	Total doses of COVID-19 vaccines administered per country	Output	Varies	Country offices	Weekly
38	Proportion of targets vaccinated with the first dose	Output	Varies	Country offices	Weekly
39	Proportion of targets vaccinated with the second dose	Output	Varies	Country offices	Weekly

Programme management

40	Number of surge deployments filled and timely from the requests received by WHO country office and IMST	Output	NA	Regional Office BOS/HR; programme area managers and WHO Representatives	Monthly
41	Percentage of funds distributed (against planned cost)	Output	100%	Regional Office PMO; BOS/ Finance; country offices	Monthly
42	Percentage of funds utilized (against funds distributed)	Output	100%	Regional Office PMO; BOS/ Finance; country offices	Monthly

BOS = Business Operations; HeRAMS = Health Resources and Services Availability Monitoring System; HR = Human Resources; IVB = Immunization, Vaccines and Biologicals; OSL = Operations Support and Logistics; PMO = Programme Management Office; RCT = randomized controlled trial; VPD = vaccine-preventable disease.

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