Global Health Multistakeholder Dialogue: from Hiroshima to Puglia

Results from a Multistakeholder Survey on G7 Priorities

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Executive Summary: Priorities and Challenges for the G7

The Global Health Multistakeholder Dialogue (GHMD) survey was conducted from September to October 2023, rendering rich and in-depth data for consideration of the Italian G7 Presidency. There were 144 completed and partially completed surveys, responses of which were analysed and compiled into this report, to be used as a background document for discussion at the 1st December 2023 conference organised by the Japan Centre for International Exchange. Survey respondents found numerous challenges pertaining to the three surveyed issue areas (R&D and access, health workforce, and health financing for UHC and PPPR), including the following:

- Insufficient/inequitable/inappropriate financing for R&D, including that there is limited financing for early-stage R&D and set-up of R&D institutions and programs
- Poor state/public financing of public health workforce and fragmented health workforce strategies at the country level
- Poor compensation of health workers and an exodus of health workers from LMICs to HICs
- A lack of political will and the shifting of domestic priorities away from PPPR and UHC, and interlinked to that poor articulation of the value of investing in both UHC and PPPR to long-term health and economic security

Based on these and other findings more comprehensively described through this report, we propose the following draft recommendations:

R&D and Access

1. In all initiatives and sources of financing for regional manufacturing, to identify key opportunities for true end-to-end financing, including funding for set-up/start-up of facilities.
2. Increase investments by every G7 country into pull investments to replenish the AMR pipeline, while simultaneously increasing investments into current push investments such as CARB-X, GARDP, and SECURE.
3. Ensure that an established pathogen/genetic sequence data platform has, inter alia (see Section 1g in this report), the following characteristics: a) Multilateral consensus/standardisation on nomenclature, such as what constitutes 'timely' sharing; b) Realtime uploading and access of data; c) elements of decentralization to regional bodies (such as to the European Virus Archive or to the Africa CDC).
4. To consult a wide range of stakeholders on the hosting and feasibility of prototype libraries for diagnostics, therapeutics, and vaccines.

Health Workforce

1. Explore models of taxes, reimbursement models, disincentives, or compensation models applicable to HIC countries that absorb LMIC workforce, with funding to be used towards development of health workforce in LMICs (including scholarships)
2. Identify financing streams/forums for the development of cohesive and long-term health workforce retention strategic plans.
3. Push for the professionalization and formalization of community health workers and support strong community health systems as integral to care in emergencies.

Sustainable Financing in PPPR and UHC

1. Endorse and facilitate discussions around a **fair share model for surge financing of PPPR**, with each country providing a percentage of GDP to funds for these purposes.[1] These should be underlined with Global Public Investment[2] principles. Given the drop-off in political will during the inter-pandemic period, these may need to be in the form of pledges secured in advance from countries. The G7 could announce this fund as a strategic initiative with the G20 and other blocs to encourage political will in other regions.

[1] It should be noted that a fair share model is presently one of the proposals for the Pandemic Accord. Negotiations are due to be concluded May 2024.

[2] Global Public Investment <https://globalpublicinvestment.org/qa/> accessed 14 November 2023

2. To discuss and explore mechanisms/conditions that these funds include/be supplemented by **absorptive capacity support** (such as human resources capacity to deploy provided financing, transportation, energy, and digital connectivity) and **public finance management capacity building**.
3. Provide technical support for taxation reforms to support sustainable UHC financing in LMICs.
4. To ensure that G7 financing decisions are made with **meaningful consultation with a wide range of local/domestic stakeholders** – this will ensure that financing for UHC is rightsized to local priorities and identifies concerns with public finance management competencies and absorptive capacity issues (such as infrastructure, human resources, and connectivity) are identified at the outset.
5. G7 and G20 to emphasise and support the development of **sustainable domestic financing plans** as the first line of defense in PPPR.

Methodology

A structured survey was designed by Matahari Global and refined in consultation with co-organisers of the GHMD conference (including JCIE, the International Pandemic Preparedness Secretariat, CEPI, and others). The survey had three sections based on issue areas, and respondents were free to respond only in the sections they had work experience in. The three sections were:

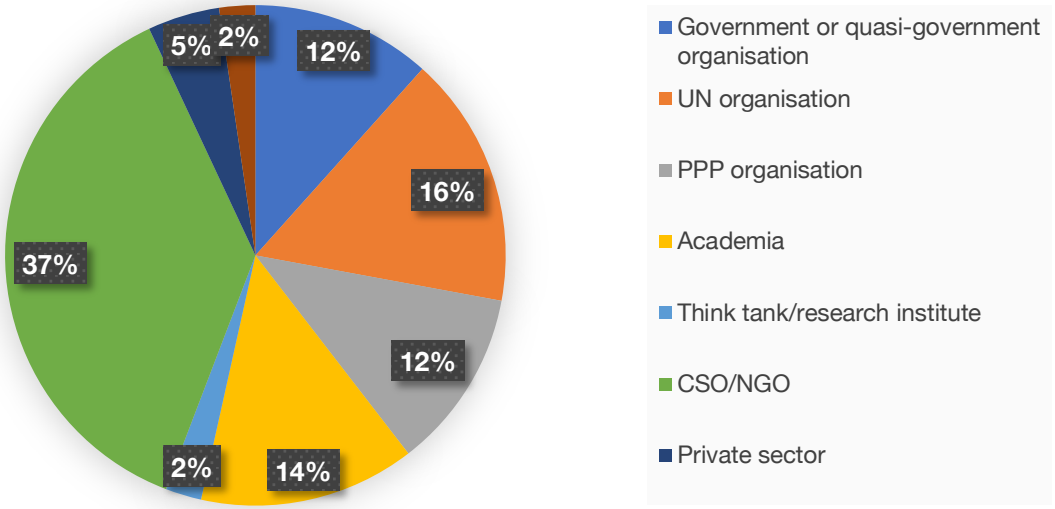
1. Equitable R&D, access to countermeasures, and pathogen data sharing.
2. Strengthened public health and emergency workforce; and
3. Financing for UHC and PPPR.

This was deployed via the Qualtrics platform in September 2023 and closed in early October 2023. Three respondents preferred in-depth interviews, and these were conducted from 2-6 October 2023. Three respondents (a PPP organisation, a CSO/NGO, and a government/quasi-government organisation) provided written responses via email. Data was consolidated into spreadsheets and thematically analysed. Preliminary results were presented to the GHMD Advisory Committee virtually on 26th October 2023, followed by a CSO consultation meeting for further feedback on 10th November 2023. Insights from both of these meetings will be used to triangulate findings in the final iteration of this report.

Findings

Demographics

The survey had a total of 144 submitted and partially completed surveys, with 43 complete surveys. Of the 43 respondents who completed surveys, 37% of respondents were from CSOs, followed by 16% UN organisations, 14% from academia, 14% from government of quasi government institutions, and 12% from public-private partnerships working in global health. Two respondents were from the private sector. Only 1 respondent (2%) was from a think tank or research institute.



According to geolocation data, 58% of respondents were based in the Global North versus 42% in the Global South. Respondents were based in 22 countries.

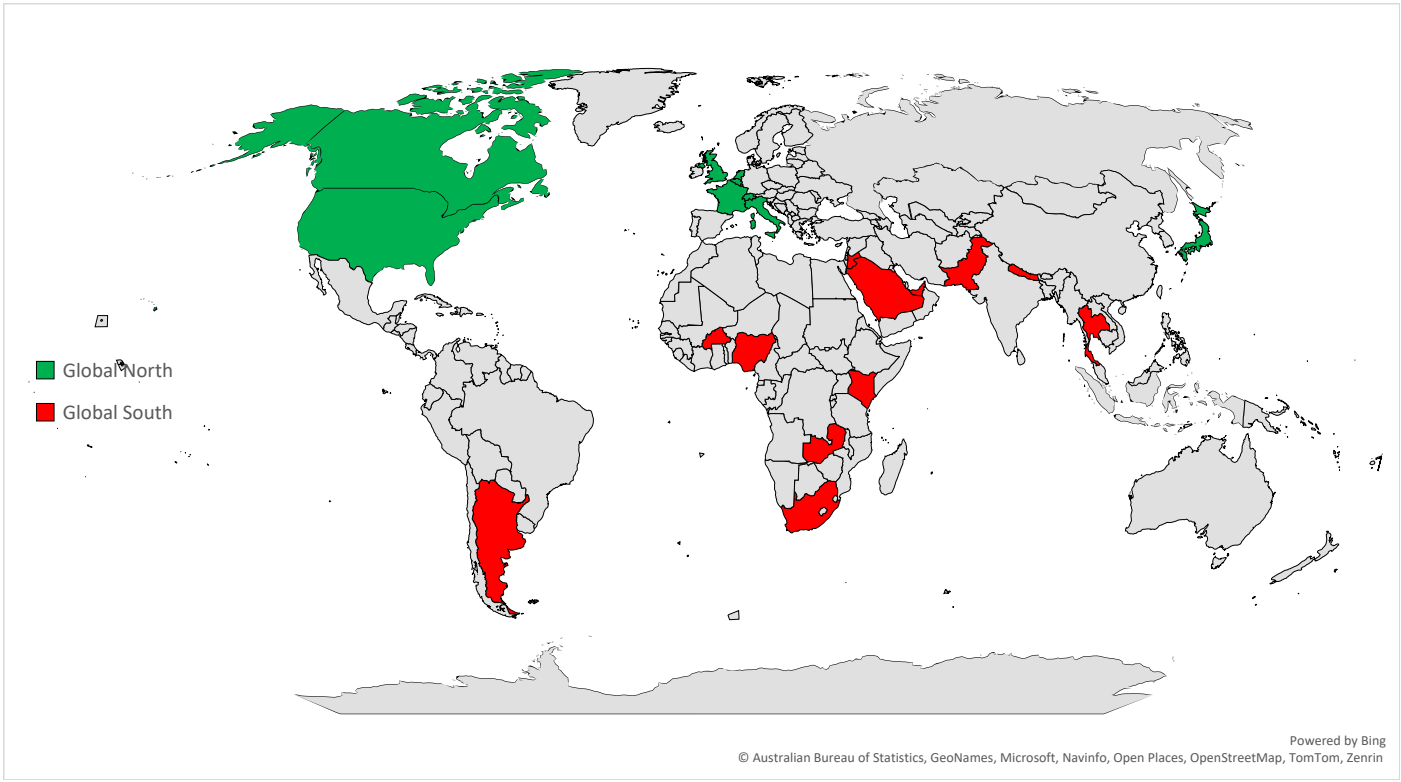


Figure 1: Geographical distribution of respondents

Issue Area 1: Equitable R&D, Access to Countermeasures, and Pathogen Data Sharing

Objective

Accelerating R&D and promoting equitable access to medical countermeasures and new antibiotics including timely and open data sharing (pathogen, clinical samples, and genetic sequence data)

Summary of Findings

Overall, respondents felt that either **insufficient/inequitable/inappropriate financing for R&D** of countermeasures was the biggest challenge in R&D and access, with inappropriate financing being associated to funding not being linked to WHO Priority Pathogen List, that there was limited funding for early- stage research in interpandemic period, and that funding was not focused on **end-to-end R&D including set-up of R&D institutions**. Intellectual property barriers were cited as the second largest barrier, followed by R&D capacities concentrated in too few (Global North) countries as the third largest barrier. Given sensitivities around intellectual property, during validation meetings stakeholders enquired whether most who named IP as a key barrier were from CSOs/NGOs, however respondents including those from UN organisations and PPP organisations. End-to-end R&D financing, including for set-up of facilities, emerged repeatedly and strongly through these sections – suggesting the need for increased focus on financing at early stages of R&D.

When asked about what practical actions should be carried out by the G7, work to reduce regulatory barriers was cited most frequently. Respondents felt actions needed to be taken from now to the medium-term to improve **regulatory alignment and coherence** between governments and with WHO, stringent regulatory authorities & ML3 regulatory agencies to ensure accelerated registration of MCMs and antibiotics. These may emanate from known issues around slow regulatory approval of products at the WHO due to insufficient human resources and a high work burden.

Respondents felt that **increased investments into both push and pull initiatives** to replenish the clinical pipeline for antibiotics, the former of which includes buttressing investments into CARB-X, GARDP, and SECURE, but also that **more prominent and visible communications** were needed around the salience of an agenda for replenishment of the clinical pipeline for antibiotics. When asked about what features should pertain to a pathogen/genetic sequence data sharing platform, respondents felt that there needed to be **realtime uploading and access to data**, elements of decentralisation/regionalisation of such a platform, timely sharing of pathogens such as within 48h of characterisation, and that it would be accessible to all countries.

On the question of whether the G7/G20 should pursue **prototype libraries for diagnostics, therapeutics, and vaccines**, 39% of respondents strongly agreed, although others believed that this should be the domain of WHO or a neutral actor, or that the libraries should be hosted in LMICs.

1a) Biggest hurdles to accelerating R&D and promoting equitable access to medical countermeasures (national, regional, global)

Of the 43 respondents that answered the survey section for Issue Area 1, 14 (33%) stated that the biggest hurdle was insufficient/inequitable/inappropriate financing for R&D of countermeasures, followed by 6 respondents (14%) who

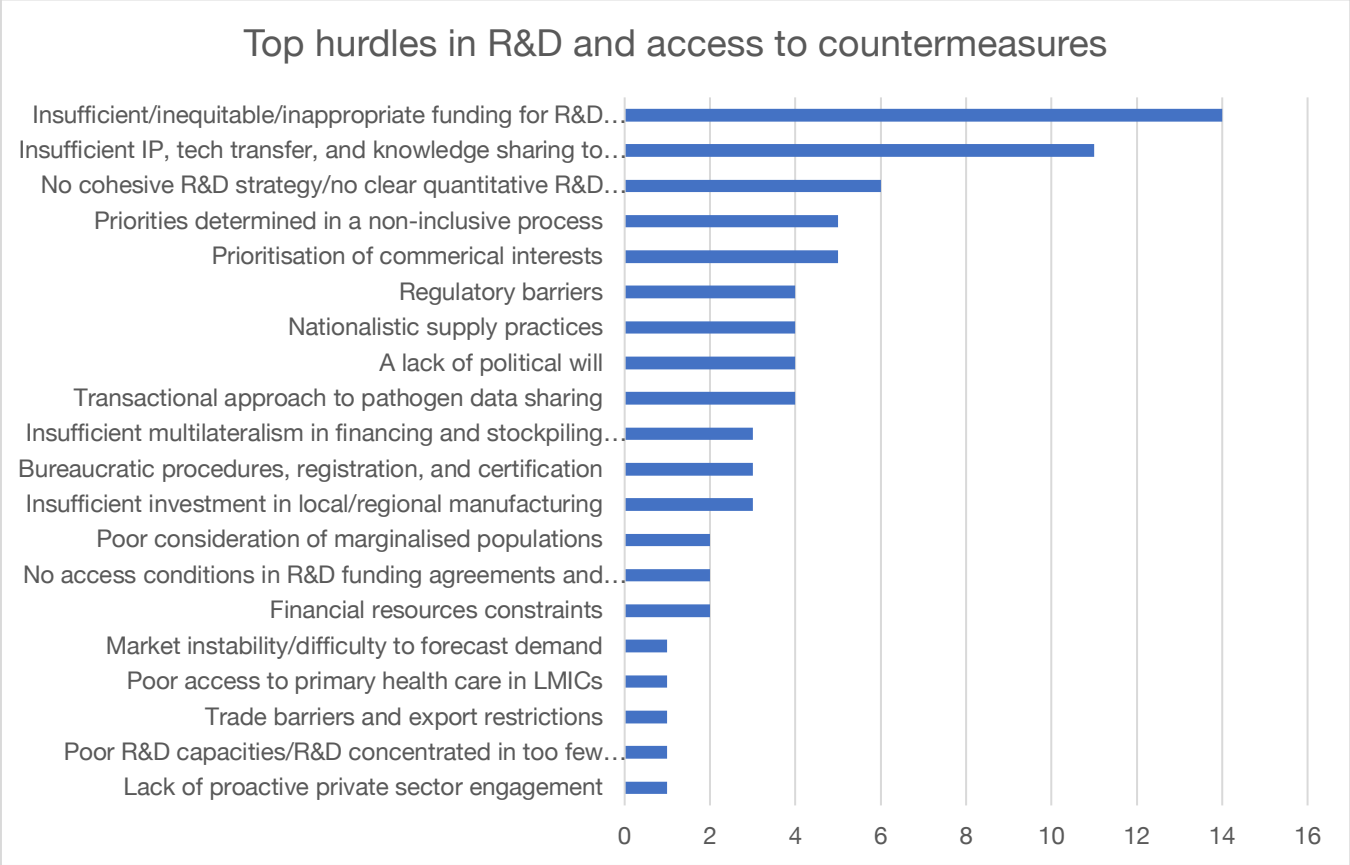


Figure 2: Top hurdles/challenges in R&D and access

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or capacities concentrated in few countries was the biggest barrier to accelerating R&D and access to countermeasures. Responses were overwhelmingly focused on R&D versus access, but when focused on access, were focused on a several key barriers, i.e., that there were issues with availability of commodities due to the lack of decentralised production at the regional level, that there was inadequate demand planning for LMIC markets, excessive export restrictions that prevented the entry of products into markets, intellectual property barriers, and inconsistent/weak engagement of civil society and community health systems for outreach to marginalised and hard-to-reach communities.

Of the sixteen respondents who believed that insufficient/inequitable/inappropriate financing for R&D of countermeasures was the biggest hurdle, half (N=8) stated that financing was insufficient overall. Others provided more detail, such as:

> *"(There is) limited funding for early-stage research in the years preceding a pandemic (preparedness), and lack of flexibility in surge funding to ensure early production and supply for low and middle-income countries." [Respondent 19]*

Whereas Respondent 34 stated that there was insufficient funding for end-to-end R&D – with most R&D ending up in publications rather than towards product introductions.

Of those who considered R&D capacities as the biggest barrier, one stated that clinical trial capabilities were poor, whereas another stated that there were many unequal R&D partnerships, with R&D capacities concentrated in only a few countries. In Respondent 6's own words:

> *"R&D capacities for pandemic MCMs are disproportionately concentrated in a few developed and emerging countries, and there are no fair or equal partnerships that promote R&D at the global level. One of the main reasons for unequal partnerships and the lack of sharing technologies in R&D is the lack of transparency in research, purchasing and distribution, which leads to higher prices and corruption."*
>
> *[Respondent 6, CSO/NGO, East Asia]*

Four respondents (9%) were more concerned about who determined priority diseases/pathogens for R&D financing and investments on access to countermeasures and stated that the process was very 'top-down' and non-inclusive. In the words of Respondent 8, for example:

> *"When a pandemic hits the US and other R&D-strong countries, the R&D is very rapid and quite effective. So, the problem is less speed of R&D response to pandemics, than (a) R&D for diseases that are not a public health threat to G7, and (b) global manufacturing and access to G7-invented health products."*
>
> *[Respondent 8, PPP Organisation, Europe]*

This was echoed by Respondent 42, but in regard to access to countermeasures:

> *"The biggest hurdle (is that) the current GHI initiatives is that they remain top-down. If you look at most of them, representation from LMICs is limited to one or two countries. A trend that has started to appear is having a Minister of Health or an African LMIC government official (very high up, Permanent Secretary or President) be a co-chair. This is not true co-creation, as the messages remain at high level."*
>
> *[Respondent 42, CSO/NGO, Southern Africa]*

Another respondent stated that pharmaceutical industry was insufficiently proactive as regards R&D for infectious diseases. In their own words:

> *"We found that in the 2022 Access to Medicine Index that only five of the twenty top large R&D-based pharmaceutical companies are currently engaging in R&D for emerging infectious diseases other than for COVID-19. Ultimately, companies are not very proactive when it comes to R&D for infectious diseases… And what we need to see is companies really investing more earlier on, being more proactive about their infectious disease investments and portfolios, ensuring that projects are moving quickly within the pipeline and have access plans attached in phase 2 and onwards, and that (these products) are ready to be tested in clinical trials, at the first signals of an outbreak, epidemic or a pandemic."*
>
> *Margo Warren, Director of Government Engagement and Policy, Access to Medicine Foundation*

Warren also stated that it was necessary for companies to think earlier on about access provisions and plans. In Warren's own words:

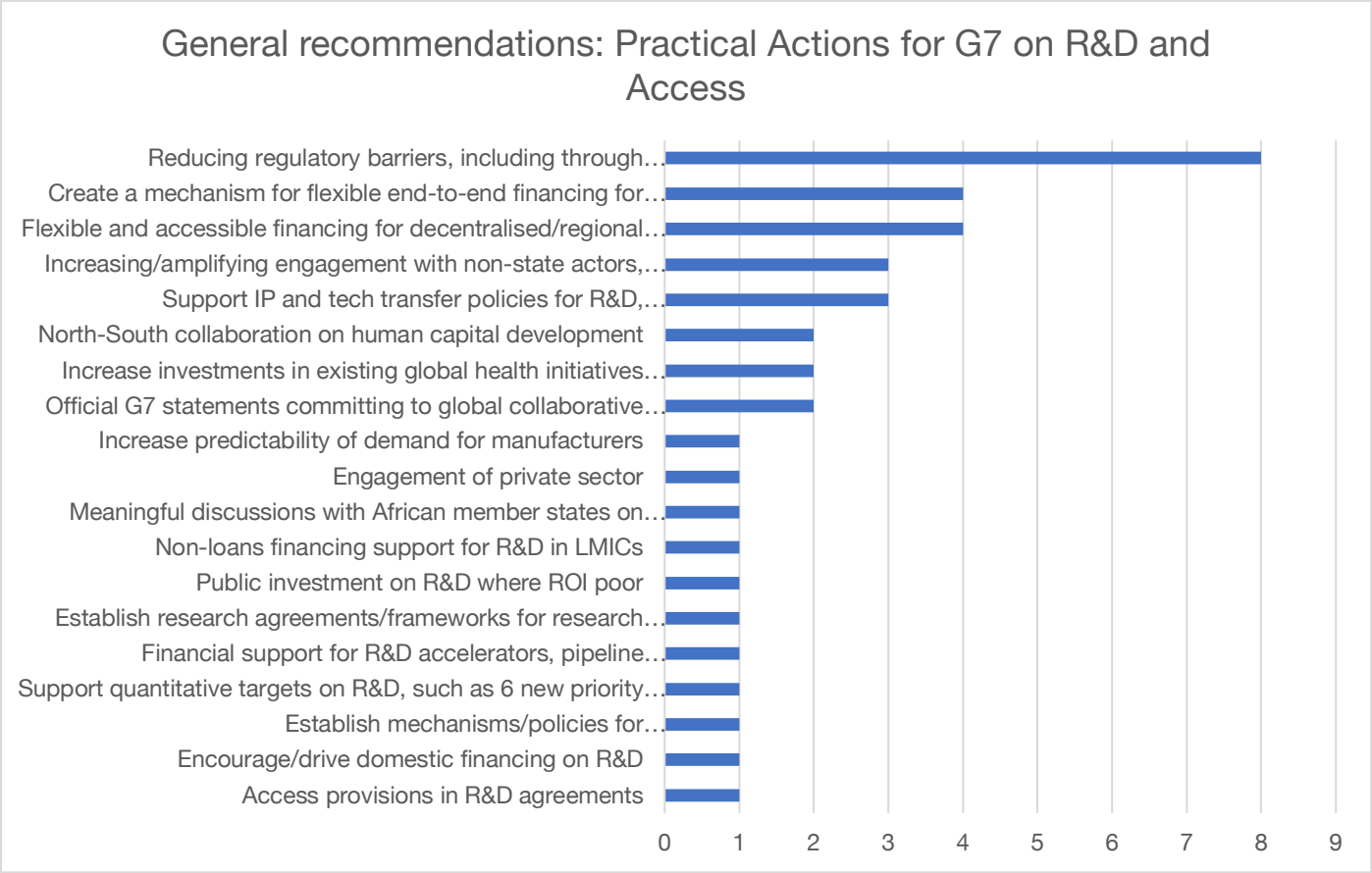
"We would like to see more companies think earlier on also about access plans, and where they're going to make their products more affordable and available, and also ensure that supply can meet demand in low-income countries and LMICs more broadly. But specifically in low-income countries, we often find that that this subset of countries are left out or not included in plans. And ultimately that has quite a significant impact once a product reaches the end of the pipeline and is approved."

Margo Warren, Director of Government Engagement and Policy, Access to Medicine Foundation

1b) Practical actions and interventions for the G7 to address R&D and access hurdles

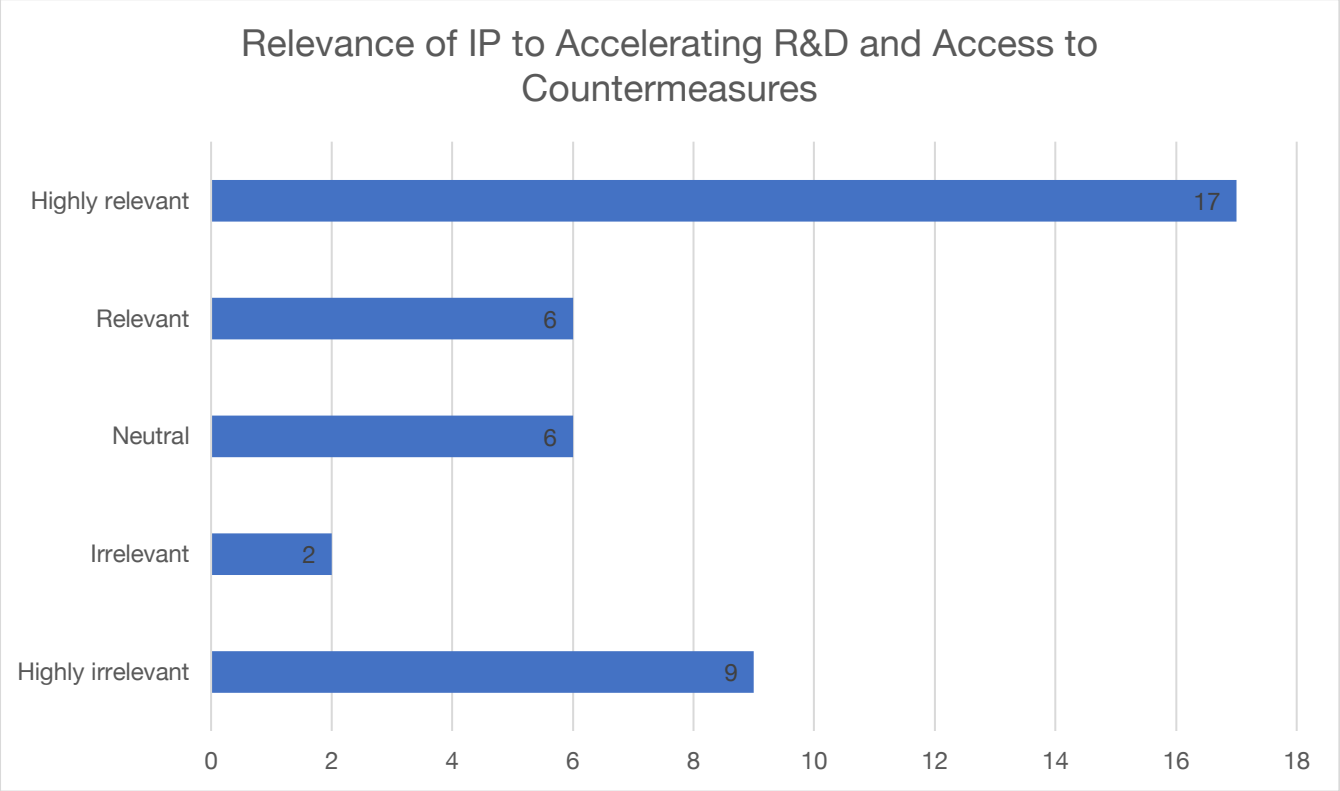
Question: What are the short-, medium- and long-term practical actions and interventions that the G7 could do to address these hurdles? Who are the stakeholders that need to be engaged and what actions can we take to shorten/accelerate product development and availability timelines in preparation for the next pandemic?

23 respondents provided 36 general recommendations for practical actions for the G7 with the reduction of regulatory barriers emerging strongly as an important intervention to address R&D and access hurdles, followed by the need to create a mechanism for end-to-end financing of R&D, and the need for flexible and accessible financing for regional manufacturing of pandemic countermeasures.



1c) Relevance of intellectual property interventions to accelerate R&D and equitable access to medical countermeasures

Of the forty respondents that answered this question, 17 (42.5%) stated that intellectual property interventions are 'highly relevant' to accelerating R&D and equitable access to medical countermeasures.



One respondent who rated this 'neutral' stated that while IP was relevant, they perceived that the ability to manufacture at scale was a bigger factor in access. In their own words:

> *"IP interventions are relevant, but we've seen with COVID that when there is a horrible global health crisis that consumes all media attention, governments are willing to override IPRs (like when Israel issued a CL against US pharma giant AbbVie just because they took more than 48h to grant a VL). IP is a huge problem, but sheer ability to manufacture at scale is an even bigger one."*
>
> *[Respondent 1, sector and region unknown (did not complete survey)]*

Another respondent from a PPP organisation stated that IP was 'highly relevant' to accelerating R&D and access to countermeasures for multiple reasons. In their own words:

> *"Intellectual property can be a means to encourage the development of new medical technologies that have an existing or future commercial market, especially on behalf of adult populations in high-income countries. Yet intellectual property may not be effective to encourage the development of new medical technologies to prepare for pandemic threats that may never materialize, nor to encourage the development of new antibiotics that ultimately must be conserved and used sparingly. Secondly, intellectual property rights can discourage the sharing of technologies, including both platform technologies on which many new pandemic countermeasures may be constructed. Finally, intellectual property rules can act as a barrier to access with respect to supply, follow-on development for specific populations, and with respect to price. However, there are approaches to addressing intellectual property that can help to mitigate these various concerns, including government use of WTO rules and voluntary licensing."*

[Respondent 14, PPP organisation, Europe]

1d) Importance of transparency of terms of R&D funding contracts (as proposed in Pandemic Accord texts) for access to countermeasures.

82% of respondents strongly agreed or somewhat agreed that terms of R&D funding contracts, including access terms (as proposed in the Pandemic Accord) was important for access to countermeasures.

1e) It is said that one of the key elements for ensuring equity in access to MCMs is regional manufacturing capacity. What is needed most to enhance regional manufacturing capacity in your view?

36 respondents provided 71 recommendations on how to enhance regional manufacturing capacity. Of these 71 recommendations, most frequently mentioned was the need for end-to-end financing, including set-up, maintenance, and human capital financing for manufacturing facilities (13 responses), followed by the development of regional capacity (including through North-South collaboration) (10 responses), and technology transfer and sharing of know-how (7 responses). The top five responses are as follows:

1. End-to-end financing, including set-up, maintenance, and human capital
2. Development of regional capacities, including through North-South collaboration
3. Technology transfer and sharing of know-how
4. Regional manufacturing hubs linked to purchase agreements
5. Clear and predictable forecasts/policy and supply environments

This need for end-to-end financing was often linked to the fourth most frequently mentioned response, i.e., that regional manufacturers should be linked to purchase agreements, as well as the need to invest in an enabling environment for manufacturing, such as regional regulatory mechanisms. In the words of one respondent from a PPP organisation:

*"Investments must be made with a realistic outlook in terms of how long it will take to develop regional capacity at a level that meets quality and regulatory standards. There is a need for **adequate investment in bricks and mortar, in human capital, and in the enabling ecosystem including regional regulatory mechanisms**. Parallel investment is needed in mechanisms that pool demand including stockpiles and pooled procurement for regional use and a pathway for exportation. Sustainability should also be addressed up front by ensuring that the capacity created is maintained through continued use." [Respondent 3, PPP organisation, North America]*

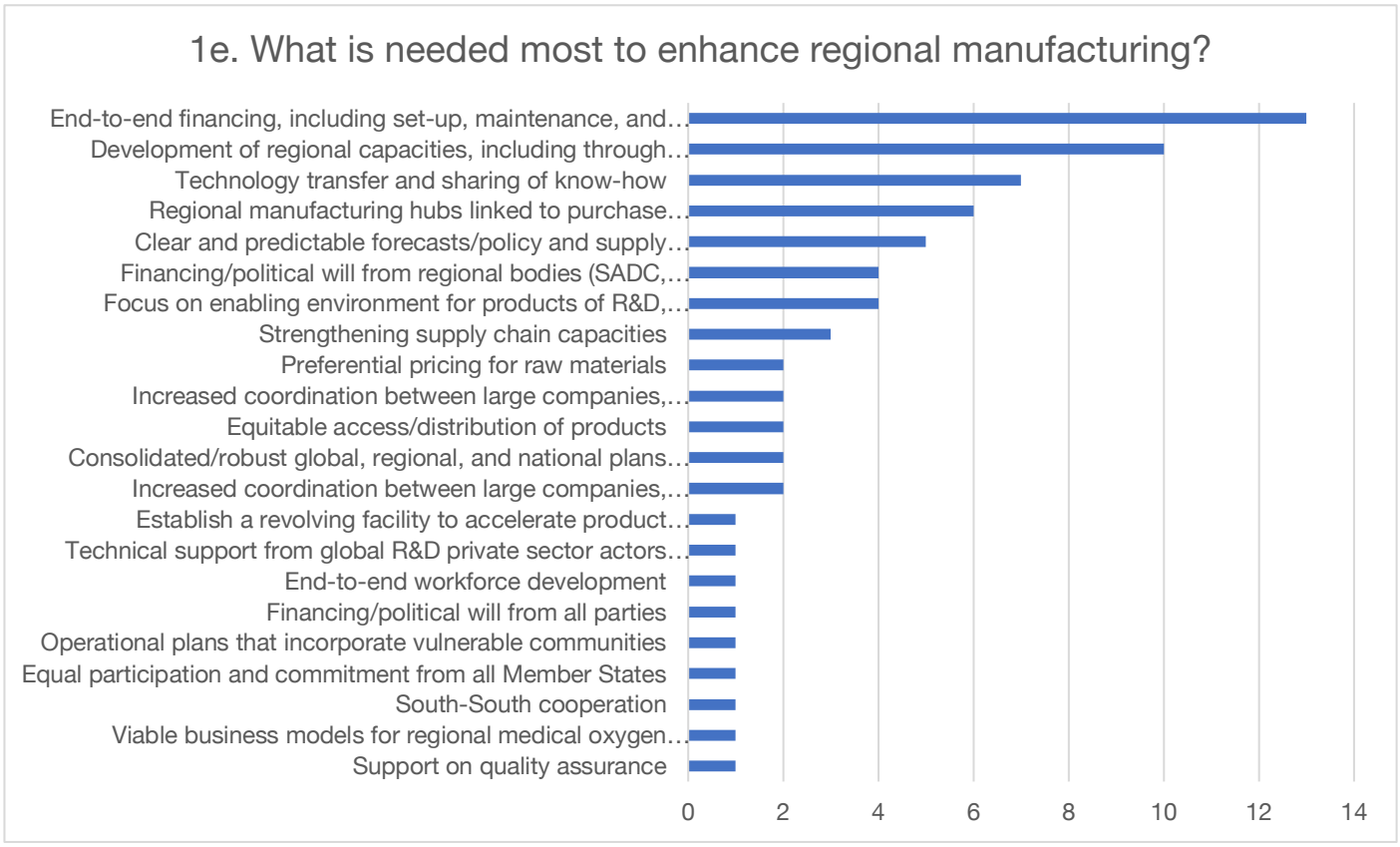


Figure 3: What is needed most to enhance regional manufacturing capacity?

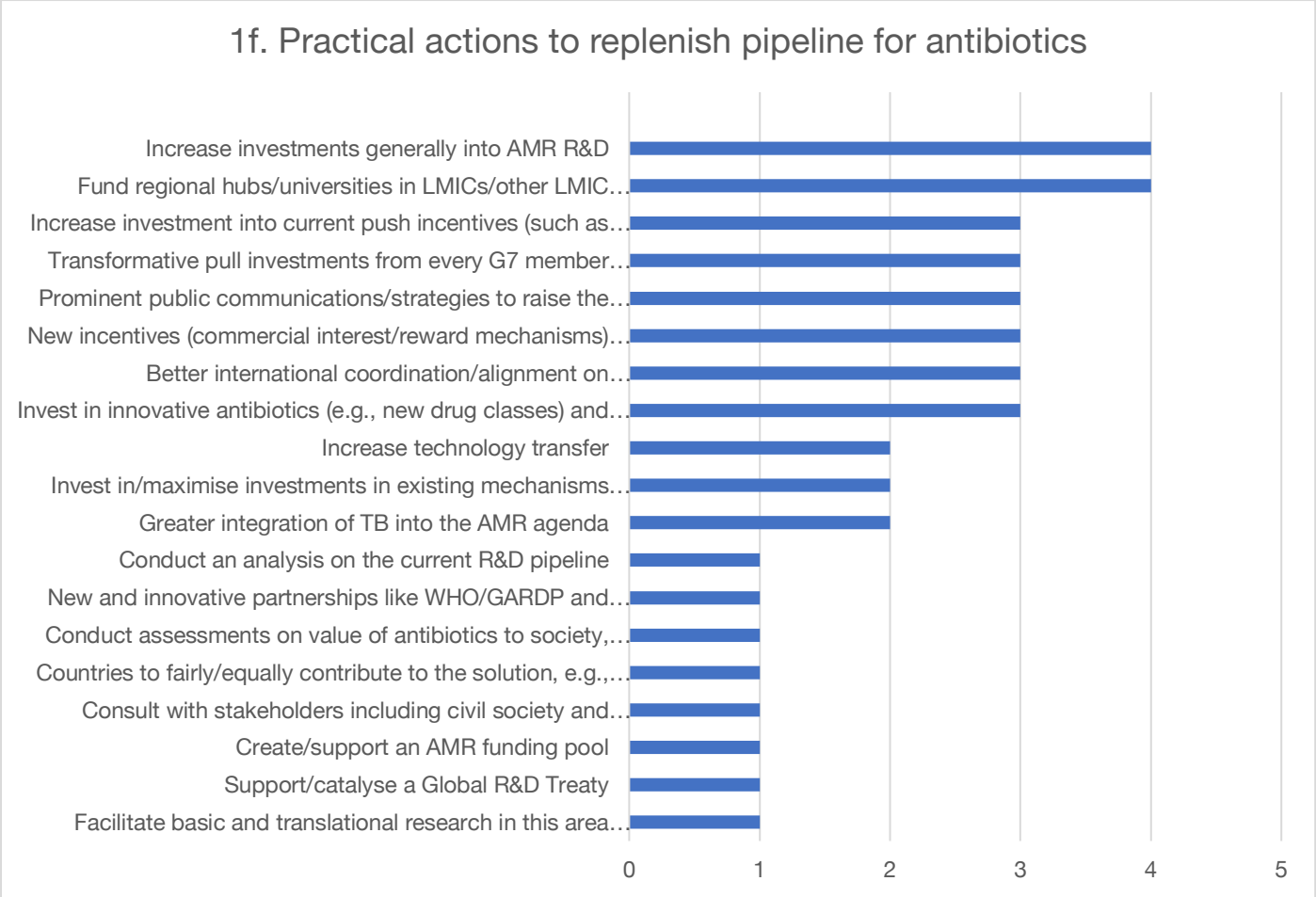
Respondents stated that North-South collaboration should occur by, inter alia, 'supporting capacity building for regional procurement and manufacturing' and 'ongoing capacity building'. Others cautioned, however, that these should be concentrated around where manufacturing hubs would be most strategic. In the words of one individual from a think tank/research institute:

"It really is about figuring out strategically and geographically where manufacturing centres should be and what sort of support they need to get off the ground… with the G7, there seems to be a very clear understanding of why (regional manufacturing) is important." [Respondent x, Think Tank/Research Institute, Europe]

1f) Practical actions can we take to replenish the clinical pipeline of new antibiotics, and ensure sustainable and equitable global access to new and existing AMR products

There were 30 respondents to this question, providing 40 eligible recommendations for replenishment of the antibiotics pipeline. 9 recommendations were ineligible for reasons of clarity or non-specificity to AMR pipelines. Importantly, respondents believed that investments generally needed to increase for AMR R&D, but also that regional hubs and

institutions in LMICs should be funded to do this. Respondents felt that investments needed to increase into both pull and push incentives such as GARDP, CARB-X, and SECURE, and that more prominent communications were needed to raise the profile and importance of replenishing the clinical pipeline for antibiotics.



Three respondents stated that there was a needed to invest in innovative antibiotics such as new drug classes. Damiano de Felice from CARB-X provided further explanation on this:

> *"Replenishing the AMR clinical pipeline with different types of innovative products, not only antibiotics (e.g., new drug classes) but also non-traditional therapeutics (e.g., peptides, phages, antibodies), is crucial if we want to address the rising levels of infections which are resistant to current treatment options. This is why four G7 governments (US, Germany, UK and Canada) and two private foundations (Wellcome and Gates) have already funded CARB-X to support a very diverse pre-clinical pipeline which includes small molecules and non-traditional approaches."*
>
> *[Damiano de Felice, Director of External Engagement, CARB-X]*

1g) What does a timely pathogen/clinical sample/genetic sequence data sharing platform look like, and what role would the new International Pathogen Surveillance Network or a potential Global Vaccine Library play?

25 respondents answered this section, although six answered don't know/not sure and two provided incomplete or irrelevant answers. The remaining 19 respondents made 39 recommendations of characteristics for a timely pathogen/clinical sample/genetic sequence data sharing platform. Based on the most cited characteristics, such a platform should have the following characteristics:

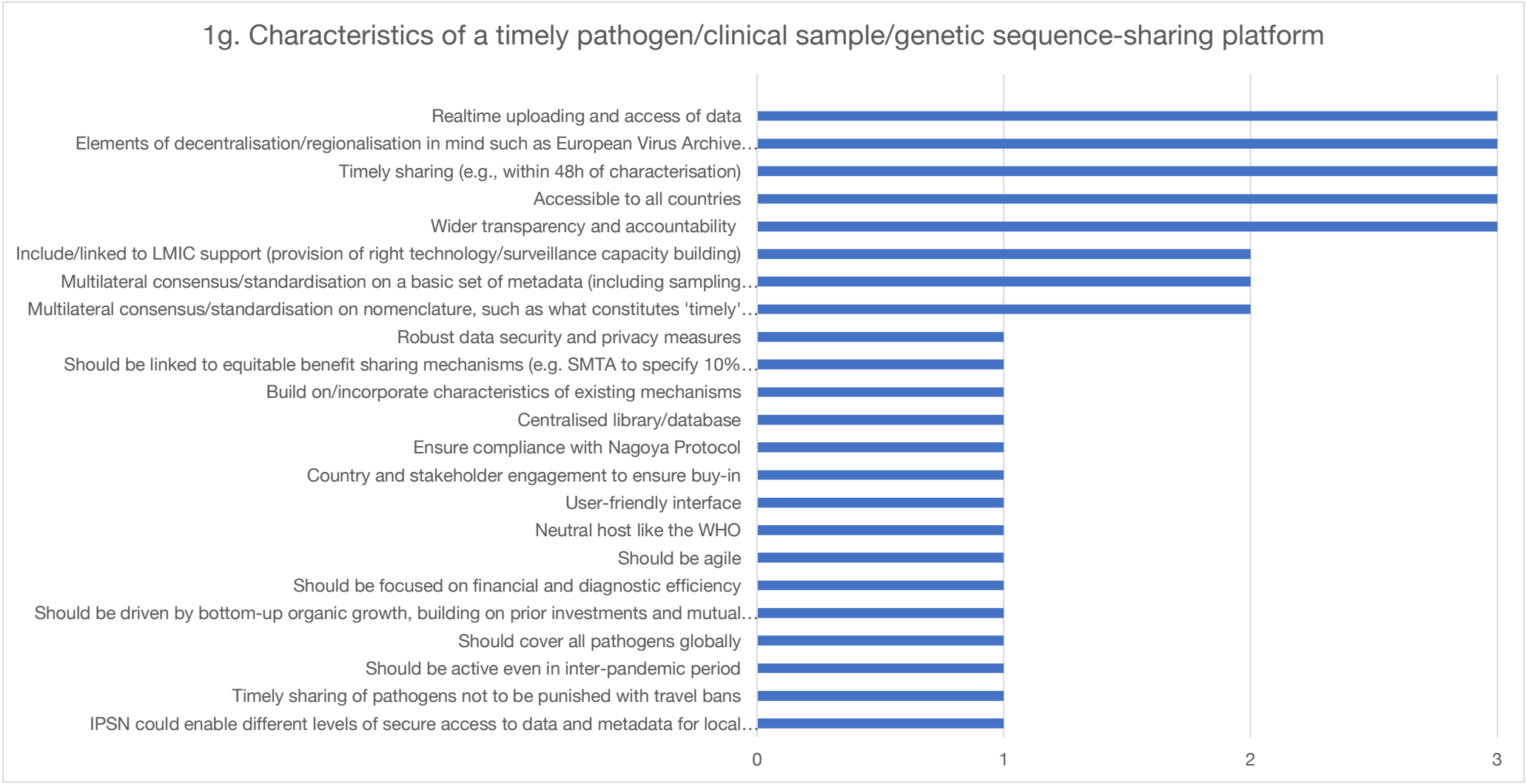
1. Realtime uploading and access of data.
2. Elements of decentralisation/regionalisation such as European Virus Archive Global (EVAg) or through Africa CDC coordination with countries.
3. Timely sharing (e.g., within 48h of characterisation)
4. Accessible to all countries
5. Wider transparency and accountability
6. Include/linked to LMIC support (provision of right technology/surveillance capacity building)
7. Multilateral consensus/standardisation on a basic set of metadata (including sampling frame, year, national/subnational location, type of sample, AST data)
8. Multilateral consensus/standardisation on nomenclature, such as what constitutes 'timely' sharing

Two respondents raised that any such pathogen sharing platform should ensure no repercussions as a result of sharing, referring to travel bans that were instituted upon sharing of data on the Omicron variant. In the words of one of these respondents:

> *"We saw that South Africa, which immediately shared information of the Omicron variant, was sanctioned by the temporary halt of international flights. Timely information sharing of pathogens should be rewarded by benefits, not harmful responses."*
>
> *[Respondent 4, CSO/NGO, East Asia]*

Another respondent pointed out that at present, most platforms were disease-specific, and a platform that worked across all pathogens may be technically difficult to achieve, despite this being the aspiration of the International Pathogen Surveillance Network:

> *"No such end-to-end platform currently exists that covers all pathogens globally and implementation of such a platform may be technically difficult due to the variety of different pathogens and their specificities. For example, the GISAID platform was initially only built as a database for influenza, however, expansion to COVID-19 and RSV was possible due to the fact that these pathogens are respiratory."*
>
> *[Respondent 9, Private Sector, Europe]*


1g. Characteristics of a timely pathogen/clinical sample/genetic sequence-sharing platform
Realtime uploading and access of data
Elements of decentralisation/regionalisation in mind such as European Virus Archive…
Timely sharing (e.g., within 48h of characterisation)
Accessible to all countries
Wider transparency and accountability
Include/linked to LMIC support (provision of right technology/surveillance capacity building)
Multilateral consensus/standardisation on a basic set of metadata (including sampling…
Multilateral consensus/standardisation on nomenclature, such as what constitutes 'timely'…
Robust data security and privacy measures
Should be linked to equitable benefit sharing mechanisms (e.g. SMTA to specify 10%…
Build on/incorporate characteristics of existing mechanisms
Centralised library/database
Ensure compliance with Nagoya Protocol
Country and stakeholder engagement to ensure buy-in
User-friendly interface
Neutral host like the WHO
Should be agile
Should be focused on financial and diagnostic efficiency
Should be driven by bottom-up organic growth, building on prior investments and mutual…
Should cover all pathogens globally
Should be active even in inter-pandemic period
Timely sharing of pathogens not to be punished with travel bans
IPSN could enable different levels of secure access to data and metadata for local…
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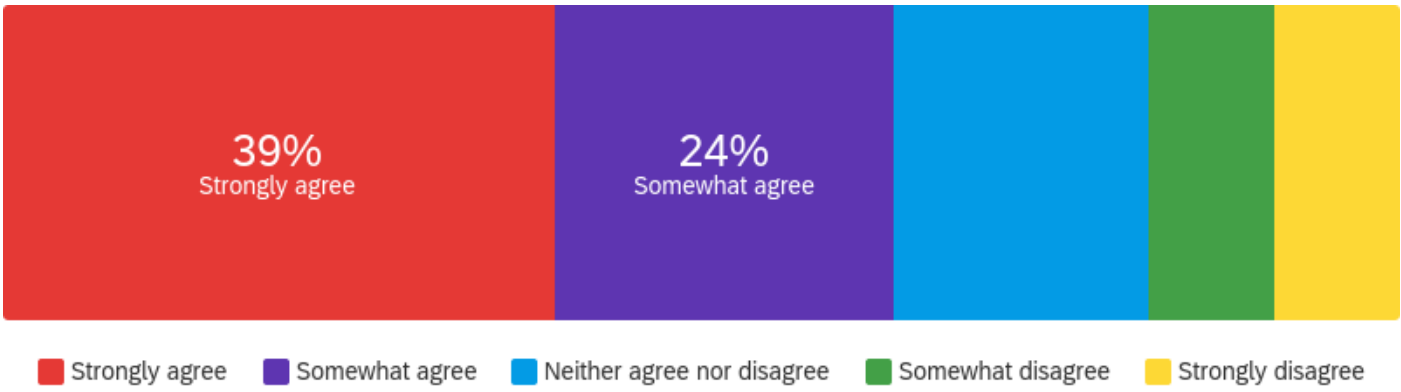
1h) To what extent do you agree that the G7 and G20 should pursue the development of prototype libraries for diagnostics, therapeutics, and vaccines and from your perspective what underpinning agreements and infrastructure would be needed to make these operational?

63% of respondents strongly agreed or somewhat agreed that the G7/G20 should pursue the development of prototype libraries for diagnostics, therapeutics, and vaccines, with the remaining stating that such libraries should be held within WHO or another neutral actor. Others cautioned that libraries should be housed within LMICs and/or should be open access to all, with three strongly disagreeing that the G7/G20 should pursue these.



One respondent cautioned that the G7/G20 should provide support to the WHO and countries to develop such libraries rather than assuming ownership of such libraries. In their own words:

> *"The development of prototype libraries for diagnostics, therapeutics and vaccines is an important perspective but we would argue that the leadership of this is more the role of global actors, particularly WHO. G7 and G20 should provide support to the WHO and countries (for the provision of scientific, technical, funding) for the achievement of this tool and collaborate actively to it."*
>
> *[Respondent 7, CSO/NGO, Middle East and North Africa]*

The same actor stated that several underpinning agreements and infrastructure would be necessary, including:

- Legal frameworks that centre on access to LMIC and prioritises vulnerable populations globally.
- Regional and central hubs that oversee data sharing agreements.
- Incentives to compensate for IP sharing.
- Shared learning and training initiatives to build local capacity and capabilities in LMIC.
- North to South and South to North peer to peer learning and collaborative initiatives benefiting career development and enhancing capabilities with innovative techniques.

These were consistent with suggestions from one respondent from a government/quasi government organisation,[3] with some additions, notably that to make these prototype libraries operational, the following would be needed:

- Data Management Infrastructure: An efficient data management infrastructure is crucial for prototype libraries. This includes robust storage systems, data backup mechanisms, and secure access controls. It should also incorporate data governance protocols to protect sensitive information and ensure data integrity.
- Collaboration Framework: A well-defined collaboration framework is needed to facilitate cooperation among different stakeholders. This framework should outline the roles, responsibilities, and expectations of each party

[3] Respondent 20, Government or Quasi-Government organisation, West Africa

involved in operating the prototype libraries. It should also establish mechanisms for communication, decision-making, and conflict resolution.

1i) What are the top 3 priorities we need to commit to ensure a global- or regional-level response to pandemics is anchored in country-level plans and strategies for pandemic tools delivery?

23 respondents provided 58 recommendations on how to anchor global and regional pandemic response expectations into national frameworks. Of these recommendations, optimizing financial strategies was the top recommendation (16 responses), which included increasing financial commitments (global and national); restructuring, reducing, and cancelling of debts of high-burden countries, and issuing collaborative funding calls. The second strategy was hardwiring equity into the principles of pandemic (7 responses). Respondents mentioned the need for global scientific cooperation and regional leadership; transfer of know-how including of product development expertise, and "no proprietary rights for health technologies that are of public interest - health technologies to be framed as global public goods."[4] Third most common responses with equal number of 5 responses each were the need for collaborative partnership and bringing shared expertise to the develop national plans on access to pandemic products; and the need to invest in LMIC healthcare systems. The top five responses are as follows:

1. Optimized financial strategies that factor in national plans, incl. debt.
2. Hardwiring equity, including in partnerships, and sharing of product development expertise.
3. Collaborative partnerships/expertise in national planning, including communities.
4. Investment into LMIC healthcare systems
5. Inclusive PPPR decision-making

Interestingly, several of the recommendations point to the importance of how plans are developed and who participates in the process. The recommendations call for international cooperation and solidarity that bring LMIC voices into the discussion. They also speak of bridging existing gaps in global manufacturing capacity, the continuation of training initiatives, and ensuring that national systems such as UHC are operating well in terms of knowledge, human and financial resources. as well as creating a participatory process within countries for the development of national plans.

Three responses pertained to making local and regional manufacturing a precondition for feasible national plans for pandemic tools delivery. One participant alluded to the building of a new paradigm as "equitable and innovative global scientific partnerships with regional capacity strengthening and leadership."[5] In line with these sentiments, another respondent stated that the exclusion of LMIC expertise meant that top-down technical frameworks were not always implemented successfully. In their own words:

> *"Above all else, engagement with LMICs to understand the country level constraints and opportunities; include LMICs in discussions. Top-down global technical frameworks are not always successfully implemented because the country level context is not built-in and financial investment is not advocated adequately for sustainable development. Priorities therefore are: 1. invest in research capacity development and training in LMICs; 2. sustainable funding mechanisms and coordination to improve LMICs capacity; 3. production capacity that is better distributed globally with LMICs included the management."*
>
> *[Respondent 8, CSO/NGO, Middle East and North Africa region]*

[4] Respondent 10.
[5] Respondent 1.

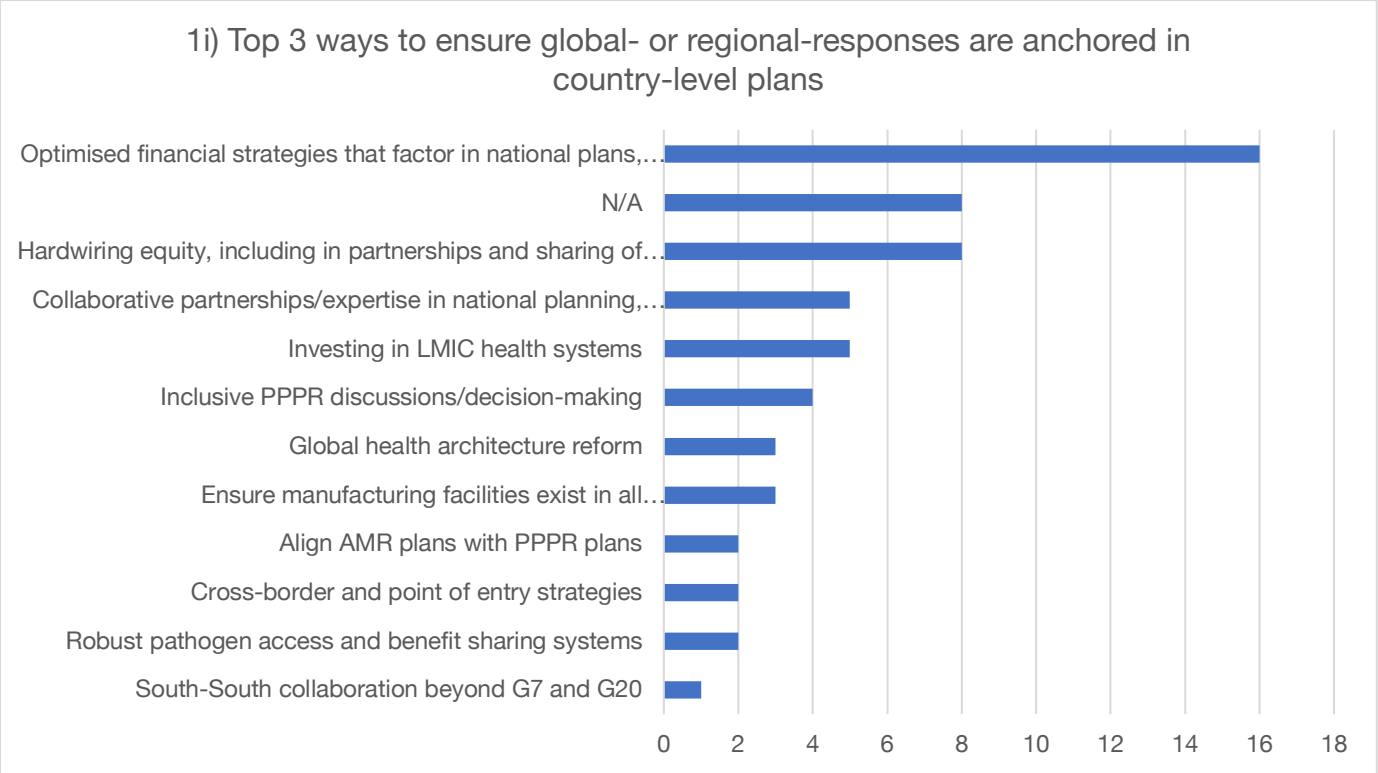


Figure 4: Top three ways to ensure global- or regional-responses are anchored in country-level plans

Building on the value of participation mentioned throughout, several respondents focused on the process of conceiving plans in a multi stakeholder process. As one respondent illustrated:

> *"Inclusive and access-oriented consultative and design processes for PPPR initiatives, with meaningful inclusion and leadership by low- and middle-income countries, regional institutions, civil society organizations, and community-based organizations."*
>
> *[Respondent 12, UN organization, European region]*

The call for meaningful participation of civil society and affected communities in global health institutions and processes is not a new recommendation. Building on the early AIDS movement, participation of civil society and communities has proven to be a powerful tool. Yet global processes, including for the building of new mechanisms and agreements (e.g., WHO Pandemic Accord, World Bank Pandemic Fund etc.) tend not to voluntarily provide opportunity for equitable participation. Similarly, LMIC government representatives have voiced concerns externally to this survey about exclusion from important decision-making processes.

1j) How do we strengthen the coordination across different diseases and products to ensure global delivery support is coordinated and more integrated?

21 respondents provided 33 recommendations to the question about cross-disease coordination for health products and integrated global delivery support. Most frequently mentioned was the need for global health architecture reform (10 responses), followed by improvements to collaboration and cooperation, including multi-sector collaboration (8 responses). Third most frequent responses tied between improved/innovative financing approaches and mechanisms; and investing in domestic health infrastructure (7 responses each). Empowering the central role of the WHO was mentioned one time.

The top responses were as follows:

1. Global health architecture reform.
2. Improvements to collaboration and cooperation, including multi-sector collaboration.
3. Improved/innovative financing approaches and mechanisms
4. Investing in domestic health infrastructure

Interestingly, the recommendations somewhat mirror the above responses to the integration of national and global pandemic responses, though in different order. The category of global health architecture reform combines those responses that spoke of the need for the establishment of new collaborative platforms or other structures. The main suggestion points to a new, centralized, accountable platform that can manage across all diseases. Responses stated that this new platform or any new mechanism must provide equal partnership with LMICs. Equity and inclusivity are predominant themes in this section. In the words of one respondent:

"Through a responsible, accountable, and transparent global coordination mechanism that is not exclusive to G7 or G20 but also includes nations to contribute to a holistic global R&D, MCMs, and health security picture. We should move from coordination to partnership."

[Respondent 13, CSO/NGO, Middle East and North Africa region]

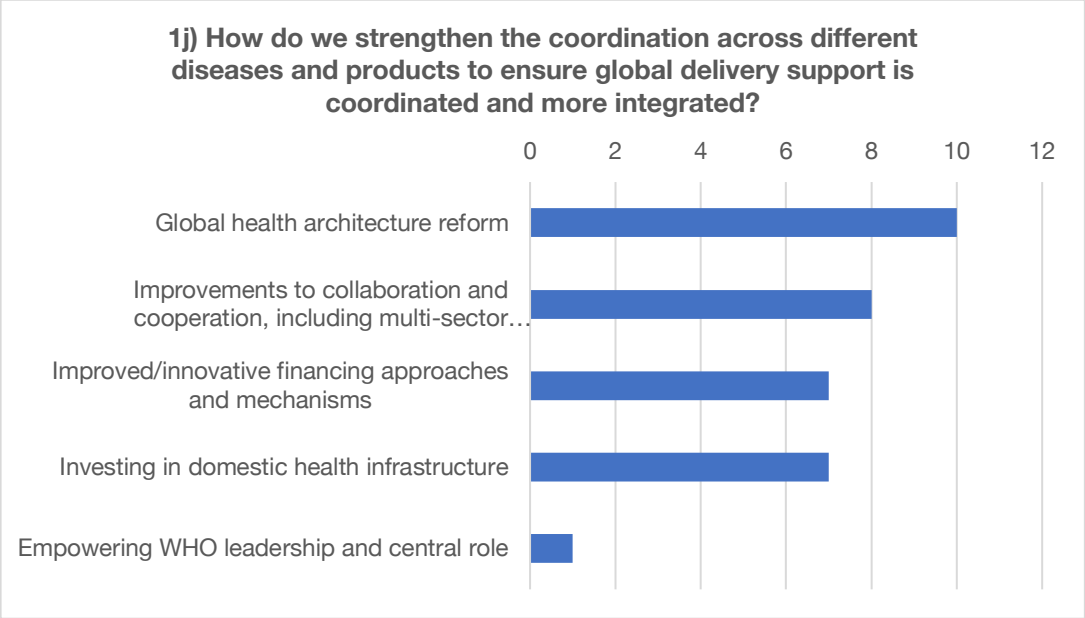


Figure 5: 1j) How do we strengthen the coordination across different diseases and products to ensure global delivery support is coordinated and more integrated?

In terms of improving collaboration, different modalities of dialogue and collaboration were mentioned for both national and international spheres, including focus on multi-sector training approaches and multi-sector networks teaching and reaffirming public health for health and non-health personnel. This category also focused on the sharing of and setting up collaborative systems for collection of data, analysis, and results sharing. One respondent emphasised the need for harmonisation of regulatory processes across diseases and products:

"(We need to) encourage the harmonization of standards, guidelines, and regulatory processes across diseases and products. This can streamline the development, manufacturing, and distribution of medical countermeasures, reducing duplication of efforts and ensuring consistent

quality. Harmonization can also facilitate the sharing of data and research findings, enabling faster decision-making and more integrated global delivery support."

[Respondent 18, Government or Quasi-Government organisation, West African region]

In the improved/innovative financing category response, pooled procurement (e.g., via UNITAID) and pooled funding for MCM were mentioned several times, alongside the need for access conditionalities, the need to fund based on country priorities, using priming funds to foster international collaboration, and making health central to economic planning. In the words of one respondent:

"G7 country leadership (is necessary) in establishing a pooled funding mechanism for medical countermeasures R&D with (target product profiles) and access conditionalities."

[Respondent 2, PPP organisation, North America]

Responses focusing on domestic heath infrastructure strengthening mentioned both systemic approaches e.g., building up vaccine deployment for adults in non-emergency time to allow quick upscaling when needed; the need for local manufacturing; and the need for additional training.

Issue Area 2: Strengthened public health and emergency workforce

Objective

Strengthening public health and emergency workforce including networking among leaderships within and between countries and regions to enable early detection of outbreaks and provide public health and medical measures, without disruption of essential services.

Summary of Findings

Our findings illustrate systemic problems and challenges at all levels with health workforce development, from poor compensation practices to fragmented workforce strategies to unsafe working conditions and infrastructure. However, **poor state/public financing of public health workforce**, **skills development and training program deficiencies**, and **weak governance/fragmented workforce strategies** emerged as the three biggest problems to public health and emergency workforce.

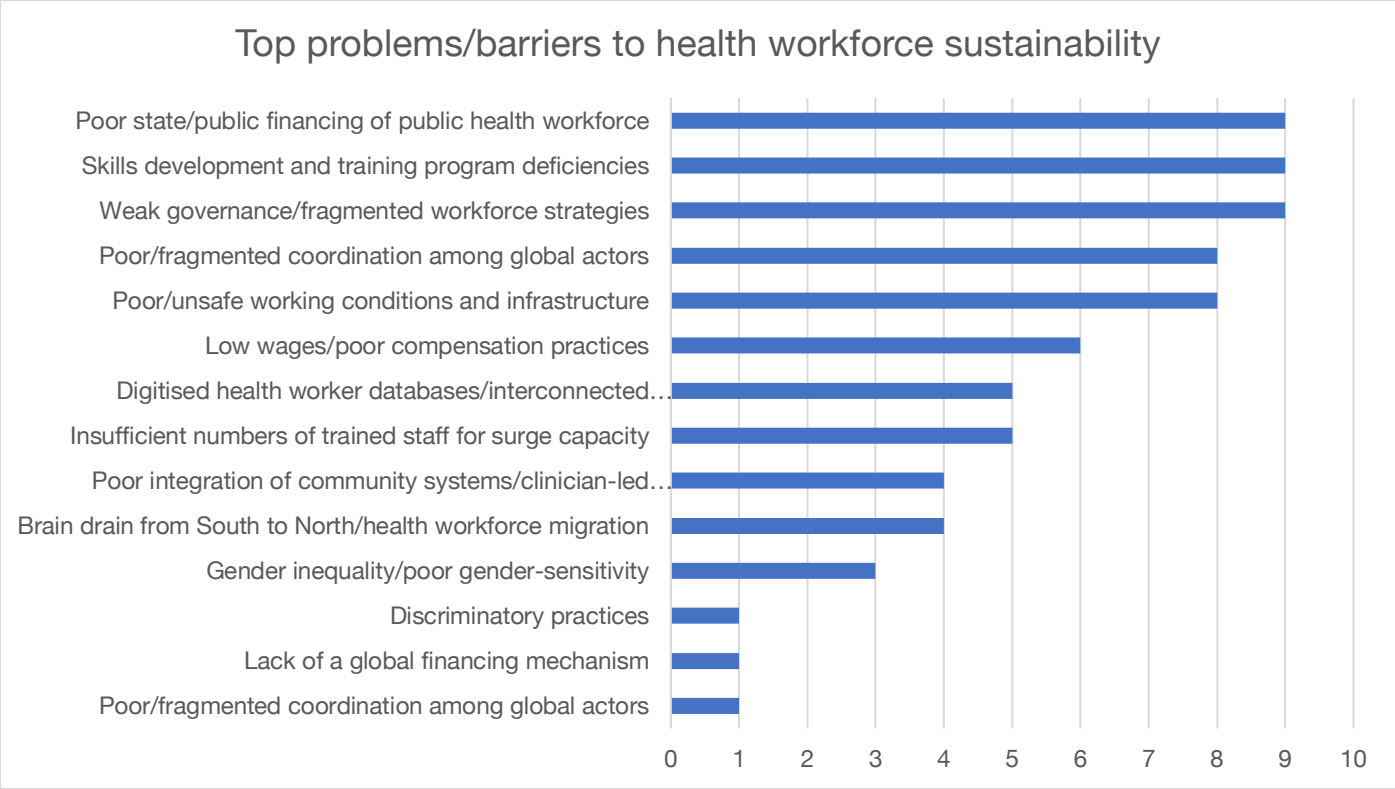
Numerous strategies were proposed to overcome these barriers which co-organisers and the advisory group may select from to address these barriers, including the need to **convene a meeting of international donors and key actors on health workforce**, encouraging **appropriate salary benchmarking** and grading of the health workforce, encourage or conduct p**eriodic audits or assessments on health workforce deficits**, and advocacy for a shared vision and accountability mechanisms on health workforce. Respondents were also generally supportive for the GHMD to explicitly and more visibly support **professionalisation and formalisation of the community health workforce** and inclusion in emergency roster databases.

Robust responses were provided in Section 2e on strategies to support LMICs on health workforce retention and reducing brain drain – where it was suggested that a **comprehensive mapping was needed on how to increase salary scales and compensation** alongside non-monetary factors such as career development opportunities and positive reinforcement/recognition of efforts, and the need to explore compensation from HICs or **reimbursement models from HICs who absorb LMIC workforce**, with the monies gained to be reinvested towards the development of health workforce in LMICs (incl. scholarships).

2a) Three biggest problems, challenges, or barriers to public health and emergency workforce strengthening and sustainability (global, regional, or national levels)

1. Poor state/public financing of public health workforce
2. Skills development and training program deficiencies
3. Weak governance/fragmented workforce strategies
4. Poor fragmented coordination among global actors
5. Poor/unsafe working conditions and infrastructure

27 respondents completed this section with a total of 73 barriers/challenges listed. Of these 73 responses, skills development and training program deficiencies, weak governance/fragmented health workforce strategies, and poor state/public financing of public health workforce were most frequently cited as barriers or challenges to strengthened and sustainable public health and emergency health workforce with nine responses each.



2c. What strategies would you recommend to the Global Health Multistakeholder Dialogue (GHMD) to make progress in the areas you specified in the question above?

21 respondents responded to this question; however, two respondents did not specify strategies or did not answer the question as it relates to health workforce, and thus were not included in our analysis. The remaining 19 respondents provided 22 recommendations of strategies that could be employed. Due to variability, responses were grouped thematically, with the need for improved coordination at all levels emerging as the most prominent theme. The recommendations are presented below:

	Theme	Recommendations for Strategies
1.	Improved coordination at all levels	▪ Convene a meeting/platform of international donors and key actors on health workforce ▪ Establish synergies on training of health workforce the WHO's Global Health Workforce Alliance, International Council of Nurses (ICN), International Confederation of Midwives (ICM) and UNFPA's Maternal Health Trust Fund ▪ Collaborate with youth and early career professional groups ▪ Work with G7 countries to implement WHA A74/A/CONF/6 resolution on protecting, safeguarding and investing in the health and care workforce. ▪ Foster stronger multistakeholder collaboration at the national level
2.	Improved processes/paradigms for priority setting	▪ Encourage audits/assessment of the health workforce deficit in LMICs ▪ Employ a gender lens in health workforce ▪ Include CSOs and communities in national strategies ▪ Ensuring health workforce investments are informed by country context, including through

	Theme	Recommendations for Strategies
		domestic evidence base and country consultations ▪ Development of investment cases in each country
3.	More robust/visible communications on health workforce	▪ To advocate for a shared vision and set a defined agenda and accountability mechanisms on health workforce ▪ Improve communications around what is needed on health workforce
4.	Strengthening knowledge base and understanding at different levels	▪ Strengthening regional and national cross sectoral understanding and governance of health workforce systems ▪ Improve health workforce data and reliance of health workforce data to improve working conditions
5.	Issue-based advocacy with countries	▪ Encourage appropriate salary benchmarking and grading of health workforce ▪ Advocate with LMICs on better financing of health workforce ▪ Advocate for decent/fair working conditions for CHWs ▪ Encourage LMIC leadership on health workforce
6.	Directing financing to specific areas	▪ Assigning larger investments to UHC ▪ Support centers of excellence on health workforce

*2d) Some efforts are underway to formalise community health worker roles, such as through the **ProCHW movement**. Is there value in this, and if so, how can the GHMD support this?*

20 respondents answered this section; however, a number demonstrated a lack of understanding of the GHMD or provided answers which did not pertain to CHW formalisation/professionalisation, leading to their responses being ineligible. As displayed in Figure 6 below, five provided general recommendations that the GHMD should support the formalisation and professionalisation of CHWs but did not provide any granularity as to how this should occur. More specific recommendations included the following:

1. GHMD to emphasise the need to ensure CHW data is included in health information systems/emergency personnel rosters.
2. GHMD to amplify how CHWs contribute to the health system.
3. Support national frameworks for professional development of CHWs, with career pathways and competencies.

Two respondents, from a government/quasi-government organisation and a PPP organisation respectively, stated that there was a need to ensure that CHWs were included in digital health workforce systems such as emergency personnel rosters. While neither comment referred to the GHMD, the GHMD may utilise this feedback to design its approach moving forward. The respondent from the government organisation for example stated that:

"There is value if the (CHW) program is integrated into the larger emergency response system. That is, the program doesn't sit alone but is something that operates during peacetime to prepare/train CHWs but also fully integrates into an IMS (Information Management System) or personnel deployment roster to be activated during an emergency."

[Respondent 15, Government or Quasi-Government Organisation, North America]

One CSO respondent who stated that there needed to be an understanding on how CHWs should enhance the health system stated that:

"The role of (CHWs) in epidemic response is well-supported by evidence, though its effectiveness depends on context and robust supervision and referral systems. CHWs enhance healthcare systems and epidemic preparedness but require concurrent investment in nursing and primary care systems to ensure adequate supervision, referrals, and clear care pathways. The GHMD can support this by taking a clear systems approach and understanding how CHWs enhance the whole system and not standalone approach."

[Respondent 9, CSO/NGO, North America]

Based on these, for example, during the GHMD conference in Tokyo on 1st December 2023, co-organisers could focus on how the GHMD could better coordinate discussions around digital health workforce systems and CHW inclusion in those or ensure that CHWs are integral to all discussions around health workforce.

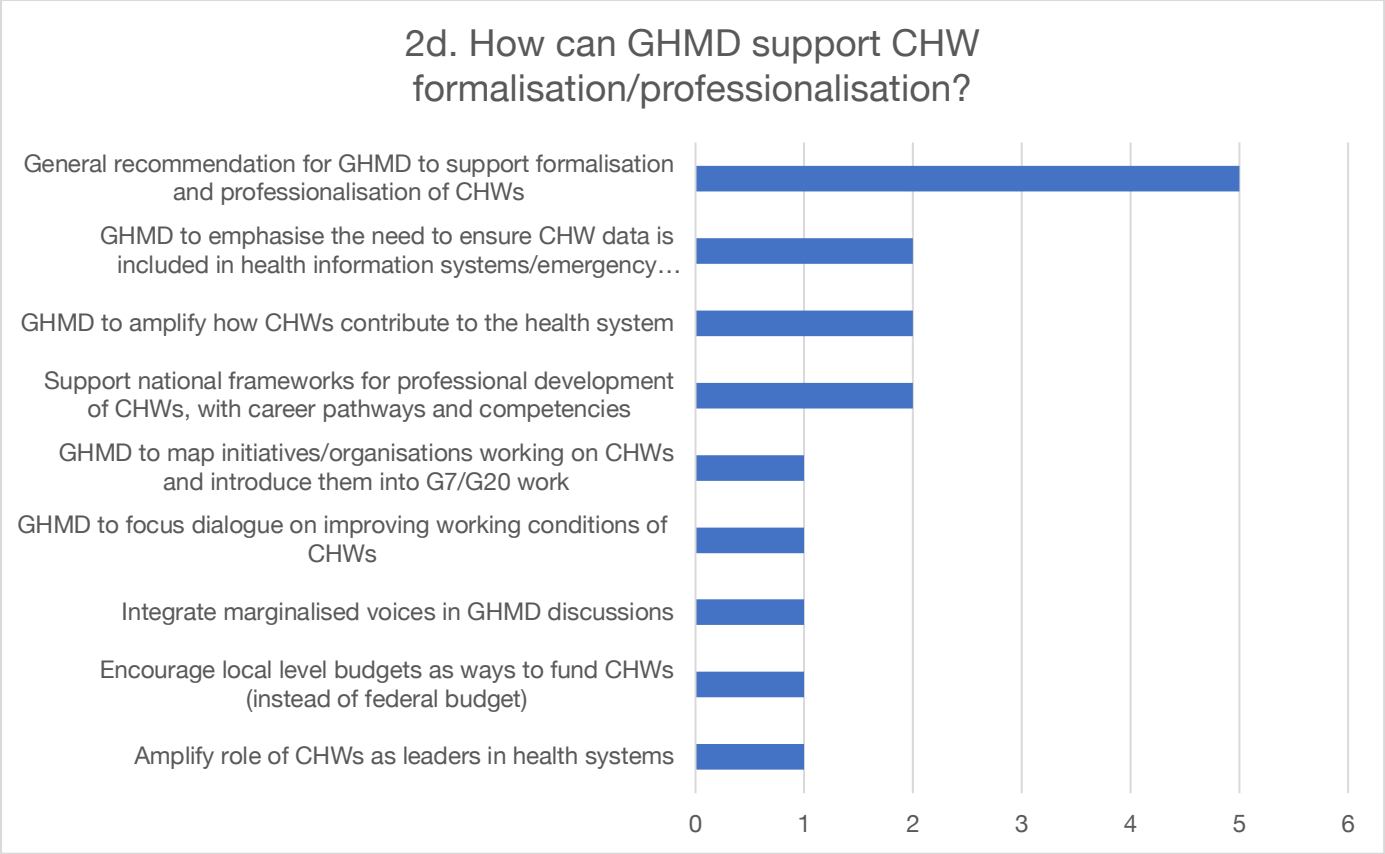


Figure 6: How can the GHMD support CHW formalisation/professionalisation?

2e. What strategies can be adopted to support LMICs with health workforce retention and improving health workforce metrics given the rate of "brain drain" in public health workforce?

Eighteen respondents provided 34 responses on supporting LMICs with health workforce retention. Responses were not always framed as strategies – with some framed as general recommendations such as 'we need to ensure decent working conditions in each country'. Responses were thematically analysed and those most frequently cited are as follows:

1. Comprehensively map how to increase salary scales/compensation alongside non-monetary factors such as career development and positive reinforcement.
2. Taxes/compensation from HICs/reimbursement models/disincentives to HIC agencies from absorbing LMIC workforce - funding to be used towards development of health workforce in LMICs (incl. scholarships).
3. Developing coherent/holistic national health workforce development strategies and health worker retention at the national level, with accountability mechanisms.
4. Regional LMIC audit, including through surveys of LMIC health workers, to assess scale of health workforce challenges (inclusive of remuneration)
5. Investing in continuous training, education, and exchange opportunities and strengthening of medical/nursing/public health schools.

Salary was seen as the largest barrier for health workforce retention in LMICs – however respondents felt that there had been no or limited concerted efforts to map and understand how compensation could be increased in tandem with improvement of non-monetary factors such as career development and positive reinforcement. One respondent from the Middle East and North Africa stated that limitations inherent to countries on improvement of salary scales could be counterbalanced by both South-South and North-South support, however that greater coordination was needed, including better liaising with potential donors and greater standardisation on remuneration and competencies.

Another respondent also raised the issue of salary benchmarking, stating that there was a need to combine these with workload assessments and skillsets that individual staff have. In their own words:

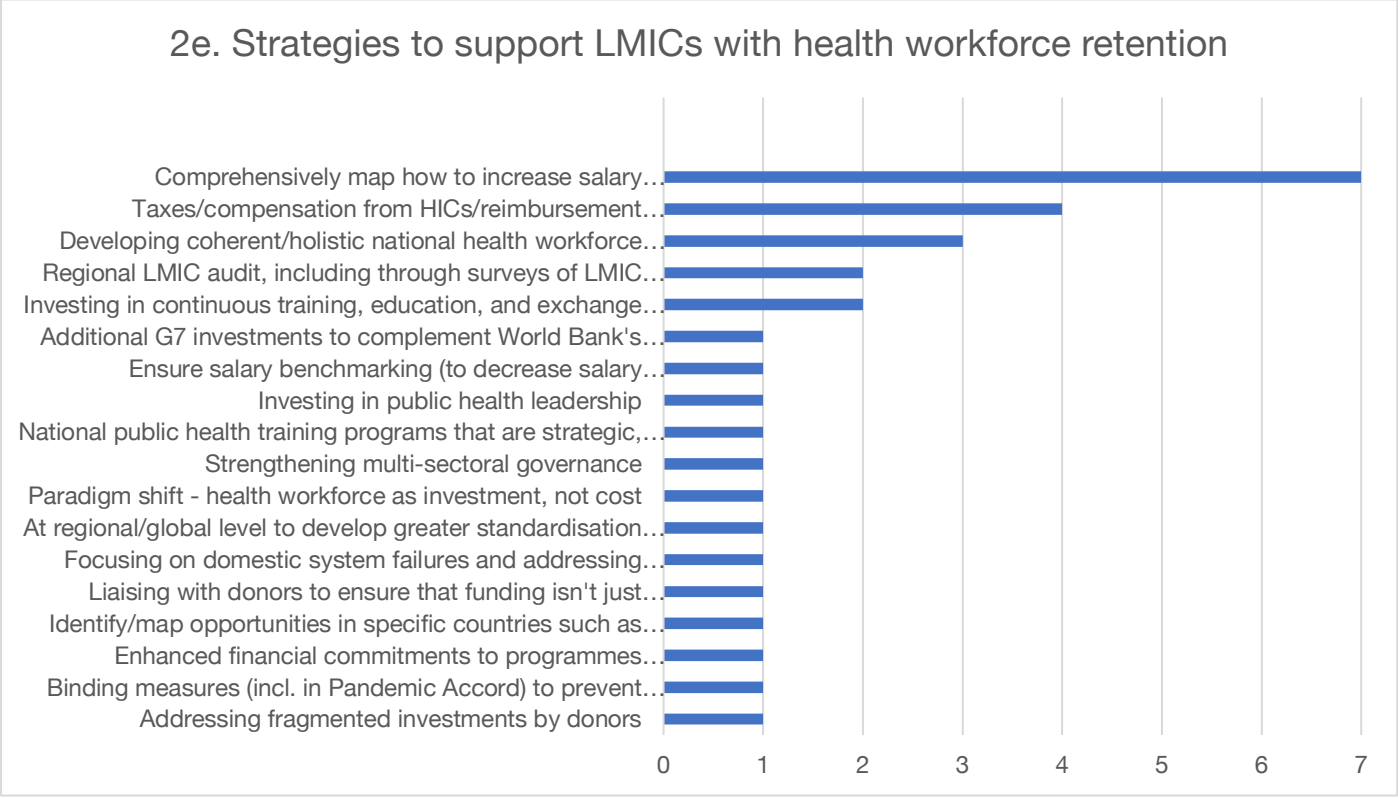
"Proper salary benchmarking and workload assessments are required to ensure fair compensation and prevent burnout in the health workforce. Our workforce migrates mainly for better renumeration and healthy working environments. Acknowledgement of skillsets and experience need to be factored into the compensation as well as the provision of growth opportunities, both professionally and financially. (In addition), skills transfer plans need to be put into place to identify critical skills required for job functions."

[Respondent 10, CSO/NGO, Southern Africa]

Respondents also spoke strongly about the exodus of health care workers to HICs from LMICs – placing responsibilities on both HICs to compensate LMICs for taking in their workforce, but also on LMICs to find creative ways to increase salary scales. In the words on one respondent:

"Middle-income and high-income countries should stop the practice of importing skilled health workforce from low-income countries. This requires coordinated and multi-sectoral approach (e.g. visa and work-permit regulations etc). Additionally, LMICs should improve working conditions and compensation packages of their health workers to reduce their motivation to seek employment abroad. Many international donors hesitate to invest in recurring costs of health workers in LMICs (e.g. salaries, top ups), since such investments do not contribute to sustainable systems strengthening. This practice needs to be revisited, since many LMICs simply do not have enough fiscal space to adequately compensate their health workers. This is one of the leading causes of the brain drain."

[Respondent 9, CSO/NGO, North America]

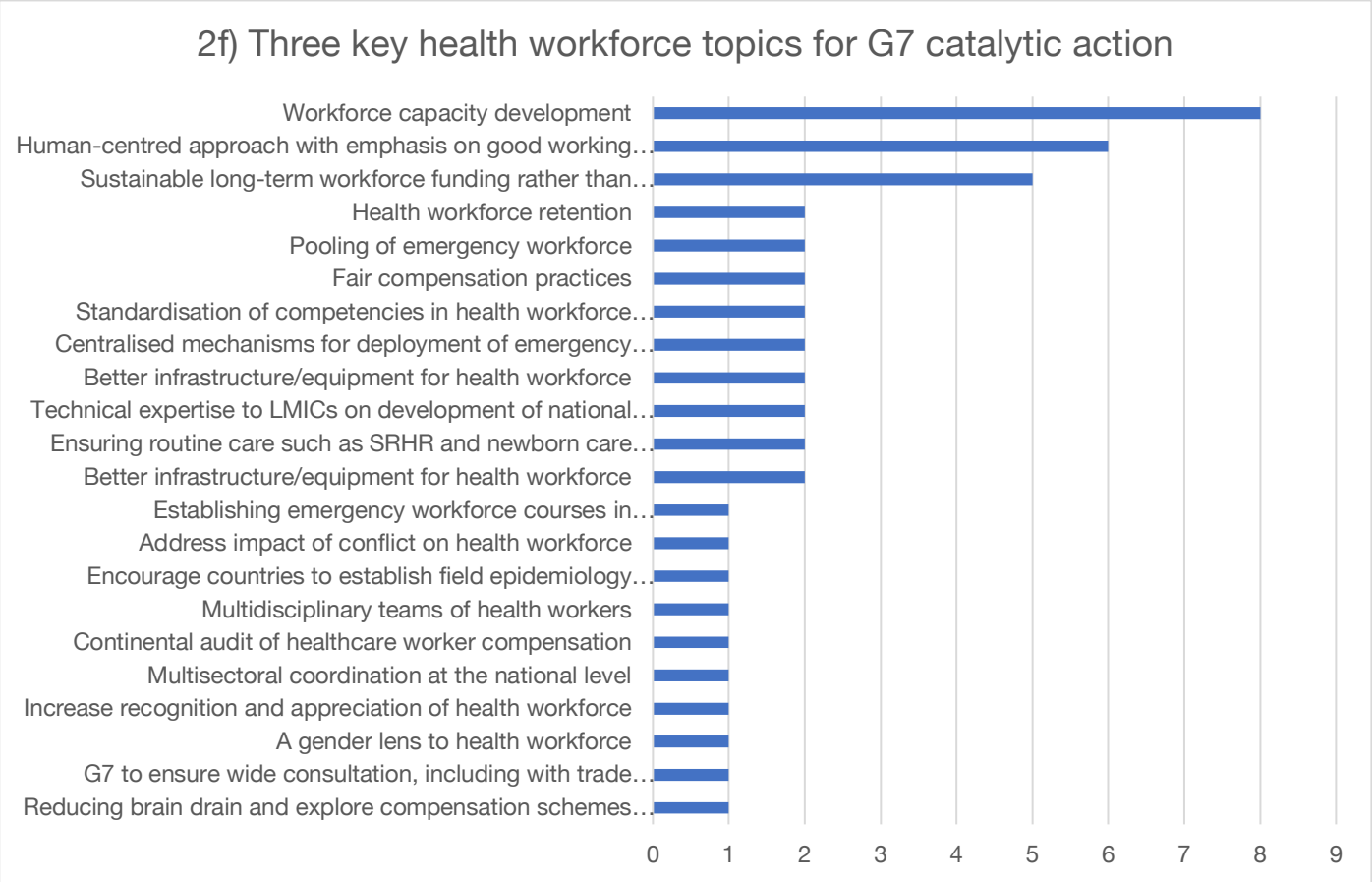


2f) What are 3 key topics around health emergency workforce that the G7 could focus on and be catalytic?

23 respondents provided 47 recommendations for key topics that the G7 should be catalytic on. Responses in this section were brief compared to other sections, and greater nuance is available in other sections, such as Section 2e

above on health workforce retention. According to our analysis, however, the top three choices for catalytic action as as follows:

1. Workforce capacity development
2. Human-centred approach with emphasis on good working conditions, hazard compensation, and psychological first aid
3. Sustainable long-term workforce funding rather than funding through vertical programs



2g) How can countries contribute to and/or benefit from the development of a multisectoral and connected health emergency leadership network such as the Global Health Emergency Corps (GHEC)?

In January 2023, the WHO proposed a Global Health Emergency Corps (GHEC) (Items 41-44, WHO Executive Board) consisting of a multidisciplinary corps of specialised health emergency responders from national institutions, who are trained and equipped for coordinating international support and response in case of health emergencies (rapid deployment).

17 respondents provided 22 recommendations regarding the utility of a proposals such as the GHEC. Four responses were not applicable to the question. A theme strongly emerging from the data was that constructs such as the GHEC would be highly desired for centralising training of healthcare workers of different geographic origins and from differing educational systems, thereby providing quality assurance and cohesion of skills (6 responses). In the words of one respondent:

> *"GHEC could support in strengthening the capacity of the emergency workforce through centralised and therefore cost-effective education and training, lead in quality assurance in emergency responses. There are other models of similar networks that could offer lessons learnt and best practices."*

[Respondent 6, CSO/NGO; East Africa]

Beyond the utility of skills-building and quality assurance, this response suggests an opportunity for cost-saving through a centralized approach. Others within this category also pointed to expediency of workforce deployment in emergencies, while also creating a professional development platform. The GHEC has an opportunity to become a professional development platform beyond the focus on centralised training if it were to incorporate opportunities for the emergency health workforce to connect in additional ways. According to a respondent from the MENA region:

"Establishing multi-sectoral communities of shared practice is essential. Peer to peer support will strengthen understanding and provide actions leading to impact based on experience and expertise."

[Respondent 4, CSO/NGO; MENA region]

The next following responses were all tied with 2 responses each, namely the need to first define clearly what the GHEC aims to achieve; the importance of domestic financial investments; a preference for regional coordination over global coordination; the need for building national resources; and ensuring that healthcare workers would be deployed and received based on national need. The remaining two responses, with one mention each, pointed to the need of timely data sharing and gender-budgeting. For visualization, the below box shows the most frequently occurring responses:

1. Centralised training and quality assurance via GHEC
2. Clearly define GHEC.
3. Domestic financial investments
4. Preference for regional coordination
5. Building national resources
6. Deploy and receive based on national need.

Several responses pointed to the usefulness of establishing communities of practice and other cross-learning platforms. Their value lies not only in providing another channel for learning, but also in building a community and shared sense of purpose.

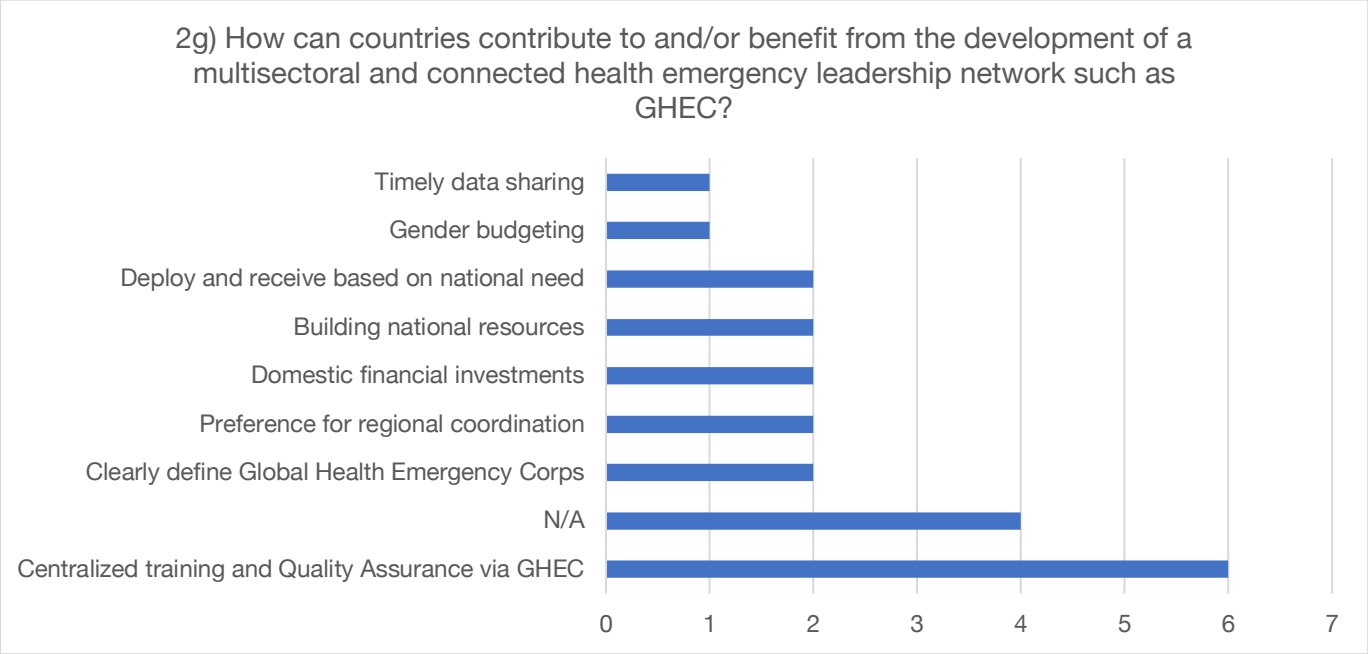


Figure 7: How can countries contribute to and/or benefit from the development of a multisectoral and connected health emergency leadership network such as GHEC?

It is important to note that some responses struggled with the concept of the GHEC. Reasons provided in the responses were manifold and incohesive. Two responses pointed to the need for a clear definition of the GHEC's purpose:

> *"It is still unclear the role, mandate, and structure of 'Global Health Emergency Corps'. A clear definition is necessary… It should have sufficient coordination with existing organisations that play similar roles, including NGOs working on humanitarian assistance."*
>
> *[Respondent 1, CSO/NGO; East Asia]*

In addition to the need for greater institutional understanding of the GHEC, the above response and others were concerned with how the GHEC would fit into existing global health architecture and how it may cause disruption with existing mechanisms. Duplication of efforts and displacement or competition with existing emergency response mechanisms are challenges that will need to be addressed. One respondent put it bluntly:

> *"It would be a duplication and very hard to govern. Regional bodies have a slightly better chance."*
>
> *[Respondent 2, Academia; Southeast Asia]*

This concern about a global response versus regional networks will need to be explored. A third concern was raised about to what extent the GHEC may drain national resources rather than strengthen a domestic emergency response, again pointing to the idea that a regional model may be of greater utility. Two respondents questioned the workability of a global approach and suggested a regional approach may be more feasible. In addition, two respondents suggested that strengthening of national and exiting mechanisms would strengthen country responses and country ownership, again voicing concern that a global mechanism may weaker domestic mechanisms and the ability to respond to emergencies.

2h) What emergency health workforce priorities/activities have decreased relevance, or for other reasons, should have reduced focus in the next Presidency?

Respondents struggled with this question. 14 respondents made 14 recommendations, of which seven were not applicable. Of the eligible responses, the top response was that none of the health workforce issues could be deprioritized (3 responses). One respondent stated the following:

"The issues of the health workforce are not prioritised in the context of UHC and PPPR in the discussions of global health policies in the G7. In the next presidency, health workforce issues should be more discussed. It is not necessary to decrease the priority and relevance of health workforces."

[Respondent 1, CSO/NGO; East Asia]

This sentiment was issued in the second most common response, which stated that if anything, health workforce issues need to be valued as essential and that they are not yet receiving the necessary importance in global discussions. One respondent pointed to the need to focus on systems change rather than the of individuals trained and to focus on building capacity in countries, connecting to the above question on the GHEC. Two respondents noted that there is no need to "reinvent the wheel" when workable solutions already exist, such as the GHEC. In summary, emergency health workforce issues needed to be addressed with the utmost urgency, and this is reflected elsewhere in this Section in more depth.

Issue Area 3: Financing for UHC and PPPR

Objective

Promoting more effective and coordinated use of existing resources, financing and financial support from other countries and global organisations, domestic resource mobilization for UHC and PPR through prioritization in national plans and exploring a "surge" financing framework for deployment of necessary funds to quickly respond to health crises.

Summary of Findings

Overall, respondents felt that there is a **lack of political will**/deprioritisation on financing for PPPR and UHC, albeit for different reasons. For PPPR, this is due to the inability of governments to justify pandemic financing in the interpandemic period, and for UHC, the lack of political will is due to priority shifting for post-pandemic recovery and for matters considered more urgent, such as security concerns, economic recovery, and climate change.

Interestingly, when suggesting solutions, more respondents perceived that there was a need in the short- and medium-term for the G7 and G20 to emphasise and support the development of **sustainable domestic financing plans** as the first line of defense in PPPR as the most important measure, followed by the need to **set clear and ambitious targets** on sustainable financing, and that G7/G20 contributions should be focused on primary healthcare/health systems strengthening/developing UHC. Several respondents stated that the G7/G20 should work towards **conditional debt forgiveness** for countries in exchange for developing sustainable financing for UHC.

When discussing why existing resources were not being used effectively, **inefficient bureaucracies and low public finance management capacities** were considered to be the top cause, followed by **low absorptive capacity** – predominantly attributed to **insufficient human resources to deploy required funding**, but also to poor infrastructure such as roads, internet connectivity, and medical products that were not suited for local contexts, and hence needed to be modified in one way or another before deployment. As suggested by respondents, these may be solved by ensuring G7 financing decisions are made with meaningful consultation with a wide range of local/domestic stakeholders, including public finance management competencies training as part of financing, and to ensure infrastructure and human resources support with health funding.

In terms of strategies and tactics to increase domestic resource mobilisation for UHC, respondents believed that **encouraging taxation reform or new taxation regimes** should be deployed as a key tactic, followed by the need to invest in **collaborative advocacy** by all stakeholders, but especially to civil society to pressure their governments on UHC. Additionally, respondents believed that there should be **better (or more strategic) messaging highlighting the interlinkages and reinforcing nature between UHC and PPPR investments** and benefits for economies, particularly given the reduced political will for financing in both areas.

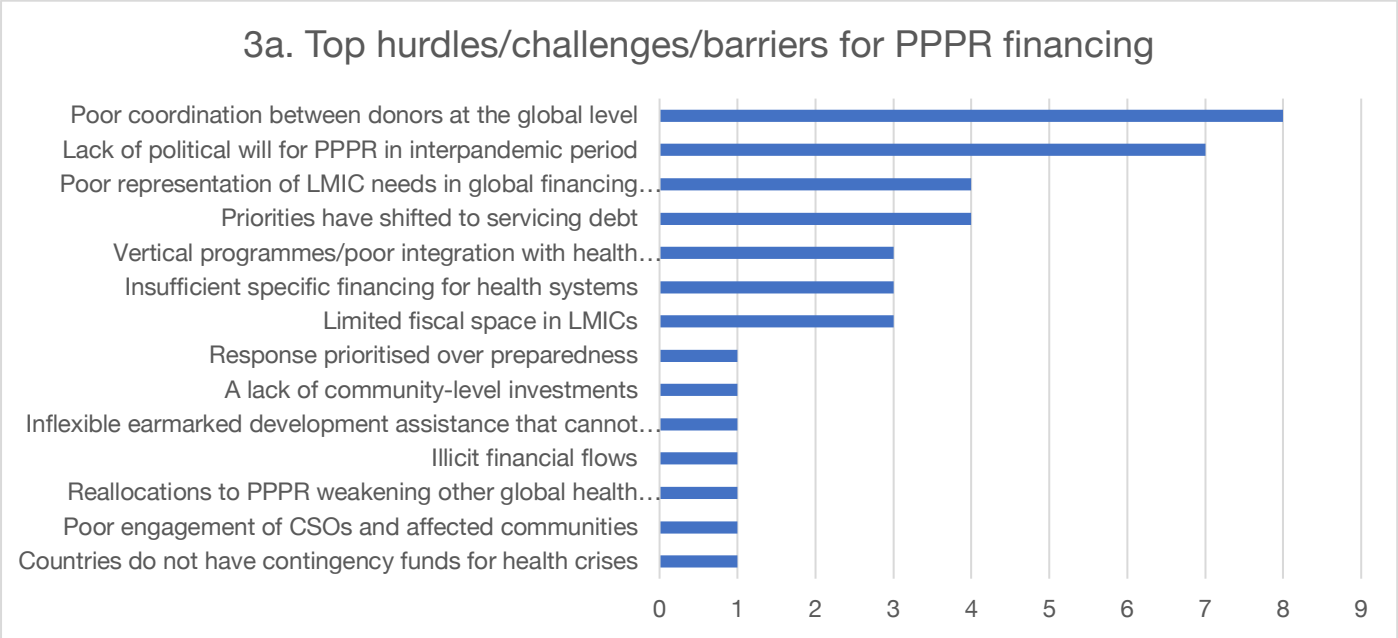
3a) In brief, what in your view are the biggest problems, challenges, or barriers whether at the global, regional, or national levels on financing of UHC and PPR? List up to three each.

28 respondents provided 39 barriers/challenges on financing for PPPR. Of these, poor coordination between donors at the global level was considered to be the biggest problem for financing, followed by a lack of political will for PPPR at the global level. 30 barriers/challenges were listed for UHC financing. These are summarised in the table below:

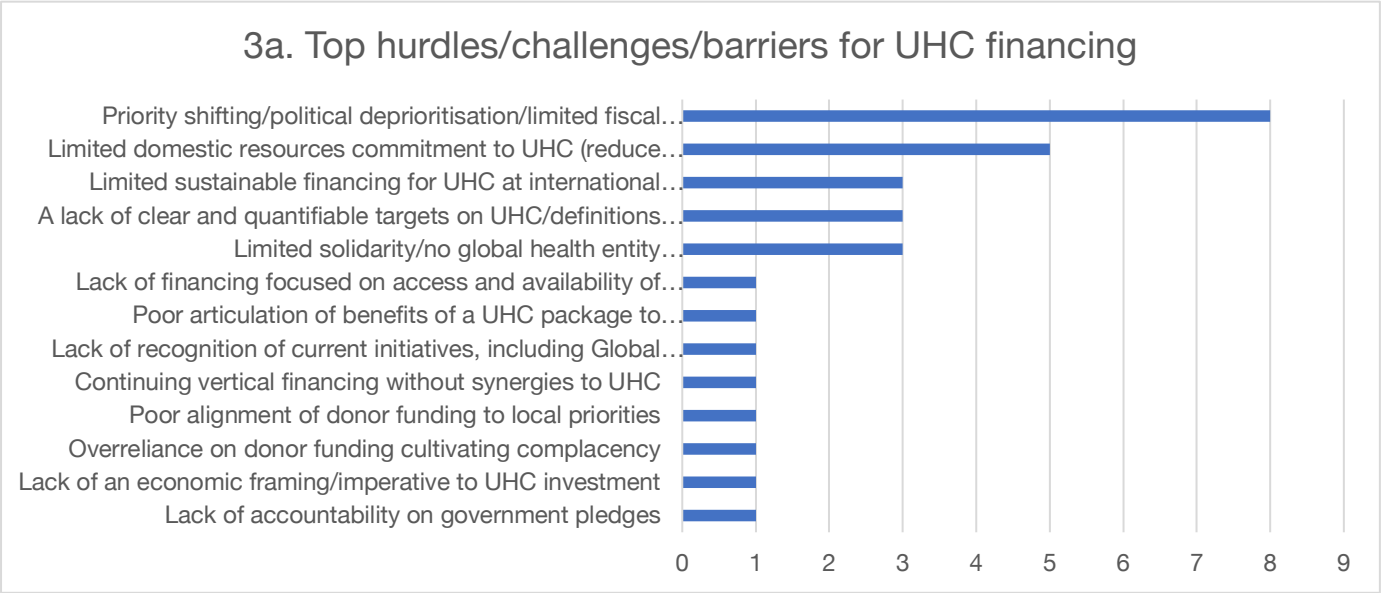
Biggest barriers for PPPR financing	Biggest barriers for UHC financing
1. Poor coordination between donors at the global level 2. Lack of political will for PPPR in interpandemic period 3. Poor representation of LMIC needs in global financing discussions. 4. Priorities have shifted to servicing debt	1. Priority shifting/political deprioritisation/ limited fiscal space at national levels towards security issues, climate change, etc 2. Limited domestic resources commitment to UHC (reduce OOP expenses & fund primary care) 3. Limited sustainable financing for UHC at international levels, given competing priorities. 4. A lack of clear and quantifiable targets on UHC/definitions of what constitutes a UHC package.

On the issue of poor coordination for PPPR, one respondent linked the poor coordination between donors at the global level to the need to build upon countries' own national health security plans – creating inefficiencies – and suggesting the need for increased coordination both between donors and with country-level actors working on national health security plans. The respondent also stated that these circumstances exist in an environment of insufficient financing for pandemics. In their own words:

> *"International funding for pandemic preparedness and response can come from multiple sources, including governments, international organizations, philanthropic foundations, and private sector contributions. Coordinating these diverse funding streams can be challenging and may lead to inefficiencies when those fail to build off countries' own prioritization and planning efforts (such as) the National Action Plans for Health Security (NAPHS). Additionally, the amount of funding currently available globally falls shorts of needs estimates, with a Pandemic Fund mechanism established to resources countries' PPR efforts oversubscribed and hinging on insufficient voluntary contributions and outdated governance arrangements.*
>
> *[Respondent 14, CSO/NGO, North America]*



In contrast, in UHC, where there were 30 responses on barriers and challenges in financing, respondents considered competing priorities and political deprioritisation to be the top barrier in financing UHC compared to economic



investments, security, and even climate change post-COVID, however this is closely linked to the second most frequently cited barrier which is the limited resources generally available for specific UHC components such as reducing out-of-pocket expenses for health and primary care at the domestic level. The third top barrier was the lack of sustainable financing for UHC at the international level, followed by the lack of clear and quantifiable targets on UHC or definitions of what constitutes a UHC package.

One respondent felt that funding provided for UHC was poorly aligned to community and country priorities, and that better upfront work could be done to rightsize investments. This individual further stated that there were low levels of domestic investments into UHC. In their own words:

> *"In UHC financing, one challenge is the lack of alignment of the existing funding to community and country priorities. Global Health agencies that are investing in country health programs that contribute towards UHC can better align how they support countries inorder to maximize the potential impact of this funding. Also, low levels of domestic investments into UHC programs present a challenge in view of sustainability."*
>
> *[Respondent 9, CSO/NGO, East African region]*

Another respondent highlighted the challenges with providing essential health services – and that framing essential health services and PPPR as interlinked and mutually reenforcing may be a useful strategy. In their own words:

> *"Fiscal space is a challenge in LMICs and insufficient political will. Also, at the country level, especially in LMICs, governments are struggling to meet essential health services. Essential health services and PPPR are framed as two separate components of the health system. hence (there is) a need to conceptualise how countries can continue to both invest in (and) provide essential health services and invest in PPPR. In addition to fiscal space and political will problems, i think there is also a challenge in how some countries have conceptualised PPPR and a failure to see the synergistic nature between PPPR and essential services."*
>
> *[Respondent 10, CSO/NGO, East African region]*

This testimony highlights the opportunities in framing both UHC and PPPR as essential and mutually reinforcing for more sustainable health systems. There may be advantages as well in drawing synergies to the 'health for all policies' maxim espoused by another respondent – as sustainable health systems as necessary for thriving economies.

3b) What are short- and medium-term interventions that the G7/G20 should focus on to address barriers you specified and catalyse change?

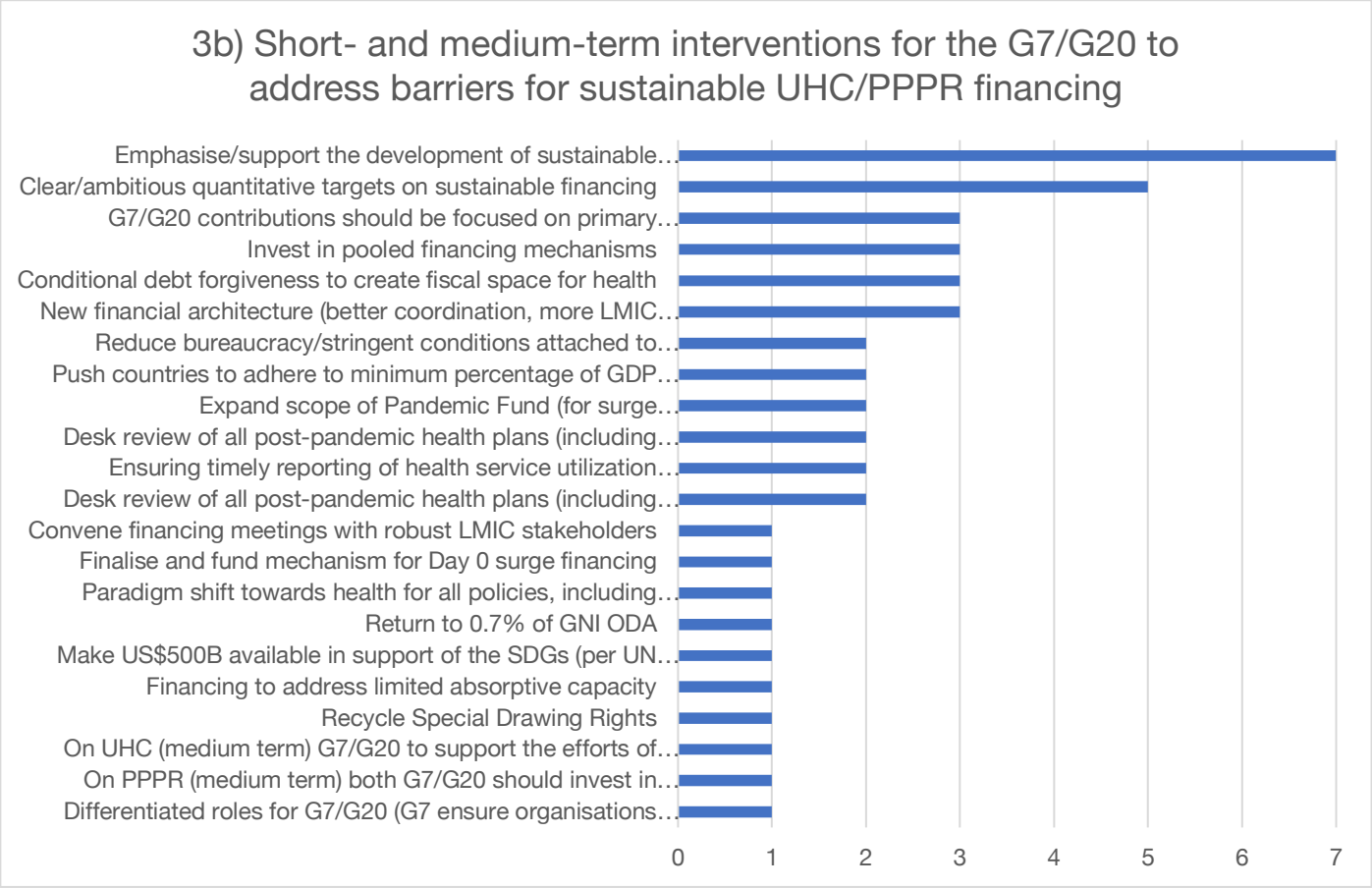
24 respondents provided 46 recommendations on how to address barriers for financing for UHC and PPPR. Interestingly, the top intervention was focused on the need to emphasise/support the development of sustainable domestic financing plans as the first line of defence, signalling the need for reduced donor reliance and increased accountability domestically for health. Secondly, respondents felt that there was a need to set clear quantitative targets on financing – whether it be to ensure that G7 countries return to 0.7% of ODA contributions or that LMICs ensure that they meet the set targets of health financing as a percentage of GDP. In the words of one respondent:

> *"Countries need to ensure that they meet the recommended % spend of gross GDP to health. WHO recommended 5% but often it needs to be higher to achieve (sustainable financing for) UHC and PPPR. It should be non-negotiable for countries to place their necessary spend on health as health is the key to successful economies and basic human rights to healthcare."*

[Respondent 16, CSO/NGO, Southern Africa]

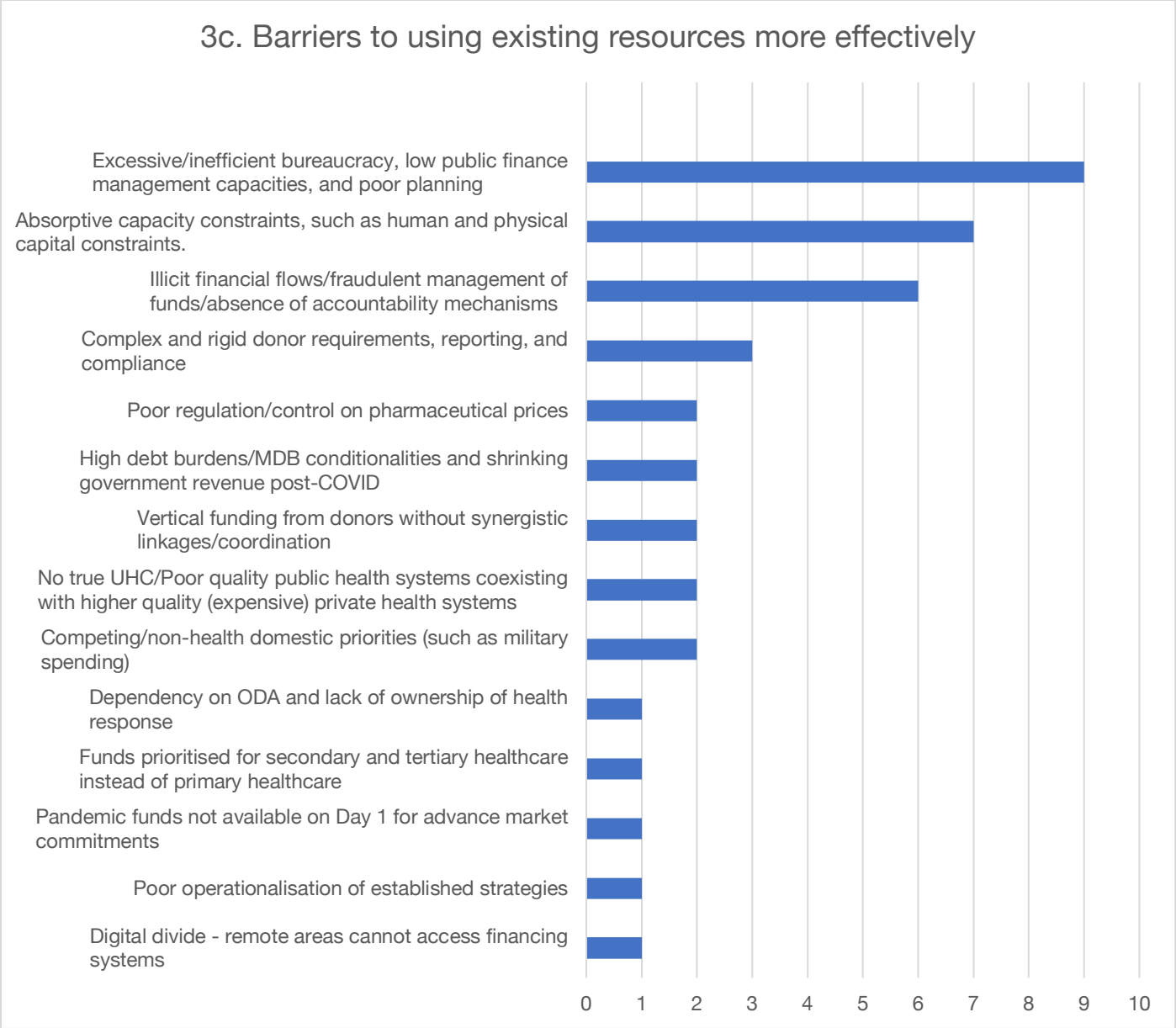
Three respondents spoke about debt swaps or conditional debt forgiveness as key priorities for interventions. In the word of one respondent:

> *"The G7/G20 should facilitate debt relief and restructuring efforts for countries with high debt burdens. This could provide immediate fiscal relief and free up resources for pandemic preparedness and response. Additionally, consider debt-for-PPR swap (as is being done for climate) and work to ensure that IFIs/MDBs programming and operations protect health (including PPR) and related spendings (e.g., prevent austerity cuts as conditions of support)."*
>
> *[Respondent 14, CSO/NGO, North America]*



3c) What are barriers to countries using existing resources more effectively? You may illustrate with examples.

20 respondents provided 38 responses on what they consider to be the biggest barriers to using resources more effectively. Ranked numerically, excessive/inefficient bureaucracy and low public finance capacities were considered to be the top barrier to using resources effectively, followed by illicit financial flows/fraudulent management of funds, and thirdly absorptive capacity constraints.



Inefficient bureaucracies and low public finance management capacities were considered to be the top barrier to efficient use of resources. According to one respondent:

> *"Common barriers include inefficient bureaucracy (sic) with complex administrative processes and excessive red tape (which) slow down public projects and hinder efficient resource allocation. For instance, obtaining permits for infrastructure development may involve numerous bureaucratic hurdles; causing delays and increased costs."*
>
> *[Respondent 14, CSO/NGO, MENA region]*

Bureaucracy challenges were intricately linked with (and exacerbated by) absorptive capacity barriers, including infrastructure deficiencies such as digital connectivity and transportation, political unrest, and environmental challenges such as flooding.

Absorptive capacity[6] is defined as including the following:

(i) human and physical capital constraints

[6] Feeny and de Silva, 'Measuring absorptive capacity constraints to foreign aid' (2012) 29(3) Economic Modelling 725-733

(ii) policy and institutional constraints
(iii) macroeconomic constraints
(iv) deficiencies in the manner in which the international donor community delivers its foreign assistance; and
(v) social and cultural constraints

This quote from a government official illustrates this interlinkage:

"We have insufficient infrastructure such as issues with transportation, energy, and even digital connectivity that can limit the ability to effectively utilise some of these resources. This is crucial when you want to optimise resource utilisation. We also have issues in terms of bureaucracy within government structures, and challenges to balance resource utilisation with environmental sustainability and environmental issues like climate change, flooding, and (geographical factors) like some health facilities are in geographical locations that are supposed to provide interventions but because of some of these environmental issues, they cannot do so, and you have to solve that environmental problem before (you can provide interventions in that particular area)."

[Respondent 20, Government/Quasi-Government Entity, African region]

Similar themes were echoed by a respondent who stated that absorptive capacity was the biggest barrier to utilising existing resources, adding more resources for operations while not simultaneously investing in human resources or equipment results in poor utilisation of existing resources. In their own words:

"From an economic perspective, production is a function of capital (finance and physical infrastructure), labour and technology. Increasing any one of these variables holding the others constant will work in the short run but not in the long run. Put simply, sometimes adding money for operations will not give more results when we are not investing in capacity of health care workers, or the equipment/technology that they use. In some countries, physical infrastructure has dilapidated or not been expanded as populations and staffing grew. So financial resources may not be efficiently used because the other variables have reached their capacity and unless the capacity is increased, absorption rate remains constrained."

[Respondent 4, UN organisation, African region]

Another respondent from a PPP organisation stated that medical products were unsuitable for deployment, hence required additional resources to adapt before deployment:

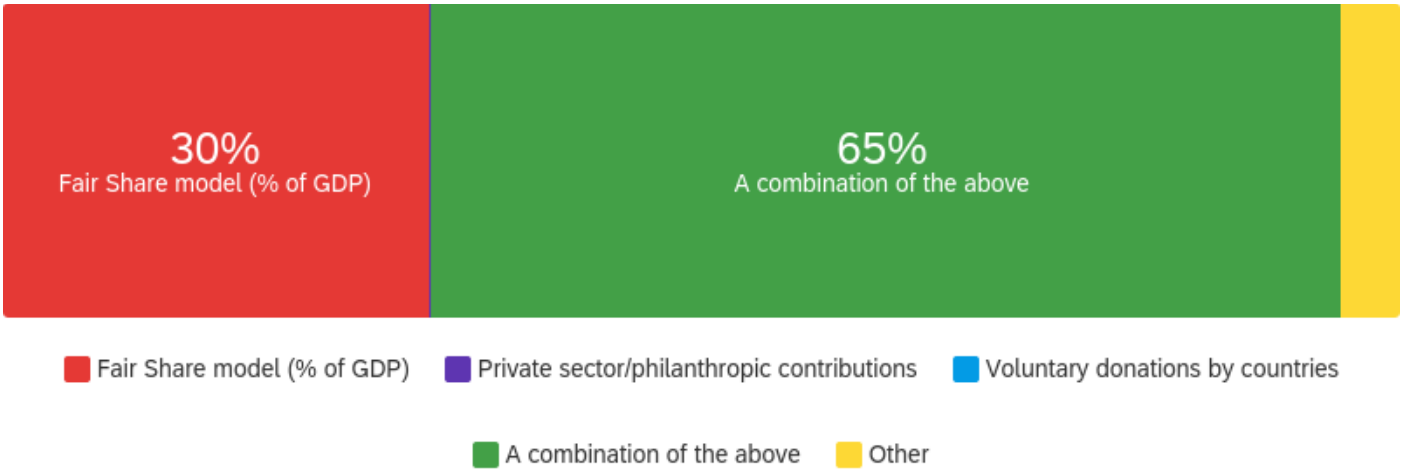
"Medical products are not appropriate for some settings (heat stability, cold chain, storage requirements and shelf life, packaging, administration form) that require additional resources to use safely and effectively."

[Respondent 12, PPP organisation, European region]

These testimonials suggest a need to ensure that G7 financing decisions are made with meaningful consultation with a wide range of local/domestic stakeholders, including public finance management competencies training as part of financing, and to ensure infrastructure and human resources support with health funding.

3d) There is some debate around the fair share model in the negotiations of the Pandemic Accord. What financing models are promising for securing PPPR financing?

Thirty percent of respondents stated that the fair share model (where each country contributes a percentage of their GDP to a fund), should be the model for securing PPPR financing. The majority of respondents, however, stated that PPPR should be financed as a combination of all three approaches, i.e., with a fair share model, private sector/ philanthropic contributions, and voluntary donations by countries. Only one respondent stated that the model should be 'Other'.



The individual who responded 'other' stated that it would be challenging to have donor countries contribute funding for a future potential pandemic given the economic outlook and stated that the approach to PPPR financing should be a pledge model attached to a set of conditions that triggers donors to contribute funding. In their own words:

> *"Given the current economy, it would be significantly challenging to have donor countries contribute funding to a fund/initiative for response to future potential pandemic. Securing contingent pledge by donors (most likely the key donor countries) with a set of conditions that triggers donors to contribute funding would be one of best approaches to secure surge financing for future health emergencies. As for deployment of funding when a health emergency occurs, the donors and key global health international agencies could come together and collectively discuss where the funding should be channeled (i.e., Vx, Dx, Tx, PPE etc.). However, the funding should be channeled via existing channels (i.e., Global Fund, Gavi, CEPI, etc.), and a new initiative should not be created when a new outbreak occurs."*
>
> *(Respondent 1, PPP organization)*

3d(i) What in your view should be the approach with surge financing for future health emergencies?

Twenty respondents provided 31 recommendations on what the approach to surge financing for future health emergencies would be. Responses were highly varied and therefore challenging to isolate more popular responses, however six respondents stated that a fair share model based on GDP contributions from all countries should be the approach for future health emergencies. Of these six respondents, one CSO respondent stated that while a percentage of contributions based on GDP from all countries was ideal, there should be 'differentiated responsibilities' for richer countries, including Gulf countries and BRICS. In their own words:

> *"On the fair share model, we need to consider how we can differentiate responsibilities of the G7 and other highly industrialised countries in the West, other high-income countries such as the Gulf kingdoms, emerging countries of large economic scale including China, India and Brazil, and other low- and middle-income countries."*

[Respondent 1, CSO/NGO, Asia]

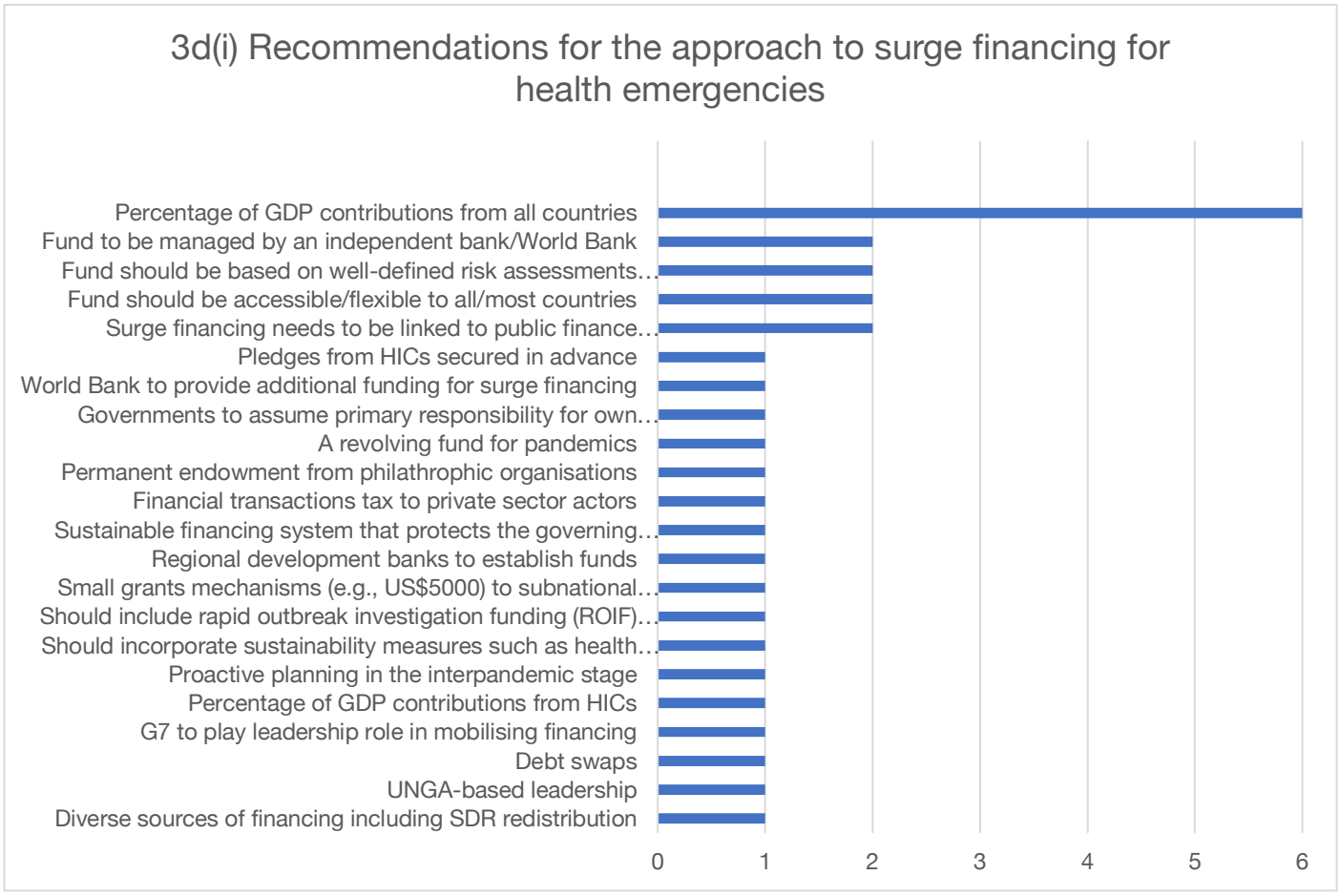
Another respondent supportive of contributions based on GDP, also from a CSO, stated that such an approach should be underlined by Global Public Investment[7] principles, which includes universal contributions (therefore eliminating patronising language of 'donor' countries providing to 'recipient' countries, and to ensure that there is representative control of finances.

Other top responses with two votes each stated that the fund should be managed by a development bank, that the fund should be based on well-defined risk assessments and would trigger disbursements based on predetermined conditions, that the fund should be accessible to all or most countries and should be flexible, and that the financing should be linked to a countries' public finance management capacities or absorptive capacity. On this latter point, one respondent from a government/quasi-government organisation stated that large sums are often moved into countries without available personnel to deploy and utilise this funding. In their own words:

"Surge financing needs to include mechanisms for the countries to use the funding judiciously and effectively. We frequently see lots of funds moving into a country but without mechanisms or personnel available to spend the money for what is needed."

[Respondent 15, Government/Quasi-Government Organisation, North America]

There were also other interesting proposals in the responses, such as the need to diversify sources of funding for surge financing to include Special Drawing Rights redistribution, and small grants for subnational-level entities for surge responses. While these did not receive support in terms of votes, given the small sample size these would merit further discussion whether in the JCIE advisory committee or at the Conference.



[7] Global Public Investment <https://globalpublicinvestment.org/qa/> accessed 14 November 2023

3e) What are engagement strategies/tactics that should be deployed to increase domestic resource mobilisation for PPPR and UHC? You may address PPPR and UHC separately or jointly, and please specify who should deploy these strategies and tactics.

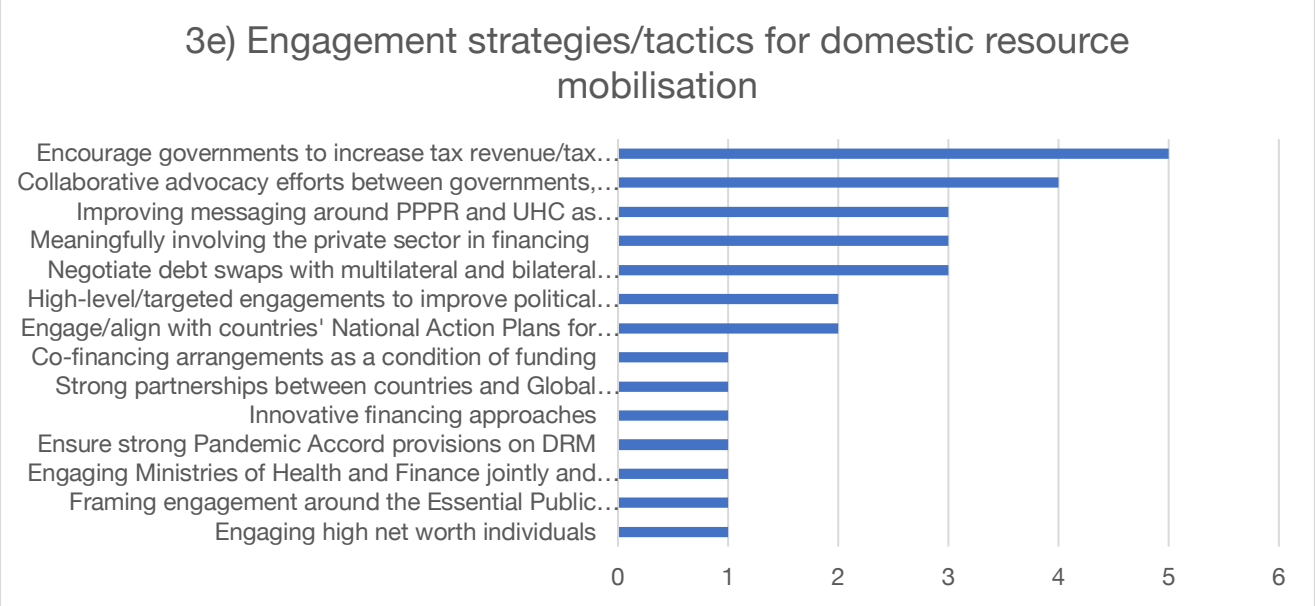
Twenty respondents provided 29 recommendations of strategies or tactics to be deployed to increase domestic resource mobilisation for PPPR and UHC. The most frequently cited recommendation was to encourage governments to increase tax revenue or to undergo taxation reform for domestic health financing, followed by collaborative advocacy efforts between governments, international organizations, civil society, and the private sector. On the former, one respondent stated that approach should be to "increase taxes on products that negatively impact heath (tobacco, alcohol, sweetened beverages etc.) and earmark revenues for health including PPP"[8] whereas others more generically stated that "government-initiated tax reform (should be) a tactic for domestic resource mobilisation."[9] Yet another respondent stated:

"We need to create more fiscal space by improving tax system design and implementation, including through the provision of technical assistance, greater transparency, and reinforcement of mechanisms to address multinational corporate and high-net-worth individuals' tax evasion or avoidance."

[Respondent 18, PPP organisation, Europe]

The third recommended engagement strategy/tactic was for improved messaging the interlinkage and mutually reinforcing nature of PPPR and UHC investments – given the lack of political will in both spheres. In summary, the top five recommended engagement strategies and tactics are as follows:

1. Encourage governments to increase tax revenue/tax reform for domestic health financing.
2. Collaborative advocacy efforts between governments, international organizations, civil society, and the private sector.
3. Improving messaging around PPPR and UHC as interlinked and mutually reinforcing.
4. Meaningfully involving the private sector in financing.
5. Negotiate debt swaps with multilateral and bilateral donors.



[8] Respondent 11, CSO/NGO, North America
[9] Respondent 4, UN organisation, East Asia

3f) There are multiple financing discussions ongoing on PPPR financing, including a financing mechanism under Article 44 of the proposed International Health Regulations Amendments and surge financing mechanisms discussed at the G20 Joint Health and Finance Taskforce. How can these different initiatives be coordinated and not duplicative? What linkages should be drawn?

Only 10 respondents answered this question – perhaps highlighting the lack of knowledge around ongoing proposals on financing for PPPR. One respondent proposed "mapping where these multiple initiatives intersect and the pooling of financial efforts under one comprehensive mechanism"[10] whereas another stated that any meaningful system should:

> *"Promote regular communication and collaboration among the various financing initiatives. This can involve sharing information on funding priorities, resource allocation, and strategies. (The mechanism should also) incentivize cross-reference and cross-participation between different financing initiatives (e.g. PF and GFATM). This could happen with representatives from one initiative participating in the governance or advisory bodies of another; purposefully calendarizing calls or proposals (aligning or staggering) and their contents; sharing technical review burdens etc."*
>
> *[Respondent 5, CSO/NGO, North America]*

More robust responses on this question may have to be solicited pursuant to an in-depth technical discussion of the features of each of the proposed mechanisms.

3g) What specific expectations do you have for "a global hub function including for financing, knowledge management, and human resources on UHC"? Please specify.

Only 12 respondents answered this question, with insufficient quality of responses to make robust recommendations. This theme may need to be discussed in more depth with an expert working group or through discussions at the Conference in Tokyo in early December 2023. Select themes from the responses are presented below:

1. Should centre better health informatics/analytics to inform UHC.
2. Should be independent from WHO.
3. Should not duplicate work of UHC2030
4. Should be open to diverse stakeholders including civil society and communities.

3h) Who or what is missing from ongoing discussions on UHC and PPPR financing? How do we ensure financing discussions are equitable and address countries most in need?

15 respondents provided 17 answers on who or what is missing from ongoing discussions on UHC and PPPR financing. The top response with close to half of responses was inclusive and participatory policymaking (8 responses), consistent to prevailing sentiment outside of this survey on the need to better rely on and integrate LMIC expertise in global health (*See*, e.g., ACT-Accelerator External Evaluation) and in other sections of this survey. This was followed by accountability of government financing (3 responses) and coherence with social protection mechanisms in-country (2 responses). The remaining four recommendations had one mention each, i.e. regional public health institutions, regional and national development banks, bacteria/AMR, and mental health. The top three factors are of who or what is missing from ongoing discussions are listed below:

1. Inclusive and participatory policymaking
2. Accountability of governments on domestic financing
3. Coherence with social protection mechanisms in-country.

[10] Respondent 2, CSO/NGO, Middle East and North Africa

Consistent with other sections in this survey, respondents felt that LMIC, LIC, civil society, and community voices were often sidelined in global health decisionmaking. In the words of one respondent:

> *"LMIC voices and those of regional public health institutions have been partly sidelined in the conversation, along with their insights about what may need to be done differently for impact."*
>
> *[Respondent 6, CSO/NGO, North America]*

When discussions of global concern are not sufficiently inclusive, the resulting recommendations miss out on important expertise and may suffer from unsatisfactory local applicability. Other missing stakeholders mentioned in this category were finance, budget, and admin personnel who are deemed essential in making emergency strategies workable. The top 2 response category suggested that domestic financing should be the main source of PPPR funding and that this need must be included, while also building accountability mechanisms into the financing structure.

While above respondents focused on government entities, another set of respondents pointed to the need for including non-state actors into the process, per the below quote:

> *"There has been limited engagement of country-based, non-state actors (including local civil society organizations, communities, non-governmental organizations, etc.) which limits inclusivity, alignment and scope of programs, as well as critical opportunities to build trust."*
>
> *[Respondent 15, PPP organization, Europe]*

The reasons for the importance of effective inclusion of these stakeholders were similar to those for government stakeholders, i.e., pointing to the need for trust and applicability of results from conversations that skirt full inclusivity.

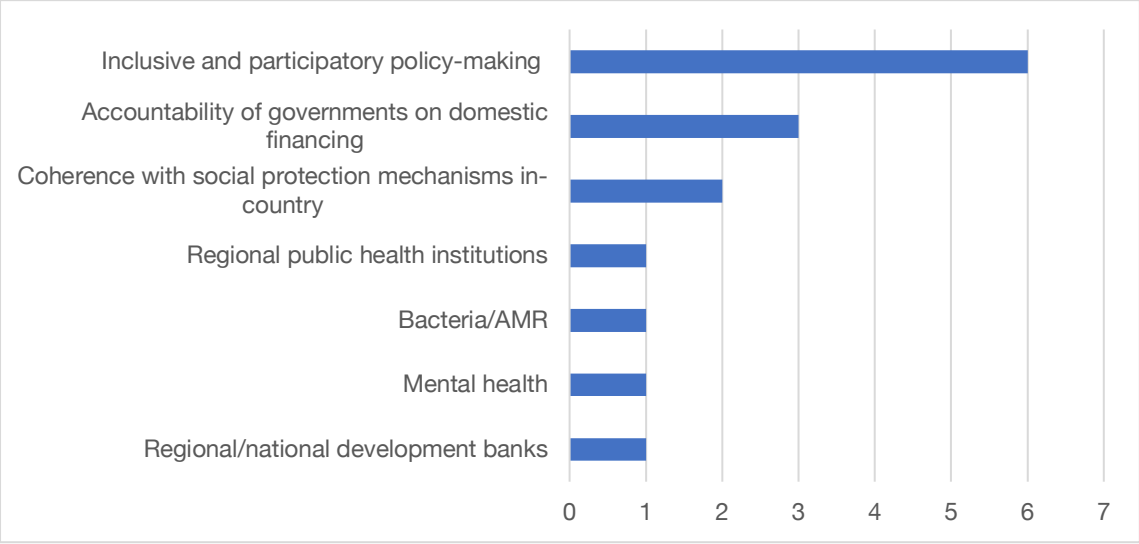


Figure 8: Who or what is missing from ongoing discussions on UHC and PPPR financing?

Two responses pointed to the need to integrate UHC financing into domestic discussions on other social security financing, and that there needs to be coordination between health security and health care agencies. In summary, domestic non-state actors, LMIC/LIC governments, and regional institutions require inclusion into discussions. Some thematic areas were also suggested as important to recognize, i.e., AMR and mental health.

Recommendations for 2024 G7 Presidency

[subject to review]

R&D and Access

1. In all initiatives and sources of financing for regional manufacturing, to identify key opportunities for true end-to-end financing, including funding for set-up/start-up of facilities.
2. Increase investments by every G7 country into pull investments to replenish the AMR pipeline, while simultaneously increasing investments into current push investments such as CARB-X, GARDP, and SECURE.
3. Ensure that an established pathogen/genetic sequence data platform has, inter alia (see Section 1g in this report), the following characteristics: a) Multilateral consensus/standardisation on nomenclature, such as what constitutes 'timely' sharing; b) Realtime uploading and access of data; c) elements of decentralization to regional bodies (such as to the European Virus Archive or to the Africa CDC).
4. To consult a wide range of stakeholders on the hosting and feasibility of prototype libraries for diagnostics, therapeutics, and vaccines.

Health Workforce

1. Explore models of taxes, reimbursement models, disincentives, or compensation models applicable to HIC countries that absorb LMIC workforce, with funding to be used towards development of health workforce in LMICs (including scholarships)
2. Identify financing streams/forums for the development of cohesive and long-term health workforce retention strategic plans.
3. Push for the professionalization and formalization of community health workers and support strong community health systems as integral to care in emergencies.

Sustainable Financing in PPPR and UHC

1. Endorse and facilitate discussions around a fair share model for surge financing of PPPR, with each country providing a percentage of GDP to funds for these purposes.[11] These should be underlined with Global Public Investment[12] principles. Given the drop-off in political will during the inter-pandemic period, these may need to be in the form of pledges secured in advance from countries. The G7 could announce this fund as a strategic initiative with the G20 and other blocs to encourage political will in other regions.
2. To discuss and explore mechanisms/conditions that these funds include/be supplemented by absorptive capacity support (such as human resources capacity to deploy provided financing, transportation, energy, and digital connectivity) and public finance management capacity building.
3. Provide technical support for taxation reforms to support sustainable UHC financing in LMICs.
4. To ensure that G7 financing decisions are made with meaningful consultation with a wide range of local/domestic stakeholders – this will ensure that financing for UHC is rightsized to local priorities and identifies concerns with public finance management competencies and absorptive capacity issues (such as infrastructure, human resources, and connectivity) are identified at the outset.
5. G7 and G20 to emphasise and support the development of sustainable domestic financing plans as the first line of defense in PPPR.

[11] It should be noted that a fair share model is presently one of the proposals for the Pandemic Accord. Negotiations are due to be concluded May 2024.

[12] Global Public Investment <https://globalpublicinvestment.org/qa/> accessed 14 November 2023