

Global Fund Advocates Network Asia-Pacific (GFAN AP)

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Subject: C20 Vaccine Access and Global Health Working Group Inputs for the White Paper on Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response

[External]

To whom it may concern,

please find attached the C20 Vaccine Access and Global Health Working Group (VAHWG) Inputs for the White Paper on FIF for PPR.

We remain available for any further clarifications and confirmation on the receipt of our inputs.

with regards on behalf of the C20 VAHWG Coordinators

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Vaccine Access & Global Health Working Group Statement

White Paper of the World Bank Group on the Proposed Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response hosted by the World Bank

In 2022, the Indonesia G20 Presidency priorities – Global Health Architecture, Digital Transformation, and Sustainable Energy Transition – aim for the world to *Recover Together Recover Stronger* from the impacts of COVID-19.

As the C20 Vaccine Access and Global Health Working Group (VAHWG)¹, we have the overarching goal of the **Right to Health for all** encompassing **people-centred Universal Health Coverage (UHC)**. The health and well-being of people through **rights-based, intergenerationally-inclusive and gender-transformative approaches are essential** for **evidence-based, economically beneficial and sustainable solutions** inclusive of **sexual reproductive health and rights and gender medicine** through mechanisms/processes that are **transparent and accountable** for **equitable health policies and solutions**.

¹ The C20 VAHWG is one of the thematic working groups of the C20, a formal engagement group of the G20.

² **Vulnerable groups** as specified in the 2030 Agenda include children, youth, persons with disabilities, people living with HIV (PLHIV), older persons, indigenous peoples, refugees, internally displaced persons, and migrants.

³ Including peoples impacted by war, conflict, terrorist insurgency, and political unrest.

⁴ This includes communities who are excluded from mainstream social, economic educational, and/or cultural life.

⁵ **Key populations** are defined according to WHO as people who inject drugs, men who have sex with men, transgender people, sex workers and people in prisons and other closed settings.

⁶ These can include but are not limited to Cholera, Ebola, Yellow Fever, Meningitis, Lassa Fever, Zika, Chikungunya, etc.

We put **vulnerable groups^{2,3}, marginalised communities⁴ and key populations⁵ at the centre of global health strategies and responses**, including ensuring the **meaningful and inclusive participation of community-based and -led, and civil society organisations in all levels of political, decision-making, implementation and monitoring processes in achieving UHC for all**.

The C20 VAHWG submits the following points in response to the White Paper: A Proposed Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness and Response (PPR) Hosted by the World Bank.

We stand behind recommendations from the **Italy C20 2021 Global Health and Finance Working Groups Communique** and emphasise that any decision for global mechanisms/initiatives developed and is part of the Global Health Architecture should be done so within globally established and recognised systems such as the United Nations.

We do not support the establishment of new parallel mechanisms for the pooling of global financial resources, that will duplicate efforts and resources in its management and implementation so as to avoid undermining effective work results to date. The global pooling of financial and medical resources and expertise should be managed within existing systems through cooperation, and on principles of transparency, accountability and integrity, and developed and rolled out with the meaningful involvement of community and civil society. For example, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has demonstrated its capacity to deliver with results, and it has been investing in activities that contribute towards pandemic preparedness and response, as well as health and community systems strengthening since its inception.

Importantly, **we call for the establishment of principles that will guide the work of the proposed FIF before establishing and finalising its governance, strategy, modalities and operations**. World leaders must find a pathway to facilitate decision making processes (including for funding) in a rights-based, inclusive, equitable and people-centred manner. The ongoing COVID-19 pandemic has proved that no country is safe until all are safe.

1. Focus on FIF Financing

Pooled resources should also advance preparedness for outbreak-prone diseases⁶ that are not of a global nature but can have significant impacts on health systems in low-and-middle income countries (LMICs). The discussions should therefore go beyond COVID-19 and beyond “emergencies” such as the current pandemic, and include existing threats such as HIV, TB, malaria, antimicrobial resistance (AMR) and neglected tropical diseases (NTDs) to be able to fulfil existing commitments in achieving SDG target 3.3.

The focus should be with the long term aim of strengthening country level responses as highlighted in the paper⁷ authored by the World Bank (WB) and WHO which notes that “COVID-19 has highlighted an urgent need for global collective action to substantially scale up investments and support to strengthen the capacity of developing countries to prevent, prepare for, and respond to the next pandemic... It is the collective responsibility of the international community to ensure that the necessary investments in PPR are made, on an urgent and sustained basis, so that low-income and lower-income countries and regions are better prepared to face the next pandemic”.

⁷ **Financing Modalities for Pandemic Prevention, Preparedness and Response (PPR)**

Learning from the International Health Regulations (IHR) and the response to previous pandemics, epidemics and outbreaks, it is clear that changes and actions happen at global, regional, sub-regional, national as well as at local levels. Therefore, global mechanisms must support national actions and funding needs to be directly provided at the national and local levels.

Currently, the FIF appears to propose financing to global institutions to then channel the funds to countries increasing both human and financial resources that could otherwise be directed to targeted countries, especially if the identified mechanisms do not have a good track record in delivering results and demonstrating value for

money. This will further fragment responses and will not empower countries to own the process and allocate their own domestic resources to PPR which requires long term investments in health systems and animal health. For example, some of the fundamental functions of PPR are based on training and recruitment of a variety of health workers including allied and community health workers, and this funding must be primarily from government budgets to ensure sustainable financing. Without long term and continuous public investments in health workers, the functions of PPR cannot be implemented even with the financial support from global institutions.

More importantly, funds directed to countries should be allocated and used through transparent, accountable and inclusive decision-making processes for both governments, communities and civil society so that these groups lead the coordination at the national level, including decisions on where and how funds are spent. The FIF can play an important role in coordinating donors and other global actors and stakeholders. However, it is at the end of the day a financing mechanism and not a global policy setting platform such as the WHO.

2. Governance

As mentioned above, we would not support the creation of another FIF which would duplicate resources. We would support the expansion of the mandate of current FIFs – such as the Global Fund which has demonstrated experience, transparency, accountability and results. We are also alarmed that the White Paper does not seem to have considered other governance models such as the Global Fund or [Migration Multi-Partner Trust Fund](#). However, we present the following arguments given the recommendations in the White Paper for perusal. We welcome a balanced and inclusive governance structure with a strong constituent representation from developing countries, including LMICs with a 50/50 split as a minimum threshold.

We recommend that all relevant institutions working on health are included in the governance structure such as the Global Fund, GAVI, UNITAID, Stop TB Partnership, Roll Back Malaria Partnership, etc. We also recommend that the quadripartite organisations (WHO, OIE, UNEP, FAO) and relevant multilateral organisations are included in the governance structure to ensure that the One Health Approach is integral to all proposed strategies.

We recommend that countries organise themselves into regions/delegations rather than the decision made according to WB and/or WHO regions. We note that the donor-recipient model as outlined in the White Paper must be aligned to the development landscape of today and the approach of the FIF needs to be one of partnership and not of donor-recipient.

We strongly object to the current framing of a top-down approach of the White Paper that relegates communities and civil society to “observers” without any alternative and better options. The changing development landscape and experiences of addressing pandemics (including COVID-19) have taught us the important role that communities and civil society have in responding to pandemics, and the White Paper only presents an option with voting representatives from governments. We believe in a governance model that has more equitable representation of not only donors and LMICs, but one that has representation from the people that are affected the most by pandemics. Therefore, **we strongly recommend that the governance model must enshrine principles of inclusiveness, diversity and meaningful engagement of communities and civil society that is not just tokenistic and treats communities and civil societies as mere observers.**

We refer to the governance model of the Global Fund which accords voting rights to communities and civil society and strongly recommend that at least two voting seats are given to communities and civil society and that they can organise these seats – either one seat for communities and one seat for civil society, or one seat for global north and one seat for global south civil society organisations, or however they choose to organise themselves. This decision should not be made without a transparent and meaningful processes of engagement with communities and civil society. In addition, that **in national decision-making and implementation, communities and civil society should be represented and have equal decision-making powers** much like the Country Coordinating Mechanism of the Global Fund. **This should be made a conditionality for recipient countries to receive funds from the FIF.**

We are concerned that this new FIF to support PPR would carry on as “business as usual” and could repeat the mistakes made before in the WB’s previous “Pandemic Emergency Financing Facility” which was discontinued after four years amidst criticisms that this was ineffective, poorly governed and was even described as an “embarrassing mistake” by the WB’s former chief economist. The world cannot afford to repeat these mistakes.

For better alignment/linkages between different platforms such as the G7, G20 and their relevant engagement groups and task forces, we caution that more thought is needed on this given that the leaderships of these platforms and engagement groups change from year to year depending on the host country. We strongly recommend that an observer seat be included across the platforms/groups/mechanisms so that attendance and

participation can be ensured across the different groups/platforms, so as not to further fragment and duplicate existing efforts.

3. Operating Modalities

In implementation, it is of utmost importance that we ensure that those who are most affected are also included not only in the decision-making processes, but also in implementation, monitoring and evaluation. Communities and civil society are important partners in holding stakeholders accountable, such as the government in terms of health spending as well as resource mobilisation.

We are concerned about the proposal for the WHO and other UN agencies to be considered implementers of the proposed FIF for PPR given that mandates of these organisations are for technical advice and monitoring. Given that conversations regarding the new Global Health Architecture are ongoing, we are concerned about the duplication of resources and efforts proposed. We strongly caution to ensure that the maximum amount of money is channelled through mechanisms that will go to countries and communities and civil society for implementation, rather than towards administration fees and lead agency human resources.

A key building block for any pandemic response to prepare for future pandemics is recognising, investing in, and utilising community systems and responses for health, as we have witnessed in HIV responses – including informal avenues of community monitoring and data collections. COVID-19 has exacerbated and veered country responses off-track for specific SDG targets – including SDG 3.3 to end the epidemics of HIV, TB and malaria. PPR cannot be strengthened in a vacuum and resources must be allocated and programmed responsively for overall health systems to achieve UHC, including community systems.

⁸ Building on pre-existing HIV infrastructure for monitoring and response, such as surveillance sites created by the HIV response that was used during COVID-19 – <https://gh.bmj.com/content/6/12/e007980>

We welcome the development in seeing prevention addressed in this White Paper and to reduce the risk of zoonotic spill over, and to strengthen animal health – through supporting countries to meet OIE standards. From a One Health perspective, the strengthening of country-level PPR capacities needs to be prioritised to include disease surveillance which is key to prevent the spill over of diseases at the animal-human-ecosystem interface. However, disease surveillance is only as strong as the data and information monitored. The capacity gaps in, and the quantity and quality of the veterinary workforce must be addressed for strong data, data [Page 4 of 4](#)

management and truly effective monitoring, surveillance and quality assurance systems. From an ecosystems perspective, the FIF should support actions to protect tropical and subtropical rainforests to support spill over prevention.

Domestic financing of health systems must be addressed immediately, including the addressing of issues such as debt restructuring and introducing/implementing progressive taxation⁹ to increase the fiscal space needed for sustainability. PPR is within the remit and overall goal towards the attainment of resilient global, regional and national public health ecosystems. As such, we stress the importance for countries to be supported to achieve the minimum target of 5% of GDP for public spending on health¹⁰ to reduce out-of-pocket health spending, and at the same time for donors to step up and meet their 0.7% target¹¹ for ODA. This is essential for complementary efforts by domestic sources.

⁹ Committed at the [High-level Meeting on Universal Health Coverage in 2019](#), paragraph 35.

¹⁰ Committed at the [High-level Meeting on Universal Health Coverage in 2019](#), paragraph 34.

¹¹ [The OECD-DAC 0.7% ODA/GNI Target](#) (accessed 25th March 2020).

Earmarking of resources should see the majority allocated to countries. We expect that this is not just towards governments but include mechanisms that will drive funding towards communities and civil society for implementation. Investments at global and regional levels should be strategic and focused to support country outcomes and to promote co-investments.

We strongly oppose any channelling of funding towards the private sector, including the private sector arms of the MDB groups. If these groups are to provide technical assistance to countries, no conflicts of interests must be ensured. The private sector has a clear conflict of interest and should not be part of decision-making or governance of the FIF. At the country level, countries can and should engage with the private sector when it is determined to be needed, through transparent and competitive bidding processes.

The proposed FIF should not micromanage funds and should channel funds based on the principles and strategy to be developed. This should encompass four non-negotiable principles of (1) Comprehensive global collaboration/participation that includes member states and non-state actors; (2) Accountability; (3) Full transparency on the use and in negotiating allocation of resources; and (4) Global equity.

Any investment in the FIF should be additional to current development assistance to health and should not dislocate global/domestic investments in health and bilateral programmes. We refer to the recommendation

made in “A Global Deal for our Pandemic Age” a June 2021 report of the G20 High Level Independent Panel on Financing the Global Commons for PPR with a clear recommendation that states clearly that the **investments for international financing for PPR “must add to, and not substitute for, existing support to advance global public health and development goals”**. As such, contributions towards the FIF should be benchmarked, for example meeting 0.7% targets for ODA. We encourage that replenishment cycles of global health and financing institutions be set in the broader health development landscape and part of the Global Health Architecture discussions to ensure that priorities are aligned and to reduce competition between institutions. We wish you fruitful deliberations and look forward to the points raised above being incorporated in your discussions so that we truly leave no one behind.