RESULTS (U.S.) Feedback – Pandemic Fund Draft Strategic Plan – April 2024

We greatly appreciate the chance to input on the Pandemic Fund's draft strategic plan, and the ongoing willingness of the Pandemic Fund board to solicit and incorporate feedback.

When the Pandemic Fund was launching in 2022, we shared what we saw as four prerequisites for it to deserve future funding and support: inclusive governance, a clear strategy for additionality of funding, priority for the highest-impact and most equitable implementing entities, and focus on community health systems (feedback shared in a series of letters and meetings with Pandemic Fund Board leadership, beginning July 2022. We are happy to reshare these letters as helpful).

Our feedback below examines the Pandemic Fund's progress against those initial criteria and the modalities that enable them, as well the key principles espoused by the Pandemic Fund at its inception. We're grateful for significant progress against several of those key areas, while we note that significant work still remains to address others.

Broad, transparent and inclusive representation in governance
Relevant to Section 6, Good Governance and Stakeholder Engagement

We are grateful for the progress from the Pandemic Fund in regards to full voting representation from Global South governments and civil society. This is central to creating a sustainable, responsive, and equitable institution. We welcome the new strategy's proposal to further enhance support and focus on these key governance constituencies (Section 6.2 and 6.3), including through: technical and financial assistance, formal mechanisms for constituency engagement, direct focus on removing barriers to participation (such as translation), and increased clarity and requirements around civil society participation at a country level in the full funding lifecycle. We encourage the Pandemic Fund to consult with the Inclusive Global Health Institutions Project for further recommendations and advice in this area (hosted by WACI Health, GFAN, GNP+, and STOPAIDS).

Additionality of funding, not borrowing or detracting from other global health initiatives
Relevant to Section 1, Principles, and Section 5, Catalyzing Additional Funding

We appreciate the Fund's stated commitment to additionality in its resource mobilization, but so far this commitment has not been meaningfully operationalized. We continue to believe the Pandemic Fund must have a plan, and verification process, to ensure its funding is additional. While some of its initial funding has been truly additional, much of it has not. Verified *additionality* of contributions should be a mandatory criteria for participation on the Pandemic Fund board by donors, with a transparent, externally verifiable methodology.

A commitment to look outside existing ODA for health – to grow the overall envelope – was a repeated commitment from the Pandemic Fund's secretariat and governance in its earliest days, and a major concern from civil society. Unfortunately this promise of additionality has not been met in reality. Strategies for innovative financing, and meaningful funding streams outside of ODA, have not come to fruition, and many donors commitments have not been additional. For example, while the United States' founding contribution (drawn from COVID relief funds) clearly was truly additional, the Biden Administration's next budget request for the Pandemic Fund came only in the context of a global health budget that simultaneously proposed *reducing* bilateral funding for tackling pandemics. This is, by definition, not additional. The contributions from the vast majority of sovereign donors are either plainly not additional, or unclear. This is particularly relevant if and when funding comes at the expense of existing global health programs (bilateral or multilateral), as simply redirecting those funds to the Pandemic Fund means they are subject to additional overhead costs without any additional impact.

The draft programmatic strategy indicates that a separate Resource Mobilization strategy is forthcoming. As civil society, we cannot support further resource mobilization unless the strategy for additionality is clear, and the modality and coordination minimum standards outlined below are fulfilled.

Pandemic investments that enhance equity and community health systems
Relevant to Section 2, Focus Areas

In order to support effective surveillance, laboratory systems and workforce built on the underlying themes (figure 3) of health equity, community engagement and gender equality, it will be critical to ensure a focus on primary and community systems. It will also be essential that the Pandemic Fund transitions away from offering only short-term projectized funding, which is often ill-suited to building sustainable, responsive systems. Using its existing resources more strategically to offer multiyear funding would allow countries to make more efficient and effective investments.

This is particularly relevant for the investment focus areas that are directly tied to existing health delivery systems. We endorse the alignment of PPPR investments with existing systems (dual-purpose funding that increase access to health services today, while preparing for the future) – but it requires even great attention to how funds are delivered, via which IEs, and on what timeline.

Examples of these areas from the Pandemic Fund's list of proposed programmatic priorities in Appendix C include: community engagement and digital infrastructure of data management (under "surveillance"); community-based laboratories (under "laboratory systems"); recruitment and training to build surveillance workforce, and training and education of community-facing workforce (under "workforce"). In each of these vital areas, the Pandemic Fund cannot afford to fund parallel, siloed investments, but must work through the IEs and national and community systems that are already supporting the existing health challenges.

While maintaining country ownership over IE selection, the Pandemic Fund must also do more to ensure that the IEs best positioned to integrate PPPR investments into existing health delivery systems are prioritized. This points especially to the GFIs, as opposed to solely MDBs or UNOs, for delivering on these priorities. As the strategy points out, MDBs' comparative value add is co-

investment mobilization, cross-sector investment, and enhancing financial stability. We recommend the Pandemic Fund focuses on catalyzing additional money *from* the MDBs for pandemic preparedness (following models like loan buy downs or the GFF), rather than channeling precious grant money *through* the MDBs.

Funding allocation methodology and modalities
Related to Section 3, Resource Allocation and Section 4, Cooperation, Coordination, Collaboration

With the Pandemic Fund's stated commitment to filling capacity gaps and fostering coordination, it bears the responsibility for ensuring its own modalities are flexible to meet the needs of the highest impact IEs. The strategy notes that the Pandemic Fund will focus on administrative requirements that are aligned with those of other PPPR funders. Given the failure to align administrative requirements with the largest existing stream of PPPR funding during the first call for proposals (the Global Fund's C19RM), this is an essential step and must be complete before the next funding round to ensure the same problem doesn't arise. In addition to the major missed opportunity for aligned impact, this presented significant additional burden on countries, with parallel administrative processes unfolding at the same time, for much of the same work. This must be solved proactively.

All institutions have a role to play in better aligning and coordinating, but if the Pandemic Fund is to be an integrator and convener for PPPR as it aspires to be, then it holds unique responsibility for ensuring its own modalities align with others, rather than requiring others to align with it. So far it has not lived up to this promise, evidenced through the inability of Africa CDC and the Global Fund to meaningfully participate in the first round (albeit for two different reasons). Several of the changes proposed in the new strategy, such as rolling application deadlines, are a critical step forward. The Fund should continue to consult with the Africa CDC, GHIs, and others to ensure its processes and modalities are truly flexible and aligned (and in the case of Africa CDC and other possible future IEs, the Pandemic Fund needs to ensure its own IE accreditation process is suited to successful, streamlined approval of high impact bodies).

We welcome the decision to offer three distinct allocation modalities, and to allocate the majority of funding based on existing gaps and financial need. It will be critical to have a transparent, specific methodology for arriving at this prioritized list and for distributing allocations among it, to ensure equity within and between countries.

For this first funding modality and grouping of countries, a pre-determined allocation-based approach and lower burden requirements is a very positive step. Based on our experience of models like this, it's important that stated funding envelopes are also accompanied by additional incentive / catalytic funding to ensure a focus on the most marginalized communities within countries, who may not otherwise be prioritized from a strict envelope-based approach.

We also applaud the decision to transition to a rolling deadline, and lower burden requirement, as particularly important for coordination and alignment with existing funding flows, and reducing burden on countries. This is a significant step forward.

Coordination and the modalities that enable it

Relevant to Section 1, Principles, and Section 4, Cooperation, Coordination, Collaboration

The new strategy states that the Pandemic Fund is well-positioned to help facilitate collaboration and coordination amongst relevant actors and stakeholders, identifying this as part of its value proposition. This is consistent with early emphasis from the Fund and its board that it would be an additive new mechanism, filling gaps to complement existing work, serving as an integrator, and maintaining the flexibility to work through a variety of institutions.

While we don't doubt the intention nor enthusiasm from the Pandemic Fund for coordination, so far its operating modalities have not proven fit for purpose in this regard.

The strategy notes how the diversity of eligible IEs is pivotal to the Fund's impact (Appendix A), yet the first Call for Proposals does not reflect these synergies nor diversity. The funds flowed exclusively through MDBs or UNOs as IEs, leaving out the GHI category entirely, despite them being the ones best positioned to serve hard-to-reach and vulnerable populations, and to integrate disease prevention into broader country-level programs, as the strategy specifically points out.

Of the "synergies with pandemic PPR funders" celebrated in section 4.2, none were included in the first call for proposals, outside of the WHO. This is a powerful test as to whether the Pandemic Fund's modalities are fit for purpose, and based on round 1, so far they are not. Notably the institutions who did not participate and/or receive funds in the first Call for Proposals are also the institutions with the most robust country engagement models (ie Global Fund, Gavi, GFF, Africa CDC), in addition to the strengths of these institutions that the strategy notes. The Strategy's aspiration to add additional IEs will be significantly hampered if this flexibility isn't addressed.

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