Summary of Proceedings and Key Messages (19 August 2022)

First Round of Civil Society Consultations for the Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response
16 August 2pm-3:30pm WIB / 10am-11:30am EAT / 8am-9:30am BST/ 9am-10:30am CET
17 August 4pm-5:30pm BST / 5pm-6:30pm CET / 11am-12:30pm ET / 10am-11:30am CDT

Pandemic Action Network, Center for Indonesia's Strategic Development Initiatives (CISDI), Eastern Africa National Network of AIDS Service Organisations (EANNASO), and WACI Health, jointly hosted the first in a series of consultations with civil society organizations (CSOs) on the new Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness, and Response (PPR) on Tuesday, August 16 and Wednesday, August 17 2022. Combined, the two consultation sessions were attended by more than 350 civil society and non-governmental stakeholders from more than 40 countries and regions. Representatives of the joint World Bank/WHO Interim FIF Secretariat, other multilateral organizations, and at least 11 of the founding contributors also joined as observers across the two consultations.

These first two CSO consultation events were focused on the topics of the FIF governance framework, civil society engagement, and the Technical Advisory Panel, given the fast-moving decisions on these issues. Pre-read materials were provided here. Participating CSOs welcomed the opportunity to provide feedback to the group of founding FIF contributors and to the World Bank/WHO Interim Secretariat to inform and shape their deliberations, but also stressed that both CSOs and non-contributing low- and middle-income countries should be engaged as co-creators and decision-makers now and at every step of FIF design, operations, and governance to ensure the FIF's success and sustainability. The hope is that this consultation process will pave the way for meaningful engagement and leadership of civil society throughout the life of the FIF.

The next round of virtual CSO consultations will take place on Tuesday 30 August, 2pm-3:30pm WIB (Jakarta) / 10am-11:30am EAT (Nairobi) / 8am-9:30am BST (London) and Wednesday 31 August, 11am-12:30pm ET (New York) / 10am-11:30am CDT (Mexico City) / 4pm-5.30pm BST. Interested CSOs are encouraged to register, and the convenors also welcome the continued prioritization of these meetings by the FIF contributors and the Interim Secretariat as critical opportunities to update, learn from, and engage with civil society.

Below is a summary of these first consultations with key takeaway messages. The annexes contain more fulsome meeting notes and written feedback provided.

Topic 1: Governing Board (Composition, Selection Process, and Decision-making)
Participants discussed the representation of CSOs and non-contributing stakeholders on the governing board of the PPR FIF, including number/proportion of seats, voting rights, selection

process for constituency seats, and decision-making protocols, including consensus and/or majority thresholds. The following questions guided the discussion:

- What is best practice board composition to appropriately balance perspectives and leadership from donors, non-donors, and community-level stakeholders?
- What are examples of successful constituency-based governance structures, and how do they operate in practice? How have these models been shaped by lessons learned, failures, and shifts in power dynamics?
- What are concrete changes to the draft governance framework that can achieve these goals?

Key Messages:

- Lessons learned from ACT-A and other multilateral funds and health initiatives show that meaningful engagement and co-creation from civil society and LMICs is critical to success and impact. CSOs and LMICs must be treated as equal partners with contributors and other stakeholders in the design and governance of the FIF.

- Civil society must have a minimum of 3 voting seats on the FIF governing board. This follows best practices and precedent of the Global Fund to Fight AIDS, Tuberculosis, and Malaria and provides room for needed diversity in CSO expertise and perspectives.

- Civil society representatives on the governing board must be chosen through a civil society-led selection process, and should represent geographically diverse CSOs, including at the community-level, not just at the global level.

- Board seats should not be allocated based on contribution size/amount. This perpetuates a “pay-to-play” mentality that will hamper inclusion, and ultimately hurt long-term reputation and performance. Other models to consider include regional seats, with different sectors represented in each region, or allocating voting rights equally across different contributor levels to encourage wide-spread buy-in and contributions.

- Equity across genders, income levels, regions, indigeneity, and other intersecting identities is also critical to meaningfully inclusive and diverse decision-making on the governing board.

- The Board should not be fixed in size; there should be some flexibility as needed to expand to accommodate other stakeholders, including additional seats for civil society - some advocated for one third of seats for CSOs.

- To fully understand who needs to be represented in design and governance decision-making, there must be more transparency and understanding of the FIF’s scope and which entities will be eligible for funding.

Topic 2: Civil Society Engagement

Civil society representatives discussed how to foster meaningful CSO engagement in PPR FIF design and operations for the longer-term, beyond CSO inclusion in the governing body, including structure and cadence of meetings, transparency and information-sharing, and accountability. The following questions guided the discussion:

- What are examples/best practices of international bodies/financing mechanisms that successfully and meaningfully engage civil society? What are the critical elements of success?
- What are opportunities to build on and/or integrate CSO engagement on the Fund with existing mechanisms?

Key Messages:

- Leadership and engagement from civil society and community representatives are needed at every level – FIF planning and design, governance, project design and implementation, funding allocations, measurement and evaluation.

- The Interim Secretariat and founding contributors must reject the false narrative that pits equity and inclusion against agility. Full participation and leadership of CSOs will enhance FIF effectiveness and should be planned from the outset. Without this diversity of expertise and insight, the Interim Secretariat and founding contributors risk not learning the lessons of the pandemic nor the best practices established in recent years.

- Mechanisms to engage with civil society must be consistent, provide room to engage at the global, national, and community levels and prioritize engagement from diverse communities, including young people, senior citizens, people living with disabilities, people in humanitarian settings, and more.

- Strong examples of civil society engagement can be found through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Global Agriculture and Food Security Program (GAFSP), World Food Program (WFP), Global Financing Facility for Women, Children, and Adolescents (GFF), and the Global Health Security Agenda (GHSA).

- To prioritize accessibility and inclusivity, tools and resources must be provided to allow for a diverse range of stakeholders to engage (including translation in multiple languages, sign language interpretation, etc.).

- Resources must be allocated to support necessary CSO engagement in the FIF. This includes sufficient resources to enable CSOs to actively and meaningfully engage (e.g. to participate in convenings, meetings, travel, translation, etc), as well as for the Secretariat staff to prioritize and consistently enable civil society engagement processes and ensure timely and transparent communications and feedback loop

Topic 3: Technical Advisory Panel

CSO representatives discussed the shape and function of the PPR FIF's Technical Advisory Panel, including its composition, mandate, and interactions with the governing board and with civil society. The following questions guided the discussion:

- What kind of competencies and perspectives are required in the Technical Advisory Panel? What should be the role of CSOs, NGOs, and other community-level experts?
- How should the WHO's technical expertise be leveraged in Fund governance and decision-making?

Key Messages:

- CSOs and communities must be included as technical experts on the Panel, especially CSOs with experience in the COVID-19 response or response to other infectious diseases.

- The Panel should include experts from outside traditional health security sectors (e.g. including animal health, climate, social sciences, and other) to ensure a more holistic perspective on prevention, preparedness, and response, including zoonotic spillover both in livestock and wildlife settings. This is in line with the One Health approach.

- The Panel should also include the perspectives of the health workforce, including frontline health workers and infectious disease professionals. Expertise in health systems strengthening and community engagement should also be prioritized.

- The Panel must be closely linked with the governing board to ensure technical needs and expert opinions influence real-time priority-setting and funding decisions.

- WHO's technical expertise and skills in other disease areas can be leveraged and transferred to pandemic preparedness and response efforts

Additional Feedback and Questions:

- **Scope and Priorities:**
    - The FIF should take a holistic view of pandemic prevention, preparedness, and response, including zoonotic spillover and prevention, universal health coverage (UHC), and One Health. Addressing containment of pandemics is not sufficient.
    - The FIF should fill a gap in the global health ecosystem by supporting country and regional capacity building for PPR.
    - The FIF scope and priorities as articulated to date still feel opaque and unsettled. CSOs should inform the shape and scope to help focus on acute needs and gaps.
    - FIF operations must prioritize the most marginalized and take into account the perspective of health workers, especially those on the frontlines

- **Feedback Loop:**
    - Many CSOs have already provided written recommendations on the FIF, including in response to the draft White Paper; however, it is not clear what happened to this feedback and whether/how it has been incorporated. A timely and iterative feedback loop is necessary for the founding contributors and the Interim Secretariat to demonstrate how they have addressed these comments.

- **Implementing Partners:**
    - Entities, including CSOs, in LMICs should be eligible for FIF funding.

Annex 1: Participation of Civil Society Organizations

There were civil society representatives from at least 44 countries (number will be updated following final analysis).

Africa (16)

- Botswana
- Cameroon
- Côte d'Ivoire
- Democratic Republic of Congo
- Ethiopia
- Ghana
- Kenya
- Nigeria
- Rwanda
- Senegal
- Sierra Leone
- South Africa
- Togo
- Uganda
- Zambia
- Zimbabwe

Latin America & the Caribbean (5)

- Argentina
- Ecuador
- Jamaica
- Mexico
- Peru

North America (2)

- Canada
- US

Asia & the Pacific region (7)

- Australia
- Fiji
- India
- Indonesia
- Japan
- Russia
- Thailand

Europe & the Middle East (14)

- Belgium
- France
- Germany
- Ireland
- Italy
- Jordan
- Lebanon
- Netherlands
- Norway
- Palestine
- Romania
- Switzerland
- Turkey
- UK

Annex 2: Tuesday 16 August Consultation - Detailed Feedback

Governing Board (Composition, Selection Process, and Decision-making)

- Equitable distribution of voting rights and funding decisions must be a priority.
- Inclusion and diversity of voices and voting rights within Board is critical to ensure equitable and holistic approach to pandemic preparedness and response.
- Civil society and community engagement is key to accountability and oversight given their knowledge and insights into what is happening on a local level.

- Number and proportion of seats, decision-making
    - Do not allocate board seats and voting rights according to size of donations to ensure equal input among all implementing partners.
    - Equal seats and voting power between LMICs and large donors - voting rights on the Board for LMICs and civil society is critical.
    - Make sure that non-donor Board seats are equally represented with voting rights, not just observers - civil society, LMIC governments and community voices must be represented with voting rights.
    - Diversity and inclusiveness in voting rights is key - GFATM has a structure with civil society involvement in program execution with links to a broad spectrum of stakeholders. This is a model that should be looked at for guidance on how to structure governance and voting rights.
    - Ensure funding decisions include grass roots and community based organizations (in addition to global and larger implementing organizations).

- Composition of the Board - What is best practice?
    - GFATM board is a model that has been successful and impactful at scale, with broad representation from a diversity of players.
    - Voting rights distributed among donors and implementing countries, advising on funding decisions, is key to successful implementation and ownership of programs funded.
    - Segmenting donor community into various groups of high, middle, and lower income and allocating voting rights equally among them can avoid disincentivizing smaller countries from contributing.
    - Sector representation on the Board should include frontline community workers, and those involved in shaping public policy, consumer behaviors, and changing business practices to address pandemic threats.
    - For FIF legitimacy and equity, parity of civil society with governments is important to represent populations at higher risk and direct resources to areas of most need.

- What changes are needed to the current draft governance framework?
    - Co-creation with civil society and LMIC governments from the outset in the design of the FIF and involvement in weekly design meetings.
    - Inclusion of civil society input on white papers informing design decisions currently underway.
    - FIF should ensure that the WHO is involved, represented, and has power to align Fund execution with efforts it's supporting elsewhere.
    - Link pandemic preparedness and response to broader global health and planetary health ecosystem for a holistic approach to pandemic threats.
    - Meaningful engagement of community groups, not limited to observation.

    - The FIF must ensure most affected communities are heard and represented.
    - Address most vulnerable populations in totality, such as refugee populations.
    - The FIF must not carry on business as usual and further an inequitable response to pandemic threats.
    - Equal representation of gender and women, their input is critical as they are on the front line of pandemic response.
    - Community and local organizations should not be left behind as they see the impact of PPR most acutely.

Civil Society Engagement

- GFATM is a FIF that has had success in part because of community involvement in policy and funding decisions. Civil society involvement is the 'oil in the engine.'
- Global Agriculture and Food Security Program (GAFSP) is a World Bank FIF that also includes civil society and is another example beyond GFATM.
- Civil society should be engaged in weekly meetings and processes before launch of the fund
- Civil society perspectives must be integrated into white papers used to inform development of the Fund architecture.
- Proper channels from civil society are needed to ensure prioritization of evidence based interventions.
- Civil society should be engaged in monitoring and evaluation of impact on the front lines.
- Voting seats allocated among stakeholders to ensure equitable distribution of funding.
- Evidence based approaches used by GFATM for civil society engagement in monitoring and evaluation are models to leverage.
- Having proper channels for civil society voice and engagement is needed.

Technical Advisory Panel

- Involve civil society and communities as technical experts.
- Pandemics often don't start within human populations, they are transferred from animals or the environment. Communication and coordination across sectors (i.e. veterinary and environment) to get ahead of pandemics needs to be built into pandemic measures.
- WHO technical expertise and skills in other disease areas can be leveraged and transferred to pandemic preparedness and response efforts.
- Investments in primary health care are vital and should be included in pandemic interventions.
- Involve civil society at every level, planning, implementation, funding allocation, measurement and evaluation.
- Central role of WHO and One Health practices for comprehensive approach

Annex 3: Wednesday 17 August Consultation - Detailed Feedback

Governing Board (Composition, Selection Process, and Decision-making)

- It is frustrating that in 2022 we are debating equal representation, eligibility, and decision-making by LMICs, MICs, and communities.
- This is an opportunity to do things differently and better than the past to be inclusive and transparent.
- Many lessons learned from ACT-A should be taken into consideration, especially where LMIC governments and civil society were not included at the beginning. This ultimately lessened the impact of ACT-A and challenged civil society mobilization to support goals and funding.

- <u>Number and proportion of seats, decision-making</u>
    - Civil society should have at least 3 seats, or ⅓ of seats on a larger board, and there must be equal representation of non-donor countries.
    - Civil society should be able to choose their 3 representatives.
    - Board seats should be by regions, not by sectors, otherwise pay-to-play will hurt reputation, performance, and civil society inclusion.
    - Decisions made by the Board should be data driven and linked to longer term objectives.
    - Unacceptable to not include LMICs and indegnious communities in the design from the onset.
    - Regional representatives, especially LMICs, need voting rights.

- <u>Composition of the Board - what is best practice?</u>
    - Civil society should select their representatives to the Board (eg. UHC 2030, GAVI).
    - GFATM offers the best example of an inclusive Board that we have to-date.
    - GFATM offers models for inclusive governance and implementing with equity.
    - Board composition must include non-traditional sectors (not just health).
    - Consider gender and representation of young people on the Board.
    - Health professionals and associations should be involved in governance.
    - The governing board should include representation from the Quadripartite as a whole (WHO, WOAH, FAO, UNEP) to ensure One Health is properly included.
    - Prevention, preparedness, and response expertise need to be built into governance structure for knowledge exchange.

- <u>What changes to the current draft governing framework?</u>
    - LMICs, civil society, and directly impacted communities need to join design meetings now!
    - Co-leadership and engagement of non-donors is key.
    - Board must take into consideration in-kind support from CSOs and communities, not only financial support.
    - Operations need to take into account the perspective of health workers, especially those on the frontlines.
    - Governance documents should include human rights and a focus on building health systems.

Civil Society Engagement

- Civil society needs to be engaged and integrated at every step of the way – starting with national action plans, and FIF funding supporting countries with national action plans that engage civil society.
- GFATM is the best model we have for civil society engagement at global, national, and local/community levels – in policy development, implementation planning. ‘CSOs are the oil in the engine.’
- The Global Financing Facility model should also be looked to for civil society engagement – utilizing national and regional workshops.
- Global Health Security Agenda (GHSA) and the GHSA Consortium is an example of meaningful civil society engagement across many levels.
- Civil society needs to be engaged in weekly design meetings.
- Ensure documents and resources are available in other languages for transparency and inclusivity.
- Need resources and Secretariat capacity to support meaningful engagement of civil society.
- For the FIF to be successful, there must be political buy-in by the LMICs and involvement of civil society in planning, implementation, and monitoring is key.
- Civil society participation is incredibly important. It's not just within the governance board, but also the layers down to the country level.

Technical Advisory Panel

- Civil society participation as technical experts is needed on the panel (beyond tokenism).
- Civil society and community networks that have been involved in pandemic responses against HIV, and more recently monkeypox need to be invited into the advisory panels as technical experts rather than just observers.
- Infectious diseases medical professionals, including physicians and scientists, must participate in the technical panel - as experts who are on the ground providing clinical care to patients and also involved in clinical research.
- The competencies and perspectives from the animal health sector need to be included in the technical advisory panel to take a holistic view of pandemics.
- Technical panel should consider regional representation with evidence based expertise and should be chosen by an independent panel among all willing candidates.
- Two needed areas of expertise that often get overlooked are social scientists and behavioral scientists.
- Panel should be linked with the governing board to link technical perspectives and needs to funding and decision-making in real-time. This worked well with ACT-A.
- Panel should clearly link to other PPR mechanisms- INB, WGPR, UHC, HLM.

Other Feedback

- Spillover prevention is a critical gap that needs to be addressed. Containment funding is simply not enough, the fund must also focus on prevention. CSO experts on the issues must be engaged.
- Issues of PHC and other epidemics need to be addressed.
- Tools of preparedness are inequitably distributed.
- Worry that funding health systems will only focus on surveillance – forgetting that the building blocks of any health information system, and therefore of any surveillance is the trained and paid clinical health workers.

Annex 4: CSO Consultation for the Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response Written Comments

Governing Board (Composition, Selection Process, and Decision-making)

What is best practice board composition to appropriately balance perspectives and leadership from donors, non-donors, and community-level stakeholders?

- 2 CSO seats as well as 2 seats for community representation - to keep balance all other stakeholders should have a limit of 2 seats

- Across the global health architecture, organizations, and mechanisms must evolve their governance structures to be more reflective of the changing reality and understanding of the global health landscape to ensure a stronger and more equal representation. This will allow the global health community to make better, more informed decisions because all key actors will be at the table to find agreement on a more equal basis. The new FIF has an important role in ensuring it does not simply mirror existing economic and political power structures in the world, instead embodying the concept of leave no one behind, breaking down rather than reinforcing power inequalities. In order to do this, the FIF must, move away from what the WHO Council on the Economics of Health for All has recognized as a 'one dollar, one vote' to a more inclusive approach that involves 'one stakeholder, one vote' with representation from high-,middle-, and low-income countries, key international and regional institutions, civil society, and communities.

- Governance statements around the FIF need to emphasize the inclusion of multiple stakeholders. This includes three CSO seats, with voting rights, on the board. The CSO seats should be representative of the Global North and the Global South.

- In the absence of full representation, a constituency-based approach that includes representation from frontline health workers - specifically community health workers - would help to ensure that FIF investments are strengthening pandemic prevention, preparedness, and response at the last mile. Community health workers can provide a critical accountability mechanism to ensure funds are reaching the last mile while also ensuring that the FIF is investing resources where they are needed most by those on the frontlines of our pandemic response.

- Any structure that excludes non-donor LMICs and front-line CSOs, as decision makers and at the design stage, is shamefully antiquated and has no place in this century. In 2022, it should never be necessary to intervene to include LMICs as equally or more important than donors or to need to argue that front-lines Indigenous and stigmatized communities, disproportionately impacted by pandemics, are fundamentally essential partners for implementing change.

  The World Bank Group's stated preference to only fund "existing entities" (other development banks, WHO, existing multilaterals) should be rejected as ineffective, and, bluntly, illogical:
    - We do not "fill gaps" by funding the exact same programs—programs with a track record now stained by COVID-19 The world does not need a global fund against pandemics that only provides modest top-ups to existing programs.

    - The model proposed considerably increases the bureaucracy, time, and money lost to overhead elapsing between funding from donors and funding reaching communities
    - This model also notably dilutes results in such a way that it will be difficult for the Pandemic FIF to demonstrate success.

- If you are following the WB definition of CSO, at least 50% should be CS as key stakeholders, recipients, implementers, etc.

- Key to the success of a range of global health initiatives is an inclusive approach, with decisions made jointly by donor and recipient countries, with the meaningful involvement of civil society and affected communities.

- Members from civil society, with strong representation from low and middle income countries and working with vulnerable groups. Gender parity in governance structures. Members of community (e.g. health workers) to be present and inform process.

- See Global Fund. Ideally, one CSO representative from Low Income Countries, one from Lower Middle Income Countries, one from Donor Countries + 2 representatives from LICs and LMIC governments

- The board must achieve a balanced representation of pandemic Prevention, Preparedness and Recovery perspectives in its decision-making.

- Have a board well balanced with 12 board members, two each from Oceania, Asia, Africa, Europe, South and North America and the Caribbean

- Have a sense of what I have done

- The FIF should avoid duplication of existing administrative procedures and mechanisms, such as those already in place under the Global Fund, so as not to increase the burden on recipient countries and keep overhead costs low. The FIF should be a transitory financial facility, while the Global Fund should be tasked with managing the implementation and government negotiations associated with the rollout of FIF-funded programs where feasible.

  The FIF should include the participation of non-state actors, such as civil society, in its governance structure so that they may have a meaningful say in its strategic direction and objectives. Such inclusivity promotes diverse perspectives and ownership among stakeholders, resulting in a stronger organization with broad public support, which is essential to long-term sustainability.

  The FIF must be accountable, transparent, and equitable. Many initial missteps in the global response to COVID-19 can be attributed to the lack of these three essential characteristics. A public health program, irrespective of size, must be based on public trust.

- CSOs need to have a voting seat on the governing board (at least 2) – these orgs need to represent the full range of pandemic prevention, preparedness, and response capacities (beyond what will be initial implementers of Gavi, CEPI, and Global Fund), including issues like biosafety and biosecurity.

- It request a good management

- Balance means more not less - you cannot get balance without a diversity of views. Efficiency is not lost by adding additional stakeholders. Efficiency is lost when the Secretariat is unprepared, does not include key stakeholders from the design stage of initiatives or processes and does not properly plan and manage processes.

- Equity and inclusion must be the key guiding principles for this board. With civil society and LMICs as observers, there is a clear imbalance of power. Beyond ensuring representation through constituency representatives, the FIF architects must look to set up systems for accountability. If this fund channels money primarily to the WHO and UN, it will sacrifice efficiency and efficacy. Civil society and LMICs have both the insight to assist in directing the funding but also the capacity to implement activities. We are concerned that if the UN is the primary implementing agency, these funds will not achieve optimal outcomes. Civil society implementers should not be overlooked or underestimated. Meaningful consultation with Low- and Middle-Income Countries at the design phase is critical. The high costs and longer timelines often associated with UN agency fund management are also of concern.

- 3 seats for CCO representatives, with voting rights

- To Marginalized all of them.

- CSOs have no role whatsoever in the governance of a public fund such as the FIF

- 3 selected from the CSO with strong gender sensitivity and relevant expertise spectrum from health Professionals, Economist with sound financing options and others

- (1) 50/50 donors + implementing countries; (2) elected, protected seats for NGOs from regions, (3) Fund countries and communities directly, not multilaterals

- It is critical to be inclusive in considering who constitutes civil society (i.e., moving beyond those who are often over-represented in civil society spaces, like academics in High Income Countries, toward increasing representation of those who are often under-represented, like frontline workers, patients advocates, etc. in Low and Middle-Income Countries), and ensure that CSO representatives are, where possible, drawn from the communities whose concerns they aim to voice (i.e., Indigenous persons representing Indigenous civil society, women representing women's voices, etc.).

- There must be balanced representation of human health, animal health, and environmental health, from the recipient countries, donors, and CSO.

- The PPR FIF must prioritize reaching and protecting the most marginalized groups and engaging civil society organizations in the founding governance mechanisms and key decision-making processes. COVID-19 has had disproportionate impact on those with limited access to health services, including adolescent girls and young women, LGBTQ+ groups, sex workers, and children. We cannot continue to worsen inequalities, and civil society and communities should be explicitly recognized as equal partners at every stage from conceptualization and design to implementation and governance of key

pandemic preparedness and response decision-making mechanisms. To this end, civil society must hold no less than three seats on the governing board of the PPR FIF.

- Equal seats for donor governments, REGIONS represented by governments, and REGIONS represented by civil society

- Get representatives from marginalised communities

- Across Regions (continents), Gender, Governments, CSOs.

What are examples of successful constituency-based governance structures, and how do they operate in practice? How have these models been shaped by lessons learned, failures, and shifts in power dynamics?

- (1) GFATM board, (2) GFATM CCM - this inclusive country mechanism is how applications should be generated

- Bottom-Top approach were inputs are managed from the community Levels for incorporation into the final output for inclusion and democratic responsiveness

- Brazil's unified health system teams demonstrate bottom up, cross sector health leadership => multidisciplinary teams work at a community level responding to household needs e.g. human, animal and environmental health all exisiting in the home/community and therefore having teams able to address those needs rather than having human health as separate from veterinary etc. Pandemic preparedness presents a similar picture at the 'front line' with everything from fishing policy, gender inequality, climate change and wildlife habitat encroachment contributing to emerging pathogens. Structuring governance to reflect the real world situation, and not just existing institutional structures can help make that paradigm shift to cross-sector One Health approaches, community participation and improved equity.

- CSEM to UHC 2030

- Equal rights to board members

- Establish a financial intermediary fund that is well represented from all groups (minorities, indigenous people and other constituents

- Mirerani h /center

- Small states - rotating lead every 3-5 years among different constellations. The proliferation of unaccountable advocacy CSOs taxes capacity that should be used to help the poor. Most of the organizations in the CSO movement have little credibility to represent anyone…

- The Global Fund board is a good example of a structure built to ensure that these principles are prioritized, they are structured as:
    - There are 20 voting members (10 implementers and 10 donors) and 8 non-voting members as follows
        - Implementers:
            - Developing countries: seven members, one from each of the six

WHO regions and an additional member from Africa.
        - Civil Society: three members, one from a developing country non-governmental organization (NGO), one from a developed country NGO, and one representative from an NGO who is a person living with HIV/AIDS or from a community living with TB or malaria.
    - Donors:
        - Government: eight members
        - Private Sector: one member.
        - Private Foundation: one member.
    - Non-voting: eight members, including the Global Fund Executive Director, the Board Chair and Vice-Chair, one representative from Global Fund partner organizations, one representative each from WHO, UNAIDS, and the World Bank, and one representative from certain public donors that are not part of a voting donor constituency.

- GHSA Consortium has a wide remit and provides an important network of CSOs to feed into the GHSA Steering Group.

- Global Fund

- I strongly recommend looking into the practice of Community Advisory Boards (CAB) used e.g. in clinical trials. They have been very successful for participation of PLHIV and people affected by TB.

- local NGO structure which are largely led by country legislation

- Other WB-hosted FIFs, Including the GFATM, include 50/50 board splits between donors and implementers, protected seats for NGOs, and fund countries directly. The Bank's current articulation of the possible is simply inaccurate.

- The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and Gavi, The Vaccine Alliance - three enormously successful health programs – have managed to develop governance rules that enable timely and efficient decision-making while ensuring that communities affected by these decisions are part of the process. Lessons from those entities should be taken into consideration by the PPR FIF interim secretariat and founding donors.

- The importance of formal representation of civil society and communities in governance structures is well recognized by organizations including the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), Unitaid, GAVI, GFF, and others. The Global Fund currently has three civil society delegations each with a vote (Communities Delegation, Developing Country NGO Delegation, and Developed Country NGO Delegation) and Unitaid currently has two delegations each with a vote (Communities Delegation and NGO Delegation). The structure at Global Fund and Unitaid also highlights the critical importance of recognizing the right to self-representation and the distinct voice of communities in governance and decision-making processes.
- Very good example for inclusive government structures is the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)

- The Global Fund is THE example of a successful constituency-based governance

structure and should be emulated and built on.

- The global fund. Since its founding in 2002 governance of new global health actors has weakened in terms of fairness, leading to perception that these institutions and agencies are driven by donors alone.

- The Global Preparedness Monitoring Board is an example, as well as The Global Fund but there are others. There are links in the following: https://impakter.com/one-health-turning-point/

- They use policy strategies

- To co-opt all Governing Board, CSOs and Technical Advisory in constituency based governance structures.

- Our colleagues at Health In Harmony and others on the call have first hand experience of building shared governance and implementing a range of cost-effective interventions proven to enormously reduce the risk of zoonotic spillover. True pandemic prevention and global health justice is stopping outbreaks from happening in the first place.

What are concrete changes to the draft governance framework that can achieve these goals?

- *(1) Fund countries and communities, not multilaterals, so as to reduce overhead, delays, and be able to demonstrate results (2) fund gaps (such as spillover prevention), not just top-ups for existing programs with an oar in the water, BINGOs to mobilize, and COVID on their track record. (3) be less racist, fund spillover prevention, in addition to outbreak containment: https://democracyjournal.org/arguments/world-bank-bias-threatens-pandemic-breakthrough/*

- Dedicated 40% resource allocation for Prevention/One Health

- Delegate FIF oversight and governance to the World Bank's Board. The EDs are well-paid and resourced to take on this responsibility. The LMICs are represented. Additional costs nil. PPR is a core government function and as such should be delivered by accountable government authorities - oversight by WB EDs is appropriate and least-cost solution. Also feasible, since EDs offices are staffed by qualified people.

- Governments from the LMICs must be robustly represented and have voting seats on the PPR FIF's governing board. Meaningful participation in decision-making is essential for ensuring their ownership of actions needed to bolster vigilance and resilience of their health systems. Additionally, civil society and affected communities are robustly represented and have voting seats on the PPR FIF's governing board. Formally including civil society in global health governance has driven transformative innovation, cultivated constituencies that can effectively advocate for health investments, promoted accountability for results, and informed health investments with the lived experiences of communities most heavily affected.

- have the fund be managed in a LMIC

- Include the voting seats as per question 1

- No information on Details of draft government framework - but meaningful CSO representation - both in board government as well as in technical advisory panel - would be crucial

- Seats need to be in place for representation from non-health sectors, if truly focusing on spillover prevention (e.g. UNEP or IUCN, WOAH or FAO). Otherwise, the scope of "prevention" must be clarified.

- Stronger involvement of civil society, with representation from LMICs.

- The FIF should establish a multi-stakeholder governance structure with equal representation of donors and representatives from low-and-middle-income countries. It also needs to include protected seats for Indigenous Peoples and affected communities. This is crucial for the FIF to build country leadership and get civil society buy-in. The FIF should also allow CSOs and LMICs to be direct recipients of funds.

- Formal communication and coordination channels across sectors and levels of society, such that every voice is given equal opportunity to be heard despite their level of funding or resourcing etc.

  For One Health, that could be a designated One Health team that sits under a central office (and therefore not a part of Ministry of Health or Agriculture) that has mechanisms in place to gather input from community based stakeholders and shared governance such that domination by one sector is avoided. Principles for governance for One Health and an operational toolkit can be found in the WHO's One Health for NTDs strategy (https://www.who.int/news/item/30-01-2022-on-world-ntd-day-who-releases-key-document-to-guide-a-paradigm-shift-towards-one-health) and the Tripartite Zoonoses Guide and Operational Toolkit (https://www.who.int/initiatives/tripartite-zoonosis-guide)

- Government leaders

- Implementers should include regional organizations and should similarly cover the full range of health security capacities. Starting financial qualification checks now for diverse implementing orgs will prevent stalling of progress.

  Decisions made by the Board should be data-driven and linked to longer-term sustainment by national level governments/budgets. The Board should consider commitments to sustainability as a condition for providing funding support. This should be linked to a longer-term goal of increasing domestic support for PPR capacity.

  Connected to this, the Board will need to take a strong role in overseeing progress, monitoring accomplishments, and build off of lessons learned. CSOs can offer tools to help with this process and we would put forward the GHS Index as one such tool.

  Board rotation should be clearly defined with determined off ramps for inaction or lack of support.

- Inclusion sensitivity, inbuilt feedback mechanism and robust monitoring and evaluation template for Service Delivery and Service Charter compliance inclusive of Best Value audits

- It is unacceptable that non-donor governments and civil society don't have seats on part with donors.

- Make the framework more flexible and allow it to be reviewed yearly

- Regular evaluation of inclusion of marginalise*d communities in every step*

- To integrate all CSOs to financial mechanisms.

- Voting rights for each of those listed and observer status for other key allies and partners. Secretariat should be ex-officio and not voting at the Governance level. Community-level stakeholders should be defined to include affected communities (which may change) and CSO's engaged in community, national, regional and global health issues. Affected communities and CSOs should be supported and financed for their participation.

- We hope to real national change

- You may not be aware that the G7 and G20 have fully embraced the One Health philosophy moving forward with any pandemic preparation. This means all disciplines that involve health---human medicine, veterinary medicine, allied health professions, environmental sciences, engineering and beyond. I propose that this be discussed by the new Governing Board that should pass a resolution on this at the outset. We cannot afford to approach preparation to the next pandemics in silos as we have done in the past…

Civil Society Engagement

What are examples/best practices of international bodies/financing mechanisms that successfully and meaningfully engage civil society? What are the critical elements of success?

- My grandmother died in a crowded hospital in one of these frontline communities in India before vaccines were available. Even after vaccination I myself am recovering from a COVID infection last week. Our current approaches of solely focusing on containment after outbreak occurs are failing us. We have an opportunity to learn from this painful experience and do better. Containment only is not enough. Must include pandemic prevention.

- National youth advocacy activities is one of best practices that can bring good result

- As noted above, the FIF could model itself after the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), Unitaid, GAVI, GFF, and others. The Global Fund currently has three civil society delegations each with a vote (Communities Delegation, Developing Country NGO Delegation, and Developed Country NGO Delegation) and Unitaid currently has two delegations each with a vote (Communities Delegation and NGO Delegation).

We also recommend that the FIF reviews models of CSO engagement implemented by international bodies/financing mechanisms in other sectors. For example the Global Environment Facility updated its vision to enhance civil society engagement in 2017, offering the FIF lessons learned and pitfalls to avoid.

- Civil Society engagement must be a chain through to implementation on the ground: a) implementation must only take place in countries with a PPR Plan prepare with CSOs and including CSO involvement in its execution; b) the Implementing Entities must be selected on the basis of CSO and implementing country involvement; and c) the TAP must include CSO and implementing country involvement. The foregoing must be included in the foundational documents of FIF in September.

- GFATM - CSO and community representatives were involved from the beginning - already at the design stage and have balanced seats in board structure as well as in implementing mechanisms

- Global Fund and Gavi, involvement of communities and most importantly involvement of those delivering care (health workers).

- Please note that there are 5 questions in this one question. There needs to be an entirely different approach/dialogue. It is not about 'engaging' civil society - civil society needs to have the same weight as governments and donors. Is the point to emulate existing multi-laterals? Critical areas of success are to: 1) think and act differently; 2) have proper representation on the Board, prioritising LMICs; and 3) distribute power, i.e. rotate Board membership every year and have meetings OPEN. It is 2022, not 1942 or 1982 - change the way things are done.

  See examples laid out in the above responses. Key elements of success also include transparent and timely information sharing to enable the most substantive input from civil society organizations and other affected communities.

- The Global Fund is a good example

- UNFCCC and UNDRR have formal mechanisms to receive cross-cutting and targeted input from CSOs. This has been critical for knowledge exchange, advocacy, and overall progress.

- Open consultations and ensure physical and virtual meetings done regularly. For instance the Global Fund Coordinating Mechanisms/CCMs

- Openness and inclusion, reportage and accountability timelines, consistent Best Value Audits and related Performance measurement framework including Bench-marking

- Save more than 2000 baby who could ever being died from hypothermia and birth asypyxia and covid ventilator

- See https://impakter.com/one-health-turning-point/

- The best practice of international bodies and financial mechanism that successfully and meaningfully engaged civil society is to domesticate and integrate CSO into stakeholders mechanism.

- The UK Research Institute (UKRI) is championing cross-sector and interdisciplinary research funding. It is trying to accommodate and incentivise the increased effort and time needed to coordinate across sectors and disciplines but recognises how important interdisciplinarity is in tackling complex global challenges - especially in health, where traditional, siloed approaches aren't enough! It has designed processes to allow funding flexibility and adaptability without a loss of rigour or transparency.

  A potential failed example for Rabies would be that GAVI would not fund dog vaccination campaigns to control rabies in people, despite the evidence that money spent on managing rabies in dogs is more impactful and less-expensive than measures targeted at humans. This came down to governance and the system was not flexible enough to adapt in the face of evidence. Any new fund should have the flexibility in place to respond to evidence and not be restrained by its founding structures.

- There should be a major investment stream for Global Fund, given its health systems emphasis, track record, transparency, inclusive governance and human rights focus. Investments in the health system must be made by institutions that can achieve the scale necessary to control the spread of a pandemic threat through global cooperation. Additionally, any approach to funding requests, decision-making, reporting and assurance need to be compatible with the Global Fund's established processes and governance structure.

- We are asking very similar questions repeatedly. We are *not* asking any questions about FIF scope of work. This pre-supposes an agreement that flatly does not exist, imposing a view that global responsibility begins and ends with preventing the spread of outbreaks, typically from the poorer to the richer. This is a strategy that sets up the FIF for failure.

- You need ample, supported representation from the design stage of all processes and policies related to the mechanism. You need ample, supported representation in all decision-making bodies, evaluation and monitoring bodies. The Global Fund is again, the example of successful and meaningful engagement of not just civil society but also affected communities.

What are opportunities to build on and/or integrate CSO engagement on the Fund with existing mechanisms?

- CSO engagement must be enshrined in the FIF foundational documents.

- Ensure inclusivity - do not have the same countries represented on similar Boards. Be thoughtful in who 'represents' - and mandate frequent rotation to hear many voices. Past experience with multi-laterals and multi-country associations has shown that one person cannot speak for many because there are so many differing views, priorities and perspectives. Implementing partners in human health, animal health and environment have vast networks down to the village level. They can provide insight into how to engage communities to ensure voices are heard.There needs to be more NGO

representation - not lumping all CSO together - back to the point of representation on the Board.

- Integrate with SDG networks, and with existing Funds (GEF, GFDRR), and allow for flexibility to keep adapting as needed.

- Involve CSOs from early on in the creation process.

- Tap into existing civil society groups for direct input: Pandemic Action Network, ACT-A Civil Society Platform, CSEM, Global Health Council, GHSAC, etc.

- The Fund must engage with a wide range of CSOs, not only in public health but also in animal and environmental health

- The Global Fund CRG Special Initiative, in particular the Community Engagement Special Initiative may be interesting models to consider. While far from perfect, the CE SI has been able to increase community engagement in global fund processes.

- The success of the FIF is contingent on CSO engagement. CSO representation is critical and needs to be layered into the design and operationalization of the FIF. This includes immediate participation in weekly FIF planning meetings, national action plans, governance structures, and assessment mechanisms.

  Lastly, implementing entities should have robust CSO governance otherwise they should not be allowed to be implementing agencies.

Technical Advisory Panel

What kind of competencies and perspectives are required in the Technical Advisory Panel? What should be the role of CSOs, NGOs, and other community-level experts?

- Addressing prevention will require that the technical advisory panel include experts beyond those in the public health sector

  The reality is that those trained in public health do not have the expertise to develop and assess interventions to address the primary cause of infectious disease emergence, which is the spill over of pathogens from animals to people. This means that the technical advisory panel must include experts in environmental conservation, veterinary medicine, and wildlife biology

- 1) We've seen across low to high income countries that social determinants drove the spread of the pandemic. One important consideration for the Technical Advisory Panel is inclusion of experts in social determinants outside the health sector, who work primarily on the variables that render marginalized populations vulnerable to disease i.e. housing, education, employment, social protection, etc.

  2) We've seen across settings that weak health systems without sufficient health workers drove the severity of the pandemic. Experts in human resources for health (ideally frontline workers themselves), spanning the spectrum from community health workers to specialists, should be included in the panel.

- Across different core Technical areas

- Competencies in mental health and mental health impacts associated with health emergencies; healthcare systems; One Health (including how all dimensions of human, animal, environmental and planetary health interlink; clinical experience as a frontline/healthcare worker and in mental health impacts and support for healthcare workers; integrative approaches to health and health emergencies including prevention, preparedness, control and recovery.

- Competencies shall cover all three pillars of One Health, including human, animal and environmental health. Prevention experts shall have an equal voice with recovery and preparedness experts. They shall have a collective expertise capable of tracking and assessing impacts at the frontline & community level and at the levels of public policies, business practices, and consumer behaviors. Experts delegated by pandemics-focused CSO networks or alliances (e.g., EndPandemics.Earth) could deliver access to a vastly multiplied pool of frontline and cross-sectoral expertise across all continents.

- CSOs and NGOs should be integrated in community level experts.

- Expertise on advocacy, campaigns and vaccine engagement. Role of NGOs and CSOs is to monitor accountability and delivery of commitments and ensuring equitable access to services and financial risk protection for universal health coverage

- Full participation is the role. Competencies and perspectives should include those who have direct knowledge of community based systems and direct experience responding to pandemics and building strong community and formal health systems.

- Health workers with sound health based background,Economist with sound financial and risk profiling options , Other related technical expertise such as animal health etc

- Highlighting the needs and shortcomings without any hesitation

- Implementers are themselves technical experts. Also include One Health and social scientists. And vaccine scientists, WHO already has Immunization, Vaccines and Biologicals (IVB) dept which facilitates technical expertise gathering too.

- A wide range of expertise is needed on the TAP, individuals and organizations with implementation and policy expertise across: disease surveillance; field epidemiology; laboratory networks for early detection and sequencing of emerging pathogens with pandemic potential, including zoonotic spillover; biosafety and biosecurity; research oversight and governance capacity at the national and sub-national levels; national, regional, and global platforms to accelerate and coordinate rapid development, manufacturing, and equitable delivery of medical countermeasures; health systems strengthening; health workforce training and development; and gender responsive and equitable approaches.

- CSOs should have a seat on the Technical Advisory Panel to ensure that there isn't tokenism. Further, we recommend that the FIF include representatives with expertise in the community health workforce on the Technical Advisory Panel. The essential role of the health workforce has become very clear during the COVID-19 pandemic. By preparing for and responding to health security risks, the health workforce enables the

provision of global public health goods. Analysis shows that community health workers who were equipped and prepared for the COVID-19 pandemic were able to maintain speed and healthcare coverage of community-delivered care during the pandemic period. Continuation of care has also been seen across disease verticals in areas where community health workers are present. For example, Liberia's National Community Health Assistants (CHAs) diagnosed 50% of rapid diagnostic test or microscopy-confirmed malaria cases and carried out 54% of malaria treatments amongst children under five in rural areas where CHAs were present. These results sustained in rural and remote communities during COVID-19 in 2020.

- NGOs are considered CSOs as per WB definition, so this question is misleading. There is technical expertise across countries who would be recipients of FIF monies. GFATM has shown that grant management is actually the biggest challenge. In fact, experts in integrated surveillance, lab system strengthening, emergency response, and other aspects of JEEs are in the countries that would be receiving the funds. It seems it would be best to have the advisory panel focus on quality assurance rather than 'advising'.

- Provide knowledge exchanges and targeted technical advisory groups on specific topics, as done with the GEF.

- Technical expertise for implementing health structures and plans - in emergency case but also beyond regarding health systems strengthening. CSO, NGOs should be recognized as equal implementing partner which have the ability to channel community needs and voices. NGOs, CSOs should be involved meaningfully in all technical aspects and decision-making process of the Technical Advisory Panel

- The FIF's technical advisory panel must include experts on spillover prevention, from CSOs, NGOs, affected communities and academia. Research shows that actions to reduce the risk of zoonotic spillover are cost-effective and more equitable than post-outbreak actions alone.

  A containment-only work-program for the FIF, focused solely on what happens after a spillover, is a very expensive way to fail. COVID-19 has demonstrated the severe limitations of "preparedness" that, at best, is able to detect an outbreak quickly and send rapid response within the first 100 days. But this very optimistic read leaves out the impact of misinformation, vaccine hoarding, and the bias that allowed 20 million smallpox doses to expire in the United States, instead of being used to go a very long way towards eradicating monkeypox in West and Central Africa. We also completely disregard that the countries with the highest preparedness rankings suffered the worst outcomes.

  Focusing only on stopping the spread but doing nothing to prevent the outbreak also accepts the deaths of mostly black people, Indigenous Peoples, and people of color who live in emerging infectious disease hotspots. To truly advance global health equity, the FIF needs to take a holistic approach which includes both post-outbreak actions and spillover prevention actions.

  What we need in addition (not instead) is a global fund against pandemics that includes in its scope of work funding for countries and communities to stop zoonotic spillover in the first place. And it fits right into the FIF's priorities. You outlined in the prep materials that the FIF should address critical gaps, complement the work of existing organizations

and work across sectors. Spillover prevention IS a critical gap, it is not addressed by any existing global health organization and it brings together multiple sectors. It is the perfect fit and it must be reflected in the scope of the FIF.

- The kinds of competencies must be double: knowledge of implementation of surveillance, labs etc.. in low-resource environments; knowledge of hos CSOs and front-line workers must be involved on the ground.

- The role of experts, regardless of background, should carry the same weight.

- Those delivering care have expertise in this area and should be at decision-making table.

- Include Indigenous communities experts from frontline zoonotic spillover hotspots. ALSO, don't pretend that expertise is not political. Again, then: (1) 50/50 donors + implementing countries; (2) elected, protected seats for NGOs from regions.

- Needs to include CSOs and represent major capacities across PPR, to include security, socioeconomic and social sciences. It must draw from a wide selection of experts across sectors to ensure research is applied well and M/E coordinated

- No any completion for my innovation

- One Health technical skills: OH competences are being developed by the WHO and the Quadripartite (and CSOs e.g. NEOH https://www.ecohealthinternational.org/regional-chapters/europe/) to by layered on to technical competences in related fields. OH competences refer to the ability to work across sectors, in a transdisciplinary way, systems thinking, reflective practice, recognition of the different languages, methodologies and evidence used by all sectors and communities etc. They recognise the need for formal training or support to bring sectors and society together and allow them to communicate and work in a synergistic way.

- Panel members should not "represent" specific fields of work (laboratory, virology, etc.) but instead be generalists with broad view of gaps and needs in system preparedness to health emergencies. Experts in those fields can be consulted and represented ad hoc as needed. The system approach should include a view beyond the health system, to include whole-of-society views (epidemics have social determinants and social consequences). Some representation from non-health sectors would bring depth of view to the panel.

- PPR FIF disbursements must address the need for robust global investment in research and development into existing pandemics as a jump start into research into new emerging pathogens. HIV vaccine research fueled the rapid progress toward an effective COVID-19 vaccine. Ensuring equitable global access to new interventions will require multiple, simultaneous policy approaches: donations PLUS suspending patents PLUS technology transfer PLUS building manufacturing capacity PLUS ensuring easy access to raw materials. Any disbursements of funds should factor in the extent to which the proposed project will equalize access to pandemic prevention and treatment innovations and their development.

Any pandemic preparedness funding mechanism must support countries to work toward universal health coverage in a way that ensures true universal access to health services across groups and geographies. Pandemics have a severe impact on broad health system functioning, and it is crucial that health coverage is strengthened to withstand the extra burden that an unexpected pandemic can place on routine essential health services. In particular, health workforce strengthening must be a top priority in distribution of the PPR FIF funds. The WHO projects a shortfall of 18 million health workers by 2030 - and it is through a robust health workforce that new pandemic threats are detected, spread is monitored, communities are informed of protection strategies, and therapies and vaccines are delivered to the population. Currently, there are very few funding streams devoted to recruiting, retaining, and supporting the global health workforce. This fund can be pivotal to filling that gap.

- The Global Fund Technical Review Panel and its interface with the Global Fund management is a good model to consider.

- The role of CSOs, NGOs will of advocating, making activities for pandemic prevention

- Veterinary health, environmental health, DRM, communications (development comms, not PR), macroeconomist, fiscal economist. Maybe add one human public-health specialist.

- We must prioritize preventing pandemics in the first place if we want this fund to be truly equitable across humanity…and yes there are innovative intervention strategies in play today around the world which decrease probability of upstream pathogen spillover into human populations. FIF investment in pandemic prevention makes enormous economic sense and is critical. The (currently containment-focused) scope of the FIF needs critical attention.

How should the WHO's technical expertise be leveraged in Fund governance and decision-making?

- WHO should be part of Fund governance and decision making for ensuring monitoring and evaluation.

- WHO should drive the FIF

- WHO should guide the operating modalities and advise on fund governance and decision making

- The Technical Advisory Panel should provide the FIF with scientific and technical advice on policies, operational strategies, programs and projects, including the assessment of proposals.

- The WHO should not be the sole entity whose expertise is leveraged in Fund governance and decision-making. The FIF should also draw from the expertise of the other Quadripartite organizations as well: WOAH, UNEP and FAO to integrate One Health across its operations.

- WHO should be an observer, along with the other three Quadripartite organizations on the TAP - with equal voice, if prevention is really an aim of the FIF.

- WHO should have coordination role and should have representation in Fund Governance and and should be involved in all technical and governmental decision making

- WHO's primary role should be related to quality assurance, measurement of JEEs, and cross-country/cross-region networking. Countries have the expertise and can learn much more from each other than someone sitting in Geneva.

- WHO's technical expertise will be critical to inform decision making. WHO experts on the TAP will also be well positioned to make needed connections between other ongoing negotiations and discussions on a range of related topics including the IHR amendment efforts through the new working group and the ongoing negotiations on the pandemic instrument.

- WHO should provide guidance and not involve itself in governance and decision making. Its first responsibility is to get its own job done…

- WHO will evaluate a good leadership

- WHO's role should include advocating/supporting continued JEE implementation and NAPHS prioritization. Similarly, FAO, OIE or other non-health related IOs (such as INTERPOL) must have a role to ensure one health approach.

Interim Secretariat
Feedback and questions regarding the official reference slides shared by the PPR FIF Interim Secretariat and more broadly. All questions will be shared with the Interim Secretariat.

Do you have feedback on the slide deck shared by the Interim Secretariat as a pre-read? If so, please briefly share.

- You may not be aware that the G7 and G20 have fully embraced the One Health philosophy moving forward with any pandemic preparation. This means all disciplines that involve health---human medicine, veterinary medicine, allied health professions, environmental sciences, engineering and beyond. I propose that this be discussed by the new Governing Board pass a resolution on this at the outset. We cannot afford to approach preparation to the next pandemics in silos as we have done in the past...

- Slide 8: The interventions to be financed by the FIF heavily focus on preparedness and response with almost no focus on prevention. The scope of the FIF should include interventions that are even more upstream than disease surveillance. It should include "interventions needed to mitigate risk and reduce the likelihood or consequences of spillover events at the human, animal, or ecosystem interfaces" as outlined in the World Bank's definition of pandemic prevention.

  Slide 9: The scope of the FIF should encompass interventions all the way to the left of the of the "prevent" section. By excluding the most upstream prevention interventions, the FIF is setting itself up to fail. Reducing the likelihood of outbreaks is possible, more equitable and cost-efficient. It should be in scope.

Slide 31: It is unacceptable for the FIF Board to endorse the FIF's governance framework and operational guidelines without further consultations with CSOs. The design process was opaque and this round of consultation focused solely on governance. Another round of consultation is needed on scope and operational guidelines.

- The deck was mentioning principles guiding the approvals of projects. One such principle should be the demonstrated involvement of civil society and front-line workers.

- The slide deck was extremely informative, thank you!

- Unfortunately the slide deck is not reachable anymore

Do you have specific questions for the PPR FIF Interim Secretariat? If so, please briefly share.

- What is meant by “Private sector activities” as this term can be very broad in meaning. Faith-based health facilities are often categorized as private sector. These essential providers deliver up to 40% of health services in sub-Saharan Africa and should be engaged as important partners. Funding support to health facilities could be channeled through associations / platforms or through national Ministries of Health.

- What will be the FIF's representation across the continents? To ensure there is no bureaucracy how will the FIF ensure that its governance structure is robust but also responsive and not involve itself in politics of rich nations?

- Will FIF fund entities based in LMICs?

- Will there be an evaluation unit that assets all approved projects, and if so, what expertise will there be on it?

- Will you prioritize preventing pandemics in the first place? Key if we want this fund to be truly equitable across humanity…please know there are already scientifically-based, innovative intervention strategies in play today around the world which decrease probability of upstream pathogen spillover into human populations. FIF investment in pandemic prevention makes enormous economic sense and is critical. The (currently containment-focused) scope of the FIF needs critical attention.

- When will you consultation CSOs on the scope of the FIF and operational guidelines?

- Is there a copy / summary of the slide desk or results available? Do you have a link / pdf of the Draft Governmental Framework of FIF or could you inform were to find the draft?

- Please leverage expertise from the Quadripartite and across the Bank and the entities it hosts - including the World Bank One Health team, GFDRR, and IFC multi-sectoral convening.

- What is the plan for ensuring leverage rather than duplication of other major funding mechanisms?