ACTaccelerator
ACCESS TO COVID-19 TOOLS

Hosted by World Health Organization

ACT-Accelerator Strategic Review

An independent report prepared by Dalberg

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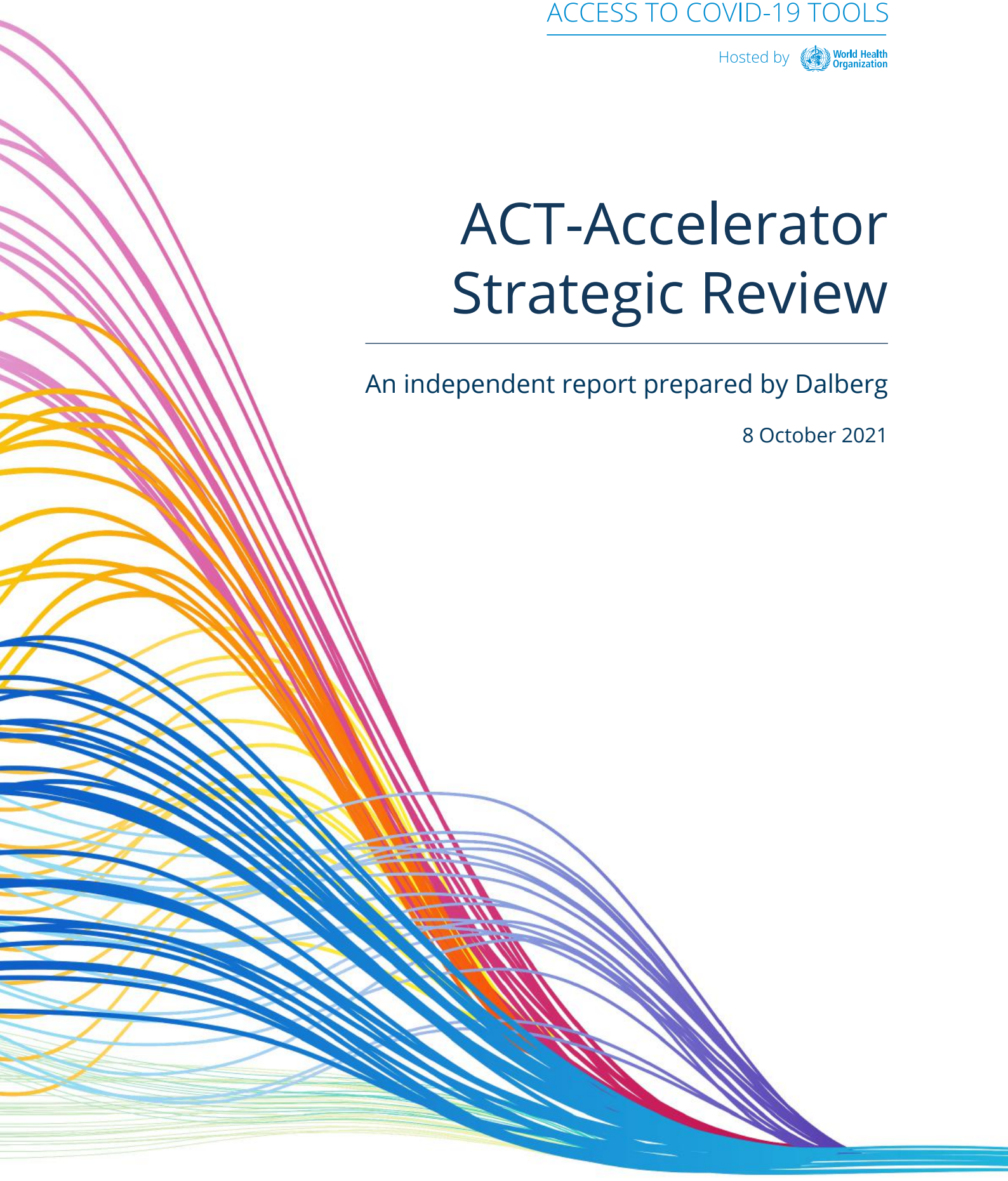

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EXECUTIVE SUMMARY

The ACT-Accelerator (ACT-A) was launched at a time of significant urgency and uncertainty. ACT-A was launched less than three months into the COVID-19 pandemic, at a time when there was no clear view to the expected length or severity of the crisis. Under those conditions, global stakeholders came together to accelerate global progress on key medical countermeasures and in doing so created an unprecedented voluntary partnership of global health organisations.

ACT-A partners deliberately chose an operating model that was informal and agile, leveraging the best of existing structures to mobilise a rapid global response. Prioritising speed of response and using the existing global health infrastructure to its fullest, ACT-A partners set up a voluntary partnership without new entities or legal structures. This approach de-facto relied on existing partner systems and governance structures to provide accountability. Over time, the partner mix was adjusted to bring in the leading players at each stage of the value chain for selected products. ACT-A has served as a coordinating mechanism for the three product Pillars, each unique in their compositions and ways of working.

This Strategy Review was designed to understand ACT-A's progress to-date, with a focus on identifying changes that could make it more effective in the short term. The review covers four dimensions: scope and objectives; operating model; financing; and the broader ecosystem. The review aimed to describe how each dimension has contributed towards achieving the partnership's overall objectives. However, the main emphasis of the review was not on assessing impact, but rather on identifying changes that could have a positive impact in the coming 12-18 months.

This work confirmed that ACT-A has played an additive and important role in accelerating the development and delivery of critical tools and has responded to country needs. Over the course of interviews with 100+ individuals across a variety of stakeholder groups, there was broad consensus that the value of ACT-A's coordination, collaboration, and prioritization enables faster progress towards development, availability, and access to critical tools. ACT-A's primary channels of support also align well with country-led priorities and processes, signalling that the partnership's offerings have been responsive to country needs.

However, ACT-A has faced several external challenges that have impeded the achievement of its objectives. First, the epidemiological dynamics of SARS-CoV-2, and in particular the emergence of new variants, has made international response a complex and shifting task. Though progress has been made, it remains always under threat. Second, geopolitical tensions and domestic-focused responses in many higher-income countries have held back the potential of truly coordinated action. While those domestic choices at times served the short-term interests of those nations, they have constrained ACT-A's impact and delayed a fully equitable and effective global response. Further, the combination of constrained product supply and the actions of some states to bilaterally procure and stockpile those tools has held back progress against ACT-A's global equity ambitions.

At the same time, ACT-A itself has faced various internal challenges that have impacted its efficacy as a mechanism for coordination and collaboration. These broadly fall into the following themes, with experiences and challenges varying across Pillars:

- **Scope:** A need for greater downstream support and outcomes-based indicators to monitor end-user impact
- **Coordination:** Opportunities for more consistent cross-Pillar planning, investment, and execution

- **Operations:** Complex model with at times unclear mandates and internal coordination; Lack of clear, accessible, and aggregated information and communications tailored to donor, recipient, or community needs
- **Representation and participation:** Insufficient inclusion and meaningful engagement of LMICs, regional bodies, CSOs, and community representatives

Looking ahead, ACT-A and its Pillars now have an opportunity to re-shape how they work and engage with countries to ensure they are as impactful as possible in the next phase of response. The partnership should maintain its agility as a coordinating mechanism, while clarifying structures and strengthening its collective external engagement. Further, as forecasts show greater availability of tools in the coming months, ACT-A and others must redouble their efforts to support distribution and effective uptake where tools are needed most. This will also depend on refined resource mobilisation efforts and sufficient donor and recipient country support. Taken together, in the coming months ACT-A has the chance to become easier to understand and engage with, better grounded in country needs, and more effective in driving equitable progress to end the COVID-19 crisis.

Seizing this opportunity through the implementing of the recommendations presented here will require a prompt process of decision making and execution. The categorization of actions outlined below offer an initial perspective on the critical path and prioritization to best serve the partnership. To begin, ACT-A should take strategic decisions around its mandate and scope. Based on those decisions, ACT-A senior leadership should define and operationalize updated norms and expectations for participation in the partnership. With those changes in place, the refined partnership should work together to take forward all other recommendations to optimise ACT-A's effectiveness and efficiency. Throughout this process, the Principals Group and individual agencies should report out on goals, progress, and any necessary adaptations as plans are put into place.

The table below provides an overview of recommendations. The recommendations presented here are not comprehensive of ACT-A's opportunities for improvement; these formal recommendations address the most significant, overarching needs for refinement. The findings and challenges highlighted throughout this report offer additional, targeted areas where ACT-A co-conveners, partners, and Facilitation Council members should work together to further improve ACT-A's future operations and impact.

Table 1: Summary of recommendations

Category	Recommendations
Mandate	• Continue ACT-A whilst there is still value in global coordination on COVID-19 tools along the entire value chain, likely throughout 2022
Health systems and country support	• In addition to maintaining the urgency and focus on R&D and regulatory efforts, increase strategic emphasis on downstream work; support in-country product uptake and work to close the equity gap for currently available tools • Focus HSC mandate to be more clearly on response and supporting gaps in country readiness and tool uptake not currently covered by the Pillars • Further link ACT-A to national COVID-19 responses by working with WHE IMSTs at all levels to better connect dynamic country needs with pillar-level strategic planning across the value chain, enabling ACT-A to take a more proactive, country-centred, and demand-driven approach • Support greater use of concessional finance and other resourcing channels as a complement to grant funding
Participation and engagement	• Increase and enhance L/MIC, CSO, and Community representation and involvement in ACT-A • Re-affirm the mandate of the Facilitation Council and set up a regular communication channel with the Principals Group
Communication and information sharing	• Align around ACT-A's collective brand to support stronger and more consistent messaging to external audiences, including i) building common advocacy messages in support of resource mobilisation efforts and ii) enabling external stakeholders to more easily understand and engage with the partnership • Build countries' awareness of the full range of products, support, and financing options available from ACT-A partners to boost overall country engagement and ensure ongoing connectedness with national response plans • Launch a 'data sharing framework' to enhance the quality and increase availability of aggregated programmatic and financial reporting
External coordination and collaboration	• Continue to lead the global movement for an equitable response, and maintain strong channels of coordination with complementary initiatives for procurement and financing

ACRONYMS

ACT-A	Access to COVID-19 Tools Accelerator
Ag RDT	Antigen-detecting Rapid Diagnostic Tests for COVID-19
AMC 92	Advanced Market Commitment
APVAX	Asia Pacific Vaccine Access Facility
AVAT	African Vaccine Acquisition Trust
BMGF	Bill & Melinda Gates Foundation
BMZ	German Federal Ministry for Economic Cooperation and Development
C19RM	Global Fund's COVID-19 Response Mechanism
CAAB	COVID-19 Advocates Advisory Board
CARICOM	Caribbean Community
CCM	Country Coordination Mechanism
CEPI	Coalition for Epidemic Preparedness Innovations
CR	Community Representative
CRD	COVAX's Country Readiness and Delivery Workstream
CSO	Civil Society Organisation
DCVMN	Developing Countries Vaccine Manufacturers Network
Dx	Diagnostics
EC	European Commission
EU	European Union
EUL	Emergency Use Listing
FIND	Foundation for Innovative New Diagnostics
FC	Facilitation Council
G7	Group of Seven
G20	Group of Twenty
GDP	Gross Domestic Product
GFATM/GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GSK	GlaxoSmithKline plc
HAC	UNICEF's Humanitarian Action for Children appeal
HIC	High-Income Country
HIV	Human Immunodeficiency Virus
HSC	Health Systems Connector
I&L	Indemnification and Liability
IAVG	Independent Allocation of Vaccines Group
IFPMA	International Federation of Pharmaceutical Manufacturers & Associations
IGBA	International Generic and Biosimilar Medicines Association
IMF	International Monetary Fund
IMST	Incident Management Support Teams
J&J	Johnson and Johnson
JAT	Joint Allocation Taskforce
L/MICs	Low- and Middle-Income Countries
MDB	Multilateral Development Bank
MLT	Multilateral Leaders Taskforce on COVID-19
MIC	Middle Income Countries
MSF	Médecins Sans Frontières
NFC	No fault compensation
NGO	Non-governmental Organisation
NDVP	National Deployment and Vaccine Plan
PAHO	Pan American Health Organization
PCR	Polymerase Chain Reaction
PPE	Personal protective equipment
PSA	Pressure Swing Adsorption
RM	Resource Mobilisation

R&D	Research and Development
SDR	Special Drawing Rights
SFF	UNICEF's ACT-A Supplies Financing Facility
SPRP	Strategic Preparedness and Response Plan
TB	Tuberculosis
TRIPS	World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights
Tx	Therapeutics
TOR	Terms of Reference
UHC	Universal Health Coverage
UNF	United Nations Foundation
UNICEF	United Nations International Children's Emergency Fund
US	United States of America
VOC	Variants of Concern
VOI	Variants of Interest
Vx	Vaccines
WB	World Bank
WHE	World Health Organization Emergency Programme
WHO	World Health Organization
WTO	World Trade Organization

I. ABOUT THE ACT-A STRATEGIC REVIEW

Background

The Access to COVID-19 Tools Accelerator (ACT-A) is a unique, time-limited, multilateral collaboration driven by ACT-A Pillar Leads, Co-Conveners, Principals, and partners to accelerate the development, production, and equitable global distribution and access of critical tools for COVID-19 response. Launched in April 2020 at an event co-hosted by the Director-General of the World Health Organization (WHO), the President of France, the President of the European Commission, and the Bill & Melinda Gates Foundation[1], it has brought together 10 agencies[2], national representatives, private sector partners, and other stakeholders with coordinated priorities across diagnostics, therapeutics, vaccines, and supporting health systems. Since then, the partnership has supported the development and rollout of diagnostics, treatments, vaccines, alongside other products and types of support.

Despite these efforts and the growing ecosystem of actors that has emerged to tackle the pandemic, today we see new surges around the world and persistent equity gaps in access to COVID-19 tools. The distribution of these lifesaving tools, including diagnostic tests, therapeutics, and vaccines, remains concentrated in higher-income countries while many low- and middle-income countries still lag behind, with women and girls and certain ethnic groups disproportionately affected.[3] Further, the pace of progress has varied across the pillars as they face different opportunities and challenges. Meanwhile, emerging variants threaten to undermine the efficacy of today's existing tools, setting the world yet further back. Even so, there remains an important opportunity for ACT-A's pillars and agencies to continue playing a crucial role in turning the tide.

Objectives

The Review considered the ACT-A mechanism's achievements, best practices, challenges, and gaps as a basis for recommendations to enhance its future work and adapt to changing needs as necessary. The analysis and recommendations were focused at the level of the overall ACT-A and its Pillars, and not detailed implementation by individual agencies. Within this scope, the review pursued five objectives:

1. **Document achievements to date in terms of ACT-A's objectives** to accelerate the development and equitable distribution of COVID-19 tools to end the acute phase of the pandemic
2. **Surface strengths and weaknesses of the ACT-A construct**, including the appropriateness and relevance of its objectives and priorities, operating model, and ways of working in planning against objectives and achieving results
3. **Review the financing of the ACT-A pillars and agencies**, including pledges, funding received, internal allocation processes, and overall levels of expenditures to achieve its objectives
4. **Identify implications of the broader ecosystem in which the ACT-A is operating** and the degree to which this facilitated or hampered the achievement of the overarching objectives
5. **Provide recommendations to improve its approaches** for greater efficacy, inclusiveness, and transparency within current operations and ACT-A's potential role beyond Q1 2022

[1] ACT-Accelerator World Health Organization Webpage. Accessed at https://www.who.int/initiatives/act-accelerator on September 2021
[2] Bill & Melinda Gates Foundation, CEPI, FIND, Gavi, Global Fund, Unitaid, Wellcome, WHO, World Bank, and UNICEF; also includes close collaboration with the World Trade Organization (WTO), and International Monetary Fund (IMF) and the Medicines Patent Pool (MPP).
[3] "100 Days Mission to respond to future pandemics", A report to the G7 by the pandemic preparedness partnership, 12 June 2021", 2021 (p.22)

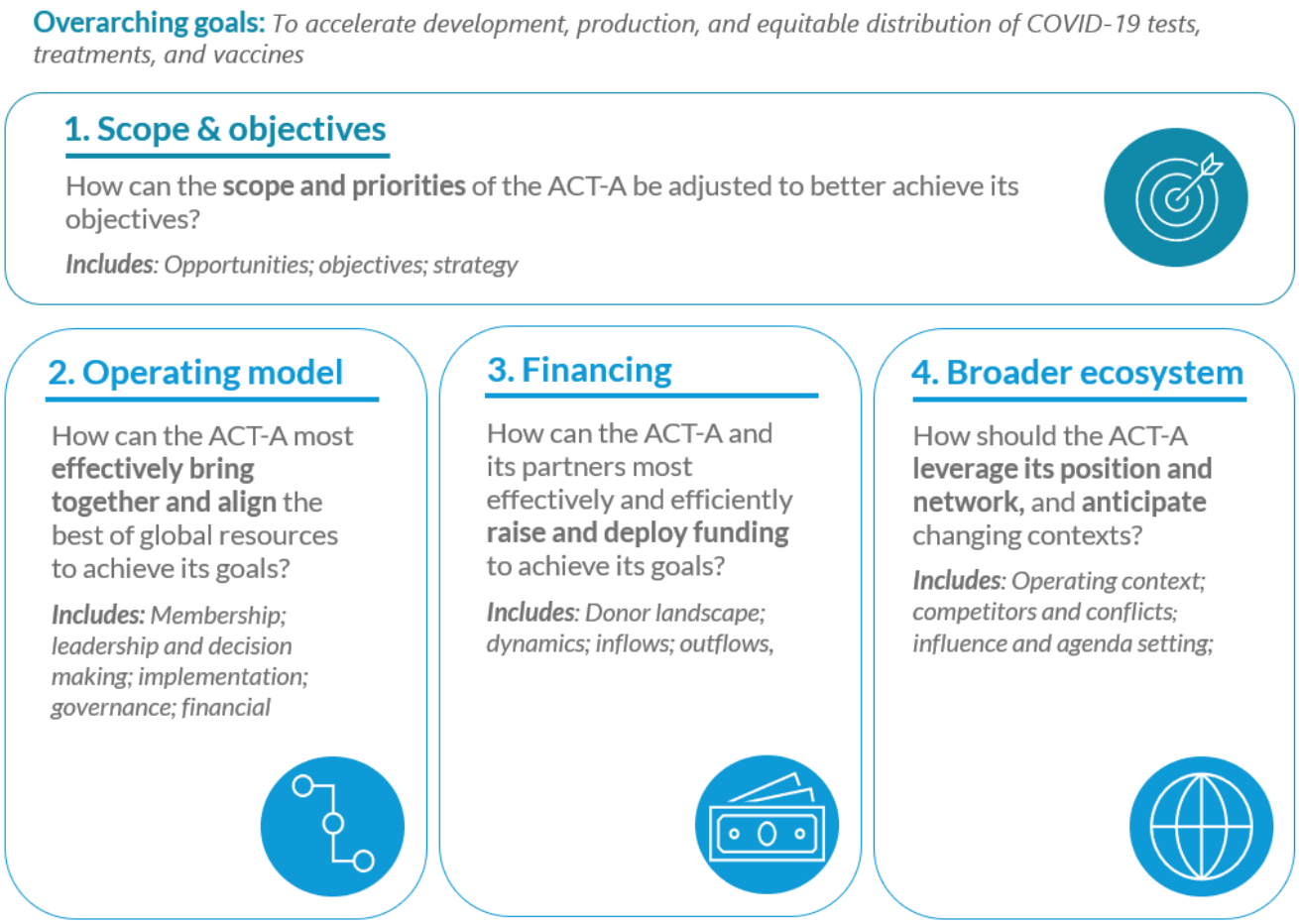
The Review was not focused on evaluating results, performing an audit, nor providing an impact assessment. Rather, it considered perspectives on ACT-A and its Pillars' achievements to date to the extent that these can inform learnings on what has worked well and where there is room for improvement. It also considered the extent to which ACT-A is focused on addressing the most pressing needs within its scope today.

Methodology overview

The Review was grounded in a four-dimension framework; each dimension examines a distinct component of the ACT-A 's approach and its various ways of working. These include:

1. **Scope and objectives**: ACT-A 's scope and priorities to-date relative to its overarching goals
2. **Operating model**: ACT-A partners' ways of working in the context of collaborative structures, systems, and overall governance
3. **Financing**: Donor landscape and ACT-A's funding inflows and outflows
4. **Broader ecosystem**: The macro global context within which the ACT-A works, how it influences partners' work, and how ACT-A partners can in turn influence it.

Figure 1: Assessment framework



The Review was conducted via a mixed-methods approach for data collection and analysis. Information was sourced from two types of sources: 1) desk research, and 2) stakeholder interviews (via both 1:1 key informant interviews and focus groups). Desk research covered a broad collection of ACT-A's public and internal strategy and planning materials, reporting, meeting materials, and external perspectives. Meanwhile, the team conducted interviews with over 100 stakeholders,

including internal agency, industry, and country representatives and external recipient countries, civil society and community representatives, and other relevant experts. Full listings of inputs (document library and interview participants) can be found in the annex.

Limitations

This review was designed to answer specific questions in a short time. As a result, specific choices were made in terms of approach and methodology that may limit the application of the findings and recommendations. An overview of those limitations is shown in the table below.

Description	Mitigation strategies
Broad scope and limited time pose challenge to capturing nuances across all dimensions or pillars	• Early alignment on strategic priorities with sponsors and reference group – including guidance on relative emphasis across questions • Ongoing communication to understand shifts in needs and priorities with sponsors
Recommendations are targeted specifically at near-term improvements, and may not address longer-term systemic adjustments for commodity markets or health security	• Transparent acknowledgement of review scope and purpose • Highlight in discussions and transition remaining open questions and importance of considering longer-term view
The unpredictable nature of the pandemic can limit the applicability of the recommendations in the short and medium-term	• Joint alignment on scope and focus of recommendations • Prioritization of recommendations focused on how ACT-A works (rather than content priorities), helping it remain adaptable to changing circumstances

II. INTRODUCTION AND CONTEXT

The ACT-Accelerator was launched at a time of tremendous urgency and uncertainty. The Public Health Emergency of International Concern had been declared by the WHO Director General only three months prior, and cases were rising rapidly around the world. By early February, the SPRP 2020 had been launched as the global strategic planning framework for the health sector response. And yet at the time, there was still much to be learnt about the novel coronavirus and there was no clear view from experts to predict how long the crisis would last, nor how bad it would be.

Under those conditions, global stakeholders came together to support global progress on medical countermeasures as quickly and efficiently as possible. WHO and major organizations in global health acknowledged early that the crisis was too large for any one actor to address alone, and that the global and uncompromising spread of the pandemic would require rapid, coordinated action. In the interest of speed, leaders opted to leverage existing actors in a voluntary, light-touch coordination body rather than create new structures. Formation was organic, bringing together a "coalition of the willing" across leaders and stakeholders from around the world. ACT-A was not set up to become an organisation, but rather a means to ensure independent but complementary initiatives could move in the same direction.

The eight co-convening agencies are WHO, Gavi, CEPI, Unitaid, Wellcome, the World Bank Group, the Global Fund, and FIND, with additional key partners of Bill & Melinda Gates Foundation and UNICEF. These are supported by a host of other partners at pillar and implementation level. In addition, key industry representatives are included, such as International Federation of Pharmaceutical Manufacturers & Associations (IPFMA), International Generic and Biosimilar Medicines Association (IGBA), and Developing Countries Vaccine Manufacturers Network (DCVMN). Civil society is also represented at the ACT-A and Pillar levels, with a range of organisations active across the partnership on behalf of diverse constituencies.

The ACT-A initiative aims to connect existing global resources to cover the end-to-end commodity value chain. ACT-A's approach aims to leverage comparative advantages and expertise from each partner, spanning research and development, market shaping, procurement, delivery, and health systems. To do so, it brings together different skills across the full value chain of tool development and delivery. The existence of ACT-A has altered the global health landscape by stimulating closer coordination between agencies and triggered some of them to adapt their mandates.

After now nearly a year and a half of operations, the partnership sought to take stock of learnings and opportunities to refine its approach, and continue adapting to evolving circumstances. Learnings from building such a mechanism, and the varied approaches taken within each Pillar, can help ACT-A to optimise its work going forward. Further, a re-evaluation of the ingoing assumptions from when ACT-A began can ensure it is best positioned to serve country needs and end the acute phase of the pandemic.

III. DIMENSION 1: SCOPE AND OBJECTIVES

Introduction

ACT-A was built on the premise that COVID-19 required a coordinated approach to medical countermeasures—where vaccines, diagnostics, nor therapeutics alone would be sufficient. COVID-19 is a complex, rapidly spreading and evolving disease which requires an agile, coordinated approach from many sides. Recognizing this, ACT-A was the first global health partnership to take on all medical countermeasures: locating the disease, treating the disease, and preventing the disease. Given the epidemiological and practical constraints of diagnostics, therapeutics, and vaccines, a coordinated approach (along with other social measures) will continue to be needed to manage outbreaks. In addition, ACT-A's scope was also based on the premise that there would be synergies in coordinated effort across these three areas.

The approach aimed to achieve accelerated development and delivery across the full value-chain for each of these medical countermeasures. In the first published investment cases, ACT-A set out its aim as to "develop essential health products for the fight against COVID-19 and to ensure they are distributed equitably through a rapid and ambitious programme of work to develop, test, bring to market, procure and distribute new diagnostics, drugs and technologies, while taking steps to help ensure health systems can deliver these tools to the people who need them".[4] This covers both upstream and downstream work for COVID-19 tools - from scaling up research and development, market preparedness and manufacturing capacity, procurement and equitable delivery, to supporting uptake. ACT-A acknowledged that although these value chain steps are sequential, the need for speed required many preparatory activities to begin in tandem so that progress in market shaping, procurement, and country readiness did not only start once tools were developed. This end-to-end approach for tool development and delivery was made possible by bringing together a diverse set of partners with complementary expertise spanning different parts of the value chain.

This scope was then divided across three product pillars, complemented by the horizontal Health Systems Connector. The Vaccines, Diagnostics, and Therapeutics Pillars were all set up with a vertical focus, and, whilst structures varied, each took on both upstream and downstream work in their respective areas. Contrastingly, the Health Systems Connector was designed horizontally to support complementary areas in health systems strengthening, PPE and oxygen[5], and connecting to country needs by addressing key bottlenecks. Findings and analysis of each of the four areas' scope and objectives, approach, and interventions across the value chain are considered in the following segments. The section concludes with a consideration of cross-cutting and forward-looking observations, and recommendations.

Findings and analysis

Diagnostics Pillar

The Diagnostics Pillar is co-convened by FIND and the Global Fund, with WHO leading on regulatory policy, product procurement and allocation, and country access and support, while supporting R&D efforts.

The Diagnostic Pillar aimed to accelerate development and production of high-quality rapid diagnostic tests and deliver them to L/MICs. When the Diagnostics Pillar set out its objectives in

[4] "What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?", World Health Organization, 6 April 2021
[5] This was before oxygen was moved to the Therapeutics Pillar in February 2021

June 2020, the performance of many first-generation rapid diagnostic tests was still weak. The pillar therefore aimed to support the development of reliable and affordable rapid tests, and make them accessible to L/MICs.[6] It also aimed to support governments with robust data solutions to assist surveillance efforts.[7] Prior to the development of effective vaccines or therapeutics, diagnostics were positioned as the most important medical technology for controlling the impact of COVID-19 and saving lives.[8]

Early breakthroughs in rapid testing meant Diagnostics could focus sooner than the other pillars on the later steps of the value chain. In the diagnostics space, the development of new rapid diagnostics test was an early success, with reliable antigen rapid diagnostic tests (Ag RDTs, which do not require laboratory facilities) being developed and ready for procurement within eight months—a feat which comparably took five years for HIV.[9] This allowed the Diagnostics Pillar to begin working on market shaping and deployment faster than the other Pillars, while continuing to review the efficacy of COVID-19 tests on the market. The Diagnostics Pillar reviewed over 90 tests between April 2020 and June 2021.[10] The market for molecular (PCR) and Ag RDT tests has expanded, and there are now over 1,000 commercially available tests on the market according to FIND's SARS-COV-2 Diagnostic Pipeline.[11] The Diagnostics Pillar has contributed to expanding manufacturing capacity by investing in two diagnostics tests to enable regional diversification.[12] Average prices of Ag RDTs can be seen to be falling – which is an important factor for expanding access: between September 2020 and June 2021 the average price of antigen RDTs decreased from US$ 5 to US$ 2.5.[13]

However, ongoing work is needed in market shaping and regulatory approval. Although progress has been made in lowering the price of tests, internal stakeholders expressed dismay that the price had not yet fallen further, citing below one dollar to be the critical threshold for expanding access and uptake. Currently, despite over 1,000 COVID-19 tests being commercially available, only four rapid tests have the necessary Emergency Use Listing (EUL) for WHO procurement (two of which are variations from the same manufacturer).[14] Stakeholders cited the slow pace of regulatory approval as a key bottleneck to deployment. The limited EUL listings were used as an illustration of why more regulatory and market shaping work still needs to be done, and the risk of L/MICs being unable to access a diverse market. Some stakeholders noted the Pillar could have taken a stronger role early-on in test validation to accelerate processes.

The Diagnostics Pillar is currently not on track to reach its procurement goals, and the goals themselves require additional contextualization to describe their intended impact. The Diagnostics Pillar set the original target of making 500 million tests accessible to L/MICs by mid-2021. It extended this in April 2021 to a cumulative total of 900 million tests procured for L/MICs by the end of 2021. The Pillar missed its mid-year goal, having procured over 84 million PCR and Ag RDTs for L/MICs by 30 June 2021[15]—only 16% of the way to their mid-year target. A significant amount of the diagnostics procurement has occurred through the C19RM (see section below). A large scale-up of procurement and delivery will be needed if the 900 million end-of-year target is still to be reached. Furthermore, stakeholders raised that the targets were low in and of themselves, when over 80% of

[6] "What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?", World Health Organization, 6 April 2021
[7] "Access to COVID-19 Tools (ACT) Accelerator Diagnostics Partnership: Investing in diagnostics to manage the course of the COVID-19 pandemic", FIND and the Global Fund, May 2020
[8] "Access to COVID-19 Tools (ACT) Accelerator Diagnostics Partnership: Investing in diagnostics to manage the course of the COVID-19 pandemic", FIND and the Global Fund, May 2020
[9] "ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021
[10] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[11]"SARS-COV-2 DIAGNOSTIC PIPELINE", FIND Accessed at: https://www.finddx.org/covid-19/pipeline/?avance=Commercialized&type=all&test_target=all&status=all&section=show-all&action=default on 14 September 2021
[12] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[13] "ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021
[14] WHO Emergency Use Listing for In vitro diagnostics (IVDs) Detecting SARS-CoV-2, World Health Organization, April 2021 (Lists: 4 Rapid tests, 23 Nucleic Acid tests (PCR), and 1 antibody test
[15] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021

the world's population live in L/MICs. Interviewees also noted that the targets were insufficiently contextualized to be able to assess their relevance. Some called for assessments on what 900 million tests could achieve in different settings and in different use-cases for public and individual health benefits. This could include the benefit of testing in surveillance strategies to monitor variants; testing as part of 'test and treat' or 'test, trace and isolate' policies; or as part of border management schemes. The benefit of these different strategies is also highly dependent on a country's broader COVID-19 strategy, which vary greatly and impact the rate of transmission (such as vaccination rate, masking, or social distancing measures).

The pillar exceeded its targets in expanding laboratory infrastructure and increasing testing capacity. L/MIC representatives interviewed during the review emphasized that a shortage of diagnostic machines and trained laboratory staff had been a major challenge at the start of the pandemic. Having supported 70 countries in this area,[16] the Diagnostics Pillar has exceeded the targets they set in February 2020 to expand testing infrastructure in 50 countries.[17] In addition, the Diagnostics Pillar has provided online training for over 23,000 healthcare workers in almost 200 countries on implementing tests.[18]

However, stakeholders noted on-the-ground support has been insufficient. Interviewees acknowledged that the pillar had significant room for improvement in terms of on-the-ground support to countries, building demand around testing, and supporting countries to develop testing and surveillance strategies. Scaling up testing in countries with constrained public health and social protection systems is a complex task, and interviewees shared that procurement of tests was not always accompanied with the sufficient technical assistance—although this has been improving since 2020. Stakeholders also noted that the Diagnostics Pillar potentially faced more challenges in this field as a newer partnership of actors compared to the Vaccines Pillar—where operational relationships and networks were more mature to support roll-out. Furthermore, diagnostics is an area where there are often fewer in-country experts compared to vaccines and therapeutics, meaning greater technical assistance and training is needed to establish the necessary systems and protocols.

Looking ahead, the Pillar is seeking to expand demand and uptake of Ag RDTs, consider opportunities in self-testing, community-based testing, and test-and-treat strategies. Although Ag RDTs increase accessibility for resource constrained settings compared to PCR tests, uptake is still low. Testing rates between HICs and L/MICs are estimated at one test being done in L/MICs for every 70 in HICs.[19] Self-tests are seen as a key opportunity to increase uptake, and the Diagnostics Pillar is supporting clinical trials of 10 affordable self-tests.[20] Linked to this, several internal and external stakeholders noted the importance of community-based testing to increase demand and uptake, and the need for this to become a larger focus within ACT-A's diagnostics strategy. The Pillar has also newly started to collaborate with the Therapeutics Pillar on test-and-treat strategies in 22 countries (see the *Therapeutics Pillar* section below for more), though interviewees noted that this collaboration had been broadly lacking to date.

The Diagnostics Pillar also has a vital role to play in the face of new variants by evaluating the implications of variants for tests, and in contributing to global surveillance efforts. The Pillar is currently on-track with targets it set in February 2021[21] to evaluate the performance of an additional 50 diagnostic tests to understand the potential impact of novel variants.[22] It is also contributing to

[16] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[17] "ACT-Accelerator Prioritized Strategy & Budget for 2021, Post Council Version of 16 February 2021", World Health Organization, February 2021
[18] "ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021
[19] "SARS-COV-2 DIAGNOSTIC PIPELINE", FIND Accessed at: https://www.finddx.org/covid-19/pipeline/?avance=Commercialized&type=all&test_target=all&status=all&section=show-all&action=default on 14 September 2021
[20] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[21] "ACT-Accelerator Prioritized Strategy & Budget for 2021, Post Council Version of 16 February 2021", World Health Organization, February 2021
[22] "ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021

the knowledge base on sequencing capacity through the setup of a new Genomic Surveillance Working Group.[23] These are important functions for the Pillar to take on considering the ongoing threat of new variants (see more in *Dimension 4: Broader Ecosystem*).

Therapeutics Pillar

The Therapeutics Pillar is co-convened by Unitaid and the Wellcome Trust, with WHO leading the policy and regulatory work and the Global Fund leading work on procurement and deployment with UNICEF as a key partner.

The Therapeutics Pillar took a L/MIC focus, looking at evidence assessment, market preparedness, and deployment. In setting its original scope, the Pillar acknowledges the power of therapeutics across all stages of the disease: prevention, early treatment, severe treatment, and recovery.[24] Within research and development, the Pillar emphasised the need to consider the applicability of different therapeutics for different resource settings with regards to price, delivery, and clinical care management.[25]

The Therapeutics Pillar kept a pulse on the research landscape and supported impactful research, but experienced challenges in skewed research agendas deriving from the emergency context. The Therapeutics Pillar has tracked more than 300 actionable trials, supported 15 clinical trials, and since April 2021 has been investigating 21 therapies in 47 countries with 85,000 patients enrolled.[26] Within this, the Pillar supported the research that identified dexamethasone as the first life-saving treatment, and provided guidance on its use.[27] However, internal and external stakeholders noted challenges in the research landscape. In response to rising numbers of hospital deaths, global research agendas began prioritizing treatments for severe cases. Although prophylactic or early treatments would avoid hospitalization, these are only now becoming a greater focus in global research efforts.[28] Some interviewees also believed too much hope had been placed on repurposed therapeutics. Many repurposed therapeutics trials were unsuccessful, and created sunk resources and distraction by being conducted inconsistently, with insufficient power, or duplicating efforts. Some stakeholders expressed that the Therapeutics Pillar could have sought to take a stronger leadership and coordination role in the research landscape to ensure the global research agenda better served all patients and needs. The WHO Solidarity PLUS trial platform has been a step toward this, representing the largest global collaboration on research for repurposed therapeutics between WHO Member states.[29]

The Therapeutics Pillar's strategy was guided by the need to secure product volumes in anticipation of potential treatments. Anticipating the possibility of future recommendations supporting use of treatments, the Therapeutics Pillar saw the need to secure supplies early to ensure rapid access for L/MICs and a sufficiently broad supply base. In early 2020, a capacity reservation for monoclonal antibodies (mABs) was arranged. Capacity reservations were made with a view to secure production capacity for L/MICs ahead of the development of a safe and effective treatment in a context of complex scale-up and long lead times. This meant making at-risk investments to reserve "product-agnostic" capacity with manufacturers equipped with key facilities. The Fujifilm Biotech capacity reservation initiated by Bill & Melinda Gates Foundation, Wellcome, and Mastercard in April 2020

[23] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[24] "COVID-19 Therapeutics Investment Case", ACT Accelerator Therapeutics Partnership, 2020
[25] "COVID-19 Therapeutics Investment Case", ACT Accelerator Therapeutics Partnership, 2020
[26] "ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021
[27] "ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021
[28] "Therapy for Early COVID-19: A Critical Need", Peter S. Kim et al, JAMA, 11 November 2020
[29] The Solidarity PLUS trial involves thousands of researchers in over 600 hospitals in 52 countries, 16 more countries than the first phase of trials. This allows the trial to assess multiple treatments at the same time using a single protocol, recruiting thousands of patients to generate robust estimates on the effect a drug may have on mortality--even moderate effects. More can be found out here: https://www.who.int/news/item/11-08-2021-who-s-solidarity-clinical-trial-enters-a-new-phase-with-three-new-candidate-drugs

was an example of this.[30,31] The Therapeutics Pillar's 2020 investment case for mABs and small molecules[32] lays this out as part of wider strategy for several capacity reservations, including capacity reservations in India. The report also acknowledges whilst although these reservations will only meet a small portion of unmet need, it is an important first step in securing L/MICs access. The investment case for US$ 365 million in capacity reservation was to reserve 9 million treatment courses at-cost (the strategy's impact was estimated at averting 35,000 deaths).[33]

Stakeholders held mixed opinions on mABs within the Therapeutics Pillars' strategy. In the fast-evolving landscape and changing viral pattern, first generation mABs became less promising against newer strains of COVID-19. In general, some stakeholders expressed reservations at the Pillar's mAB strategy. They noted that mABs take a long time to produce and hold challenges for local manufacturing due to requiring highly specialized facilities (animal cells in temperature-sensitive bioreactors); and are a high-cost treatment. The combination of limited supply and high prices, in addition to delivery and ease-of-use constraints, mean that access challenges for mABs remain extremely high. Recipient country stakeholders also noted prohibitive prices as a constraint on their demand. Several stakeholders commented that the Therapeutics Pillar needed to take a clear decision on whether it will continue to pursue expensive treatments with significant access constraints, (with CSOs in particular emphasizing the potential for complementary strategies to increase supply such as technology transfer and licensing agreements). At the same time, with a limited number of candidates advancing in the pipeline for near-term use the Pillar also needs to consider interventions that might be less compatible with scale-up in L/MICs to ensure L/MICs are not left behind. Stakeholders also noted that, given the uncertainty of the pandemic's evolution, mid- to longer-term pathways that could prove efficacious should not be fully ruled out.

In February 2021, the Principals Group moved the responsibility for medical oxygen from HSC to the Therapeutics Pillar, broadening its scope beyond new therapies to include managing existing countermeasures. In the first quarter of 2021, many L/MICs saw severe oxygen shortages,[34] and many external groups called on ACT-A to more actively manage oxygen. In the updated Strategy and Budget presented in February 2021 oxygen had been moved under Therapeutics[35] and by the end of the month the Emergency Oxygen Taskforce had been formed together with key CSO groups.[36] There was consensus amongst interviewees that, as a life-saving treatment which also works well in combination with dexamethasone, oxygen fit better under the mandate of Therapeutics. Many stakeholders believed oxygen should have been under the Pillar's mandate since inception, and commented its exclusion was a result of the Pillar's up-stream, innovation focus. With the redefinition of its scope, stakeholders agreed the Pillar was more on track to meet its objectives. The Emergency Oxygen Taskforce has recently taken stock of its first six months of operation, and will continue in its strategic priorities of expanding liquid and PSA sources of oxygen, providing immediate oxygen coverage, and procuring essential services and complementary equipment.[37]

In response to the limited number of effective treatments discovered, the Therapeutics Pillar's revised down its ambitions for procurement and delivery. In the original investment cases, Therapeutics set the target of delivering 245 million treatment courses to L/MICs by 2021[38]. However, these targets were revised down to 100 million new treatment courses by the end of 2021 (subject to evidence supporting their use case and product availability). For existing treatments, they aim to promote successful uptake of oxygen and corticosteroids (including dexamethasone) for 12

[30] https://www.pharmaceutical-technology.com/uncategorised/fujifilm-biotech-reserves-manufacturing-space-for-gates-foundations-covid-19-accelerator/
[31] https://www.gatesfoundation.org/ideas/articles/coronavirus-trevor-mundel-therapeutics-collaboration
[32] "Investment case summary for monoclonal antibodies and small molecules", ACT-Accelerator Therapeutics Partnership, 2020.
[33] "Investment case summary for monoclonal antibodies and small molecules", ACT-Accelerator Therapeutics Partnership, 2020.
[34] "Medical oxygen crisis: a belated COVID-19 response", Ann Danaiya Usher, The Lancet, 6 March 2021
[35] "ACT-Accelerator Prioritized Strategy & Budget for 2021, Post Council Version of 16 February 2021", WHO, February 2021
[36] CSOs engaged: Every Breath Counts, Save the Children, Clinton Health Access, PATH
[37] Internal stakeholder interview.
[38] "ACT-Accelerator Investment Case", World Health Organization, 26 June 2020

million severe and critical cases.[39] CSO stakeholders noted that this target reduction took place without wider Pillar consultations, and expressed concern on the number of treatments versus the size of the population to serve.

Even with this downwards revision, Therapeutics is yet to meet its product deployment targets. As of June 2021, the Pillar had allocated US$ 37 million worth of treatments, including dexamethasone, equating to 1.8 million treatments, and had awarded a further US$ 35 million directly to countries for their direct procurement and operationalization of treatments.[40] Oxygen procurement moved relatively quickly despite being added later, with over US$ 233 million allocated for oxygen procurement and 800,000 oxygen provisions being delivered by June.[41] This included rapidly responding to the oxygen crises in India, Bangladesh, and Zambia. The Pillar also made a further US$ 219 million available for countries experiencing COVID-19 surges to procure and operationalize oxygen treatments themselves, within which India received US$ 75 million in fast-track funding to increase its oxygen supply. The majority of the Pillar's therapeutics procurement has occurred through the C19RM (see section below). Furthermore, the Therapeutics Pillar has also signed memorandums of understanding with two multinational oxygen suppliers to set up long term agreements, and the O_2 Market Shaping Expert Advisory group is continuing diagnoses of critical bottlenecks and engaging with suppliers.[42]

Anticipatory and preparatory work is needed to ensure rapid availability and uptake of any new treatments, and is a core priority of the Therapeutics Pillar. Therapeutics Pillar stakeholders stressed the importance of market readiness work in preparation for new treatments. Unlike COVAX, the Therapeutics Pillar does not yet have a clearly articulated procurement structure to supply countries or to negotiate contracts. The Pillar is also yet to engage in Advance Market Commitments, which external stakeholders noted put the Pillar at risk of becoming non-competitive against national bilateral deals. They expressed concern that, without rapid pre-emptive action, the Pillar could face similar challenges to COVAX in ensuring sufficient supply for L/MICs if new effective treatments are discovered. Existing advanced market purchases of Molnupiravir (an anti-viral in Phase 3 clinical trials which is hoped to treat mild to moderate COVID-19)[43] by the USA were noted as examples of this risk.[44] Therapeutics Pillar stakeholders acknowledged that greater cross-Pillar learning and information sharing would be an important contributor to this work. For one, a common view of expected need, given the close linkages in demand for therapeutics and other tools, would benefit all Pillars. However, effective demand projections have been a challenge for the Pillar's work, as a result of the high uncertainty in the COVID-19 therapeutics market, the reliance on limited L/MIC data, and modelling capabilities the agencies themselves are not always best-placed to provide.

The Pillar has initiated market shaping work around licensing and technology transfer, market assessments, and country readiness support. The Pillar has been tackling access issues in licensing and technology transfer in its engagement with pharmaceutical companies, including efforts to speed up development and prequalification. This work has also been supported through the Pillar's engagement with the Medicines Patent Pool and C-TAP. The Pillar has also been conducting market assessments for priority products, including assessments of global markets and manufacturing

[39] "ACT-Accelerator Prioritized Strategy & Budget for 2021", World Health Organization, 12 April 2021
[40] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[41] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[42] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[43] "Merck Announces Supply Agreement with U.S. Government for Molnupiravir, an Investigational Oral Antiviral Candidate for Treatment of Mild to Moderate COVID-19.", 9 June 2021, Accessed at: https://www.merck.com/news/merck-announces-supply-agreement-with-u-s-government-for-molnupiravir-an-investigational-oral-antiviral-candidate-for-treatment-of-mild-to-moderate-covid-19/ on 15 September 2021
[44] It is worth noting that although ACT-A has not engaged in securing Molnupiravir for L/MICs, Merck has taken steps to facilitate this should the drug prove to be safe and effective. In April 2021 Merck announced voluntary licenses and provided technology transfers to multiple Indian generic manufacturers with histories of supplying global quality assured medicines, GMP certifications and WHO prequalification and would be able to supply Molnupiravir to over 100 L/MICs. More information available here: https://www.merck.com/news/amid-humanitarian-crisis-in-india-merck-announces-voluntary-licensing-agreements-with-five-indian-generics-manufacturers-to-accelerate-and-expand-global-access-to-molnupiravir-an-investigational-ora/

capacities. In an effort to increase country readiness, Unitaid and FIND have recently launched programmes in 22 countries as a cross-pillar collaboration. The programmes will cover topics such as evidence generation, supply chain strengthening, enabling environments for policy, demand creation, and effective transition and scale up within national programs.[45] It is important to note that external stakeholders criticized the Therapeutics Pillar for a lack of action in each of these areas. Internal stakeholders acknowledged that, due to limited cases where products had advanced in the pipeline, there had been limited visibility on these efforts externally. This highlights challenges faced in information sharing, which is needed to keep the broad set of stakeholders in the Therapeutics space engaged.

The Pillar is also newly engaging with test and treat strategies. External stakeholders commented that the Diagnostics and Therapeutics Pillars have been slow to launch a collaboration on test and treat. Should promising antivirals be proven effective, test and treat strategies will be of great value to L/MICs given persistent vaccine inequity, and will require advanced planning to allow for a successful roll-out. The programmes which Unitaid and FIND plan to run in 22 countries (see above) also include catalytic implementation of test, isolate and treat solutions. Furthermore, the two Pillars have newly started a closer collaboration and are meeting more regularly in an effort to foster a closer alignment.

Cross-pillar procurement through Global Fund's COVID-19 Response Mechanism (C19RM)

Global Fund set up C19RM to rapidly respond to the impact of COVID-19 on countries' health systems. In April 2020, the Global Fund set up the C19RM to provide grant funding to countries for: (1) COVID-19 Response; (2) COVID-19-related adaptation of programmes to fight HIV, tuberculosis, and malaria; and (3) Strengthening health and community systems.

The C19RM takes a demand-driven approach by funding country applications in line with their national response plans. This mechanism builds on existing Country Coordination Mechanism (CCM)[46] processes and partners. This approach leveraged existing Global Fund HIV, TB, and malaria decision tools to expedite C19RM planning. In applying for funds, applicants must undertake inclusive, multi-sectoral consultation,[47] align their funding requests with entities coordinating the national COVID-19 response, and ensure alignment under the National Strategic Preparedness and Response Plan (SPRP).[48] Countries have options of full-funding requests—for which they are encouraged to prepare both a base and above-base allocation to capture an ambitious projection of their needs—and fast-track funding requests which can expedite urgent procurement needs in PPE, diagnostics, and therapeutics (including oxygen), or costs to support deployment.[49]

To date, US$ 3.6 billion has been channelled through C19RM to 107 countries and 18 multi-country programmes. Of this, 72% has been allocated towards reinforcing national COVID-19 responses,

[45] Internal documents from Therapeutics and Diagnostics pillar.
[46] Country Coordinating Mechanisms are national committees that submit funding applications to the Global Fund and oversee grants on behalf of their countries. They are a key element of the Global Fund partnership. Source: "Country Coordinating Mechanism", Global Fund Webpage. Accessed at: https://www.theglobalfund.org/en/country-coordinating-mechanism/ on 27 September 2021.
[47] Applicants must consult with, at minimum, the HIV, TB, and malaria national control programmes, civil society, key and vulnerable populations as well as communities, including those most severely affected by COVID-19. Source: "COVID-19 Response Mechanism Guidelines", The Global Fund, 17 April 2021. Accessed at: https://www.theglobalfund.org/media/10759/covid19_c19rm-guidelines_external_en.pdf on 27 September 2021.
[48] "COVID-19 Response Mechanism Guidelines", The Global Fund, 17 April 2021. Accessed at: https://www.theglobalfund.org/media/10759/covid19_c19rm-guidelines_external_en.pdf on 27 September 2021.
[49] "COVID-19: Response Mechanism", The Global Fund, Webpage. Accessed at https://www.theglobalfund.org/en/covid-19/response-mechanism/ on 27 September 2021.

16% to mitigating COVID-19 impact on HIV, TB, and malaria programmes, and 12% to strengthening health and community systems.[50]

C19RM supports a cross-pillar approach, providing funding and procurement for a range of support across the Therapeutics and Diagnostics pillars as well as the HSC. This includes procurement of tests and lab equipment, oxygen and related supplies, PPE, pharmaceutical treatments, and other key products and activities.[51] In being able to apply for COVID-19 support across pillars, C19RM supports coordination of ACT-A offerings for COVID-19 response at country level. As of 17 September 2021, 86% of US$ 2.67 billion in C19RM investments made in 2021 had been directed towards ACT-A activities (27% to diagnostics, 26% to therapeutics, 33% to HSC (of which 53% has been PPE), and 14% to complementary cross-pillar activities and programme management).[52]

The C19RM has also highlighted the critical unmet demand in countries to-date, with over US$ 1 billion in unfunded demand[53] from 65 applicants for non-vaccine COVID-19 support.[54] Acknowledging the continued burden of COVID-19 on global health systems and acute needs at country level, the Global Fund Board has extended the C19RM Timeline to continue mobilising donor funds until December 2021, and awarding funds through March 2022.[55] C19RM has a US$ 10 billion fundraising target for 2021.[56]

Vaccines Pillar

The Vaccines Pillar, also known as COVAX, is co-convened by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, the Vaccine Alliance, and the World Health Organization (WHO), with UNICEF as a key delivery partner.

The Vaccines Pillar, or COVAX, took a global lens, aiming to accelerate progress across the full vaccine value chain to achieve equitable global access and uptake. This is unique from the other two pillars which exclusively focused on L/MICs. In June 2020, the Vaccines Pillar set out its objectives as "speeding up the search for effective vaccines for all countries" and "supporting the building of manufacturing capabilities and buying supply, ahead of time, so that two billion doses can be distributed fairly in the places of greatest need, worldwide, by the end of 2021". [57] When this scope was set, major challenges included low chances of vaccine development success within the first year,[58] a need to manage manufacturing risk to increase production capacity ahead of regulatory approval, and significant equity risk in the distribution of vaccines.

COVAX contributed to the global push for vaccine development through broad investments into vaccine candidates and trials, and supported manufacturing scale-up. COVAX set the objective of ensuring the most promising vaccine candidates receive the funding they need, and that regulatory conditions be in place to allow a safe, seamless passage from early stages of development through to licensure and use.[59] CEPI moved quicky in this space, taking action to make investments in R&D that were attached to access commitments beginning in January 2020. When the first ACT-A investment cases came out in June 2020 there were over 200 vaccine candidates being developed

[50]"Global Fund support to fight COVID-19: As of 14 September 2021", The Global Fund, 2021. Accessed at: https://www.theglobalfund.org/en/our-covid-19-response/ on 27 September
[51]"C19RM Health Product Segmentation Framework", The Global Fund, 17 August 2021. Accessed at: https://www.theglobalfund.org/media/10765/covid19_health-product-segmentation_framework_en.pdf on 27 September 2021
[52] "Global Fund C19RM update, Awards", prepared by Global Fund for ACT-Accelerator, 20 September 2021. *Internal document*.
[53] 'Unfunded demand' is the total value of funding requests to C19RM for which the Global Fund currently does not have sufficient funds to support.
[54] Unfunded Demand of US$1,002 million for 65 applicants. Source: "Global Fund C19RM update, Awards", prepared by Global Fund for ACT-Accelerator, 20 September 2021. *Internal document*.
[55] "GF/B44/EDP18: Second Extension of C19RM Timeline and Operational Flexibility for COVID-19", The Global Fund, 30 March 2021. Accessed at: https://www.theglobalfund.org/board-decisions/b44-edp18/ on 27 September 2021.
[56] "Our COVID-19 Response", The Global Fund, Webpage. Accessed at: https://www.theglobalfund.org/en/our-covid-19-response/ on 27 September 2021.
[57] "ACT-Accelerator Investment Case", World Health Organization, 26 June 2020
[58] "COVAX explained", Dr Seth Berkley, Accessed at: https://www.gavi.org/vaccineswork/covax-explained on 15 September 2021
[59] "ACT-Accelerator Investment Case", World Health Organization, 26 June 2020

around the world,[60] and by September 2020, COVAX held the world's largest and most diverse R&D portfolio of COVID-19 vaccines.[61] As of April 2021, the Vaccines Pillar had invested US$ 1.2 billion of R&D funding into a portfolio of 12 vaccine candidates. Three of these were shown to have clinical efficacy in preventing severe disease, two have received emergency use listing (EUL), and two are targeting emerging variants.[62] CEPI is also continuing to invest in new generations of COVID-19 vaccines.[63] Other work has included the establishment of model indemnification and liability terms and a no-fault compensation programme for Advanced Market Commitment (AMC) participants,[64] supporting Emergency Use Listings for Vaccines (both supporting countries to leverage authorizations of EUL vaccines, and a policy formulation stream working on priorities and policies for EULs), safety assessment processes, and expanding the footprint of vaccine production in Africa through the Manufacturing Taskforce.[65] However, CSO stakeholders have commented that COVAX could still go further in some places to expand production and promote local action, for example through support for the TRIPS waiver and greater emphasis on technology transfer.

For procurement, COVAX took on a unique global scope aimed to maximise collective buying power for its participants while reducing the lag between L/MICs and HICs receiving vaccines. Core to the original COVAX model was a goal to be the central vaccine procurer on behalf of all countries around the world. Stakeholders noted that the launch of this model leveraged a critical window of opportunity when countries did not know which vaccines under development would prove safe and effective.[66] To collectively share this risk and the benefits of vaccine development, there were strong incentives to joining a global collaborative model. As a result, the COVAX Facility, administered by Gavi, the Vaccine Alliance, has 195 participants representing over 90% of the global population.[67] By pooling global demand, the partnership aimed to simultaneously bring greater leverage to price and volume negotiations with manufacturers, while also ensuring equitable distribution between higher- and lower-income countries.[68] In addition, the COVAX advance market commitment (AMC) mechanism was designed to de-risk full-scale production and alleviate supply constraints. The AMC also enabled donor contributions to support the procurement of doses for the 92 lowest-income participants.[69] To further incentivise higher-income country participation and raise needed funding, COVAX offered "Optional Purchase Arrangements" to self-financing participants (higher-income countries paying for their own dose allocations) that were prepared to pay more upfront. These agreements allowed such participants to opt in or out of certain products. Self-financing countries were also permitted to increase their coverage ceilings.[70] While intended to maximise HIC participation and prevent HICs from locking up all early doses, some external commentators believed this tiered approach ran counter to ACT-A and COVAX's underlying equity goals. [71] Earlier this year, recognising there were populations still not covered by the COVAX Facility and without a path to securing doses, the Facility also ringfenced 5% of COVAX-procured doses and 5% of AMC funding in March 2021 for a Humanitarian Buffer to ensure vaccine access in humanitarian settings.[72] CSOs had advocated for this important extension to COVAX, which covers populations that cannot be served through the core country-based model.

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[60] "ACT-Accelerator Investment Case", World Health Organization, 26 June 2020
[61] "COVAX explained", Dr Seth Berkley, Accessed at: https://www.gavi.org/vaccineswork/covax-explained on 15 September 2021
[62] "ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021
[63] "Our Portfolio", CEPI, Accessed at https://cepi.net/research_dev/our-portfolio/ on 27 September 2021.
[64] ACT-Accelerator Prioritized Strategy & Budget for 2021 April 2021
[65] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[66] This window fully ended in December 2020, when the first vaccine products received approval for emergency use authorization by the US FDA.
[67] Press release: "Gavi COVAX AMC: a shot in the arm for international cooperation", Dr Seth Berkley, 6 November 2020. Accessed at: https://www.gavi.org/vaccineswork/gavi-covax-amc-shot-arm-international-cooperation on 15 September 2021.
[68] "COVAX Facility Explainer Participation Arrangements for Self-Financing Economies", COVAX, 2020.
[69] "COVAX AMC Explained", Gavi, Accessed at: https://www.gavi.org/vaccineswork/gavi-covax-amc-explained on 15 September 2021
[70] "COVAX Facility Explainer Participation Arrangements for Self-Financing Economies", COVAX, 2020
[71] "A beautiful idea: how COVAX has fallen short", The Lancet, Ann Danaiya Usher, 19 June 2021
[72] "The COVAX Humanitarian Buffer Explained", Gavi, 30 March 2021. Accessed at: https://www.gavi.org/vaccineswork/covax-humanitarian-buffer-explained on 27 September 2021.

COVAX set the first-step target of reaching at least 20% coverage in participating countries, to protect frontline health workers, people above 65, and those with underlying risk factors.[73] ACT-A's cross-cutting Access & Allocation workstream and COVAX worked jointly with partners to develop the Fair Allocation Framework for COVID-19 Vaccines to guide proportional allocation between countries. To ensure the first vaccine distributions protected the most vulnerable, the framework's goal was for the highest-priority population groups to receive vaccines in the same timeframe across all countries, with some adjustment based on the "principle of equity for differences in risk profile across countries". [74] As a result, the initial 20% target was set based on the assessment that it would be enough to cover those populations globally, and coincided with best estimates for global manufacturing capacity at that time—coming to approximately two billion doses by end of 2021.[75] In April 2021, the COVAX Facility added an additional target of 500 million more doses for AMC economies (bringing total coverage near 30%), based on securing an additional US$ 2 billion in funding.[76] Within these global targets, as doses become available, the Joint Allocation Taskforce allocates shipments to countries based on requests, relative need, and other factors, under approval by the Independent Allocation of Vaccines Group (IAVG).[77] While COVAX notes that these 20% targets remain first steps in the global vaccine rollout, it has received criticism for not being sufficiently ambitious to protect L/MIC populations and significantly curtail community transmission. In addition, external stakeholders expressed that the proportionality model for equity did not adequately adjust for those countries experiencing higher incidence rates, securing purchases outside COVAX, or having more vulnerable populations.

Challenges in the vaccine market have constrained COVAX's ability to meet early targets. The large bilateral deals made between many HICs and vaccine producers already by August 2020 undermined COVAX's global procurement vision.[78] Many countries purchased doses covering more than 100% of their populations,[79] leaving COVAX with limited ability to scale procurement or negotiate prices (see *Dimension 4: Broader Ecosystem* for more). COVAX had aimed to mitigate such behaviour by including self-financing participants to work through the Facility. Instead, HICs not only joined COVAX as self-financing participants but also secured direct access to early doses, before COVAX had raised sufficient funds from those same countries to cover its own procurement and could enter into contracts to lock in doses for lower-income participants. Although critics expressed that COVAX ought to have done more, internal stakeholders noted it had few tools at its disposal to further influence the HICs' purchasing choices. These events constituted a change in the underlying assumptions of COVAX.

As a result, the COVAX Facility has adapted its focus to better serve countries in this new environment. The latest COVAX allocation round was the first where doses went to those with the lowest coverage from all vaccine sources based on best available data (departing from previous practice of proportional distribution based exclusively on COVAX allocations).[80] In addition, in response to an acute supply gap caused by unanticipated export restrictions from India (COVAX's initial primary supplier to AMC-supported countries), and the emergence of countries with excess supply, dose sharing has now become a major component of the COVAX Facility's distribution.[81]

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[73] Or less than 20% if participants request less.
[74] "WHO Concept for fair access and equitable allocation of COVID-19 health products – Final Working Version", World Health Organization, 9 September 2020, pp. 24.
[75] "ACT-Accelerator Prioritized Strategy & Budget for 2021", World Health Organization, 12 April 2021
[76] "ACT-Accelerator Prioritized Strategy & Budget for 2021", World Health Organization, 12 April 2021
[77] "WHO Concept for fair access and equitable allocation of COVID-19 health products – Final Working Version", World Health Organization, 9 September 2020
[78] "The G20 Must Recommit to COVAX", Seth Berkley COVAX, September 2021. Accessed at: https://www.gavi.org/vaccineswork/g20-must-recommit-covax on 15 September 2021
[79] "COVID-19 Vaccine Access", Dataset, Last updated 7 September 2021. Graduate Institute Geneva, Global Health Centre. Accessed at: https://www.knowledgeportalia.org/covid19-vaccine-arrangements 1 October 2021
[80] Internal Stakeholder Interview
[81] "What does COVAX latest supply forecast tell us?", Aurelia Nguyen, COVAX, 23 June 2021 Accessed at: https://www.gavi.org/vaccineswork/what-does-covaxs-latest-supply-forecast-tell-us on 15 September 2021

COVAX has called for countries with excess supply to donate, and by October 2021 over 900 million doses have been pledged.[82] Donated doses earmarked for specific recipients are handled separately to COVAX's allocation mechanism for procured doses, though in the updated allocation framework these earmarked doses are then accounted for in subsequent rounds. Donated doses come with new transaction costs (e.g., in negotiating with donors and supplementing shipping costs), added logistical challenges (e.g., potentially short expiry times on donated doses and shortened planning time prior to delivery), and delay regularisation of prices and supply of the vaccine market. If and as distribution inequities of current supply are rebalanced before full coverage is reached, stakeholders acknowledged there will be a need to move progressively away from donations.

By the end of September 2021, COVAX has delivered over 319 million vaccines, with a forecast of meeting its two-billion target in the first quarter of 2022.[83] This is approximately 16% of the way to the original end-of-year goal of two billion doses. However, the September 2021 COVAX supply forecast predicts a large increase by the fourth quarter of the year. Current projections are that COVAX will reach 1.4 billion vaccines by the end of the year (70% of the two-billion target), and will exceed the target within the first quarter of 2022 (reaching 2.6 billion by the end of March 2022).[84] Of the 1.4 billion forecasted for 2021, approximately 1.2 billion will be available for AMC participants. This is equivalent to 20% population coverage in all 92 AMC economies.[85] COVAX's procurement has faced a number of challenges, including difficulties to diversify the portfolio (with HICs cornering products produced in the EU and US and continued uncertainty on access to contracted product from India), scale up challenges at key manufacturing sites, and timings on key EUL approvals.

To support rapid vaccine uptake at the country level, the Vaccines Pillar has set up a Country Readiness and Delivery (CRD) workstream which works closely with countries and is aligned with national Strategic Preparedness and Response Plans (SPRPs). Mass immunisation of large cohorts, and the logistical requirements of many of the vaccines, pose challenges for all countries and especially resource-constrained settings, including supply and cold-chain requirements, labour force, quality assurance, accessing remote and vulnerable populations, risks of misinformation, and risks of wastage at points of care. To gain insight into L/MICs' challenges, COVAX conducted over 140 country readiness assessments in November 2020.[86] COVAX also introduced the National Deployment and Vaccination Plan (NDVP), a standardised operational plan across all aspects of roll-out[87]—which AMC countries need to submit to be eligible to receive COVAX consignments, and all countries have been encouraged to develop.[88] These NDVPs are supported by a toolbox of planning tools and guides,[89] and are integrated within countries' national SPRPs[90] to ensure harmony with national plans. In October of 2020, seeing a potential gap, the Gavi Board approved the provision of US$ 150 million in initial funding to jumpstart support for COVAX AMC participants to deliver COVID-19 vaccines, in the form of planning, technical assistance and cold chain equipment.[91] This was an initial investment ahead of the World Bank's announcement of a US$ 12 billion financing

[82] "Launch and Scale Speedometer: Vaccine Donations and Exports", Duke University Global Health Innovation Center, 2021. Accessed at https://launchandscalefaster.org/covid-19/vaccinedonations on 6 October 2021
[83] "UNICEF COVID-19 Vaccine Market Dashboard", UNICEF. Accessed at: https://www.unicef.org/supply/covid-19-vaccine-market-dashboard on 1 October 2021
[84]"COVAX Global Supply Forecast", CEPI, Gavi, UNICEF and World Health Organization, 8 September 2021
[85] "COVAX Global Supply Forecast", CEPI, Gavi, UNICEF and World Health Organization, 8 September 2021
[86] This was then joined with processes from HSC (see Section *"Health Systems Connector"* for more information).
[87] The NDVP includes a realistic budget for vaccine deployment and vaccination, target populations and vaccination strategies, supply chain and health care waste management activities, human resource management and training, vaccine acceptance and demand approaches, vaccine safety steps and monitoring, and immunisation monitory strategy.
[88] "Country readiness for COVID-19 vaccines", World Health Organization, Gavi, 26 February 2021. Accessed at: https://www.gavi.org/vaccineswork/country-readiness-covid-19-vaccines on 27 September 2021.
[89] "Generating acceptance and demand for COVID-19 vaccines", World Health Organization, Webpage. Accessed at: https://www.who.int/initiatives/act-accelerator/covax/covid-19-vaccine-country-readiness-and-delivery/acceptance-and-demand on 27 September 2021.
[90] "Pillar 10 COVID-19 Vaccine Deployment Readiness Map", World Health Organization, 2021. Accessed at: https://covid19partnersplatform.who.int/en/pillar10 on 27 September 2021.
[91] "Gavi to provide US$ 150 million to support low- and middle-income countries' readiness to deliver COVID-19 vaccines" Accessed at: https://www.gavi.org/news/media-room/gavi-provide-us-150-million-support-low-and-middle-income-countries-readiness

envelope, of which US$ 5.8 billion[92] has been used so far (see more in *Dimension 3: Resourcing*). To respond to gaps in timely and flexible funding support for countries, UNICEF's ACT-HAC was also set up as a centralised mechanism to channel flexible resources for this purpose.[93] In June 2021, with the endorsement of its Board, Gavi began the process of rolling out an additional US$ 775 million based on donor contributions to support the delivery of COVAX-funded doses in lower-income economies and humanitarian zones over the next two years.[94] This funding comes in addition to the previous Board-approved envelope of US$ 150 million in delivery support.[95]

Health Systems Connector

The Health Systems Connector (HSC) is co-convened by the Global Fund, the World Bank and WHO, with support from The Global Financing Facility for Women, Children and Adolescents (GFF).

The Health Systems Connector (HSC) has three distinct roles: connecting the pillars, providing oxygen and PPE access, and supporting country readiness and health systems capacity. HSC's mandate was laid out in September 2020[96] as the following:

> *"The vision for a Health Systems Connector is to act as a "connector" between the three Pillars. ACT-Accelerator's main goal under the Health Systems Connector is to make two critical tools not provided by the other pillars – oxygen[97] and personal protective equipment – available as high priority commodities. In addition, the connector aims to support countries to build the required capacity and support health systems to deploy new tools effectively and efficiently when available."*[98]

Unlike the other pillars, which take a vertical approach through the value chain, horizontality is at the core of HSC's mandate. This is not only in connecting across the tools and pillars, but also in supporting an integrated health service delivery at the country level (rather than parallel systems for COVID-19). HSC's internal workplans as of January 2021 anchor on major bottlenecks in COVID-19 tool implementation across the health system, including financing, data, workforce, clinical care, supply chain, and limited engagement with affected communities.[99] Internal stakeholders noted earlier, original plans for HSC had a narrower "gap-filling" scope which aimed to avoid duplicating efforts of the product pillars. In addition, the roadmap highlights that most resources will come from countries, and that health systems strengthening efforts must be country-led.

[92] "How the World Bank Group is helping developing countries to vaccinate their populations", World Bank Group, 23 September 2021
[93] "Access to COVID-19 Tools Accelerator", Humanitarian Action for Children, UNICEF, 2021. Accessed at https://www.unicef.org/media/94126/file/2021-HAC-ACT-A.pdf on 27 September 2021.
[94] "Gavi Board strengthens commitment to reaching the most vulnerable through routine immunisation and COVAX", Gavi, 2021, Accessed at: https://www.gavi.org/news/media-room/gavi-board-strengthens-commitment-reaching-most-vulnerable-through-routine on 15 September 2021
[95] "Gavi to provide US$ 150 million to support low- and middle-income countries' readiness to deliver COVID-19 vaccines" Accessed at: https://www.gavi.org/news/media-room/gavi-provide-us-150-million-support-low-and-middle-income-countries-readiness
[96] When the scopes of the product pillars were laid out in the June 2020 investment case, the Health Systems Connector's scope, objectives, and budgets were still being revised and so were not published. At that time, the HSC's scope was written as "The final, Health Systems Connector pillar, led by the World Bank and the Global Fund, is working to ensure that these tools reach the people who need them" (pp. 3) and budgets were listed as "in the process of being calculated and will be released in the near future" (pp. 5). Source: "ACT-Accelerator Investment Case", World Health Organization, 26 June 2020.
[97] Oxygen has since been moved to the Therapeutics Pillar.
[98] "ACT-Accelerator Status Report & Plan, September 2020 – December 2021", World Health Organization, 25 September 2020. Pp. 15.
[99] "ACT Accelerator Health System Connector Vision: A Roadmap," January 2021, *Internal document*

Debate and tension over the appropriate mandate for HSC, often described as a trade-off between emergency response and health systems strengthening, impeded progress and impact. Stakeholders expressed concern that HSC held disjointed workstreams from the start which lacked a natural synergy. A key conflict was on whether HSC should take a humanitarian or development lens to health systems. This was captured as the tension between emergency response (commodities delivery and country readiness to absorb tools) and health systems strengthening (broader systems building). Internal early discussion documents noted these tensions and risks within HSC's scope from the outset, specifically noting differing perspectives around the challenge of focusing on COVID-19 response versus wider health systems work. What could be feasibly achieved within budget constraints was also a factor in these debates. Stakeholders noted that the formation of HSC started later than the other Pillars, and on-going discussions on aligning on its scope and budget meant that these were also released publicly later than the other pillars.[100]

> "HSC was seen as the 'water between the islands' that were the product pillars, but there were very different perspectives on HSC's scope, and different institutions had different views in mind."
> *~ Co-convening agency member*

The WHO's Health Emergencies Programme (WHE) has a relevant mandate and plays a critical role to support countries' national responses; limited central-level coordination between the HSC and WHE led to missed opportunities for ACT-A to better support national response mechanisms. The WHE holds WHO's emergency mandate and is responsible for supporting countries' SPRP process, as well as coordinating Incident Management Support Teams (IMST) at regional and country level—both of which have direct relevance and importance to HSC, and ACT-A's objectives broadly. Yet so far, according to most internal stakeholders, WHE and HSC have not been closely linked.[101,102] There are areas of important collaboration, for example with COVAX through the SPRP and NVDP processes, and with C19RM and the CCM processes in which WHE has provided technical assistance, expertise, and established linkages with national COVID-19 response structures.[103] Even so, more collaboration through ACT-A and the HSC (at a 'central' level) might have provided opportunities including: (i) to share emerging IMST guidance to inform Pillars' near-term priorities, and (ii) to improve coordination between SPRP work (on WHE side) and procurement and country readiness planning (on ACT-A Pillars' side). From WHO's side, the WHO's Universal Health Coverage (UHC) partnership team have played a leading role in HSC. UHC have a mandate focused on broader health systems work—aiming to "strengthen country capacities and reinforce the leadership of the Ministry of Health in building resilient and effective health systems in a sustainable manner."[104] That UHC team have been leading HSC efforts, whilst WHE has been less involved, illustrates the above-mentioned tension between emergency response and health systems strengthening.

HSC's scope was narrowed when the responsibility for the management of oxygen was moved to the Therapeutics Pillar in February 2021. This move happened after a number of severe oxygen crises were seen globally. Stakeholders expressed oxygen should have been originally under the Therapeutics Pillar *(*see previous section *Therapeutics Pillar)*, but also believed HSC had not been sufficiently proactive in managing oxygen. The shift means HSC now holds procurement and delivery

[100] In June 2020 the Investment Case had HSC as "still under development" ("ACT-Accelerator Investment Case", World Health Organization, 26 June 2020) and there was limited description of its scope.
[101] It should be noted that WHE plays a critical role at global and country level in supporting the COVID-19 response, beyond the ACT-A construct.
[102] It should be noted that some public reports suggest WHE and HSC operate in an integrated manner, e.g., the 2021 SPRP, taken from "COVID-19 strategic preparedness and response plan (SPRP): 1 February 2021 – 31 January 2022", World Health Organization, 2021
[103] C19RM funding requests are developed in collaboration with the entities coordinating each country's national response, including (ideally) collaboration with national response pillar working groups and related technical bodies – and should be aligned with the national SPRPs Source: "COVID-19 Response Mechanism Guidelines", The Global Fund, updated 26 August 2021.
[104] "Universal Health Coverage Partnership", Webpage. Accessed at: https://www.uhcpartnership.net/about/ on 27 September 2021.

responsibility for a single commodity: PPE. Paired with the other main workplans for HSC, which primarily lie in information gathering and knowledge sharing (such as country readiness surveys and generating reports and knowledge documents), there appear to be on-going imbalances in its activities.

HSC did not set any quantitative targets, but did set out high-level priority areas for activities. In April 2021, it set out four priority areas for the year: "(1) Fully integrate the work and products of the Pillars with a strengthened, ongoing COVID-19 response"; "(2) Rapidly identify and address country-specific health systems bottlenecks to ensure readiness, rapid scale-up, and delivery of COVID-19 tools", "(3) Accelerate availability and use of PPE as a crucial tool for protecting health workers and ensuring the resilience of the health system", and "(4) Manage linkages and synergies with complementary activities for the delivery of essential health services and strengthening of health systems"[105]. Although HSC holds the responsibility for PPE, it did not set numeric targets for distribution (as seen in the other pillars), nor did it set targets for numbers of countries or health workers to reach. Internal stakeholders noted one reason for not setting numeric targets was because HSC's planned activities were to be highly dependent on the roll-out of the other Pillars' tools, and designed to be additive and supporting.

HSC made notable progress in hosting early consultations with countries, deploying PPE, and setting up a knowledge platform. By April 2021, HSC had procured PPE over a total value of US$ 500 million,[106] and between April and mid-June had procured a further US$ 234 million in PPE.[107] This included a rapid response to the April-May surge in South Asia.[108] HSC's PPE procurement has been funded largely through the C19RM. HSC has also produced a knowledge sharing platform[109] which collates key knowledge products on topics including budgeting and health financing options, community readiness plans, clinical care, supply-chain, protecting frontline health workers, data monitoring, and private sector engagement. Knowledge production work has included a flagship report "Transforming the Medical PPE Ecosystem", jointly written by UNICEF, the World Bank, the Global Fund, and other key experts.[110] As the Secretariat for HSC, the World Bank also led several important consultations with countries, utilizing its strong network to both health and finance ministers. This included starting early to conduct country focus groups to understand what is happening on the ground, and identify key needs and bottlenecks.

It should be noted that CSO stakeholders emphasized there had not been sufficient focus on health workers in HSC. Health workers are a vital part of the health systems response, and over the last 18 months have faced significant strain and personal risk in carrying out their work. Protecting workers through PPE and vaccination is one part of this issue (considered in HSC's 'Workforce Surge and Protection Workstream'), however, stakeholders raised that timely and adequate human resourcing and renumeration was an overlooked area. Several L/MIC representatives also raised that renumeration for health workers was a key challenge they were facing, especially for community-based health workers (which often include large numbers of volunteers). This is exacerbated by the fact that L/MICs frequently have a smaller number of health workers relative to their population size.[111] There are therefore serious risks from health care workers leaving the profession, and from the need for surge capacity in the workforce to roll out tools. CSOs have called for an investment case to be conducted in this specific area that calls for investments to recruit, train and pay the health

[105] "ACT-Accelerator Prioritized Strategy & Budget for 2021", World Health Organization, 12 April 2021, pp. 22-23
[106] "ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021
[107] "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[108] This South Asia surge response included shipping more than 48 million gloves, 16.6. million surgical masks, 448,000 N95 respirators, 120 million gowns, 27,000 goggles, and 1.8 million face shields. Source: "Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021
[109] "Health Services Learning Hub: ACT-A Health Systems Connector", Accessed at: https://hlh.who.int/act-a-hsc-connector on 15 September 2021
[110] "Transforming the medical PPE ecosystem", ACT-Accelerator Rethinking PPE initiative, July 2021
[111] "Global Health Workforce statistics database", World Health Organization, Dataset. Accessed at: https://www.who.int/data/gho/data/themes/topics/health-workforce on 30 September 2021.

personnel that diagnose, trace, and treat COVID-19. Investing into the workforce also serves the role of supporting essential health services that have suffered indirectly due to reallocation of resources or suspension of services during COVID-19.

HSC has also not driven an integrated approach to country readiness across pillars. In HSC's January 2021 workplans, HSC laid out intention to connect all pillars by managing a coordinated approach to health systems strengthening via readiness assessments, integrated country plans, and technical assistance and guidance.[112] However, in practice, HSC did not drive country readiness, and rather each of the Pillars set up their own country readiness streams to support delivery and uptake of their respective tools.[113] The World Bank, in conjunction with its role in the HSC, did support the Vaccines Pillar in its November 2020 country readiness assessments of over 140 countries.[114] However, internal stakeholders caveated that this only occurred after it was realized two parallel processes had been started, and a joint effort was taken only later as a course correction. Currently, there is some engagement of HSC members with COVAX's Country Readiness and Delivery Workstream (particularly WHO, e.g., on modelling of health work force and costs of such required for various levels of vax coverage and the CVIC costing tool), but it is not always clear what of this falls under HSC itself. Additionally, internal stakeholders from the Diagnostics Pillar expressed HSC had not been fast enough to mobilise support for diagnostics-specific country surveys, which due to the early availability of tests were needed rapidly. Siloed efforts across Pillars to survey countries and identify key bottlenecks mean that HSC has not delivered synergy in this space, as was aimed for in its mandate.

Cross-cutting and forward-looking observations

Although there have been debates on the scope and planned duration of ACT-A, there was consensus that ACT-A's work needs to continue

External stakeholders expressed that it was unclear whether ACT-A intended to be part or all of the pandemic response. ACT-A, as highlighted in its name, has a clear focus on COVID-19 tools. However, through its end-to-end approach and varied interpretations of HSC, it was unclear to some whether it was responsible just for the production and roll-out of medical countermeasures, or was taking a wider lens over the whole COVID-19 response across health systems and communities. Stakeholders often captured this as the "tools" versus "solutions" debate, and whether ACT-A was "a part" or "the whole" of the pandemic response. This uncertainty around ACT-A's scope made it hard for some stakeholders to tell where its responsibility began and ended. Both internal and external stakeholders noted that this led to ACT-A being held to different standards and expectations in different fora. In addition, stakeholders noted it posed a risk of creating a "false sense of security" in the international response by presenting as a comprehensive solution. Furthermore, uncertainty on the boundaries of ACT-A's scope was compounded by differences in geographical reach across Pillars, where only COVAX took a global lens. Although COVAX's global approach stemmed from an important strategy choice to be a global-level procurer, there was some confusion over how this related to other aspects of ACT-A. This external uncertainty was compounded, for example, by the initial inclusion of COVAX self-financing participants in ACT-A's budgets and subsequent removal. Overall, the Review found that more needed to be done in clearly communicating ACT-A's purpose

[112] "ACT Accelerator Health System Connector Vision: A Roadmap," January 2021, *Internal document*
[113] The Diagnostics Pillar has a "Country Preparedness" workstream run with Africa CDC and PAHO , the Therapeutics Pillar has a "dedicated push for country preparedness" led by Unitaid and WHO , and COVAX has the "Country readiness and delivery workstream" Sources: Internal Workplans of Therapeutics, Vaccines and Diagnostics Pillars, *Internal documents*; Therapeutics Presentation to the Facilitation Council, Therapeutics Pillar, March 2021; "COVAX: The Vaccines Pillar Of The Access To Covid-19 Tools (Act) Accelerator Structure And Principles", COVAX, 9 November 2020
[114] Readiness assessments were conducted in 140+ countries jointly with Gavi, Global Fund, UNICEF, WHO, World Bank and the Global Financing Facility (GFF) Source: "ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021

and ambitions in relation to its place within the full global COVID-19 response and its linkages to nationally owned priorities (see *Dimension 4: Broader Ecosystem* for more).

This was furthered by conflicting expectations on ACT-A's duration, and activities with different time horizons within ACT-A. From the outset, ACT-A was expressly described as a "time-limited global collaboration".[115] The extent of this collaboration will necessarily depend on the evolution of the pandemic and the need for coordinated action within each Pillar. However, interviews revealed conflicting expectations on this ideal duration. These ranged from those who believed it should soon transition towards ending, and those who believed ACT-A should be formalized into a permanent partnership structure with a view to future pandemic preparedness. Clear time horizons matter as they define the type of objectives and activities that should be included and excluded, as well as planning for a transition period. Further, in addition to addressing tool-specific needs within each Pillar, ACT-A currently houses activities with explicitly longer-term focuses, such as some long-term health systems strengthening elements and goals of setting up new regionalized manufacturing hubs in the longer term. Although these are important topics, internal stakeholders questioned whether they belong within ACT-A's mandate of "ending the acute phase of the pandemic". Similarly, the majority agreed that although there was a need in the global health space for longer-term pandemic preparedness structures, that this should be a new entity and is not within the scope of ACT-A.

Despite these uncertainties, there was clear consensus that as the only global initiative for a coordinated approach to these tools, ACT-A will still be needed for at least another year. Although the progress presented in the sections above note each Pillar has a significant way to go to reach their targets, there was agreement that ACT-A had added value against the counterfactual where actors had not come together to collaborate. With COVAX, there was a 39-day lag between the start of vaccinations in L/MICs and HICs[116]—a difference which historically has been years for delivery of tools against, for example, meningitis, HIV, or tuberculosis.[117] ACT-A has also served to cast a light on equity issues. For example, the COVAX Vaccine Manufacturing Task Force, with support from the Facilitation Council's Vaccine Manufacturing Working Group, has been an important forum to push for L/MIC ownership of pharmaceutical development and manufacturing. It has already seen progress in the cases of Aspen producing Johnson & Johnson vaccines and the launch of a manufacturing training hub, both in South Africa.[118,119] Furthermore, ACT-A is the only global initiative offering diagnostics, therapeutics, and vaccines—a combined approach that will need to continue. Although vaccination rates are increasing around the world, emerging concerns around achievability of herd immunity thresholds, uneven vaccine roll-out, and new variants mean surges are predicted to continue and vaccines alone will not be enough to end the pandemic. Many internal and external stakeholders expressed concern that vaccines had dominated the COVID-19 narrative, and that the vital continuation of other COVID-19 tools would be at risk. The fundraising differences between pillars show that at donors have favoured the Vaccines Pillar whilst other pillars remain severely underfunded (see *Dimension 3: Resourcing*). As the only multilateral partnership offering support on all three medical countermeasures, ACT-A holds a unique role to advocate for a comprehensive approach.

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[115] "What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?", World Health Organization, 6 April 2021

[116] There was a 39-day gap between vaccination in UK and first COVAX vaccine injected in India. It was 80 days to the first injection in Africa. The difference between India and Africa is primarily due to delays in EUL approvals. "Report to the Board 23-24 June 2021: COVAX Update", Gavi, June 2021. There was an 80-day gap between the first COVAX shipments to Ghana and Côte d'Ivoire and the first vaccine roll-out in HICs.

[117] "Whose pandemic is it anyway?", Peter Sands, 07 July 2021. Accessed at: https://www.theglobalfund.org/en/blog/2021-07-07-whose-pandemic-is-it-anyway/

[118] "Aspen confirms release of COVID-19 vaccines to Johnson & Johnson for supply to South Africa", Shauneen Beukes, Aspen Holdings, 26 July 2021. Accessed at: https://www.aspenpharma.com/2021/07/26/aspen-confirms-release-of-covid-19-vaccines-to-johnson-johnson-for-supply-to-south-africa/ on 27 September 2021.

[119] It is worth noting that technology transfer for the production for COVID-19 vaccines has also been extensive outside of the ACT-A construct. The following resource from the Global Health Centre of the Graduate Institute Geneva keeps track of existing manufacturing agreements: https://www.knowledgeportalia.org/covid19-vaccine-manufacturing

Countries are central to the COVID-19 response as downstream efforts ramp up

Now that effective tools exist, an emphasis is needed on downstream support to urgently close the equity gap in tool distribution. At the same time, there remains a clear and urgent need for ongoing R&D. Global inequities are stark. While several HICs are expanding vaccinations to under-18s and other low risk groups, many L/MICs continue without vulnerable citizens and key health workers being vaccinated.[120] Testing rates between HICs and L/MICs are estimated at one test in L/MICs for every 70 done in high-income countries,[121] and L/MICs have seen preventable deaths as a result of lack of vital therapeutics such as oxygen.[122] Now that effective tools are available, there is a need to increase efforts on expanding access and uptake globally. Expanding coverage is not only a matter of equity, it is the only way to end the acute phase of the pandemic as slowing the rates of transmission globally will be necessary to curtail the progression of new outbreaks and variants. At the same time, precisely because of the emergence of variants, combined with other potential risks (e.g., vaccine efficacy waning), and a lack of effective broad-based treatments, the need for continued R&D efforts remains high and urgent.

Product supply is projected to rapidly increase and health systems will need support in rolling out tools. Tools that were previously scarce commodities are now increasingly available. Vaccine production is expected to increase over the next two quarters, with estimates suggesting global production could total as much as 11 billion in 2021.[123] Similarly, global supply of COVID-19 tests and testing capacity has increased, for example India has gone from testing around 300,000 people a day in June 2020 to 1.7 million a day in September 2021.[124] Taking lessons from the experience of rapidly rolling out COVID-19 tools in industrialized economies, there were significant challenges faced in terms of delivery logistics, staffing, equipment, reaching vulnerable populations, countering misinformation, and creating lists of priority patients.[125] L/MICs are likely to experience similar challenges with the projected ramp-up in supply in the fourth quarter of 2021. So far, COVAX have managed to minimize vaccines expiring before use to just 0.2% of shipped doses (estimated to be significantly lower than wastage in HICs),[126] however they acknowledge continued risk as supply ramps up.[127] The results of 140 country readiness assessments conducted in November 2020 and released in a World Bank report March 2021 highlighted key areas of concern around training vaccinators, generating public demand and trust, and management of donated doses.[128] From September onwards, the COVAX forecasts project approximately 400 million more doses will become available every month[129,130]—requiring a substantive acceleration in absorption above what many countries have previously experienced. The vaccine space is supported by ongoing collaborative efforts such as the Global Market Assessment and the Implementation Monitoring

[120] "Director-General's opening remarks at the World Health Assembly", World Health Organization, 24 May 2021
[121] "FIND SARS-COV-2 test tracker." Accessed at: www.finddx.otg/covid-19/test-tracker on 10 September 2021
[122]"COVID-19 oxygen emergency impacting more than half a million people in low- and middle-income countries every day, as demand surges", World Health Organization, 25 February 2021. Accessed at: https://www.who.int/news/item/25-02-2021-covid-19-oxygen-emergency-impacting-more-than-half-a-million-people-in-low--and-middle-income-countries-every-day-as-demand-surges on 15 September 2021.
[123] "COVID-19 Vaccine Briefing: Science based forecasts for the short- and long-term", Airfinity prepared on behalf of the World Trade Organization, 29 June 2021. Accessed at: https://www.wto.org/english/tratop_e/trips_e/techsymp_290621/hansen_presentation.pdf on 27 September 2021.
[124] Daily COVID-19 Tests 7 day rolling average, Our World in Data. Accessed at: https://ourworldindata.org/grapher/daily-covid-19-tests-smoothed-7-day on 15 September 2021
[125] Roll out of COVID-19 vaccines in the EU/EEA: challenges and good practice", European Centre for Disease Prevention and Control, 29 March 2021. Accessed on: https://www.ecdc.europa.eu/en/publications-data/rollout-covid-19-vaccines-eueea-challenges-and-good-practice on 15 September 2021
[126]"Lower-income countries are letting far fewer COVID-19 vaccine doses expire than wealthier nations", COVAX, 21 September 2021. Accessed at: https://www.gavi.org/vaccineswork/lower-income-countries-are-letting-far-fewer-covid-19-vaccine-doses-expire on 27th September 2021.
[127] "Risk and assurance report 2021, Annex C: Covax Report", Gavi, 2021 Annex
[128] "Assessing country readiness for COVID-19 vaccines: First insights from the assessment rollout", World Bank, March 2021
[129] "What does COVAX latest supply forecast tell us?", Aurelia Nguyen, COVAX, 23 June 2021 Accessed at: https://www.gavi.org/vaccineswork/what-does-covaxs-latest-supply-forecast-tell-us on 15 September 2021
[130] "COVAX Global Supply Forecast", CEPI, Gavi, UNICEF and World Health Organization, 8 September 2021

Review, both of which are assessing supply and demand challenges to identify and mitigate risks. Such efforts will be critical to ensure the forecasted influx of doses are effectively used.

"ACT-A has to decide if it is a global project to be delivered in countries, or global coalition to empower countries to deliver for themselves." ~ *Co-convening agency member*

Countries steer their own responses, and ACT-A can better support this through clearer ways of working, comprehensive communications to countries, and a demand-driven approach. As countries have diverse needs and constraints, a top-down approach might not successfully support rapid and scaled-up deployment. Governments should be at the centre of decision-making and response planning, tailoring to their country's demand and integrating initiatives into their existing health systems. A large number of stakeholders raised that ACT-A needed to take a more country-centred approach, whereby tools and polices are not handed down to countries, but rather ACT-A serves existing country response structures. One of the primary planning tools used by countries is the national SPRP, a process supported by WHE and other partners. There are several instances where ACT-A activities directly support countries' SPRPs, including COVAX's NVDP—which sits under Pillar 10 of the SPRP,[131] and Global Fund's C19RM—which funds therapeutics, diagnostics and health systems strengthening activities in support of countries' SPRPs.[132] However, despite several ACT-A initiatives working closely with countries' national plans, the Review noted a lack of understanding between agencies on what country level work was being done by other partners, and also that not all ACT-A partners' country-level work was well integrated with national SPRPs – highlighting an opportunity for greater coordination. Furthermore, from the perspective of recipient countries, stakeholders lacked a clear overview of the full range of offerings and financings available from ACT-A. As countries regularly coordinate with many partners, several stakeholders suggested ACT-A create clearer forums for participation and priority setting, and clearer communications to countries. This could reduce countries' transaction costs, and support uptake of tools across their national plans. Finally, these disconnects between countries and the broader construct of ACT-A have limited ACT-A's ability to take a demand-based approach in its strategic planning (above the level of individual agencies or Pillars). Being too supply-driven in its planning was a common criticism of the ACT-A construct, raised across stakeholders in the Review and also in external assessments.[133]

Recommendations

1. **Continue ACT-A whilst there is still value in global coordination on COVID-19 tools along the entire value chain, likely throughout 2022**.

   ACT-A should continue its crucial role as the only global level partnership bringing a coordinated effort across medical countermeasures (diagnostics, therapeutics, and vaccines). The time-limited partnership should continue as long as there remains an acute need for coordinated support around driving equitable access (including R&D, introduction, and scale-up) of COVID-19 tools in L/MICs. (Given the likely upcoming supply increase for critical tools, it is possible that the acute need for global coordination of such support may decrease during 2022 – but note that this relies on modelling and projections that are beyond the remit of this review, and so this question will require assessment in the future.)

[131] "Pillar 10 COVID-19 Vaccine Deployment Readiness Map", World Health Organization, 2021. Accessed at: https://covid19partnersplatform.who.int/en/pillar10 on 27 September 2021.
[132] "COVID-19: Response Mechanism", The Global Fund, Webpage. Accessed at: https://www.theglobalfund.org/en/covid-19/response-mechanism/ on 27 September 2021.
[133] "Access to Vaccines, Therapeutics, and Diagnostics, Background paper 5", The Independent Panel for Pandemic Preparedness and Response, May 2021

Although there will be a need to consider structures for future pandemic preparedness which build on the lessons learnt from ACT-A, this lies beyond ACT-A's scope. Activities which will outlive ACT-A, or are focused on future pandemics, should be moved outside the ACT-A construct. To this end, stakeholders should identify channels through which lessons from ACT-A and from consultations with countries can be considered for future pandemic preparedness arrangements.

2. **In addition to maintaining the urgency and focus on R&D and regulatory efforts, ACT-A should increase its strategic emphasis on downstream work. This means supporting in-country product uptake and working to close the equity gap for currently available tools.**

   Product procurement and delivery are the most pressing priorities for countries today. In the face of new variants and the current lack of a broad-use treatment for COVID-19, continued R&D and efficient regulatory processes across all pillars will be critical to staying 'ahead' of the epidemic. This will include planning for different scenarios and working to minimize inequalities in future tools. However, given that a) effective tools are available, b) supply is forecasted to increase in the coming months and c) major inequities persist in use of those tools between higher- and lower-income countries, in the current phase a relative priority within ACT-A's strategy and budget should be on ensuring equitable allocation and uptake. This should include both the Procurement (contracting, allocation and prioritization, timely shipment) and Delivery (readiness assessment, demand generation, health systems support) components of the value chain.

   Strengthening uptake capacity now will also support future outcomes. Building country capacity for uptake will also ensure future tools that are developed (if and as relevant) can also be adopted quickly. In addition, effective uptake of tools now will reduce transmission and case numbers, and in turn reduce the pressure for research and development stemming from the threat of new variants.

3. **ACT-A should seek to build countries' awareness of the full range of products, support, and financing options available from ACT-A partners to boost overall country engagement and ensure ongoing connectedness with national response plans.**

   ACT-A should support countries to understand the full scope of support available from C19RM, COVAX, SFF and HAC, WB, WHO and other agencies and mechanisms that are part of ACT-A. This can be in the form of clear and regular communications sent jointly on behalf of the ACT-A partnership to leaders of all eligible recipient countries. This is with the aim of i) reducing transaction costs for countries who are coordinating multiple partnerships, ii) highlighting to countries that offerings between different partners are coordinated and complementary and iii) enabling timely and tailored connections with partners as needed, in line with country priorities. Within this, ACT-A should encourage alignment of financing with national priorities and domestic resources from the start, with ACT-A partners and mechanisms coordinating and harmonizing funding mechanisms and working through government systems where possible.

   Clearer communication on offerings available could drive higher product uptake across all pillars and support more comprehensive COVID-19 strategies that include testing, surveillance, and treatment. Additionally, the process of creating coordinated communications to countries could encourage greater synergies between pillars on areas such as technical assistance, data management, and country readiness.

   As a cross-cutting exercise, collating these offerings to communicate to countries could be a role for the Health Systems Connector.

4. **Focus the HSC mandate to be more clearly on response and supporting gaps in country readiness and tool uptake not currently covered by the Pillars.**

   As ACT-A's primary goal is to end the acute phase of the pandemic through access to key tools, HSC's efforts should be concentrated on strengthening those elements of the health system which directly support the roll-out of those tools as quickly, safely, and sustainably as possible in support of national SPRP priorities. This includes ensuring that essential health services are not disrupted, availability of PPE is increased, appropriate waste management for all tools is available, there is appropriate recruitment of and support to human resourcing for health—and parallel systems are not created throughout. Overall, investments should primarily focus on supporting the rapid uptake of ACT-A-supported tools, while maintaining sight of long-term sustainability and integration with routine services. In line with ACT-A's overarching objective, activities which do not directly link to a country's COVID-19 response should be housed outside of ACT-A.

5. **Further link ACT-A to national COVID-19 responses by working with WHE IMSTs at all levels to better connect dynamic country needs with pillar-level strategic planning across the value chain, enabling ACT-A to take a more proactive, country-centred, and demand-driven approach.**

   There are opportunities to strengthen country support by creating stronger feedback loops between ACT-A and countries. WHE, C19RM, and COVAX already work together to ensure the support from each channel is aligned with countries' SPRPs. However, there is an opportunity to better support countries by more closely linking with the work of WHE through IMSTs (at regional and country levels) across pillars. For example, information on Situations of Concern could be used to better inform procurement and distribution plans, priorities in upstream work, reprogramming of existing resources, and the types of technical assistance agencies offer. More generally, closer integration of ACT-A and WHE could provide a stronger feedback loop between countries' national plans and ACT-A support. While countries continuously adapt their national strategies to the latest available tools, supply conditions, and policy changes, ACT-A could be more closely involved in informing these choices and in turn using the information as input to its own procurement and distribution efforts. This will help countries keep their plans up to date, and will also help ACT-A gauge demand for tools.

IV. DIMENSION 2: OPERATING MODEL

Introduction

The ACT-A operating model was intentionally defined as an informal coordinating mechanism, avoiding the establishment of new legal entities. It serves to facilitate, but not formally institutionalise linkages between different parts of the global health ecosystem active in the response to the COVID-19 pandemic, and the development of medical countermeasures specifically. Ten agencies are designated as 'partners', the EC and WHO are 'co-hosts', and participants from other stakeholder types serve as 'representatives' of their respective constituencies. ACT-A is not a new legal entity, but rather a platform for coordination and alignment, which the different types of members participate and collaborate in. Their participation in ACT-A is time-bound, with the time frame based on achievement of ACT-A objectives.

ACT-A partners set out an overarching 'action framework' comprising Pillars, cross-cutting workstreams, and overarching coordination and leadership fora, but stopped short of establishing a new overall governance structure[134]. Instead, the actors delivering on different aspects of ACT-A activities act on authority of their own operating constructs, relying on existing governing bodies to exercise this authority. Similarly, the actors delivering on ACT-A activities are not subject to any formal accountability mechanisms within the ACT-A construct, although some informal accountability dynamics exist.

Some core aspects of this operating model, built in by design, pose trade-offs between speed and responsiveness versus ease of accountability and broad inclusion of stakeholders in governance. During its design, agility and flexibility were considered priorities for ACT-A's operating model. As a result, establishing a single ACT-A legal entity and associated centralised governance structures was widely considered unrealistic given the context of urgent need, and too restrictive given the likely level of responsiveness needed in the context of pandemic response.[135] ACT-A was also expected to be a time-bound construct, further supporting the rationale for using existing governance mechanisms rather than creating new ones. The operating model is therefore one of decentralised governance, at the expense of a consolidated accountability mechanism. Given that the need for agility and responsiveness still hold, along with the time-bound nature of ACT-A, this review does not propose a change to that fundamental structure. However, other aspects are potentially adaptable, creating some opportunities to rebalance that trade-off.

The following section expands on the working of the overall operating model, benefits and challenges arising from it to date, and opportunities to improve on this key component of how ACT-A delivers its mission. It will do so across three main areas: membership, structure and roles; governance; and ways of working.

Findings and analysis

Membership, structure, and roles

ACT-A was formed when an initial group of global health actors committed to joining an "unprecedented partnership" to respond to the escalating risk of COVID-19 in early 2020.[136] The

[134] Some new governance structures were created for parts of ACT-A e.g., COVAX AMC Engagement Group, Shareholder Group. See Governance section for more detail.
[135] Stakeholder interviews, August – September 2021
[136] "Commitment and call to action: Global collaboration to accelerate new Covid 19 health technologies", World Health Organization, 24 April 2021. Accessed at: https://www.who.int/news/item/24-04-2020-commitment-and-call-to-action-global-collaboration-to-accelerate-new-covid-19-health-technologies on 31 August 2021

group came together based on a shared belief that "as long as anyone is at risk from this virus, the entire world is at risk", and the need at the time to expedite the development and equitable deployment of medical countermeasures.[137] Achieving this mission would require a range of competencies, and the actors who came together did so on the belief that they would be more effective and faster bringing their different types of expertise together in collaboration. The composition of this group arose organically, without specifically targeted inclusion of different capabilities.

ACT-A internal documents illustrate a series of adjustments to its internal structure over time, although the three pillars and most of their co-convening roles have remained constant since being launched. Reflecting the dynamic context in which the partnership was established, the roles and configuration of different stakeholder types and specific actors were not set from the outset. While the processes driving these adjustments are not always clear, the major stakeholder groups have taken different paths through their ACT-A participation. A synopsis of some key transitions as reflected in documents compiled and published on behalf of ACT-A follows.[138]

Table 2 :Timeline of key internal transitions and milestones

Stakeholder type	Key transitions and adjustments
Donor countries / regional groupings	• **March 2020:** In a statement on COVID-19 from the Extraordinary G20 Leaders' Summit, the G20 leaders commit to supporting and voluntarily financing immediate resources to combat the pandemic. This precedes the launch of ACT-A the next month, by highlighting the need to "coordinate the international fight against the pandemic, including … diagnostic tools, treatments, medicines and vaccines" with reference to the full value chain from R&D to delivery, as well as strengthening of health systems[139] • **April-June 2020:** June 2020 Investment Cases document explains that a number of donor countries formed a 'Facilitation Group' when ACT-A was launched, which is to transition into a *Facilitation Council* comprising government and regional representatives from the global North and South, international organizations, private philanthropy, and civil society, but membership is not yet determined at this stage.[140] The European Commission serves as co-host of the Facilitation Council • **September 2020:** Facilitation Council is convened, replacing the donor-driven Facilitation Group. Norway co-chairs
Global health agencies	• **April 2020:** BMGF, CEPI, Gavi, Global Fund, UNITAID, Wellcome Trust, and WHO partake in public 'Commitment and Call to Action',[141] later cited as the launch of ACT-A. Creation of COVAX and the COVAX facility

[137] "Commitment and call to action: Global collaboration to accelerate new Covid 19 health technologies", World Health Organization, 24 April 2021. Accessed at: https://www.who.int/news/item/24-04-2020-commitment-and-call-to-action-global-collaboration-to-accelerate-new-covid-19-health-technologies on 31 August 2021

[138] This section draws on a draft timeline compiled by Brian Hutler of the JHU Berman Institute of Bioethics for WHO ACT-A Ethics and Governance Working Group. This document has not yet been published.

[139] "Extraordinary G20 Leaders' Summit: Statement on COVID-19", http://www.g20.utoronto.ca/2020/2020-g20-statement-0326.html, March 2020

[140] "ACT-Accelerator Investment Case", World Health Organization, 26 June 2020

[141] "Commitment and call to action: Global collaboration to accelerate new Covid 19 health technologies", World Health Organization, 24 April 2021. Accessed at: https://www.who.int/news/item/24-04-2020-commitment-and-call-to-action-global-collaboration-to-accelerate-new-covid-19-health-technologies on 31 August 2021

	• **June 2020:** Pillar structure defined in ACT-A's first Investment Cases;[142] initial set of agencies all listed as co-convenors of their respective pillars, with the exception of BMGF, and the addition of FIND (Diagnostics Pillar) and the World Bank (Health System Connector) • **April 2021:** ACT-A publication "What is the ACT-A, how is it structured and how does it work?" is published. Principals Group publicly acknowledged for first time,[143] although stakeholder interviews indicate it had been active in some form for some time by this stage. UNICEF now included in Vaccines Pillar as a "key delivery partner"
WHO	• **April 2020:** Resolution 74/274 of the United Nations General Assembly calls for the WHO to "promote and ensure global access to medicines, vaccines and medical equipment needed to face COVID-19". WHO is party to the initial 'Commitment and Call to Action that launches ACT-A' • **May 2020:** World Health Assembly Resolution WHA 73.1(3) calls upon Director General Tedros to develop plans for "scaling up development, manufacturing and distribution capacities needed for transparent, equitable and timely access to quality, sage, affordable and efficacious diagnostics, therapeutics, medicines and vaccines for the COVID-19 response"[144] • **June 2020:** WHO is listed as a co-convener of Vaccines Pillar and Health Systems Connector, leader of the Access & Allocation Workstream and co-lead on several workstreams across Pillars. WHO is also co-host of ACT-A alongside the European Commission, and hosts a 'Hub' (later, 'Executive Hub') which plays a central coordinating role and eventually serves as a secretariat to the Facilitation Council
Industry associations	• **April 2020:** Three major industry associations, the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), the International Generic and Biosimilar Medicines Association (IGBA), and the Developing Countries Vaccine Manufacturers Network (DCVMN) are party to the initial 'Commitment and Call to Action' • **April 2021:** Industry Associations are listed as part of the wider Principals Group in the 'What is ACT-A' publication
Sponsors / Envoys	• **April 2020:** Dr Ngozi Okonjo-Iweala (WTO, Gavi Board Chair) and Sir Andrew Witty (former CEO of GSK) identified as WHO Special Envoys for ACT-A • **By June 2020:** The sponsors start chairing the Principals Group • **December 2020 -April 2021:** Dr Okonjo-Iweala and Sir Witty step down as special envoys, and are replaced by Mr Carl Bildt (former Prime Minister of Sweden)

[142] "ACT-Accelerator Investment Case", World Health Organization, 26 June 2020
[143] This group has been meeting in different configurations for some time before this, but this is the first formal recognition of it as an ACT-A structure
[144] "Commitment and call to action: Global collaboration to accelerate new Covid 19 health technologies", World Health Organization, 24 April 2021. Accessed at: https://www.who.int/news/item/24-04-2020-commitment-and-call-to-action-global-collaboration-to-accelerate-new-covid-19-health-technologies on 31 August 2021

Civil Society Organizations and Community Representatives	• **September 2020 - February 2021:** In a letter to the ACT-A agencies, civil society organisations and community representatives state that after around six months "to secure CSO-led selection processes and representation of civil society and communities across all the ACT-A pillars", this group has 35 representatives across 19 working groups informing ACT-A discussions[145] • **April 2021:** CSOs are listed as 'working with' all parts of the ACT-A construct in the 'What is ACT-A' publication
Non-donor countries / regional groupings	• **September 2020:** The Facilitation Council is convened, including members from non-donor countries and regional groupings. South Africa co-chairs • **July 2021:** AMC 92 members are represented in the COVAX AMC Engagement Group, and self-financing countries are represented in the Shareholders Council
Multilateral Development Banks, International Financial Institutions	• **June 2020:** The World Bank is listed as a pillar co-convenor, but not one of the ACT-A partners • **September 2020:** IMF, WB, WTO represented in FC • **August 2021:** Multilateral leaders task force formed *(not part of ACT-A)*

Overall, ACT-A comprises cross-cutting coordination fora and programmatic focus areas, supported by relevant sub-structures. The section below describes the structure and roles of these different parts of ACT-A, followed by commentary on how these impact ACT-A's ability to deliver on its mission.

Coordination fora

Three coordinating fora support interconnectedness and visibility across the Pillars and workstreams.

The Principals Group comprises the Principals (CEO or similar) of the co-convening agencies of the Pillars and HSC, as well as UNICEF and BMGF in their capacity as lead agencies.[146] Over time, this group grew to include a range of invitees including representatives from industry, CSOs and Community Representatives, international financial institutions, and country representatives from the Facilitation Council. In order to allow for focused discussions amongst the Principals of the lead agencies, in mid-2021 the group shifted to meeting in two formats in alternating weeks, first as only the core members above, and second as the wider group for broader discussions. The Principals Group has no formalized Terms of Reference that sets out the objectives of these different groupings. However, over time the Group has served as a forum to address cross-cutting strategy and delivery considerations. The larger group has also increasingly focused on sharing information on country-level challenges and lessons learned.

The Facilitation Council is the political leadership forum of ACT-A. It mainly comprises country members from across founding donors to 'market shapers', recipient countries, and non-governmental partners. Formally established in September 2020, this group built on the founding members from the G7 and G20 to include regional cooperation groups, market shapers, and other

[145] "Civil Society & Community Engagement in the Access to COVID-19 Tools-Accelerator (ACT-A)", Letter to Lead Agencies, The Civil Society and Community Representatives of the ACT-A,22 February 2021
[146] "What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?", World Health Organization, 6 April 2021

countries by invitation.[147] It also offers standing invitations to representatives from civil society, communities, and industry. As such, this is the dedicated forum for non-agency stakeholders in ACT-A.

In its Terms of Reference, the Facilitation Council's original mandate is set out as follows (emphasis added):[148]

> "*To **provide high-level political leadership** and enabling advice to facilitate the work of the "Access to COVID-19 Tools Accelerator" (ACT-A), its global collaborative framework, and its partnerships to ensure the realization of the ACT-A vision… The advice of the Council would include **advocacy for collective approaches to solutions in the global interest** and for the **mobilisation of additional resources as needed."**[149].*

It further states that, with respect to other parts of ACT-A, ***"Subsidiarity applies** – the Council acts in support of the partners in each Pillar, who are the central actors of the ACT-A framework and responsible for the delivery of their objectives."*[150]

This Terms of Reference is still in place to date.

The Facilitation Council has also established three working groups to focus on developing technical inputs and support the Pillars with political dimensions of their work. The Financial Working Group is responsible for defining ACT-A's financing framework (which articulates considerations around different funding sources), and developed the Fair Burden-Sharing Model which sets out an approach for determining how much different countries could contribute to ACT-A. The Resource Mobilisation Working Group supports the Facilitation Council co-chairs in their outreach to countries. The Vaccine Manufacturing Working Group provides political support to enhance supply of Vaccines through COVAX, for example around matters of supply chain, production, and dosage sharing. These working groups comprise representatives from a subset of member countries of the Council, with support from the Executive Hub and BMGF (for Resource Mobilisation Working Group).[151]

The Executive Hub is a small group hosted by WHO which "plays a central coordination function and aims to facilitate synergies across the partnership".[152] It serves as the secretariat for the Facilitation Council and coordinates the Principals Group, as well as hosting and coordinating other regular meetings for specific activities across ACT-A partners. The Hub also plays an important role in gathering, synthesising, and sharing cross-pillar information. For example, it develops several joint publications (including many referenced in this review) on behalf of the full ACT-A membership, and collates and publishes the status of funding pledges.[153] It is staffed by representatives from WHO, UN Foundation, and Unitaid, with support from external consultancies.

WHO Special Envoy(s) for ACT-A provide "guidance on key strategic issues, and facilitate high-level advocacy and political engagement, both directly and through the Facilitation Council".[154] They also

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[147] Country members of the Facilitation Council, by region and World Bank income level classification as at September 2021 include: Africa – South Africa (UM), Rwanda (L), Democratic Republic of the Congo (L); Americas – Brazil (UM), Canada (H), Mexico (UM), Saint Kitts & Nevis (H), USA (H); Eastern Mediterranean – Saudi Arabia (H), Bahrain (H); Europe – Belarus (UM), EC, France (H), Germany (H), Italy (H), Norway (H), Russia (UM), Spain (H), United Kingdom (H); Southeast Asia – India (LM), Indonesia (LM), Nepal (LM); Western Pacific – Brunei Darussalam (H), China (UM), Fiji (UM), Japan (H), Republic of Korea (H), Singapore (H).

[148] The Facilitation Council Terms of Reference were originally drafted by the WHO and EC, after which they were refined with the Facilitation Council itself.

[149] "ACT-A Facilitation Council Terms of Reference", Facilitation Council, 9 February 2021. Emphasis added

[150] "ACT-A Facilitation Council Terms of Reference", Facilitation Council, 9 February 2021. Emphasis added

[151] "ACT-A Facilitation Council Financial Working Group Terms of Reference", Facilitation Council, 26 May 2021; "ACT-Accelerator Facilitation Council Financing Campaign: Resource Mobilization Working Group", Facilitation Council, 14 March 2021.; "Context and Terms of Reference for the ACT-Accelerator Facilitation Council Vaccine Manufacturing Working Group", Facilitation Council, 3 June 2021.

[152] "What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?", World Health Organization, 6 April 2021

[153] "What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?", World Health Organization, 6 April 2021

[154] "What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?", World Health Organization, 6 April 2021

chair the Principals Group meetings. This role was initially served by Dr Ngozi Okonjo-Iweala and Sir Andrew Witty, and is currently held by Mr Carl Bildt.

Programmatic focus areas: Pillars and cross-cutting workstreams

The Pillars and their supporting workstreams are responsible for developing technical solutions, and for implementing ACT-A initiatives. They are convened under self-defined Terms of Reference that set out high-level mandates, compositions and working modalities of these groups, adopted on a consensus basis by their participating members.

The Pillars operate with significant autonomy, and as a result, have different operating structures and compositions, reflecting their specific commodity focus. Each Pillar has a Coordinating Committee comprising Leads from the co-convening agencies, WHO Principals, and workstream leads. The workstreams are typically led or co-led by representatives from convening agencies. The Pillars have similarities and differences in their number and focus of workstreams as illustrated in the table below.

Figure 2: Comparison of workstream coverage across Pillars[155]

	Research, development, market preparedness		Allocation mechanisms	Supply, procurement, and delivery		Data	Other
Dx	R&D / Digital	Market readiness	*Not applicable*	Supply	Country support[156]	Modelling consortium	Genomic Surveillance
Tx	Rapid evidence assessment	Market preparedness	Allocation *(within Procurement and deployment)*	Procurement & deployment[157]	Country preparedness	*With Strategy & Coordination*	Oxygen Taskforce
Vx[158]	Development & manufacturing [159]	*Not applicable*	Policy & allocation[160]	Procurement and delivery at scale (incl. COVAX facility & AMC)[161]	*Not applicable*	*Not applicable*	*Not applicable*

In addition to the three Pillars and their reporting sub-structures, the programmatic focus areas include the cross-cutting Health Systems Connector and the Access & Allocation workstream. See *Dimension 1: Strategy and Objectives* for more detail on these bodies.

The membership, structure, and roles played across the different parts have offered both benefits and challenges to the delivery of ACT-A's mission, in a variety of ways, set out below.

[155] Categorizations of workstreams based on Dalberg analysis
[156] Includes sub-group on Advocacy & Community Engagement
[157] This workstream has recently integrated an allocation working group, led by WHO
[158] COVAX, is led from the COVAX Coordination Meeting (CCM), and supported by these workstreams and their sub-structures, listed below. For details of membership, mandates and working modalities, see "COVAX: Structure and Principles", Gavi, 9 November 2020 (updated 17 March 2021. Accessed online: https://www.gavi.org/sites/default/files/covid/covax/COVAX_the-Vaccines-Pillar-of-the-Access-to-COVID-19-Tools-ACT-Accelerator.pdf on 24 September 2021.
[159] Includes Research & Development and Manufacturing Investment Committee, Technical Review Group, SWAT teams and Regulatory Advisory Group.
[160] Includes COVAX Facility, Office of the COVAX Facility, COVAX Shareholders Council, COVAX AMC Engagement Group, COVAX Consensus Group, Independent Product Group, Gavi Board, Market-Sensitive Decisions Committee, Audit and Finance Committee, Country Readiness and Delivery, Learning Monitoring and Evaluation
[161] Includes WHO Strategic Advisory Group of Experts (SAGE) on Immunisation, Allocation Mechanism (comprising the Joint Allocation Taskforce and the Independent Allocation Validation Group) and various Policy and Allocation Working Groups

Several stakeholders highlighted a lack of clarity and alignment on the role of the Facilitation Council, limiting its impact.[162] Despite the Council having a written mandate in its TOR focused on political advocacy, strategic guidance and support, this challenge was raised by many stakeholders from the Council itself as well as other parts of ACT-A. The lack of alignment around a clear role and objectives seems to stem, at least in part, from differing views of the Facilitation Council and specifically donors' role in ACT-A governance (see next sub-section on Governance for detail on this). This challenge has manifested in Facilitation Council meetings tending to focus on structured information sharing with little opportunity for interaction and alignment on common objectives. This has contributed to variable attendance of senior government figures, further reducing opportunities to achieve concrete outcomes.

"Even for the members, the FC currently has an unclear role, but we believe it can serve to put ACT-A into the wider context." ~ *Donor country representative*

ACT-A's structure and operating model do not define clear links or interactions between the Facilitation Council and Principals Group. While these two coordination fora often invite each other to join their respective working sessions, this process is ad hoc. The absence of regular, targeted interactions across these two important groups can inhibit information sharing across them, contributing to a perceived lack of accountability of the implementing agencies amongst Facilitation Council members (see next sub-section on Governance for further considerations on this point).

Overall, the Executive Hub and Principals Group's coordination efforts have provided meaningful benefits, although subject to some limitations. There was broad agreement amongst interviewees that the Executive Hub plays a valuable role in streamlining and simplifying complex interactions across many stakeholders. With its intentionally broad set of roles and responsibilities, it has been able to plug a variety of gaps over time. These span secretariat functions for large group sessions of the Facilitation Council and Principals Group, management of the ACT-A strategy and budget setting process, and collating and distributing information across ACT-A, amongst others. Nonetheless, it faces some constraints on its effectiveness in these roles, such as not always having access to timely and complete information on the various structures' activities, and limited resourcing for this team. Among the Principals Group, several stakeholders credited bringing together the heads of the co-convening agencies into a specific coordination forum with enabling less inter-agency competition and a new level of collaboration. However, some also suggested that agencies' considerations for their own long-term interests may at times be at odds with short-term needs or the interests of the wider ACT-A.

In addition, the absence of a central programmatic direction-setting and coordinating function poses risks of gaps and incoherence in ACT-A's activities across pillars. Decentralised structures need not inherently result in incoherent or conflicting activities. This risk is typically managed by specific actors taking responsibility for actively focusing on synthesis and integration, playing a 'challenger' role to test the relevance and cohesiveness of individual strategies and workplans at programmatic level. In doing so they can identify any overlaps, gaps, or tensions across separate parts. While the Principals Group can play this role across Pillars to some extent, this may be limited by individual agencies being inherently biased in favour of their own plans and approaches. The other coordinating fora (the Hub and Facilitation Council) are also constrained in their ability to play this role. This is because they are removed from the initial strategy development and planning (which happens at agency level), and at later stages in the process, they do not have formal authority to decide any changes.[163] Importantly, while this reflects the nature of a decentralised governance

[162] Stakeholder interviews, August – September 2021.
[163]Stakeholder interviews, August-September 2021

model rather than being a problem per se, some stakeholders have pointed to instances of costly incoherence across pillars which might have been mitigated by the presence of a clearer 'challenger' role. For instance, several stakeholders have suggested that some elements of ACT-A's initial strategies and budgets were unclear or not well substantiated, posing challenges to fundraising efforts.[164] Examples of this included estimations of global delivery costs which were seen to have not been sufficiently validated with receiving countries to account for operational realities on the ground, and gaps in accounting for the cost of increased manufacturing space.[165] Some donors also noted concerns that early budgets did not clearly disaggregate which elements would be grant funded versus which should be covered from loan financing.[166] If a decentralised structure is to be maintained, as recommended in this review, means for strengthening the ability of coordinating fora to play a 'challenger' role are advisable.

The commodity-focused vertical Pillar structure has enabled benefits of specialisation, although it requires siloing risks to be managed carefully. In the verticalized structure most individual agencies are assigned to a single Pillar. Agencies noted that the benefit of this is that it brings specialised focus and tailoring of approaches across different value chain steps, while other stakeholders highlighted that a drawback to this approach is that it can limit direct visibility across Pillars.[167] However, some stakeholders argued that this structure has resulted in missed synergies across steps of the value chain. For example, the strengths of partner agencies with particularly deep experience in certain value chain steps, like CEPI for R&D or Gavi for procurement, could possibly have been better harnessed in support of other Pillars under a different structure. Despite these challenges, it is important to consider that alternative structural options, such as organising horizontally across value chain steps (e.g., R&D, manufacturing etc.) or a matrix-style arrangement, may have resulted in different siloing risks, or unnecessary complexity. In addition, the multi-Pillar roles of some agencies can help mitigate against silos forming. For example, the Global Fund's C19RM mechanism, which helps coordinate cross-Pillar country-level delivery of resources and support illustrates that where agencies participate across Pillars, the risk of siloing can be reduced.

Despite these challenges, the autonomy of different parts of the structure allows for responsiveness needed in a rapidly evolving emergency context. New working groups specific to the Pillar's needs can be set up quickly when needed. For example, once vaccine candidates were approved for production, supporting vaccine manufacturing workstreams and working groups were rapidly established to focus on preventing or addressing production bottlenecks.

However, the decentralised approach to setting up sub-structures has also resulted in some unclear and potentially overlapping mandates of different groups. Some stakeholders pointed to a perceived "proliferation of sub-structures" across ACT-A, driving concerns that it is becoming increasingly difficult to understand where and how different parts of ACT-A's scope are being addressed. Interviewees cited examples of two distinct sub-structures focusing on vaccine manufacturing, and multiple country preparedness workstreams. Even if the rationale for having these different groups is sound, it can be difficult for stakeholders to understand and navigate these structures. Stakeholders also noted that as more sub-structures are formed, coordinating effectively across related groups becomes more complex and time-consuming. This could be exacerbated by several structures being added over time, while few appear to have been removed or scaled down.

While ACT-A includes a broad range of stakeholder types, it was widely noted that L/MICs', CSOs', and Community Representatives' (CRs') inputs are not always adequately represented or considered. This challenge was raised by a significant portion of interviewees as a key issue. With a few exceptions, most stakeholders suggested that this is typically not a challenge of ensuring that

[164] Stakeholder interviews, August-September 2021
[165] Stakeholder interviews, August-September 2021
[166] Stakeholder interviews, August-September 2021
[167] Stakeholder interviews, August-September 2021

representatives from L/MICs, CSOs, and Communities have *access* to ACT-A fora, but rather emphasized that they feel they are not always included in a way that is conducive to them speaking openly. Additionally, when they do make contributions, these are not always taken into full and meaningful consideration.[168] The drivers and potential consequences of this challenge vary for L/MICs versus CSOs and CRs.

Donor country voices and perspectives tend to dominate L/MICs' contributions, posing risks of developing solutions that are not truly responsive to recipient countries' needs. L/MICs gave examples of being included late in certain processes, making it difficult to contribute without the same prior exposure, or only being included once decisions or actions are taken.[169] Donor countries raised concerns about L/MICs being less vocal in group fora, while L/MIC representatives explained that it can be politically difficult to input, especially to raise criticisms, while in a position of receiving support.[170] This is exacerbated by L/MICs frequently having significantly fewer representatives present than HICs in many fora. For example, 15 out 24 (nearly two-thirds) current member countries of the Facilitation Council are categorized as HICs.[171] Furthermore, broader power disparities and bilateral relationship dynamics also come to bear, especially where actors rely on each other for other needs beyond ACT-A.[172] CSOs in particular also raised concerns that membership of the Facilitation Council is not determined through an open and democratic process, with membership to date evolving through selection or invitation of new members, although this may be somewhat mitigated by Facilitation Council meetings being open for public attendance.[173] These and other examples contribute to a sense amongst L/MICs of not always being considered equal owners of plans and decisions, and can ultimately work against the objective of equitable access.

> "Some HICs are not incorporating intellectual input from L/MICs or CSOs. Instead, they present their ready-made solution." ~ *CSO representative*

Stakeholders reported that CSOs' and CRs' contributions have been diminished at times, risking key context-specific considerations for the development and deployment of COVID-19 tools being missed. For instance, some stakeholders cited instances of being included in meetings with reduced access to interaction tools compared to other participants, such as not having access to chat functionality. At times, CSOs and CRs have been prevented from contributing on an equal footing by being included very late in certain processes, or receiving long and complex materials for consultation without adequate time to engage with these effectively[174]. Importantly, when CSOs and CRs perspectives have been considered, they have helped avert challenges, such as pre-empting key considerations around data privacy for digital testing strategies.[175] These actors provide a key link to the end recipients of ACT-A tools, including disproportionately vulnerable groups such as women and children, people living with disabilities or co-morbidities, refugees and displaced people, and members of the LGBTQI+ community. As such, including their insights and feedback as ACT-A's focus shifts more towards downstream delivery, where success is contingent on community-level responses, is essential and central to ACT-A's equity goals. ACT-A should address some of the challenges to adequate representation of L/MICs, CSOs and CRs through targeted adjustments to the composition of its fora, and its processes and working norms.

[168] Stakeholder interviews, August - September 2021
[169] Stakeholder interviews, August - September 2021
[170] Stakeholder interviews, August – September 2021
[171] See breakdown of member countries by income levels in 'Membership, structure and roles' section above
[172] Stakeholder interviews, August – September 2021
[173] Stakeholder interviews, August – September 2021
[174] Stakeholder interviews, August – September 2021
[175] Stakeholder interviews, August – September 2021

There is also not alignment on the appropriate degree and manner of inclusion of industry representatives, and mechanisms to manage risks of conflicts of interest. Industry plays a key role in delivering on ACT-A's mission as developers and producers of tools and supporting products to counter COVID-19. As for-profit actors who stand to benefit from decisions and approaches decided in ACT-A fora, but also key partners in resourcing and developing solutions (often taking on significant risks themselves), there has not always been consensus amongst stakeholders on how best to integrate these important actors in ACT-A fora. CSOs have argued that, in an emergency context, ACT-A should have focused on leveraging its collective influence to put pressure on industry to minimize profits, maximize production, and help expand production capacity by foregoing intellectual property protections on new tools and supporting technology transfers.[176] Others have been in favour of acting within conventional commercial constructs, and including industry representatives in ACT-A fora to ensure they are kept abreast of changing priorities for developing medical countermeasures. To this end, the different pillars have articulated principals for how they are managing conflict of interest.[177] These perspectives have also been reflected in differing views over whether confidential details of industry's involvement in the production and distribution of COVID-19 tools, such as production volumes and product flows to different countries, should be made public, as a source of information about equitable access to these tools. Overall, Pillars have had varying success in finding ways to manage conflicts of interest while harnessing the important contributions of the private sector. All participants should remain vigilant about this risk, and partner agencies should share best practices for mitigation amongst each other.

Governance

In a context of urgency, ACT-A's founders adopted a decentralised governance model relying on the existing governance bodies of ACT-A's partner agencies in the interest of speed and simplicity. Under this decentralised model, 'partner' agencies of ACT-A took on responsibility and accountability[178] for delivering on different parts of ACT-A's mission, under their existing legal identities. Specific agencies co-convene the Pillars, HSC, and the Access and Allocations workstream, making decisions on defining and implementing specific initiatives in consultation with other Pillar agencies. Donors contribute to individual ACT-A partner organisations directly, who are responsible for the deployment of these funds.[179] As such, ACT-A relies on the ACT-A agencies' legitimacy and reputations as the primary holders of legal and fiduciary responsibilities and accountability over ACT-A resourcing and activities.

ACT-A partners did not pursue a centralised governance model because of the complexity and time it would take to set this up, with overarching decisions taken outside of a formal governance structure. Unlike decision-making for the Pillars and HSC, overarching strategy, budget, and priority setting takes place outside of individual agencies' governing bodies. Such decisions are taken on the basis of consensus building across the agencies, co-ordinated by the Executive Hub, under the guidance of the Principals Group and the Facilitation Council. Stakeholders noted that setting up centralised governance would be politically and practically onerous, especially in terms of defining the extent and manner in which this would have authority over aspects of partner agencies' work. To come into effect, it would also have to be ratified by partner agencies' existing governance

[176] Stakeholder interviews, August – September 2021. Some CSOs also queried whether industry representatives' inclusion in certain fora may be at odds with procurement practices for the use of public funds, which preclude sellers from participating in decision-making by the buyer.
[177] These are available on request from Pillar leads.
[178] Throughout this section, these terms are taken to have the following meanings: those *responsible* are those who do the work to complete a given task, possibly delegating some aspects of this to others; those *accountable* are ultimately answerable for meeting all pre-requisites for completion of the task. Those accountable and responsible may not be the same person / entity, if the *accountable* entity delegates *responsibility* for executing the task to someone else (although they will remain accountable for delivery, including relevant fiduciary aspects).
[179] "How to contribute to the ACT-Accelerator", World Health Organization, July 2021. Accessed at: https://www.who.int/initiatives/act-accelerator/how-to-contribute on 24 September 2021.

structures. On the other hand, countries, CSOs and Community Representatives (CRs) highlighted that relying on informal governance processes for these overarching decisions at times poses limits to ensuring that a broad range of stakeholders can have input into (and visibility of) when and how these decisions are taken. This is in contrast to decisions taken through agency boards, where countries and CSOs often have a formal role.

Governance has been a key theme in ACT-A's establishment and subsequent development, and remains a major focus area across stakeholder types when considering the partnership's future. From the initial "Commitment and Call to Action" and through multiple subsequent ACT-A documents, commitments to key governance principles of transparency and accountability are frequently emphasized.[180] Stakeholders' perspectives on how feasible and desirable it is to make changes to ACT-A's current governance models vary widely, with differing views on if the chosen model is still fit for purpose for the current and future context, or if it should be modified (and if so, to what extent). This is further complicated by uncertainties underpinning assumptions about the evolving epidemiological landscape which will influence how long ACT-A will continue to operate, and remain in its current form. Acknowledging these uncertainties, this section focuses on identifying challenges and opportunities for enhancing ACT-A's governance in the next 12-18 months, and does not consider what would be required for a longer-term permanent structure.

The decision-making capabilities and authority of different coordinating bodies in ACT-A are detailed below, followed by commentary on how governance has been working to date in ACT-A.

Principals Group and Pillars

ACT-A's partner agencies are accountable for the execution of ACT-A-related activities, making decisions through their governing bodies and legal instruments. The governing bodies of these agencies are ultimately accountable for the actions of their agencies, and delegate responsibility for delivering upon decided objectives to their authorized officers, namely the agencies' chief executive officers (or equivalent), who in turn comprise the core Principals Group.

Some partner agencies have added or modified governance bodies and processes to support their ACT-A activities. For example, the Vaccines Pillar has established further governance bodies specific to COVAX (the Shareholders Council, AMC Engagement Group, AMC Investors Group and COVAX Consensus Group) ultimately feeding up into the Gavi Board and its committees. The Shareholders Council and AMC Engagement Group convene their respective constituencies with the aim of "providing strategic guidance and advice to the Office of the COVAX Facility" on operational aspects.[181] To support C19RM, the Global Fund tailored its review timelines, processes, approval bodies, and decision frameworks to facilitate alignment with relevant technical expertise, and country-level priorities. CEPI tailored its governance procedures to promote greater speed and agility. Stakeholders noted that COVAX's AMC Engagement Group and Shareholders Council in particular are examples of new governance structures that address some of the challenges arising from the overall model to leverage existing governance structures for decision-making, in that they specifically bring the effected countries into decision-making processes. However, it is important to note that COVAX's governance approach builds from its partners' extensive previous experience in coordinating emergency response for vaccines. Other parts of ACT-A's structure do not have the same experience, or networks and practices to readily deploy. Some of these approaches may be applicable for other Pillars to consider in the future.

[180] Brian Hutler of the JHU Berman Institute of Bioethics comments on this in an as-yet unpublished paper written for the WHO ACT-A Ethics and Governance Working Group.
[181] "COVAX Facility Governance", Gavi, no date. Accessed online: https://www.gavi.org/vaccineswork/covax-facility-governance-explained on 24 September 2021

Agencies are responsible for adhering to their governing bodies' transparency and reporting requirements[182], but there are no further formalized transparency or reporting requirements within ACT-A. For instance, there are not formal transparency requirements for decisions taken at the overarching level by consensus across agencies, rather than by a specific agency. ACT-A currently does not produce standardized, regular aggregated pillar-level reporting of key decisions or operational and financial performance indicators. The Executive Hub compiles and publishes quarterly reports that address some of these aspects, but this does not include standard sections or indicators that can be easily tracked over time, aside from the overall funding pledged to date.[183]

Receiving agencies have fiduciary responsibility for the deployment of donor funds, in line with their agency policies.[184] While co-convenors are jointly responsible for developing the workplans, budgets, and investment cases of their respective pillars, donors allocate their pledges to specific agencies. Grant management and financial reporting to donors are then managed by the receiving agency. No other entities within ACT-A have formal roles in financial and operational management.

Facilitation Council

The Facilitation Council has no formal decision-making authority as a collective body, and is not formally accountable or responsible for the delivery of ACT-A's objectives. In the absence of an underpinning treaty, the sovereign states who are members of the Facilitation cannot be bound by decisions made by the Facilitation Council or its Working Groups.[185] Public actors nonetheless remain accountable to their domestic constituencies for actions taken through their participation in the Facilitation Council. Without formal authority, the Facilitation Council is dependent on 'soft' political power to influence countries' responses to COVID-19 and encourage practical and financial support for ACT-A activities. The ACT-A construct also does not, and cannot empower the Facilitation Council to make binding decisions over Pillar activities. Instead, the Council can issue guidance and advice (typically developed at the level of its working groups) to the Pillars and Principals Group. No formal ratification or endorsement process is required to approve country communications or guidelines issued by the Facilitation Council, beyond informal support and consensus from the group's members.

Similar to the Principals Group and Pillars, the Facilitation Council has no formal accountability or reporting requirements to other parts of ACT-A for actions it takes and positions it adopts.

Overall, despite some challenges, decentralised decision-making over ACT-A initiatives through the implementing agencies' governing structures is an appropriate solution for the multilateral partnership. The adoption of decentralised governance avoids the need for multiple layers (at agency level, and collectively) of decision-making. Having agencies take decisions directly also avoids the lags that can accumulate over multiple steps, and increases the likelihood of meeting the thresholds to confirm a decision more rapidly. This was an appropriate choice of governance system, given the urgent nature of the response. Nonetheless, the decentralised model is not without drawbacks. Because collective consensus is not formally required, stakeholders may not 'buy in' to decisions taken by individual agencies, although this can be significantly mitigated by agencies gathering input and consulting on key decisions with other stakeholders (other agencies, and members of the Facilitation Council). Relying on existing governance structures means that some impacted parties may not have direct input into decision-making that impacts them (although they can be consulted). In addition, the effectiveness of decentralised governance depends on how well agencies' internal

[182] For example, online publication of Board meeting minutes, making decision registers available
[183] See ACT-A Quarterly Progress Reports for reference.
[184] "ACT-Accelerator Investment Case", World Health Organization, 26 June 2020
[185] In addition, the level of seniority of different member states' is typically varied; this disparity could pose a challenge to multilateral decision-making.

governance processes, such as grant proposals and approvals, can adjust to accommodate the requirements of a context of emergency response. While assessing each agency's governance process is beyond the scope of this review, some stakeholders did flag limitations on this aspect as a potential concern.[186] On balance however, compared to the complexity and resourcing requirements of setting up a more centralised governance model, the flexibility and pragmatism of the decentralised approach remains fit-for-purpose for ACT-A's time-bound mandate.

Furthermore, ACT-A's governance model enables decision-making to be based on specialist expertise, and relatively (but not entirely) shielded from potentially contradictory political interests. For a coordinated approach to succeed, it must be able to demonstrate sufficient credibility for stakeholders to buy into it, and must not unduly favour individual participants' interests over those of the collective. Despite not being purposely designed for this context, the existing structure of the co-convening agencies' governing bodies are compatible with these requirements. Based on their overall mandates, the agencies have assembled Boards that are well-versed in specialist subject matter, be it on specific commodities (diagnostics, therapeutics, vaccines) or functions (for example, manufacturing or procurement). These Boards also include a range of stakeholder types and perspectives, as specialist expertise is not inherently neutral to different interests, requiring a variety of inputs to be considered in support of fair and equitable outcomes. Additionally, while various regions, countries and communities are represented on these boards, single actors generally do not have outsized influence and are unlikely to be able to sway overall decision-making in their favour at the expense of overarching goals.[187]

Some Facilitation Council members perceive a tension in their mandate stemming from the decentralised governance model, in that they are asked to fundraise and advocate for ACT-A, without having direct oversight over Pillar activities. Two key challenges were emphasized by stakeholders. Firstly, donor countries in particular noted that ACT-A's lack of direct channels for them to steer the use of donated funds is challenging, as they are accountable for the use of public funds.[188] Secondly, Facilitation Council members cited limitations on their visibility of fund deployment and outcomes achieved.[189] Together, these factors can constrain government (financial and political) support (from donors and recipients) which can in turn limit ACT-A's overall ability to succeed in its mission.

In terms of lacking direct decision-making authority in ACT-A fora, stakeholders' membership in agencies' governing boards mitigates against this, as a pragmatic alternative suited to the context. Implementing agencies' governing bodies have generally been used 'as-is' as the entities accountable and responsible for delivering ACT-A's mission, without specific provision for including other ACT-A stakeholders.[190] Nonetheless, given the significant and long-standing role of these agencies in global public health, there is already significant overlap across implementing agencies' Boards and the Facilitation Council. For example, five of the six countries on Unitaid's Board are also Facilitation Council members, alongside other rotating representatives from other stakeholder types like CSOs.[191] This pattern is similar across most of the implementing agencies' governing bodies, although not all provide a formal role for CSOs specifically, with a need for consultation processes through ACT-A bodies where this is the case. These Board members have direct influence over agencies' decision-making and accountability mechanisms, albeit not through a specific ACT-A channel. Furthermore, the Facilitation Council can provide a platform for stakeholders who are not members

[186] Stakeholder interviews, August – September 2021
[187] Desk review of governing bodies structures and decision-making mechanisms
[188] Stakeholder interviews, August – September 2021
[189] The Executive Hub compiles and publishes quarterly reports which address some of these aspects, but this does not include standard sections or indicators that can be tracked over time, aside from the overall funding pledged to date. SPRP reporting provides another source of aggregate level information, it does not separate out ACT-A components, and as such does not fully address the challenge ACT-A donors cite of not having clear visibility of the impact of their donations.
[190] An exception to this is the establishment of specific governance structures for COVAX, beyond the Gavi board.
[191] Brazil, China, France, Norway, and the UK are all members of Unitaid's board, and the Facilitation Council. The Board also includes representatives from African Countries, Communities, Foundations, NGOs, and the WHO.

of agency boards to share information on their needs and challenges with those who are, to take up in these fora. Thus, while ACT-A's decentralised governance model does not offer complete, direct representation of all ACT-A stakeholders in all decision-making bodies, in a time-bound emergency response context, this trade-off is not inappropriate and can nonetheless facilitate broad-based accountability of implementing agencies.

Practical steps can be taken to give the Facilitation Council enhanced visibility of operational and financial information to support and enable them in confidently advocating and fundraising for ACT-A. Several countries explained that to be able to advocate for ACT-A they require easy access to clear, simple reporting to illustrate ACT-A's ability to deploy funds effectively to advance its mission. They indicated that this need goes beyond the level of reporting on agency- and Pillar-level funding pledges and progress against their objectives that is currently available.[192] Providing more frequent, standardised, and integrated reporting would go beyond the regular level of reporting which agencies are already committed to in line with their own policies, and the additional reporting already being done through the Executive Hub. However, this additional effort could in turn serve as an enabler to securing continued political and financial support at the scale needed to support ACT-A's fulfilment of its mission.

> "Countries have put their energy and support into ACT-A; now we need data about what impact there is in countries to be able to advocate for more funding." ~ *Facilitation Council member*

Outside of the main members of the coordination fora, several stakeholder types expressed a lack of clarity over governance mechanisms, and where to access information on decision-making. Specifically, participants explained that it was not always clear which parties had taken certain decisions, on what basis, and under what authority. This demonstrated how ACT-A's model and limited communications makes it difficult for representatives to determine who to engage with inputs or feedback, and limits their ability to engage on future decision making.[193] Importantly, this feedback does not necessarily point to any fundamental accountability or transparency gaps in the ACT-A operating model, as set out above. Nonetheless, this feedback does indicate that not all stakeholders have clear visibility of these arrangements, with potential for these to be more clearly and consistently communicated.

Ways of working

The diverse set of stakeholder types and informality of the ACT-A construct mean that different ways of working have emerged organically across the structure. This section considers three aspects which emerged as key focus areas in stakeholder interviews, and comments on how they have impacted ACT-A's efforts to date. These are collaboration and coordination, agile vs structured approaches, and resourcing.

Collaboration and coordination:

To collectively deliver on of ACT-A's mission in the most impactful and efficient way possible, agencies which ordinarily operate separately are required to prioritise joint working.[194] Achieving ACT-A's objectives requires coordination across the steps of the value chain to avoid bottlenecking, and to identify and leverage operational synergies. For this reason, the ACT-A coordination fora have

[192] Stakeholder interviews, August – September 2021
[193] Stakeholder interviews, August – September 2021
[194] See "Commitment and call to action: Global collaboration to accelerate new Covid 19 health technologies" , World Health Organization, 24 April 2021. Accessed at: https://www.who.int/news/item/24-04-2020-commitment-and-call-to-action-global-collaboration-to-accelerate-new-covid-19-health-technologies on 31 August 2021. This text highlights that proactive stakeholder engagement, alignment and coordination of efforts, and collective development of solutions are key requirements for ACT-A to succeed.

sought to provide collaborative settings for planning, coordination, and timely information-sharing across different parts of ACT-A.

However, no specific entity or entities are formally responsible for coordinating and identifying gaps or opportunities for synergies across focus areas or agencies. Rather, under the decentralised model, the workload of delivering on ACT-A's mission is distributed across different specialist entities. This approach may limit, but does not preclude, possibilities for first-hand identification of opportunities or needs to coordinate, with mixed outcomes to date as described below.[195]

Some successful instances of collaboration have emerged within and across coordinating fora, and through proactive efforts to leverage different expertise across the partnership. Principals in particular shared anecdotal evidence of numerous instances of providing each other with rapid, tactical support across their respective strengths, facilitated by their regular engagement in the smaller Principals Group sessions. Interviewees also gave examples of agencies advocating for funding on each other's behalf, especially benefiting agencies less experienced in fundraising of this nature (for instance, the Global Fund advocating for funding on behalf of FIND or Gavi leveraging IFFIM, its innovative financing mechanism, to fund CEPI).[196] Collaborative efforts have also emerged from information sharing in the broader Principals Group sessions. For instance, the Global Fund was prompted to share data it held with WHE when it learned of WHE requirements for predicting case surges, and testing challenges raised by Botswana led to a rapid turn-around in refining WHO guidelines through streamlined channels.[197]

However, fragmented approaches and Pillars being out of step with each other have led to some missed opportunities for operational synergies in a setting where resources are already limited. For instance, country readiness assessments undertaken in one Pillar were not leveraged by others, who in turn conducted separate assessments. Similarly, some stakeholders suggested that efforts to strengthen vaccine delivery workforces could have gone further to also include capacity building in support of other Pillars. Individual agencies have also been seen to seek their own country focal points for coordinating their initiatives, rather than streamlining their outreach and communication through integrated channels.[198] Importantly, in many instances, it may be appropriate for Pillars to work separately (such as where a customized or unique approach is needed). Collaboration is also not always costless, especially if it depends on one Pillar delaying its own progress to wait for another to be ready to work together, or requires significant incremental effort for collaborators. Nonetheless, in a resource constrained setting, opportunities for synergies must be scrupulously identified and pursued to maximize overall impact. As mentioned in earlier sections, agencies having roles across Pillars (where appropriate) and robust information sharing in coordination fora are key mechanisms for identifying and delivering synergies.

Agile vs structured approaches:

The extent to which different types of organizations can adopt more ad hoc approaches varies, including in time-pressured contexts. Quick, pragmatic decision-making can work well for agencies, whose governance constructs can allow for flexible, rapid pivots, but can be harder for countries which face specific constraints as public actors, including reporting requirements, and decision-making processes and hierarchies. For example, government representatives often cite needing more time to engage on information shared with them for consultation than agencies think is necessary to provide. Some stakeholders suggested that these differences can be a source of misalignments and frustrations at times, and might feed into perceptions of insufficient accountability as described in the previous section on Governance. [199]

[195] Stakeholder interviews, August – September 2021
[196] Stakeholder interviews, August – September 2021
[197] Stakeholder interviews, August – September 2021
[198] Stakeholder interviews, August – September 2021
[199] Stakeholder interviews, August – September 2021

Resourcing:

The need to resource different parts of ACT-A rapidly meant drawing from existing pools in many instances, with resourcing typically dependent on limited numbers of repurposed and 'surge' staff. As time has progressed, ACT-A work has continued to require intensive input across stakeholder types, including from very senior stakeholders.

The ongoing need for resourcing to deliver on ACT-A's mission has been challenging across multiple stakeholder types. For example, several CSOs have explained how, in the absence of dedicated capacity to respond to the new threat of COVID-19, ACT-A has had to draw on already overstretched advocates and organizations active in other disease responses (e.g., HIV, TB, and Malaria). It has also been challenging for countries to balance participation in ACT-A with tackling the domestic impact of COVID-19. Agencies too have had to balance new activity on COVID-19 with their existing portfolio of activities, including allocating resources from supporting functions like RM and communications. The reliance on a few core implementing agencies, while minimizing complexity, exacerbates this challenge.[200] This pattern of repurposing staff or drawing on existing teams also threatens the sustainability of the activities which these people previously supported.

Resourcing constraints have also been compounded by varying levels of commitment and practical support. As with any initiative for developing global public goods, the ACT-A collaboration has faced challenges of free-riding, whereby not all stakeholders contribute proportionately to the benefit they stand to gain, with interviewees describing varying levels of commitment and practical support across different members.[201] Interviewees also gave examples of senior stakeholders increasingly sending more junior members to attend ACT-A engagements on their behalf.[202] Overall, these resourcing challenges pose risks to continuity, the accumulation of institutional knowledge, and the formation of trusting and collaborative relationships.

Recommendations

1. **Re-affirm the mandate of the Facilitation Council and set up a regular communication channel with the Principals Group.**

   The Facilitation Council (FC) should reaffirm its original mandate to provide "advocacy for collective approaches to solutions in the global interest and for the mobilisation of additional resources as needed", as set out in its current Terms of Reference.[203] To date, the Council has not always been successful in building sufficient political support for the ACT-A construct and its objectives, and this goal requires renewed focus. As such, the FC should internally reiterate and reaffirm their mandate as set out in the Terms of Reference.

   A one-off session should be held between the FC and the smaller Principals Group to affirm their respective roles in ACT-A's governance, and norms for how they work collaboratively. This session should affirm the following key aspects:

   - The FC and PG play bi-directional advisory roles and share information to support the successful execution of their respective tasks.
   - The FC does not have oversight responsibility over the Pillars and HSC (i.e., it is not designed to approve decisions, monitor or assess delivery, or hold implementers accountable), as this authority is held by the co-convening agencies' governing bodies. This is in line with the principle of subsidiarity adopted in the FC TOR, whereby decision-making at agency level is preserved.[204]

[200] Stakeholder interviews, August - September 2021
[201] Stakeholder interviews, August - September 2021
[202] Stakeholder interviews, August - September 2021
[203] "ACT-A Facilitation Council Terms of Reference", Facilitation Council, 9 February 2021
[204] "ACT-A Facilitation Council Terms of Reference", Facilitation Council, 9 February 2021

- The Principals Group and partner agency boards have ultimate responsibility and accountability for delivering on ACT-A's objectives.
- The FC is consulted on overarching ACT-A decisions including strategy, budget, and priority setting; these decisions are made by consensus across the co-convening agencies[205] facilitated by the Executive Hub.
- The FC supports these efforts through political advocacy and resource mobilisation for ACT-A; to enable the FC to be effective in this role, the partner agencies should provide the FC with clear and regular visibility of their progress towards the Pillars and HSC's goals, and related financial flows, based on an agreed data sharing framework (see related recommendation below for details).

Regular meetings between the FC Co-Chairs and the Principals Group should be established for bi-directional information sharing and advisory. The Special Envoy should support this coordination in his or her capacity as Chair of the Principals Group. While the FC Co-chairs and Principals already have significant demands on their time, this important connection should not be neglected.

2. **Increase and enhance L/MIC, CSO, and Community representation and involvement in ACT-A.**

   All ACT-A participants should contribute to behaviours and practices to ensure that representation of L/MICs, CSOs, and Community Representatives (CRs) in ACT-A forums is timely, proportionate, and meaningful. Recognising the importance of these stakeholders' own experience and perspectives requires they be given the opportunity to engage in ACT-A forums on an equal footing as others.

   Greater L/MIC representation should be driven through the Facilitation Council, the Pillars, and HSC.[206] Emerging models[207] to balance regional representation and specifically to increase L/MIC membership in the Facilitation Council and its working groups should be finalised and implemented. This can be done while still managing the overall size of these bodies, and through identifying individuals with relevant expertise. Processes and working norms around regional representation should be developed and agreed. These must facilitate country representatives collecting and reflecting input from their regional counterparts who are not Facilitation Council members, and enable and empower them to share information back with their region. The broader Principals Group, Pillars and HSC should ensure that L/MIC representatives are consulted on key strategy and budget considerations that will impact recipient countries before these are raised to agencies' governing bodies for final decisions.

   All ACT-A structures should consult with CSOs and CRs, and potentially through the Platform for ACT-A Civil Society and Community Representatives, to agree and coordinate timely and balanced inclusion of perspectives. CSOs and CRs must be able to contribute on

[205] Each agencies' inputs into these processes are subject to the governance of their respective governing bodies. Importantly, many Council members hold seats on co-convening agencies' governing bodies and can directly hold those organisations to account through these channels. These roles are held as representatives of their own constituencies and not as members of the ACT-A FC, and thus should not flow into the FC, whose focus needs to remain clear in order to maximize its advocacy value.

[206] The Principals Group is not listed here as it does not have country members.

[207] Options currently under consideration by the Facilitation Council include: i) adding representatives from regions currently proportionately underrepresented relative to their total population, such that more than 50% of the population in each region would be represented by a council member, or ii) adding representatives from regions currently proportionately underrepresented relative to the number of states in the region, such that all regions would have at least 15% of their member states represented in the council. Option i) would require the addition of new members from Africa and the eastern Mediterranean region, while option ii) would require the same as well as increasing membership from the Americas. Neither of these options directly considers income levels as a criterion for equitable representation.

an equal footing as other participants, including having timely access to relevant materials to enable meaningful consultation.

All ACT-A structures should define and adopt specific practices for including and reflecting different perspectives. L/MICs, CSOs, and CRs should be included from inception or as early as possible thereafter in working groups to be able to engage fully. Read-outs and reporting from meetings at all levels should outline different stakeholder viewpoints for the record. Meeting formats should endeavour to accommodate different practical restrictions to not preclude certain stakeholders from participating effectively.

Importantly, all stakeholders must remain conscious that practical levers alone cannot necessarily address intangible drivers of under-representation. All stakeholders must challenge and counteract biases and behaviours in themselves and others that downplay, limit, or otherwise diminish some participants' contributions.

3. **Launch a 'data sharing framework' to enhance the quality and increase availability of aggregated programmatic and financial reporting.**

   ACT-A should provide clear consolidated operational[208] and financial reporting to all ACT-A stakeholders, including those not participating in agency-specific governance processes. These communications would articulate ACT-A's impact in countries and effectiveness in sum, and build greater confidence in its collective work. This greater visibility, specificity and ease of access will be key enablers to future resource mobilisation—potentially bringing even greater future impact in turn. Practical barriers to accessing clear and timely information should be reduced where possible, including having to consult multiple sources, or not having access to comparable information across entities. This is to help donors and other stakeholders have a clear and accurate view of ACT-A's performance, so that they can make informed and timely decisions.

   The Executive Hub should lead an effort to establish a robust information sharing framework and cadence, with supporting input from partner agencies. Donors, the Facilitation Council, and partner agencies should be consulted to determine what key information is available and needed to support ongoing fundraising and advocacy. While this can build from existing efforts (e.g., ACT-A quarterly progress reports) it should provide new aggregation and close current gaps to not duplicate existing efforts, and to address donor asks. This may include, amongst others, providing timely integrated updates on funding received and deployed, and quantitative tracking of key deliverables by recipient (where relevant). Reporting should focus on outcomes as well as outputs. Stakeholders proposed an option to establish a standing committee to support these efforts, which should be considered.

4. **Make it easier to understand and engage with different parts of ACT-A.**

   ACT-A should develop clear descriptions of the mandates of different bodies, roles of different stakeholders, and authorities over different types and levels of decision-making. This is to provide open information about the mechanisms and channels through which ACT-A operates for all stakeholders, and to enable them to identify and engage with the appropriate entities where they may have reason to do so. This information should be easy to find and access, and updated on a regular basis. This effort could be coordinated by the Executive Hub, with supporting input from other ACT-A members.

[208] Operational reporting would include qualitative and quantitative tracking of delivery against stated objectives, to demonstrate what impact funding is achieving, how rapidly and where.

Additionally, ACT-A members should take opportunities to simplify and streamline the operational structure on an ongoing basis. Particular attention should be paid to potential duplication of roles and responsibilities, excessive structural complexity, and avoiding the inclusion of activities that exceed ACT-A's specific scope and time-horizon. Co-conveners of the Pillars and Workstreams and members of the Facilitation Council should lead this collaboratively, to take into account the overall composition of ACT-A.

V. DIMENSION 3: RESOURCING

Introduction

Since its launch in April 2020, ACT-A has mobilised US$18 billion in pledges from sovereign funders, as well as private sector and philanthropic contributors. The first pledging event led by the European Commission brought over US$3 billion in pledges for the Pillars.[209] As of September 2021, pledges now include US$16 billion from sovereign donors, US$1 billion from private donors (through direct donations to partner organisations, or the ACT Together Fund[210] hosted by the United Nations Foundation), and US$1 billion from multilateral donors. Pledges also include 721 million shared doses through COVAX by 17 governments.[211] Additionally, the World Bank has committed US$20 billion in financing to support developing countries in purchasing and distributing COVID-19 tools, among other upcoming commitments (not included in the table below).[212]

Table 3: Pledges as of 3 September 2021

Type of donor	Donor	Pledge (Millions, US$)
Sovereign donors	United States	$ 6,214
	Germany	$ 2,636
	European Commission	$ 601
	Italy	$ 487
	Sweden	$ 307
	France	$ 307
	Other European countries	$ 408
	Japan	$ 1,215
	United Kingdom	$ 1,135
	Canada	$ 1,110
	Norway	$ 495
	Switzerland	$ 410
	Saudi Arabia	$ 310
	Republic of Korea	$ 212
	Australia	$ 132
	China	$ 100
	Other countries (non-European)	$ 140
Private donors	Bill & Melinda Gates Foundation	$ 420
	Gates Philanthropy Partners	$ 119
	UNICEF National Committees	$ 103
	Mastercard	$ 58
	Wellcome Trust	$ 75
	Other private donors	$ 217
Multilateral donors	The Global Fund (COVID-19 Response Mechanism); Gavi (core resources); Diagnostics Consortium for COVID-19; Unitaid (core resources) and, WHO flexible funding	$ 1,304

Partners drew on ACT-A's collaborative ethos in designing the financing model for the initiative. This collaboration led to an integrated investment case calling for US$31.3 billion in required funding for all pillars as the basis for coordinated funding appeals to donors[213]. The unified narrative around

[209] "ACT-Accelerator Investment Case", World Health Organization, 26 June 2020
[210] Private donors have the option to provide flexible funding to the ACT-Accelerator by donating to the ACT Together Fund, hosted by the United Nations Foundation.
[211] ACT-A Accelerator Online Commitment Tracker
[212] Other initiatives contributing to the COVID-19 response (in addition to ACT-A e.g., the European Commissions' Horizon 2020 programme) have received over US$10 billion in pledges. Source: "The COVID-19 Health Funding Tracker", The Economist Intelligence Unit, 27 September 2021
[213] "ACT-Accelerator: An economic investment case & financing requirement, 24 Sept 2020-Dec 2021", World Health Organization, September 2020

the importance of comprehensive response was designed to mobilise more funding collectively than would be possible through individual initiatives. This was possible due to an exceptional move from traditional global health fundraising strategies to a more cooperative approach that reduced competition for funding in a typically competitive environment.

While all partners jointly launched the investment case, funds are independently collected and managed by each partner. As ACT-A is not a new organisation or decision-making body and thus does not have a legal entity, each agency manages funds through their existing financial systems and procedures, thereby reducing transaction costs and facilitating faster fund deployment. Through this procedure, donors pledge funds to specific pillars and agencies, contributing to ACT-A's joint investment ask. The Facilitation Council's Financial Working Group formulated a Funding Framework[214] to monitor funding gaps and measure the mobilisation efforts required. The framework included a breakdown of the costs per pillar, as well as potential funding sources prioritised by size, speed of disbursement, and complexity to set up. As a result of this analysis, it became clear that historical ODA would not be sufficient to cover ACT-A's financial requirements, and more sovereign grants would be needed. Sovereign grants were also prioritised over other funding avenues due to their speed and flexibility, particularly during the early months of the pandemic when research and procurement activities required immediate funding.

Some partners developed funding and disbursement mechanisms that cut across pillars—including the Global Fund's C19RM which is the primary channel for funding and procurement across the therapeutics and diagnostics pillar (and aspects of the HSC). Although most agencies receive funding for specific pillars, the Global Fund and UNICEF developed funding facilities that allowed them to fundraise and distribute funds (and products and support) across multiple pillars. The Global Fund's COVID-19 Response Mechanism (C19RM) is the primary channel for funding and procurement across the therapeutics and diagnostics pillars, as well as the HSC. As of August 2021, Global Fund has approved US$3.6 billion to 107 countries and 18 multi-country programmes for critical tests, treatments, and medical supplies and, has acted as the predominant funding and procurement channel for the treatment and diagnostics pillars, as well as PPE (See *Dimension 1: Scope & Objectives* for more on C19RM).[215] Similarly, UNICEF launched the Access to COVID-19 Tools Accelerator Supplies Financing Facility (ACT-A SFF), a pooled fund dedicated to supporting L/MICs access COVID-19 tools (including vaccines, therapeutics and diagnostics), which has received US$370 million as of June 2021.[216] UNICEF has also managed US$126 million for COVID-19 tools roll-out through its ACT-A Humanitarian Action for Children.[217]Other agencies leveraged existing innovative finance tools such as the International Finance Facility for Immunisation (IFFIm), which issues vaccine bonds to fund immunisation programmes through Gavi. IFFIm made significant investments to support CEPI's vaccine research and development for COVAX.[218]

A second investment case was published in September 2020, highlighting the social and economic rationale for investing in ACT-A.[219] The total investment ask was revised up to US$38 billion, and underscored that the global benefits of resumed trade and travel would offset the value of this investment in just 36 hours.[220] The analysis highlighted the social benefits of investing in ACT-A such as facilitating access to COVID-19 tools through a diverse R&D portfolio of products and strengthened health systems. Access to these tools will help L/MICs reduce the number of COVID-

[214] "Funding Framework", Financial Working Group, 30 November 2020
[215] "Additional Support for Country Responses to COVID-19", Global Fund, 9 April 2020.Accessed at Additional Support for Country Responses to COVID-19 C19RM provides funding for part of ACT-A for which the Global Fund is one of the possible channels of response, as well as other strategies to mitigate the effect of COVID-19 on HIV, TB and malaria programmes.
[216] "Quarterly Report on the ACT-A SFF", UNICEF, 30 June 2021
[217] "ACT-A Humanitarian Situation Report", UNICEF, 16 July 2021
[218] "IFFIM helps COVAX bring fair, global access to COVID-19 vaccines", IFFIM, 10 May 2021
[219] "ACT-Accelerator: An economic investment case & financing requirement, 24 Sept 2020-Dec 2021", World Health Organization, September 2020
[220] "ACT-Accelerator: An economic investment case & financing requirement, 24 Sept 2020-Dec 2021", World Health Organization, September 2020

19 severe cases and emerge from the health crisis to restore international mobility and trade. By highlighting the social and economic rationale, ACT-A's investment case aspired to bring more funding from major political players.

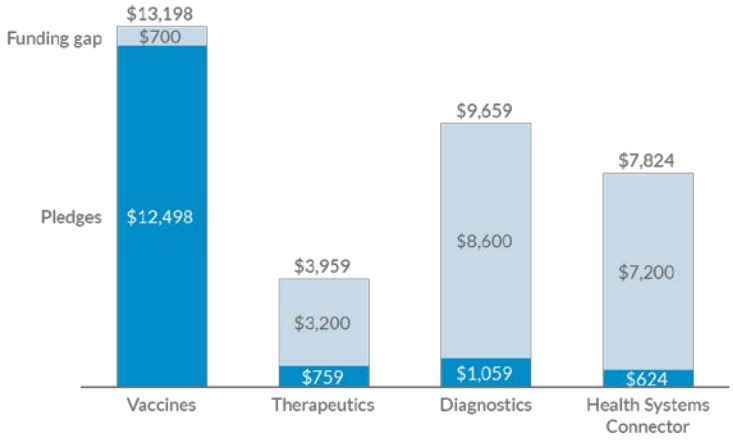
In March 2021, the co-chairs of the Facilitation Council launched the new 'ACT-A Fair Burden Share Model'. Despite strong mobilisation efforts, funding was still limited. Only a few larger agencies were able to start making grants against pledges. To address the funding shortfall, the Facilitation Council launched the 'ACT-A Fair Burden Share Model'. The model uses a technical, equitable methodology aiming to mobilise funding among 89 high-and middle-income countries. The model also aims to raise awareness of global health security value as a global public good, and the need to have collective models for financing this good among states. Following the IMF quota approach, it calculates a target contribution for each country based on GDP and GDP per capita levels, openness of economy, and a buffer margin for non-contributing countries.[221] The contributions of the top 30 countries should result in the collection of 90% of ACT-A's funding target.[222] The Co-Chairs of the Facilitation Council sent letters to every country considered in the model in order to galvanise governments around the multifaceted value of contributing to the Accelerator, with promising results. As of September 2021, five countries have reached or exceeded their 'fair share targets', and another seven have contributed at least 50% of their suggested share.[223]

Overall, ACT-A's innovative collaborative approach showed the potential to mobilise significant resources from a broad range of donors in a short period of time. Despite the structural constraints of multilateral collaborations and emergency responses, ACT-A rapidly mobilised over US$3 billion in under three months. Early commitments from major donors were key in catalysing international goodwill and financing from multiple sources, including HICs, MICs, international philanthropy, multilateral organisations, and the private sector. For some Pillars, being part of ACT-A has increased their visibility in the global health space and allowed much greater financing than would have been possible without this mechanism. These members also benefitted from a novel degree of collaboration in global fundraising.

However, ACT-A still faces a US$16.6 billion deficit to fully fund its work as described in the September 2020 Investment Case. Despite its successes, ACT-A has struggled to maintain the level of support needed to continue its efforts over the extended term. This represents approximately 50% of the total investment ask across all pillars, with significant gaps in the Diagnostics and Health Systems Connector pillars. Furthermore, a substantial fraction of the US$18 billion in pledges has yet to be converted into contributions agreements with ACT-A's partners.

[221] "Financing Global Health Security Fairly", John-Arne Røttingen, Halvor Hvideberg, Eero Tölö, Benjamin Sarda and Bruce Aylward, Center for Global Development, 21 April 2021. Accessed at: https://www.cgdev.org/blog/financing-global-health-security-fairly
[222] "Financing Global Health Security Fairly", John-Arne Røttingen, Halvor Hvideberg, Eero Tölö, Benjamin Sarda and Bruce Aylward, Center for Global Development, 21 April 2021. Accessed at: https://www.cgdev.org/blog/financing-global-health-security-fairly
[223] Germany, Norway, Canada, Saudi Arabia, Kuwait, Iceland, Japan, Switzerland, United States, Italy, United Kingdom and Sweden

Figure 3 : ACT-Accelerator budget and funding gap per pillar as of 3 September 2021 (US$ million)



**Graph does not include US$ 3,128 million pending allocation*[224]

The following sections explore some of the drivers of these challenges and opportunities to address them.

Findings and analysis

Funding appeals

ACT-A's Pillars designed their budgets based on analyses and assumptions of health needs and supply availability. Most Pillars' teams grounded their budgeting processes on epidemiological conditions, product availability and pricing, target coverage and at-risk populations, among other health criteria and supply factors.[225] While product availability considerations were a central factor, demand assumptions such as product uptake were not systemically considered as part of the budgeting process. Stakeholders tended to agree budgeting process put greater weight on supply provision indicators, rather than following a needs-based costing methodology. To this date, there is not a costing exercise of what would be required to end the pandemic that could serve as a benchmark to the funding appeals.[226] Several donors and other stakeholders expressed the need to have more visibility of L/MICs' priorities regarding their national COVID-19 responses, and a clear framework that links funding appeals with Pillars' interventions. Donors also expressed that without this framework, it is difficult to assess the funding appeals, and at times they seem disproportionate to countries' needs. Similarly, several donors stressed the importance to link funding appeals to measurable health and economic outcomes to enhance visibility and implementer accountability

In addition to a stronger outcome-narrative, funding appeals could further leverage ACT-A's economic benefits to the global economy and countries. The Investment Cases developed by ACT-A partners and working groups articulate the economic benefits of investing in L/MICs to end the pandemic and recognise ACT-A as one of the most viable solutions for restarting the global economy. However, donors and other stakeholders reported that agencies' direct appeals often relied back on health outcomes rather than on economic benefits to the global economy and recipient countries. Many stakeholders suggested appeals might gain more support from donor countries if ACT-A members emphasised the economic and development benefits of the proposed investments. Including these strong economic arguments is particularly relevant for donor countries, where

[224] Including CAD 230 million from Canada yet to be allocated, CHF 135 million from Switzerland, USD 59 million to WHO in flexible funding from multiple donors, and USD 2.7 billion of the new USG commitment of USD 3.5 billion to the Global Fund
[225] Individual Pillar budgets documents *(internal documents)*
[226] Stakeholder interviews, August - September 2021

economic stimulus packages are coming to an end, or economic recovery is at risk from new variants of COVID-19.

Resource mobilisation and complementary financing

ACT- A internal partners

Agencies, as well as members of the Facilitation Council's working groups, led resource mobilisation efforts. Co-conveners defined investment asks for their individual pillars and led resource mobilisation with donors, while the working groups acted as a sounding board for pillars on budget and financial decisions. The Facilitation Council and its working groups also led outreach and advocacy efforts to raise awareness of the fair burden-share framework to address funding gaps across all pillars.

Despite its collaborative design, in practice, resource mobilisation teams at the central and agency level were not consistently aligned. There was a limited delineation of roles and responsibilities between the Financial Working Group, Resource Mobilisation Working Group, and the different agencies' resource mobilisations teams. As a result, resource mobilisation teams used different communication tools during their donor outreach, which often led to mixed or contradictory messaging and hindered ACT-A's collaborative ethos. These fragmented communications also raised accountability concerns from donors, as some of them received multiple appeals from central and agency teams, without a general accountability framework to follow on delivery of ACT-A activities.[227]

One key area where this difference in strategies was reflected was the Fair Burden-Sharing Model. While several countries have contributed at least 50% of their target share and many stakeholders see clear value in having a "fair share" approach, it has not received the expected buy-in from many donors. Some internal stakeholders highlighted the Fair Share model might resonate to different degrees among targeted governments. For example, stakeholders noted that the approach may be inconsistent with some governments' grant-making principles and procedures, especially considering the highly politicised context in which most pandemic response strategies operate. Similarly, sometimes the model conflicted with agencies' existing strategies beyond ACT-A, particularly for agencies with long-term engagements with some donors, jeopardising existing or future commitments for ACT-A and other programmes.[228] Additionally, it raised concerns among some agencies that the model itself provides incentives for donors who had met their "fair share" to limit future contributions to ACT-A activities.

Further, some agencies lacked intra-agency communication to coordinate in the execution of fundraising initiatives. Agencies followed different strategies based on their level of experience conducting resource mobilisation with sovereign funders, with limited coordination with other agencies during their execution. For example, agencies with more experience leveraged existing channels with donors and were able to launch stronger advocacy campaigns. Other smaller agencies with more limited experience managing relationships with sovereign donors relied on ACT-A's visibility in the health space to obtain funding, or leveraged other agencies' networks. Some deployed joint fundraising efforts with their pillar's partners. Going forward, some smaller agencies saw an opportunity to receive more guidance and tactical support (e.g., sharing contact information, previous appeals) from experienced partners to increase the collective funding levels for ACT-A. They also saw an opportunity for a more collaborative fundraising strategy, calling for increased impact from investing across pillars. For example, some agencies suggested launching a joint fundraising

[227] Stakeholder interviews, August - September 2021
[228] Stakeholder interviews, August - September 2021

campaign, highlighting the ability to measure the success of vaccination efforts through a targeted diagnostics strategy in selected countries.

As resources come in, only pledges are publicly reported in ACT-A's consolidated Financial Commitments Tracker limiting stakeholders' ability to have a full picture of ACT-A's funding flows.[229] Given formal governance of the work of each agency lies within their own administration and systems, funds received and disbursed through the pillars are reported through each agency's reporting mechanisms. As such, aggregate received, committed, and disbursed funding flows are not easily accessible. Donors and other stakeholders voiced a desire for greater visibility on these aggregate financial flows across all pillars. From the donors' point of view, access to this information could enable prioritisation of funding appeals as well as greater implementer accountability. However, agencies noted limitations to provide more detailed or frequent financial reporting related to ACT-A activities. For example, some agencies have integrated ACT-A funds as part of their global COVID-19 response programmes, limiting their ability to identify and monitor the flow of funds received to support ACT-A activities. Others have indicated difficulties to provide more frequent updates due to their audit cycles and resource constraints. These constraints will need to be further assessed to determine a feasible level of specificity across agencies.

Looking ahead, addressing the imbalances in funding raised between Pillars will require a stronger and more cohesive joint resource mobilisation strategy. Numerous stakeholders, including recipients, CSOs, Pillar members, and some donors, emphasised to urgency of ensuring all Pillars are adequately funded to deliver on ACT-A's goals. Achieving this will require strongly coordinated action. Given the complexity and transaction costs involved, establishing a flexible central resource pool remains out of scope for ACT-A. As such, anchoring resource mobilisation strategies in a robust narrative that accentuates the benefits of a comprehensive cross-pillar response is the strongest option. This will require ACT-A to use its joint platform, with agencies working together to better represent the importance and complementarity of all tools. As new variants emerge and the likelihood of entering an endemic stage increases, ACT-A should leverage this narrative to raise total ACT-A funding, and achieve more balanced distribution across Pillars.

> "We need to build a stronger narrative to raise attention on the need to invest more in all pillars. With new variants, we need therapeutics and tests more than ever." ~ *Civil Society representative*

Sovereign and private donors

The political climate played heavily into resource mobilisation results. Most early donors prioritised resourcing for domestic response, reducing or re-allocating pledges to other COVID-19 efforts, including national initiatives.[230] Moreover, early support from donor countries, particularly G7 and G20 nations, did not inspire more support from countries outside these groups. Many donor countries went to pursue bilateral deals with pharmaceutical companies outside of the ACT-A pillars' strategies. By August 2020, members of G7 and G20 had already secured vaccine doses for more than 100% of their populations, undermining ACT-A's goal to ensure equity in COVID-19 tools

[229] "Access to COVID-19 tools funding commitment tracker", World Health Organization, 27 September 2021 accessed at https://www.who.int/publications/m/item/access-to-covid-19-tools-tracker
[230] "ACT-Accelerator: An economic investment case & financing requirement, 24 Sept 2020-Dec 2021", World Health Organization, September 2020

allocation and delivery and in existing negotiations with pharmaceutical companies.[231] Other middle-income economies followed similar strategies and reduced their planned contributions to ACT-A.[232]

Donors have consistently focused their investments on the vaccines pillar; the lack of funding to other pillars was, and continues to be, a major barrier to achieving ACT-A's objectives. In spite of ACT-A's joint investment appeals and advocacy efforts emphasising the need to balance investments across pillars to enable a more comprehensive response, donors have allocated the most resources to the Vaccines Pillar. This was based on a number of factors, not least the relative conceptual ease of reporting vaccine impact (as compared to other commodities). From a strategic angle, donors saw vaccines as the way to end the acute phase of the pandemic and achieve herd immunity. A few countries supported ACT-A's unified narrative and distributed available funds across pillars.[233] However, as of 3 September 2020, the Vaccines Pillar has been the target of more than 60% of total donor pledges for ACT-A, and it is the only pillar close to being fully funded. The other pillars remain severely underfunded, which has negatively affected their ability to meet their targets on time or in full (for example, C19RM current has more than US$1 billion in unfunded demand). In some cases, agencies made reservations with manufacturers and could not follow through with procurement due to limited funding. Many agencies struggled to secure contracts with manufacturers given their inability to provide large and consistent demand commitments to manufacturers.[234]

The lack of a coherent narrative and alignment on agency- or activity-specific appeals affected donors' engagement with ACT-A. While all agencies have existing reporting mechanisms and some Pillars offered shared reporting tools and forums, donors reported struggling with limited visibility and low implementer accountability at the aggregate, cross-Pillar level. They voiced a desire to have a unique structure and visibility on appeals, with a logical prioritisation on most urgent needs for all Pillars. While they saw the value of joint funding asks, this created uncertainty regarding how to allocate funding to specific agencies and activities, and how it would contribute to ACT-A's overall goals. They further noted that clear investment cases that prioritise funding appeals and highlight the importance of investing in all tools, particularly with new variants emerging, would be powerful components of future resource mobilisation efforts and would help to balance funding across Pillars.

Multilateral Development Banks

Financing from multilateral development banks (MDBs) has seen limited uptake. In October 2020 the World Bank approved an envelope of US$12 billion for developing countries to finance the purchase and distribution of COVID-19 vaccines, tests, and treatments for their citizens. In June 2021, the funding envelope increased to US$ 20 billion over 18 months to continue supporting COVID-19 tools purchasing and deployment.[235] Yet as of October 2021, US$ 5.8 billion have been approved for rollout. Other facilities such as the Asia Pacific Vaccine Access Facility from the Asian Development Bank have also seen limited use.[236] Several factors are likely driving this. According to stakeholder interviews, including with recipient countries, governments with high debt levels were reluctant to contract more debt to fund their COVID-19 response programmes. This was exacerbated by the perceived lack of coordination between financing and support sources, leaving uncertainties around whether additional donor grants would be forthcoming or whether MDB financing would replace it. At the same time, complex discussions at national level around competing economic priorities also contributed to stalling those decisions. Some stakeholders pointed to the complexity

[231] "Launch and Scale Speedometer: Vaccine Donations and Exports", Duke University Global Health Innovation Center, 2021. Accessed at https://launchandscalefaster.org/covid-19/vaccinedonations on 15 September 2021
[232] Stakeholder interviews, August - September 2021
[233] Examples include Germany, United Kingdom, France, Netherlands, Canada, Norway, Switzerland, among others
[234] "A 100 days mission to respond to future pandemic threats", Pandemic Preparedness Partnership, 12 June 2021
[235] "How the World Bank Group is helping developing countries to vaccinate their populations", World Bank Group, 23 September 2021
[236] "A proposal to end the COVID-19 pandemic", IMF, 19 May 2021

of adopting these mechanisms as barriers to uptake. They cited the procedural rigidity as an issue, particularly in the context of the pandemic when funding was needed immediately.

ACT-A has played a limited role in advising on or connecting countries to supplementary financing sources. As ACT-A increases its emphasis on deployment, sovereign grants are unlikely to be sufficient to cover growing resource needs, particularly delivery costs. Donors and other stakeholders emphasised the need for countries to use IFI financing to help ensure tools are appropriately delivered and distributed in countries at sufficient scale, while funding for commodities could go through ACT-A's grant funding mechanisms. To date, ACT-A partners haven't played a strong role in communicating or advising countries on additional financing sources. [237] Stakeholders tended to agree on the need to provide a clear financial framework to countries, covering all relevant funding and financing partners, that emphasises the principle of complementarity between grants and other financing in their COVID-19 responses. Indeed, the Finance Working Group, aligned to external analyses[238], has recently proposed a revised financial framework in response to global shifts[239] in which concessional funds would be prioritised for long-term health infrastructure and health systems strengthening to support delivery costs. Some stakeholders also raised the importance of galvanising additional domestic health resourcing to support governments in integrating the COVID-19 emergency response into their regular health systems strategy.

The continued and closer involvement of MDBs will be critical to connect grant funding and other financing at country-level to speed up access to tools. Stakeholders noted that the involvement of MDBs in ACT-A fora has increased over time. For example, the World Bank's Operations team—in addition to the WB Health Nutrition and Population team, which already acts as the HSC secretariat and represents the WB in the Principals Group—has become more closely involved in working groups and Principals meetings over time, as has International Monetary Fund leadership. Despite the early lack of coordination between ACT-A support and MDB financing, stakeholders welcomed the closer involvement of these institutions to help ensure stronger coordination and linkages between WB/IFI financing provision and ACT-A support. This is a critical linkage to help achieve ACT-A's overarching goals.

> "Countries should better leverage concessional finance, the impact you can have with a greater envelope at a low interest rate is unmeasurable in this emergency context." - *Donor representative*

As an ACT-A partner sitting in a cross-pillar role, the World Bank is uniquely positioned to enable collaborations and facilitate the connection between ACT-A support and its own finance offerings to countries. One example is the recently announced COVAX-World Bank cost-sharing mechanism to improve vaccine supply in L/MICs. Building on Gavi's AMC cost-sharing arrangement, this new mechanism allows AMC countries to use World Bank financing to purchase doses beyond the fully donor-subsidised doses they are already receiving through COVAX.[240] The mechanism enables COVAX to aggregate demand across countries and make advance purchases from vaccine manufacturers using financing from the World Bank and other MDBs. The mechanism also aims to mitigate the risks and uncertainties in country demand that stem from financing ability.[241] This model can act as a basis for stronger collaboration between the World Bank and other MDBs and the other ACT-A Pillars.

[237] Stakeholder interviews, August - September 2021
[238] "A Proposal to End the COVID-19 Pandemic", International Monetary Fund, 19 May 2021
[239] "Financial Framework", ACT-A's Finance Working Group, 24 August 2021
[240] "COVAX and World Bank to Accelerate Vaccine Access for Developing Countries", World Bank, 26 July 2021
[241] "New Bank COVAX collaborative mechanism to accelerate COVID-19 vaccine supply for developing countries", World Bank, July 2021

Recommendations

1. **Strengthen and align ACT-A's collective advocacy efforts for resource mobilisation, anchored on outcomes-based narratives that emphasize the mandates and importance of all Pillars.**

   ACT-A partners should seek greater alignment between agency RM efforts and the Facilitation Council's advocacy efforts. Stakeholders must build alignment around respective roles and expectations, built on a shared advocacy strategy, goals and messaging. This includes clear understanding of what RM-related activities will be executed through the FC (i.e., global advocacy efforts for ACT-A, tracking of funding gaps, etc.), and agencies (i.e., direct fundraising), as well as fundraising targets. It will also involve clear alignment on key messaging with donors to ensure a cohesive narrative across Pillars and other ACT-A's structures. This will enable the partnership to leverage the best of all available resources to achieve future fundraising targets. It should also align with a core strategic principal in managing the pandemic, i.e., that multiple tools are required in an appropriate balance over time.

   ACT-A should anchor on an investment case and resource mobilisation narrative clearly linking funding requests to countries' needs and measurable local health and economic outcomes. In keeping with strong requests from donors, ACT-A fundraising stakeholders should align behind an outcomes-based narrative for future appeals. This approach would articulate a narrative that reinforces the value of donor investment while further emphasising the importance of a fully funded comprehensive (cross-pillar) response for the local and global economies. Likewise, future investment cases should focus on ensuring requests have enough specificity to easily map against results in country. This will pave the way for longer-term relationships with donors and greater implementer accountability.

2. **Increase availability and granularity of aggregate data through a 'data sharing framework'.**

   ACT-A should ensure regular access to up-to-date consolidated financial data to enhance trust and accountability between donors and agencies. As described under *Dimension 2: Operating Model*, there is need to show clear accountability and transparency to all ACT-A stakeholders, particularly for funding flows across agencies. Access to financial data at the cross-pillar-, pillar-, agency-, or activity-level would allow donors and other stakeholders to effectively monitor funding flows and make the link to measurable health and economic impacts on the ground. Each agency would continue using current systems and accountability mechanisms and remain responsible for reporting financial information to donors. Examples of this data include inflows (pledged and received funds), and outflows (committed and disbursed funds) at the lowest level feasible (e.g., first tier of implementors). In the case of health and economic outcomes, data could be disaggregated by gender and socioeconomic variables to monitor equity in the global response.

   The ACT-A Executive Hub and agencies should align on a data-sharing framework that ensures more consistent financial and operational reporting while upholding each agency's autonomy. This framework would define the frequency, format, level of detail and financial structure that is needed to provide more visibility at the aggregate level and feasible for agencies to follow. If possible, this framework should follow international recognized standards, aligned to each agency's financial rules and regulations. The framework should also consider special characteristics and limitations on each agency's financial systems to ensure feasibility and internal coherence in the reporting.

3. **Support greater use of concessional finance and other resourcing channels as a complement to grant funding.**

   In addition to maximising grant funding opportunities, ACT-A should further expand resource offerings by offering the use of WB/IFI funding. This would include leveraging the Financial Working Group's revised financial framework and new available funding tools (e.g., SDRs), and collaborate with MDBs to identify and address obstacles to access finance for governments. For example, ACT-A could replicate the World Bank-COVAX cost sharing mechanism to increase available funding and facilitate engagement with recipient countries for all Pillars.

   Partners should build awareness of all financing options in support of country level decision-makers. ACT-A Partners and working groups should further reinforce the complementary between grant and loan funding in their communications with recipient countries. This would include recommendations on most suitable types of funding—grant, concessional, or other—based on the planned intervention.

   To achieve this, MDBs should take a more integrated and coordinated role in ACT-A. MDBs and other financial institutions should be further integrated into ACT-A's Pillars and working groups to help accelerate achievement of the aims mentioned above.

VI. Dimension 4: Broader ecosystem

Introduction

This dimension considered the external forces and global developments relevant to ACT-A's work. The findings and implications are structured into three areas: general environment and implications for ACT-A's mission and role (*situation*); new initiatives since ACT-A began and how it fits into that changing landscape (*external*); and how ACT-A represents itself, influences, and works with that landscape (*internal*).

Findings and analysis

Situation and operating environment

Epidemiologically, the shifting COVID-19 pandemic has forced ACT-A to adapt. New emerging science on the virus itself, its waves through various geographies, and emerging learnings on prevention and treatment have all influenced the needs for ACT-A support in countries. This has been an important factor in the mechanism's reliance on agile and adaptable structures, including: frequent strategy cycles to evaluate goals and approaches, evolution of tool offerings within pillars (e.g., medical oxygen), and pragmatism and rapid decision making among principles (see *Dimension 2: Operating Model* for more).

Despite these efforts, new emerging variants continuously threaten our progress to date. Since the designation of the first significant SARS-CoV-2 variant in December 2020, the WHO has recognized nine Variants of Concern (VOC) or Variants of Interest (VOI).[242] This indicates the significant ongoing threat to global progress in terms of both case control and the efficacy of countermeasures. Though existing tools have remained effective, proactive R&D will be an ongoing priority for all product categories even while greater efforts are made on downstream delivery and country uptake. Further, it highlights the need for comprehensive responses, making use of diagnostic testing to monitor breakthrough infection and effective treatments for severe cases.

Further, expert consensus has begun shifting to consider the implications of SARS-CoV-2 as an endemic threat. In light of the ongoing widespread community transmission and risk of new variants, there are growing concerns of COVID-19 as a long-term threat.[243] As a result, many stakeholders have begun looking ahead to the integration of such work into long-term global health programmes. While ACT-A remains focused on accelerating uptake of tools to end the acute phase of the pandemic, this suggests a coming pivot in objectives toward longer-term country support and sustainability.

At global level, geopolitical tensions played a major role in defining ACT-A's initial potential. As countries began mobilising in the first days of the pandemic, their varied willingness to engage in collaborative response was a key input to determining the scope of possible ACT-A opportunities. In particular, reluctance among China, India, and the United States to engage at the start was a major constraint, in terms of both establishing coordinated global procurement and influence power for global health. This has potentially had repercussions throughout ACT-A's work, from the engagement of key partners in HSC to the availability of critical commodity supplies from domestic suppliers.

[242] "Tracking SARS-CoV-2 Variants", World Health Organization, 2021: Accessed at: https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/ on 15 September 2020
[243] "The coronavirus is here to stay – here's what that means", Nature, 16 February 2021, Accessed at: https://www.nature.com/articles/d41586-021-00396-2 on 15 September 2021

Though this landscape has begun to shift more recently, especially with increased involvement from the US, the early impacts of these choices continue to constrain ACT-A today.

Within countries, exceptional socioeconomic turmoil has driven a focus on domestic response. Underlying governments' decisions to participate in ACT-A at the start was the reality of extreme domestic challenges. The surging pandemic brought economies to a rapid halt, resulting in sharp declines in employment and significant GDP loss around the world. In response, governments in higher-income countries invested heavily in domestic stimulus and response packages, estimated to total over US$10 trillion in just the first two months of the pandemic.[244] While these measures showed some local impact, it significantly constrained the options available to ACT-A agencies and participating countries for resourcing and tool procurement.

Most visible in this has been the unanticipated extent of vaccine nationalism, complicating efforts for coordinated action. The nature of COVID-19 countermeasures as common-pool resources meant as new tools became available, higher-income countries and those with domestic vaccine production capacity pursued bilateral contracts or restricted export of domestic products. The competing incentives to protect one's own citizens while promoting an equitable response has limited the power of ACT-A. This was particularly acute for vaccines (but could equally become an issue for treatments if new solutions are identified). The vast majority of early vaccine production was secured by higher-income countries through bilateral contracts, with insufficient supply left for COVAX. To date, 39 countries have secured doses in quantities covering more than 300% of their population.[245] These domestic choices have constrained how the international community can mobilise and use shared funding and has forced re-evaluation of the potential for globally coordinated distribution.

Responses around the world have been further complicated by rising levels of vaccine hesitancy, putting national immunisation plans at risk. Despite the widespread availability of vaccine doses today in higher-income countries, scepticism of the new tools has resulted in lower-than-expected uptake. This hesitancy shows institutional mistrust and divisive political dynamics and has been exacerbated by inconsistent communication and widespread misunderstanding of vaccine R&D and approval processes. Further, if communities refuse vaccinations, significant quantities of scarce doses could be put at risk of expiry and wastage (though to date no significant wastage has been observed in COVAX-delivered doses). This emphasises the importance of holistic operations that support the effective use of tools to ensure the world maximises the impact of scarce products. Further, ongoing messaging from clear and locally trusted sources will be key to support on-the-ground delivery.

External landscape and emerging initiatives

The combination of shifting need and recognition of persistent gaps has driven the emergence of new international efforts for COVID response. As the COVID-19 pandemic has gone on, actors have continued to seek new ways of meeting local needs. This spread of initiatives has spanned global, regional, and bilateral efforts, across the commodity value chain. There has been a particular focus on overall response coordination and support to vaccines, with less proliferation in the Tx and Dx spaces.

At the global level, new multilateral efforts have sought to expand coordination and access to financing. In particular, the Multilateral Leaders Taskforce on Scaling COVID-19 Tools (MLT)[246] offers an opportunity to bring the major multilateral financing bodies together to align funding plans, and represent one voice to countries around offerings and resource opportunities. Other innovative

[244] "Total stimulus for the COVID-19 crisis already triple that for the entire 2008-09 financial crisis", McKinsey and Company, 2020 Accessed at https://www.mckinsey.com/featured-insights/coronavirus-leading-through-the-crisis/charting-the-path-to-the-next-normal/total-stimulus-for-the-covid-19-crisis-already-triple-that-for-the-entire-2008-09-recession on 15 September 2021
[245] "Launch and Scale Speedometer: Vaccine Purchases", Duke University Global Health Innovation Center, 2021. Accessed at https://launchandscalefaster.org/covid-19/vaccinepurchases on 30 September 2021
[246] Includes IMF, WB, WHO, and WTO

or tailored resourcing approaches, such as the IMF's exceptional distribution of special drawing rights (SDRs), have also been mobilised to support country responses. Looking to the future, a growing landscape of global health security efforts will further complement the role of ACT- A and its members. This includes efforts on upstream spill-over prevention (e.g., Preventing Pandemics at the Source), earlier detection and forecasting (e.g., WHO Hub for Pandemic and Epidemic Intelligence), response (e.g., Ending Pandemics), and cross-cutting financing (e.g., recently announced USA-backed global health financial intermediary fund). These efforts will all build on today's emergency-focused work to support longer-term preparedness and health security. However, in the short term, there is also a risk they draw resources away from ACT-A's emergency work, and necessitate clear messaging and prioritisation to avoid risks.

Regional efforts have further expanded vaccine procurement among participating countries. The growth of new regional initiatives has been most significant in the vaccine space, where efforts have focused on expanding local access to doses. Country- and region-led partnerships—such as the African Vaccine Acquisition Trust (AVAT, via African Union) and the Asia Pacific Vaccine Access Facility (APVAX, via Asian Development Bank)—have successfully began securing doses for member states to augment COVAX distributions. These have shown progress in supplementing planned deliveries to date, though there remains a risk of fragmenting coordinated procurement efforts and undercutting the bargaining power of each initiative.

Donors and manufacturers have also pursued bilateral arrangements with L/MICs for vaccine procurement and donation. Further to regional procurement, lower-income countries have also undertaken direct negotiation with rich countries and manufacturers. To date, higher-income countries have donated over one billion total doses out of excess domestic supply, of which approximately 75% have flowed through COVAX.[247] Given the constrained supply situation impacting scale-up of COVAX's delivery, these donations have been an important source of doses for many countries. However, donations given directly to receiving countries, or via COVAX with country-specific earmarks, may not be guided by ACT-A's equity focus and risk furthering disparities between receiving countries. Further, these donations forego COVAX's standard indemnification and liability (I&L) agreements and no-fault compensation (NFC) programme, which protect countries against liabilities from adverse effects following immunisation. In some cases, there is also significant risk that donations are not fully suited to country needs and may cause diversions from optimal response—for example as a result of donated doses arriving already close to expiry or lacking requisite ancillary kits.

This growing landscape will necessitate strong coordination between ACT-A and others to ensure ACT-A's continued value for an efficient response. In many cases, countries have turned to these new initiatives in response to perceived shortcomings in ACT-A's mission or ability to deliver. Further, local efforts have built on greater knowledge of local needs and priorities. These initiatives offer promising new avenues to accelerate the delivery and uptake of tools where they are needed most. However, to avoid further fragmentation of procurement and promote equitable uptake, it will be key that ACT-A works closely with these initiatives to align on strategic plans and complementarity. Further, many of the emerging efforts may not be as focused on supporting local health systems to facilitate product uptake, for which ACT-A would remain an important central coordinator.

Internal operations for communications and influence

How ACT-A agencies jointly represent and engage externally will be major enabler of alignment and influence. Much of ACT-A's work depends on international buy-in and political will to collaborate. Further, it must do so at a time of ongoing uncertainty and national competition. Therefore, its public

[247] "Launch and Scale Speedometer: Vaccine Donations and Exports", Duke University Global Health Innovation Center, 2021. Accessed at https://launchandscalefaster.org/covid-19/vaccinedonations on 15 September 2021

presence and ability to build and maintain support from countries and agencies is an important tool to advance its cross-agency work. Furthermore, effectively promoting a three-pillar strategy as the most effective way to address the pandemic is best supported by a coherent and consistent narrative across each pillar. This means agencies consistently communicating the value of a three-pillar strategy, and aligning their resource mobilisation discussions around the same strategy and budget to achieve it.

However, to date ACT-A has lacked a distinct brand presence or single public "voice". The ACT-A partnership has no unified website, published materials, or single representative. Rather, the Executive Hub (hosted by WHO) has served as a central coordinator, and shared materials such as meeting minutes and published papers are posted to a WHO-hosted webpage. Beyond this, only the Vaccines Pillar has a widely recognized external presence, under COVAX. Otherwise, the partnership has relied on each agency to represent its respective role. This has been an intentional choice in keeping with ACT-A's decentralised model and utilizing existing systems, as well as to avoid potential sensitivities around competing brands or ceding influence in the partnership. However, the approach has come with a significant trade-off around lack of clarity and unity in ACT-A's external presence. Even when messaging has been developed on behalf of ACT-A, there has not always been full alignment between agencies on approach or tailoring to audience needs.

> *"Although a loose partnership might make sense internally, it is very hard for anyone outside of ACT-A to understand - including CSOs, donors, governments, and journalists."* ~ Internal stakeholder

These challenges contribute to a lack of awareness of ACT-A's priorities, work, and impact and constrains its ability to advocate for coordinated global response. Interviewees often noted uncertainty around what ACT-A "is", what it does, and who to go to with inquiries or concerns. Even recipients of ACT-A products showed at times confusion around the model or its mandate, and a lack of awareness that mechanisms such as COVAX or C19RM were part of a broader strategic partnership. These challenges severely limit the partnership's ability to build global credibility and influence beyond the work of the individual agencies. Perhaps most notably, it has to date failed to sufficiently convince donors and governments of the importance of a comprehensive response using all three tools, as shown in the distribution of funding to ACT-A Pillars and domestic response priorities. Meanwhile, it also risks allowing duplication or undercutting by other initiatives, especially those with more local presence or those operated through existing regional bodies.

Recommendations

1. **Establish a strong external-facing ACT-A brand with consistent messaging.**

   ACT-A should consolidate around a common, unified representation of the partnership. At root, this means aligning partnership-wide communications through a shared branded resource (e.g., website) and providing consistent external messaging. It should publish shared documents, ongoing reporting, and significant announcements as one partnership through this resource, and ensure that communications to both donors and recipient countries are sent in alignment with this shared branding. To facilitate this effort, ACT-A should designate an existing entity or body to coordinate and support decision-making on developing and maintaining such communications (such as, for example, the Executive Hub or Principals Group).

   ACT-A should leverage this brand presence to garner greater support for the multi-tool strategy. By working through a publicly known brand, ACT-A can build community support

for its work and more clearly articulate the aggregated impact of its multi-pillar approach. This will strengthen its collective messaging and ultimate seek to garner more support.

2. **Continue to lead the global movement for an equitable response, and maintain strong channels of coordination with complementary initiatives for procurement and financing.**

   ACT-A should continue to be the global advocate and central resource for equitable and effective tool uptake. ACT-A must continue to drive for coordinated and strategic allocation of scarce tools. At minimum, it should implement recommended standards for bilateral donations, such as remaining time to product expiry, local readiness for uptake (e.g., appropriate cold chain or ancillary kits), and others to ensure maximum impact. Going further, to the extent countries with excess stock continue to share products, ACT-A should continue to advocate for its role as a clearing house to channel all donations, with the flexibility to allocate them according to need among recipient countries.

   In addition, ACT-A should continuously define areas of collaboration and complementarity with new efforts. It should work closely with both global and regional initiatives, including those in place today and others as they arise in the future. It should explicitly articulate ways of working and promote efficient coverage in all countries. In particular, at global level, ACT-A should work closely with the MDBs to signal to recipient countries the global coordination of health financing tools, and to ensure that MDB resources are available to support ACT-A objectives if and as countries deem this the right approach for their own national responses. Regionally, ACT-A should work closely with AVAT, APVAX, and others as relevant to be clear on respective access to limited supply of tools and plans for distribution, coordinate on delivery timing, and collaborate to identify and address barriers to country uptake.

VII. SYNTHESIS OF RECOMMENDATIONS

Forward-looking objectives

The recommendations in this report were developed with a view to supporting ACT-A to be as effective and efficient as possible. This means ensuring it has the members, systems, and ways of working that will enable it to best reach its targets. Overall, the recommendations are intended to help achieve the following objectives:

- **Close the equity gap in COVID-19 tools:** Support all communities around the world to access and use the life-saving tools they need to end the acute phase of the COVID-19 pandemic.
- **Have countries at the centre:** Ensure that recipient countries and their representatives play an active and meaningful role in shaping the work of ACT-A, to ensure the global response is as relevant, tailored, and dignified as possible.
- **Capitalise on organisations' strengths:** Leverage the best of existing capacity and expertise from across the global health community to accelerate the work of the ACT-A partnership.
- **Build strengthened visibility and accountability:** Make it as easy and open as possible for stakeholders everywhere to follow the collective work of ACT-A, monitor investments and evolving gaps between need and deliveries, and understand linkages between outputs and impact.
- **Speak with a unified voice and clear positioning on needs, objectives, and approach:** Expand global recognition of the ACT-A partnership and its goals to make it easier to understand and engage with, and in turn strengthen its credibility and influence with all stakeholders.

All recommendations are focused on near-term adjustment and optimization. The scope of this Review specifically targeted adjustments to ACT-A's approach and ways of working for the remainder of its current mandate. To that end, all recommendations are intended to be actioned promptly to have impact in the next 6-18 months.

The recommendations made in this section are not comprehensive of ACT-A's opportunities for improvement. These formal recommendations address the most significant, overarching needs for refinement. They do not address specific Pillar- or workstream- level adjustments or priorities. However, the findings and challenges highlighted throughout this report offer additional, targeted areas where ACT-A co-conveners, partners, and Facilitation Council members should work together to further improve ACT-A's future operations and impact. (Note as well that the recommendations below are a synthesis of those presented within each *Dimension*.)

Sequencing and prioritization

Implementing these recommendations will require a prompt process of decision making and execution. The key to realising the impact of these recommendations will be the timeliness with which they are put in place, to benefit the remainder of ACT-A's work. The categories of recommendations as outlined below offer an initial perspective on the critical path and prioritization to best serve the partnership. Throughout this process, the Principals Group should remain accountable for monitoring and verifying the execution of all recommendations selected for implementation.

To begin, ACT-A should take strategic decisions around its mandate and scope. The recommendations pertaining to "health systems and country support" raise the greatest implications

for the partnership's overall approach and priorities for the coming year. These choices will also have the most impact for many of the actions that follow.

Based on those decisions, ACT-A senior leadership should define and operationalize updated norms and expectations for participation in the partnership. After aligning on strategic choices, the Principals Group should then ensure that the right partners are at the table and working as effectively together as possible. This includes in particular the recommendations on "participation and engagement.

With those changes in place, the refined partnership should work together to take forward all other recommendations to optimise ACT-A's effectiveness and efficiency. Within the agreed strategy, and working with both existing and new partners, ACT-A should implement the recommendations pertaining to "communication and information sharing" and "external coordination and collaboration". Throughout this process, the Principals Group and individual agencies should report out on goals, progress, and any necessary adaptations as plans are put into place.

Mandate

- **Continue ACT-A whilst there is still value in global coordination on COVID-19 tools along the entire value chain, likely throughout 2022.**

  ACT-A should continue its crucial role as the only global level partnership bringing a coordinated effort across medical countermeasures (diagnostics, therapeutics, and vaccines). The time-limited partnership should continue as long as there remains an acute need for coordinated support around driving equitable access (including R&D, introduction, and scale-up) of COVID-19 tools in L/MICs. (Given the likely upcoming supply increase for critical tools, it is possible that the acute need for global coordination of such support may decrease during 2022 – but note that this relies on modelling and projections that are beyond the remit of this review, and so this question will require assessment in the future.)

  Although there will be a need to consider structures for future pandemic preparedness which build on the lessons learnt from ACT-A, this lies beyond ACT-A's scope. Activities which will outlive ACT-A, or are focused on future pandemics, should be moved outside the ACT-A construct. To this end, stakeholders should identify channels through which lessons from ACT-A and from consultations with countries can be considered for future pandemic preparedness arrangements.

Health systems and country support

- **In addition to maintaining the urgency and focus on R&D and regulatory efforts, increase strategic emphasis on downstream work. This means supporting in-country product uptake and working to close the equity gap for currently available tools.**

  Product procurement and delivery are the most pressing priorities for countries today. In the face of new variants and the current lack of a broad-use treatment for COVID-19, continued R&D and efficient regulatory processes across all pillars will be critical to staying 'ahead' of the epidemic. This will include planning for different scenarios and working to minimize inequalities in future tools. However, given that a) effective tools are available, b) supply is forecasted to increase in the coming months, and c) major inequities persist in use of those tools between higher- and lower-income countries, in the current phase a relative priority within ACT-A's strategy and budget should be on ensuring equitable allocation and uptake. This should include both the Procurement (contracting, allocation and prioritization, timely shipment) and Delivery (readiness assessment, demand generation, health systems support) components of the value chain.

Strengthening uptake capacity now will also support future outcomes. Building country capacity for uptake will also ensure future tools that are developed (if and as relevant) can also be adopted quickly. In addition, effective uptake of tools now will reduce transmission and case numbers, and in turn reduce the pressure for research and development stemming from the threat of new variants.

- **Focus the HSC mandate to be more clearly on response and supporting gaps in country readiness and tool uptake not currently covered by the Pillars.**

  As ACT-A's primary goal is to end the acute phase of the pandemic through access to key tools, HSC's efforts should be concentrated on strengthening those elements of the health system which directly support the roll-out of those tools as quickly, safely, and sustainably as possible in support of national SPRP priorities. This includes ensuring that essential health services are not disrupted, availability of PPE is increased, appropriate waste management for all tools is available, there is appropriate recruitment of and support to human resourcing for health—and parallel systems are not created throughout. Overall, investments should primarily focus on supporting the rapid uptake of ACT-A-supported tools, while maintaining sight of long-term sustainability and integration with routine services. In line with ACT-A's overarching objective, activities which do not directly link to a country's COVID-19 response should be housed outside of ACT-A.

- **Further link ACT-A to national COVID-19 responses by working with WHE IMSTs at all levels to better connect dynamic country needs with pillar-level strategic planning across the value chain, enabling ACT-A to take a more proactive, country-centred, and demand-driven approach.**

  There are opportunities to strengthen country support by creating stronger feedback loops between ACT-A and countries. WHE, C19RM, and COVAX already work together to ensure the support from each channel is aligned with countries' SPRPs. However, there is an opportunity to better support countries by more closely linking with the work of WHE through IMSTs (at regional and country levels) across pillars. For example, information on Situations of Concern could be used to better inform procurement and distribution plans, priorities in upstream work, reprogramming of existing resources, and the types of technical assistance agencies offer. More generally, closer integration of ACT-A and WHE could provide a stronger feedback loop between countries' national plans and ACT-A support. While countries continuously adapt their national strategies to the latest available tools, supply conditions, and policy changes, ACT-A could be more closely involved in informing these choices and in turn using the information as input to its own procurement and distribution efforts. This will help countries keep their plans up to date, and will also help ACT-A gauge demand for tools.

- **Support greater use of concessional finance and other resourcing channels as a complement to grant funding.**

  In addition to maximising grant funding opportunities, ACT-A should further expand resource offerings by offering the use of WB/IFI funding. This would include leveraging the Financial Working Group's revised financial framework and new available funding tools (e.g., SDRs), and collaborate with MDBs to identify and address obstacles to access finance for governments. For example, ACT-A could replicate the World Bank-COVAX cost sharing mechanism to increase available funding and facilitate engagement with recipient countries for all Pillars.

  Partners should build awareness of all financing options in support of country level decision-makers. ACT-A Partners and working groups should further reinforce the complementary between grant and loan funding in their communications with recipient countries. This would

include recommendations on most suitable types of funding—grant, concessional, or other—based on the planned intervention.

To achieve this, MDBs should take a more integrated and coordinated role in ACT-A. MDBs and other financial institutions should be further integrated into ACT-A's Pillars and working groups to help accelerate achievement of the aims mentioned above.

Participation and engagement

- **Increase and enhance L/MIC, CSO, and Community representation and involvement in ACT-A.**

  All ACT-A participants should contribute to behaviours and practices to ensure that representation of L/MICs, CSOs, and Community Representatives (CRs) in ACT-A forums is timely, proportionate, and meaningful. Recognising the importance of these stakeholders' own experience and perspectives requires they be given the opportunity to engage in ACT-A forums on an equal footing as others.

  Greater L/MIC representation should be driven through the Facilitation Council, the Pillars, and HSC.[248] Emerging models[249] to balance regional representation and specifically to increase L/MIC membership in the Facilitation Council and its working groups should be finalised and implemented. This can be done while still managing the overall size of these bodies, and through identifying individuals with relevant expertise. Processes and working norms around regional representation should be developed and agreed. These must facilitate country representatives collecting and reflecting input from their regional counterparts who are not Facilitation Council members, and enable and empower them to share information back with their region. The broader Principals Group, Pillars and HSC should ensure that L/MIC representatives are consulted on key strategy and budget considerations that will impact recipient countries before these are raised to agencies' governing bodies for final decisions.

  All ACT-A structures should consult with CSOs and CRs, and potentially through the Platform for ACT-A Civil Society and Community Representatives, to agree and coordinate timely and balanced inclusion of perspectives. CSOs and CRs must be able to contribute on an equal footing as other participants, including having timely access to relevant materials to enable meaningful consultation.

  All ACT-A structures should define and adopt specific practices for including and reflecting different perspectives. L/MICs, CSOs, and CRs should be included from inception or as early as possible thereafter in working groups to be able to engage fully. Read-outs and reporting from meetings at all levels should outline different stakeholder viewpoints for the record. Meeting formats should endeavour to accommodate different practical restrictions to not preclude certain stakeholders from participating effectively.

  Importantly, all stakeholders must remain conscious that practical levers alone cannot necessarily address intangible drivers of under-representation. All stakeholders must

[248] The Principals Group is not listed here as it does not have country members.

[249] Options currently under consideration by the Facilitation Council include: i) adding representatives from regions currently proportionately underrepresented relative to their total population, such that more than 50% of the population in each region would be represented by a council member, or ii) adding representatives from regions currently proportionately underrepresented relative to the number of states in the region, such that all regions would have at least 15% of their member states represented in the council. Option i) would require the addition of new members from Africa and the eastern Mediterranean region, while option ii) would require the same as well as increasing membership from the Americas. Neither of these options directly considers income levels as a criterion for equitable representation.

challenge and counteract biases and behaviours in themselves and others that downplay, limit, or otherwise diminish some participants' contributions.

- **Re-affirm the mandate of the Facilitation Council and set up a regular communication channel with the Principals Group.**

  The Facilitation Council (FC) should reaffirm its original mandate to provide "advocacy for collective approaches to solutions in the global interest and for the mobilisation of additional resources as needed", as set out in its current Terms of Reference.[250] To date, the Council has not always been successful in building sufficient political support for the ACT-A construct and its objectives, and this goal requires renewed focus. As such, the FC should internally reiterate and reaffirm their mandate as set out in the Terms of Reference.

  A one-off session should be held between the FC and the smaller Principals Group to affirm their respective roles in ACT-A's governance, and norms for how they work collaboratively. This session should affirm the following key aspects:

  - The FC and PG play bi-directional advisory roles and share information to support the successful execution of their respective tasks.
  - The FC does not have oversight responsibility over the Pillars and HSC (i.e., it is not designed to approve decisions, monitor or assess delivery, or hold implementers accountable), as this authority is held by the co-convening agencies' governing bodies. This is in line with the principle of subsidiarity adopted in the FC TOR, whereby decision-making at agency level is preserved.[251]
  - The Principals Group and partner agency boards have ultimate responsibility and accountability for delivering on ACT-A's objectives.
  - The FC is consulted on overarching ACT-A decisions including strategy, budget, and priority setting; these decisions are made by consensus across the co-convening agencies[252] facilitated by the Executive Hub.
  - The FC supports these efforts through political advocacy and resource mobilisation for ACT-A; to enable the FC to be effective in this role, the partner agencies should provide the FC with clear and regular visibility of their progress towards the Pillars and HSC's goals, and related financial flows, based on an agreed data sharing framework (see related recommendation below for details).

  Regular meetings between the FC Co-Chairs and the Principals Group should be established for bi-directional information sharing and advisory. The Special Envoy should support this coordination in his or her capacity as Chair of the Principals Group. While the FC Co-chairs and Principals already have significant demands on their time, this important connection should not be neglected.

Communication and information sharing

- **Align around ACT-A's collective brand to support stronger and more consistent messaging to external audiences, including i) building common advocacy messages in support of resource mobilisation efforts and ii) enabling external stakeholders to more easily understand and engage with the partnership**

  ACT-A should consolidate around a common, unified representation of the partnership. At root, this means aligning partnership-wide communications through a shared branded

[250] "ACT-A Facilitation Council Terms of Reference", Facilitation Council, 9 February 2021
[251] "ACT-A Facilitation Council Terms of Reference", Facilitation Council, 9 February 2021
[252] Each agencies' inputs into these processes are subject to the governance of their respective governing bodies. Importantly, many Council members hold seats on co-convening agencies' governing bodies and can directly hold those organisations to account through these channels. These roles are held as representatives of their own constituencies and not as members of the ACT-A FC, and thus should not flow into the FC, whose focus needs to remain clear in order to maximize its advocacy value.

resource (e.g., website) and providing consistent external messaging. It should publish shared documents, ongoing reporting, and significant announcements as one partnership through this resource, and ensure that communications to both donors and recipient countries are sent in alignment with this shared branding. To facilitate this effort, ACT-A should designate an existing entity or body to coordinate and support decision-making on developing and maintaining such communications (such as, for example, the Executive Hub or Principals Group). ACT-A should leverage this brand presence to garner greater support for the multi-tool strategy.

ACT-A should develop clear descriptions of the mandates of different bodies, roles of different stakeholders, and authorities over different types and levels of decision-making. This is to provide open information about the mechanisms and channels through which ACT-A operates for all stakeholders, and to enable them to identify and engage with the appropriate entities where they may have reason to do so. This information should be easy to find and access, and updated on a regular basis. This effort could be coordinated by the Executive Hub, with supporting input from other ACT-A members.

ACT-A partners should seek greater alignment between agency RM efforts and the Facilitation Council's advocacy efforts and anchor on a narrative clearly linking funding requests to countries' needs and measurable local health and economic outcomes. Stakeholders must build alignment around respective roles and expectations, built on a shared advocacy strategy, goals and messaging. This includes clear understanding of what RM-related activities will be executed through the FC (i.e., global advocacy efforts for ACT-A, tracking of funding gaps, etc.), and agencies (i.e., direct fundraising), as well as fundraising targets. It will also involve clear alignment on key messaging with donors to ensure a cohesive narrative across Pillars and other ACT-A's structures. In keeping with strong requests from donors, ACT-A fundraising stakeholders should align behind an outcomes-based narrative for future appeals. This approach would articulate a narrative that reinforces the value of donor investment while further emphasising the importance of a fully funded comprehensive (cross-pillar) response for the local and global economies.

- **Build countries' awareness of the full range of products, support, and financing options available from ACT-A partners to boost overall country engagement and ensure ongoing connectedness with national response plans.**

  ACT-A should support countries to understand the full scope of support available from C19RM, COVAX, SFF and HAC, WB, WHO and other agencies and mechanisms that are part of ACT-A. This can be in the form of clear and regular communications sent jointly on behalf of the ACTA partnership to leaders of all eligible recipient countries. This is with the aim of i) reducing transaction costs for countries who are coordinating multiple partnerships, ii) highlighting to countries that offerings between different partners are coordinated and complementary and iii) enabling timely and tailored connections with partners as needed, in line with country priorities. Within this, ACT-A should encourage alignment of financing with national priorities and domestic resources from the start, with ACT-A partners and mechanisms coordinating and harmonizing funding mechanisms and working through government systems where possible.

  Clearer communication on offerings available could drive higher product uptake across all pillars and support more comprehensive COVID-19 strategies that include testing, surveillance, and treatment. Additionally, the process of creating coordinated communications to countries could encourage greater synergies between pillars on areas such as technical assistance, data management, and country readiness.

As a cross-cutting exercise, collating these offerings to communicate to countries could be a role for the Health Systems Connector.

- **Launch a 'data sharing framework' to enhance the quality and increase availability of aggregated programmatic and financial reporting.**

  ACT-A should provide clear consolidated operational[253] and financial reporting to all ACT-A stakeholders, including those not participating in agency-specific governance processes. These communications would articulate ACT-A's impact in countries and effectiveness in sum, and build greater confidence in its collective work. This greater visibility, specificity and ease of access will be key enablers to future resource mobilisation—potentially bringing even greater future impact in turn. Practical barriers to accessing clear and timely information should be reduced where possible, including having to consult multiple sources, or not having access to comparable information across entities. This is to help donors and other stakeholders have a clear and accurate view of ACT-A's performance, so that they can make informed and timely decisions. Each agency would continue using current systems and accountability mechanisms and remain responsible of reporting financial information to donors.

  The Executive Hub should lead an effort to establish a robust information sharing framework and cadence, with supporting input from partner agencies. Donors, the Facilitation Council, and partner agencies should be consulted to determine what key information is available and needed to support ongoing fundraising and advocacy. This may include, amongst others, providing timely integrated updates on funding received and deployed, and quantitative tracking of key deliverables including both outputs and links to outcomes/impact. Wherever relevant, the framework should follow international recognized standards, aligned to each agency's financial rules and regulations. The framework should also consider special characteristics and limitations on each agency's financial systems to ensure feasibility and internal coherence in the reporting. Stakeholders proposed an option to establish a standing committee to support these efforts, which should be considered.

External coordination and collaboration

- **Continue to lead the global movement for an equitable response, and maintain strong channels of coordination with complementary initiatives for procurement and financing.**

  ACT-A should continue to be the global advocate and central resource for equitable and effective tool uptake. ACT-A must continue to drive for coordinated and strategic allocation of scarce tools. At minimum, it should implement recommended standards for bilateral donations, such as remaining time to product expiry, local readiness for uptake (e.g., appropriate cold chain or ancillary kits), and others to ensure maximum impact. Going further, to the extent countries with excess stock continue to share products, ACT-A should continue to advocate for its role as a clearing house to channel all donations, with the flexibility to allocate them according to need among recipient countries.

  In addition, ACT-A should continuously define areas of collaboration and complementarity with new efforts. It should work closely with both global and regional initiatives, including those in place today and others as they arise in the future. It should explicitly articulate ways of working and promote efficient coverage in all countries. In particular, at global level, ACT-A should work closely with the MDBs to signal to recipient countries the global coordination of health financing tools, and to ensure that MDB resources are available to support ACT-A objectives if and as countries deem this the right approach for their own national responses.

[253] Operational reporting would include qualitative and quantitative tracking of delivery against stated objectives, to demonstrate what impact funding is achieving, how rapidly and where.

Regionally, ACT-A should work closely with AVAT, APVAX, and others as relevant to be clear on respective access to limited supply of tools and plans for distribution, coordinate on delivery timing, and collaborate to identify and address barriers to country uptake.

VIII. ANNEXES

Annex 1: Guiding assessment questions

Dimension	Indicative assessment questions
Overarching: What overall learnings can we take forward from ACT-A's formation and activities to date, to optimize its future impact?	• In what ways did the **operating context**[254] **or assumptions** influence ACT-A's original design/set-up? How has that context evolved since launch, and what does it mean for ACT-A's ways of working going forward? • What have been the key **strengths and successes** of the focus and construct of the ACT-A to date? • What **key challenges** has the ACT-A faced to date, and what learnings can it take from these to potentially adjust its focus and approach going forward? • What **comparative advantages** / unique value does the ACT-A bring to its scope of influence (development, production, and equitable provision of COVID-19 tools)? In what ways has it enhanced or detracted from the work of individual partner agencies?
Dimension 1 - Scope and objectives: How can the scope of ACT-A be adjusted to better achieve its objectives?	• What were ACT-A and its Pillars original **strategy and priorities** (including scope of focus)? How have these, and subsequent activities, changed over time? How does it account for evolving knowledge and evidence pertaining to SARS-CoV-2 and COVID-19? • To what extent were ACT-A's original objectives and priorities **appropriate** to global needs at the time they were set? To what extent do they remain fit for purpose to address today's most pressing needs? • To what extent have the ACT-A's and its Pillars' priorities (Dx/Tx/Vx/HSC) **supported the overall objective** to accelerate development, production, and equitable access to COVID-19 tools? • Are ACT-A's **unified workplans and budgets** well-suited to achieving its objectives? Do they sufficiently account for diverse country-level needs, and promote country ownership? • What has influenced the **relative focus** between pillars/priorities to date? How, if at all, should that focus change, and what would be required to do so successfully?
Dimension 2 - Operating model: Is ACT-A's operating model optimized to effectively	• Do the respective domains of expertise and scopes of work of **partner organizations** complement each other effectively to meet ACT-A's goals? Are there any duplications or gaps? • Do the **leadership fora** and Pillars ensure programmatic consistency and coordination between partners? Are there opportunities to better leverage **synergies** across workstreams and pillars, or reduce **siloing**?

[254] The operating context refers to considerations including (but not limited to) latest epidemiology, global needs and priorities, disparities in country-based responses, prevailing R&D landscape, and partner and donor landscapes.

draw on and bring together the best of global resources to achieve its goals?	• To what extent have the roles played across ACT-A and its Pillars been assigned to **suitable partners**? • Are **coordination and decision-making processes**[255] at the ACT-A / Pillar level timely and responsive to needs at country level? To what extent is decision making inclusive of **diverse perspectives,** especially recipient countries not represented in ACT-A? What, if any, changes would improve decision making? • What, if any, **governance practices and reporting** support implementation and monitor progress against shared objectives? How might these practices be improved to provide effective and transparent programmatic and financial management (including allocation, disbursement, and expenditure)?
Dimension 3 - Financing: How can ACT-A and its partners most effectively and efficiently raise and deploy funding to achieve their goals?	• How do **fundraising models** vary by pillar? To what degree do these models meet the needs of participating agencies? the needs of the agencies? • Where has funding come from to date, and what have been the benefits and drawbacks of that **donor landscape**? What changes in the approach and donor types should the ACT-A pursue in future? Why? • When the ACT-A has faced **funding shortfalls**, what have been the main drivers? What can partners do to ensure sustainable financing? • How have ACT-A Pillars managed gaps between funding **needs** vs. **commitments** in the past? What, if anything, should be changed (when applicable) going forward? • How has **funds deployment** functioned to date? How can this process be improved[256]?
Dimension 4 – Broader ecosystem: How should ACT-A leverage its position and relationships, and proactively shape and respond to changes in the ecosystem in the future?	• What major **external trends** (e.g., epidemiological, geopolitical, macroeconomic, shifts global health systems) have had the greatest impact on ACT-A Pillars' abilities to deliver on their goals to-date, and how can they best stay adaptive to these going forward? • How can the ACT-A partners leverage their relationships with different types of **external actors** (e.g., governments, civil society, industry, media / public) to support it in achieving their goals? • What **levers** can ACT-A and partners use to influence the **incentives and economics** for different stakeholders (public, private, and civil sector) across the COVID-response ecosystem to collaborate (collaboration, financing, support)? • What **related new initiatives** have emerged since ACT-A's launch, and how does ACT-A ensure alignment and complementarity? What are implications for ACT-A's future work?

[255] Noting that ACT-A and its Pillars were not set up as formal decision-making entities, this question relates to collectively agreed items such as overall strategies, and budgets and operating arrangements

[256] Optimizing for timely and reliable disbursement, cognisant of recipient absorption capacity

Annex 2: Interview list

Amanda Banda	*Wemos*
Ameenah Gurib-Fakim	*Government of Mauritius (former)*
Americo Beviglia Zampetti	*European Commission*
Analía Porras	*PAHO*
Anders Nordström	*Independent Panel Pandemic Preparedness and Response*
Aurelia Nguyen	*Gavi*
Benjamin Sarda	*ACT-A Executive Hub*
Bernhard Braune	*Government of Germany*
Breno Hermann	*Government of Brazil*
Brook Baker	*Health GAP*
Bruce Aylward	*WHO*
Bruno Rivalan	*Global Financing Facility*
Carlos Passarelli	*UNAIDS*
Carmen Pérez-Casas	*Unitaid*
Carolyn Gomes	*Caribbean Vulnerable Communities Coalition*
Catharina Boehme	*WHO*
Chase Perfect	*Coalition Plus*
Chris Elias	*Bill & Melinda Gates Foundation*
Clare Wenham	*London School of Economics*
Claudia Nannei	*WHO*
Courtenay Howe	*STOPAIDS*
Dan Peters	*Bill & Melinda Gates Foundation*
Danny Kibble	*Government of the United Kingdom*
Dianne Stewart	*Global Fund*
Eloise Todd	*Pandemic Action Network*
Emily Smith	*Government of the United Kingdom*
Emily Wroe	*Partners in Health*
Emma Hannay	*FIND*
Enow Awah Georges Stevens	*Women Deliver*
Eva Kadilli	*UNICEF*
Fifa Rahman	*NGO Delegation, Unitaid Board*
Felipe Carvalho	*MSF*
Feng Zhao	*World Bank*
Gabriella Fesus	*European Commission*
Gambo Aliyu	*Government of Nigeria*
German Velasquez	*South Center*
Grata Werdaningtyas	*Government of Indonesia*
Hamza Haloui	*ACT-A Executive Hub*
Hanan Balkhy	*WHO*
Harjyot Khosa	*YRG Care*
Hazel Laws	*CARICOM Representative*
Heather Ignatius	*PATH*
Ian Dalton	*Government of the United Kingdom*
James Dray	*Brunswick Group*
Jamie Bay Nishi	*Global Health Technologies Coalition*
Jane Barratt	*International Federation on Aging*
Janet Ginnard	*Unitaid*
Jemesa Tudravu	*Government of Fiji*
Jeremy Farrar	*Wellcome*
Jo Keatinge	*Government of the United Kingdom*
Joao Lucas Quental Novaes de Almeida	*Government of Brazil*
John Denton	*International Chamber of Commerce*

John Otokoye	*WHO, Democratic Republic of Congo*
John-Arne Røttingen	*Government of Norway*
Joshua Tabah	*Government of Canada*
Juan Pablo Uribe	*World Bank*
Judith Soentgen	*Government of Germany*
Karrar Karrar	*Save the Children*
Katrin Josten	*Government of Germany*
Kurt Vandenberghe	*European Commission*
Laia Ruiz Mingote	*CAAB*
Lars-Hendrik Röller	*Government of Germany*
Lebogang Lebese	*Government of South Africa*
Leonardo Bencini	*Government of Italy*
Linda Muller	*ACT-A Executive Hub*
Lynette Mabote	*Treatment Action Group*
Mahmudur Rahman	*Government of Bangladesh*
Mara Pillinger	*Georgetown University*
Marie-Ange Saraka-Yao	*Gavi*
Marijke Wijnroks	*Global Fund*
Martin Bergfelder	*Government of Germany*
Michaela Pfeiffer	*WHO*
Michelle Childs	*DNDi*
Michael Ryan	*WHO*
Muhammad Ali Pate	*World Bank (Former)*
Myriam Henkins	*MSF*
Nel Druce	*Government of the United Kingdom*
Olive Shisana	*Government of South Africa*
Omar Abdi	*UNICEF*
Patricia Garcia	*Government of Peru (former) / University of Washington*
Peter Ng'ola Owiti	*Wote Youth Development*
Peter Sands	*Global Fund*
Philippe Duneton	*Unitaid*
Priya Basu	*World Bank*
Rachael Crockett	*DNDi*
Rajinder Suri	*DCVMN*
Revati Chawla	*Frontline AIDS*
Richard Hatchett	*CEPI*
Rodrigo López Tovar	*Government of Mexico*
Rosemary Mburu	*WACI Health*
Ruchir Agarwal	*IMF*
Sai Prasad	*DCVMN*
Sana de Courcelles	*Government of France*
Saul Walker	*Government of United Kingdom*
Scott Pendergast	*WHO*
Seth Berkley	*Gavi*
Sharonann Lynch	*Georgetown University*
Simon Brombeiss	*Government of Germany*
Solomon Abera	*WHO, Somalia*
Sophie Evekink	*Wellcome*
Steffen Kongstad	*Government of Norway*
Stephanie Seydoux	*Government of France*
Suerie Moon	*IHEID*
Theophile Dushime	*Government of Rwanda*
Thomas Cueni	*IFPMA*
Toomas Palu	*World Bank*
Tracey Bender	*Government of Canada*
Usman Mushtaq	*WHO*
Vanessa Kerry	*Seed Global Health*

Victor Dzau	*National Academy of Medicine*
Yuan Qiong Hu	*MSF*
Zane Dangor	*Government of South Africa*
Zsuzsanna Jakab	*WHO*

Annex 3: Documents included in desk review

Publicly available documents

"100 days mission to respond to future pandemics", A report to the G7 by the pandemic preparedness partnership, 12 June 2021

"A global deal for our pandemic age", Financing the Global Commons for Pandemic Preparedness and Response, Report of the G20 High Level Independent Panel, June 2021

"A proposal to develop an equitable global pathogen surveillance network in 2021 that can prevent and respond to emerging and endemic infectious diseases at speed and at scale", Sir Jeremy Farrar at request of UK Presidency of G7, 2021

"A proposal to end the COVID-19 Pandemic", International Monetary Fund, 19 May 2021

"A world in disorder", Global Preparedness Monitoring Board, World Health Organization, 2020

"Access to COVID-19 Tools (ACT) Accelerator Diagnostics Partnership: Investing in diagnostics to manage the course of the COVID-19 pandemic", FIND and the Global Fund, May 2020

"Access to COVID-19 Tools (ACT) Accelerator Diagnostics Pillar country roundtable", Meeting Recording, 7 May 2021. Accessed at: https://youtu.be/KLimYXxz4_o on 10 September 2021

"Access to COVID-19 Tools Accelerator overview and update, July 2021", ACT-Accelerator, July 2021

“Access to COVID-19 tools funding commitment tracker”, World Health Organization, 27 September 2021 accessed at https://www.who.int/publications/m/item/access-to-covid-19-tools-tracker

"Access to Vaccines, Therapeutics, and Diagnostics, Background paper 5", The Independent Panel for Pandemic Preparedness and Response, May 2021

"ACT Accelerator Facilitation Council Financial Working Group", Terms of Reference, ACT-Accelerator, 26 May 2021

"ACT- Accelerator: Case for private sector support", World Health Organization, March 2021

"ACT now, ACT together 2020-2021 Impact Report", World Health Organization, April 2021

"ACT-A Facilitation Council Terms of Reference", Facilitation Council, 9 February 2021

“ACT-A Humanitarian Situation Report”, UNICEF , 16 July 2021

"ACT-Accelerator - An economic investment case & financing requirements, September 2020 – December 2021", World Health Organization, 25 September 2020

"ACT-Accelerator Diagnostics Pillar", Explainer and Advocacy Document, Global Fund and FIND, 2021

"ACT-Accelerator Facilitation Council Financial Working Group", Terms of Reference, ACT-Accelerator, 26 Many 2021

"ACT-Accelerator Facilitation Council Financing Campaign Resource Mobilisation Working Group", Terms of Reference, ACT-Accelerator, March 2021

"ACT-Accelerator Impact Report: Summary", ACT-Accelerator, 23 April 2021

"ACT-Accelerator Investment Case", World Health Organization, 26 June 2020

"ACT-Accelerator launches urgent US$ 7.7 billion appeal to stem surge of dangerous variants and save lives everywhere", RADAR Press Release, World Health Organization, 16 August 2021

"ACT-Accelerator Prioritized Strategy & Budget for 2021", World Health Organization, 12 April 2021

"ACT-Accelerator Status Report & Plan, September 2020 – December 2021", World Health Organization, 25 September 2020

"ACT-Accelerator Urgent Priorities & Financing Requirements at 10 November 2020", World Health Organization, 10 November 2020

"ACT-Accelerator: A financing framework for the 2021 ACT-A funding gap", ACT-Accelerator, 3rd Facilitation Council Presentation, 14 December 2020

"ACT-Accelerator: The human cost of COVID-19", World Health Organization, 2020

"ACT-Accelerators generous contributors have funded US$ 14.6 billion", 6th ACT-Accelerator Facilitation Council Presentation, May 2021

“Additional Support for Country Responses to COVID-19”, Global Fund, 9 April 2020

"Assessing country readiness for COVID-19 vaccines: First insights from the assessment rollout", World Bank, March 2021

"Assessment of the Covid-19 Supply Chain System (CSCS) Summary Report ", The Yellow House, Commissioned by the World Health Organization, 26 February 2021

"C19RM Monthly Update to the Board (June-July Report)", Global Fund, 18 August 2021

"CEPI launches COVAX Marketplace to match buyers and sellers of critical manufacturing supplies and speed up global access to COVID-19 vaccines through COVAX", CEPI, 15 July 2021. Accessed on https://cepi.net/news_cepi/cepi-launches-covax-marketplace-to-match-buyers-and-sellers-of-critical-manufacturing-supplies-and-speed-up-global-access-to-covid-19-vaccines-through-covax/?swcfpc=1 on 15 September 2021.

"Chairs’ Summary of the 2nd Meeting of the Access to Covid-19 Tools (ACT) Accelerator Facilitation Council", ACT-Accelerator, 3 November 2020

"Civil Society & Community Engagement in the Access to COVID-19 Tools-Accelerator (ACT-A)", Letter to Lead Agencies, The Civil Society and Community Representatives of the ACT-A, 22 February 2021

"Co-Chairs Outcome Statement from the 6th Access to COVID-19 Tools Accelerator (ACT-A) Facilitation Council, 12 May 2021", ACT-Accelerator, 12 May 2021

"Context & Terms of Reference for the ACT-A Facilitation Council Vaccine Manufacturing Working Group", ACT-Accelerator, 3 June 2021

“COVAX and World Bank to Accelerate Vaccine Access for Developing Countries”, World Bank, 26 July 2021

"COVAX Facility Explainer Participation: Arrangements for Self-Financing Economies", COVAX, 2020

"COVAX Facility Information Session with Industry", CEPI, GAVI, World Health Organization, 12 August 2020

"COVAX: The Vaccines Pillar of the Access to COVID-19 Tools (ACT) Accelerator: Structure and Principles", COVAX, 9 November 2020

“COVID-19 Vaccine Access”, Dataset, Last updated 7 September 2021. Graduate Institute Geneva, Global Health Centre. Accessed at: https://www.knowledgeportalia.org/covid19-vaccine-arrangements 1 October 2021

"COVID-19 Therapeutics Investment Case", ACT Accelerator Therapeutics Partnership, 2020

"COVID-19 Vaccine Manufacturing: DCVMN's contribution to the global scale-up", Sai D. Prasad and Rajinder Suri DCVMN, 16 March 2021

“COVID-19 Vaccine Manufacturing”, Dataset, Global Health Centre, Graduate Institute of Geneva. Last updated on 7 September 2021. Accessed at https://www.knowledgeportalia.org/covid19-vaccine-manufacturing on 30 October 2021.

"COVID-19: Make it the last pandemic", The Independent Panel for Pandemic Preparedness and Response, May 2021

"Daily COVID-19 Tests 7 day rolling average", Our World in Data. Accessed at: https://ourworldindata.org/grapher/daily-covid-19-tests-smoothed-7-day on 15 September 2021

"DCVMN Statement on WTO TRIPS Intellectual Property Waiver", DCVMN, 7 May 2021

"Decolonise COVAX: an African critique", Ann Danaiya Usher, Development Today, 13 July 2021

"Ending the Covid-19 Pandemic: The Need for a Global Approach", Eurasia Group, 25 November 2020

"Enhancing Global Cooperation to End the COVID-19 Pandemic: Statement of the Lancet COVID-19 Commission", Statement of the Lancet COVID-19 Commission, 12 February 2021

"Equity in the Fight Against COVID-19: The Benefits to Germany from a Global Approach", Bill and Melinda Gates Foundation, 25 November 2020

"Extraordinary G20 Leaders' Summit: Statement on COVID-19", G20, 26 March 2020

"Financing Global Health Security Fairly", John-Arne Røttingen, Halvor Hvideberg, Eero Tölö, Benjamin Sarda and Bruce Aylward, Center for Global Development, 21 April 2021. Accessed at: https://www.cgdev.org/blog/financing-global-health-security-fairly

"FIND SARS-COV-2 test tracker". Accessed at: www.finddx.otg/covid-19/test-tracker on 10 September 2021

"Five reasons Five reasons why COVID herd immunity is probably impossible", Nature, 18 March 2021 Accessed at https://www.nature.com/articles/d41586-021-00728-2 on 15 September 2021

"Global Action Principles", World Economic Forum, January 2021. Accessed at: http://www3.weforum.org/docs/WEF_Global_Action_Group_Principles_2021.pdf, 13 September.

"Global Health Workforce statistics database", World Health Organization, Dataset. Accessed at: https://www.who.int/data/gho/data/themes/topics/health-workforce on 30 September 2021.

"Global Humanitarian Response Plan COVID-19 United Nations Coordinated Appeal April- December 2020", United Nations Office for the Coordination of Humanitarian Affairs, 2020

"Goal framework: 2022 Goals Development", World Health Organization, 8 June 2021

"Health leaders criticise limited ACT-A review", The Lancet, 21 August 2021

"Health Services Learning Hub: ACT-A Health Systems Connector", Accessed at: https://hlh.who.int/act-a-hsc-connector on 15 September 2021

"Health systems in the ACT-A", David B Hipgrave, Aboubacar Kampo, Luwei Pearson, The Lancet, 27 March 2021

"IFFIM helps COVAX bring fair, global access to COVID-19 vaccines", IFFIM, 10 May 2021

"IMF Staff discussion note: A proposal to end the COVID-19 Pandemic", Ruchir Agarwal, Gita Gopinath, International Monetary Fund, May 2021

"Improving Pandemic Preparedness: Lessons From COVID-19", Sylvia Mathews Burwell, Frances Fragos Townsend, Thomas J. Bollyky, Stewart M. Patrick, Council on Foreign Relations, 2020

"Investment case summary for monoclonal antibodies and small molecules", ACT-Accelerator Therapeutics Partnership, 2020

"Joint Statement by the Heads of the World Bank Group, International Monetary Fund, World Health Organization, and World Trade Organization on the First Meeting of the Task Force on COVID-19 Vaccines, Therapeutics and Diagnostics for Developing Countries", World Bank, 30 June 2021. Accessed at: https://www.worldbank.org/en/news/statement/2021/06/30/joint-statement-on-first-meeting-of-task-force-on-COVID19-vaccines-therapeutics-and-diagnostics-for-developing-countries on 13 September 2021

"Launch and Scale Speedometer: Vaccine Donations and Exports", Duke University Global Health Innovation Center, 2021. Accessed at https://launchandscalefaster.org/covid-19/vaccinedonations on 15 September 2021

"Macro Changes to the ACT-A: A briefing by the ACT-A Civil Society and Community Representatives", WACI Health, STOPAIDS and the Global Fund Advocates Network (GFAN) Platform for ACT-A Civil Society and Community Representatives, no date.

"New Bank COVAX collaborative mechanism to accelerate COVID-19 vaccine supply for developing countries", World Bank, July 2021

"News release: Meeting discusses COVID-19 vaccine manufacturing bottlenecks that must be urgently tackled for C19 vaccine output to reach its full potential", Meeting summary Chatham House, in collaboration with COVAX, IFPMA, DVCMN, and BIO on Global COVID-19 Vaccine Supply Chain & Manufacturing Summit on 8th and 9th March

"Press release: AVAT to partner with UNICEF in scaling up vaccine deliveries to African Union Member States", UNICEF, 2 August 2021

"Principles for sharing COVID-19 Vaccine Doses with COVAX", COVAX, 8 December 2020

"Quarterly Update Q2: 1 April - 30 June 2021", ACT-Accelerator, 2021

"Quarterly Report on the ACT-A SFF", UNICEF, 30 June 2021

"Recommendations for the Review of the Access to COVID-19 Tools Accelerator", Civil Society letter endorsed by Every Breath Counts Coalition, GLIDE, Global Citizen, Global Health Technologies Coalition, Global Vaccination Advisors, Korean

Advocates for Global Health, Management Sciences for Health, ONE, Pandemic Action Network. PATH, RESULTS UK, Sabin Vaccine Institute, Village Reach, Women in Global Health, 11 August 2021 Internal document

"Report to the Board 23-24 June 2021: Annex B COVAX Reporting Framework", GAVI, 2021

"Report to the Board 23-24 June 2021: Annex B COVAX Reporting Framework", GAVI, 2021

"Report to the Board 23-24 June 2021: Audit & Finance Committee Chair Report", GAVI, 2021

"Report to the Board 23-24 June 2021: COVAX AMC Financial Forecast", GAVI, 2021

"Report to the Board 23-24 June 2021: COVAX Update", GAVI, 2021

"Review of Decisions, Board Meeting 23-24 June 2021, Virtual Meeting", GAVI, 24 June 2021

"Roll out of COVID-19 vaccines in the EU/EEA: challenges and good practice", European Centre for Disease Prevention and Control, 29 March 2021. Accessed on: https://www.ecdc.europa.eu/en/publications-data/rollout-covid-19-vaccines-eueea-challenges-and-good-practice on 15 September 2021

"SARS-COV-2 DIAGNOSTIC PIPELINE", FIND Accessed at: https://www.finddx.org/covid-19/pipeline/?avance=Commercialized&type=all&test_target=all&status=all&section=show-all&action=default

"Scaling-up Vaccine Production Capacity: Legal Challenges and Recommendations: Background paper 6" , Ellen 't Hoen, Christopher Garrison, Pascale Boulet, Kaitlin Mara, & Katrina Perehudoff Commissioned by The Independent Panel for Pandemic Preparedness and Response, May 2021

"Statement from the first ACT-Accelerator Facilitation Council meeting", ACT-Accelerator, 10 September 2020

"Statement of the Co-Chairs of the 3rd ACT Accelerator Facilitation Council, 14 December 2020", ACT-Accelerator, 14 December 2020

"Statement of the Co-Chairs of the 4th ACT Accelerator Facilitation Council, 9 February 2021", ACT-Accelerator, 9 February 2021

"Statement of the Co-Chairs of the 5th Access to COVID-19 Tools Accelerator (ACT-A) Facilitation Council", ACT-Accelerator, 23 March 2021

"The ACT Accelerator Funding Tracker", World Health Organization, Accessed at: https://www.who.int/initiatives/act-accelerator/funding-tracker on 13 September 2020.

"The ACT Accelerator: heading in the right direction?", The Lancet, 24 April 2021

"Towards Vaccinating The World: Landscape of Current COVID-19 Supply Chain and Manufacturing Capacity, Potential Challenges, Initial Responses, and Possible "Solution Space" - a Discussion Document", Richard Hatchett, Melanie Saville, Matthew Downham, Thomas Cueni, Laetitia Bigger, Phyllis Arthur, Rajinder Suri, Sai D. Prasad, Rasmus Bech Hansen,9 March 2021

"Tracking SARS-CoV-2 Variants", World Health Organization, 2021: Accessed at: https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/ on 15 September 2021

"Transforming the medical PPE ecosystem", ACT-Accelerator Rethinking PPE initiative, July 2021

"UNICEF COVID-19 Vaccine Market Dashboard", UNICEF. Accessed at: https://www.unicef.org/supply/covid-19-vaccine-market-dashboard on 6 September 2021

"Unprecedented international support drove USD 14.6 Bn in funding to the ACT-Accelerator over 2020-21, but a USD 18.5 Bn gap remains for 2021", ACT-Accelerator summary of Financing Framework, 2021

"Urgent needs to accelerate the race for COVID-19 therapeutics", Carolina Batista et al. , EClinicalMedicine, 23 May 2021

"What is the Access to COVID-19 Tools (ACT) Accelerator, how is it structured and how does it work?", World Health Organization, 6 April 2021

"2nd Access to COVID-19 Tools (ACT) Accelerator Facilitation Council meeting", Recording and notes,3 November 2020. Accessed at:https://www.who.int/news-room/events/detail/2020/11/03/default-calendar/2nd-access-to-covid-19-tools-accelerator-facilitation-council-meeting

"3rd Access to COVID-19 Tools (ACT) Accelerator Facilitation Council meeting", Recording and notes,14 December 2020. Accessed at:https://www.who.int/news-room/events/detail/2020/12/14/default-calendar/3rd-access-to-covid-19-tools-accelerator-facilitation-council-meeting

"4th Access to COVID-19 Tools (ACT) Accelerator Facilitation Council meeting", Recording and notes, 8 February 2021. Accessed at: https://www.who.int/news-room/events/detail/2021/02/09/default-calendar/4th-access-to-covid-19-tools-(act)-accelerator-facilitation-council-meeting

"5th Access to COVID-19 Tools (ACT) Accelerator Facilitation Council meeting", Recording and notes, 23 March 2021. Accessed at:https://www.who.int/news-room/events/detail/2021/03/23/default-calendar/5th-access-to-covid-19-tools-(act)-accelerator-facilitation-council-meeting

"6th Access to COVID-19 Tools (ACT) Accelerator Facilitation Council meeting", Recording and notes, 12 May 2021. Accessed at: https://www.who.int/news-room/events/detail/2021/05/12/default-calendar/6th-access-to-covid-19-tools-(act)-accelerator-facilitation-council-meeting

"A beautiful idea: how COVAX has fallen short", The Lancet, Ann Danaiya Usher, 19 June 2021

"Access to COVID-19 Tools Accelerator", Humanitarian Action for Children, UNICEF, 2021. Accessed at https://www.unicef.org/media/94126/file/2021-HAC-ACT-A.pdf on 27 September 2021.

"Access to COVID-19 Tools Accelerator", Humanitarian Action for Children, UNICEF, 2021. Accessed at https://www.unicef.org/media/94126/file/2021-HAC-ACT-A.pdf on 27 September 2021.

"ACT Accelerator Facilitation Council Briefing for members and WHO Member States", Recording and notes, 6 July 2021 . Accessed at: https://www.who.int/news-room/events/detail/2021/07/06/default-calendar/act-accelerator-facilitation-council-briefing-for-members-and-who-member-states

"ACT-Accelerator Prioritized Strategy & Budget for 2021, Post Council Version of 16 February 2021", World Health Organization, February 2021

"ACT-Accelerator", World Health Organization Webpage. Accessed at https://www.who.int/initiatives/act-accelerator on September 2021

"ACT-A Facilitation Council Financial Working Group Terms of Reference", Facilitation Council, 26 May 2021

"ACT-Accelerator Facilitation Council Financing Campaign: Resource Mobilisation Working Group", Facilitation Council, 14 March 2021.

"Context and Terms of Reference for the ACT-Accelerator Facilitation Council Vaccine Manufacturing Working Group", Facilitation Council, 3 June 2021.

"Africa's COVID-19 vaccination drive is off to a slow start", The Economist, 24 April 2021. Accessed at: https://www.economist.com/middle-east-and-africa/2021/04/24/africas-covid-19-vaccination-drive-is-off-to-a-slow-start on 15 September 2021

"Amid Humanitarian Crisis in India, Merck Announces Voluntary Licensing Agreements with Five Indian Generics Manufacturers to Accelerate and Expand Global Access to Molnupiravir, an Investigational Oral Therapeutic for the Treatment of COVID-19", Merck, 2021. Accessed at: https://www.merck.com/news/amid-humanitarian-crisis-in-india-merck-announces-voluntary-licensing-agreements-with-five-indian-generics-manufacturers-to-accelerate-and-expand-global-access-to-molnupiravir-an-investigational-ora/ on 1 October 2021.

"As a rich-world covid-vaccine glut looms, poor countries miss out", The Economist, 4 September 2021. Accessed at: https://www.economist.com/international/2021/09/04/as-a-rich-world-covid-vaccine-glut-looms-poor-countries-miss-out on 15 September 2020.

"Aspen confirms release of COVID-19 vaccines to Johnson & Johnson for supply to South Africa", Shauneen Beukes, Aspen Holdings, 26 July 2021. Accessed at: https://www.aspenpharma.com/2021/07/26/aspen-confirms-release-of-covid-19-vaccines-to-johnson-johnson-for-supply-to-south-africa/ on 27 September 2021.

"C19RM Health Product Segmentation Framework", The Global Fund, 17 August 2021. Accessed at: https://www.theglobalfund.org/media/10765/covid19_health-product-segmentation_framework_en.pdf on 27 September 2021.

"C19RM Monthly Update to the Board, 18 August (June-July Report)", The Global Fund, 18 August 2021

"Commitment and call to action: Global collaboration to accelerate new Covid 19 health technologies" , World Health Organization, 24 April 2021. Accessed at: https://www.who.int/news/item/24-04-2020-commitment-and-call-to-action-global-collaboration-to-accelerate-new-covid-19-health-technologies on 31 August 2021

"Commitment and call to action: Global collaboration to accelerate new Covid 19 health technologies" , World Health Organization, 24 April 2021. Accessed at: https://www.who.int/news/item/24-04-2020-commitment-and-call-to-action-global-collaboration-to-accelerate-new-covid-19-health-technologies on 31 August 2021

"Country Coordinating Mechanism", Global Fund Webpage. Accessed at: https://www.theglobalfund.org/en/country-coordinating-mechanism/ on 27 September 2021.

"Country readiness for COVID-19 vaccines", World Health Organization, Gavi, 26 February 2021. Accessed at: https://www.gavi.org/vaccineswork/country-readiness-covid-19-vaccines on 27 September 2021.

"COVAX AMC Explained", Gavi, Accessed at: https://www.gavi.org/vaccineswork/gavi-covax-amc-explained on 15 September 2021

"COVAX Global Supply Forecast", CEPI, Gavi, UNICEF and World Health Organization, 8 September 2021

"COVAX Global Supply Forecast", CEPI, Gavi, UNICEF and World Health Organization, 23 June 2021

"COVID 19: Response Mechanism", The Global Fund, Webpage. Accessed at https://www.theglobalfund.org/en/covid-19/response-mechanism/ on 27 September 2021.

"COVID-19 oxygen emergency impacting more than half a million people in low- and middle-income countries every day, as demand surges", World Health Organization, 25 February 2021. Accessed at: https://www.who.int/news/item/25-02-2021-covid-19-oxygen-emergency-impacting-more-than-half-a-million-people-in-low--and-middle-income-countries-every-day-as-demand-surges on 15 September 2021.

"COVID-19 Response Mechanism Guidelines", The Global Fund, 17 April 2021. Accessed at: https://www.theglobalfund.org/media/10759/covid19_c19rm-guidelines_external_en.pdf on 27 September 2021.

"COVID-19 strategic preparedness and response plan (SPRP): 1 February 2021 – 31 January 2022", World Health Organization, 2021

"COVID-19 Vaccine Briefing: Science based forecasts for the short- and long-term", Airfinity prepared on behalf of the World Trade Organization, 29 June 2021. Accessed at: https://www.wto.org/english/tratop_e/trips_e/techsymp_290621/hansen_presentation.pdf on 27 September 2021.

"COVID-19 vaccine stock forecast for 2021 and 2022", Airfinity, 5 Sep 2021

"Draft timeline of ACT-A governance" compiled by Brian Hutler of the JHU Berman Institute of Bioethics for WHO ACT-A Ethics and Governance Working Group. This document has not yet been published.

"Financial Framework", ACT-A's Finance Working Group, 24 August 2021

"First access to COVID-19 Tools (ACT) Accelerator Facilitation Council meeting", Notes, 10 September 2020. Accessed at: https://www.who.int/news-room/events/detail/2021/02/09/default-calendar/4th-access-to-covid-19-tools-(act)-accelerator-facilitation-council-meeting

"Funding Framework", Financial Working Group, 30 November 2020

"G20 and OECD Finance Ministries Meeting", Joint Press Release from Ministers Sanner and Mboweni, 29 January 2021, Accessed at: https://www.who.int/publications/m/item/joint-press-release-from-ministers-sanner-and-mboweni

"Gavi Board strengthens commitment to reaching the most vulnerable through routine immunisation and COVAX", Gavi, 2021, Accessed at: https://www.gavi.org/news/media-room/gavi-board-strengthens-commitment-reaching-most-vulnerable-through-routine on 15 September 2021

"Gavi to provide US$ 150 million to support low- and middle-income countries' readiness to deliver COVID-19 vaccines" Accessed at: https://www.gavi.org/news/media-room/gavi-provide-us-150-million-support-low-and-middle-income-countries-readiness

"Generating acceptance and demand for COVID-19 vaccines", World Health Organization, Webpage. Accessed at: https://www.who.int/initiatives/act-accelerator/covax/covid-19-vaccine-country-readiness-and-delivery/acceptance-and-demand on 27 September 2021.

"GF/B44/EDP18: Second Extension of C19RM Timeline and Operational Flexibility for COVID-19", The Global Fund, 30 March 2021. Accessed at: https://www.theglobalfund.org/board-decisions/b44-edp18/ on 27 September 2021.

"Global Fund support to fight COVID-19: As of 14 September 2021", The Global Fund, 2021. Accessed at: https://www.theglobalfund.org/en/our-covid-19-response/ on 27 September

"Independent Allocation of Vaccines Group (IAVG) Terms of Reference", World Health Organization, no date. Accessed at: https://www.who.int/groups/iavg/terms-of-reference on 1 September

"Independent Allocation of Vaccines Group (IAVG) Terms of Reference", World Health Organization, no date. Accessed at: https://www.who.int/groups/iavg/terms-of-reference on 1 September.

"Lower-income countries are letting far fewer COVID-19 vaccine doses expire than wealthier nations", COVAX, 21 September 2021. Accessed at: https://www.gavi.org/vaccineswork/lower-income-countries-are-letting-far-fewer-covid-19-vaccine-doses-expire on 27th September 2021.

"Medical oxygen crisis: a belated COVID-19 response", Ann Danaiya Usher, The Lancet, 6 March 2021

"Merck Announces Supply Agreement with U.S. Government for Molnupiravir, an Investigational Oral Antiviral Candidate for Treatment of Mild to Moderate COVID-19.", 9 June 2021, Accessed at: https://www.merck.com/news/merck-announces-supply-agreement-with-u-s-government-for-molnupiravir-an-investigational-oral-antiviral-candidate-for-treatment-of-mild-to-moderate-covid-19/ on 15 September 2021

"Our COVID-19 Response", The Global Fund, Webpage. Accessed at: https://www.theglobalfund.org/en/our-covid-19-response/ on 27 September 2021.

"Our Portfolio", CEPI, Accessed at https://cepi.net/research_dev/our-portfolio/ on 27 September 2021.

"Pillar 10 COVID-19 Vaccine Deployment Readiness Map", World Health Organization, 2021. Accessed at: https://covid19partnersplatform.who.int/en/pillar10 on 27 September 2021.

"Pillar 10 COVID-19 Vaccine Deployment Readiness Map", World Health Organization, 2021. Accessed at: https://covid19partnersplatform.who.int/en/pillar10 on 27 September 2021.

"Risk and assurance report 2021, Annex C: COVAX Report", Gavi, 2021 Annex

"The Solidarity PLUS Trial", World Health Organization, Webpage, 2021. Accessed at: https://www.who.int/news/item/11-08-2021-who-s-solidarity-clinical-trial-enters-a-new-phase-with-three-new-candidate-drugs on 30 October 2021

"The Absorption Capacity Challenge", Tony Blair Institute for Global Change and Lawrence Institute for Transformative Medicine of USC, August 2021

"The coronavirus is here to stay – here's what that means", Nature, 16 February 2021, Accessed at: https://www.nature.com/articles/d41586-021-00396-2 on 15 September 2021

"The COVAX Humanitarian Buffer Explained", Gavi, 30 March 2021. Accessed at: https://www.gavi.org/vaccineswork/covax-humanitarian-buffer-explained on 27 September 2021.

"The economic case for global vaccinations: an epidemiological model with international production networks", International Chamber of Commerce, 2021; "Ending the COVID-19 pandemic: the need for a global approach", Eurasia Group, 3 December 2020

"The G20 Must Recommit to COVAX", Seth Berkley COVAX, September 2021. Accessed at: https://www.gavi.org/vaccineswork/g20-must-recommit-covax on 15 September 2021

"Therapeutics Presentation to the Facilitation Council", Therapeutics Pillar, March 2021

"Therapy for Early COVID-19: A Critical Need", Peter S. Kim et al, JAMA, 11 November 2020

"Total stimulus for the COVID-19 crisis already triple that for the entire 2008-09 financial crisis", McKinsey and Company, 2020 Accessed at https://www.mckinsey.com/featured-insights/coronavirus-leading-through-the-crisis/charting-the-path-to-the-next-normal/total-stimulus-for-the-covid-19-crisis-already-triple-that-for-the-entire-2008-09-recession on 15 September 2021

"Trojan horse': bulk of UK vaccine donations to poor countries set to expire in September", Telegraph, 28 July 2021

"Universal Health Coverage Partnership", Webpage. Accessed at: https://www.uhcpartnership.net/about/ on 27 September 2021.

"What does COVAX latest supply forecast tell us?", Aurelia Nguyen, COVAX, 23 June 2021 Accessed at: https://www.gavi.org/vaccineswork/what-does-covaxs-latest-supply-forecast-tell-us on 15 September 2021

"WHO Concept for fair access and equitable allocation of COVID-19 health products – Final Working Version", World Health Organization, 9 September 2020

"WHO Emergency Use Listing for In vitro diagnostics (IVDs) Detecting SARS-CoV-2", World Health Organization, April 2021

"WHO Emergency Use Listing for In vitro diagnostics (IVDs) Detecting SARS-CoV-2", World Health Organization, October 2020

"Whose pandemic is it anyway?", Peter Sands, 07 July 2021. Accessed at: https://www.theglobalfund.org/en/blog/2021-07-07-whose-pandemic-is-it-anyway/

"World Bank Approves $12 Billion for COVID-19 Vaccines", World Bank, 13 October 2021. Accessed at: https://www.worldbank.org/en/news/press-release/2020/10/13/world-bank-approves-12-billion-for-covid-19-vaccines on 27 September 2021

"World Bank Support for Country Access to COVID-19 Vaccines", World Bank, Webpage. Accessed at: https://www.worldbank.org/en/who-we-are/news/coronavirus-covid19/world-bank-support-for-country-access-to-covid-19-vaccines on 27 September 2021

Internal documents

"Allocation logic and algorithm to support allocation of vaccines secured through the COVAX Facility: Explainer based on commonly asked questions", ACT-Accelerator, 15 February 2021 Internal document

"Civil Society & Community Engagement in the Access to COVID-19 Tools-Accelerator (ACT-A)", Letter to Ms Ursula von der Leyen, Dr Tedros Adhanom Ghebreyesus, Dr Richard Hatchett, Dr Seth Berkley, Dr Jeremy Farrar, Dr Philippe Duneton, Dr Catharina Boehme, Mr Peter Sands, Mr David R. Malpass, from Fifa Rahman, Rohit Malpani, Kenly Sikwese, Andriy Klepikov., Carolyn Gomes, Maurine Murenga, Erika Castellanos, Robin Montgomery, Joia Mukherjee, Maty Dia, Rafael Vilasanjuan, Khuat Thi Hai Oanh. Evalin Karijo, Javier Hourcade Bellocq, Smitha Sadasivan, Justin Koonin, and Masaki Inaba, 5 June 2020

"Ideas for optimizing ACT-A's performance in a radically different landscape", Internal letter to the Principals Group by Chris Elias, Jeremy Farrar and Victor Dzau, 31 August 2021

"Introduction to ACT-A ecosystem – mapping of COVID-19 tools response beyond ACT-A ", ACT- Accelerator, 21 July 2021

"ACT-A Strategic Review – DNDi inputs to Dalberg", Written inputs from DNDi for consideration in the ACT-A Strategic Review, DNDi, September 2021

"ACT-Accelerator Health System Connector Vision: A Roadmap," January 2021

"ACT-Accelerator Therapeutics Partnership Structure: Discussion Document, Therapeutics Pillar", 13 May 2020

"Global Fund C19RM update, Awards", prepared by Global Fund for ACT-Accelerator, 20 September 2021. Internal document.

"Inclusive representation of civil society and communities across the whole ACT-Accelerator structure", Letter to Ms Ursula von der Leyen, Dr Tedros Adhanom Ghebreyesus, Dr Richard Hatchett, Dr Seth Berkley, Dr Jeremy Farrar, Dr Philippe Duneton, Dr Catharina Boehme, Mr Peter Sands, Mr David R. Malpass, from Fifa Rahman, Rohit Malpani, Kenly Sikwese Andriy Klepikov., Carolyn Gomes, Maurine Murenga, Erika Castellanos, Robin Montgomery, Joia Mukherjee, Maty Dia, Rafael Vilasanjuan, Khuat Thi Hai Oanh, Javier Hourcade Bellocq, and Justin Koonin, 17 June 2020

"RE: Accelerated Evaluation of COVID Antigen RDT Submissions for WHO PQ EU", Letter to World Health Organization from Katy Kydd Wright (GFAN), Dr Fifa A Rahman (CS Rep to the Diagnostics Pillar, Facilitation Council, and Principals Group) and Chase Perfect, (CS Rep to the Diagnostics Pillar), 19 August 2021

"RE: Upcoming WHO COVID-19 Testing Guidelines and use of Ag RDTs", Letter to World Health Organization on behalf of C/CSO representatives to the ACT-A diagnostics Pillar, 9 June 2021

"RE: Urgent coordination between ACT-A Diagnostic and Therapeutic Pillars towards the development of a test-and-trace strategy", Letter to FIND, Wellcome, Unitaid and World Health Organization on behalf of C/CSO representatives of the ACT-A Diagnostic and Therapeutic Pillars, 25 August 2021

Diagnostic Pillar Facilitation Council and Member State briefings March 2020 to June 2021

Diagnostics Pillar internal newsletters: "Diagnostics Digests" between March 2021 and August 2021

Diagnostics Pillar Working Principles, Structure and Strategy documents, Strategy and Budget meetings, Pillar coordination meetings between July 2020 and June 2021

Facilitation Council co-chairs document on options for adapting the Council's composition

Finance Working Group Meeting presentations between November 2020 and August 2021

"Financial Framework", ACT-A's Finance Working Group, 24 August 2021

HSC Initial discussion documents, Scope of Work, Preliminary budgets, Strategic Refresh presentations between April 2020 and July 2021

Resource Mobilisation Working Group Meeting presentations between March 2021 and August 2021

Therapeutics Pillar Manufacturer webinars between October 2020 and June 2021

Therapeutics Pillar partnership structures, partner Principles and ways of Working, Workstream coordination, Secretariat materials, Alignment across workstreams, partnership meeting materials, and partnership member mappings between June 2020 and April 2021

Therapeutics Pillar reporting to the Facilitation Council between October 2020 and March 2021

Therapeutics Pillar Resource Mobilisation materials between August 2020 and July 2021

Therapeutics Pillar updates to Principal's Group between August 2020 and August 2021

Therapeutics Pillar workplans and working sessions, budget model, costed strategy between November 2020 and March 2021

Therapeutics Pillar Workstream Leads meetings between October 2020 and July 2021

Therapeutics Pillar Tx Partnership: Principles & Ways of Working

Vaccine Manufacturing Working Group meeting notes, roundtables and presentations between May 2021 and September 2021

Vaccine Manufacturing Working Group workplans between June and July 2021

Annex 4: Financial overview

The following table presents an overview of inflows and outflows for ACT-A partners. Figures presented are cumulative totals in USD million for the most recent available reporting. Note that all figures are unaudited and subject to change.

Fund categories are as follows:

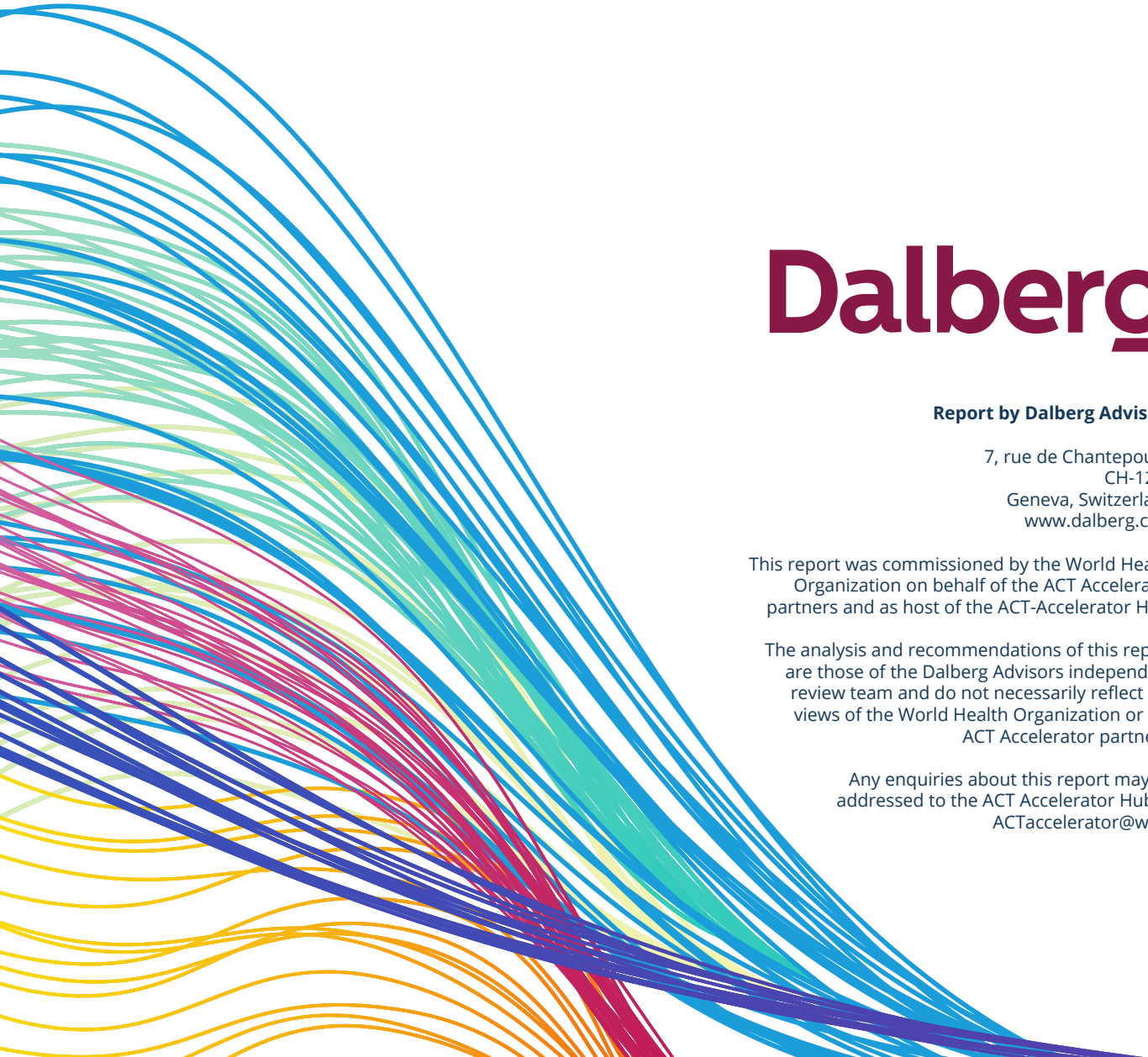
- **Pledged**: Total amount pledged by all donors, against the requested amount.
- **Received**: Total actual amount received from donors.
- **Committed/approved**: Total amount already committed and / or approved for spend.
- **Spent/disbursed**: Total amount disbursed to date in support of ACT-A activities.

All figures in USD million

	Pledged	Received	Committed / Approved	Spent / Disbursed	Figures as of	Notes
CEPI	1,640	1,474	1,673	952	16-Sept	• Pledged amounts in currencies other than USD converted to USD at pledge date rates for public sector donors, at actual/budget rates for private sector donors • Committed / approved figures include signed contracts, plus contracts approved by CEPI/COVAX governance bodies that are currently under due diligence/negotiation and not yet signed (Committed = USD 1,610,000,000 and Approved (to be signed) = USD 63,000,000)
Gavi	10,828	7,400	10,060	5,100	5-Aug	• Figures include vaccine delivery and/or logistics to AMC 92
Unitaid	98	98	81	45	31-Aug	• Pledges have been indicated as received once confirmed by signed agreements • Spent/ Disbursed figures reflect cumulative disbursements by Unitaid to implementers by the end of August 2021
FIND	360	219	202	104	31-Aug	• Spent/Disbursed figures do not include all expenses as FIND only closes and audits accounts biannually
Global Fund	3,170	258	2,173	-	3-Sep	• Received indicate allocations to the various pillar workstreams (based on allocations made through C19RM) • Pledge conversion continues alongside normal pledge conversion thus not reported separately. By Board decision all contributions to C19RM are included in funding for the Sixth Replenishment period • Received figures reported as of 31 Dec 2020 • Committed figures reported as of 3 Sept 2021 • Disbursement information is not available. C19RM disbursements are integrated with normal grants and therefore not a distinct funding flow

	Pledged	Received	Committed / Approved	Spent / Disbursed	Figures as of	Notes
UNICEF	675	389	386	284	30-Aug	• ACT-A activities have been integrated into regular programming; funds allocated to ACT-A activity are not reported separately • Pledged figures include US$96M from Gavi expected as part of the CDS envelope funded by BMZ • Disbursed/Spent figures reflects funds that have been disbursed for use to UNICEF offices
WHO	652	652	652	335	16-Sept	• Discrepancy with pledges in the online tracker due to rounding and potential exchange rate differences • These figures are based on earmarked ACT-A funding received by WHO from donors • Spent/disbursed figures are based on actual implementation activities; this number may increase in the future based on an expenditure review
Tx Accelerator	453	-	-	165	30-Jun	• Figures include funds managed by BMGF and Wellcome Trust • Spent figures include grants by BMGF, Gates Philanthropy Partners, and Wellcome Trust • Received and committed figures are not generally reported
GFF	42	32	32	30	13-Sep	• ACT-A activities have been integrated into GFF COVID-19 Essential Health Services Grants • Spent/disbursed figures are based on World Bank Board approved activities
Total	**17,918**	**10,522**	**15,262**	**7,015**		
% of pledges received, committed and spent		59% [257]	85%	39%		

[257] Note this figure is artificially low due to lag in available reporting on received funding for the Global Fund; actual conversion of pledges is estimated at approx. 97%.



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This report was commissioned by the World Health Organization on behalf of the ACT Accelerator partners and as host of the ACT-Accelerator Hub.

The analysis and recommendations of this report are those of the Dalberg Advisors independent review team and do not necessarily reflect the views of the World Health Organization or the ACT Accelerator partners.

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