

**An Agenda for Action: the role of the UK in strengthening
Pandemic Prevention, Preparedness and Response**



Introduction

The COVID-19 pandemic has exposed existing inequalities in the global health architecture that existed prior to the pandemic. These inequalities have in turn contributed to disparities in access to vaccines and other tools and disruptions as well as backsliding of essential primary health care (PHC) services, reversing decades of progress in global health. In addition to the indirect impacts of the pandemic efforts to curb it, including the COVID-19 vaccine rollout, have highlighted the inequitable distribution of resources and the weakness of systems required to deliver universal vaccination. The need to strengthen systems and vaccination capacity has perhaps never been so visible. Current and ongoing global pandemic prevention, preparedness and response (PPR) negotiations, including the development of a new Pandemic Accord, provide a pivotal opportunity for systems strengthening and the progressive development of global health architecture.

The role of the UK Government in PPR

The UK has made some significant contributions to global efforts on PPR including the hosting of the Global Pandemic Preparedness Summit in March 2022¹ and the financial contribution to the new World Bank Financial Intermediary Fund for Pandemic Prevention Preparedness and Response in June 2022².

Building on this, the UK has an important role to play in enhancing PHC and systems strengthening through the negotiations of a new World Health Organisation (WHO) Pandemic PPR Accord which will take place over the next couple of years. As Pandemic PPR agenda develops, the UK Government has a clear opportunity to implement and uphold the ambition of the Foreign, Commonwealth and Development Office's Health System's Strengthening Position Paper³.

This briefing examines four priority areas which are critical for driving progress on PPR:

1. Primary Health Care and Systems Strengthening
2. Research & Development
3. Financing
4. Governance

In each area, we outline the steps that the UK Government must take in the Accord negotiations and beyond to address each of these four areas and make policy recommendations.

PPR timeline at a glance

2023	
30 Jan – 7 Feb	World Health Assembly Executive Board
27 Feb – 3 March	4 th International Negotiating Body (INB) of the Pandemic Accord Meeting
3 – 6 April	5 th INB of the Pandemic Accord Meeting
21 – 30 May	World Health Assembly
17 – 21 July	6 th INB of the Pandemic Accord Meeting
August – October	Regional Committees on the Pandemic Accord
5 – 6 December	7 th INB of the Pandemic Accord Meeting
2024	
19 Feb – 1 March	8 th INB of the Pandemic Accord Meeting
18 – 29 March	9 th INB of the Pandemic Accord Meeting
24 May	World Health Assembly

1 – Primary Health Care & Systems Strengthening

PPR efforts for future pandemics and health emergencies require the incorporation of comprehensive approaches to strengthening PHC services. As was clear during the COVID-19 pandemic, these will be the crucial mechanism through which any response is delivered.

Strengthen immunisation systems

The ability of countries to deliver essential vaccines at scale to their populations relies heavily on the capacity of their immunisation systems. Prior to the COVID-19 pandemic, almost 20 million children each year missed out on basic vaccines, such as diphtheria, tetanus and pertussis.⁴ The COVID-19 pandemic has further exposed global disparities in access to vaccination. As of October 2022, only 19% of people in low-income countries (LICs) have been fully vaccinated, as opposed to 74% in high-income countries.⁵ Recent data shows that disruption caused by the COVID-19 pandemic has led to the largest sustained backslide on immunisation in almost 30 years, with 25 million children missing out on basic vaccines in 2021 and 18 million children not receiving any vaccines at all in 2021.⁶

Verticalization and fragmentation of COVID-19 vaccine delivery negatively impacted both the rollout of COVID-19 vaccine (which relied heavily on existing immunisation systems) and, as above, led to trade-offs with resources diverted away from routine immunisation services, resulting in declining immunisation coverage.

The ongoing disparities in access to vaccination in LICs are attributable to a range of factors including limited health workforce capacity, lack of resources and infrastructure, and logistical constraints.

Only through strengthening PHC and immunisation services can countries be better equipped to simultaneously safeguard essential child health services and respond effectively to future health emergencies and pandemics, including those which require the introduction of new vaccines.

Strengthening and expanding immunisation systems requires expanding and bolstering logistics and supply chain for vaccination. Recent developments and investments in vaccine science offer the opportunity to leverage investment in research to create new and improve existing vaccines and the utilisation of new digital tools and infrastructure to maximise efficiencies in immunisation services. Also countering misinformation and improving community trust in vaccination will also be needed to increase vaccine access and uptake.

Strengthening PHC will be vital to respond effectively to future health emergencies, safeguard essential health services against disruption and accelerate progress towards reaching global health targets, such as those included within Immunisation Agenda 2030 and the Sustainable Development Goals (SDGs).

Increase and bolster the capacity of the health workforce

Community health workers (CHWs) are an integral part of PHC systems, playing a crucial role in the delivery of essential services and improving communities' confidence in and demand for healthcare. Despite this, the WHO predicts that by 2030 there will be a shortage of 15 million health workers globally.⁷

The recruitment of health workers must be prioritised and resourced to strengthen PHC systems. Currently, many countries have not fully integrated CHWs into their national health systems. A recent analysis of 24 countries in Africa found only 14% of CHWs were salaried.⁸ To attract and retain a dedicated workforce it is essential to ensure CHWs are supported financially and offered the necessary training and support to deliver their demanding roles.

Developing an adequate health workforce will be imperative to prevent the diversion of human resources away from the delivery of essential health services in future pandemics and global health emergencies. Health workforce capacity will be imperative to delivering global health targets and addressing multiple crises currently facing low-and-middle-

income countries (LMICs), including backsliding in routine immunisation and rising rates of hunger and malnutrition. CHWs must be a focal point for ensuring communication strategies are tailored and disseminated effectively within local contexts.

Develop community demand and increase confidence in health services

Building community trust is critical to increasing the uptake of vaccination and other life-saving health interventions. Effective communication strategies with communities will be essential towards increasing demand, raising awareness of available services, and disseminating information on the full course of vaccination needed to ensure immunity and protection against vaccine-preventable diseases. Vaccine promotion interventions need to be tailored to audiences with communication strategies targeted to specific concerns among unvaccinated populations.

Recommendations

1. Ensure the PPR Accord contains explicit commitments to strengthening systems to improve primary health care, including the following:
 - a. Strengthening of health and immunization systems
 - b. Prioritizing, recruiting, and supporting the health workforce
 - c. Targeting communication strategies to enhance demand for and confidence in vaccination and essential healthcare services

2 – Research & Development

While the increase in global travel, trade, interconnectedness, and the spillover between the environment, animal and human health has meant infectious disease outbreaks of international concern are becoming inevitable, their ability to cause millions of deaths and trillions of dollars in economic damage, is not. High-quality research and development (R&D) builds the world's capacity to prevent, prepare for and respond to the next infectious disease outbreak, whether that be an unknown pathogen (Disease X) or a disease already in circulation.

As demonstrated by the recent outbreaks of mpox, the world has been equipped to respond due to decades of vast investment in R&D against a pathogen closely related to the disease, smallpox. Known as a prototypic vaccine approach, funding R&D against smallpox not only meant that it is the only human disease to be eradicated but also led to the development of multiple vaccines and treatments against other orthopoxviruses, of which mpox is one.

Coalition for Epidemic Preparedness Innovations and 100 Day Mission

The Coalition for Epidemic Preparedness Innovations (CEPI) is advancing this prototypic vaccine approach to build a library of vaccine candidates for multiple diseases, such as betacoronaviruses, the genus of viruses that includes COVID-19. CEPI is achieving this by supporting multiple programmes to develop a vaccine that provides broad protection against COVID-19 variants, and in the future, an all-in-one betacoronavirus vaccine. Nevertheless, CEPI's pathogen portfolio recognises the importance of R&D beyond COVID-19 and covers MERS, Nipah, Chikungunya, Lassa Fever, Rift Valley Fever, Disease X, and Ebola.

This, however, is not the trend in the wider medical R&D community due to a reluctance to engage where there are few commercial prospects. According to recent data⁹, there are just 13 R&D projects across five non-coronavirus diseases, such as Ebola and Zika virus, and zero for other priority pathogens that are flagged as an epidemic/pandemic risk, such as Rift Valley fever and Nipah virus. It is essential that global health R&D equally covers a diverse range of infectious diseases in order to truly fulfil PPR ambitions, with any vaccine, test, and treatment produced made free at the point of use and accessible to everyone, regardless of income status and geographic positioning.

By channelling long-term and sustainable investment in R&D through mechanisms such as CEPI, it significantly compresses the time it takes to respond to outbreaks. This will bring the world closer to achieving the '100 Day Mission'; reducing the timeline of safe and effective vaccines, treatments and tests from 300 to 100 days. Put forward by and committed to by the UK Government, backed by G7 and G20 leaders, and supported by the Life Sciences industry, this mission, which sits at the core of the CEPI 2.0 Strategy¹⁰, will only be within reach if a substantial investment is made in R&D.

Investment in R&D

At the Global Pandemic Preparedness Summit in March 2022, only US\$1.5 billion was raised of the US\$3.5 billion required to finance CEPI 2.0, subsequently hampering the ability of the world to achieve the 100 Day Mission and unleash the power of science to prepare and protect the world against emerging epidemic and pandemic threats. The 100 Days Mission report¹¹ prepared for the G7 in 2021 by the Pandemic Preparedness Partnership, which was chaired by the UK Government's Chief Scientific Adviser, articulated that this requires finance sources beyond official development assistance (ODA).

Whilst R&D for PPR is intrinsically connected to international development, it should not be dependent on ODA. The OECD Development Assistance Committee guidelines¹² set

out that not all contributions to CEPI should be counted as ODA, as developing a successful vaccine is a global public good that benefits high-income countries as well as those with other global income brackets. Furthermore, it stated that countries can source 47% of this funding from beyond ODA budgets in 2020.

The UK Government has already recognised the ability to use both non-ODA and ODA resources in global health R&D. It used the Department of Health and Social Care's domestic budget to invest in COVID-19 sequencing capabilities in LMICs¹³. Another example is the announcement of a new model for international science collaboration, using ODA and non-ODA funding, replacing the Global Challenges Research Fund and Newtons Fund¹⁴. Using non-ODA resources to finance R&D for PPR could remove the limitations that come with ODA funding, acknowledging that PPR is a global responsibility, not limited to LMICs, and a national and regional priority of the UK, whilst increasing fiscal space within ODA budgets for health systems strengthening.

R&D is a global public good, however it is not a fixed outcome. It requires long-term sustainable financing to deliver an ongoing and adaptable set of tools to provide readiness and resilience within regional, national and international communities for the next inevitable outbreak.

Recommendations

1. Sustainably invest in R&D using non-ODA resources to help fill the funding gap in PPR efforts, and subsequently achieve the 100 Day Mission. Specifically:
 - a. Increase the existing pledge made to CEPI's 2.0 Strategy from £160 million to £300 million, to build on the UK's previous contribution and match the increased global need for PPR;
 - b. Encourage international peers to commit to CEPI 2.0 and thereby raise the full amount of US\$3.5 billion required to deliver on the 100 Day Mission.
2. Use the UK's position as a sovereign donor to the Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness, and Response (PPR) to affirm R&D as a central component of PPR, thereby endorsing CEPI as an implementing entity of the Fund.

3 – Financing

Significant, yet insufficient, funds were disbursed by governments to respond to the pandemic. The mass and rapid reallocation of financial resources was detrimental to routine immunisation, access to PHC and the fight against other diseases.¹⁵ The

pandemic's high death toll and economic burden fuelled calls to invest more intentionally in pandemic PPR, both between and during pandemics.

In 2022, the war in Ukraine, the rapidly escalating impacts of climate change, famine in the Horn of Africa and a global cost of living crisis mean that ever more funding is required by a number of compounding challenges. This includes investments in the global COVID-19 response and other health priorities, particularly for LMICs that were and continue to be most affected by the intersecting impacts of COVID-19, conflict and climate change.

Protect overseas aid budgets for PPR, PHC and routine immunisation

ODA is not increasing sustainably to meet the growing needs of the most vulnerable countries. The 4.1% real growth¹⁶ in total ODA seen in 2021 was largely driven by financing the cost of COVID-19 vaccine donations, with overall COVID-19 spending detracting from other health priorities. International aid to Ukraine and the first year costs of settling refugees has also come from existing ODA budgets. Analysis¹⁷ shows that global in-donor refugee costs alone could exceed an estimated US\$45.5 billion in 2022, which would be 26.0% of the total ODA spent in 2021.

This presents a challenge for health and PPR spend. Even before COVID-19, international aid for pandemic preparedness and health systems strengthening was highly insufficient. Now, with the attention in the development community shifting¹⁸ to insufficient food and energy supplies, inflation and the cost of living crisis, it becomes ever more imperative that we prevent further diversion of resources from PHC and health systems strengthening. These challenges are particularly acute with several donor governments thinking of or already cutting aid budgets¹⁹, meaning a number of urgent, but competing priorities are vying for the same pot of money. COVID-19 showed that ending the health crisis is vital for the economy and national security. It reinforces the need for national governments to value and resource health and PPR as a critical pillar to a country's economic security, so that it can build resilience to global shocks.

Research and promote new, innovative, sustainable non-ODA funding for health and PPR

There are a wide range of innovative financing options, from leveraging more funding through reforming multilateral development banks to various forms of taxation. One avenue through which financing could be unlocked is explored below in more detail:

Multilateral development bank (MDB) optimization

- **Opportunities:** The G20 identified \$500 billion to \$1 trillion in additional financing that could be unlocked through ambitious MDB reforms, including through reassessing capital adequacy thresholds. Given the role of regional MDBs in PPR, i.e., the African Development Bank²⁰, leveraging more funding through MDB reforms provides a good opportunity.
- **Challenges:** Reform will take time and requires political will. There will be many different policy priorities vying for this source of additional financing. It is most likely to benefit existing recipients of MDB financing, e.g., middle-income countries
- **What it would take to implement:** Reforms will likely need the agreement of shareholders, including the UK, in line with respective governance arrangements, and will require shifting risk-averse MDB management. Public awareness-raising campaigns are needed on the “excess capacity” that development banks are not lending, but could, making an explicit connection to pandemic preparedness as a critical GPG that requires massive increases in global public financing from this additional funding source.

Invest in health/PPR and (community) health workers

Different sources have different ways of measuring the return on investment of PPR, but all of them are clear on one thing: PPR investments are small, i.e., an additional \$10.5 billion yearly for the next five years, compared to financing the economic costs of a pandemic. Estimates from McKinsey and an independent G20 panel²¹ suggest that by 2025, COVID-19 will have a global economic burden of \$16–\$35 trillion¹.

PPR financing should prioritise (community) health workers. Apart from the crucial role they play in the delivery of essential services and health emergencies, the return on investment is high. A study, carried out in the first year of the pandemic, suggests that an investment of \$9.6 billion to protect healthcare workers in all LMICs would save over two million lives across LMICs, and yield a societal return on investment of \$755.3 billion²².

Recommendations

1. Maintain and prioritise ODA for existing health and immunization commitments in addition to increased investment in PPR funds and mechanisms, meeting fair share of global financial PPR requirements.
2. Engage relevant global and regional stakeholders, e.g., MDBs, to unlock innovative, non-ODA funding mechanisms for health and PPR.

¹ These are high-level estimates with wide error bars. They include pandemic-specific strengthening of health systems but not the full health-system-strengthening agenda

3. Raise awareness on the benefits of health and PPR financing for the wider economy and other development areas.

4 – Governance

The PPR Accord is part of a set of mechanisms and frameworks that have been designed to strengthen Health Emergency Preparedness and Response (HEPR). As such, its effectiveness lies not only in its application as a stand-alone mechanism, but rather in its interaction with other elements that have been designed to create a robust global architecture including the Universal Health and Preparedness Review and the Financial Intermediary Fund established for PPR at the World Bank, not to mention what may emerge from the ongoing Access to COVID-19 Tools - Accelerator review. It is therefore essential to further explore opportunities for synergies and potential links between these key elements across the three pillars of global HEPR architecture: governance, systems and financing.

This fragmentation of the PPR architecture is reflective of global health governance as a whole, and this only multiplies challenges to the promotion of equity and accountability as well as for representation and decision-making power. It remains the case that global health is heavily led by the donor-recipient model of financing, and has decision-making and participatory structures which reflect this and magnify the power of large donor countries and philanthropies at the expense of countries at lower income levels, communities and civil society. Beyond the problematic principles of this issue, through COVID-19 we have seen that it is also a practical issue which limits the effectiveness of pandemic response: limiting flows of vaccines and other essential goods to where they are needed most, and in the other direction restricting critical frontline information from civil society and communities to distant decision-makers. To operate effectively there must be meaningful participation from countries of all income levels, as well as directly from non-state actors - particularly affected communities and civil society.

While these central multilateral institutions will be at the heart of pandemic governance, through this Accord - and the other developing strands of Pandemic governance architecture - it is necessary for both preparedness and response that regional governance mechanisms and institutions are strengthened and supported to reduce dependency and promote equitable access to medicines. For example, support for institutions such as the Centre for Disease Control Africa is critical to ensure not only that there is adequate regional resourcing and capacity for surveillance and prevention, but also for the diversification of manufacturing capacity to enable the effective distribution of medicines in any pandemic response. Given that COVID-19 vaccine inequality remains deeply entrenched, it is clear the current system has not worked.

Recommendations

1. Ensure the formal participation of LMIC governments and CSOs in the governance of all pandemic preparedness institutions and mechanisms.

Summary of Recommendations to the UK Government

Primary Health Care and Systems Strengthening

1. Ensure the PPR Accord contains explicit commitments to strengthening systems to improve primary health care, including the following:
 - a. Strengthening of health and immunization systems
 - b. Prioritizing, recruiting, and supporting the health workforce
 - c. Targeting communication strategies to enhance demand for and confidence in vaccination and essential healthcare services

Research & Development

2. Sustainably invest in R&D using non-ODA resources to help fill the funding gap in PPR efforts, and subsequently achieve the 100 Day Mission. Specifically:
 - a. Increase the existing pledge made to CEPI's 2.0 Strategy from £160 million to £300 million, to build on the UK's previous contribution and match the increased global need for PPR;
 - b. Encourage international peers to commit to CEPI 2.0 and thereby raise the full amount of US\$3.5 billion required to deliver on the 100 Day Mission.
3. Use the UK's position as a sovereign donor to the Financial Intermediary Fund (FIF) for Pandemic Prevention, Preparedness, and Response (PPR) to affirm R&D as a central component of PPR, thereby endorsing CEPI as an implementing entity of the Fund.

Financing

4. Maintain and prioritise ODA for existing health and immunization commitments in addition to increased investment in PPR funds and mechanisms, meeting fair share of global financial PPR requirements.
5. Engage relevant global and regional stakeholders, e.g. MDBs, to unlock innovative, non-ODA funding mechanisms for health and PPR.
6. Raise awareness on the benefits of health and PPR financing for the wider economy and other development areas.

Governance

7. Ensure the formal participation of LMIC governments and CSOs in the governance of all pandemic preparedness institutions and mechanisms.

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Photo on front cover: On 13 September 2022, a health worker vaccinates a child for hepatitis at a UNICEF-supported Mobile Health Unit for flood victims. © UNICEF/Noorani

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