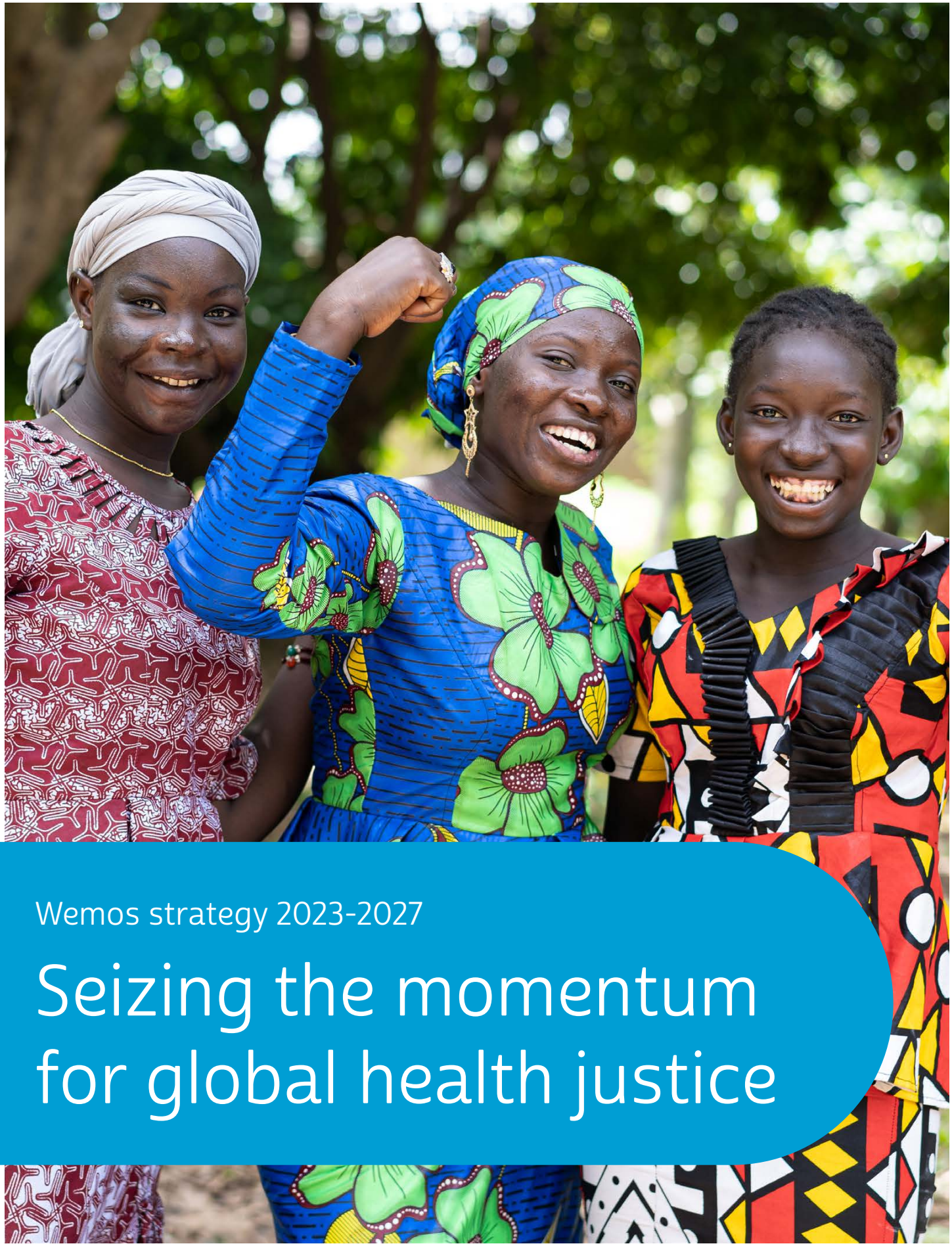

Wemos strategy 2023-2027

Seizing the momentum for global health justice

wemos

Make health justice happen

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Our strategy at a glance

It has been a turbulent few years, with one crisis after another in the world around us. Our hope is that global actors and national governments will seize the moment as an opportunity to strengthen health systems worldwide. In this five-year strategy, we continue to focus on four areas where improvements are feasible.

Finance for health - the need for well-funded health systems accessible to all individuals

Financial and social protection is under threat in many countries, where insufficient health budgets are blocking meaningful progress towards universal health coverage. Health justice requires strong public systems, but many multilateral donors and funders have increasingly taken a 'private first' approach. Addressing the world's challenges clearly requires new types of global public funding.

External support to strengthen health systems
We call on global health actors to:

- Provide predictable and unconditional health funding for low- and middle-income countries, without restrictions that limit its use for recurring expenditure.
- Implement global health governance and decision-making that is inclusive and ensures democratic oversight, civil society consultation, transparency and accountability.

Public rather than private health systems
We call on global health actors to:

- Refrain from diverting development and public finance towards the private healthcare sector unless it contributes to equitable access to care.

Reforming global financial architecture
Our focus includes:

- Reinforcing calls for global tax justice, ending illicit financial flows, and promoting fair and sustainable solutions to the debt crisis.
- Supporting the #EndAusterity movement, calling on the International Monetary Fund to discontinue harmful advice or conditionalities towards austerity measures.
- Joining forces with movements proposing financing reforms, to create mechanisms like fair share contributions to global funds, equal decision-making and allocation according to need.

Access to medicines - everyone, everywhere, should have the products that meet their needs

Several important faults in the current market-based system undermine affordable access to medicines. Despite a World Health Assembly resolution to improve the situation, there is still a lack of transparency affecting countries worldwide. Market monopolies lead to expensive new products and huge profits, with public-funded research findings being sold to private companies, as investments are made with no conditions set. Structural solutions are needed.

Product pipeline based on health-for-all
We aim to convince the Dutch parliament and key stakeholders at universities and ministries of the need to:

- Safeguard health knowledge and treat it as a global common good.
- Promote transparency in prices and R&D costs.
- Develop an EU-wide database on net prices.
- Put conditions on health technologies financed with public funds relating to transparency, pricing, intellectual property, know-how and technology sharing.
- Develop and enforce laws on disclosure obligations for pharmaceutical companies.

Increased sovereignty and self-reliance
We will lobby global health institutions, bilateral donors and regional bodies to:

- Support and finance functional technology sharing mechanisms that can increase the production of relevant vaccine, diagnostics and therapeutics.
- Take policy measures that contribute to sustainable manufacturing capacity in Africa – financing, distribution, coordination, technology transfer, regulation, procurement and pricing.

Human resources for health training and maintaining skilled, motivated and properly supported health workers

There is currently a critical shortage of health workers, and this workforce is also unevenly distributed, with a clear net migration to high-income countries. More people need to be trained at all levels, and funding must be available to keep them in the countries where they are needed most.

More funding for health workers
We call on global health actors to:

- Provide predictable and unconditional health funding in low- and middle-income countries, without restrictions that limit its use for recurring expenditure such as health worker salaries.

Equitable distribution of health workers
We aim to:

- Lobby EU and global institutions for effective implementation of Sustainable Development Goal target 3c – to substantially increase health financing and the recruitment, development, training and retention of the health workforce – across all EU member states.

Dutch global health policy towards an integral approach to current and future global issues

Lobbying has led to growing attention for global health in the EU and the Netherlands, with both the European Commission and the Dutch government presenting new strategies at the end of 2022. A Dutch global health hub will be created to engage stakeholders in discussions on implementation. And strong, resilient health systems are increasingly considered vital to issues such as sexual and reproductive health and rights (SRHR).

Commitment to financing global health
We want the Dutch government and parliament to:

- Commit to the structural investments that are needed in terms of quality and quantity to deal with current and future global health issues.

Focus on systems for health to deliver SRHR
We are asking the Dutch government and parliament to:

- Express and implement a greater focus on health systems within its development cooperation policy, Africa strategy and global health strategy.
- Adopt an integrated and coherent vision of systems for health and SRHR.

Health in All Policies approach
We want the Dutch government to:

- Establish an implementing and decision-making structure for interdepartmental policymaking on global health.
- Implement a transparent assessment framework for policies affecting health, reflecting a planetary health approach, the SDGs and a cross-border perspective.

How do we work to achieve these changes?

With equitable partnerships, with evidence-building and with lobby and advocacy. Effective programme coordination is key to having an impact. As an organization, we aim for a sustainable financial basis. And with strategic and convincing communication, we hope to realise our ultimate ambition of global health justice.

Introduction

Wemos is a global health advocacy organization based in the Netherlands. We were founded in 1979 by a group of Dutch medical students who believed that medical interventions in low- and middle-income countries can only be effective if the underlying causes of health inequity and injustice are addressed. Today, we continue to advocate the right to health for all.

In our new pandemic-prone world, global health has become mainstream. The Covid-19 pandemic has shown once again that health has no borders. The planetary crisis has huge and increasing impact on people's health. Hard-fought health gains of the past decade are at risk, including sexual and reproductive health and rights (SRHR). This is particularly true for minoritized and vulnerable populations.

There is now momentum to address decades of chronic under-investment in health everywhere, including the capacity to control and address global public health threats such as epidemic diseases. This requires a concerted effort to leave no one behind in our pursuit of health justice. At the same time, global social movements such as 'decolonizing global health' and 'shifting power' force us to critically reflect on our own role and to make conscious decisions.

In this 5-year strategy, covering the period 2023 to 2027, we envision structural changes to how systems for health are organized, funded and governed. In doing so, we focus on the key themes most strongly influenced by global developments and power relations.

Finance for health

We want all governments to be able to allocate sufficient funding for public health systems that are accessible to all citizens.

Access to medicines

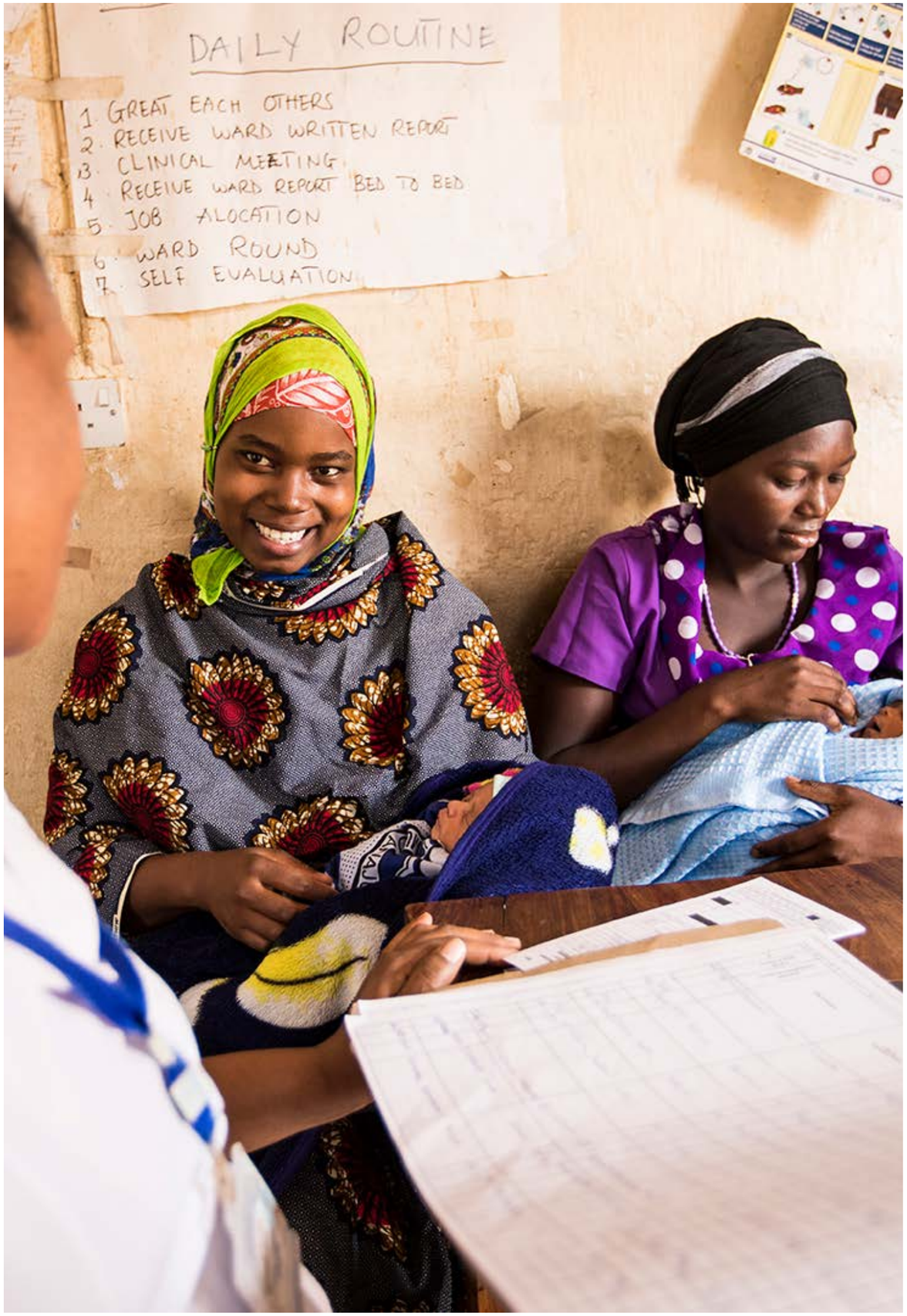
We want all people, everywhere, to have access to pharmaceutical products that meet their medical needs.

Human resources for health

We want everyone, everywhere, to have access to skilled, motivated and properly supported health workers.

Dutch global health policy

We want the Dutch government to implement an integral approach for dealing with current and future global health issues.



About Wemos

Our vision
Wemos envisions a world where we can all be as healthy as possible.

Our mission
We advocate structural change to achieve global health justice.

What do we mean by global health justice?

Health is everyone's most valuable asset. It allows you to lead a pleasant life and have opportunities in, for example, education and work. A person's health depends on many modifiable and non-modifiable factors. We cannot all have the same level of health, but you should be able to attain your full potential for health.

We are witnessing large, avoidable disparities in health between populations and parts of the world. A health equity approach recognizes that people have different circumstances and needs, and offers support that ensures equal opportunities for good health outcomes.

Global health justice looks beyond equity for individuals, aiming to create equity in systems as well. Health systems should be designed, funded and governed to effectively provide healthcare services, foster health promotion and address health security challenges. This leads to a world in which everyone can have optimal access to quality healthcare and be protected against health threats.

Our guiding principles

Health is a human right
As health is a fundamental need, it is established as a human right in international treaties. Governments are therefore responsible and accountable for ensuring the conditions to achieve optimal access for all to healthcare, as well as protection against health threats. It also means that public health interests must take precedence over political and economic interests.

Health justice requires structural change
Creating resilient health systems and health policies that benefit everyone calls for structural change. This includes political, economic and social change, both within countries and globally. It also means that change is needed in laws and priority-setting, financing mechanisms and medical innovation models, and better ways to involve stakeholders in policy development. At the same time, policy coherence across government departments – as well as national and international governing bodies – is essential, to avoid policies conflicting with health interests.

Health justice means leaving no one behind
No one should be left behind. This is a central promise of the Sustainable Development Goals (SDGs). There should be no unfair, avoidable or remediable differences in health outcomes among different groups of people, whether they are defined socially, economically, demographically, geographically or, for example, in terms of sex, gender, ethnicity, ability or sexual orientation.

Health justice is a shared responsibility
In our globalized world, the pursuit of equitable access for all to quality healthcare, and protection against health threats, is a shared responsibility – as well as a shared benefit. Many actors have a role to play: governments, international donors, multilateral institutions, civil society and communities. Inequity between countries and populations often has its roots in colonial history. That is why high-income countries in particular have a responsibility to support progress towards global health justice.

This is how we work:

1 Equitable partnerships
Achieving global health justice requires working together across sectors and countries. We foster productive relationships with civil society from all over the world, participate in effective European and global networks, link with expert groups, and create new alliances. Being based in the Netherlands, we are aware of the opportunities we have to access information and resources. In our partnerships we look to mutually strengthen each other's capacity and knowledge, enhance learning and share networks.

2 Evidence-building
We thoroughly analyse the factors hindering health justice and the possible solutions for overcoming these barriers. We often initiate our work with partners in low- and middle-income countries, based on their most urgent issues related to health justice. Jointly, we gather sound information to build our positions and recommendations for structural change. We will continue to ground our global lobby in country contexts and place national organizations at the centre of our work, aiming to connect to their knowledge and amplify their voices.

3 Lobby and advocacy
As an organization based in the Netherlands, we push our Dutch government – and by extension the European Union (EU) and global health institutions – to address structural causes of health inequity and injustice. We call ourselves 'the critical friend'; we are critical of policies and decisions that create barriers health, but always aim to have a constructive dialogue.

In our lobby and advocacy we collaborate with allies worldwide. We aim to align our global interventions with the advocacy work in countries where we are active, to ensure our focus is relevant and contributes to national change processes. We want to add value by linking global and national level developments and discussions. Increasingly, we use our influence to call out power asymmetries in global health institutions. That is because we want to make way for organizations in low- and middle-income countries to lobby global decision-makers, advocate at global events, and take up seats at decision-making tables.

Strategic communication
Communication is the backbone of our work. Clear and inclusive communication facilitates collaborations. This allows us to expand our network, comprehend the realities of the contexts in which we work, and enhance our shared messaging. We translate evidence into knowledge products tailored to specific audiences, so that facts and data from a national level support our policy change recommendations. We strive for a positive perspective, emphasizing possibilities rather than problems. By being strategic and deliberate, our communication raises awareness, expands knowledge and influences the opinions of relevant policymakers and other stakeholders who can push for policy change.

Our strategy to achieve global health justice

How we work

Equitable partnerships
Working with civil society organizations worldwide, actively sharing our network and knowledge, and creating space for others.

Evidence-building
Jointly analysing barriers that hinder health justice, both at national and global level, and developing solutions.

Lobby and advocacy
Convincing Dutch, European and global decision-makers and policymakers to act, aligning our global interventions with advocacy work in other countries.

The 5 cumulative changes we push for

Behavioural change Key actors change their behaviour and implement meaningful policies at all relevant levels.

Policy change Decision-makers and policymakers amend or adopt policies, strategies and laws.

Procedural change Changes are made in decision-making processes, e.g. opening of new spaces

Discursive change Advocacy targets start adopting our terminology, rhetoric and framing of the issue.

Agenda setting After drawing attention and creating awareness, the issue is put on the political agenda.

We connect global with national developments and vice versa.

Our focus areas and goals

Finance for health
All governments are able to allocate sufficient funding for public health systems that are accessible to all citizens.

Access to medicines
All people, everywhere, have access to pharmaceutical products that meet their medical needs.

Human resources for health
Everyone, everywhere, has access to skilled, motivated and properly supported health workers.

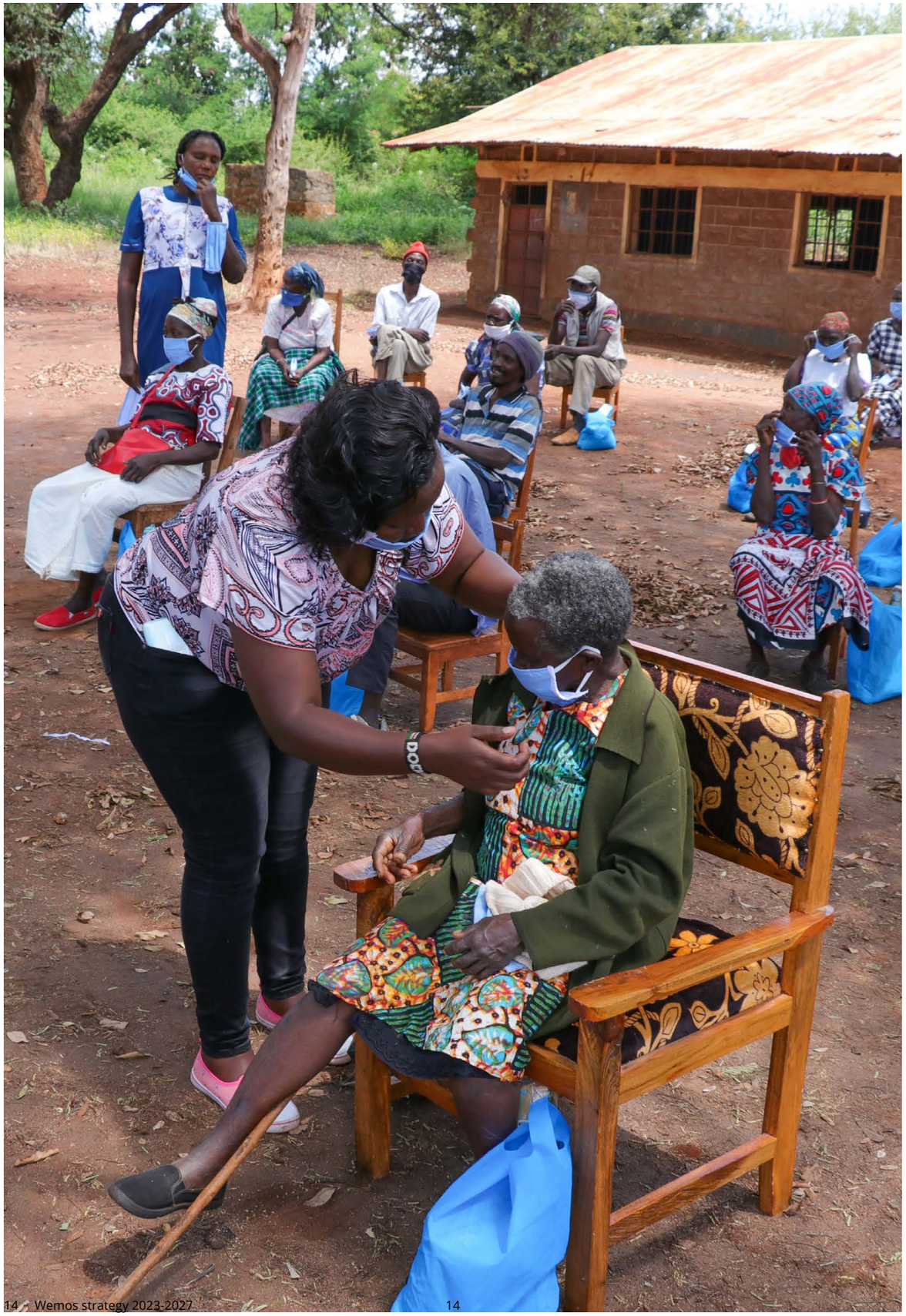
Dutch global health policy
The Dutch government implements an integral approach for dealing with current and future global health issues.

Ultimate goal

Global health justice

Everyone has optimal access to quality healthcare and is protected against health threats, no matter who they are, where they live or how much money they have.

We develop solutions that are inclusive and leave no one behind.



General developments affecting global health

We examine the root causes of health inequity and injustice through the perspective of systems for health[1], against the backdrop of the planetary crisis, Covid-19 pandemic, shifting power dynamics, and increased attention for gender and intersectionality.

Triple planetary crisis

The triple planetary crisis refers to climate change, loss of biodiversity and pollution. Climate change is said to be the biggest threat to health worldwide, with indirect effects such as population displacement, conflict and loss of livelihood.[2,3] While flooding increases the risk of disease, droughts have a major impact on nutritional food production. Loss of biodiversity leads to the emergence of infectious pathogens,[4] and affects food supplies and access to clean water.[5] Pollution is now a major cause of mortality and morbidity, and is linked to antimicrobial resistance – a new global health threat.[6]

The most vulnerable and disadvantaged are disproportionally affected by the social, cultural, political and economic factors linked to the planetary crisis. So tackling the broad systemic determinants of health requires a planetary health lens. Human health should be considered in the context of animal and environmental health, especially when applying a global perspective. In the coming years, we will further embed this in our focus areas.

Covid-19 pandemic

The Covid-19 pandemic shook the world, causing over 15 million deaths worldwide.[7] Its huge impact put an extra burden on individuals and decreased countries' resources for health and well-being. The disruption of essential and emergency services, including sexual and reproductive health and HIV/AIDS, caused major setbacks for the SDGs.[8]

The pandemic amplified health inequalities, highlighting the need to remove financial barriers for health services and to ensure sufficient funding for healthcare and health workers.[9] To sustain health gains you need resilient public health systems that provide access to quality prevention and care services for all, especially for people living in poverty and those who are most minoritized.[10] Commercialized and fragmented health systems are far less effective in responding to health crises, both in high- and low-income countries.[11,12]

Covid-19 has confirmed the need for a broader system that addresses the challenges of health security and health promotion while continuing to provide essential services.[13]

Shifting power dynamics

Many health system failures are rooted in unequal power relations within global health institutions and between low- and high-income countries. We need to recognize and address these power dynamics and re-examine the factors relating to health that stem from colonialism.[14,15,16] Development partners increasingly speak of "shifting power to the South" with community participation or "country ownership". Similarly, the global health community – including Wemos – is starting to reflect on the role of power and privilege in partnerships and interventions.

Increased attention for gender and intersectionality

Inequities, oppression and discrimination in societies are reproduced in health systems too.[17] Biological differences and socially constructed gender roles create health and gender inequity, affecting life expectancy, bodily autonomy, and access to health services. Gender inequity can also significantly impact opportunities to contribute as health professionals.[18] Women represent over 70% of the health workforce, but only 25% of leadership positions.[19] Gender and other biases have affected health research and clinical practice for decades, leading to dismissal, mistreatment and misdiagnosis.[20] Growing conservatism and political, male-dominated forces seek to limit bodily autonomy and make it difficult for women and girls and LGBTQI+ people to realize their SRHR.

In all societies, it is the furthest behind who experience multiple and intersecting disadvantages. They are at risk of being discriminated, disempowered and excluded from mainstream health services, policy and planning.[21] Using an intersectional, gender-transformative approach enables us to identify and advocate policy solutions that redress these inequities.

Our focus areas

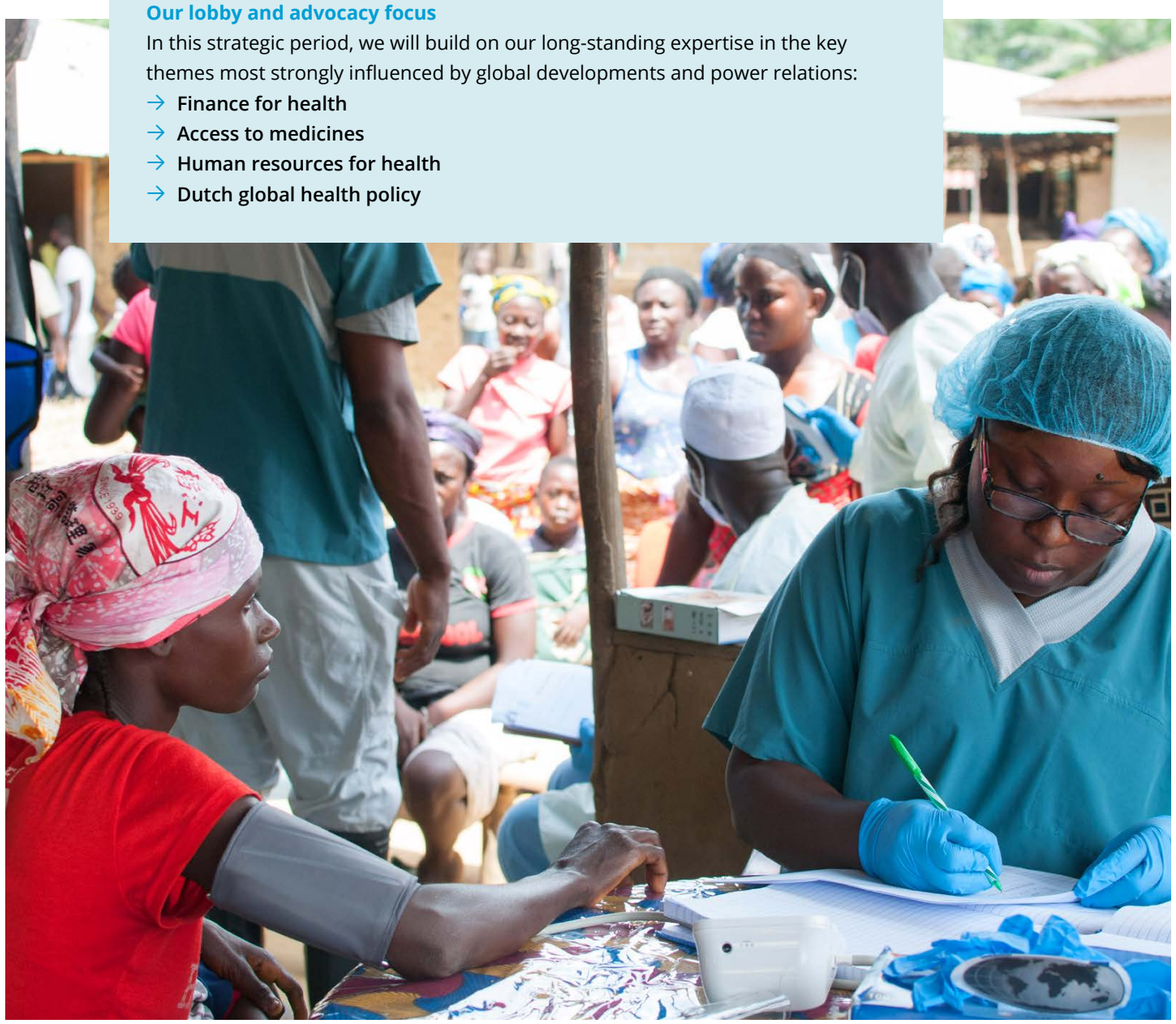
Systems for health

We apply a *systems for health*[22] perspective that not only looks at universal access to services, but also aims to ensure health security and create healthy populations. A broad, holistic system for creating and promoting health is dependent on multisectoral collaboration and should address all socioeconomic, political, environmental and commercial drivers of health.

Our lobby and advocacy focus

In this strategic period, we will build on our long-standing expertise in the key themes most strongly influenced by global developments and power relations:

- → **Finance for health**
- → **Access to medicines**
- → **Human resources for health**
- → **Dutch global health policy**



Finance for health

Key developments

Financial and social protection under threat

Persisting inequalities in access to care are linked to structural problems in finance for health. Between 2000 and 2019, an estimated one in six households in Sub-Saharan Africa experienced a catastrophic increase in health expenditure, spending over 10% of their household budget on health.[23] This is a vicious cycle of poverty leading to preventable illness and death. During the pandemic, nearly 60% of households in low-income countries could not access health services due to lack of money.[24]

Insufficient health budgets

Many low- and middle-income countries lack the means to make meaningful progress towards universal health coverage (UHC). UHC means that everyone has access to the health services they need, when and where they need them, without financial hardship.[25] Although many governments' health budgets have grown, most low- and middle-income countries have insufficient financing for providing people with a basic health service package. This affects minoritized and poor populations in particular.[26]

Accumulation of unsustainable debt, and the severe burden of repayments, seriously hamper an increasing number of countries' fiscal space for social services, including health. This crisis has worsened due to the pandemic and a continuous drain of resources through Illicit Financial Flows.[27,28] Catastrophic health expenditure is expected to increase, and low- and middle-income countries' health budgets are likely to decrease in both absolute and relative terms. [29] Transitioning from low- to middle-income status also means losing extra health funding.

Health equity requires strong public systems

According to World Health Organization (WHO) guidance, the most effective, equitable ways of delivering public health services are publicly funded and have limited user charges at the point of access.[30,31,32] The World Bank agrees.[33] Nevertheless, many multilateral and bilateral donors and funders have increasingly taken a 'private first' approach. Using public funds, including development aid to strengthen the private health sector diverts development funding from more effective ways to reach UHC. And it can even be harmful. Public-private partnerships risk draining a government's public purse, and can put up financial barriers for people in need of care.

New approaches to global public funding

The pandemic, and the economic crises that followed, worsened the long-standing global health funding gap and made it more visible. Traditional health funding – whether through global initiatives or bilaterally – can only partly alleviate this gap. It has its limitations too, being based on charity and earmarked by those who provide the money.

Addressing the world's challenges clearly requires new approaches to financing. In 2020, an expert group of thought leaders started discussing key technical and political aspects of Global Public Investment – a new approach to public finance for sustainable development.[34] This approach includes the principle of 'fair share' contributions to global development and sustainability goals, next to principles of equal power in decision-making and re-distribution according to need.

Our goal

We want all governments to be able to allocate sufficient funding for public health systems that are accessible to all citizens.

We advocate

External support to strengthen health systems

In most low- and middle-income countries, external global actors influence the fiscal space for health. Collectively, they have massively increased the volume of resources for health. But if external funding is not well-aligned with national plans and systems, it can challenge national leadership, cause fragmentation[35] and disrupt policy implementation.

To prevent fragmentation, global health funding needs to be channelled via a harmonized and transparent system that facilitates the country's accountability and ownership. It should be predictable and not have undue restrictions, such as those limiting its use for recurring expenditure like salaries (see section on human resources for health).

Specifically, we call on global health actors to:

- Provide predictable and unconditional health funding for low- and middle-income countries, without restrictions that limit its use for recurring expenditure such as health worker salaries.
- Implement global health governance and decision-making that is inclusive and ensures democratic oversight, civil society consultation, transparency, accountability, and due diligence procedures.

Public rather than private health systems

Universal and equitable public health systems require public financing. Despite the risks of widening gaps, some global health actors encourage private financing in the health sector, both for recurring expenditure (often as private health insurance), and capital investment (e.g. private hospitals and clinics or public-private healthcare partnerships). We ask global health actors to be critical of private sector solutions, and to primarily support public health systems.

Specifically, we call on global health actors to:

- Refrain from diverting development and public finance towards the private healthcare sector unless it contributes to equitable access to care.

Reforming global financial architecture

Although development aid fills important financing gaps, this does not make up for structural drains on the public purse in many countries. The money low- and middle-income countries lose through unfair global tax rules, illicit financial flows, and debt servicing is almost double the inflow of official development assistance (ODA).[39] Ultimately, a real change is needed in global financial and health architecture and the way funding is raised and allocated. We need reforms to reverse the flow of resources from low- and middle-income countries to high-income countries. This will not only enlarge a country's public purse but will also increase national sovereignty and self-sufficiency.

Wemos strives to connect the work of economic justice movements to the global health finance debate. We want global health actors to become vocal on these issues, by acknowledging the need for – and supporting calls for – global financial architecture reforms to expand the public purse of low- and middle-income countries.

Our focus includes:

- Reinforcing calls for global tax justice, ending illicit financial flows, and promoting fair and sustainable solutions to the debt crisis.
- Supporting the #EndAusterity movement, calling on the International Monetary Fund to discontinue harmful advice or conditionalities towards austerity measures.
- Joining forces with movements that propose reforms in development aid and financing to create progressive mechanisms such as fair share contributions to global funds, equal decision-making and allocation according to need.

The UN Multistakeholder Hearing on Universal health coverage in Washington, 9 May 2023

Access to medicines

Key developments

Faults in the system

Essential medicines, vaccines and other critical pharmaceutical technologies help people to be as healthy as possible and to prevent illness and death. But millions of people around the world do not have access to any of this. The current market-based system undermines affordable access to needs-based health products. Expected financial return determines which products are brought to market, leaving unprofitable yet critical health needs under-researched and underdeveloped. Below, we describe three important faults in the system.

1 Lack of transparency

Even though the World Health Assembly (WHA) adopted a resolution entitled 'Improving the transparency of markets for medicines, vaccines and other health products' in 2019, this remains a major problem affecting nations and leading to high prices worldwide. Instead of setting a reasonable profit margin based on transparent costing of research & development (R&D) and production, pharmaceutical companies use a value-based model which determines prices based on what countries are willing to pay. Governments, in turn, are under pressure to pay excessive prices to make essential medicines and other health products available to their citizens.

2 Market monopolies

International legislation rewards innovations by pharmaceutical companies with a 20-year patent. During those years of monopoly, a company has no competition and can determine both the price and supply of their product. The result: expensive new products and huge profits for pharmaceutical companies.

Monopoly positions were exploited to keep the availability of Covid-19 vaccines artificially low. Low- and middle-income countries depended on donations – which were not sufficient and often came too late - even though they would have been able to produce vaccines themselves, if pharmaceutical companies had shared their knowledge, data and intellectual property.

3 Investments with no conditions

In the current system, the shift from public to private occurs when publicly funded research institutions sell basic and applied research findings to biotech and pharmaceutical companies. They usually do so without adding any access and equity conditions that could guarantee affordable pricing and ensure that know-how and technology is shared. That is how a private company obtains an exclusive license to develop a product. Ultimately it is a country's citizens that pay for all this: in taxes that cover public research, with costly medical insurance and/or personal health expenses, and through reduced access to healthcare because of their government's depleted health budget.

Lack of sovereignty and self-reliance

During the Covid-19 pandemic, the countries that were last in the Covid-19 vaccine queue said they needed structural solutions instead of charity responses. Africa was worst hit by the uneven distribution. Currently, 99% of all vaccines administered in Africa are manufactured outside Africa.[36] In 2021, the WHO issued a resolution on strengthening local production of medicines and other health technologies to improve access.[37] In the same year, the WHO, the Medicines Patent Pool and COVAX established a global mRNA technology transfer hub. This aimed to help manufacturers in low- and middle-income countries produce their own vaccines, ensuring they have all necessary operating procedures and know-how to manufacture mRNA vaccines at scale and according to international standards.

Our goal

We want all people, everywhere, to have access to pharmaceutical products that meet their medical needs.

In 2022, the African Union and African Centre for Disease Control (CDC) launched the Partnership for African Vaccine Manufacturing (PAVM) to expand Africa's capacity to produce vaccines, medicines and other pharmaceutical products. The PAVM's goal is to produce 60% of the vaccine demand in Africa by 2040, developing five vaccines for neglected diseases, building and streamlining regulatory capacity and completing 23 technology transfers.[38]

Various global initiatives – ranging from multilateral financing institutions such as the World Bank Group to the EU and high-income governments – intend to mobilize billions of dollars in public funds to support the PAVM goal. Some manufacturers, like BioNTech and Afrigen,[39] have agreed to partner with development institutions in these initiatives.

We advocate

Product pipeline based on health-for-all

Unfair, avoidable and remediable system faults in all stages of the pharmaceutical product development and access pipeline need to be fixed. A health-for-all pharmaceutical product pipeline has the following characteristics:

- At the basic and applied research stage, knowledge is a global common good for health,[40] rather than private property.
- Research developed with public funding is sold to pharmaceutical companies with clear equity conditions and strict patentability criteria to ensure public health interests are placed above commercial interests.
- During product R&D, pharmaceutical companies are transparent about their R&D costs. And governments apply alternative business models such as cost-plus pricing instead of value-based pricing.
- At the regulation stage, governments adopt policy measures that result in pharmaceutical products with added therapeutic value.
- In the final stage of manufacturing, supply, procurement and distribution, pharmaceutical companies share their knowledge for upscaling, further innovation and capacity strengthening.

The pipeline of medical innovations

Errors in the current system	Solutions
Basic and applied research at universities	**Basic and applied research at universities**
✗ Research is funded with public money, but licenses are sold without conditions to ensure access for all.	✓ Conditions are attached to public funding to promote access for all.
✗ Innovations are patented for 20+ years, patent holder gets a monopoly.	✓ Licenses are sold with conditions to ensure access for all.
✗ Knowledge becomes private property.	✓ Knowledge becomes public good.
Product research & development by companies	**Product research & development by companies**
✗ Investments are directed by expected profits rather than priority health needs.	✓ Alternative business models are set up for innovation aimed at access for all.
✗ Limited collaboration with other actors, which hinders innovation.	✓ Stricter criteria for patents to avoid *evergreening*.
✗ Patents are extended by making minor changes to existing innovations *(evergreening)*.	✓ Transparency on the costs of research & development.
✗ No transparency on the costs of research & development.	
Regulation	**Regulation**
✗ Products are regulated that have no added therapeutic value.	✓ Only products that have added therapeutic value are regulated.
Manufacturing, supply, procurement and distribution	**Manufacturing, supply, procurement and distribution**
✗ Pharmaceutical companies determine the prices despite public funding.	✓ Transparency between countries on the prices they pay.
✗ No transparency between countries on the prices they pay.	✓ Sharing of intellectual property, knowledge and data.
✗ No sharing of intellectual property, knowledge and data.	✓ Expansion of production capacity, particularly in low- and middle-income countries.
✗ Limited production capacity, particularly in low- and middle-income countries.	✓ Prices are based on costs.
✗ Prices are not based on costs, but on 'value'.	
Scarcity	Sufficient global availability
High prices	Fair prices
Unmet health needs, neglected diseases	Health needs are met
Low- and middle-income countries depend on charity	Low- and middle-income countries are self-sufficient
Lack of access for everyone, everywhere	Access for everyone, everywhere

Global health institutions, donors and governments should make significant financing available to build, diversify and increase regional production capacity in a way that promotes health equity, self-reliance and sovereignty. There needs to be an inclusive and equitable global governance mechanism, including a new international instrument for pandemic prevention, preparedness and response based on equity principles.

Governments play a central role in setting the mission for a health-for-all pharmaceutical product development pipeline.[41, 42] This particularly applies to high-income countries with disproportionate power to influence global innovation and access policies and investments. Our lobby starts in the Netherlands. We aim to constructively challenge and inspire Dutch leadership to return to their progressive positions of the recent past and be a global leader in advancing innovations and initiatives that are need-driven and designed for access for all.

We aim to convince Dutch parliamentarians and other key stakeholders at universities and the ministries of health, foreign affairs, economic affairs, finance and education of the need to:

- Safeguard health knowledge and treat it as a global common good.
- Promote transparency in prices and R&D costs for instance by implementing the WHA resolution.
- Develop an EU-wide database on net prices.
- Put conditions on health technologies financed with public funds relating to transparency, pricing, intellectual property, know-how and technology sharing.
- Develop and enforce transparency laws on disclosure obligations for pharmaceutical companies.

Increased sovereignty and self-reliance

For the African Union to realize its goal of self-reliance, sovereignty and health equity relating to access to medicines, several barriers need to be addressed. This includes improving knowledge transfer, increasing professional staffing numbers, adapting regulatory frameworks, policy environments, patents and other intellectual property rights, increasing R&D capacities, and strengthening input and ingredient supply chains. As vaccine production on the African continent relies on international financing, global actors play a key role in helping to create an enabling environment. They must support the African Union in addressing key bottlenecks relating to the pharmaceutical product pipeline.

Specifically, we will lobby global health institutions, bilateral donors – including the Netherlands – and regional bodies such as the EU to:

- Support and finance functional technology sharing mechanisms that can increase the production of relevant vaccine, diagnostics and therapeutics.
- Take policy measures that contribute to sustainable manufacturing capacity in Africa – in financing, distribution, initiative coordination, IP and technology transfer, regulation, procurement and pricing.

Human resources for health

Key developments

Critical shortage of health workers

A strong, effective health workforce is critical to achieving UHC, but is currently unevenly distributed across the world. The biggest staff shortages are in countries with the highest disease burden. Many have health worker density levels beneath the UHC threshold level of 44.5 (doctors, nurses and midwives) per 10,000 population.

High-income countries also suffer from health worker shortages – a combination of an ageing society, ageing health workforce, more chronic and non-communicable diseases, and fewer new students due to the

Our goal

We want everyone, everywhere, to have access to skilled, motivated and properly supported health workers.

profession's decreasing popularity. But the health worker density in these countries is still 6.5 times higher than in low-income countries.[43]

The Covid-19 pandemic triggered other developments in the global health workforce. These relate to recruitment and migration, physical and mental ill health due to stress and overwork, and early retirement.

Push and pull

The WHO estimates that approximately 15% of health and care workers work outside their country of birth, or where they gained their first professional qualification.[44] While international labour migration is not a bad thing, there is a clear net migration of health workers from low- and middle-income countries to high-income countries. By 2030, the global health workforce will probably be 84 million, with an anticipated 40 million new jobs becoming available, mostly in high-income countries.[45] Without additional investments, it is unlikely that these vacancies will be filled by the domestic workforce, resulting in a strong pull effect on health workers from low- and middle-income countries.

Funding is needed for training more people to work in healthcare at all levels. But even where significant numbers of health workers are trained, a lack of fiscal space may make it difficult to employ them, especially in low- and middle-income countries. The result is a paradox – a severe shortage of health workers while many unemployed health workers are looking for jobs.

We advocate

Increased national and external financing

There is an urgent need for more funding for human resources to solve the growing health worker crisis. Low-income countries experience finance gaps, but high-income countries are also not investing enough in their health workforces, leading to many vacancies and the need to attract workers from abroad. Ultimately, countries should raise their domestic resources in line with global targets, investing long-term in planning and forecasting, and in the recruitment, development, training, retention and management of their health workforce.

We advocate long-term co-investment from global health actors in low- and middle-income countries' health workforces to boost the quantity and quality of health workers and provide the best conditions to retain them.

Specifically, we call on global health actors to:

- Provide predictable and unconditional funding for health in low- and middle-income countries, without restrictions that limit its use for recurring expenditure such as health worker salaries.

Equitable distribution of health workers

The movement of health labour in the European single market follows a clear South/East to North/West divide, mostly benefiting the richer member states and draining lower- and middle-income EU countries. Similar dynamics play out between high-income and low-income countries, and within countries. This goes against the spirit of solidarity and shared prosperity in the EU, and against the principles of global health justice.

What we advocate is that a number of relevant actors address the issue at three interlinked 'levels': source countries, global level (EU Commission, Parliament and Council, WHO, global health institutions) and destination countries.

Our experience in the European context provides important input as we lobby for equitable distribution of health workers at a global level. We bring together civil society organizations to create sufficient critical mass and momentum for meaningful and sustained policy change. Jointly, we develop lobby and advocacy strategies for organizations in source countries. They can then advocate for improvements in working conditions and retention strategies for health workers. We do the same for destination countries, so they can hold their governments accountable for the recruitment of health workers from countries where they are needed most.

Specifically, we:

- Lobby EU and global institutions for the effective implementation of SDG target 3c (substantially increase health financing and the recruitment, development, training and retention of the health workforce) across all EU member states, particularly those with the lowest UHC service coverage index or lowest health worker densities.

Dutch global health policy

Key developments

Growing attention for global health

In 2021, after years of lobbying efforts by Wemos and other members of the Dutch Global Health Alliance – of which Wemos is a founding partner – the Dutch government announced their intention to develop a Dutch global health strategy. The strategy was published at the end of 2022. It identifies three priority areas:

- Strengthening global health architecture and national health systems.
- Improving international pandemic preparedness and minimising cross-border health threats.
- Addressing the impact of climate change on public health and vice-versa.

A few months earlier, the Minister for Foreign Trade and Development Cooperation had presented a new policy note, 'Doen waar Nederland goed in is' ('Doing what the Netherlands is good at'). This note and the strategy form the basis for Dutch global health policy in the coming years. Both documents place significant emphasis on public-private partnerships and involving the private sector and private money in healthcare, without acknowledging the risks associated with that. Additionally, the strategy pays insufficient attention to tackling systemic barriers in access to essential medical products.

New global health hub

In the global health strategy, the government announced its intention to create a new platform for discussion on strategy implementation and other related issues. This 'Dutch Global Health Hub' will engage stakeholders such as civil society organizations, knowledge institutes and academia, and the private sector.

European global health strategy

The European Commission released a new European Global Health Strategy in November 2022, aiming to bundle and coordinate its efforts on global health. This global strategy, the pandemic accord negotiations, and the European Commission's commitment to multilateral initiatives by the WHO, Pandemic Fund and Global Fund, reflect the increasingly important role of the EU in global health policymaking. It is important for the Netherlands to monitor the European strategy roll-out, looking at how it connects with Dutch global health strategy to ensure coherence.

Strong systems for health

For years, the Netherlands has been internationally recognized as a leader and advocate for SRHR. In the context of a global health strategy, it is important that the Netherlands continues to fulfil this pioneering role, as one of the few countries to commit to the theme both politically and financially. Increasingly, the Netherlands sees strong, resilient systems for health as a necessary prerequisite for realizing SRHR and making the Dutch commitment sustainable.

We advocate

Commitment to financing global health

Funding for global health should not be regarded as a cost, or a way to produce 'return on investment'. Investing in global health should be seen as investing in everyone's interest. Importantly, the required funds for global health must be additional, multisectoral and not come predominantly from the ODA budget.

We want the Dutch government and parliamentarians to:

- Commit to the structural investments that are needed in terms of quality and quantity to deal with current and future global health issues.

Our goal

We want the Dutch government to implement an integral approach for dealing with current and future global health issues.

Focus on systems for health to deliver SRHR

A coherent, integrated approach to strong systems for health that can deliver SRHR brings added benefits to both. We help civil society organizations in low- and middle-income countries who are working on SRHR to adopt a systems for health approach. Together we build country-based evidence for responses to global developments.

We are asking the Dutch government and parliamentarians to:

- Express and implement a greater focus on systems for health within its development cooperation policy, Africa strategy and global health strategy.
- Adopt an integrated and coherent vision of systems for health and SRHR.

Health in All Policies approach

Policy incoherence becomes clear when different government departments issue or implement policies that are conflicting or contradictory. This undermines and frustrates overall government ambitions. The Dutch government should adhere to a Health in All Policies approach, to ensure policy coherence for human health and planetary health.

Adopting a planetary health perspective reveals how policy areas are linked at the intersection of human health, environmental health and animal health. This can be seen in trade agreements, energy policy and air pollution. Dealing with these complex issues requires coherence between different ministries, such as the Ministry of Health and the Ministry of Finance, as well as between relevant sectors, such as health, economic affairs, finance, agriculture, education and research. Coherence is also needed between departments within a single ministry. Lack of this is seen, for example, in the sometimes conflicting Aid and Trade agenda of the Ministry of Foreign Affairs.

We want the Dutch government to:

- Establish an implementing and decision-making structure for interdepartmental policymaking on global health.
- Implement a transparent assessment framework for policies affecting health, reflecting a planetary health approach, the SDGs and a cross-border perspective.

Pandemic prevention, preparedness and response

Cross-cutting topic

Member states of the WHO are developing a ‘pandemic accord’ to improve global prevention, and the preparedness for and response to pandemics. So far, funding for this purpose has proved to be grossly insufficient. Considering the already large funding gaps for health, funding for pandemic prevention, preparedness and response must not affect ODA financing in any way. Nor should it add to the debt burden of low- and middle-income countries. Health justice needs to be at the core of the pandemic accord, safeguarding everybody in society, no matter who you are or where you live.

Our goal

We want national governments to seize this moment as an opportunity to strengthen health systems worldwide.

We advocate:

Focuses on strengthening health systems

For greater resilience against pandemics, the accord must include provisions to realize a strong health workforce, equitable access to pharmaceutical products and adequate finance for health.

Specifically, we call on WHO member states to ensure:

- The accord identifies expansion of the global health workforce as a top priority, provides firm guidance for member states on building a strong workforce, and enables mobilization of surge capacity.
- The accord includes provisions safeguarding transparency on costs and prices of pharmaceutical products, and compels the sharing of intellectual property, know-how and technology to increase global supply and the self-reliance of low- and middle-income countries.
- Mechanisms for necessary additional funding break with the donor-recipient approach, are inclusive, and focus on prevention and all that it takes – not only containing outbreaks, but also environmental and animal health, plus surveillance and monitoring.
- Countries contribute financially according to ability, and benefit according to need – following Global Public Investment principles.

A healthy organization to support our mission

Working towards impact

Planning, monitoring, evaluation and learning is integral to our work. All the work we do is guided by our Theory of Change. Creating the pathways to change forces us to think and plan more comprehensively, and to test our assumptions, while learning from the change process. We monitor the effects of our lobby and advocacy on the five levels of change (see pages 12 and 13). That helps us to stay alert, adapt to developments in the world around us, and learn from both our successes and our failures.

In this strategic period, we will expand the monitoring we do – to demonstrate our impact as an organization. Developing an organizational learning agenda is also part of our strategy. Besides building our employees' technical skills and expertise, we will strengthen the 'softer' skills that allow us to be agile, responsive and a trusted partner to organizations across the world.

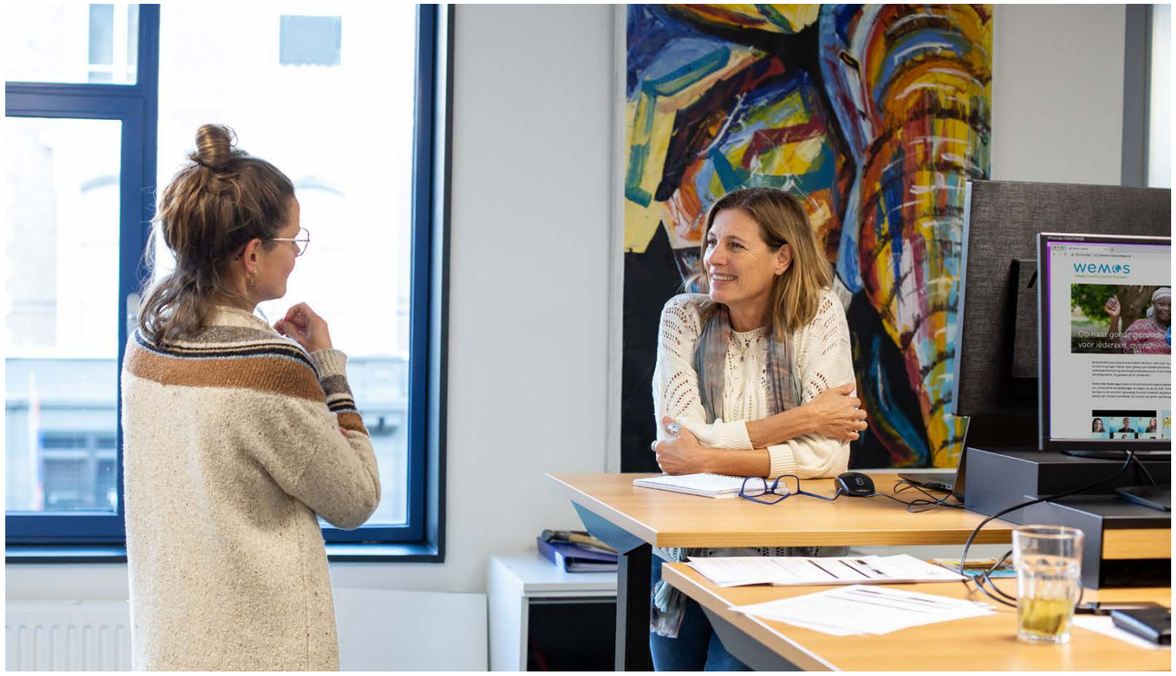
Effective programme coordination

In recent years, we have gained extensive expertise and experience in leading large international, multi-partner programmes that cover all our focus areas. Within these partnerships, we deliberately create flat governance structures to ensure equal participation of all collaborating partners and reduce power differentials. We attach great value to equality, transparency and complementarity in partnerships.

Our preferred role in a partnership depends on the context, the other partners and our expertise on the topic. It also requires a critical reflection of our added value as a Northern-based organization. To ensure the power lies with organizations in the countries where we want to see the greatest change in terms of health justice, we aim to give them the necessary support to take on responsibilities. This could, for example, involve management and coordination, financial management, due diligence, planning, monitoring and evaluation, reporting, or internal and external communication.

Convincing communication

A solution-oriented advocate for structural change to achieve global



health justice. That is the Wemos identity. The key elements in our own story are a solid history, our constructive and fair ways of working, and our belief in joint responsibility and action. Our themes are not always easy to understand, but making our communication as appealing and understandable as possible is a challenge we enjoy.

Applying an inclusive and hope-based approach is essential in our branding and communication. That means we always use positive framing, talking about constructive solutions and people's strengths and opportunities. Linking our messages to shared values, such as health justice, well-being and fair opportunities, gives us the best opportunity to connect with our audiences, truly capturing and convincing them.

Building a strong identity requires clear communication, not only on the what and how of solutions to the issues we encounter, but also on the why. Making the Wemos brand more human and personal is very much part of that, using storytelling for example, but also through visual communication. With this, we aim to reach a larger audience and increase Wemos' visibility and recognizability.

Sustainable financial basis

Diversifying our sources of income is key to remaining a financially stable and professional organization with the flexibility to respond to a changing environment. Income from institutional donors has always been important for Wemos, whereby we aim to receive no more than 50% of our funding from one institutional donor (the Dutch Ministry of Foreign Affairs). We continue to invest in our relationships with trusts and foundations, who we expect to provide 30-40% of our income. Another 10-20% should be funded by individual donors and other sources. Currently, we are investing in expanding our individual donor base to ensure broad support for our work.

References

Endnotes

[1] World Health Organization. (2022) *Systems for health: everyone has a role.* ahpsr.who.int/publications/i/item/systems-for-health-everyone-has-a-role

[2] World Health Organization. (2021, October 30). *Climate change and health*. WHO Factsheets. www.who.int/news-room/fact-sheets/detail/climate-change-and-health

[3] Whitmee S., Beyrer C., Boltz F., Capon A. G., Ferreira de Souza Dias B., Ezeh A., Frumkin H., Gong P., Head P., Horton R., Mace G. M., Marten R., Myers S. S., Nishtar S., Osofsky S. A., Pattanayak S. K., Pongsiri M. J., Romanelli C., Soucat A., Vega J., Yach D. (2015, July 16). Safeguarding human health in the Anthropocene epoch: report of The Rockefeller Foundation–Lancet Commission on planetary health. *The Lancet*, ; 386: 1973–2028. doi.org/10.1016/S0140-6736(15)60901-1

[4] Schmeller, D. S., Courchamp, F., & Killeen, G. (2020). Biodiversity loss, emerging pathogens and human health risks. *Biodiversity and conservation*, 29(11-12), 3095–3102. doi.org/10.1007/s10531-020-02021-6

[5] United Nations. (2022, April 13). What is the Triple Planetary Crisis? *United Nations Climate Change Blog Post*. unfccc.int/blog/what-is-the-triple-planetary-crisis

[6] United Nations Environment Programme. (2023). *Bracing for Superbugs: Strengthening environmental action in the One Health response to antimicrobial resistanc*e. www.unep.org/resources/superbugs/environmental-action

[7] World Health Organization. (2022, May 5). *14.9 million excess deaths associated with the COVID-19 pandemic in 2020 and 2021* [News Item] www.who.int/news/item/05-05-2022-14.9-million-excess-deaths-were-associated-with-the-covid-19-pandemic-in-2020-and-2021

[8] World Health Organization. (2022, May 20) *World Health Statistics 2022* [Departmental News] www.who.int/news/item/20-05-2022-world-health-statistics-2022

[9] UHC2023. (2020). *Living with COVID-19: Time to get our act together on health emergencies and UHC*. Discussion Paper. www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Health_emergencies_and_UHC/UHC2030_discussion_paper_on_health_emergencies_and_UHC_-_May_2020.pdf

[10] World Health Organization. (2021). *Global expenditure on health: Public spending on the rise?* www.who.int/publications/i/item/9789240041219

[11] Williams O. D. (2020). *COVID-19 and Private Health: Market and Governance Failure*. Development (Society for International Development), 63(2-4), 181–190. doi.org/10.1057/s41301-020-00273-x

[12] Lal, A., Erondu, N. A., Heymann, D. L., Gitahi, G., & Yates, R. (2021). Fragmented health systems in COVID-19: Rectifying the misalignment between global health security and Universal Health Coverage. *The Lancet*, 397(10268), 61–67. doi.org/10.1016/s0140-6736(20)32228-5

[13] World Health Organization. (2022) *Systems for health: everyone has a role*. ahpsr.who.int/publications/i/item/systems-for-health-everyone-has-a-role

[14] Khan, M., Abimbola, S., Aloudat, T., Capobianco, E., Hawkes, S., & Rahman-Shepherd, A. (2021). Decolonising Global Health in 2021: A roadmap to move from Rhetoric to reform. *BMJ Global Health*, 6(3). doi.org/10.1136/bmjgh-2021-005604

[15] Richardson, E. T. (2021). *Epidemic illusions: On the coloniality of global public health*. The MIT Press.

[16] Büyüm, A. M., Kenney, C., Koris, A., Mkumba, L., & Raveendran, Y. (2020). Decolonising Global Health: If not now, when? *BMJ Global Health*, 5(8). doi.org/10.1136/bmjgh-2020-003394

[17] Global Health 5050. (2023, June 8). Gender and Global Health. Retrieved June 8, 2023, from globalhealth5050.org/gender-and-global-health/

[18] Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., Dey, A., Dehingia, N., Morgan, R., Atmavilas, Y., Saggurti, N., Yore, J., Blokhina, E., Huque, R., Barasa, E., Bhan, N., Kharel, C., ... Gender Equality, Norms, and Health Steering Committee (2019). Disrupting gender norms in health systems: making the case for change. *Lancet (London, England)*, 393(10190), 2535–2549. doi.org/10.1016/S0140-6736(19)30648-8

[19] World Health Organization. (2019). *Delivered by women, led by men: A gender and equity analysis of the global health and social workforce*. (Human Resources for Health Observer Series No. 24) www.who.int/publications/i/item/978-92-4-151546-7

[20] Dusenbery, M. (2019). Doing harm: The truth about bad medicine and lazy science leave women dismissed, misdiagnosed,and sick. HarperOne.

[21] United Nations Development Programme. (2018). *What does it mean to leave no one behind?* Discussion Paper. www.undp.org/publications/what-does-it-mean-leave-no-one-behind

[22] World Health Organization. (2022) *Systems for health: everyone has a role*. ahpsr.who.int/publications/i/item/systems-for-health-everyone-has-a-role

[23] Eze, P., Lawani, L. O., Agu, U. J., & Acharya, Y. (2022). Catastrophic health expenditure in sub-Saharan Africa: systematic review and meta-analysis. *Bulletin of the World Health Organization*, 100(5), 337–351J. doi.org/10.2471/BLT.21.287673

[24] World Bank. (2023, June 8). *COVID-19 Household Monitoring Dashboard*. World Bank Data. Retrieved June 8, 2023, from www.worldbank.org/en/data/interactive/2020/11/11/covid-19-high-frequency-monitoring-dashboard

[25] World Health Organization. (2023, June 8). Universal Health Coverage: Overview. World Health Organization Health Topics. Retrieved June 8, 2023 from www.who.int/health-topics/universal-health-coverage#tab=tab_1

[26] United Nations. (2023, June 8) SDG Report 2021, *Goal 3*. United Nations, Department of Economic and Social Affairs, Statistics Division. Retrieved June 8, 2023, from unstats.un.org/sdgs/report/2021/goal-03/

[27] Defined by the Inter-Agency and Expert Group on the Agenda for Sustainable Development as “financial flow that are illicit in origin, transfer or use; that reflect an exchange of value and that cross country borders”.

[28] Mahler D.G., Yonzan N., Hill R., Lajner C., Wu H., Yoshida N (2022, April 13). Pandemic, Prices and Poverty. World Bank Blog. blogs.worldbank.org/opendata/pandemic-prices-and-poverty

[29] World Health Organization. (2021) *Global monitoring report on financial protection in health 2021*. www.who.int/publications/i/item/9789240040953

[30] World Health Organization. (2020). *Assessing country health financing systems: the health financing progress matrix*. Guidance paper. www.who.int/publications/i/item/9789240017405. and World Health Organization. (2022). *Strengthening public sector capacity, budgets and dynamic capabilities towards Health for All- Council Brief No. 4*. WHO Council on the Economics of Health for All. www.who.int/publications/m/item/strengthening-public-sector-capacity--budgets-and-dynamic-capabilities-towards-health-for-all---the-who-council-on-the-economics-of-health-for-all---council-brief-no.-4

[31] Kutzin J. (2013). *Health financing for universal coverage and health system performance: concepts and implications for policy*. Bulletin of the World Health Organization, 91 (8), 602 - 611. World Health Organization. dx.doi.org/10.2471/BLT.12.113985

[32] Jowett M., Kutzin J., Soonman K., Hsu J., Sallaku J., Gregoriao Solano J. (2020). *Assessing country health financing systems: the health financing progress matrix*. Health Financing Guidance No 8. Bulletin of the World Health Organization 91 (8): 602 – 611. apps.who.int/iris/handle/10665/337938

[33] World Bank. (2019). *High-Performance Health-Financing for Universal Health Coverage: Driving Sustainable, Inclusive Growth in the 21st Century*. www.worldbank.org/en/topic/universalhealthcoverage/publication/high-performance-health-financing-for-universal-health-coverage-driving-sustainable-inclusive-growth-in-the-21st-century

[34] Expert Working Group on Global Public Investment. (2023, June 9) *A Transformation in International Cooperation*. Retrieved June 9, 2023, from globalpublicinvestment.org/

[35] Mathauer I., Vinyals Torres L., Kutzin J., Jakab M., Hanson K. (2020). *Pooling financial resources for universal health coverage: options for reform.* Bulletin of the World Health Organization 98(2):132–139. doi:10.2471/BLT.19.234153

[36] Irwin A. (2021, April 21). How COVID spurred Africa to plot a vaccines revolution. Nature. www.nature.com/articles/d41586-021-01048-1

[37] World Health Organization. (2021). WHA74.6 *Strengthening local production of medicines and other health technologies to improve access*. Overview Report by the Director-General.www.who.int/publications/i/item/WHA74.6-Strengthening-local-production-of-medicines-and-other-health-technologies-to-improve-access

[38] Partnerships for African Vaccine Manufacturing (2022). *PAVM Framework for Action*. africacdc.org/download/partnerships-for-african-vaccine-manufacturing-pavm-framework-for-action/

[39] World Health Organization. (2023, June 9) The mRNA vaccine technology transfer hub. Retrieved June 9, 2023, from www.who.int/initiatives/the-mrna-vaccine-technology-transfer-hub

[40] These are public health functions that do not benefit individuals directly, but that are essential for health systems to protect and promote healthy populations. World Health Organization (2023, June 9) *Common goods for health*. Retrieved June 9, 2023, from www.who.int/health-topics/common-goods-for-health#tab=tab_3

[41] World Health Organization. (2021) G*overning health innovation for the common good - The WHO Council on the Economics of Health for All - Council Brief No. 1*. www.who.int/publications/m/item/governing-health-innovation-for-the-common-good

[42] UCL Institute for Innovation and Public Purpose (2018). The people's prescription: Re-imagining health innovation to deliver public value. IIPP Policy Report, 2018-10. STOPAIDS, Just Treatment, Global Justice Now. www.ucl.ac.uk/bartlett/public-purpose/publications/2018/oct/peoples-prescription

[43] Boniol, M., Kunjumen, T., Nair, T. S., Siyam, A., Campbell, J., & Diallo, K. (2022). The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage?. *BMJ global healt*h, 7(6), e009316. doi.org/10.1136/bmjgh-2022-009316

[44] World Health Organization (2022, June 2). *WHO Global Code of Practice on the International Recruitment of Health Personnel: Fourth round of reporting.* News item. www.who.int/news/item/02-06-2022-who-global-code-of-practice-on-the-international-recruitment-of-health-personnel--fourth-round-of-reporting

[45] Boniol, M., Kunjumen, T., Nair, T. S., Siyam, A., Campbell, J., & Diallo, K. (2022). The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage?. *BMJ global health*, 7(6), e009316. doi.org/10.1136/bmjgh-2022-009316

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