



Health for All Now! People's Health Movement

Policy Brief for the 79th World Health Assembly
Prepared by the People's Health Movement WHO Watch Team
May 2026

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Agenda Item 12.3 Communicable Diseases - End TB Strategy

Relevant Documents

Document **EB 158/10**

Resolutions **WHA73.3** and **WHA67.1** (Global strategy and targets for tuberculosis prevention, care and control after 2015)

A67/11 (Draft global strategy and targets for tuberculosis prevention, care and control after 2015)

UNHLM on TB, 2023

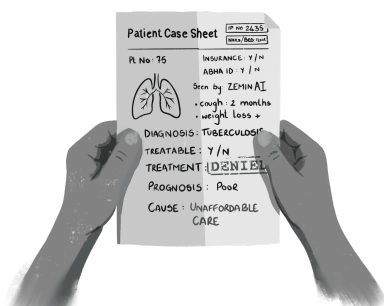
Background

Document EB158/10 is the Director-General's **report** to the 158th session of the World Health Organization Executive Board (December 2025), providing an update on **global progress toward ending the tuberculosis (TB) epidemic**. Submitted pursuant to resolution WHA73.3 (2020), which mandates **biennial reporting** until 2030, the report is intended to inform Member States and guide preparations for the third United Nations High-Level Meeting on TB in 2028.

Context

Despite significant progress, the world remains **off track** to achieve the tuberculosis targets of the End TB Strategy and the Sustainable Development Goals, owing to persistent underfunding; the impacts of the COVID-19 pandemic; widening inequalities; and the growing consequences of climate change, conflicts and other disasters.

The scale-up of TB treatment and antiretroviral therapy for TB–HIV coinfection has saved an estimated 83 million lives. While post-COVID declines in TB incidence and improved service access are reported, **TB remains a leading infectious cause of death**. The reported increase in access to care is partly due to COVID19 disruptions that delayed diagnoses and care and an actual rise in TB cases due to increased transmission. Declining development assistance now threatens progress, particularly in low-income countries.



Despite free TB testing and treatment in 28 of 30 high-burden countries, **catastrophic costs persist**: 47% of TB-affected households and 82% of those affected by drug-resistant TB incur expenses exceeding 20% of income—far from the End TB Strategy target of zero catastrophic costs by 2020 and beyond. Use of rapid molecular diagnostics as the initial diagnostic test has increased (47% in 2022 to 54% in 2024), but remains well below the 100% target set for 2027.

Funding for essential TB services remains stagnant at USD ~\$6 billion annually and will **need to quadruple** to reach the \$22 billion 2027 target. Progress in expansion of health service

coverage has slowed since 2015 and most high-burden countries have below-average index levels for health service coverage.

The 79th World Health Assembly Requested the Director-General to develop a post-2030 TB strategy that ensures alignment with PHC, UHC, and global health security, taking into consideration the changing international public health architecture, to submit the strategy to WHA in 2028 and continue reporting on TB progress (2028, 2030) towards the third United Nations high-level meeting in 2028.

PHM position

PHM welcomes the honest reporting and acknowledges the conflicts affecting access to medicines, food, livelihoods compounding humanitarian crises affecting health as a whole. PHM also appreciates the reported decline in TB incidence, improved access to services and increased use of rapid molecular diagnostics as the initial diagnostic test and establishment of the WHO Civil Society Task Force on Tuberculosis facilitating engagement with governments, guideline development groups and other bodies to support the tuberculosis response at all levels.

However, it is evident that the **TB strategy remains vertical** and integration remains an aspiration. PHM is concerned that the End TB strategy anticipates that new technologies will change the game and remains disproportionately focussed on biomedical and technocratic solutions. This approach has its limits and is only effective for patients that access and enter the care cascade. Better tools only benefit those who enter the health system; **without Universal Primary Health Care (PHC), symptomatic individuals will remain undiagnosed.**



The evidence for **poor nutrition** being the single largest risk factor for TB is well established but remains largely unaddressed in the current report.

Furthermore, the **report misses an important opportunity to link Resolution WHA78.5 "Promoting and prioritizing an integrated lung health approach,"** which explicitly calls for moving beyond disease-specific silos toward horizontal, PHC-based approaches linked to the End TB Strategy and the Multisectoral Accountability Framework for TB.

Call to Action

We urge Member States to:

1. **enact and implement legislation that allows for the full use of TRIPS flexibilities,** to facilitate equitable access to any new TB treatments, vaccines and diagnostics that come to market.

2. **design and implement policies guaranteeing formal contracts, fair wages, social security, occupational protection, TB screening, and access to care for Community Health Workers** who play a central role in TB responses and suffer heightened occupational risks due to their informal and poor working conditions.
3. **centre a rights-based approach to TB and broader public health governance**, which requires the meaningful participation of CHWs, people with lived experience of disease, and civil society organisations across governance, R&D, procurement, and accountability processes.
4. **use an integrated lung health approach** addressing TB alongside NCDs, asthma, and pneumonia.
5. strengthen TB surveillance through **disaggregated data** by gender, occupation, and urban–rural location, while enforcing protections for workers in high-risk sectors, including mining and stone work, against occupational hazards affecting lung health.

We urge the WHO to:

- re-consider the entire approach to TB control by **recognising tuberculosis as a social disease that cannot be addressed through biomedical interventions alone**. PHM calls for a strategy centred on action on the social determinants of health, including poverty, undernutrition, housing, and labour conditions, and integrated within universal, publicly financed **comprehensive Primary Health Care** providing free care across primary, secondary, and tertiary levels. The strategy must also ensure financial protection and social support for affected households, while addressing stigma, mental health, and psychosocial needs as integral components of TB care.
- mandate the **reporting of undernutrition as a baseline indicator** in TB surveillance and monitoring frameworks, recognising it as the single largest risk factor driving tuberculosis globally.
- in the context of ongoing wars, which have exposed the **vulnerability of access to API** (Active Pharmaceutical Ingredient) **and medicine supply chains**, to undertake efforts to promote security of supply by supporting **technology transfer, geographically diversified manufacturing, public pharmaceutical production, use of TRIPS flexibilities, and mandating cost and pricing transparency** of essential medicines.
- prioritise context-appropriate technologies instead of insisting on rapid molecular methods that may remain inaccessible in resource-constrained settings.
- develop **diagnostic tools and indicators for Post-TB Lung Disease (PTLD)**, with integrated psychosocial and rehabilitative support for people living with long-term sequelae after treatment completion of a disease perpetuated by systemic violence.
- recognise how religious and cultural biases embedded within national policies can restrict access to nutrition and care, increasing vulnerability to disease.
- recommend the inclusion of **Access and Benefit-Sharing (ABS) obligations** in clinical trials to ensure communities participating in research actually benefit from resulting technologies and therapies.

Agenda Item 12.10

Harmonization of regulatory approaches, governance and standards for data, digital health and artificial intelligence in the health sector

Relevant Documents

Documents **A79/5**

Document **EB158/19**

Background

The Executive Board at its 158th session noted the report on harmonization of regulatory approaches, governance and standards for data, digital health and artificial intelligence in the health sector.

We welcome board members' emphasis in that discussion on the importance of addressing harmonizing regulatory frameworks and governance relating to data, digital health and artificial intelligence; ensuring ethical and safe use of artificial intelligence, including data protection, and for increased investment in digital health and public infrastructure in the next strategy on digital health (2028–2033).

Context

Document EB158/19 focuses on technical issues like data reliability, interoperability, and digital health tools that can be used to implement precision medicine. The report acknowledges that the “health sector is undergoing profound transformations driven by advances in artificial intelligence and other digital technologies, in data science, bioinformatics, genomics proteomics and pharmacogenomics. This period of rapid innovation is happening in a context of competing fiscal priorities and often misaligned funding models.” It also acknowledges that “Many Member States face complex digital landscapes characterized by parallel, fragmented systems with limited interoperability, resulting in compromised quality and increasing maintenance costs.” It rightly acknowledges that “Without reliable, representative and interoperable data, artificial intelligence risks amplifying biases and inefficiencies rather than addressing them.”

Importantly, EB158/19 argues that “Equity must remain central to the digital transformation of health. Integrating gender, human rights and equity considerations across digital health policies, strategies and tools is essential to ensure that innovation drives inclusion, especially to meet the needs of marginalized populations.” This is an important commitment.

PHM Position

The WHO's efforts to develop normative guidelines and regulatory and governance standards for data, digital health and artificial intelligence in the health sector is welcome. However, this discussion fails to acknowledge that the technical fixes in this report have little relevance in contexts defined by war and conflict, the use of data for surveillance and targeted attacks on health and civilian infrastructure, internet connectivity costs, and energy poverty. Developing good governance principles for new and emerging digital health technologies is important, but will do little to improve health outcomes in the absence of addressing these structural factors, along with strengthening the public health system.

The document also fails to acknowledge the risks of partnering with corporate actors to incorporate digital health and AI tools into national health systems. Health equity requires more than using digital health tools and AI for improved health outcomes, it also means protecting national health systems and budgets from data extractivism and directing public funds to corporates that provide digital health services, rather than building public infrastructures that can deliver the same services in an effective, transparent and accountable manner.

Health data should be taken as a collective resource and the production of health information should be a central part of health systems. Democratically-led health data governance should take as a departure point a structure that brings data-based solutions, including AI, to the public domain, by building digital public infrastructure that is independent from the corporate sector, especially Big Technology companies and by regulating digital health activity through taxation and safety protection.

WHO could play a key role on that matter by moving beyond harmonization and taking leadership on the development of digital independent solutions and infra-structures, including health data sharing mechanisms that abstain from simply promoting free flow of data through interoperability and also structure ways of protection countries and populations of dispossessions of their own information. Existing experiences, such as the PIP Framework, can set the example for health data pools.

Call to Action

In developing the next strategy on digital health (2028-2033) we call on WHO and Member States to consider the below:

- Specify that digital health technologies should **be suited to function well in the context of the infrastructure constraints** of the national health systems where they are used.
- Specify that **digital health technologies are not a substitute for employing a sufficient number of health and care workers** capable of addressing the health needs of the population, guided by the comprehensive primary health care approach.
- **Acknowledge that health data is not only a personal issue, it is also a collective asset that public health systems** depend on to effectively plan, promote and deliver health services. Sovereign rights to national health data should be acknowledged and respected in the new strategy. Big tech and for-profit health and insurance corporations should not know more about our health systems and societies than our governments.
- **Acknowledge that AI technologies depend on algorithms that display biases resulting in discrimination against poor and marginalised communities, and that AI is being used to plan and execute military campaigns** that result in deaths, disability and deepen socioeconomic and ecological crises. AI is a commercial determinant of health that can have very negative consequences and the strategy should acknowledge and address this.
- **Reduce dependence on big tech and create public alternatives**, including thinking about public infrastructure for health data management generated innovators embedded in the health customs, perspectives and practices of their communities.

Agenda Item 14.1

WHO's work in health emergencies

Relevant Documents

Document **A79/9**

Documents **EB158/20, A78/13, EB156/18, A78/12, EB156(31), WHA78.3**

PHM comments on **WHA77 Item 14.1, EB156 Item 15, and WHA78 Item 17.1**

Background

Multiple, overlapping crises continue to place WHO's Health Emergencies Programme under enormous pressure. Armed conflicts, forced displacement, climate-related disasters, outbreaks, food insecurity, attacks on health care, and weakened public health systems have made health emergencies a permanent feature of the global landscape.

The latest WHO report to the Seventy-ninth World Health Assembly, A79/9, shows that in 2025 WHO responded to 50 emergencies across 82 countries and territories, including 20 Grade 3 emergencies requiring the highest level of Organization-wide support. WHO also assessed and triaged nearly half a million raw signals on potential public health events, with 472 events risk-assessed for possible international public health implications.

The report confirms that climate breakdown is now a major driver of health emergencies. Climate-related events were an exacerbating factor in more than 75% of acute and protracted Grade 3 emergencies. WHO also verified 1351 attacks on health care in 2025, including damage or destruction of 925 health facilities, and the injury, killing or obstruction of 609 medical personnel.

Despite these pressures, WHO continues to play a vital operational role. In 2025, WHO coordinated over 1500 health cluster partners across 24 humanitarian settings where 165 million people needed humanitarian health assistance. Local and national NGOs accounted for 66% of these partners. By 30 November 2025, health partners had reached 32 million people through more than 8100 health facilities and 1423 mobile clinics, providing over 61 million outpatient consultations.

The report also documents WHO's responses to mpox, cholera, viral haemorrhagic fevers, COVID-19 surveillance, earthquakes, floods, cyclones, typhoons, and humanitarian crises in countries including the Democratic Republic of the Congo, Haiti, Myanmar, South Sudan, Sudan and Yemen.

However, these achievements are taking place in a very difficult context. Humanitarian organizations are finding it harder to reach people because of conflict, insecurity, political restrictions, and lack of funding. At the same time, many donors are reducing their support. As a result, the global humanitarian response for 2025 had to be scaled back sharply. Instead of planning health assistance for all 81.4 million people who were originally identified as needing support, the response was narrowed to only 45 million people deemed to have the most urgent cases. This means that 52.6 million people may receive reduced health services or none at all. This is deeply worrying because it suggests that the world is beginning to accept a situation where care is rationed in emergencies, and millions of people are left behind

PHM Position

PHM recognizes the essential role of the WHO in health emergencies. WHO's work in coordinating health clusters, supporting ministries of health, deploying technical expertise, sustaining essential services, documenting attacks on health care, and supporting emergency response in fragile settings is indispensable. **WHO's Health Emergencies Program must be defended, strengthened, and sustainably financed.**

At the same time, PHM is deeply concerned that global health emergency governance continues to treat emergencies mainly as events to be detected, graded, managed, and financed, rather than as crises produced by unjust political and economic systems. **Many of the drivers of today's health emergencies are avoidable.** These include war, occupation, militarization, disregard for international law, climate breakdown, food systems that contribute to zoonotic diseases and malnutrition, austerity, debt, corporate impunity, weakened public health systems, and trade and intellectual property rules that restrict diversified regional production of health products.

A79/9 clearly shows the consequences of these structural failures. Mpox remained a Grade 3 acute emergency even after the public health emergency of international concern ended. In 2025, 98 countries reported 52 974 confirmed mpox cases, with the African Region carrying the heaviest burden. Cholera also worsened, with 33 countries reporting 614 828 suspected and confirmed cases and 7598 deaths, surpassing the 2024 totals. Seventeen countries reported case fatality ratios above the WHO's 1% emergency threshold.

These figures reflect more than biological threats. They show the deadly consequences of weak water and sanitation systems, underfunded primary health care, inadequate surveillance, insufficient vaccine production, fragile supply chains, and unequal access to essential health technologies.

PHM is also concerned that humanitarian "hyper-prioritization" risks becoming a euphemism for abandoning millions of people. When tens of millions lose access to health services because global humanitarian targets are narrowed, this should be understood as a political failure, not a neutral managerial adjustment.

The continued attacks on health care must also be treated as a crisis of international law and accountability. WHO's documentation of attacks is important, but documentation must lead to action. Health workers, hospitals, ambulances, patients, and humanitarian operations must be protected, and perpetrators must be held accountable.

PHM also emphasizes that emergency responses must pay special attention to those most at risk of being left behind. This includes women and girls, survivors of gender-based violence, children suffering from severe malnutrition, people with disabilities, displaced people, and other marginalized groups. A79/9 shows that WHO is already supporting some of these groups through sexual and reproductive health services, care for survivors of violence and nutrition support. These forms of care should not be seen as extra or less important. They are basic and essential parts of any humanitarian health response and must not be cut when funding is reduced.

PHM therefore argues that WHO's emergency work should not focus solely on detecting outbreaks, issuing alerts, organizing supplies, and responding quickly. These are important, but they are not enough. To truly prepare for and respond to emergencies, countries need strong public health systems, peace, action on climate change, social protection, food security, gender

equality, community participation, fair access to medicines and health technologies, and a fairer global economic system.

Call to Action

- **Member States should increase predictable, flexible and sustainable financing for WHO's Health Emergencies Programme.** WHO must be able to respond rapidly and independently, without being constrained by delayed, earmarked or politically vulnerable donor contributions. Emergency financing must be treated as a public obligation, not charity.
- **Member States should replenish and protect the Contingency Fund for Emergencies.** A79/9 reports that the Fund released US\$29.4 million in 2025 for 24 emergencies, but ended the year with only US\$19.5 million available. This severely limits WHO's ability to respond rapidly to new and escalating crises.
- **Member States should reject the normalization of humanitarian rationing.** "Hyper-prioritization" must not become a technocratic cover for abandoning people in need. Humanitarian health assistance must be guided by need, not by donor retreat.
- **WHO and Member States must address the structural causes of health emergencies.** Emergency response must explicitly confront war, occupation, militarization, climate breakdown, debt, austerity, corporate impunity, forced displacement and weakened public health systems.
- **Member States should move from health security to health solidarity.** Preparedness must not be reduced to surveillance and response capacities. Domestic and international solidarity, equity, redistribution, universal public services, labour protection, public trust and community participation must be treated as core emergency capacities.
- **Member States must protect health care in conflict and hold perpetrators accountable.** Diplomatic, legal and political tools must be used to prevent attacks on health facilities, workers, ambulances and patients, and to enforce international humanitarian law.
- **Governments must desist from militarization and war economies and instead invest in peace-building.** War and arms economies are major drivers of health emergencies. Public resources must be redirected toward public health systems, social protection, climate adaptation and humanitarian response.
- **Member States should strengthen public health systems and primary health care.** Emergency response cannot be separated from strong routine systems. Countries need resilient primary care, protected health workers, functioning hospitals, laboratories, water and sanitation systems, surveillance capacities and reliable public supply chains.
- **Local and national actors must be supported without abandoning public responsibility.** A79/9 indicates that local and national NGOs account for 66% of health cluster partners. Their role should be recognized and funded, but not used as a substitute for strong public systems or state obligations.
- **Member States should make sure that everyone can access vaccines, tests, medicines and essential supplies during emergencies.** The continuing spread of cholera, mpox and viral haemorrhagic fevers shows that countries cannot depend on a few producers or on charity. More

regions should be able to produce the health products they need, and these products should be distributed fairly, openly and according to public health needs.

- **Climate justice must be central to emergency preparedness.** Since climate-related events now make many major health emergencies worse, emergency planning cannot be separated from climate action. Countries must reduce emissions, help communities adapt, provide financing for climate-related loss and damage, relieve debt burdens, and hold major polluters accountable.
- **Emergency responses must protect people who are most at risk of being left behind.** Sexual and reproductive health care, support for survivors of gender-based violence, maternal and child health, disability support, mental health care, nutrition and protection services must be treated as essential parts of emergency response. These services should not be cut when funding becomes tight.
- **Public health measures should be based on evidence that also looks at fairness and social impact.** When governments use measures such as distancing rules, school closures, quarantine, mask policies or movement restrictions, research should not only ask whether they reduce disease spread. It should also ask how they affect people's income, work, food access, housing, mental health, disability rights, gender equality, trust in authorities and human rights.
- **People affected by emergencies must have a real voice in decision-making.** Communities, health workers, civil society groups and social movements should be involved in planning, carrying out and evaluating emergency responses. Decisions should not be dominated by powerful governments, private companies or organizations with conflicts of interest.
- **Member States must work toward a fairer global economic system.** The repeated pattern of preventable emergencies, lack of funding and unequal access to care cannot be fixed by technical solutions alone. The global rules that keep many countries poor, dependent and vulnerable must be changed so that health, dignity and public needs come before profit and power.

Agenda Item 15.5

Draft strategy on the economics of health for all

Relevant documents

Document **A79/5**

Document **A79/5 Add.1**

Document **EB158/2026/REC/1**

Decision **EB158(8)**

Background

The 1974 call for a New International Economic Order (NIEO), reinforced by the Alma-Ata Declaration's recognition that health as a human right depends on economic transformation, represented a structural reform agenda from the Global South. It demanded permanent sovereignty over natural resources, fair pricing for exports, industrialization, regulation of transnational corporations, and technology transfer tailored to local conditions.

Six years ago, amid renewed crisis, the WHO revived this spirit by convening the Council on the Economics of Health for All (EH4A) to gather evidence and draft a progressive framework. However, the 2026–2030 EH4A Draft Strategy, intended to operationalize that framework, marks a shift toward strategic containment rather than advancement. While the Council's work was ambitious (if incomplete), the new strategy dilutes core NIEO principles, neutralizing over five decades of Global South demands for economic justice.

Yet the NIEO vision is not entirely lost. The public pharma initiative in Europe, a collaborative model for non-commercial drug development, demonstrates that NIEO principles can still be manifested and operationalized. By prioritizing collective ownership, equitable access, and need-driven innovation over profit motives, such initiatives offer a living alternative to the containment strategy of the EH4A, proving that structural economic transformation for health remains possible outside mainstream institutional frameworks. This is crucial because pharmaceutical production currently relies heavily on the private sector, particularly large transnational corporations known as Big Pharma, an essentially flawed model that significantly hinders the global realization of the right to health. Its dysfunctions are long-standing, predating and exacerbating the COVID-19 pandemic: a chronic disconnection between R&D efforts and public health needs, persistent shortages of essential health technologies, unaffordable prices, massive carbon footprints, and deep power asymmetries between states and transnational corporations (especially for the Global South). These are not crisis-specific failures but structural impediments that have impaired public health for decades, precisely the kind of inequities the NIEO was designed to dismantle.

What is Public Pharma?

Public Pharma refers to a state-owned infrastructure dedicated to researching, developing, manufacturing, and distributing pharmaceutical products or other health technologies. It encompasses all institutional arrangements in which there is genuine democratic decision-making power and can establish governance driven by public health needs. It does not include, for example, Public-Private Partnerships (PPPs) or any other arrangement where the state uses public resources to de-risk private enterprises.

What is missing from the current debate? A focus on Public Pharma

The current draft strategy omits three key issues: sovereign debt and fiscal austerity (demanding health spending increases while ignoring debt service obligations), financialization of health (treating private investment as a resource rather than a structural driver of fragmentation), and geopolitical asymmetry and imperial power (erasing how Global North trade, currency, IP, and sanction regimes constrain Global South policy space). Together, these omissions reveal a strategy that treats the symptoms of an unjust system while leaving its structure intact. Debt austerity starves public health budgets. Financialization fragments health systems into profit centers. Geopolitical asymmetry locks the Global South into extractive trade and IP regimes. The EH4A draft strategy proposes adjustments, debt relief dialogues, private finance guidelines, trade agreement assessments, that work around these barriers rather than dismantling them. This is striking because one of the Council's recommendations explicitly cited transformative alternatives, including the mRNA technology transfer hub, as concrete examples of how structural change could be operationalized. The draft strategy's retreat from such ambition signals containment, not progression.

This is precisely why a state-owned and controlled pharmaceutical infrastructure offers a more fundamental alternative. While legally binding technology transfer, TRIPS flexibilities, pathogen access and benefit-sharing (PABS), and Southern manufacturing are welcome steps, they merely amend an essentially flawed system, still operating within a global proprietary model dominated by Big Pharma. By contrast, public pharma, a state-owned, mission-driven infrastructure, grants governments direct decision-making power over pricing, R&D priorities aligned with public health needs, control over private use of publicly financed products, and implementation of intellectual property rights. Such an infrastructure does not negotiate around the barriers of debt, financialization, and asymmetry. It bypasses and eventually dismantles them, delivering health for all as a public good, not a market outcome.

Call to Action

1. **Amend the EH4A Draft Strategy to address sovereign debt and fiscal austerity.** We call on Member States to require WHO to include concrete recommendations on debt restructuring and cancellation, recognizing that demanding increased domestic health financing from indebted states while ignoring debt service obligations is a contradiction that renders the Strategy unworkable.
2. **Member States must engage constructively in the Intergovernmental Negotiations for a UN Framework Convention on International Tax Cooperation.** The rhetoric of national ownership and expanded domestic resource mobilisation for health rings hollow when countries remain constrained by debt burdens and IMF austerity. A fairer international tax regime that works to eradicate illicit financial flows and tax avoidance will enable more domestic resources for health financing.
3. **Incorporate a critical analysis of financialization.** We call on Member States to revise the Strategy's framing of private investment as a resource to be harnessed, replacing it with an evidence-based examination of how private equity, investor-owned health facilities, pharma share buybacks, and pandemic bonds designed to protect investor capital are structurally fragmenting health systems and driving inequity.

4. **Address geopolitical asymmetry, including IP rights and trade agreements.** We call on Member States to require the Strategy to move beyond recommending health impact assessments toward implementable mechanisms that dismantle these asymmetries, including full use of TRIPS flexibilities and preventing IP provisions that override domestic health priorities.
5. **Recognize and incorporate alternatives.** The Strategy must document and draw from transformative alternatives, including state-led manufacturing models, public pharmaceutical initiatives, and regional technology transfer hubs.