

Reimagining the Future of Global Health Initiatives



Reimagining the Future of Global Health Initiatives

Authors:

Sophie Witter¹, Natasha Palmer¹, Rosemary James², Shehla Zaidi³, Severine Carillon⁴, Rene English⁶, Shifa Habib³, Jeff Tan³, Fatouma Hane⁴, Giulia Loffreda¹, Emilie Venables², Seyed-Moeen Hosseinalipour², Valery Ridde^{4,5}, Maria Paola Bertone¹, Adama Faye⁴, Karl Blanchet²

-
1. Queen Margaret University, Edinburgh, Scotland
 2. Geneva Centre of Humanitarian Studies, Faculty of Medicine, University of Geneva, Switzerland
 3. Aga Khan University (International) in the UK
 4. Cheikh Anta Diop University, Dakar, Senegal
 5. Institut de Recherche pour le Développement, France
 6. Stellenbosch University, South Africa

Contents

Acronyms and abbreviation	5
Acknowledgements	7
Foreword	8
Executive summary	10
Background	10
Methods	10
Findings	11
2 Study aims	19
3 Data and methods	21
4 Findings	25
4.1 Trends in financing and actors in the global health landscape	25
4.2 Overview of focal GHIs	27
4.3 Future challenges for global health - the evolving landscape for the GHIs	30
4.4 Positive contribution of the GHIs to date	31
4.4.1 Contribution to improved health outcomes	31
4.4.2 Innovative financing and market shaping	31
4.4.3 Ensuring access to vaccines and other commodities and technologies	31
4.4.4 Donor coordination around specific global health agendas	32
4.4.5 Fund mobilisation, especially for GFATM and Gavi	32
4.4.6 Innovative governance structures	32
4.4.7 Focus on reaching underserved populations and working with CSOs	33
4.4.8 Showing adaptability	33
4.4.9 Recent progress on alignment of donor support with national plans at country level	33
4.4.10 Data collection and reporting systems	34
4.5 Challenges and unintended negative consequences of GHIs' investments	35
4.5.1 Global level	35
4.5.1.1 Concerns relating to mandates	35
4.5.1.2 Competition for funding and insecurity over future funding	35
4.5.1.3 Governance challenges with GHI Boards	36
4.5.1.4 Disputed funding allocations for GFATM	37
4.5.1.5 Questionable results metrics	37
4.5.1.6 Private sector engagement concerns	38
4.5.1.7 Concerns about conflicts of interest	38
4.5.2 Country level	38
4.5.2.1 Distortion of national priorities	38
4.5.2.2 Country governance and ownership issues	38
4.5.2.3 Need to better track public financing to monitor displacement effects	40
4.5.2.4 Lack of success in building national and local health system capacity	40
4.5.2.5 Operating systems that reduce efficiency and effectiveness	42

4.5.2.6	Lack of transparency and oversight; strain on management capacity	42
4.5.2.7	Frustration with external, short-term technical assistance	43
4.5.2.8	Role deviation for others in the global health system	43
4.5.2.9	Corruption	43
4.5.2.10	Challenges with transitioning	43
4.5.3	Summary of the strengths and challenges of the GHIs	45
5	Understanding the political economy of the GHI landscape	47
5.1	Global level	47
5.2	Country level	49
6	Vision and principles for changes	52
6.1	Vision statement for GHIs and global health actors	52
6.2	Principles underlying changes	52
7	Recommendations for strengthening the GHI ecosystem	55
7.1	Recommendations	55
7.2	Change management	60
8	Conclusion	63
	References	64
	Appendices	74
4	Study Methods (including PEA Framework)	74
5	Key informant interview topic guides	74
6	Online survey questions	74
7	Board Composition of the GHIs	74
8	Overview of GHI funding disbursement models	74
9	Global-level key informant interview summary	74
10	Online Survey: summary of findings	74
11	Pakistan country case study summary	74
12	South Africa country case study summary	74
13	Senegal country case study summary	74
14	Individual summaries of each multi-stakeholder consultation	74
15	Lessons learned from previous alignment and coordination initiatives	74

Acronyms and abbreviations

ACT-A	Access to COVID-19 Tools Accelerator
BMGF	Bill & Melinda Gates Foundation
BoD	Burden of Disease
CCM	Country Coordinating Mechanism
CDC	Centres for Disease Control and Prevention
CEPI	The Coalition for Epidemic Preparedness Innovations
COVAX	COVID-19 Vaccine Global Access
CSO	Civil Society Organization
DAH	Development Assistance for Health
DRM	Domestic Resource Mobilisation
EMRO	Eastern Mediterranean Region
FCAS	Fragile and Conflict Affected States
FGHI	Future of Global Health Initiatives
FIND	Foundation for Innovative New Diagnostics
SDG3 GAP	Sustainable Development Goal 3 Global Action Plan
Gavi	Gavi, the Global Vaccine Alliance
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
GFF	Global Financing Facility
GPG	Global Public Goods
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
KI	Key informant
LMIC	Low and middle income country
MDG	Millennium Development Goals
MoH	Ministry of Health
NCD	Non-communicable disease
NGO	Non-governmental organisation
ODA	Official Development Assistance

PEA	Political Economy Analysis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary healthcare
PPP	Public-Private Partnership
PFM	Public Financial Management
R&D	Research and Development
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
RSSH	Resilient and Sustainable Systems for Health
SDG	Sustainable ° Goals
SEARO	South-East Asia Regional Office
TB	Tuberculosis
TA	Technical Assistance
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization
WPRO	Western Pacific Region

I Acknowledgements

This report was authored by a consortium of five universities¹. The consortium extends gratitude to all of the study participants, the Wellcome Trust, FGHI Secretariat, Co-Chairs, Steering Group and Research Learning and Task Team for making this study possible. The consortium and FGHI Secretariat also wish to thank the Africa Centres for Disease Control and Prevention for co-hosting a hybrid deliberative discussion at the African Union headquarters in Addis Ababa, Ethiopia in June 2023. Finally, thank you to those who took the time to provide valuable feedback on the draft report.

The Reimagining the Future of Global Health Initiatives Study was funded and commissioned by the Wellcome Trust. Input and oversight were provided by the Wellcome Policy Team with key contributions from Clare Battle, Simon Hall and Tom Harrison.

The findings presented in this report are not the individual views of the consortium members, but a synthesis of data analysed from interviews, the online survey and consultations. The findings and recommendations have not been endorsed by Wellcome, FGHI Steering Group members, or their organisations or governments, but will constitute an important part of the evidence base that the FGHI process will use to deliberate its conclusions and commitments.

Further information on the FGHI process can be found here: futureofghis.org.

Suggested citation:

Witter S., Palmer N., James R., Zaidi S., Carillon S., English R., Loffreda G., Venables E., Habib S., Tan J., Hane F., Bertone M.P., Hosseinalipour S-M., Ridde V., Faye A., Blanchet K., 2023, Reimagining the Future of Global Health Initiatives, Research Report, Queen Margaret University, Geneva Centre of Humanitarian Studies, Aga Khan University, Cheikh Anta Diop University, Institut de Recherche pour le Développement, Stellenbosch University.

If you need further information about the study, you can contact:

Professor Sophie Witter

Professor Karl Blanchet

SWitter@qmu.ac.uk

karl.blanchet@unige.ch

The Reimagining the Future of Global Health Initiatives Study was funded and commissioned by the Wellcome Trust. Input and oversight were provided by the Wellcome Policy Team with key contributions from Clare Battle, Simon Hall and Tom Harrison.

We also want to acknowledge the tremendous work carried out in such a short time period by the research teams coordinated by Dr Rosie James.

¹ Geneva Centre of Humanitarian Studies, University of Geneva (Switzerland), Queen Margaret University, Edinburgh (Scotland), Aga Khan University (International) in the UK, Cheikh Anta Diop University (Senegal), Stellenbosch University (South Africa)

I Foreword

Since 2000, the number and diversity of Global Health Initiatives (GHIs) has increased considerably, accompanied by rising levels of development assistance for health. In this time GHIs have contributed to enormous progress in protecting lives and improving the health of people globally, including significant progress against individual diseases like polio, malaria and HIV/AIDS, and increasing coverage of specific interventions like childhood vaccination.

But while in general global life expectancy is increasing, large inequalities in health outcomes and health coverage remain. At the same time, the world is undergoing significant epidemiological and demographic changes – notably ageing populations and a growing burden of non-communicable diseases – as well as political and economic shifts that present challenges for sustainable resource mobilisation. There are also growing threats from environmental degradation, climate change and new disease outbreaks, and the emergence of new actors and initiatives means the global health architecture is becoming more complex, with increasing fragmentation of external financing streams.

With the COVID-19 pandemic throwing a renewed spotlight on the strengths and weaknesses of the current system, there is a valuable window of opportunity to take stock of how GHIs could evolve to better address the shifting landscape of global health. In particular, there is an urgent need to consider how global cooperation, and the financing that underpins it, can best support national health priorities, incentivise increased and sustained domestic investments in health, and catalyse country-level progress towards universal health coverage.

This report, building on a foundation of existing research, analyses evidence on the strengths and weaknesses of the GHI ecosystem and the lessons learnt from previous proposals for change. It also draws on new consultations with over 200 experts at global, regional and country level, to propose a vision for how things could be improved and provide a roadmap of potential changes to take us there. It has been developed as an input to the ongoing Future of Global Health Initiatives (FGHI) process, which brings together a group of global, regional and national health stakeholders – including governments, global health institutions, civil society organisations, and academics – to reflect on these vital questions, and build momentum behind collective action.

While this report's recommendations have not been endorsed by the FGHI Steering Group members or their organisations or governments, the independent findings and recommendations outlined will provide valuable insights as the FGHI process moves forward, and ensure crucial discussions about the future of the global health system are grounded in the experience and perspectives of key stakeholders, particularly in implementing countries. In doing so, it is hoped this study will inform further deliberations and thereby help drive the changes that are urgently needed to ensure our global health system is as efficient, effective and equitable as possible in the decades to come.



“The Ethiopian Ministry of Health appreciates the achievements of the health sector in partnership and support of the different global health initiatives and institutions and looks forward to a continued support with stronger alignment to enhance efficiency and accelerate the progress towards UHC by investing on country priorities. We believe the FGHI dialogue and study will provide us with the evidence and insight on how we will be able to attain this stronger collaboration.

Ministry of Health, Ethiopia



Post-crisis countries such as the Central African Republic face the challenge of adequate domestic financing to build health system capacity and achieve UHC. Partnerships with GHIs remain vital for these countries. However, we strongly recommend that their operating and country support procedures can be improved.”

Dr. Bernard Boua, Director of Neglected Tropical Diseases and Non-Communicable Diseases, Ministry of Health and Population, Central African Republic



We expect GHI that will reflect the demand-driven need of our national interest, sustainability to impact people’s lives, and transparency and accountability to clear management and allocation of resources. Moreover, Somalia expects GHIs to support our efforts to guarantee UHC.”

Dr. Mohamed Hassan Mohamed, Bulaale, Deputy Minister of Health Federal Government of Somalia and MP

I Executive summary

Background

The Future of Global Health Initiatives (FGHI) process is an ongoing multi-stakeholder exercise to explore how Global Health Initiatives (GHIs) can effectively accelerate country-led progress towards Universal Health Coverage (UHC) and the broader Sustainable Development Goals (SDGs) 2030 Agenda. The process, which started in 2022, aims to make recommendations on how GHIs can be more efficient, effective and equitable and to catalyse collective action to ensure that they are fit for purpose through 2030 and beyond. The work presented here forms an input to that process. This report and its annexes present findings from a rapid scoping review and extensive individual and group consultations at country, regional and global levels to gather views on how GHIs could evolve to support this process over the next 20 years.

The process is focused on six GHIs, as identified by FGHI, which differ in form and function: the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), Gavi, the Vaccine Alliance (Gavi), the Global Financing Facility for Women, Children, and Adolescents (GFF), Unitaid, the Foundation for Innovative New Diagnostics (FIND), and the Coalition for Epidemic Preparedness Innovations (CEPI). Importantly, the work presented in this report is not an evaluation of any individual GHI, but rather a review of how this aspect of the global health system as a whole is serving, and could better serve, country needs.

Methods

The study set out to do the following:

1. outline a vision of what the GHIs should seek to achieve over the next 15-20 years to strengthen health system capacities and deliver health impacts
2. analyse the extent to which GHIs' current mandates and ways of working will need to evolve to enable them to effectively, efficiently and equitably deliver this vision, and the contextual factors that would support or hinder such a shift
3. provide recommendations on how and when the GHIs' current mandates and ways of working should evolve

The study adopted a UHC lens and focused on countries' experiences and needs from the GHIs. It took place over a period of six months (February to July 2023), led by five universities, independent of but reporting to the FGHI Steering Group.

The study draws on a number of data sources: 1) a scoping review of available peer-reviewed and grey literature (271 documents included); 2) burden of disease and health financing data; 3) global-level key informant (KI) interviews; 4) three in-depth country case studies; 5) regional consultations with key stakeholders in all six WHO regions; 6) an online survey targeted to KIs who could not join interviews or group consultations; and 7) consultative meetings, including one in June 2023 to discuss preliminary findings. Study participants (a total of 335 across data strands, including members of GHIs) were based in a total of 66 countries. All data sources were synthesised to inform this report and a political economy lens has been adopted throughout the analysis and synthesis.

Findings

Positionality of study participants

The data revealed divergent perspectives on the strengths and weaknesses of GHIs as well as paths for evolution. The differences in views are partly based on the positionality of different KIs within the system, and their own experiences, interests and perspectives, but also on a range of very different contexts, models of delivery and levels of investment in which different GHIs operate in countries. Overall, some national actors, implementers and funders were more incrementalist in their approach, whereas other national actors, multilaterals, and academics tended to be more radical. There is however a lot of variation within these groups, and there were surprisingly critical voices from within the GHIs themselves.

In the interviews and consultations, informants spoke more about GFATM and Gavi and this emphasis is reflected in the findings. This was to be expected, given the size of these GHIs and their level of activity at country level, alongside their longer track records since they were founded.

The evolving landscape: health financing, burden of disease and emerging challenges

The global health system has undergone significant expansion over the past few decades, linked in part to efforts to reach the Millennium Development Goals (MDGs), including a continued increase in both the number and diversity of actors within it and the volume of funding. In addition, there has been a marked increase in the distribution of development assistance for health (DAH) through GHIs, driven by the creation of the GFATM and Gavi, which accounted for 14% of DAH by 2019. Four “*mega-trends*” of proliferation, verticalization, circumvention of government systems, and fragmentation are identified, which go beyond but include the role of the GHIs. In relation to health financing, it is also important to note that DAH still forms a large part of the health budgets for many low income countries (LICs) in particular, and yet that the overall amount of financing for health is not adequate to fund the achievement of the SDGs. These factors argue for an urgent review to ensure that all global health resources are used as effectively as possible. The mismatch of DAH overall to global and country burden of disease suggests scope for improvement.

In addition, we highlight emerging challenges such as climate change, antimicrobial resistance, and a rise in non-communicable diseases, which are unlikely to be addressed by the GHIs within their current mandates. Plateauing DAH and shrinking fiscal space post-COVID-19, a stormy geopolitical context, and growing health needs and costly health technologies are amongst the additional expected stressors.

Strengths and weaknesses of GHIs

The GHIs included in this process vary in size, form and function and bring very different focus and weight to a range of activities. It is also important to note that the six GHIs analysed here represent a small sample of the overall number of GHIs in the current global health system; the high number of GHIs is part of the challenges in fragmentation that many low and middle income countries (LMICs) face, and new GHIs are continuing to be created in response to new priorities or new funder interests and positioning.

Over recent decades, many GHIs have grown and become major players in the global health system. Some of the longest-standing GHIs, such as GFATM and Gavi, have evolved from organisations originally seen as focusing on finance-raising and channelling funds into large complex organisations with their own internal dynamics and priorities.

We highlight some of the key features which made the focal GHIs attractive to funders, and form the basis for their contribution. In particular, by focusing on specific, high-priority diseases, they were able to make a significant contribution to improving health outcomes in these areas, also mobilising additional funding to support that, and working with a range of actors to shape markets for global goods for these diseases, investing in improved and lower cost vaccines, pharmaceuticals, supplies and diagnostics. They offer funders tight controls on fiduciary risks and have adopted approaches which prioritise reaching target populations, which may be neglected by public authorities for a variety of reasons, including stigma.

However, these strengths are increasingly challenged, particularly when viewed from the country perspective, where funding by the larger GHIs has long been observed to distort national priorities and health systems, creating heavy costs in terms of preparation and implementation of grants, which do not use national systems, typically, or align with national plans, budgets, Public Financial Management (PFM) systems, human resource or information systems. Grant proposals developed by external consultants, away from the national context; siloed funding to elements and specific population groups within a system; support for unsustainable delivery strategies (in terms of cost); lack of focus on efficiency across the health system; lack of downward accountability of GHIs to countries, and failure to build national capacity to sustain gains in the long term (through system strengthening) are amongst the key concerns at national level. In addition, the results claimed by GHIs were always emergent from a wider set of investments, including by governments and other bilateral and multilateral funders.

Political economy

The report analyses some of the political economy dynamics underlying the patterns found and the lessons from previous attempts to reform global health architecture. Where organisational mandates and incentives remain unaligned, efforts at coordination have been very frustrating. There is also considerable path dependency in the system, such as it is easier to create new structures than to reform old. The GHIs solved many funders' problems by creating structures which converted funding into credible results, while at the national level, clients were created who gained resources and therefore power from the funding. The wider global health system has been distorted by the relative volume of funding passing through GHIs, compared to other players with substantial roles, such as WHO. Incentives have been primarily focused on grant disbursement, more than achieving stronger, more effective and more sustainable health systems. Transparency of what is being spent in which health area and through what channels, as well as its longer term impact on the health system, is still hard to achieve for some GHIs.

Vision and principles proposed

In response to the findings on current and emerging challenges and strengths and weaknesses of the focal and wider GHI landscape, a vision for GHIs and other global health actors is proposed as follows:

'A global health system where all actors, including GHIs, contribute effectively to the achievement of country-led UHC and hence equitable population health and wellbeing. This means that all actors, including GHIs, plan, fund, evaluate and account for their funds and programmes to national governments in a coherent and integrated way, working in synergy with other global health actors and based on their comparative advantage, countries' priorities and needs, and the imperative to build country capacity to sustain UHC (including PHC) through strong and resilient health systems.'

In terms of roles, this vision implies that:

- implementing countries take increasing responsibility for essential, cost-effective interventions as and when they have the capacity and finance to do so;
- GHIs support countries in this effort, embedding sustainability, supporting affordable commodities, and setting clear trajectories towards transition; and
- donors shift accountability for delivery more to countries, demonstrating a higher risk appetite and accepting broader Primary Health Care (PHC) and UHC results.

Linking to the vision, we propose that all changes to GHIs are founded on seven core principles. These need to be reflected not just in organisational policies but also in the way that GHIs operate on a daily basis.

Recommendations

GHIs are operating in a complex wider web of actors, who contribute to challenges as well as successes; many of the problems noted relate to the wider actors, however, the focus here on GHIs is driven by the fact that they are newer creations in the global health architecture; there is more flexibility in relation to them and more tendency to proliferation of them.

The focus in changes to be introduced should be on changing the internal incentives to improve the effectiveness of the GHIs, taking a systemic perspective and aiming for a correct balance of roles and accountability vertically (between GHIs and countries/sub-national authorities) as well as horizontally (between GHIs and other actors). Guiding progress towards UHC and health system strengthening (HSS) is primarily the responsibility of governments; however, the GHIs have a responsibility to support these crucial efforts by ensuring their investments are coherent with sustainable system strengthening, and do not undermine or distort national investment priorities, including in areas of emerging priority.

In line with this premise, a set of recommendations has been developed, aimed at GHI funders, their Boards and the Secretariats, as well as Ministries of Health. These are grouped under six main themes:

- 1. Making a stronger contribution to UHC, including emerging disease burdens**
- 2. Strengthening or at least doing no harm to health systems**
- 3. Reducing costs for countries and increasing efficiency and effectiveness of GHI investments**
- 4. Supporting country ownership, capacity building and charting a clear path to ending dependence on GHIs**
- 5. Enforcing more effective alignment between GHIs and with wider health actors**
- 6. Limiting proliferation of GHIs; focusing on strengthening existing architecture**

These changes recognise that while some countries will transition from GHI support over the next 20 years, there will likely remain a group of low-income and conflict-affected countries that will continue to need grant support to meet basic health needs, and therefore that the GHIs should continue, though it is recommended that funders agree on the exit strategy for the GHIs (especially the country funding ones). This will provide an urgency to building country technical capacities and incentivising government take-over of financial responsibilities.

Management of change

All actors have contributed to the landscape as it currently stands, and all will need to be brought on board with changes. Funders, for example, will need to focus more on contributions to overall system performance metrics as their outcome measure (and managing performance risks), and focus less exclusively on attribution of results and fiduciary risks. Government leadership will also be central. Many of the changes depend on government engagement and capacity to be successful, so piloting could be in countries with higher levels of these, looking to introduce changes gradually as countries become ready. Whether there is a window for change is hard to establish, but our consultations reveal the urgency of taking action. The context is shifting, and to continue without adapting brings the GHIs risk of redundancy and dwindling support.

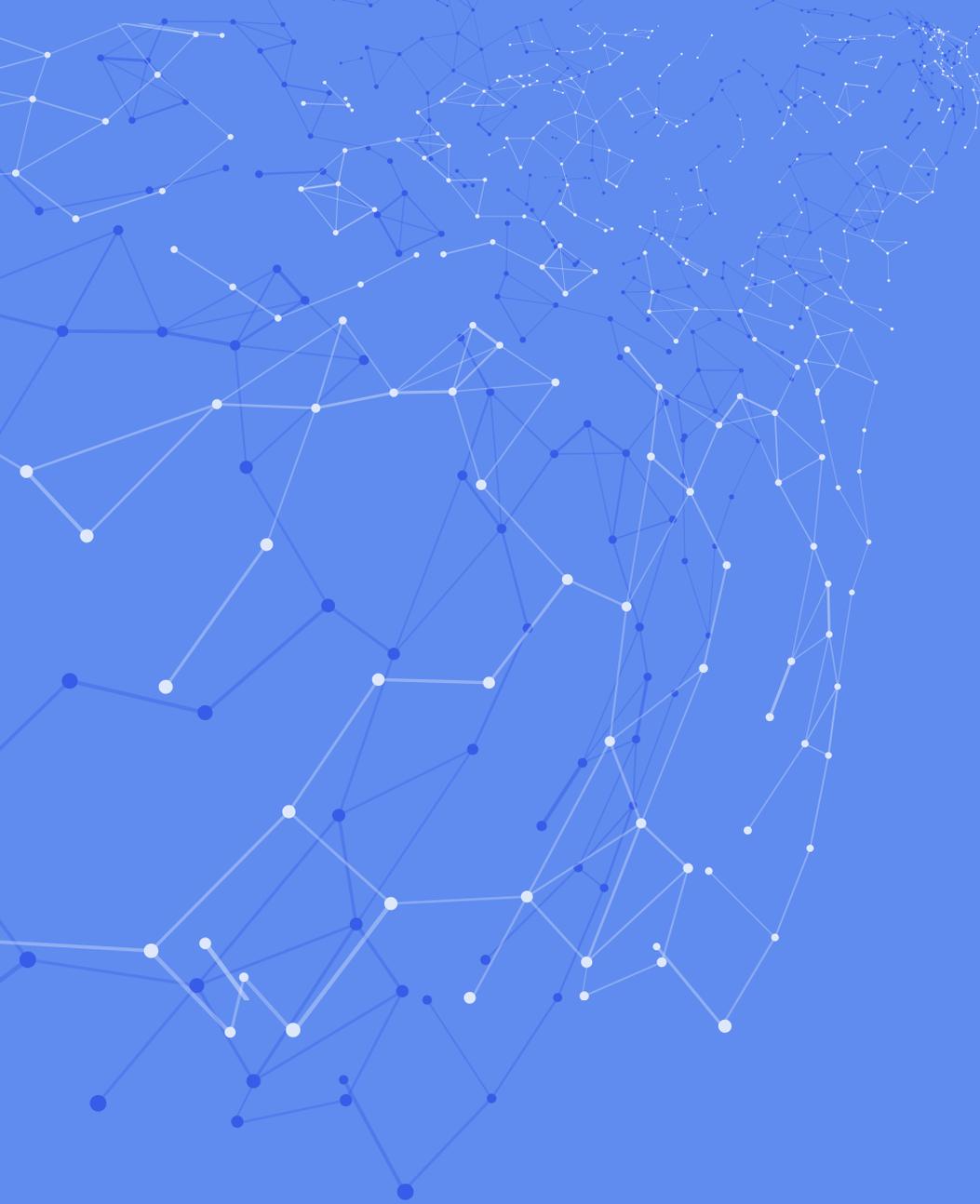
Conclusion

There has been considerable investment in global health through GHIs, with strong short-term results in some areas, but national health systems remain weak and not always in the driving seat. Needs are growing and funds are either stagnant or dwindling, so change is essential for higher efficiency. There were no voices in our consultation arguing that the status quo should be the way forward. There were arguments for radical change (abolition of GHIs in their current form), but these represented a minority of views. The majority view was for the GHIs to remain but undertake substantial changes that would make them more effective in supporting countries' capacity to deliver UHC – and all of its components – over the long term.

The suggested changes apply at ecosystem and individual GHI level and imply quite significant shifts in the current operating model, especially for the GHIs that are providing funding and commodities directly to countries. The key proposed changes involve:

- moving from disease-siloed to integrated delivery and care;
- providing support to health systems as whole, rather than vertical components within health systems;
- streamlining GHI systems (within and across GHIs) to make them more manageable and efficient at country level;
- charting a clearer course towards ending dependence on GHIs, though building country capacity while also providing clarity on transition;
- making alignment across GHIs into a core performance metric for them as well as for their funders;
- funders committing to strengthen existing architecture and reduce proliferation of GHIs.

The selection, further development, sequencing and implementation of the recommended changes should be taken forward by global and national health actors.



_____ **1**
Background



1 Background

The Future of Global Health Initiatives (FGHI) process is an ongoing multi-stakeholder exercise to explore how GHIs can effectively accelerate country-led progress towards universal health coverage and the broader Sustainable Development Goals (SDGs) 2030 Agenda. The process, which started in 2022, aims to make recommendations on how GHIs can be more efficient, effective and equitable as well as to catalyse collective action to ensure they are fit for purpose through 2030 and beyond (1). As countries approach the deadline for the SDGs, it is important to review the way in which different GHIs support countries to develop key capacities for achieving Universal Health Coverage (UHC)² and the wider SDGs. This report presents findings from a scoping review and a series of rapid consultations and individual interviews to gather views on how GHIs could evolve to support this process over the next 10-20 years.

This work was commissioned by the Wellcome Trust and has been carried out by a consortium of five universities and was conducted between February and July 2023. It aimed to inform the FGHI process by gathering evidence of how GHIs can best support countries to develop the health system capacities required to achieve UHC. The purpose of the study was to produce a vision and recommendations, informed by recipient country perspectives, of what GHIs should or could look like in 15 to 20 years, to accelerate the achievement of UHC.

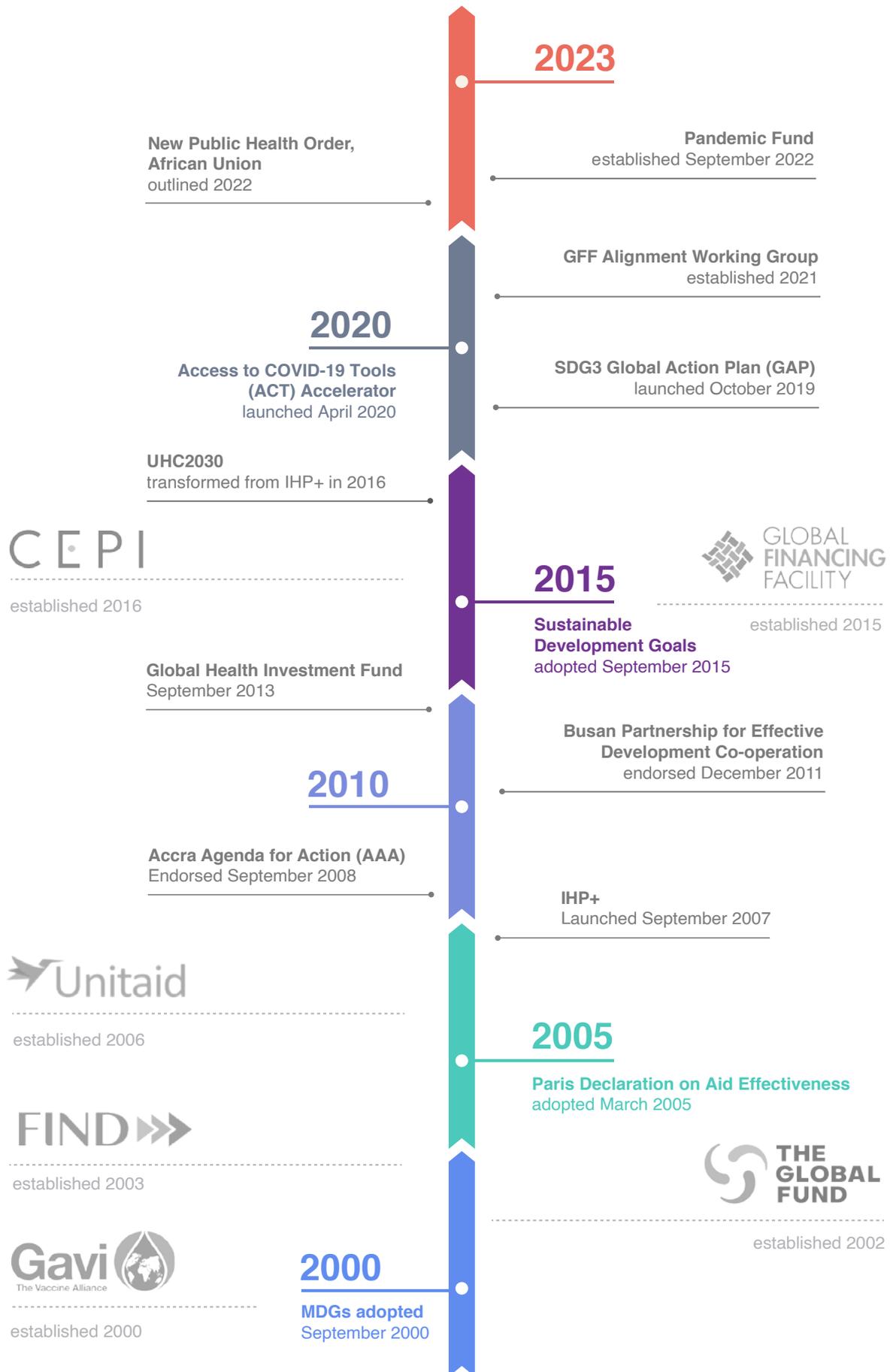
The process was focused on six GHIs (Table 2), which differ in both form and function: the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), Gavi, the Vaccine Alliance (Gavi), the Global Financing Facility for Women, Children, and Adolescents (GFF), Unitaid, the Foundation for Innovative New Diagnostics (FIND), and the Coalition for Epidemic Preparedness Innovations (CEPI).

The GHIs³ are international partnerships that aim to address specific goals in global health. They have been established since the early 2000s. At the same time, there have been a number of parallel efforts to coordinate the growing number of actors in global health, as well as efforts to improve the effectiveness and coordination of development assistance for health (DAH) in general (a timeline is shown in Figure 1).

2 The FGHI process uses the WHO definition of UHC (2); this includes PHC as a core component, including emphasis on primary care and community initiatives, community engagement and multi-sectoral action.

3 GHI is a term used to refer to organisations that integrate the efforts of stakeholders around the world to mobilise and disburse funds to address health challenges and do so by supporting the implementation of health programmes in low- and middle-income countries (1).

Figure 1 Timeline of GHI establishment and coordination efforts since 2000





_____ **2** Study aims



2 Study aims

The study set out to do the following:

- 1 Outline a vision of what the GHIs should seek to achieve over the next 15-20 years to strengthen health system capacities and deliver health impacts
- 2 Analyse the extent to which GHIs' current mandates and ways of working will need to evolve to enable them to effectively, efficiently and equitably deliver this vision, and the contextual factors that would support or hinder such a shift
- 3 Provide recommendations on how and when the GHIs' current mandates and ways of working should evolve

The study team was asked to adopt a UHC lens and a focus on countries' experiences and needs from the GHIs.

It is important to note that this was not an evaluation of any specific GHI, but rather a consultation on the extent to which some of the main GHIs, as a group, are supporting countries to reach and maintain UHC, and to propose changes to strengthen the system as a whole.



3

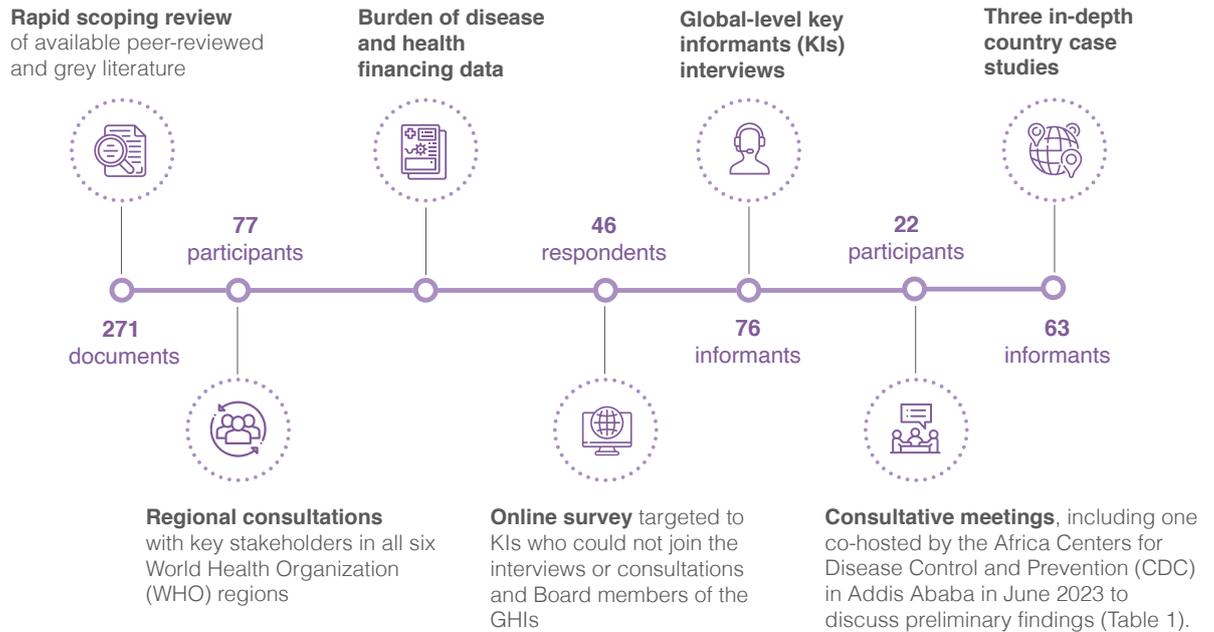
Data and methods



3 Data and methods

3.1 Data sources

The study draws on a number of data sources:



The study participants (total of 335) were based in 66 countries (Figure 2).

Study participants were purposely selected based on their level of experience working with GHIs and their membership of relevant constituencies (GHIs, academia, multilateral or bilateral donors, CSOs, private sector and philanthropic foundations). A first list of informants was drafted by the FGHI Secretariat and then completed by the social network of the research consortium. During the course of the study, new KIs were added based on suggestions from people interviewed (snowball technique).

Figure 2

Global distribution of all study participants (n=335)

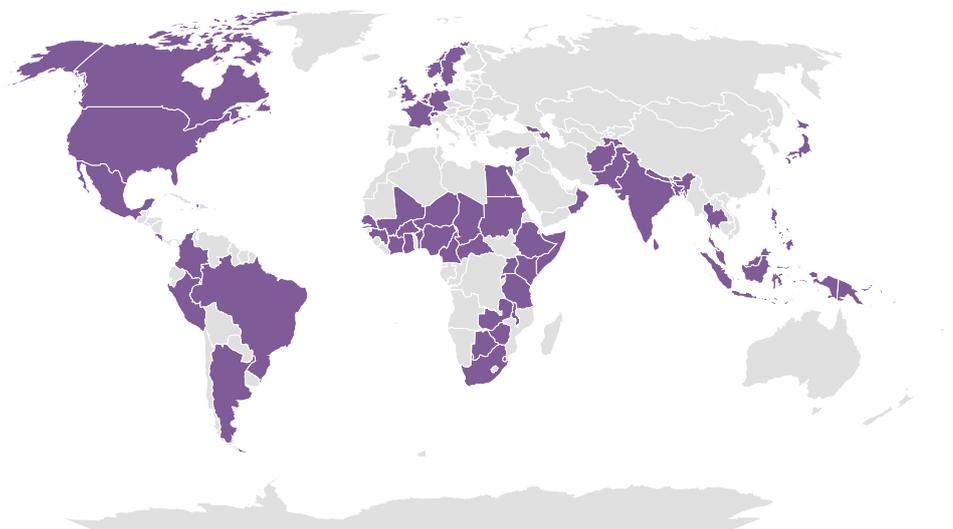


Table 1 | Number and category of study participants by data source

Data Stream	Number of participants	Category of participants
Global-level interviews	76	GHI (n=18), Academic (n=11), Multilateral (n=16), Bilateral donor (n=15), CSO (n=10), Private Sector (n=4), Foundation (n=2)
Country-level interviews (Pakistan, Senegal, South Africa)	63	Government (n=22), CSO (n=10), Academic (n=10), Implementation partner (n=4), Technical/Financial partner (n=6), National and provincial disease programme (n=4), Technical Assistance provider (n=1), Multilateral (n=3), Regional organisation (n=2), Private Sector (n=1)
Regional consultations (all six WHO regions)	77	Multilateral (n=23), CSO (n=23), Implementing government (n=17), Academic (n=11), Implementation partner (n=3)
Product Development Partnership Coalition Consultation	6	Product development partnership member (n=6)
Targeted online survey	46	Academic (n=15), CSO (n=11), GHI (n=6), Implementing government (n=4), Bilateral donor (n=4), Multilateral (n=4), Foundation (n=1), Other (n=2)
Hybrid Deliberative Discussion co-hosted by Africa CDC	45 (30 in-person, 15 online)	In-person: Government (n=9), FGHI (n=4), CSO (n=4), Multilateral (n=3), Regional organization (n=3), Africa CDC (n=3), Bilateral donor (n=2), Foundation (n=2) Online: CSO (n=2), Product development partnership (n=1), Government (n=2), Foundation (n=5), Bilateral donor (n=2), Independent global health consultant from the African continent (n=1), Multilateral (n=1), Academic (n=1)
FGHI Steering Group Consultative Meeting	22	Multilateral (n=2), Recipient government (n=3), CSO (n=2), Bilateral donor (n=8), Foundation (n=5), FGHI (n=2)
Total number of study participants*	335	CSO (n=62, 19%) Government (n=57, 17%) Multilateral (n=52, 16%) Academic (n=48, 14%) Bilateral donor (n=31, 9%) GHI (n=24, 7%) Foundation (n=15, 4%) PDP (n=7, 2%) FGHI (n = 6, 2%) Private Sector (n=5, 1%) Other (n=29, 8%)

*some participants may have been counted twice (e.g. if they participated in both an interview and a consultation)

3.2 Data analysis

All data sources were synthesised to inform this report. The qualitative data were recorded, transcribed, and coded inductively and deductively. The researchers convened to discuss the emerging findings, and during analysis, examined similarities and differences among GHIs and across participant categories. Political economy analysis (PEA) (3–7) was used throughout the study to inform the analysis and synthesis. Such an approach allowed the team to reflect on the dynamic interaction between actors, their relative power and respective interests and incentives, and elements of the broader context, and how the outcome of the interaction affects the likelihood and content of future changes. Full details of the methods used for this study can be found in Appendix 1.

3.3 Ethical considerations

The study was approved by the ethics review boards of University of Geneva, Cheikh Anta Diop University, Stellenbosch University, and Aga Khan University. Informed consent was obtained from the study participants to record and pseudonymise the qualitative data, to protect the study participants from being identified.

3.4 Study limitations

The study adopted appropriate methods for a rapid set of consultations on complex issues (see Appendix 1 for further details). It set out to capture the views of highly expert stakeholders with deep insights into the workings of the GHIs, but also different perspectives on the topic, representing all the key parts of the global health system.

It is important to note several limitations in this work, largely as a result of a tight timeframe. The data we collected were qualitative and based on interviews, consultations and a rapid non-systematic literature review. Not all of the points raised in our consultations could be verified and underpinned with independently checked quantitative data. This was particularly true because a systematic evidence base on the work and effects of the GHIs since their inception did not exist. It is also important to highlight that this is a contested area, and there were conflicting positions, which we try to reflect in this report.

The country case studies were not meant to be a representative sample, but were chosen due to strong research partnerships within the country, as well as representing a range of regions and contexts in which GHIs are active. Findings of one country are not meant to be generalisable to other contexts, but to shed light on the dynamics that occur around GHIs and different experiences of country stakeholders.



4 Findings



4 Findings

This section presents a brief overview of the evolution of the GHIs within the global health system, as well as a summary of upcoming challenges linked to the changing global context. This is followed by a summary of the strengths and weaknesses of the GHIs, as perceived by the participants in consultations and interviews, also drawing from our scoping review, and reflections on the political economy of the current operation of the GHIs at global and country level. We have also drawn on findings from our scoping review, but it is important to note that the evidence around much of the activities and investments by the GHIs is still relatively undeveloped. This is particularly true at the country level, where it is often hard to find full details of the size and nature of GHI operations published openly.

These overall findings have been used to feed into the proposed vision and recommendations. A full description of methods and results from each data source are summarised in appendices.

Positionality and awareness of participants:

The data revealed divergent perspectives on the role and possible future path of the GHIs. Some country-level actors, implementers and funders were incrementalist in their approach to change, whereas other country-level actors, multilaterals, and academics tended to be more radical. There is also a lot of variation within these groups. It is notable that there were surprisingly critical voices from within the GHIs themselves.

In the interviews and consultations, KIs had more to say about GFATM and Gavi than the other four GHIs, and this emphasis is reflected in the findings. This was to be expected, given their size and their level and length of activity at country level. GFF, while also country-facing, is not present in all countries and is younger, and there was more uncertainty about its role by KI, especially its relationship with the World Bank. Our findings are therefore less rich in relation to the GFF and also the R&D-focused GHIs which have less country engagement.

In this section, we indicate when an issue is specific to one or two GHIs as much as possible. Given the great differences between the GHIs selected for the study, it should not be assumed that all points made refer to all GHIs. However, there are broad features of GHIs which come out from analysis and interpretation of all the data.

4.1 Trends in financing and actors in the global health landscape

The global health ecosystem has undergone significant expansion over the past few decades, linked in part to efforts to reach the MDG goals (10). Total funding for global health interventions increased from approximately USD 7 billion in 1990 to USD 36 billion in 2015 (9) and kept increasing during the last few years thanks to exceptional investments to respond to the COVID-19 pandemic. In 2021, DAH increased by 8.6% compared to 2020, with an estimated \$67.4 billion invested in 2021.

There has also been a significant increase in the number and diversity of actors within the system (10). Whilst 30 years ago, it comprised primarily of bilateral and multilateral arrangements between nation-states, it is now a varied landscape, which also includes private firms, philanthropies, non-governmental organisations (NGOs) and GHIs (11). The increase in DAH disbursements from 1990-2015 was accompanied by a five-fold increase in the number of actors involved in global health, with a particularly rapid rate of growth in the number of civil society organisations (CSOs) between 2005-2011 (11). In addition, there has been a marked increase in the distribution of DAH through GHIs, driven by the creation of the GFATM and Gavi (13). There have also been changes to the GHI's funding to partners: recent

analysis suggested that GFATM's share of disbursements to governmental organisations has been declining, from 80 percent in 2003 to 40 percent of all disbursements in 2021 (14). Many of the CSOs funded are focussed in specific health areas: separate work has found that over one-third of CSO channels are only providing funds for the implementation of programmes in one health area e.g. HIV/AIDS, malaria, child and maternal health or nutrition (11).

These changes have been accompanied by a concomitant fall in the percentage of DAH in the form of loans from International Bank for Reconstruction and Development (IBRD) and International Development Association (IDA) in health, and the emergence of four “*mega-trends*”: proliferation, verticalisation, circumvention of government systems, and fragmentation (15). These trends are not supportive to countries to reach UHC and the wider SDGs.

Box 1

Official Financial Flows and the Aid Architecture

A recent analysis by the World Bank (15) has concluded that:

- The increase in DAH has been accompanied by significantly increased proliferation in donors and donor funding entities during the last two decades.
- The proliferation and fragmentation trends have been accompanied by the verticalisation of aid and the circumvention of government systems.
- While vertical programs have had many advantages, they have not contributed to an aid architecture that is ‘fit-for purpose’ in addressing the challenges of tomorrow, e.g., ageing, climate, pandemics, etc.
- The fragmentation and duplication also undermines efficiency and sustainability and increases transaction costs for countries.
- The increasingly more complex aid architecture makes development more challenging for poor countries, which are struggling to deal with the overlapping crises.

Three further features are relevant in understanding resource flows to health. First, health budgets in many low-income countries (LICs) and humanitarian crises-affected countries still rely proportionately more on grant aid and overall DAH than many other sectors (15). Grant aid is argued to make sense in health because returns are non-pecuniary, there are large positive externalities and the recipients are often de-linked from those who will eventually repay the loan. Over one-third of Official Development Assistance (ODA) is allocated to social sectors (15). This is also likely to indicate a discrepancy between the priority accorded to the health sector and specific health programs (e.g. HIV/ AIDS, RMNCAH-N, malaria, immunisation) by donors (19,20) as compared to the allocation of resources at the national level. Low levels of domestic funding allocated to health (even decreasing in some countries⁴ from 2015 to 2020 (21)) could also indicate that governments are capitalising on donors’ interest in health to redirect resources towards more neglected sectors (22,23,24).

DAH has particular importance in LICs: in 2021, DAH represented only 0.5% of total health spending in the world but accounted for 27.7% of total health spending in LICs and 2.4% in lower middle-income countries. In 2021, HIV, TB and malaria programmes received almost 23% of total DAH (11).

Second, despite the large share of ODA devoted to health, the overall portfolio of financing available for health and the achievement of the SDGs is inadequate, and there is a clear need for better access to long-term flexible and concessional finance to leverage the amounts of money available for countries to be able to orient health budgets towards achieving UHC (and this is especially true of a group of low-income and fragile countries which struggle in absolute terms to meet their basic health needs) (25,26,27).

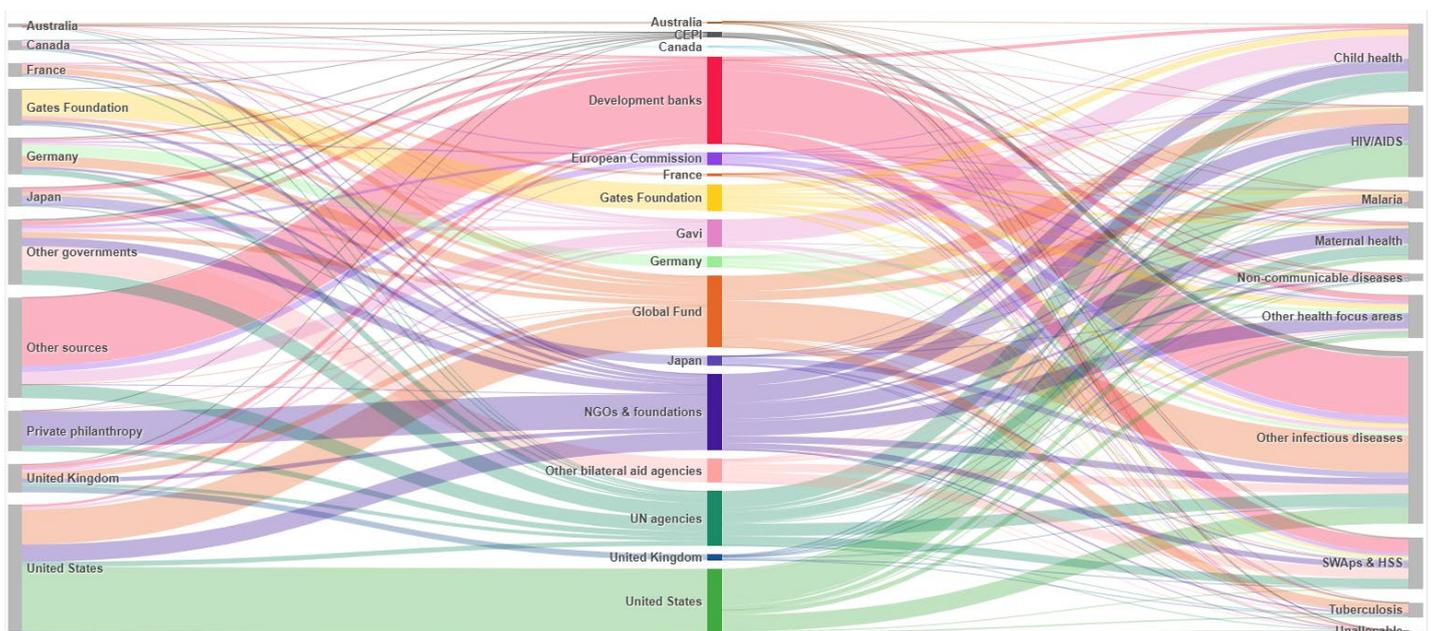
4 Algeria, Angola, Chad, Lesotho, Madagascar, Namibia, Nigeria, Sierra Leone, Zambia, and Zimbabwe

Approaches that seek to attract such funding into the health sector will be important to prioritise.

Third, there is also evidence of a mismatch between the levels of funding allocated to different programmes by donors and the burden of disease that they address. Lower-income countries are facing an epidemiological transition toward noncommunicable diseases (NCDs): according to the most recent Global Burden of Disease study, six of the top ten causes of disease were NCDs (28). However, NCDs are currently receiving only 2.8% of DAH worldwide (29).

Figure 3 below shows the total US dollar spent for all channels of DAH in 2021 and the degree to which certain disease programmes receive a disproportionately large share of funds. It is important however to note that aligning global health financing with the burden of disease is complex and the relationship should not necessarily be linear (30).

Figure 3 Flows of global health financing in 2021 (Source: IHME VizHub, 2021 (31))



4.2 Overview of focal GHIs

Since their inception, GHIs have become powerful institutions in their own right, due to the financial resources that they mobilise and also the specific role that they have grown to fill in the broader global health landscape (32). They were established to tackle global health threats, reduce disparities within communities and between nations and contribute to a world where people live healthier, safer and longer lives (33). They were also established to coordinate the response to specific challenges that were seen to be of high importance within global health at particular times (e.g. access to antiretrovirals in the early 2000s) by reducing fragmentation of DAH flows through bilateral channels.

Over recent decades, many GHIs have grown rapidly and become major players in the global health system. They are active at global, regional and country level. Some of the longest-standing GHIs such as GFATM and Gavi have evolved into large and complex organisations with the size of their secretariats reflecting this institutional growth. They have inevitably developed their own internal dynamics and priorities. GHIs now raise and channel 14% of DAH (13) and have taken on a growing range of roles, most recently including COVID-19 responses (34).

The GHIs included in this process vary in size, form and function and bring very different focus and weight to a range of activities. It is important to note that the six GHIs analysed here represent a small sample of the overall number of GHIs; the high number of GHIs is part of the challenges in fragmentation that many low-and-middle income countries (LMICs) face. The functions of the six GHIs under analysis include:

- market shaping (including pooled procurement)⁵ and advanced market commitment;
- research and development (R&D) of new technologies and medicines;
- grant giving⁶ and/ or concessional and blended finance (with grant and loan components) to country programmes and actors, either directly or via a third party
- provision of technical assistance (TA) for specific programmes or system strengthening;
- purchase and supply of commodities and technologies on behalf of country programmes;
- advocacy, especially for marginalised and disadvantaged groups

⁵ Market shaping is a process to improve access and affordability to global public goods. It is thought to increase the sustainability of funding and reduce dependency on donors (35).

⁶ Grants can be given for a variety of programmes including disease prevention and control, public health and health system functions.

Table 2

Overview of the global health initiatives that are within the scope of the study

GHI	Est.	Objective	Approximate size	Type of funding	Function
Funding model based mainly on grants					
	2002	To attract leverage and invest additional resources to end epidemics of HIV, TB, malaria, reduce health inequities and support attainment of the SDGs	\$5.2 billion per year ⁷	Mainly grants co-ordinated through a country led Country Co-ordinating Mechanism	Country facing support (mainly grants and technical assistance) for disease programmes and health systems strengthening/ equity related to these programmes. Support for the development and procurement of drugs & technologies.
	2000	To save lives and increase people's health by increasing the equitable and sustainable use of vaccines	\$2.6 billion per year	Co-financing for procurement of vaccines. Grants for health systems and immunisation strengthening (HSIS); Technical support. Market shaping.	Country facing support (mainly grants and technical assistance) for vaccination programmes and health systems strengthening/ equity related to these programmes. Support for the procurement of vaccines.
	2006	1-To accelerate the introduction and adoption of key health products 2-To create systemic conditions for sustainable, equitable access 3-To foster inclusive and demand-driven partnerships for innovation	\$210 million per year	Grants awarded following an open call for proposals	Investment to accelerate the development, introduction, and adoption of new health products and to create sustainable market conditions for equitable access via implementers at global, regional or country level.
	2003	To drive equitable access to reliable diagnosis through collective action	\$60million increasing to \$150 million during COVID-19	Grants awarded following calls for proposals	Investment for Research and Development for new diagnostics
	2016	To accelerate the development of vaccines and other biologic countermeasures against epidemic and pandemic threats to be accessible to all	\$200 million per year (36)	Grants awarded following an open call for proposals	Global Research and Development for new vaccines and other measures to prevent epidemics/ pandemics
Funding model based on leveraging concessional finance					
	2015	To end all preventable maternal, child and adolescent deaths by 2030, through a health systems strengthening approach	Multi-Donor Trust Fund of £2 Billion, embedded within the World Bank	Grants aim to catalyse funding from Multilateral Development Banks and domestic resource mobilisation. An average of \$7 dollars of World Bank funds are linked to each dollar of GFF grant.	Country facing support (grants as seed funding and technical assistance) rooted in a broad investment case, with Government as grant implementer. Links to the World Bank assists work beyond the Ministry of Health. Works through and alongside existing government systems.

⁷ By taking the last replenishment total and dividing by the three year cycle; not a measure of actual expenditure per year

These six GHIs fall into three groups. There are two large (in terms of budget), country-facing, grant giving GHIs (GFATM and Gavi) (see Appendix 5), although these are also highly active in market shaping and other forms of support. There is one smaller but still significant country-facing GHI that works through government systems, using money from a trust fund to leverage IDA and IBRD funds and therefore encourage greater flows of financing for health from these sources (GFF). Finally, there are three smaller, more global public good (GPG)-focused agencies that have a focus on different elements of R&D (Unitaid, FIND, CEPI), with FIND and CEPI providing early-stage R&D while Unitaid focuses on late-stage R&D and market introduction and access.

4.3 **Future challenges for global health - the evolving landscape for the GHIs**

The COVID-19 pandemic showed weaknesses in the current global health system (37) at a time when the world faces many new and growing challenges. These include a shift in the global burden of disease, with NCDs predicted to account for the majority of the burden of disease globally by 2040 (38), (39). Deaths attributable to communicable, neonatal, maternal, and nutritional diseases are predicted to decrease in all regions up to 2040 (5), whilst deaths from NCDs will remain stable globally, with the burden attributable to diabetes, cancer and mental disorders steadily increasing (ibid). Other global health challenges, such as antimicrobial resistance(40), new epidemics (41), air pollution (42), (43) and climate change (21), armed conflicts (44,45), and increasing life expectancy/ageing populations with reduced fertility rates (39), (46), (47) are also predicted to continue to cause significant changes to morbidity and mortality trends. Whilst the burden of disease is shifting, a considerable remaining challenge continues in delivering basic health services that address the medical conditions that affect women, children and adolescents, and this has been subject to recent stagnation, suggesting continued weakness in many health systems (48), (49).

At the same time, DAH is expected to plateau (27) and reduce, unless new sources are identified (e.g. if emerging economies increase their role as donors, although these might lead to new conditionalities). This is likely to affect the GHIs' funding sources, making transition planning for the GHIs even more urgent. It is also likely that aid will be reallocated to new challenges such as addressing climate change, so potentially away from health, which has traditionally a relatively large amount of ODA.

Domestic resource mobilisation is growing in some countries but there is likely to remain a significant group of countries that, even with high allocation from general government revenues, still cannot finance essential health care (27,50), (20), (27,50). These countries are in the low-income group, as well as fragile and conflict-affected settings (FCAS) (44,45). Many countries, including donors, are also predicted to face shrinking fiscal space (17) and there are growing concerns about debt overhang affecting a substantial minority of LMICs (51).

The geopolitical context is also likely to remain stormy; a multi-polar world presents challenges to resolving global problems, and there is a likelihood of shocks of various kinds over the next two decades, which will create new health challenges and potentially increase precarious migration (52). The growth in refugee numbers over recent years calls for more regional approaches to problems that extend beyond national boundaries (53).

The growth in new technologies to respond to health issues is also expected to continue (54,55)- this is clearly a positive development, but those will also create cost burdens and choices for constrained budgets. The development of local capacity to prioritise will therefore be increasingly important.

4.4 Positive contribution of the GHIs to date

The GHIs are highly heterogeneous in mandate, structure and age (Table 1; Appendices 4 and 5); however, the literature and consultations highlight some important cross-cutting areas of achievement, which we summarise here.

4.4.1 Contribution to improved health outcomes

Most critically, the GHIs have contributed to the reduction in the global burden of disease for HIV, malaria, TB, and vaccine-preventable diseases of childhood and adolescence (especially GFATM and Gavi) (56,57,58,59). In addition, GFF countries show higher average annual rate of changes in family planning and vaccination than GFF-eligible countries⁸ (60,61), although their reliance on routine data makes it difficult to ascertain direct contribution to these outcomes. KIs recognised that the GHIs have helped to ensure focus on these priority areas, which governments have not universally prioritised, although questions are raised (below) on whether the strategies adopted were the most cost-effective approaches.

“Gavi and Global Fund have clearly brought new money. They’ve brought political priority to their areas and they’ve brought together coalitions. They’ve supported national institutions and countries and clearly have had measurable wins on immunisation and on HIV, TB and malaria.” (Global KI)

4.4.2 Innovative financing and market shaping

The GHIs are recognised for their role in promoting and facilitating new financing mechanisms. Examples include the airline levy for Unitaid (62,63); the International Finance Facility for Immunisation (IFFIm), which has disbursed \$4.6 billion since 2006 to support Gavi’s vaccinations (64), Gavi’s matching fund (65), advanced market commitments, as well as GFATM’s Debt2Health program. (63, 64, 66, 67).

They have also been active in market-shaping and use of subsidies to encourage investment in GPGs⁹ and reduce the price of commodities and technologies using public-private partnerships (PPPs), patent pools¹⁰, and pooled procurement, e.g. for antiretroviral therapy, for combination therapy, for pneumococcal vaccine and diagnostics (e.g. GeneXpert (71)), and also for bed-net production in Africa.

“[GHIs are] basically donors to us. They have a crucial role in helping in scaling up the interventions in the initial phase, in the phase when they actually need to create their own markets.” (PDP Coalition consultation KI)

4.4.3 Ensuring access to vaccines and other commodities and technologies

One of the main contributions, especially for Gavi, Unitaid and the GFATM, has been increasing access to vaccines, medicines, technologies and other GPGs (66), (72). Every year, roughly half of GFATM’s investments – about US\$2 billion – are used to procure medicines and health products for TB, HIV and malaria (73).

8 GFF, Direct Communication, 27 July 2023

9 GPGs can be defined as institutions, mechanisms, and outcomes that provide quasi universal benefits, covering more than one group of countries, several population groups, and extending to both current and future generations (68)

10 Unitaid founded the Medicines Patent Pool in 2010, which has been instrumental in negotiating voluntary licences with patent holders to improve affordability and access to medicines for LMICs. It has been a particular success for HIV, TB and Hepatitis C drugs (69), (63), (70).

Gavi also spends a large proportion of its funds on procuring commodities. Further examples are Unitaid and GFATM's provision of GeneXpert diagnostic machines to TB reference laboratories (71). In Senegal, FIND and Unitaid have recently invested in local manufacturing of affordable rapid diagnostic tests for the Africa region for certain viruses, including COVID-19, through a PPP with the Institut Pasteur in Dakar (74), (75) (Appendix 10).

4.4.4 Donor coordination around specific global health agendas

As the GHIs act to pool funding between donors for certain programmes at global level, there is a view that they have supported donor coordination for some specific aims, such as vaccination, although by adding to proliferation there is a strong counter-view too (see next section).

The study identified some areas of recent progress in global alignment in which the GHIs took part, e.g. Access to COVID-19 Tools Accelerator (ACT-A), the Sustainable Financing for Health Accelerator (which is part of the SDG3 Global Action Plan (GAP) (76), the Supply Chain Funders Forum (to link across initiatives) (77), and co-financing initiatives with the IDA. Since their inception, Gavi and the Global Fund have served to improve donor coordination in specific areas - e.g. childhood immunisation, malaria, and HIV prevention (with UNAIDS, and the US President's Emergency Plan for AIDS Relief - PEPFAR).

4.4.5 Fund mobilisation, especially for GFATM and Gavi

It is hard to establish whether the GHIs have leveraged new money for global health given the absence of a counterfactual. However, in the case of the grant focussed GHIs, it seems likely that they contributed to some increase in donor-related funding, mobilising effectively from newer sources, such as philanthropic foundations. This success is attributed by KIs to their focus and ability to demonstrate results (but see next section for concerns about reporting on these). KIs talk about the 'huge PR machine' deployed by the larger GHIs. The GFF also claims a significant increase in funds mobilised for health as additional IDA and IBRD loans, as a result of GFF grants which act as an incentive for governments to allocate funds to health.

It should be noted that the bulk of funding for the larger grant giving GHIs is from public sources, and that the sources of funding have been relatively constant (27,67).

For market shaping and catalytic funding, the grants provided by GHIs can be used to support specific innovations and pilots, playing a catalytic role. An example was provided in the South East Asian Region (SEARO) consultation, where the Bill & Melinda Gates Foundation (BMGF) and then the GFATM provided catalytic funding for TB control PPPs in India, which were later picked up by the government. Gavi's INFUSE Innovation Hub mobilises commercial and philanthropic investors to fund entrepreneurs and accelerate innovations (78).

4.4.6 Innovative governance structures

The boards of some of the GHIs were seen as innovative when first set up, with representatives from a range of constituencies, including implementing countries, donor countries, CSOs and the private sector. The GFATM's Board has equal voting seats for donors and implementers, with 10 constituencies respectively. Within the 10 voting implementer constituencies, seven are implementer governments. Gavi also has representation from the vaccine industry and research and technical health institutes. Instead of a traditional board, the GFF established an Investors Group (79), which includes a range of actors, including nine Ministers from GFF partnership countries, CSO and youth representatives, and a Trust Fund Committee (See Appendix 4 for more information on the GHI boards).

However, the effectiveness and power dynamics on the boards were often called into question by study participants (see below).

4.4.7 Focus on reaching underserved populations and working with CSOs

One of the key founding ideals behind the longer-standing GHIs, in particular GFATM, was that they could work better in sensitive political spaces compared to other global health actors, and this remains critically important in many countries. The GFATM, Gavi and GFF are all focused on reaching target populations, which are not always prioritised or effectively reached by governments, and many KIs recognised this as an important part of their value. For example, during the HIV/AIDS denialism years in South Africa, support for antiretrovirals through CSO channels was very important. In addition, some (again especially the GFATM) have brought CSOs into Country Coordinating Mechanism (CCM) representation at country level, which raises CSOs' profile and influence nationally.

As another example, Gavi has begun investing additional efforts to reach 'Zero-Dose' children, which is defined as not having received the first dose of diphtheria-tetanus-pertussis containing vaccine (DTP1) (80). By 2030, Gavi aims to reduce the number of Zero Dose children by 50% (81). The GFF's Strategy 2021-2025 includes specific mention of gender equity and reaching "*vulnerable and marginalised populations such as rural populations, refugees or those impacted or displaced by conflict or climate change,*" and indicates that their voices will be included in national telephone surveys to capture reproductive, maternal, newborn, and child health user experiences (82). The GFF also maintains a focus on youth and CSOs having a voice in their country platforms.

4.4.8 Showing adaptability

GHIs have demonstrated adaptability over time within their focal areas. Examples include changed grant-making processes, periodic review of performance metrics, the introduction of regional grants (e.g. such as the Artemisinin-resistance initiative in the Mekong region (83)), and developing a Challenging Operating Environments Policy (84). They have demonstrated their ability to undertake new roles in response to emergencies, e.g. establishing partnerships such as the ACT-A(85,86) during the COVID-19 pandemic (see appendix 12), and invested in new areas, such as the GFATM providing funding for co-infections and co-morbidities, such as viral hepatitis (87), and certain cancers (88), although this has led to concerns by some actors in the wider global health system about mandate creep (see below).

The market-shaping GHIs have adapted their scope. Unitaid has been looking at Intellectual Property issues, providing grants and market shaping for oxygen, in collaboration with GFATM since COVID-19 (89), and is now contributing to new technology to aid progress towards cervical cancer elimination (90). FIND has expanded its focus from TB to infectious diseases more widely, and now to NCDs, and expanding Primary Health Care (PHC) testing and surveillance. Since the COVID-19 pandemic, it has added pandemic preparedness as a goal. FIND has strengthened its focus on market-shaping initiatives, R&D for surveillance products and point-of-care testing, and country engagement (91).

4.4.9 Recent progress on alignment of donor support with national plans at country level

Recently, there has been some movement towards more aligned ways of working by some of the GHIs. For example, the GFF emphasises support to governments to lead the coordination and alignment of national partners, including donors, achieved through the development and tracking of the implementation of an Investment Case. The GFF provides TA to strengthen resource mapping and national data generation and use, as well as other functions to strengthen capacity to lead this alignment process. In addition, with a focus to provide funds on-budget, through public channels, and placing a higher priority on broader

domestic trends, the GFF is structuring incentives around disbursement-linked indicators, where countries can get access to more grants if they reach a certain threshold of domestic resource allocations. There is also a push to encourage countries to allocate more domestic resources to PHC, and align GHIs and other donors around spending at the margin (92), (93).

“They [the GHIs] now recognise national plans, though some of these suffer from being too broad, not very prioritised.” (Global KI)

GHIs are increasingly using the concept of integration, though it is not clear how far this is translated into practice.

“For the new funding from Global Fund and Gavi, there is a lot of emphasis on integration and support through the essential package of health services. We still do not know how this is going to materialise.” (Hybrid Deliberative Discussion participant).

Pooled funding at national level for some programmes is also seen as a step forward. In India, for example, the GFATM pooled funding with the Government of India and the World Bank for the TB programme recently, which was seen as giving the government more of a lead role (SEARO consultation). Across several GHIs (including Gavi) and the World Bank there are examples of experimentation with pooled financing (e.g. in Pakistan, Nigeria as well as India).

Some countries have shown notable progress in adopting a more integrated approach to the utilisation of GHI funding – e.g. Malawi is currently making efforts in that direction; additionally, Ethiopia, Rwanda, Somalia, and certain provinces of South Africa have been recognised as enforcing a more harmonised approach across funders, including GHIs. Ethiopia, for example, has had a health harmonisation platform since 2008, which includes the GHIs and it is working towards implementing ‘one budget, one plan, one report’ (94). Progress is reviewed every month, with the aim to ensure that funds contribute to national priorities (national stakeholder, consultative meeting). Ethiopia is leading the GFF Alignment Working Group and has used the GFF Investment Case as its national health transformation plan. This indicates the scope for countries to shape GHI support, where will and capacity exist, although this is not always facilitated by the GHI requirements, as discussed below.

In the last two years, FIND has been asked to develop specific memorandums of understanding and work plans for support to Brazil, India (95), Indonesia (96), Kenya, South Africa, and Vietnam and in partnerships with Africa CDC and PAHO. With the adoption of the World Health Assembly Resolution on Diagnostics in May 2023, these requests are likely to increase (97). This development starts to ensure demand-focused work plans and strategies.

4.4.10 Data collection and reporting systems

GHIs have invested in national health information systems, strengthening data and accountability, although this picture tends to be focused on only focal areas that they specialise in rather than a holistic system. GFATM and Gavi have been investors in some aspects of the district health information system and the GFF provides an emphasis and TA on using nationally generated routine monitoring data and encouraging national governments to generate, analyse and use data. Conversely, access to data reporting by GHIs on their own activities has been a weak point, especially at country level (see country case studies- appendices 8-10) (98).

4.5 Challenges and unintended negative consequences of GHIs' investments

While strengths and achievements were recognised, the literature, interviews and consultations raised a number of substantial concerns, which are summarised here and which informed the vision and recommendations. Note that many of these are focused on the larger GHIs, due to their influence and financial weight, as well as their greater presence in-country. These are presented at the global and country levels. The global level findings cover the ecosystem more broadly, as well as the focal GHIs.

4.5.1 Global level

4.5.1.1 Concerns relating to mandates

Some interviewees, especially global KIs, expressed concern about what they perceived and experienced as constantly expanding mandates, particularly regarding the GFATM and Gavi. They pointed out that these organisations have been expanding their roles and venturing into new areas, such as health system strengthening (HSS) (99,100). However, in their opinion, there is little evidence to suggest that GHIs are appropriately structured and technically equipped to handle these responsibilities. In particular, persistent tensions and inevitable compromises in quality when attempting to address “horizontal” functions through a “vertical” approach were raised (see Country level section 4.5.2). In 2019 a review of the GFATM Resilient and Sustainable Systems for Health (RSSH) investments rated them as ‘needing significant improvement’ (101) and in the same year the Technical Evaluation Reference Group published a thematic review which highlighted a number of weaknesses, including the contradiction between a project cycle approach and health system investments, which require longer timeframes (102). A 2019 review of Gavi’s HSS support highlighted a few limitations in their grant’s contribution to sustainability, and a difficulty to integrate their interventions to PHC services (103).

“It’s the same program managers who developed the same applications or hired the same consultants to write the same applications. There are three-year time horizons, it’s short-term. Short-term money, short-term thinking and the grant managers...all of the incentives for the grant managers are to get the money out the door. That’s honestly the main key performance indicator: Get the money out the door.” (Global KI)

This mandate expansion can also lead to overlapping roles among and between GHIs and other global health actors, which can create inefficiencies – for example, Unitaid was set up to provide catalytic funding for new product and market introduction, which is now also available with the GFATM.

In addition to overlaps, there is a recognition of a gap in relation to the growing NCD burden of disease, in particular, with very limited funding going to prevention, promotion and management within countries as well as through global support.

4.5.1.2 Competition for funding and insecurity over future funding

Global KIs perceived competition for funding between GHIs and other global-level organisations, creating a sense of a zero-sum game, where funds may also not align with the actual needs in terms of disease burden or the functional role of different organisations. The competition for funding from the same pot of money was said to likely contribute to a perceived eagerness of GHIs to take on new roles and expand mandate, as organisations jostle for roles and funding. The existing system of staggered replenishments by GHIs was perceived as challenging for bilateral donors and governments of LMICs to manage (104–106) and there were concerns regarding the overall financial sustainability of the repeated, increasing GHI requests for replenishment.

In relation to the future, KIs were concerned that the funding base to support GHIs was considered insecure and not likely to expand as anticipated. GHIs were reported to be struggling to access new sources of funding, with “innovative” approaches such as social or development impact bonds failing to meet expectations, presenting conflicts of interests and lacking transparency (67,107) (64). These issues could affect future ambitions of the GHIs.

4.5.1.3 Governance challenges with GHI Boards

While the Boards of the GHIs (Appendix 4) are designed to monitor and ensure the performance of these organisations, there were varying perspectives on where the authority to challenge and rectify issues actually resided or was effectively exercised. Despite being theoretically representative, several KIs indicated that the Boards of some bigger GHIs have been structured in a way that fosters a balance of constituencies, resulting in rather slow and inefficient decision-making.

KIs highlighted that the boards of GHIs are very large and unwieldy and this can make changing course trickier as consensus for change is hard to reach. As board members typically have short tenures, this maintains an asymmetry in organisational knowledge and skills between the Boards and Secretariat, which has institutional memory (108). They also noted that there is a mismatch in the profiles of board members from the Global South and Global North, impacting their ability to effectively contribute and engage in decision-making processes. There are two key elements to this that came up in our interviews. The first is that the people sitting on Boards from the Global North are not of equivalent seniority to those representing the Global South - the example of government ministers representing the South whilst the North is represented by ‘bureaucrats’ from donor agencies was given. Second, the nature of the interaction appears to be unequal, with several KIs stating that it was not possible to “speak out” in Board meetings. Concerns were raised regarding the effectiveness of Board processes in facilitating active and open debates, especially for country representatives. It was observed that specific influential bilateral organisations, as well as certain large NGOs, hold more power than the recipient countries themselves.

“On paper [GHI Boards are] diverse but I don’t think that the practical spaces that they provide actually allow people to speak in the way that they need to speak. It’s all muted and it all becomes politics and corridor speak. This is why I don’t go to [GHI] meetings anymore.”
(Global KI)

Although major bilateral organisations have the potential to influence the outcomes of the GHIs’ Boards, their actions are not perceived as being coordinated.

‘The accountabilities are to the capital donors and to getting the money out the door. And there’s not enough accountability to real results in country or to efficiency oriented concerns.’
(Global KI)

The boards were also seen as not having the right technical expertise to address the challenges that the GHIs and the global health system now need to face, in particular those of strengthening health systems and achieving UHC.

“When you talk to [GFATM] about the importance of working with others to strengthen health systems in a way that’s not specific to HIV, you tend to get pretty blank looks... That’s not what they’re there for... They’re there to finish the job on HIV, and maybe TB and malaria.”
(Global KI)

Another aspect of unclear accountability at the global level was raised by some KIs in relation to the lack of transparency of reporting by some GHIs on their activities and investments as well as independent evaluations of their effect and cost efficiency.

4.5.1.4

Disputed funding allocations for GFATM

Global KIs have expressed concerns about the funding allocations within the GFATM, highlighting two specific issues. First, they assert that the distribution of funds across the three diseases within the GFATM does not match the overall burden of disease for these conditions. For instance, despite TB causing more deaths than HIV in some contexts, and having a much higher global prevalence (109), only 18% of GFATM funds are allocated to TB compared to 50% for HIV and 32% for malaria (110). This discrepancy was partly attributed by KIs to HIV lobby groups.

Adjustments have been made recently in the allocation formula (111) and according to GFATM, it regularly reassesses the methodology for global allocation. In developing and approving the latest six-year strategy, the Board did consider the implications of changing the scope of investments but the trade-offs in terms of loss of attention and investment were measured in lives lost. Nevertheless, these concerns remained amongst stakeholders consulted in this study.

“The epidemiology suggests that there should be more money for TB than HIV, and there’s no other money. It’s not like there’s another PEPFAR for TB.” (Global KI)

Secondly, global KIs contend that the allocations do not align with the financial needs at the country level. The allocations to countries within the GHIs are deemed unsatisfactory because they do not take into account the specific needs and financial capacities of each country, nor do they address existing gaps. Consequently, high-burden countries such as India receive large allocations even if they may not necessarily require significant support. This observation highlights the need for a more tailored and needs-based approach to funding allocations within the GHIs.

“India doesn’t need the money, but we know that we need their numbers. We cannot claim their numbers if we don’t give them money. So those are the issues that come first ... the big countries are getting massive amounts of money.” (Global KI)

The classification of spending as supporting RSSH was also questioned by global KIs, who claim that what is counted as RSSH and what is seen as disease-specific does not follow a clear logic. There has been ongoing debate and lack of clarity around how much money spent by GFATM and GAVI can be classified as actually strengthening the health system in a sustainable way (112). Various attempts to classify expenditure have been made that have ranged from 27% to 7% (99,102). The most recent study suggested that the amount allocated to RSSH by the GFATM was much lower than estimated by the GFATM itself - more likely in the region of 7% of the portfolio (99). Wherever this disputed figure lies, it is clearly problematic that a true figure has not been developed in a robust fashion over time. This is a further point that feeds into the debate around whether GHIs are effective actors for HSS, with the general consensus being that their investments in this area are more supporting programmes than strengthening systems (92).

4.5.1.5

Questionable results metrics

While the GHIs are recognised to have made substantial contributions to the results chain for their focal areas, many global KIs and the literature (113) (114) (98) reported that some of them over-claim results, especially ‘lives saved’. Specifically, they are perceived to claim credit for the entire outcome of broader investments, which encompassed contributions from LMIC governments and from other funders. In some cases, reported results have been primarily based on modelling, rather than comprehensive evaluations.

“They get the receipts [for inputs], but they don’t really know what they are producing.” (Global KI)

The GFF has moved away from this model and reports on assessed contribution to national/country results, with a clear line of sight to the nature and value add of the GFF contributions,

which makes their reported results less questioned by KIs. However, this was mentioned by some KIs as having weakened their case for impact in comparison to some other GHI claims. This shows the pressure that GHIs are under to compete and 'out claim' one another in order to attract or maintain funding.

4.5.1.6 Private sector engagement concerns

Private sector KIs reported that they were often engaged late in R&D conversations, and that they would like the market-shaping GHIs to address some structural factors, like regulatory barriers at country level and the need for simpler regional approaches.

4.5.1.7 Concerns about conflicts of interest

In the literature as well as among global-level KIs (especially CSOs and academics), a different set of concerns were identified regarding the role of "*philanthrocapitalism*" (115, 116), use of for-profit consulting firms (117), and the pharmaceutical sector's influence on GHIs.

4.5.2 Country level

A number of challenges were highlighted in relation to country health systems. Note that these are not exclusive to GHIs and may affect or be features of wider DAH in varying degrees. However, our focus here is on the GHI contribution to these issues, without neglecting the importance of the wider ecosystem. It is also important to note that these issues do not apply equally to all GHIs; with GFATM and to a lesser extent Gavi being talked about most in this context given their prominence within countries. The GFF is working more through government systems, which may lessen the relevance of some of these points to their operation.

4.5.2.1 Distortion of national priorities

Some GHIs are focussed on national priorities, but a long-standing concern with those that focus on specific disease areas relating to the distortion of funding nationally, with allocations not matched to national health priorities, as articulated in national strategies and essential packages of health care (118) (119). Some countries are good at using resources for other areas, so local and national leadership does also play a role here. In the South African case study (Appendix 9), one relatively well-resourced province was cited as having made effective use of GFATM resources for broader purposes thereby providing an example of how countries can leverage funding to address broader disease and health system priorities. However, GHI priorities can feel imposed by some countries, which have to adapt their own plans and approaches to access funds:

"Targets are seen as donor-driven rather than based on Burden of Disease analysis, with funding in areas of donor interest and with no consideration of the country's economic context or circumstances." (Pakistan case study KI).

"It was Mozambique - something like 80% of the health budget is for HIV. Once you get to that level, you've lost your way." (Global KI)

4.5.2.2 Country governance and ownership issues

Governance challenges were highlighted in the case studies - for example, in Senegal, where the presence of multiple governance structures across GHIs is problematic and generates high transaction costs and risks of uncoordinated initiatives for the government (120) (see

case study Appendix 10). Each GHI has its own operating methods, procedures, contacts and coordinating bodies. In Senegal, for example, the CCM is the coordinating body for the Global fund, while the Srmena platform is that of the GFF. There is an HSS platform within the Ministry of Health (MoH), established with GFATM support to help coordination, however, it is not working as intended, due to challenges in uniting the stakeholders and a lack of leadership for effective coordination.

In the case of the GFATM's CCM, some concerns regarding its current make-up and operations were raised, as it is typically representative of specific interest groups, more aligned to the three diseases. It was felt that this may undermine the quality of other elements of the proposals, e.g. CCMs which lack the technical expertise needed to develop strong HSS proposals.

Other concerns relate to the possible blurring of roles and responsibilities and potential conflicts of interest. For example, in South Africa, the South African National AIDS Council (SANAC) runs the CCM but is also a recipient of GFATM money and implements programmes within health facilities. The Secretariat for SANAC is also the Secretariat of the GFATM (South Africa case study, Appendix 9). There is however strong CSO representation and SANAC is co-chaired by the country's deputy President.

Several country KIs emphasised that the GHIs suffer from excessive centralization, being primarily based in Northern capital cities with limited or no physical presence in the countries they serve. The GFF benefits from its ability to collaborate with World Bank offices when feasible, but none of the GHIs operates their own country offices. While this approach is acknowledged for its resource-saving potential and was initially intended to promote local governance and ownership, it hinders the GHIs from adopting an embedded approach and gaining a better understanding of the context, which is crucial for effectively supporting the achievement of UHC. According to several country-level KIs, the power balance tilts too heavily in favour of GHIs rather than LMICs.

"The power lies with the GHIs, the final words come from them and the countries follow their guidelines religiously." (EMRO consultation KI)

Lack of country ownership is a commonly raised point (by both country- and global-level KIs). For example, for the grant-giving GHIs, grant proposals are often written by external consultants, which means that they may not be well embedded in local contexts. GHIs claim to adhere to national plans, yet the prevailing local perspective is that they wield all the decision-making power. This also creates missed opportunities to build and leverage in-country expertise.

"The government or NGOs don't have any power, they just follow what the donors want. If the global donors are investing in nutrition, and you suddenly see so many experts on nutrition, and now the donors are spending money on NCD, you will see so many specialists on NCDs. There is a very big imbalance. and the decisions are mostly made by those people who have no real ground experience." (SEARO consultation KI)

This can be a dance with two sides: governments lack capacity and GHIs fill the gap, writing unrealistic plans and targets, which are then poorly executed due to local capacity issues.

"The government is meant to set targets but GHIs set priorities because the government is unable to define priorities. The country is thus pushed to achieve targets set elsewhere with the local context (e.g. economic climate, available resources, burden of disease, political realities) are ignored. This is because of very limited state capacities that is reflected in a weak national programme, a Health Department with no vision or capacity, the absence of a public health approach, (realistic) health financing strategy or medium-term (five-year) and long-term (15-20 year) plans." (Pakistan case study KI)

According to South African KIs, GHIs and larger donors often by-pass government and provide direct funding to NGOs, CSOs, Parliament and higher education institutions, undermining control and overview of central institutions such as the Department of Health and Treasury. Reportedly, approximately half of the GFATM funds are allocated to government recipients,

but even among those, a significant portion remains off-budget. (18) (121). In pursuit of their goal to channel 55% of funding through government systems by the end of 2021, Gavi has made strides in increasing the share. However, as of 2021, only 41% of the funding had been successfully directed through these systems. Whilst there is an understanding that there will be a proportion of funds that go directly to in-country entities, government officials reported the importance of being able to account for all funds within the health system. This knowledge also enables them to better manage or understand how funds are being used to address key priorities, and this creates opportunities for them to provide input into how funds can be better spent towards achieving national goals. Other raised concerns that reports are sent to 'Geneva' or to GHIs funders or stakeholders, but not necessarily to the local policy-makers responsible for delivering health services (consultative meeting KI). Multiple KIs urged for better country engagement and transparency regarding funding to enable a collaborative action plan.

"From a country perspective, I would give them 4/10 for improving health outcomes; 2/10 for improving the health system capacity, 1/10 for graduating from dependence on international finance, and 0/10 for ownership by the government and supporting their policies." (Global KI)

4.5.2.3 **Need to better track public financing to monitor displacement effects**

KIs highlighted the need to track overall spending on health, including by the government, to monitor displacement effects of funding. It was reported that some GHIs such as GFF are trying to support this process.

"There's enough evidence globally to show that when GHIs put money into the health system and vertical programmes, that money is redirected to other projects, including infrastructure development. If GHIs don't look at the health budget and there is no attempt to look at the medium-term expenditure framework for health, it's actually hurting the country." (SEARO consultation KI)

Fungibility is rational, but donor and GHI allocations should be based on realistic bottom-up costing and identification of funding gaps, allowing for differential absorptive capacity and execution rates.

"The fungibility is real...And it's just rational resource allocation in the face of constraints. With COVID-19, once we sell something as a global public good, there's an inherent market failure where countries are like: this is the global public good; why should we put money into HIV when we know this is a global priority?" (Global KI)

4.5.2.4 **Lack of success in building national and local health system capacity**

A major concern raised by KIs is that despite considerable funding (not just from GHIs, but also the wider global health system), there are very few examples of countries where national capacity to lead has been growing over the past two decades. Generally, results have been short-term with little evidence of 'system strengthening'. Fragmentation and duplication of activities among GHIs was noted to be a major challenge among KIs and in the literature (122), (123–127).

According to KIs, the larger GHIs tend to adopt a project-based approach due to their established procedures and grant cycles. For instance, initiatives like active case finding of presumptive TB cases and referrals are often executed intensely as short-term campaigns, incentivizing volunteers to conduct door-to-door activities. However, this approach is not integrated into their routine work and lacks sustainability. While these project-based efforts may prove effective within their designated areas and timeframes, they typically conclude when the project ends, and their impact is not extended beyond the project area. Additionally, these projects can be demanding and divert the attention of staff and healthcare workers

from their regular responsibilities. Moreover, they may use higher rates than MoH ones, for example, for daily allowances and transportation expenses.

Some of the GHIs that do not work through government systems are seen as not adhering to the 'do no harm' principle. They create parallel systems, such as bank accounts and management units which contribute to system weakening. It is important to note that this does not apply to GFF, which operates differently. However, GFATM, due its stringent accounting requirements, often faces challenges in working through government structures.

"The Global Fund model and the Gavi models are interesting. They say they are not going to establish their own in-country presence, but what they've done is create their own in-country institutional monsters in some respects. We have the ministries of AIDS, right?" (Global KI)

This also applies at lower levels of the system where, for example, district managers may not have control over activities in their area.

"In Ghana, in talking to district managers, they were so frustrated because these donors were coming in, running their funding off budget and basically bypassing them... The district managers have very little power in how these resources are allocated, but they're held accountable for delivering within their districts. It's crazy, right? And there's so much frustration at that level. I think from a governance side they should be very transparent." (Global KI)

As highlighted by KIs and in the literature (128,125,127,129,130), disease siloes can distort and weaken local health systems, with staff paid at different rates, also with varied types of per diem payments, for example, leading to internal brain drain and deviation from core tasks, while siloed funding for equipment, supplies and information systems undermines integrated delivery of care (131).

"In one country it was reported that funded in-country partners drive long distances to administer one dose of vaccine, whereas had the funders and partners worked together they could have integrated their efforts. Further, not vaccinating parents against COVID when providing vaccines to children was another cited example of missed opportunities, inefficiencies." (Southern African consultation KI)

Due to some of the features described, HSS funding is not perceived as effective. Instead, it is often directed towards vaccine delivery systems at Gavi or inputs like training within GFATM, which do not necessarily fall under the category of true HSS.

"They create multiple information systems – for example, EPI [Expanded Programme of Immunisation] tracking for Gavi, HIV for PEPFAR. All say that they invest in DHIS2 but that is in addition to their information systems, not instead of. They still rely on household surveys and do many of them." (Global KI)

The quality of HSS proposals was also questioned, as they are reportedly led by individuals lacking a good understanding of HSS and for whom disbursement is a key incentive.

There are also some unintended negative effects on local production and procurement capacity, though purchasing of LMIC vaccines is growing (according to a Gavi KI) and Gavi is supporting local manufacturers where feasible. In relation to product development and production, a lack of capacity-building at local level was also noted during interviews with global KIs.

Part of the challenge relates to the timeframe and institutional incentives: building capacity takes longer and is harder to measure.

"[GHIs are] top-down, selective, short-termist, and kind of have a bias towards delivering things that can be measured. In a neglect of important things that need to be improved or strengthened. But which can't necessarily be measured in a way these initiatives tend to want to measure things – which is by counting things." (Global KI)

“So health systems work is by nature difficult. Part of what it achieves is preventing more bad things from happening. That’s always difficult to gauge and assess” (Global KI)

4.5.2.5 Operating systems that reduce efficiency and effectiveness

Some of the operating systems of the funding GHIs are laborious and inefficient from a country perspective. For example, the GFATM and Gavi largely rely on input-based financing, which is bureaucratic, time-consuming, and not results-oriented. The input-based and centrally-planned modality lead to duplication of activities and huge waste on the ground in some cases.

In the Senegal case study, a KI expressed frustration over complex and cumbersome procedures (Appendix 10):

“Stakeholders spend a lot more time looking at how to comply with GFATM directives and how to avoid ineligible expenditure, than on achieving results in the field. The focus is much more on satisfying Geneva than the communities.”

In addition, the structure of funding applications does not align with government budgets, making it challenging to create a complementary relationship between the two and avoid duplication of funding.

“There’s no crosswalk to a government budget whatsoever, so even if you’re in a program, sitting in Pakistan, for example, you have your AIDS program budget that comes from the domestic government and then you have your AIDS program budget that’s off budget, that runs from the Global Fund, and you have overlapping line items. Basically, they’re just plugging holes in the system. There’s no conceptualization of complementarity.” (Global KI)

Pooling of funds at the national level is challenging, especially for the GFATM, and country-level KIs perceive the funds as inefficient, with too many ‘middle men’ before any funds reach the actual beneficiaries (Principal Recipients, Sub Recipients etc, for GFATM, for example).

The systems are primarily designed to prioritise minimising fiduciary risk, which is crucial for donors. However, it may not be inherently more important than addressing programme and system risks, such as the risk of failing to achieve progress, failing to strengthen programmes, or causing unintended harm. Enhancing effectiveness may involve increasing flexibility, even if it results in higher fiduciary risk. This aspect becomes particularly significant in FCAS, where the circumstances are dynamic and require adaptability. KIs point out that more work needs to be done on balancing the costs of different approaches and using more context-adapted measures.

“There is a problem with the financing flexibility. The Global Fund, for example, has very strict budget lines and in conflict settings, it does not allow us to adapt according to the current situation.” (EMRO consultation KI)

4.5.2.6 Lack of transparency and oversight; strain on management capacity

Currently, there are multiple parallel financing flows within countries, especially in the case of the GFATM, which frequently channels funds through UN agencies and large NGOs. The complexity and intricacy of these funding channels make it exceedingly challenging to track the allocation and utilisation of resources.

“There needs to be some connection, transparency because right now the house is not in order. Nobody knows who’s funding what, where, when and how.” (Global KI)

Consequently, this fragmented funding landscape leads to the proliferation of plans, funds, reporting mechanisms, and auditing processes. Such fragmentation not only contributes to inefficiency but also proves ineffective, overwhelming the capacity of the country to effectively manage these resources.

“Gavi has its immunisation financing, technical support and then polio has its polio transition. And GFF has its UHC alignment. And we’re just all pulling the same people to the same meetings. And the organisations themselves aren’t accountable for the fact we just distract and are selling our own products and justifying our own existence through these processes.” (Global KI)

Lack of transparency in GHI decision-making and evaluations was frequently highlighted as a concern for both donors and recipient countries (55, 56). While organisations like GFATM, for example, are recognised for their transparency in terms of spending (and sourcing), evaluations, and strategy, some GHIs are criticised for their lack of transparency (57). Some evaluations are not published or made available, thereby limiting their accountability to both donors and recipient countries (58).

4.5.2.7 Frustration with external, short-term technical assistance

The GHIs are criticised for over-reliance on external TA, which often includes short-term assignments (117), (132), (133), including for preparing grant applications. This reliance was seen as problematic due to a lack of embeddedness, capacity strengthening and coordination with national priorities.

“We’ll spend a lot of time in aeroplanes flying into the capital, spending 24 hours there, and then flying off to the next thing. We don’t even know where we are...” (Global KI)

4.5.2.8 Role deviation for others in the global health system

The GHIs, by holding a significant portion of global health resources, have had an impact on the role of other actors within countries. This has led to a transformation of the UN from primarily a normative entity to a supplier and subcontractor, heavily dependent on GHI funding. The Pakistan case study illustrates this phenomenon (Appendix 8). At the same time, NGOs have also experienced a shift from advocating for health issues to assuming supply roles in response to the influence of GHIs.

4.5.2.9 Corruption

Despite the focus on minimising fiduciary risks, there are concerns that the GHIs may inadvertently contribute to or escalate corruption risks. This concern stems from the use of multiple independent bank accounts and off-budget systems, which can create opportunities for financial irregularities. Periodic crises have been linked to poor accounting practices and inadequate tracking of fund usage. Concerns over corruption were also highlighted in the literature (134) (135) (136,137) (138). This issue is less relevant to the GFF, which works alongside the World Bank to strengthen the government’s capacity to guard against corruption.

4.5.2.10 Challenges with transitioning

Transition and co-financing for GHIs present significant challenges. Although there are rules in place to guide the transition from GHI support, KIs perceived them as vague and lacking clarity. The requirements for co-financing have also posed difficulties for countries as they have struggled to meet obligations.

“Global Fund hasn’t done very well with transition at all. And maybe the idea that you transition at a certain GNI point and then you fall off a cliff is not the best approach to that. Maybe transition starts from day one and you begin to build in a sustainability approach where you gradually take on certain elements of the core package and then you’re supported to work to expand that in terms of reach, quality, coverage.” (Global KI)

An evaluation of Gavi's Eligibility and Transition and Co-Financing Policies stressed that whilst this is a cornerstone of Gavi's model, and the predictability and transparency were identified as strengths, the lack of flexibility has created a 'growing need for ad hoc exceptions' (139). The use of gross national income per capita was seen as a crude indicator for eligibility, with more attention needing to be paid to programme readiness, equity and other indicators, as well as the timeframe for transition (140).

In addition, across GHIs, the separate transition plans and different co-financing requirements are reported to lead to competition over scarce resources to meet these targets, instead of looking for efficiencies and synergies across the system. Some matching grants from GFATM also require governments to show funding for specific programmes and groups, which is not necessarily possible with government reporting systems (South Africa case study).

More broadly, domestic revenue generation trends over the period since the start of the GHIs do not support the idea that countries will be able to transition successfully, especially for a large group of LMICs (27). In the case of Gavi, the countries next approaching transition may find it harder to sustainably move into the self-financing phase. Some further argue that the GHIs are not the right vehicle to encourage increased domestic resource mobilisation (DRM) and also that DAH given in the form of grants is likely to be disincentivising or limiting domestic health financing, at least in some contexts (92).

"There are very few countries where the international community pays for a majority of health spending. Trying to increase both the government investment and the structure of the national financing so that it is progressive and not regressive. That is hard policy work and political work at the national level, right? It's not just persuading the President or the Finance Minister, it's often changing entire societal norms about: who's responsible for health, who pays for health, how important is health as a value, what kind of solidarity do we have within a country. It's really hard, long-term work." (Global KI)

There is also an argument made by some KIs that the GHIs, in their focus on reaching target populations, have set up models that are not cost-effective or sustainable – for example, preferring campaigns and Health Days for EPI, rather than strengthening routine PHC services, including vaccination. KIs cited concerns that countries are encouraged to take on costs by GHIs that they cannot sustain. A lack of publicly available data tracking the costs of different programmes means that evidence to support or dispute these concerns is usually lacking.

"Take a product that is not affordable given the physical reality of the country right now. And you incentivize them to introduce it and you say over the next 3, 4, 5 years they will exit and you'll have to continue to pay for it." (Global KI)

In addition, there are challenges relating to transitioning services for groups that are not always legally recognised by the government.

Finally, the fact that GHIs primarily fund inputs, rather than improving the way the system actually works, means that there is continuing dependence.

"We've done really well over 20 years in bringing down the incidence rate of HIV, saving people from dying of HIV with TB and malaria as well. But of course as soon as the money dries up, that all starts to disappear, all those gains, and that's what we saw over COVID, right?" (Global KI)

Summary of the strengths and challenges of the GHIs

Table 3 provides an overview of the strengths and weaknesses of the GHIs, as highlighted in the study. These form the basis for the recommendations described in the next section, which aim to strengthen the global health system as a whole, reducing the gaps in support to countries, the high costs and unintended systemic effects and the collective failure to build national capacity.

Table 3 Summary of main strengths and challenges of GHIs

Strengths	Challenges
Contributions to health outcomes	Partial focus; distortive of local priorities Lack of credibility of metrics used for measuring outcomes and claimed contribution Gap in ecosystem relating to NCDs
Innovative financing for global health	Mostly public funds raised globally, with limited from private sources
Fund mobilisation, including for global public goods	Same old donors; not mobilising from new sources
Market shaping	Some concerns over how the GHIs set their priorities in market shaping
Pooled procurement and supply chain	Risk of undermining local production and procurement chains
Ensuring access to vaccines and other technologies	Direct supply of vaccines undermines local producers Undermining domestic government funding of vaccines by purchasing instead of subsidising for countries with resources
Efficient (small Secretariat; no country offices etc)	Growing GHI secretariats Removed from country contexts Operating systems that impose high transaction costs, especially on country governments
More inclusive governance	Boards 'balanced' so power sits elsewhere; very centralised model vis-a-vis countries; accountability up not down Lack of country ownership Poorly functioning CCMs in some countries
'Safe pair of hands' (audit, focus on fiduciary risks)	Not focusing on programme risks; operating systems are input-based and inflexible; not integrated at country level; not sustainable and accountable to LMICs
Adaptability	Expansion of mandate without considering comparative advantage of all actors
Reaching vulnerable groups and key populations	At high cost; unsustainable delivery strategies
Some progress on alignment	Very limited (with the exception of the GFF); mainly driven by GHIs' own objectives, especially getting money spent and attribution of focal results
Catalytic funding role for some of the GHIs	Often funding recurrent costs, creating dependency Struggle to support countries to transition
Support to information systems at country level	Health system investments are not well classified or their effectiveness measured Damaging effects on local health systems with vertical approach Contributing to fragmentation of health systems and service delivery Failure to build national systems and their capacity to manage current and future challenges



_____ 5

Understanding the political
economy of the GHI landscape



5 Understanding the political economy of the GHI landscape

The structures and dynamics of GHIs within the global health system described in the previous section need to be understood through a political economy lens (3–7) (Appendix 1). This allows an appreciation of the position and power of different actors who are involved, how GHIs fit within the broader system and the perspectives on change of different actors. These issues apply at both global and country levels, but power and interests are distributed differently at these two levels. We deal with each in turn below, and identify many institutional and structural disincentives for change in the way that system currently operates.

5.1 Global level

Interrelationships between actors in the global health system are becoming increasingly intricate, with some GHIs as central players (10). As noted in the previous section, there can be competition between actors for funds, as well as moves towards greater alignment.

Key stakeholders at global level are:

- **Donor agencies**, which constitute the main funders of the GHIs: (bilateral, multilateral and private foundations).
- **GHIs**, which are instrumental in creating and responding to specific agendas by mobilising funding and collective action. Within the GHIs themselves, it is useful to distinguish several potential loci of power and influence. The Boards (see Appendix 4) are the official mechanism of governance, but other parts of the organisations such as the Secretariats or technical teams can also be important actors. In the case of the GFATM, there are other bodies which act independently, such as the Office of the Inspector General and the Technical Review Panel and Technical Evaluation Reference Group, which has since been replaced by the Independent Evaluation Panel (IEP)(141).
- **Political and interest groups**, which exert pressure on donor governments and GHIs (lobby and campaigning groups, international NGOs, transnational corporations).
- **Multilateral agencies** (WHO, other UN agencies, World Bank) and regional development banks, which work in the same field as the GHIs, often have country presence, and can act as collaborators or competitors.
- **Recipients of GHI funding at global level** include universities, international NGOs and private sector (e.g. consultancy, pharmaceutical). Many actors are keen to continue to receive funding from GHIs.

The types of power and influence wielded depends on the scope of the actor, which is summarised here with reference to broad categories (acknowledging that there are nuances within each). The funders of GHIs were identified as the most powerful actors in the analysis, with the Boards as the principal mechanism through which they can wield that power.

Bilateral donors of the GHIs have diverse focal areas but tend to function in accordance with their own interests and values. This means that donor coordination and alignment can be weak. They are each accountable for their tax-payer-funded investments, hence they seek reassurance on fiduciary risks, as well as measurable impact. This also makes them attentive to the views of interest groups within their own countries (see below). DAH departments within HIC governments are required to be accountable to the wider foreign and economic policies and objectives of the country, and this creates additional layers of tensions and compromises for a purely health agenda. Some bilaterals favour disease-specific investments, while there is a group which is more system-oriented. However, they too benefit from the GHIs as an

efficient (for them) vehicle for aid spending. Foundations may have other interests, including using the GHIs as vehicles for projection of influence.

Within the GHIs, senior leadership was seen as highly influential, not least because of the challenges noted for Boards. At global level, technical power also sits with the GHI Secretariats, and especially the country portfolio managers (more so than technical advisory staff), who are in charge of fund disbursement. Fund disbursement is a key indicator of performance in some of the country-facing GHIs.

It is worth noting how several KIs mentioned what they interpreted as powerful and vocal interests grouped around the GHIs at global level, which have strong interests in shaping the narrative about the strengths and successes of GHI activities and have the resources to do this. This is in contrast to more critical voices at country level and globally, which are not able to project with such power. As was highlighted in the findings section, some Board members also feel less enabled to speak out in the face of these power differentials.

The World Bank was seen by KIs as potentially an important and powerful actor but one that was less engaged with the GHIs at global level and overall less active in the health sector than it could be. Many stakeholders felt that the World Bank could and should play a much larger role, given its holistic view of the health system, its use of public financing channels and its strong analytical capacity. However, its non-concessional and concessional finance comes at less attractive terms for governments, given the relatively generous amount of grant aid available for health (see earlier section).

Finally, elements of civil society have vested interests in supporting the growth of GHIs because they are recipients of funding via these actors. Other elements, notably the single interest lobby groups that campaign on certain health targets are highly influential by mobilising public opinion amongst voters and taxpayers internationally. They can effectively bring pressure upon bilateral donors about how DAH budgets are allocated. There are few incentives within any of the actors to maximise collaboration.

While reforming existing institutions is challenging, establishing new ones appears to be an easier route to address new global challenges. Hence proliferation and fragmentation are perpetuated, impacting on recipient countries. Over the past few years, for example, several new funds have been created, some even during the short period of this consultation (see box 2). The relevance, functioning and unintended consequences of these new funds, largely supported by the same bilateral donors, UN agencies and foundations, need to be evaluated. They add a new layer of complexity and fragmentation to the global health architecture.

- Established in 2019, the Hepatitis Fund (EndHep2030) is a collaboration between WHO, the ZeShan Foundation and the US Centers for Disease Control and Prevention to provide catalytic funding to eliminate viral hepatitis with a 'limited lifespan' of 25 years (142). A resource mobilisation conference in May 2023 aimed to raise \$150 million but fell short of this target (143)(144).
- Established in May 2021, the Health4Life Fund, which is a partnership between UNDP, UNICEF and WHO, catalyses action for NCDs and mental health and aims to mobilise and invest US\$ 250 million over five years(145).
- In November 2022, the Pandemic Fund was launched. It is hosted by the World Bank and has so far raised over \$1.6 billion USD(146)(147).
- In April 2023, the Global Oxygen Alliance was formed after a joint response from GFATM and Unitaid to provide medical oxygen during the COVID-19 pandemic. It has raised more than US\$1 billion to 'boost access to medical oxygen, including financing to expand production, lower the price of oxygen and provide technical support to governments'. It comprises Unitaid, GFATM, PAHO, Africa CDC, WHO, and UNICEF (148).

Most recently, in June 2023, WHO announced a partnership with three regional multilateral development banks (Africa, Europe, Islamic) for an investment platform for PHC. This 'Health Impact Investment Platform' is aiming to catalyse wider PHC investments in support of LMIC government health strategies (149).

5.2 Country level

At the country level, some GHIs wield considerable power, depending on the approach of their engagement. GFATM and Gavi are important funders to governments, NGOs and civil society. A comparison of WHO's Global Health Expenditure Database (April 2023 update) (21) and OECD Creditor Reporting System (18) data, Gavi and GFATM gross disbursements accounted for a larger combined budget than domestic government funding in seven sub-Saharan African countries¹¹ in 2020, giving these two institutions considerable influence. GFATM and Gavi may work through a variety of channels at country level but they may not always pay adequate attention to devolved power and they sometimes empower particular actors or programmes that become advocates for them (see country case studies- appendices 8-10).

There are also imbalances within government, in that funds go disproportionately to some programmes (HIV, AIDS, malaria), which creates inequities and also vested interests amongst some departments. For instance, in Mozambique, 80% of the funding received is for HIV, which creates a set of vested interests at this level out of balance with the rest of the health system, and little incentive for these beneficiaries to support a more integrated system. The ability to gain such disproportionate benefits from GHI funding, including as a result of the opaque mapping of funding to public expenditure, creates pockets of strong resistance to reforming the GHIs as they are currently functioning at country level.

Those who are more critical of GHIs may not be able to project these criticisms very successfully; and may also fear the loss of resources or prestige that may come with being seen as being critical of these powerful actors.

¹¹ Central African Republic, Democratic Republic of the Congo, Eritrea, Guinea, South Sudan, Uganda, Zimbabwe

Unitaid, FIND and CEPI are also important funders in the field of R&D in some countries but this is less widespread. GFF channels its money through government systems, based on a model of leveraged finance, which reduces its scope to act as an independent entity in-country and increases its alignment to broader government agendas.

WHO was often described by KIs as weaker in a partner coordination role than desirable, absent from some of the roles perceived to be important parts of its function, and not managing to support UHC effectively (150). There are also potential conflicts of interests and inefficiencies as WHO applies to GHIs for funding from country portfolios, and often assumes the role of a supplier of both TA and services in the presence of a weak government system –government systems remain weak and passive with funding flow tilted to UN agencies within the country. Like all large organisations, WHO has divergent positions and interests internally, and global KIs report that its disease programmes are more aligned to the way of working of the GHIs than other parts of the organisation which focus on integration. Indeed, some of the fragmentation in global health is linked to WHO programme demands (e.g. for separate disease plans, rather than integrated ones at the country level) and a large staff of consultants supported by GHI country funding. At the country level, some UN agencies and large NGOs are reliant on GHIs for “*soft-funding*” to pay key members of staff on their programmes.

The World Bank is a lead player in several countries, providing its finance and convening power to bring bilateral and GHIs together for investment on specific country priorities. The provision of soft loan rather than grant in aid is considered to be less attractive for governments, however. In some countries, such as Pakistan, there has been pooled investment from GFATM, Gavi, GFF and bilaterals coordinated by the World Bank - in this case, for a national primary healthcare initiative linked to UHC, using disbursement-linked indicators.

Finally, in countries it is important to flag the issue of “*technical assistance*”. Domestically there can be a revolving door of key, knowledgeable and highly skilled individuals between government, NGOs, GHIs and independent advisory work. They can themselves influence changes given their own background and views. They can also represent an unfortunate brain drain out of central government roles. Internationally, there can be a plethora of TA both from the region and globally, often funded by GHIs or other partners, often with unclear terms of reference and possibly overlapping activities.

In conclusion, due to the way that GHIs create fragmented yet powerful interest groups both internally and at country level, the political economy can reflect stasis and inertia in relation to reforms. Reflecting on the lessons that KIs and literature highlighted in relation to previous efforts at coordination and alignment, it is clear that individuals and organisations follow their own incentives, which need to be altered for behaviour change to follow. Voluntarist approaches which do not change rewards and sanctions are unlikely to gain traction (see Appendix 12 on previous alignment and coordination attempts). One of the key elements which would need to be addressed to set GHI incentives on a more UHC-supporting course would include funders and recipient governments coalescing around performance metrics for the GHIs which emphasise longer term gains, with more focus on system performance rather than disbursement (possibly spending less money but spending it better).



_____ **6**

Vision and principles for changes



6 Vision and principles for changes

In this section, the research team presents a draft vision and recommendations for addressing the challenges identified in the GHIs and the landscape. These were developed based on the findings, giving special weight to country perspectives, and have been refined after consultative meetings (see Appendix 11). They will feed into the FGHI Steering Group deliberations, which will adopt and further develop recommendations.

6.1 Vision statement for GHIs and global health actors

The vision (Box 3), developed based on the study findings, focuses on the role of the GHIs within a wider global health system which is supporting countries to progress towards UHC. It posits that their success should be measured through their contribution to country-led UHC that is sustained over time.

Box 3

Vision statement

A global health system where all actors, including GHIs, contribute effectively to the achievement of country-led UHC and hence equitable population health and wellbeing. This means that all actors, including GHIs, plan, fund, evaluate and account for their funds and programmes to national governments in a coherent and integrated way, working in synergy with other global health actors and based on their comparative advantage, countries' priorities and needs, and the imperative to build country capacity to sustain UHC (including PHC) through strong and resilient health systems.

In terms of roles, this vision implies that:

- implementing countries take increasing responsibility for essential, cost-effective interventions as and when they have the capacity and finance to do so;
- GHIs support countries in this effort, embedding sustainability, supporting affordable commodities, and setting clear trajectories towards transition; and
- donors shift accountability for delivery more to countries, demonstrating a higher risk appetite and accepting broader PHC and UHC results.

6.2 Principles underlying changes

Linking to the vision, we propose that all changes to GHIs are founded on some core principles, including the following. These need to be reflected not just in organisational policies but also in the way that GHIs operate on a daily basis.

1. That GHIs should be accountable to countries, led by the countries' UHC needs (as expressed in national strategies) and able to respond to diverse needs across countries and regions
2. That GHIs are responsible for considering systemic effects when investing in specific service areas, and should do no harm to the wider health system

3. That GHIs support should strengthen integrated delivery of services, based on a strong PHC foundation
4. That GHIs support should be adaptive to dynamic (and unpredictable) environments, providing flexible support to build learning health systems
5. That GHIs should support equitable UHC delivery, aiming to reduce inequities and leave no-one behind
6. That GHIs should be evaluated through their contribution to increasing countries' capacity to progress towards UHC, such that transition from GHI support can be successful and sustained
7. That GHIs should focus on their comparative advantage areas within the global health architecture, including in global public goods, and when there is duplication in roles or functions between different actors, these should be shifted or merged



7

Recommendations for strengthening the GHI ecosystem



7 Recommendations for strengthening the GHI ecosystem

The recommendations of the team flow from the following summarised findings of this report:

- There is a recognition of strong achievements by the GHIs in specific areas by most experts (at global and country levels), which should be safeguarded
- There is also recognition that the GHIs' support to countries is not optimal at present, and there are significant transaction costs for countries, unintended negative effects and inefficiencies generated by their current operating approach, as well as limited sustainability
- From a country perspective, the Paris Aid Effectiveness principles (151) remain valid and have not been fully respected by the majority of funders and GHIs; all reforms should be tending towards greater compliance with them
- The changes in global health landscape and population health needs expected over the next 20 years also drive the need for adaptations, particularly in relation to emerging burdens of disease which the current GHIs are not addressing and constrained financing
- There is no consensus on approaches to change; all changes have costs and benefits; vested interests and positionality of actors are an important consideration in management of change; previous reform efforts focused on coordination have not borne much fruit as they failed to change fundamental incentives
- GHIs are operating in a complex wider web of actors, who contribute to challenges as well as successes; many of the problems highlighted in the study also relate to the wider actors, however, the focus here on GHIs is driven by the fact that they are newer creations in the global health architecture and have gained major influence over the years and could potentially drive change
- LMIC countries are at varying levels of capacity to achieve UHC and a graduated and tailored approach to support is needed for every country; while some countries will transition from GHI support over the next 20 years, there will likely remain a group of low-income and conflict-affected countries which will continue to need grant support to meet basic health needs

7.1 Recommendations

The recommendations have been grouped under six main themes, albeit recognising linkages across them. The focus in changes to be introduced should be on changing the internal incentives to improve the effectiveness of the GHIs, taking a systemic perspective and aiming for a correct balance of roles and accountability vertically (between GHIs and countries/sub-national authorities) as well as horizontally (between GHIs themselves and other actors). Guiding progress towards UHC and HSS is primarily the responsibility of governments; however, the GHIs have a responsibility to support that through making their investments coherent with system strengthening.



1

Making a stronger contribution to UHC, including emerging disease burdens

In order to address gaps in coverage, especially for emerging disease burdens, including NCDs, but also for specific population groups, GHIs should move towards supporting integrated service delivery platforms and contributing to ensuring that services are routinely available for all, not just clients with a specific focal disease. A discussion amongst global actors will be needed to ensure that NCD policies addressing the social and commercial determinants of NCDs are adequately supported by the global health ecosystem as a whole.

Lead actors: GHI secretariats; MoH

- GHs should co-fund, with government and other donors, the essential health care service package or equivalent.
- GHIs - the GFATM in particular – should deploy expertise that has been developed in supporting management of chronic diseases, to support other areas of relevance locally:
 - For example, using the HIV approach for viral hepatitis or sexually transmitted infections, where these are prevalent; widening TB systems to include other chronic lung conditions, such as chronic obstructive pulmonary disease (COPD) and chronic asthma; adding acute care for febrile illnesses to malaria treatments).
 - The chronic care model, including for diabetes and hypertension, should be integrated within PHC. It should include community health systems and preventive/promotive approaches as relevant, including to address the common risk factors (tobacco use, harmful alcohol, unhealthy diet and lack of exercise).
 - In Gavi's case, vaccines may be added to prevent additional infectious diseases such as malaria and also address viral-induced cancers.
 - FIND can contribute by supporting the development of more point-of-care (or near point of care) rapid tests to ensure more rapid diagnosis (e.g. of pneumonia and other bacterial infections), with appropriate treatment and referral and efficient use of essential drugs.
- In support of this broader, more integrated approach led by local burden of disease and cost-effectiveness of interventions, the GFATM Secretariat should also revise its global resource allocation across disease areas and across countries, to ensure that funding is matched to epidemiological and financing needs, which key informants indicate is still not the case, despite recent reviews.

Lead actors: GHI Boards; other global health actors

- The GHI Boards, funders and other global health actors should review how best to support the adoption and implementation of appropriate policies to control and reduce the rising burden of NCDs (addressing their social and commercial determinants, such as the WHO 'Best Buys'). The focal GHIs such as the GFATM have some expertise to contribute from their engagement in multisectoral action against HIV/AIDS, but a full assessment of comparative advantage in this area, considering also other existing organisations, is needed.



2 Strengthening or at least doing no harm to health systems

GHIs' investments should all be designed to support national and sub-national health systems and to not undermine them, to contribute to building systems rather than programmes or projects.

Lead actors: GHI secretariats; MoH

- In relation to planning, GHIs should support integrated planning at country level, rather than requiring separate plans per disease area. Programme plans should be embedded in national sector strategies. This will require support from other global health actors too, such as WHO.
- In relation to governance, as a minimum, CCMs and equivalent mechanisms for other GHIs should be reviewed in each context to ensure that they are capable of effectively planning UHC investments. Global and local TORs and recruitment should be adapted as needed and board expertise in this area audited.
- More ambitiously, in contexts where government/DP health sector governance mechanisms are functional, the CCM functions could be transferred to the routine governance structures. This should be piloted in a few promising contexts before wider roll-out.
- In terms of financing, all funding should contribute to realistic and costed national plans, which are led by the MoH, with partner support for development as necessary.
- The GHIs should shift to longer grant periods (where this has not yet happened) - five years or more, which are better suited to achieving complex results. This requires an adaptation of funders' funding cycles.
- In terms of staffing, it is a priority for all GHIs (along with all other DPs) to use national pay scales for health staff and CHWs, working in coordination with the MoH.
- GHIs should use national health information systems for collecting data and reporting results, in order to invest in and reinforce national health information systems. However, the task of linking existing disease reporting systems into the main HMIS is complex, and will first need to be piloted in a few settings to avoid losing chronic disease outcome reporting.
- For supplies and medicines, Gavi and the GFATM should focus on investing in core functions, including overall procurement and supply chains.

Lead actors: GHI funders; GHI Boards; WHO

- To support a system strengthening approach, GHI funders should ensure that all GHIs have core performance metrics related to alignment with national systems and with each other, which should routinely be tracked by their Boards; this is currently the case with the GFF but not the other larger GHIs.
- GHIs should also agree, working with other actors and especially WHO, on common metrics for HSS and UHC and all should report on the same set of indicators, accepting that GHIs will only be able to claim a contribution to results. WHO should lead this discussion as it already has a system-wide mandate and focus. The work can build on the HSS evaluation international collaboration (152) , in which the GHIs participated.



3

Reducing costs for countries and increasing efficiency and effectiveness of GHI investments

GHI investments must be made more efficient and effective in order to contain account costs at country level, reduce duplication and waste and improve overall system efficiency, which is key to sustaining services in constrained times with growing needs.

Lead actors: GHI Secretariats; GHI funders

One set of recommendations here relate to reducing transaction costs and building capacity at country level by the larger GHIs:

- Harmonise timelines, application processes and disbursement calendars across the funds. This needs to be aligned with funding cycles so prior agreement with funders is needed.
- GHIs to support joint investments in shared core functions, such as the DHIS, drug procurement, and strengthening PFM systems.
- Where they are not funding through PFM system, GHIs should at least adopt a common disbursement process, rather than different financial management centres, to build national capacities and reduce complexity for countries.
- Merge Project Implementation Units, and where possible site them in the MoH.
- Conduct joint reports, audits, and missions. This requires changes to organisational rules, with funder buy-in, as well as the establishment of a cross-GHI working group to operationalise these points.

Others are more related to achieving better financial allocations and transparency:

- GFATM and Gavi should progressively increase the number of countries where their funds are on-budget, reporting this proportion to their Boards as a key performance indicator.
- They should ensure that funding applications are structured in an appropriate way to be able to map to and complement public budgets, working with the MoH budget departments.
- All GHIs should provide transparency on resources disbursed for government and local (e.g. district) health managers (reported against the public budget).
- A shift away from input-based financing is also desirable so that countries can manage their own processes, however, this will require gradual instruction and piloting. Programme based budgeting or existing output-based payment systems in country need to be sufficient to enable this to be done effectively.



4

Supporting country ownership, capacity building and charting a clear path to ending dependence on GHIs

While seeing the GHIs as important in the current landscape, there needs to be clarity on when they are expected to close, and how. This is primarily a responsibility of the GHI funders. Agreement in this area will provide an urgency to building country technical capacities and incentivising government take-over of financial responsibilities.

Lead actors: GHI funders; GHI Boards

- Convene a discussion on the exit strategy, distinguishing by GHI but also by function within them and by country readiness.
- Boards should ensure that the allocation criteria of support to countries take into account their ability to pay (deprioritising better-off countries and focussing on those with greater resource constraints).

Lead actors: GHI Secretariats; MoH; GHI funders

- GHIs should all report on progress and funding to relevant departments in each country, not just to their funders and Boards.
- GHI-funded TA should be commissioned and coordinated by a focal point in the MoH, based on agreed national priorities, and should prioritise local expertise (including language). This is already undertaken by some GHIs in relation to national plans but should be broadened to include all GHIs.
- GHIs should increasingly put their funding through governments as partners, except for very specific services that governments cannot deliver.
- The GFATM in particular should provide clearer rules on co-financing and transition as this was seen as very opaque at present, not providing clear incentives for countries to prepare.
- Strengthen working of GHI Boards to ensure effective participation and representation (e.g. meetings between GHI boards, more transparency, frequent changeovers in board seats etc.). This will require a deep-dive into barriers to effective participation, including access to information, opportunities to question the secretariat, feedback on decisions, ensuring that all implementing countries feel represented.

Lead actors: R&D GHIs

- The GHIs working more in the R&D area should increase collaboration with local partners working on R&D, production and regulatory systems, leveraging local manufacturing opportunities for specific products when appropriate. Streamlining regulatory systems will require engagement with regional actors.



5

Enforcing more effective alignment between GHIs and with wider actors

Beyond the reforms within individual GHIs and their relationships with governments, there is a need to ensure alignment across the group of GHIs and with wider actors so that overall effectiveness of the ecosystem is maximised.

Lead actors: GHI funders; GHI Boards

- There is a need for regular dialogue across Boards and between the formal meetings to ensure synergies, encourage partnerships across agencies at a strategic level on shared objectives, and agree on how best to achieve these objectives, with clear definition of roles between GHIs.
- A Joint Facilitation Council across the governing bodies of the GHIs is one option to consider to facilitate that dialogue.
- The development of a Joint monitoring and accountability framework for the GHIs could be a key product of this group.
- Funders should also ensure that GHI boards have metrics and mechanisms for shared accountability on collaboration and alignment across global health actors. This is already built into GFF to some extent and could be incorporated in GFATM and Gavi strategic plans, though potentially not before their next revision.
- In support of more harmonised and simplified support to countries, funders and Boards should align replenishment cycles and models across the GHIs.
- More frequent and in-depth independent evaluations of GHIs with a health system and overall service delivery focus would generate better evidence to support course correction of GHIs, including alignment across them.
- More generally, GHIs should invest in the relevant analytics to provide the evidence-base for what works well or does not and to fill data gaps highlighted in this report. There should be a wealth of experiential learning and lessons from the past 20 years to inform improvements in support and outcomes.

Lead actors: MoH; GHI secretariats

- At the country level, if coordination of GHIs is not integrated within routine sector governance, as highlighted above, an alternative would be to develop a single integrated governance structure across all GHIs at country level. This would require strong national leadership and would benefit from piloting in a few contexts showing willingness and capacity.



6

Limiting proliferation of GHIs; focusing on strengthening existing architecture

There has been a tendency to add new structures when challenges emerge, rather than strengthening or reforming existing platforms, which adds to overload at country level and potentially wastes resources. GHI funders and other global health partners should commit to curbing proliferation of GHIs and addressing duplication through streamlining of functions or organisations.

Lead actors: GHI funders

- Although challenging to achieve, an agreement by global health actors on strengthening existing structures rather than circumventing them with new ones would be very welcome at the country level.
- Selective structural reforms which would strengthen functioning should be appraised - for example, CEPI and Gavi already work closely on vaccines, equally Unitaid and GFATM work together on innovations, while GFATM and Gavi share many core functions, such as finance and audits. Where GHIs can integrate and pool functions, that should be pursued to streamline support to countries. A joint services model may be one approach to achieving this streamlining.

7.2 Change management

These recommendations require action by governments and funders in the first instance, to agree on core tenets of reforms. The next stage would be to look at their operationalisation, working closely with senior leadership of the GHIs and their secretariats, along with national MoH, other global health actors and CSO representatives. Resistance is anticipated; however, if funders align on a reform agenda, then operational rules (for example, audit rules which prohibit pooled funding at present for the GFATM) can be changed to enable more aligned working. The timeframe for this could be the next 1-3 years. A cross-GHI mechanism for follow up of the recommendations (as prioritised in the full FGHI process) will be an important component.

This will require funders to focus more on overall system performance metrics as their outcome measure (and managing performance risks), and give up some of their controls over fiduciary risks (unless there are specific circumstances which highlight the need for particular measures). One aspect that will be important to the reforms is accepting new ways of assessing contribution, rather than attempting to control inputs and processes so as to achieve attribution of results.

Many of the changes depend on government engagement and capacity to be successful, so piloting could be initiated in countries with higher levels of these, looking to introduce changes gradually as countries become ready. This is not necessarily linked to income level, as LICs have also shown strong leadership over their health system development in the past (Vietnam, Ethiopia and Rwanda are frequently cited as models). Investment needs to be customised to each country's capacity, with a stronger role for GHIs in fragile and humanitarian contexts and a differentiated role of GHIs in countries with strong leadership and domestic health financing.

Whether there is a window for change is hard to establish, but our consultations reveal the urgency of taking action, and this message will need to be conveyed to more political levels. The changing landscape, as highlighted, means that we cannot afford to continue in our current track. Better and more sustainable support is necessary. The MDG focus that informed the GHIs must give way to consideration of the SDG agenda and beyond. The consultations have revealed a variety of positions and it is clear that change is perceived as threatening for some of the actors, including some sections within the GHIs and some at country level who derive influence and resources from the current configuration. At the same time, the context is shifting, and continuing without adapting brings even more grave risks – the risk of redundancy and dwindling support. Many within the GHIs are critical of the current set-up and their knowledge and insights will be key to crafting future successful reforms.

These changes have to be a partnership between the secretariat of the GHIs, their Board, their funders, the wider set of global health actors and of course the countries (governments and civil society) that the GHIs were established to support. They require that all parties commit to changes – not just the senior management of the GHIs, though these are critical; but also the funders and foundations whose internal fragmentation of programming has contributed to the problem; and other partners, such as within the UN system, which have also reinforced a siloed, disease-programme-based approach; NGOs, which have benefited from expensive, parallel delivery systems; and national country leadership, parts of which have benefited from the fragmented and untransparent funding flows. They are all part of a complex system with inter-dependencies, which have not been the focus here but have become an important part of the landscape.

As with all changes, there will be losers as well as winners, but the prize would be to build a global health system that is more equitable, more effective and more efficient, where funds are channelled to areas of greatest need and least ability to fund (including in fragile states and humanitarian settings), where national responsibility for coordinating the prioritisation, funding and delivery of health services is respected, and where investments result in long term gain and sustainable capacity-building through integrated programming and elimination of waste.



8

Conclusion



8 Conclusion

This report represents the findings of a set of rapid consultations at country, regional and global level on the role of some key GHIs in contributing to the globally accepted goal of UHC.

There were no voices arguing that the status quo should be the way forward. There were arguments for radical change (abolition of GHIs in their current form), but these were minority views and less represented at county level. The majority view was for the GHIs to remain but undertake substantial changes that would make them more effective in supporting countries' capacity to deliver UHC – and all of its components – over the long term, including in the face of shocks and stressors. These reforms need to be shaped by clear transparency and accountability principles and performance metrics that change internal incentives away from disbursement of money to a common goal of achieving SDG3 and especially UHC. Without changing fundamental metrics, the problems noted here will continue.

The suggested changes would strengthen the ecosystem, as well as the effectiveness of individual GHIs (especially the GHIs that are providing funding and commodities directly to countries). The key changes involve:

- moving from disease-siloed to integrated delivery and care;
- providing support to health systems as whole, including integrated disease control, rather than with vertical (unintegrated) components within health systems;
- streamlining GHI systems (within and across GHIs) to make them more manageable and efficient at country level;
- charting a clearer course towards ending dependence on GHIs, though building country capacity while also providing clarity on transition;
- making alignment across GHIs into a core performance metric for them as well as for their funders;
- funders committing to strengthen existing architecture and reduce proliferation of GHIs.

Support to countries must be driven by country priorities, needs (financial as well as epidemiological and social) and performance, in a global partnership that results in stronger and more resilient health systems which produce sustainable UHC for all.

References

1. Wellcome (Internet). (cited 2023 Mar 19). Future of Global Health Initiatives process. Available from: <https://wellcome.org/what-we-do/our-work/future-global-health-initiatives-process>
2. Universal health coverage (UHC) (Internet). (cited 2023 Jul 5). Available from: [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))
3. Australian Government Department of Foreign Affairs and Trade (Internet). (cited 2023 Jul 8). Political Economy Analysis Guidance Note. Available from: <https://www.dfat.gov.au/about-us/publications/Pages/political-economy-analysis-guidance-note>
4. BEAM Exchange (Internet). (cited 2023 Jul 8). Political economy analysis how-to note. Available from: <https://beamexchange.org/resources/468/>
5. Harris D. Applied political economy analysis: a problem-driven framework. 2014 Jun 27 (cited 2023 Jul 8); Available from: <https://odi.org/en/publications/applied-political-economy-analysis-a-problem-driven-framework/>
6. Fritz V, Levy B, Ort R. Problem-Driven Political Economy Analysis: The World Bank's Experience (Internet). World Bank Publications; 2014. 266 p. Available from: <https://play.google.com/store/books/details?id=AyNwAgAAQBAJ>
7. Bertone MP, Wurie H, Samai M, Witter S. The bumpy trajectory of performance-based financing for healthcare in Sierra Leone: agency, structure and frames shaping the policy process. *Global Health* (Internet). 2018 Oct 20;14(1):99. Available from: <http://dx.doi.org/10.1186/s12992-018-0417-y>
8. Buse K, Hawkes S. Health in the sustainable development goals: ready for a paradigm shift? *Global Health* (Internet). 2015 Mar 21;11:13. Available from: <http://dx.doi.org/10.1186/s12992-015-0098-8>
9. Institute for Health Metrics and Evaluation (Internet). 2018 (cited 2023 Jul 8). Financing Global Health 2017: Funding universal health coverage and the unfinished HIV/AIDS agenda. Available from: <https://www.healthdata.org/policy-report/financing-global-health-2017>
10. Hoffman SJ, Cole CB. Defining the global health system and systematically mapping its network of actors. *Global Health* (Internet). 2018 Apr 17;14(1):38. Available from: <http://dx.doi.org/10.1186/s12992-018-0340-2>
11. Fergus CA. Power across the global health landscape: a network analysis of development assistance 1990-2015. *Health Policy Plan* (Internet). 2022 Jun 13;37(6):779–90. Available from: <http://dx.doi.org/10.1093/heapol/czac025>
12. Nishio A, Tata G, Nishio A, Tata G. Insights on proliferation and fragmentation to boost aid effectiveness during crises (Internet). World Bank Blogs. World Bank Group; 2022 (cited 2023 Jul 8). Available from: <https://blogs.worldbank.org/voices/insights-proliferation-and-fragmentation-boost-aid-effectiveness-during-crisis>
13. Institute for Health Metrics and Evaluation (Internet). (cited 2023 Jul 8). Financing global health. Available from: <https://vizhub.healthdata.org/fg/>
14. Smitham E. Center For Global Development | Ideas to Action. (cited 2023 Jul 27). Is the new Pandemic Fund where vertical can finally meet horizontal? Available from: <https://www.cgdev.org/blog/world-banks-new-pandemic-fund-where-vertical-can-finally-meet-horizontal>
15. Akihiko Nishio, Vice President, Development Finance, The World Bank. Insights on the Proliferation and Fragmentation of Aid in the Health Sector. 2023 Jun 29.
16. Sorensen BH, Masaki E, Panyanouvong T, Vongsonephet T, Thitsy S, Chamleunsab M, et al. Managing transitions : reaching the vulnerable while pursuing Universal Health Coverage (Vol. 2) (Internet). Washington, D.C. : World Bank Group.; 2017 Dec. Report No.: 121809. Available from: <http://documents.worldbank.org/curated/en/861981512149155081/health-financing-system-assessment-in-Lao-PDR>

17. Global Burden of Disease 2021 Health Financing Collaborator Network. Global investments in pandemic preparedness and COVID-19: development assistance and domestic spending on health between 1990 and 2026. *Lancet Glob Health* (Internet). 2023 Mar;11(3):e385–413. Available from: [http://dx.doi.org/10.1016/S2214-109X\(23\)00007-4](http://dx.doi.org/10.1016/S2214-109X(23)00007-4)
18. OECD. Creditor Reporting System (CRS) (Internet). (cited 2023 Jun 24). Available from: <https://stats.oecd.org/Index.aspx?DataSetCode=crs1>
19. Knox D. Development Initiatives. (cited 2023 Jul 12). Aid spent on health: ODA data on donors, sectors, recipients. Available from: <https://devinit.org/resources/aid-spent-health-oda-data-donors-sectors-recipients/>
20. Institute for Health Metrics and Evaluation (Internet). (cited 2023 Jun 24). Financing global health. Available from: <http://vizhub.healthdata.org/fgh/>
21. Global health expenditure database (Internet). (cited 2023 Jul 27). Available from: <https://apps.who.int/nha/database>
22. Global Burden of Disease 2020 Health Financing Collaborator Network. Tracking development assistance for health and for COVID-19: a review of development assistance, government, out-of-pocket, and other private spending on health for 204 countries and territories, 1990-2050. *Lancet* (Internet). 2021 Oct 9;398(10308):1317–43. Available from: [http://dx.doi.org/10.1016/S0140-6736\(21\)01258-7](http://dx.doi.org/10.1016/S0140-6736(21)01258-7)
23. Ifeagwu SC, Yang JC, Parkes-Ratanshi R, Brayne C. Health financing for universal health coverage in Sub-Saharan Africa: a systematic review. *Glob Health Res Policy* (Internet). 2021 Mar 1;6(1):8. Available from: <http://dx.doi.org/10.1186/s41256-021-00190-7>
24. Chu A, Kwon S, Cowley P. Health Financing Reforms for Moving towards Universal Health Coverage in the Western Pacific Region. *Health Syst Reform* (Internet). 2019;5(1):32–47. Available from: <http://dx.doi.org/10.1080/23288604.2018.1544029>
25. Bertone MP, Jowett M, Dale E, Witter S. Health financing in fragile and conflict-affected settings: What do we know, seven years on? *Soc Sci Med* (Internet). 2019 Jul;232:209–19. Available from: <http://dx.doi.org/10.1016/j.socscimed.2019.04.019>
26. Graves CM, Haakenstad A, Dieleman JL. Tracking development assistance for health to fragile states: 2005–2011. *Global Health* (Internet). 2015 Mar 19;11(1):12. Available from: <https://doi.org/10.1186/s12992-015-0097-9>
27. Chang AY, Cowling K, Micah AE, Chapin A, Chen CS, Ikilezi G, et al. Past, present, and future of global health financing: a review of development assistance, government, out-of-pocket, and other private spending on health for 195 countries, 1995–2050. *Lancet* (Internet). 2019 Jun 1 (cited 2023 Jul 9);393(10187):2233–60. Available from: <http://www.thelancet.com/article/S0140673619308414/abstract>
28. The Institute for Health Metrics and Evaluation (Internet). (cited 2023 Jul 27). Global Burden of Disease 2019 disease, injury, and impairment summaries. Available from: <https://www.healthdata.org/node/7849>
29. (Micah) AA, Dieleman J. The Institute for Health Metrics and Evaluation. (cited 2023 Jul 27). Financing Global Health 2021: Global health priorities in a time of change. Available from: <https://www.healthdata.org/research-analysis/library/financing-global-health-2021-global-health-priorities-time-change>
30. Voigt K, King NB. Out of Alignment? Limitations of the Global Burden of Disease in Assessing the Allocation of Global Health Aid. *Public Health Ethics* (Internet). 2017 Nov;10(3):244–56. Available from: <http://dx.doi.org/10.1093/phe/phx012>
31. Compare GBD, Hub IV. Vizhub. healthdata. org. 2021.
32. Hoffman SJ, Cole CB, Pearcey M. Research Paper (Internet). (cited 2023 Jul 12). Available from: https://www.chathamhouse.org/sites/default/files/field/field_document/20150120GlobalHealthArchitectureHoffmanColePearcey.pdf
33. English publisher. World Health Organization - Regional Office for the Eastern Mediterranean. (cited 2023 Jul 8). Global health initiatives. Available from: <https://www.emro.who.int/health-topics/global-health-initiative/index.html>

34. Institute for Health Metrics and Evaluation (Internet). 2023 (cited 2023 Jul 8). Global investments in pandemic preparedness and COVID-19: tracking development assistance and domestic spending on health between 1990 and 2026. Available from: <https://www.healthdata.org/research-article/global-investments-pandemic-preparedness-and-covid-19-tracking-development>
35. Savage M, Albala S, Seghers F, Kattel R, Liao C, Chaudron M, et al. Applying market shaping approaches to increase access to assistive technology in low- and middle-income countries. *Assist Technol* (Internet). 2021 Dec 1;33(sup1):124–35. Available from: <http://dx.doi.org/10.1080/10400435.2021.1991050>
36. Funding and Expenditure (December 2018) (Internet). CEPI; 2018 Dec. Report No.: 050319. Available from: https://cepi.net/wp-content/uploads/2019/03/050319-Funding-and-Expenditure-Final_V3.pdf
37. Agyepong I, Spicer N, Ooms G, Jahn A, Bärnighausen T, Beiersmann C, et al. Lancet Commission on synergies between universal health coverage, health security, and health promotion. *Lancet* (Internet). 2023 Jun 10;401(10392):1964–2012. Available from: [http://dx.doi.org/10.1016/S0140-6736\(22\)01930-4](http://dx.doi.org/10.1016/S0140-6736(22)01930-4)
38. Foreman KJ, Marquez N, Dolgert A, Fukutaki K, Fullman N, McGaughey M, et al. Forecasting life expectancy, years of life lost, and all-cause and cause-specific mortality for 250 causes of death: reference and alternative scenarios for 2016–40 for 195 countries and territories. *Lancet* (Internet). 2018;392(10159):2052–90. Available from: [https://www.thelancet.com/journals/lanchi/article/PIIS0140-6736\(18\)31694-5/fulltext](https://www.thelancet.com/journals/lanchi/article/PIIS0140-6736(18)31694-5/fulltext)
39. GBD 2019 Viewpoint Collaborators. Five insights from the Global Burden of Disease Study 2019. *Lancet* (Internet). 2020 Oct 17;396(10258):1135–59. Available from: [http://dx.doi.org/10.1016/S0140-6736\(20\)31404-5](http://dx.doi.org/10.1016/S0140-6736(20)31404-5)
40. O'Neill J, Others. Review on antimicrobial resistance: tackling drug-resistant infections globally: final report and recommendations. Review on antimicrobial resistance: tackling drug-resistant infections globally: final report and recommendations (Internet). 2016; Available from: <https://www.cabdirect.org/globalhealth/abstract/20163354200>
41. Kelly-Cirino CD, Nkengasong J, Kettler H, Tongio I, Gay-Andrieu F, Escadafal C, et al. Importance of diagnostics in epidemic and pandemic preparedness. *BMJ Glob Health* (Internet). 2019 Jan 29;4(Suppl 2):e001179. Available from: <http://dx.doi.org/10.1136/bmjgh-2018-001179>
42. Lee KK, Bing R, Kiang J, Bashir S, Spath N, Stelzle D, et al. Adverse health effects associated with household air pollution: a systematic review, meta-analysis, and burden estimation study. *Lancet Glob Health* (Internet). 2020 Nov;8(11):e1427–34. Available from: [http://dx.doi.org/10.1016/S2214-109X\(20\)30343-0](http://dx.doi.org/10.1016/S2214-109X(20)30343-0)
43. Boogaard H, Walker K, Cohen AJ. Air pollution: the emergence of a major global health risk factor. *Int Health* (Internet). 2019 Nov 13;11(6):417–21. Available from: <http://dx.doi.org/10.1093/inthealth/ihz078>
44. Jowett M, Dale E, Griekspoor A, Kabaniha G, Mataria A. Synthesis of evidence and policy recommendations: health financing policy and implementation in fragile and conflict-affected settings. Geneva: World Health.
45. Synthesis of evidence and policy recommendations: Health financing policy and implementation in fragile and conflict-affected settings (Internet). World Health Organization; 2020 (cited 2023 Jul 9). Available from: <https://www.who.int/publications/i/item/978-92-4-000351-4>
46. GBD 2019 Demographics Collaborators. Global age-sex-specific fertility, mortality, healthy life expectancy (HALE), and population estimates in 204 countries and territories, 1950-2019: a comprehensive demographic analysis for the Global Burden of Disease Study 2019. *Lancet* (Internet). 2020 Oct 17;396(10258):1160–203. Available from: [http://dx.doi.org/10.1016/S0140-6736\(20\)30977-6](http://dx.doi.org/10.1016/S0140-6736(20)30977-6)
47. Ezeh A, Kissling F, Singer P. Why sub-Saharan Africa might exceed its projected population size by 2100. *Lancet* (Internet). 2020 Oct 17;396(10258):1131–3. Available from: [http://dx.doi.org/10.1016/S0140-6736\(20\)31522-1](http://dx.doi.org/10.1016/S0140-6736(20)31522-1)
48. Kurjak A, Stanojevi M, Dudenhausen J. Why maternal mortality in the world remains tragedy in low-income countries and shame for high-income ones: will sustainable development goals (SDG) help? *J Perinat Med* (Internet). 2023 Feb 23;51(2):170–81. Available from: <http://dx.doi.org/10.1515/jpm-2022-0061>

49. Yuan H, Wang X, Gao L, Wang T, Liu B, Fang D, et al. Progress towards the Sustainable Development Goals has been slowed by indirect effects of the COVID-19 pandemic. *Communications Earth & Environment* (Internet). 2023 Jun 8 (cited 2023 Jul 27);4(1):1–13. Available from: <https://www.nature.com/articles/s43247-023-00846-x>
50. Health Organization W. Tracking universal health coverage: 2021 global monitoring report (Internet). (cited 2023 Jul 12). Available from: <https://apps.who.int/iris/bitstream/handle/10665/357607/9789240040618-eng.pdf>
51. A call to expand international debt relief for all developing countries to increase access to public resources for health care (Internet). (cited 2023 Jul 27). Available from: <https://apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2023/01/18/Expand-International-Debt-Relief>
52. Abubakar I. The future of migration, human populations, and global health in the Anthropocene. *Lancet* (Internet). 2020 Oct 17;396(10258):1133–4. Available from: [http://dx.doi.org/10.1016/S0140-6736\(20\)31523-3](http://dx.doi.org/10.1016/S0140-6736(20)31523-3)
53. UNHCR (Internet). UNHCR - The UN Refugee Agency; (cited 2023 Jul 9). Global trends report 2022. Available from: <https://www.unhcr.org/global-trends-report-2022>
54. Schwalbe N, Wahl B. Artificial intelligence and the future of global health. *Lancet* (Internet). 2020 May 16;395(10236):1579–86. Available from: [http://dx.doi.org/10.1016/S0140-6736\(20\)30226-9](http://dx.doi.org/10.1016/S0140-6736(20)30226-9)
55. World Economic Forum (Internet). (cited 2023 Mar 9). Global Health and Healthcare Strategic Outlook: Shaping the future of health and healthcare. Available from: <https://www.weforum.org/reports/global-health-and-healthcare-strategic-outlook-shaping-the-future-of-health-and-healthcare/>
56. Low-Beer D, Komatsu R, Kunii O. Saving lives in health: global estimates and country measurement. *PLoS Med* (Internet). 2013 Oct;10(10):e1001523. Available from: <http://dx.doi.org/10.1371/journal.pmed.1001523>
57. Komatsu R, Low-Beer D, Schwartländer B. Global Fund-supported programmes contribution to international targets and the Millennium Development Goals: an initial analysis. *Bull World Health Organ* (Internet). 2007 Oct;85(10):805–11. Available from: <http://dx.doi.org/10.2471/blt.06.038315>
58. Komatsu R, Korenromp EL, Low-Beer D, Watt C, Dye C, Steketee RW, et al. Lives saved by Global Fund-supported HIV/AIDS, tuberculosis and malaria programs: estimation approach and results between 2003 and end-2007. *BMC Infect Dis* (Internet). 2010 Apr 30;10:109. Available from: <http://dx.doi.org/10.1186/1471-2334-10-109>
59. Jaupart P, Dipple L, Dercon S. Has Gavi lived up to its promise? Quasi-experimental evidence on country immunisation rates and child mortality. *BMJ Glob Health* (Internet). 2019 Dec 3;4(6):e001789. Available from: <http://dx.doi.org/10.1136/bmjgh-2019-001789>
60. WHO/UNICEF estimates of national immunization coverage (Internet). (cited 2023 Jul 27). Available from: <https://www.who.int/teams/immunization-vaccines-and-biologicals/immunization-analysis-and-insights/global-monitoring/immunization-coverage/who-unicef-estimates-of-national-immunization-coverage>
61. Track20 (Internet). (cited 2023 Jul 27). Available from: <https://www.track20.org/>
62. Carter B. Micro levies for global public goods (Internet). *gsdrc.org*; 2015 (cited 2023 Mar 16). Available from: <http://gsdrc.org/wp-content/uploads/2015/12/HDQ1318.pdf>
63. Bermudez J, 't Hoen E. The UNITAID Patent Pool Initiative: Bringing Patents Together for the Common Good. *Open AIDS J* (Internet). 2010 Jan 19;4:37–40. Available from: <http://dx.doi.org/10.2174/1874613601004020037>
64. Hughes-McLure S, Mawdsley E. Innovative Finance for Development? Vaccine Bonds and the Hidden Costs of Financialization. *Econ Geogr* (Internet). 2022 Mar 15;98(2):145–69. Available from: <https://doi.org/10.1080/00130095.2021.2020090>
65. Gavi Matching Fund (Internet). (cited 2023 Jul 27). Available from: <https://www.gavi.org/investing-gavi/innovative-financing/gavi-matching-fund>

66. Atun R, Silva S, Knaul FM. Innovative financing instruments for global health 2002-15: a systematic analysis. *Lancet Glob Health* (Internet). 2017 Jul;5(7):e720–6. Available from: [http://dx.doi.org/10.1016/S2214-109X\(17\)30198-5](http://dx.doi.org/10.1016/S2214-109X(17)30198-5)
67. Moon S, Omole O. Development assistance for health: critiques, proposals and prospects for change. *Health Econ Policy Law* (Internet). 2017 Apr;12(2):207–21. Available from: <http://dx.doi.org/10.1017/S1744133116000463>
68. Diofasi A. Center For Global Development | Ideas to Action. (cited 2023 Jul 25). Global public goods for development: How much and what for. Available from: <https://www.cgdev.org/publication/global-public-goods-development-how-much-and-what>
69. Unitaid (Internet). 2017 (cited 2023 Jul 27). The medicines patent pool. Available from: <https://unitaid.org/project/medicines-patent-pool/>
70. Velásquez G. Where Does Global Health Funding Come From and Where Does It Go? (Internet). The South Centre; 2023 Mar. Available from: https://www.southcentre.int/wp-content/uploads/2023/04/RP176_WHERE-DOES-GLOBAL-HEALTH-FUNDING-COME-FROM-AND-WHERE-DOES-IT-GO_EN.pdf
71. Chattu VK, Soosanna K. The growing epidemic of MDR-TB and concerns for global health security. *Int J Contemp Med Res* (Internet). 2016;3:329–31. Available from: https://www.researchgate.net/profile/Vijay-Kumar-Chattu/publication/288839929_The_Growing_Epidemic_of_MDR-TB_and_Concerns_for_Global_Health_Security/links/5a466c2aa6fdcce1971b6a19/The-Growing-Epidemic-of-MDR-TB-and-Concerns-for-Global-Health-Security.pdf
72. Parmaksiz K, Pisani E, Bal R, Kok MO. A systematic review of pooled procurement of medicines and vaccines: identifying elements of success. *Global Health* (Internet). 2022 Jun 11;18(1):59. Available from: <http://dx.doi.org/10.1186/s12992-022-00847-z>
73. Sourcing & management of health products (Internet). (cited 2023 Jul 11). Available from: <https://www.theglobalfund.org/en/sourcing-management/>
74. Launch of the rapid diagnostic test production platform at the Institut Pasteur in Dakar (Internet). (cited 2023 Jul 12). Available from: <https://www.pasteur.sn/en/news/actualite-covid/launch-rapid-diagnostic-test-production-platform-institut-pasteur-dakar>
75. Unitaid (Internet). 2021 (cited 2023 Jul 12). FIND and Unitaid invest to support technology transfer and boost local production of COVID-19 rapid tests in low- and middle-income countries. Available from: <https://unitaid.org/news-blog/find-unitaid-technology-transfer-covid-19/>
76. World Health Organization. What worked? What didn't? What's next? 2023 progress report on the Global Action Plan for Healthy Lives and Well-being for All (Internet). World Health Organization; 2023. 42 p. Available from: <https://play.google.com/store/books/details?id=3aq9EAAAQBAJ>
77. Global supply chain finance forum – home of supply chain finance terminology (Internet). (cited 2023 Jul 12). Available from: <http://supplychainfinanceforum.org/>
78. The US\$ 500 million challenge: Gavi launches INFUSE 2.0 to scale up innovations in immunisation (Internet). 2023 (cited 2023 Jul 27). Available from: <https://www.gavi.org/news/media-room/us-500-million-challenge-gavi-launches-infuse-20-scale-innovations-immunisation>
79. Investors Group (Internet). (cited 2023 Jul 27). Available from: <https://www.globalfinancingfacility.org/investors-group>
80. Ivanova V, Shahabuddin ASM, Sharkey A, Johri M. Advancing Immunization Coverage and Equity: A Structured Synthesis of Pro-Equity Strategies in 61 Gavi-Supported Countries. *Vaccines* (Basel) (Internet). 2023 Jan 16;11(1). Available from: <http://dx.doi.org/10.3390/vaccines11010191>
81. Zero-dose children and missed communities (Internet). (cited 2023 Jul 19). Available from: <https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal/zero-dose-children-missed-communities>
82. GFF. Global Financing Facility Strategy 2021-2025 (Internet). 2020 Oct. Available from: https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Strategy-2021-2025.pdf
83. News releases. *Environ Law Manage* (Internet). 2000 Jul (cited 2023 Jul 8);12(4):107–29. Available from: <https://www.theglobalfund.org/en/news/2017/2017-04-25-new-global-fund-grant-aims-for-malaria-elimination-in-the-mekong/>

84. The Global Fund's Challenging Operating Environment Policy and Additional Safeguards Policy: What do these really mean? – Aidspace (Internet). (cited 2023 Jul 8). Available from: <https://aidspace.org/the-global-funds-challenging-operating-environment-policy-and-additional-safeguards-policy-what-do-these-really-mean/>
85. Storeng KT, de Bengy Puyvallée A, Stein F. COVAX and the rise of the “super public private partnership” for global health. *Glob Public Health* (Internet). 2021 Oct 22;1–17. Available from: <http://dx.doi.org/10.1080/17441692.2021.1987502>
86. Eccleston-Turner M, Upton H. International Collaboration to Ensure Equitable Access to Vaccines for COVID-19: The ACT-Accelerator and the COVAX Facility. *Milbank Q* (Internet). 2021 Jun;99(2):426–49. Available from: <http://dx.doi.org/10.1111/1468-0009.12503>
87. Hicks J, Singh G, Penicaud C, Gustafson K, James C, Burke-Shyne N, et al. Financing viral hepatitis: catalysing action for impact. *Lancet Gastroenterol Hepatol* (Internet). 2023 Jul;8(7):606–7. Available from: [http://dx.doi.org/10.1016/S2468-1253\(23\)00152-8](http://dx.doi.org/10.1016/S2468-1253(23)00152-8)
88. The Global Fund. Guidance Note Prioritization Framework for Supporting Health and Longevity Among People Living With HIV Allocation Period 2023-2025 (Internet). 2023 Feb. Available from: https://www.theglobalfund.org/media/12165/core_prioritization-framework-supporting-health-longevity-people-living-hiv_guidance_en.pdf
89. Usher AD. Medical oxygen crisis: a belated COVID-19 response. *Lancet* (Internet). 2021 Mar 6;397(10277):868–9. Available from: [http://dx.doi.org/10.1016/S0140-6736\(21\)00561-4](http://dx.doi.org/10.1016/S0140-6736(21)00561-4)
90. Unitaid (Internet). 2022 (cited 2023 Jul 8). Cervical Cancer. Available from: <https://unitaid.org/investment-area/cervical-cancer/>
91. FIND (Internet). 2022 (cited 2023 Jul 8). Strategy. Available from: <https://www.finddx.org/about-us/strategy/>
92. Regan L. Center For Global Development | Ideas to Action. (cited 2023 Jul 11). Reimagining global health financing: How refocusing health aid at the margin could strengthen health systems and futureproof aid financial flows. Available from: <https://www.cgdev.org/publication/reimagining-global-health-financing-how-refocusing-health-aid-margin-could-strengthen>
93. Center For Global Development | Ideas to Action (Internet). (cited 2023 Jul 12). Family planning and the global financing facility: Current evidence and a learning agenda. Available from: <https://www.cgdev.org/publication/family-planning-and-global-financing-facility-current-evidence-and-learning-agenda>
94. Tadesse AW, Gurmu KK, Kebede ST, Habtemariam MK. Analyzing efforts to synergize the global health agenda of universal health coverage, health security and health promotion: a case-study from Ethiopia. *Global Health* (Internet). 2021 Apr 26;17(1):53. Available from: <http://dx.doi.org/10.1186/s12992-021-00702-7>
95. MoU between ICMR and the Foundation for Innovative New Diagnostics (FIND), Switzerland (Internet). (cited 2023 Jul 27). Available from: <https://main.icmr.nic.in/content/mou-between-icmr-and-foundation-innovativenew-diagnostics-find-switzerland>
96. FIND (Internet). 2023 (cited 2023 Jul 27). FIND and Republic of Indonesia Ministry of Health ink partnership to drive access to essential diagnostic tests. Available from: <https://www.finddx.org/publications-and-statements/press-release/find-and-republic-of-indonesia-ministry-of-health-ink-partnership-to-drive-access-to-essential-diagnostic-tests/>
97. FIND (Internet). 2023 (cited 2023 Jul 24). FIND welcomes adoption of historic World Health Assembly Resolution on diagnostics as the organization enters its 20th anniversary year. Available from: <https://www.finddx.org/publications-and-statements/press-release/find-welcomes-adoption-of-historic-world-health-assembly-resolution-on-diagnostics-as-the-organization-enters-its-20th-anniversary-year/>
98. McCoy D, Jensen N, Kranzer K, Ferrand RA, Korenromp EL. Methodological and policy limitations of quantifying the saving of lives: a case study of the Global Fund's approach. *PLoS Med* (Internet). 2013 Oct;10(10):e1001522. Available from: <http://dx.doi.org/10.1371/journal.pmed.1001522>
99. The Global Fund. Technical Evaluation Reference Group: Global Fund Mapping Health Systems Strengthening (HSS) Component of the Resilient and Sustainable Systems for Health (RSSH) Investments: TERG Position Paper, Management Response, and Final Report (Internet). The Global

- Fund; 2023 Jun p. age 7. Available from: https://www.theglobalfund.org/media/13115/terg_mapping-hss-component-rssh_report_en.pdf
100. Storeng KT. The GAVI Alliance and the “Gates approach” to health system strengthening. *Glob Public Health* (Internet). 2014 Aug 26;9(8):865–79. Available from: <http://dx.doi.org/10.1080/17441692.2014.940362>
 101. Office of the inspector general (Internet). (cited 2023 Jul 28). Available from: <https://www.theglobalfund.org/en/oig/updates/2019-05-03-managing-investments-in-resilient-and-sustainable-systems-for-health/>
 102. Technical Evaluation Reference Group: Position Paper - Thematic Review on Resilient and Sustainable Systems for Health (RSSH) (Internet). The Global Fund; 2019 Jul. Available from: http://dx.doi.org/https://www.theglobalfund.org/media/8793/terg_resilientsustainablesystemsforhealthreview_paper_en.pdf
 103. Swiss Tropical and Public Health Institute. Review of Health Systems Strengthening (HSS) Support (Internet). Version 4. Gavi; 2019 Mar. Report No.: RFP RHSS042018 . Available from: <https://www.gavi.org/our-impact/evaluation-studies/health-system-strengthening-evaluations>
 104. The Lancet. The Global Fund: replenishment and future-proofing. *Lancet* (Internet). 2022 Sep 10;400(10355):787. Available from: [http://dx.doi.org/10.1016/S0140-6736\(22\)01735-4](http://dx.doi.org/10.1016/S0140-6736(22)01735-4)
 105. Clinton C, Sridhar D. Who pays for cooperation in global health? A comparative analysis of WHO, the World Bank, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance. *Lancet* (Internet). 2017 Jul 15;390(10091):324–32. Available from: [https://doi.org/10.1016/S0140-6736\(16\)32402-3](https://doi.org/10.1016/S0140-6736(16)32402-3)
 106. Sridhar D, Woods N. Trojan multilateralism: Global cooperation in health. *Glob Policy* (Internet). 2013 Nov;4(4):325–35. Available from: <https://onlinelibrary.wiley.com/doi/10.1111/1758-5899.12066>
 107. Hulse ESG, Atun R, McPake B, Lee JT. Use of social impact bonds in financing health systems responses to non-communicable diseases: scoping review. *BMJ Glob Health* (Internet). 2021 Mar;6(3). Available from: <http://dx.doi.org/10.1136/bmjgh-2020-004127>
 108. Advisors N. 2020 Governance Performance Assessment. 5th Board Meeting. 11-12 May 2021, Geneva. Background document. The Global Fund; 2021 May. Report No.: GF/B45/21.
 109. Institute for Health Metrics and Evaluation (Internet). (cited 2023 Jul 12). GBD Compare. Available from: <https://vizhub.healthdata.org/gbd-compare/>
 110. The Global Fund. Global Disease Split for the 2023-2025 Allocation Methodology 46th Board Meeting (Internet). Vol. GF/B46/04 Reision 1 . Available from: <https://www.theglobalfund.org/board-decisions/b46-dp04/>
 111. Allocation Methodology for the 2023-2025 Allocation Period 47th Board Meeting 10-11-12 May 2022, Geneva / Virtual (Internet). 2022. Report No.: GF/B47/03 . Available from: https://www.theglobalfund.org/media/12051/bm47_03-2023-2025-allocation-methodology_report_en.pdf
 112. Bertone MP, Palmer N, Kruja K, Witter S, HSSEC Working Group 1. How do we design and evaluate health system strengthening? Collaborative development of a set of health system process goals. *Int J Health Plann Manage* (Internet). 2023 Mar;38(2):279–88. Available from: <http://dx.doi.org/10.1002/hpm.3607>
 113. Friebel R, Silverman R, Glassman A, Chalkidou K. On results reporting and evidentiary standards: spotlight on the Global Fund. *Lancet* (Internet). 2019 May 11;393(10184):2006–8. Available from: [http://dx.doi.org/10.1016/S0140-6736\(18\)33055-1](http://dx.doi.org/10.1016/S0140-6736(18)33055-1)
 114. Hanefeld J. How have Global Health Initiatives impacted on health equity? *Promot Educ* (Internet). 2008;15(1):19–23. Available from: <http://dx.doi.org/10.1177/1025382307088094>
 115. McGoey L. Philanthrocapitalism and its critics. *Poetics* (Internet). 2012 Apr 1;40(2):185–99. Available from: <https://www.sciencedirect.com/science/article/pii/S0304422X12000150>
 116. Birn AE. Philanthrocapitalism, past and present: The Rockefeller Foundation, the Gates Foundation, and the setting(s) of the international/global health agenda. *Hypothesis* (Internet). 2014 Nov 1;12(1). Available from: <http://www.hypothesisjournal.com/?p=2503>

117. Eckl J, Hanrieder T. The political economy of consulting firms in reform processes: the case of the World Health Organization. *Review of International Political Economy* (Internet). 2023 Jan 10;1–24. Available from: <https://doi.org/10.1080/09692290.2022.2161112>
118. Kim S, Tadesse E, Jin Y, Cha S. Association between Development Assistance for Health and Disease Burden: A Longitudinal Analysis on Official Development Assistance for HIV/AIDS, Tuberculosis, and Malaria in 2005–2017. *Int J Environ Res Public Health* (Internet). 2022 Oct 28;19(21). Available from: <http://dx.doi.org/10.3390/ijerph192114091>
119. Dieleman JL, Graves CM, Templin T, Johnson E, Baral R, Leach-Kemon K, et al. Global health development assistance remained steady in 2013 but did not align with recipients' disease burden. *Health Aff* (Internet). 2014 May;33(5):878–86. Available from: <http://dx.doi.org/10.1377/hlthaff.2013.1432>
120. Mwisongo A, Nabyonga-Orem J. Global health initiatives in Africa - governance, priorities, harmonisation and alignment. *BMC Health Serv Res* (Internet). 2016 Jul 18;16 Suppl 4(Suppl 4):212. Available from: <http://dx.doi.org/10.1186/s12913-016-1448-9>
121. World Bank. The broader analysis of the global aid landscape draws on the findings of the World Bank, A Changing Landscape: Trends in Official Financial Flows and the Aid Architecture (Internet). 2021 Nov. Available from: <https://thedocs.worldbank.org/en/doc/9eb18daf0e574a0f106a6c74d7a1439e-0060012021/original/A-Changing-Landscape-Trends-in-Official-Financial-Flows-and-the-Aid-Architecture-November-2021.pdf>
122. Lal A, Erondy NA, Heymann DL, Gitahi G, Yates R. Fragmented health systems in COVID-19: rectifying the misalignment between global health security and universal health coverage. *Lancet* (Internet). 2021 Jan 2;397(10268):61–7. Available from: [http://dx.doi.org/10.1016/S0140-6736\(20\)32228-5](http://dx.doi.org/10.1016/S0140-6736(20)32228-5)
123. Cohn J, Russell A, Baker B, Kayongo A, Wanjiku E, Davis P. Using global health initiatives to strengthen health systems: a civil society perspective. *Glob Public Health* (Internet). 2011 May 24;6(7):687–702. Available from: <http://dx.doi.org/10.1080/17441692.2010.521165>
124. Desai M, Rudge JW, Adisasmito W, Mounier-Jack S, Coker R. Critical interactions between Global Fund-supported programmes and health systems: a case study in Indonesia. *Health Policy Plan* (Internet). 2010 Nov;25 Suppl 1:i43–7. Available from: <http://dx.doi.org/10.1093/heapol/czq057>
125. Craveiro I, Dussault G. The impact of global health initiatives on the health system in Angola. *Glob Public Health* (Internet). 2016 Jan 13;11(4):475–95. Available from: <http://dx.doi.org/10.1080/17441692.2015.1128957>
126. Health Organization W. Report of the WHO technical workshop on addressing cross-programmatic inefficiencies in the WHO African Region, 7 (Internet). (cited 2023 May 28). Available from: <https://apps.who.int/iris/bitstream/handle/10665/365375/9789240064218-eng.pdf?sequence=1>
127. Calain P, Abu Sa'Da C. Coincident polio and Ebola crises expose similar fault lines in the current global health regime. *Confl Health* (Internet). 2015 Sep 16;9:29. Available from: <http://dx.doi.org/10.1186/s13031-015-0058-1>
128. Hanefeld J. The Global Fund to Fight AIDS, Tuberculosis and Malaria: 10 years on. *Clin Med* (Internet). 2014 Feb;14(1):54–7. Available from: <http://dx.doi.org/10.7861/clinmedicine.14-1-54>
129. Spicer N, Walsh A. 10 best resources on ... the current effects of global health initiatives on country health systems. *Health Policy Plan* (Internet). 2012 May;27(3):265–9. Available from: <http://dx.doi.org/10.1093/heapol/czr034>
130. Ooms G, Van Damme W, Baker BK, Zeitz P, Schrecker T. The “diagonal” approach to Global Fund financing: a cure for the broader malaise of health systems? *Global Health* (Internet). 2008 Mar 25;4:6. Available from: <http://dx.doi.org/10.1186/1744-8603-4-6>
131. Hanson K, Brikci N, Erlangga D, Alebachew A, De Allegri M, Balabanova D, et al. The Lancet Global Health Commission on financing primary health care: putting people at the centre. *Lancet Glob Health* (Internet). 2022 May;10(5):e715–72. Available from: [http://dx.doi.org/10.1016/S2214-109X\(22\)00005-5](http://dx.doi.org/10.1016/S2214-109X(22)00005-5)
132. Kiefer S, Knoblauch AM, Steinmann P, Barth-Jaeggi T, Vahedi M, Maher D, et al. Operational and implementation research within Global Fund to Fight AIDS, Tuberculosis and Malaria grants: a situation analysis in six countries. *Global Health* (Internet). 2017 Mar 24;13(1):22. Available from: <http://dx.doi.org/10.1186/s12992-017-0245-5>

133. Okunogbe A, Bowser D, Gedik G, Naseri S, Abu-Agla A, Safi N. Global Fund financing and human resources for health investments in the Eastern Mediterranean Region. *Hum Resour Health (Internet)*. 2020 Jul 8;18(1):48. Available from: <http://dx.doi.org/10.1186/s12960-020-00483-x>
134. Kohler JC, Bowra A. Exploring anti-corruption, transparency, and accountability in the World Health Organization, the United Nations Development Programme, the World Bank Group, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Global Health (Internet)*. 2020 Oct 20;16(1):101. Available from: <http://dx.doi.org/10.1186/s12992-020-00629-5>
135. García PJ. Corruption in global health: the open secret. *Lancet (Internet)*. 2019 Dec 7;394(10214):2119–24. Available from: [http://dx.doi.org/10.1016/S0140-6736\(19\)32527-9](http://dx.doi.org/10.1016/S0140-6736(19)32527-9)
136. Gorodensky A, Bowra A, Saeed G, Kohler J. Anti-corruption in global health systems: using key informant interviews to explore anti-corruption, accountability and transparency in international health organisations. *BMJ Open (Internet)*. 2022 Dec 22;12(12):e064137. Available from: <http://dx.doi.org/10.1136/bmjopen-2022-064137>
137. Chang Z, Rusu V, Kohler JC. The Global Fund: why anti-corruption, transparency and accountability matter. *Global Health (Internet)*. 2021 Sep 18;17(1):108. Available from: <http://dx.doi.org/10.1186/s12992-021-00753-w>
138. Mackey TK, Kohler JC, Savedoff WD, Vogl F, Lewis M, Sale J, et al. The disease of corruption: views on how to fight corruption to advance 21st century global health goals. *BMC Med (Internet)*. 2016 Sep 29;14(1):149. Available from: <http://dx.doi.org/10.1186/s12916-016-0696-1>
139. October. Co-financing, eligibility and transition policies evaluation 2019 (Internet). (cited 2023 Jul 11). Available from: <https://www.gavi.org/our-impact/evaluation-studies/co-financing-eligibility-and-transition-policies>
140. Cernuschi T, Gaglione S, Bozzani F. Challenges to sustainable immunization systems in Gavi transitioning countries. *Vaccine (Internet)*. 2018 Oct 29;36(45):6858–66. Available from: <http://dx.doi.org/10.1016/j.vaccine.2018.06.012>
141. Office of the inspector general (Internet). (cited 2023 Jul 12). Available from: <https://www.theglobalfund.org/en/oig/updates/2021-11-04-evolving-the-technical-review-panel-model/>
142. The Hepatitis Fund (Internet). EndHEP2030; 2018 (cited 2023 Jul 20). The Hepatitis Fund. Available from: <https://endhep2030.org/>
143. Mogojwe H. Clinton Health Access Initiative. 2023 (cited 2023 Jul 25). The Hepatitis Fund and the Clinton Health Access Initiative announce high-level donor mobilization conference to eliminate viral hepatitis to be held in Geneva, Switzerland, on May 17, 2023. Available from: <https://www.clintonhealthaccess.org/news/hepatitis-fund-and-chai-resource-mobilization-conference-world-health-assembly/>
144. Root RL. Devex. 2023 (cited 2023 Jul 25). High hopes but low pledges for hepatitis conference in Geneva. Available from: <https://www.devex.com/news/high-hopes-but-low-pledges-for-hepatitis-conference-in-geneva-105550>
145. Health4Life Fund. A global financing partnership on non-communicable diseases and mental health (Internet). (cited 2023 Jul 20). Available from: https://knowledge-action-portal.com/en/news_and_events/news/6559
146. World Bank (Internet). (cited 2023 Jul 19). Priority themes. Available from: <https://www.worldbank.org/en/programs/financial-intermediary-fund-for-pandemic-prevention-preparedness-and-response-ppr-fif/governance-structure>
147. Pandemic fund vastly oversubscribed, more money needed - World Bank. Reuters (Internet). 2023 Mar 7 (cited 2023 Jul 19); Available from: <https://www.reuters.com/world/pandemic-fund-vastly-oversubscribed-more-money-needed-world-bank-2023-03-07/>
148. Unitaid (Internet). 2023 (cited 2023 Jul 19). Global Oxygen Alliance launched to boost access to life saving oxygen. Available from: <https://unitaid.org/news-blog/global-oxygen-alliance-launched-to-boost-access-to-life-saving-oxygen/>
149. Multilateral development banks and WHO launch new investment platform to strengthen primary health care services (Internet). (cited 2023 Jul 11). Available from: <https://www.who.int/news/item/23->

06-2023-multilateral-development-banks-and-who-launch-new-investment-platform-to-strengthen-primary-health-care-services

150. Country strategy and support (Internet). (cited 2023 Jul 9). Available from: <https://www.who.int/countries/country-strategy-and-support>
151. Paris Declaration and Accra Agenda for Action - OECD (Internet). (cited 2023 Jul 25). Available from: <https://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm>
152. Itad (Internet). 2022 (cited 2023 Jul 31). Health systems strengthening evaluation collaborative. Available from: <https://www.itad.com/project/health-systems-strengthening-evaluation-collaborative/>

Appendices

- 1** Study Methods (including PEA Framework)

- 2** Key informant interview topic guides

- 3** Online survey questions

- 4** Board Composition of the GHIs

- 5** Overview of GHI funding disbursement models

- 6** Global-level key informant interview summary

- 7** Online Survey: summary of findings

- 8** Pakistan country case study summary

- 9** South Africa country case study summary

- 10** Senegal country case study summary

- 11** Individual summaries of each multi-stakeholder consultation

- 12** Lessons learned from previous alignment and coordination initiatives

