

Appendix 6

Global Level Key Informant Interviews

Summary of key findings

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Acronyms and abbreviations

CEPI	The Coalition for Epidemic Preparedness Innovations
CSO	Civil Society Organization
DAH	Development Assistance for Health
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
GFF	Global Financing Facility
GHI	Global Health Initiative
GPG	Global Public Goods
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
IHP+	International Health Partnership and related Initiatives
KI	Key informant
LMIC	Low and middle-income countries
MoH	Ministry of Health
NCD	Non-communicable disease
PHC	Primary healthcare
PPP	Public-Private Partnership
QMU	Queen Margaret University
TA	Technical Assistance
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNIGE	University of Geneva
WHO	World Health Organization

1. Introduction

This appendix provides an overview of the main themes and findings arising from the global-level key informant interviews. These interviews were conducted and analysed between February and June 2023 by the members of the FGHI research consortium based at Queen Margaret University Edinburgh and the University of Geneva. This appendix provides additional details to those synthesized in the main report. Key informants are referred to as 'KIs' throughout this document. Quotes are attributed to the category of informant rather than to an individual or an organisation, to provide some context while preserving anonymity. This summary includes the main themes that were identified through the analysis, as well as illustrative quotes.

2. Methods

The KIs were selected based on their longstanding and first-hand experience and expertise regarding the GHIs of focus. A range of bilateral, multilateral, Civil Society Organisation (CSO), private sector, and academic KIs were purposively selected by the research consortium. Names were suggested by the Wellcome Trust, the FGHI secretariat, and through the research consortium's professional connections, in addition to recommendations from other KIs through a process of snowballing. More detail is provided on the study's methodology in Appendix 1.

2.1. Data collection

The interviews were conducted by five researchers via Zoom, Microsoft Teams, or in-person, between February and June 2023. The interviews lasted between 40 and 60 minutes. A semi-structured topic guide (Appendix 2) was developed and used. The questions were formulated using the Political Economy Analysis (PEA) framework (Appendix 1) and focused on the current state of GHIs and the wider global health system (weaknesses and strengths), predicted challenges for the next 15-20 years, power and interests of actors, lessons learned from previous initiatives, how GHIs should or could evolve, and how the success of the global health system should be measured. A total of 77 global-level KI interviews were conducted (Table 1), 15 of which were with FGHI Steering Group members. Interviews were recorded and transcribed verbatim.

Table 1 Global-level key informant interview demographics

Type of informant	Number of interviews	Gender (male/female)
Global Health Initiative (the six GHIs within the scope of this study)	18	11M, 7F
Academic / Policy Analyst (e.g. university professors)	11	7M, 4F
Multilateral (e.g. UN agencies, World Bank)	16	9M, 7F

Bilateral (e.g. high-income country donors)	15	7M, 8F,
Civil Society Organization (e.g. NGOs, advocacy groups)	11	4M, 7F
Private Sector (e.g. for-profit diagnostic and pharmaceutical companies, consulting firms)	4	4M
Philanthropic Foundation	2	1M, 1F
GRAND TOTAL:	77	43M (57%), 33F (45%)

2.2. Data analysis

All interview transcripts were thematically analysed by three trained qualitative researchers using NVivo qualitative data analysis software and a coding framework. Firstly, they read a sub-set of the transcribed interviews to familiarize themselves with the information provided. The researchers then coded a sample of transcripts and in discussion refined a coding framework that was co-developed by the research consortium based on the topic guide. Following this, all transcripts were independently coded, then underwent review by the group, with themes and sub-themes emerging in an iterative process. Researchers then met to discuss emergent findings, and as necessary, case-sensitive analysis was also conducted to account for similarities and differences between GHIs and by participant categories. Codes were then merged, to compare across themes and identify any gaps in the data.

2.3. Limitations

There are some limitations that are worth noting. Firstly, some GHIs were over-represented in the interview data (e.g., GFATM, Gavi). Whilst this potential bias was mitigated as much as possible through inviting a wide range of potential KIs, it was not possible to overcome this completely as not all KIs had experience with or knowledge of all the six GHIs within the scope of the study. Some of the findings are presented in general terms to prevent individuals from being identified. There may also have been an informant bias, with some KIs more comfortable expressing their views than others. It is possible that there was selection bias, as KIs were purposively selected by the research team. However, the team cast a wide net, also including some suggestions of KIs by the FGHI secretariat, and the large research consortium were able to bring diverse positions and perspectives in addition to that of the participants. Finally, it is important to acknowledge that researcher perspectives may influence the work and findings. To minimize the bias, the researchers actively reflected and discussed their positionality, as individuals and as a team, throughout the analysis and write-up.

3. Findings

The findings are organised according to a PEA conceptual framework (Appendix 1) into the following thematic categories 1) Actors including relations between actors (challenges and lessons learned), 2) Frames and framing 3) Context with a focus on predicted challenges. Against this backdrop, common suggestions for change proposed by the KIs are presented. There are a multitude of divergent views and reflections regarding the future of the GHIs, in many cases underpinned by political, institutional and personal interests. Despite this, there were clear themes and trends that emerged. The global health system overall appears dynamic with a myriad of initiatives and reforms, of which impact is contested amongst the KIs.

3.1. Actors: interests and power

3.1.1 Unbalanced power dynamics

During the interviews, KIs were asked for their perceptions on the distribution of power within the current global health system and what they thought an ideal distribution would be. The findings revealed that funders such as bilateral donors, the Bill and Melinda Gates Foundation, as well as GHI structures such as boards (which also include funders in their composition) and secretariats held significant power, particularly in terms of financial and governance-related matters. Interestingly, these influential entities were perceived as lacking coordination and often disagreeing on priorities and approaches, as discussed in more detail in subsequent sections. Key KIs highlighted the importance of GHIs' boards as agents of change, yet also noted a lack of incentives for transformation among both GHIs and donors.

In contrast, there was a general perception that countries lacked sufficient power and decision-making authority to establish investment priorities and shape the policy agenda in the global health system. Several reasons were identified for this situation. Some KIs noted that countries were either excluded from important discussions or not given adequate representation. Additionally, countries often faced limitations in terms of time and resources, making it challenging for them to actively engage in influential roles. Moreover, there was a fear among countries of challenging the status quo or taking actions that might jeopardize funding from GHIs, leading to a reluctance to "rock the boat."

"[GHIs] come with an agenda that has been created by the Global North that says we're interested in, for example, eradicating polio. But that's not a priority for many countries when malaria is the biggest killer. The agenda-setting is where the issue is. I'm not suggesting that GHIs don't fund things. I'm suggesting that they also understand the space in which they are providing the funding. [...] We had a meeting in Kigali in March, and we convened Ministers of Health and other key players to talk to them about the future of GHIs. And all the ministers said, 'You guys, you just come in and you want to take care of what you want to take care of. You don't even listen to us. We have work plans. We have country plans. You don't even examine those and see what our priorities are.'" (CSO KI)

Some KI perceived bilateral donors as prioritizing visible and rapid results to safeguard the health security of their own citizens, such as addressing communicable diseases and preventing their cross-border spread.

The influence of philanthropists in global health was highlighted as a significant factor shaping the investments and actions of GHIs and multilateral institutions. The growing presence of philanthropists in the global health arena has brought additional financial resources, innovation, and attention to critical health issues. However, this influence also raises concerns regarding the potential concentration of power and the influence of private interests on global health agendas.

Philanthropists who directly fund GHIs, and in some cases, sit on their boards, were recognised by KIs as being able to steer investments towards specific health priorities, research areas, or interventions. This can impact the allocation of resources and the direction of global health initiatives, potentially diverting attention from broader public health needs or creating imbalances in resource distribution.

Overall, many KIs, particularly those from CSOs, noted the importance of ensuring that the Global South voices are included in the key global health forums:

“Global governance infrastructure is kind of centred on the North, epistemologically...that's been challenging. Where's the Global South voice? We have all these global meetings and then our Global South colleagues cannot even attend because, number one, they have no resources, and number two they are visa limitations. In the old days we looked at gender, but now we have to look at how the Global South is unrepresented. How do you ensure that the voice of the Global South is reflected in the decision-making boardrooms?” (CSO KI)

While the current multistakeholder models adopted by the global health system and GHIs are deemed valuable for facilitating multisectoral collaboration and seeking input from various actors, there was recognition that these models can also pose challenges. One concern is that these models may inadvertently increase power differentials between stakeholders, potentially undermining the ability of LMIC governments and other key stakeholders to exert their influence and shape decision-making processes effectively.

“It is important to ensure that you have funded constituencies so that there's proper representation and accountability, but also that you're addressing the power differentials. Even if you have seats, it doesn't mean that everyone has the same power, [or] that their voice is heard equally. What's shocking is just how you know little voice and power LMIC governments have in these institutions. The fact that you have to try and still make the case for LMIC governments to be part of these forums is shocking. I think one shift that's crucial and necessary is to move decisions about public health out of kind of multi-stakeholder forums and into government-driven processes. Transparency requirements is a kind of more powerful set of tools that you can use to pressure them to explain what they're doing and why and how this came about.” (CSO KI)

The major donors, including the United States, United Kingdom, Germany, and France were recognized as imposing a results-driven culture, and as having the most power to influence the future of GHIs. However, GHIs were noted to be constantly evolving based on donor interests, in an effort to appease their donors and meet their next replenishment targets. At the board level, some GHIs struggled with conflicting ideas between board members. The boards are large and formed of multiple types of actors, some described as a limiting factor for strong strategic direction and decision-making. At country level, contextual elements, including geopolitics, financial challenges,

frequent turnover of political parties, and political conflicts were noted to be contributing factors to a lack of sustainable power and common interests among country actors.

Many CSO KIs raised concerns about the current status quo, noting that many GHIs lack meaningful participation of communities and civil society in their decision-making processes. They emphasized the importance of ensuring that CSOs representing communities have active engagement in the decision-making processes of GHIs.

However, it is important to consider the distinctions between CSOs and other non-state actors who may advocate for private interests, cautioned another CSO KI. While the meaningful participation of CSOs representing communities is crucial, it is equally important to ensure transparency and scrutiny to differentiate between genuine CSOs working in the public interest and those driven by private agendas. Robust mechanisms should be in place to assess the credibility, accountability, and alignment with public health goals of non-state actors to avoid undue influence or conflicts of interest. Striking the right balance between inclusive engagement and careful vetting of actors can help maintain the integrity and effectiveness of decision-making processes in the global health arena.

“The ethical political orientation of non-state actors gets obscured or erased. I would say there is a distinction between civil society actors or non-state actors that is perhaps functioning more like a lobby group representing private interests versus civil society organisation that is advocating for a greater representation of particular communities.” (CSO KI)

The power dynamics among GHIs and the broader global health system emerged as a prevalent theme among the KIs. Power imbalances were recognized as a significant obstacle to bringing about change from the existing status quo and impeding country-led action.

A multilateral KI provided further insights into the power imbalances, expressing that there was at times a sense of scepticism and a lack of respect among GHIs regarding the capacity of countries to make decisions. Despite recognizing the importance of countries taking the lead in decision-making, this sentiment reflects a prevailing scepticism towards in-country capacity.

One of the main criticisms raised regarding current GHI models is the concentration of power in the hands of the Boards and Secretariats, primarily located in Geneva (Gavi, GFATM, FIND, Unitaaid), as well as Washington DC (GFF). KIs highlighted the lack of consistent and nationally owned in-country presence by GHIs. This absence was described by one key informant as perpetuating colonialism, suggesting that power dynamics within GHIs reflect historical imbalances.

Furthermore, the over-reliance on short-term international consultants instead of fostering the development of in-country expertise was described as a power struggle for countries. This practice can limit the ability of countries to build sustainable capacity and retain control over their own health agendas. A CSO informant provided insight into this issue, reflecting on the challenges associated with this power dynamic.

“Who are our global health experts? If we need a consultant to do a piece of work, where do we automatically look? Most of the time, it’s the same consultant that we’re bringing in. And they look a certain way, and they are a certain colour. And they’re not the colour of the people that they are actually working on behalf of. The actual end user.” (CSO KI)

Some KIs suggested that GHIs may perpetuate private sector interests. Additionally, conflicts of interest among donors and within GHIs were observed to have a notable impact on power dynamics. These competing interests and conflicts of interest contribute to the complex power dynamics within the global health system.

“These [global health] initiatives have coalesced around public-private partnerships (PPP) without adequate safeguards for protecting public interests. I think in many ways, they’ve allowed conflicts of interest to exist [...].” (Academic KI)

Some CSO KIs raised concerns about the donation-based model of pharmaceutical companies providing vaccines to GHIs like Gavi. They argued that this model perpetuates private sector interests and does not effectively enable equitable access to vaccines in a sustainable manner. The donation-based approach allows pharmaceutical companies to make high-profile donations, often accompanied by aggressive public relations campaigns. While these donations may provide short-term benefits by increasing vaccine availability, they may not address the underlying systemic issues that hinder equitable access to vaccines.

3.1.2. Relations between actors: lack of coordination and governance mechanisms

When discussing how the relations between the different actors described above played out, many KIs highlighted what they viewed as insufficient coordination among various global health governance structures, including GHI boards, which has resulted in increased fragmentation and expanding mandates within the global health landscape. The lack of coherence and coordination at the global, regional, and country levels between GHIs and the wider global health system was identified as a significant challenge.

The existing global-level coordination mechanisms for GHIs were considered ineffective due to diverse political economy factors and a lack of incentives to promote collaboration. Despite attempts to establish coordination platforms, the KIs noted that power struggles and conflicting interests hindered effective coordination and cooperation among GHIs and other global health actors. One academic who was interviewed stressed the need for improvements in coordination amidst these power struggles. Recognizing the importance of effective coordination mechanisms, the key informant emphasized the necessity of addressing these challenges and enhancing coordination efforts within the global health system.

*“There’s an unending call for better coordination...yet we still go through the motions... A plan, a declaration, a meeting or conferences...but none of these seem enough to actually push a set of relatively autonomous actors to give up some of that autonomy.”
(Academic KI)*

The KI emphasized the co-dependence between different GHIs, citing examples such as Unitaid relying on GFATM for implementing innovations and the interdependence between The Coalition for Epidemic Preparedness Innovations (CEPI) and Gavi. However, they also highlighted the absence of robust coordination or governance mechanisms for collaborative work at the global level.

KIs noted that some GHIs have initiated closer working relationships, but primarily through informal channels and personal connections that have developed over time. Unfortunately, there is limited publicly available information about these informal collaborations or dialogues between GHIs. One informant characterized GHIs as not "playing well with others," indicating a lack of cohesive collaboration among these organizations. While some KIs recognized the coordinating role of the World Health Organization (WHO) among GHIs, concerns were also expressed regarding the WHO's effectiveness in fulfilling this coordinating role.

"[WHO] can't do all of the things that it's being asked to do. Therefore it will try to do all of them sort of suboptimally rather than try and reduce to do a couple of things better." (Academic KI)

3.1.2. Lessons learned from previous collaboration initiatives

The KIs were asked about the lessons learned from previous formal collaboration efforts and initiatives, such as IHP+ (International Health Partnership) and The Sustainable Development Goal 3 Global Action Plan (SDG3 GAP) (Appendix 12). There was a general consensus that these initiatives were initially conceptualized with good intentions, particularly regarding aid effectiveness and the need for organizations to work together towards common goals in a fragmented global health landscape. However, the KIs noted that the implementation of these initiatives has yielded only minor gains without significant sustainable impact.

The KIs highlighted several challenges associated with these initiatives. They pointed out that they were often set up or led by a minority of donors, which limited their inclusivity and hindered their ability to achieve broad engagement and buy-in from all relevant stakeholders. As a result, some of these initiatives gradually lost momentum due to a lack of political or financial traction and a dearth of accountability mechanisms and incentives to encourage meaningful action from members.

Additionally, KIs expressed that coordinating actors with different structures and mandates proved to be a difficult task, contributing to the limited effectiveness of these initiatives. One academic informant specifically remarked that such initiatives, while important, are not sufficient to address complex problems within the global health arena:

"There is still a big constituency in the global health community that still believes that there are tidy technical solutions [referring to the IHP+] to complex political organizational problems." (Academic KI)

"This health systems funding platform originally was supposed to be a funding platform, functioning as a kind of pooling platform globally to sort of improve working together across different funders."

There was supposed to be money attached to it, but that never got any legs. No one ever gave it any money.” (GHI KI)

“ACT-A was ultimately a collection of GHIs, and in theory, you had this Facilitation Council and a bunch of governments that were supposed to be the principals, right? They were supposed to be overseeing it. The reality is they had very limited understanding and insight and ability to influence what these GHIs were doing day-to-day....the accountability challenges that raised...” (Academic KI)

The SDG3 GAP initiative, aimed at fostering collaboration among GHIs, was mentioned by many KIs. However, it was commonly perceived as lacking incentives and accountability mechanisms to effectively facilitate collaboration at the global level.

“[The SDG3 GAP] is an endless cast of characters. So they all came together and decried how fragmented the system was and how they would all make nice plans together. And I think it's come to absolutely nothing. Because there's no agency behind it.” (Academic KI)

While there may be differing opinions regarding the need for additional initiatives, there was a consensus among KIs on certain recommendations. It was emphasized that any new initiatives should be equipped with mechanisms that ensure accountability and effectiveness. KIs suggested that these initiatives should consider structural changes to address the underlying issues within the global health system.

A key recommendation put forth by the KIs was the importance of involving both donors and recipient countries in the decision-making process. They emphasized the need for a collaborative approach where all stakeholders have an active role in shaping and driving the initiatives. Furthermore, KIs stressed the significance of initiatives having meaningful enforcement mechanisms, or "teeth," to ensure compliance and results.

3.2. Frames and framing

Frames and framing refer to the beliefs, narratives and discourses that key stakeholders have (in this study) in relation to GHIs and the wider global health system, and in particular in relation to its challenges. Frames and narratives, often attached to the ideas and values that individual actors or groups of actors have, help making sense of the issue, but in the case of charged and controversial questions they form the basis of policy contestation and disagreement (9). In this section, the main “frames” that emerge from the global key informant interviews around the GHIs and how they are perceived and views by the main group of actors and what are the discourses that have crystallized around challenges are presented.

3.2.1. Added value of the GHIs to-date

One of the most common narratives, and one for which there was consensus among many KIs is that of the significant contributions of GHIs to the broader global health system and their comparative advantages over other actors - which was seen to justify their creation and (to a point) their existence. One of the most widely acknowledged contributions is the substantial impact GHIs have had in reducing the burden of communicable diseases, specifically human immunodeficiency virus (HIV), Tuberculosis (TB), and malaria. GHIs were also praised for their efforts in promoting equitable access to essential medicines, diagnostics, and vaccines. A multilateral informant emphasized the success of GHIs, particularly GFATM and Gavi, in achieving their original objectives. The GFATM was lauded for its pivotal role in mobilizing resources and coordinating global efforts to combat HIV, TB, and malaria. Gavi was recognized for its instrumental role in expanding immunization coverage and improving access to life-saving vaccines, particularly in low-income and middle-income countries.

“GHIs have made huge contributions towards helping eliminate, eradicate and control many infectious diseases globally, helping accelerate market shaping and paving the way for procurement of critical supplies and really shining a spotlight on the other needs of LMICs.” (Multilateral KI)

The KIs, particularly from GHIs, recognized the effectiveness of replenishment models employed by GHIs in mobilizing substantial funds to achieve significant milestones in disease eradication efforts. The ability of GHIs to raise substantial resources through their replenishment mechanisms has played a crucial role in supporting global health interventions.

Another important aspect highlighted by the KIs was the role of GHIs in reaching marginalized populations. GHIs have been instrumental in directing funds directly to CSOs and initiatives that operate outside of traditional government channels. This approach has facilitated targeted resource allocation towards marginalized and vulnerable populations who often face barriers in accessing healthcare and essential services.

A CSO informant, who closely collaborated with some GHIs, acknowledged the invaluable contribution of GHIs in reaching marginalized populations. They also highlighted the financial support provided by GHIs for advocacy work, which is frequently overlooked by other funders. This includes funding initiatives focused on ensuring equitable access to medicines, an area that may not receive sufficient attention and funding from alternative sources.

“The Global Fund has always been really strong on the importance of sort of funding for the most affected. Unitaid also has played a really important role in funding work around access to medicines, which almost no other institution is interested to fund because of the strong power of, you know, pharmaceutical [industry].” (CSO KI)

In addition to the strengths mentioned earlier, KIs highly regarded the innovative financing mechanisms employed by GHIs. Market shaping and PPPs were specifically highlighted as areas where GHIs excel and bring added value to the global health landscape.

KIs, including GHIs and multilateral organizations, emphasized the adaptability of GHIs as another notable strength. They praised GHIs for their ability to quickly reallocate funds and adjust their focus in response to emerging challenges. This agility was contrasted with the perceived slower response of certain UN agencies in similar situations. The COVID-19 pandemic served as a prominent example, where GHIs demonstrated their capacity for effective coordination and flexible responses. Notably, the GFATM and Unitaid collaborated to address access to oxygen, while the ACT-Accelerator brought together multiple GHIs to address various aspects of the pandemic response.

3.2.2. Frames and narratives on the weaknesses of the GHIs

On the other hand, contrasting frames emerged around narratives in relation to other aspects of the GHIs role and contribution within the global health system, and to country health system and HSS efforts. Described here are the most contested elements that emerged from the interviews.

3.2.2.1. Vertical programming and fragmentation of national health systems

One of contrasting frames and narratives was around the contribution of GHIs to the health systems at country level. A key concern voiced by some KIs revolves around the inadvertent creation of parallel systems by GHIs, leading to the fragmentation of national health systems. This fragmentation has resulted in discrepancies and gaps within the broader health system. An academic expert interviewed during the research was straightforward in stating that the current GHI system does not effectively serve countries *"the current [GHI] system is not serving the countries well. Period."*

GHIs face significant criticism for the lack of alignment between their investments and country strategies. This critique is often attributed to their top-down approaches, which may result in funding that is not integrated into national budgets. Consequently, this approach hampers country ownership, sustainability, and the decolonization of the global health agenda.

Furthermore, the proliferation of separate national health plans and budgets contributes to the fragmentation of health systems. For instance, one informant mentioned that Malawi has over 20 different health plans in use. This fragmentation imposes significant transaction costs on national ministries in terms of initiating, managing, and monitoring GHIs' investments. Additionally, the presence of other donors with similar levels of transparency and bureaucracy operating simultaneously adds to the complexity.

“It doesn't make sense to me that we're saving a child from HIV only to watch it die of diarrhoea. I mean, you know? How did we go so wrong?” (Multilateral KI)

Nearly all KIs highlighted the fragmentation present within the wider global health system and within GHIs themselves. This fragmentation was found to be primarily driven by the disease-specific approach that GHIs were initially designed to follow, and diverging donor priorities and agendas. The emphasis on specific diseases like HIV, TB, and malaria has led to varying levels of funding across different components of the health system, creating imbalances and inconsistencies. KIs unanimously recognized the limitations of vertical programs. Such an approach was seen as detracting from more essential investments in Primary Health Care (PHC), UHC, infrastructure, institutional knowledge, and preparedness for future epidemics and emergencies. However, the impact of GHIs on HSS was a subject of debate.

While GHIs claim to contribute to HSS through their vertical or diagonal programs, there are differing views on their actual impact. Some KIs expressed concerns about the potential negative consequences of GHI programmes on health systems. One concern is that the focus on specific diseases or interventions funded by GHIs may divert attention and resources away from other crucial areas of the health system. This imbalance in resource allocation can hinder the overall strengthening of the health system.

Another issue raised by KIs is the potential diversion of the health workforce toward GHI-funded interventions, which may result in imbalances within the workforce and neglect of other essential healthcare services. This siloed approach to funding can contribute to fragmentation within the health system, where resources and attention are concentrated on specific areas while other aspects of healthcare may be overlooked.

These concerns raise questions about the actual impact of GHIs on HSS. A multilateral KI questioned the extent to which GHIs truly contribute to broader HSS objectives.

“Global Fund and Gavi are highly financed and have a narrow scope. They will tell you that they're strengthening health systems. That is not correct. They're contributing to financing systems that only benefit their own results, which are important, but to be honest, it is no longer the biggest killers.”
(Multilateral KI)

Some KIs have highlighted how GHIs lack a clear focus on building capacity and capability to govern health systems and coordinating health programs, which is particularly critical in contexts where health stewardship roles and capabilities are weak. This erodes even further ministerial authority.

3.2.2.2 Evolving and expanding mandates

Some KIs, including multilaterals, frequently expressed concerns about ever-expanding mandates among the GHIs. This refers to a situation where the mandates of GHIs become unclear or overlap with each other. This lack of clarity can lead to inefficiencies, duplicated efforts, and a fragmented approach to global health interventions. However, other KIs such as bilaterals and academics, discussed that forcing GHIs to focus on areas that do not fall into their expertise (e.g., noncommunicable diseases (NCDs), HSS) could cause numerous challenges.

The relevance of the current mandates of GHIs was also questioned by KIs. They raised concerns about whether these mandates have kept pace with evolving global health challenges and if they are adequately addressing the needs of countries and communities. There is a growing call for GHIs to evolve their mandates to better align with the changing global health landscape and address emerging priorities.

3.2.2.3 Weaknesses with financing models and dispersal of funds

A number of KIs expressed concerns over challenges associated with GHI financing models and the allocation of funds. Diverging frames were expressed on the benefits of innovative financial models and the replenishment models utilized by certain GHIs, such as the GFATM and Gavi.

One perspective around replenishment models stresses their innovative approach and the fact that they foster competition. However, others counter this framing by stressing that competition results in limited funding opportunities. This competitive environment can create challenges for smaller actors and hinder their ability to implement impactful health programs.

Moreover, the sustainability of these replenishment models came into question, particularly considering the anticipated reduction in fiscal space for Development Assistance for Health (DAH). As resources become constrained, doubts arise about the long-term viability and stability of these financing models.

Another issue raised by KIs pertained to the proliferation of externally funded programs, leading to competition in fundraising between GHIs themselves and between GHIs and other global health actors. This competition for funding can introduce inefficiencies and potentially undermine collaboration and coordination efforts.

“Depending on who makes the better investment case, that's who receives more money, we, regardless of the sort of burden of disease or contribution that exist.” (CSO KI)

An informant pointed out a concerning perception that only a small portion of the funds allocated by donors or governments for specific interventions effectively reaches the communities that are most in need. This observation indicates a disconnect between the allocation and utilization of resources, and the limited influence that communities have over determining how those resources can be best utilized. It raises concerns about the effectiveness and efficiency of resource allocation mechanisms, and the need for improved processes that ensure funds reach the intended beneficiaries and align with their needs and priorities.

“Only 2% of financing actually gets to communities and then the rest of it goes through all these fundamental lies... Of \$100 given by a government, only \$2 of that actually reaches the community for them to use and decide how to work with them. So \$98 of that \$100 goes to the donut.” (CSO KI)

KIs at the global level, including multilaterals, raised concerns about the existing grant application processes, citing significant burdens placed on country counterparts in terms of time and effort. They also criticized the reliance on external consultants rather than leveraging local capacity to support grant applications, highlighting a weakness in the system.

Furthermore, the short duration of GHI grant periods, typically lasting three years, was considered inadequate for sustainable HSS efforts. This limited timeframe often prioritizes short-term successes over the long-term goal of building capacity within health systems.

Another critical issue highlighted by KIs was the funding bypassing governments, leading to a lack of on-budget financing. This situation has important implications for accountability and sustainability within the global health system. When funds are not fully integrated into national budgets and planning processes, it restricts the ability of governments to effectively manage and allocate resources in alignment with national priorities. The issue of off-budget funding and lack of transparency has repercussions at sub-national and district levels where district managers are often bypassed and have little accountability:

“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. A lot of the way these GHIs work is the money, just a lot of the resources come in kind. Or the resources sit at the national program level, even in the context of decentralization. This is Nigeria. This is Tanzania. This is Ghana. And this is Pakistan. 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, [the GHIs] should be very transparent.”
(Multilateral KI)

Transparency is essential and participants encouraged a shift from inputs to outputs-based funding:

“If you're really willing to move towards accountability at the level of outputs or outcomes, then really be willing to do that because right now they're not. I mean, they talk about that, but there's nothing about it. [...we should be promoting] this more output-based or structured funding because, as you say, they're all working on input-based funding.” (Multilateral KI)

A challenge widely recognised, and source of concern was the shrinking of the global health fiscal space; this was predicted to continue to reduce amidst economic crises and transition by some bilateral donors toward bilateral DAH:

“Since the COVID pandemic, donors are concentrating their funds on very few GHIs. The GFATM is doing quite well. And it will become more and more complex to raise funds to fund new programmes. So we will have a problem of availability of resources to fund new programmes. And at national level, global south countries should invest more! They don't invest enough.” (GHI KI)

Another key challenge discussed by KIs was around co-financing and governments' contribution to health programmes and health systems. Policies around co-financing are perceived as unclear and there are lessons learned from middle-income countries that were able to implement transparent co-financing strategies:

“I also think the policies around co-financing: what we've looked at is they're all as clear as mud. I mean, Gavi is quite clear. I mean, Gavi is clear, but the rest of you know, the Global Fund is completely unoperated... They just kind of make-up7 numbers. It's not clear. And then co-financing for what? It's not just a matter of saying we're gonna put in X amount of money. It's actually saying, well, well, what is the domestic government paying for in relation to what the donor is paying for? They don't. They don't unpack it at that level. I think you certainly could move, should move, more towards an output orientation from middle income countries.” (Multilateral KI)

GHIs are perceived to distort governments funding for health since there might be a lack of

incentives for country governments to increase and maintain financing for health:

“The principle [GHI] recipients in many countries are NGOs, and in many cases, northern NGOs. [...] We fund NGOs to deliver services. The governments are saying, ‘well, that’s too expensive. We’re not going to do that.” (GHI KI)

“We’ve taken away, we’ve distorted power dynamics in country Ministries of Health. whether we’ve stunted the growth or weakened the capacities we cannot replace that by hiring more people to sit in these technical units. You’ve got to change the funding model.” (Multilateral KI)

“It’s not just persuading the President or the Finance Minister, it’s often persuading, I mean, 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’s really hard, long-term work?” (Academic KI)

3.2.2.3 Accountability mechanisms and choice of indicators

A point of debate and divergence between KIs concerned the existing accountability mechanisms for GHIs and the use and choice of indicators.

One main narrative, particularly among bilaterals and GHIs KIs, is that clearly defined output and outcome indicators and a performance focus drive results and improve accountability of GHIs, and represents a major strength compared to other actors and approaches.

However, others especially academics, multilaterals and CSOs, expressed critical views, highlighting the lack of consistency in indicators and reporting mechanisms across different organizations. They noted that current indicators tend to focus on narrow, visible results, often driven by the requirements of donors.

The KIs raised concerns about the limited scope of these indicators, which may not capture the broader impact and complexities of global health interventions. There was a call for more comprehensive and context-specific indicators that can effectively measure the outcomes and progress of GHIs in achieving their goals.

Furthermore, the KIs emphasized the need for accountability mechanisms that go beyond mere reporting of quantitative data. They advocated for a more holistic approach that includes qualitative assessments, stakeholder engagement, and meaningful participation of communities and civil society organizations.

Overall, the KIs expressed a desire for greater coherence, consistency, and inclusivity in the selection and implementation of performance indicators and accountability mechanisms within GHIs. They emphasized the importance of aligning these mechanisms with the broader goals of global health and ensuring they reflect the diverse needs and contexts of different countries and communities.

“All of [GHI] metrics today are geared towards satisfying the donor” (CSO KI)

Performance indicators that GHIs use are not reflective of their impact on HSS, domestic health spending, and the overall well-being of communities, as exemplified by one academic key informant below:

"[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 which 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." (Academic KI)

A CSO informant suggested a shift in culture from attribution (for every dollar spent) towards contribution (to health systems):

"I also think that the donors are to blame in a good part because of the demand for accountability and making sure that every dollar shows its attribution to specific. We need to move away from attribution to contribution. So if there's a shared understanding of HSS, which there isn't, each organisation understands it in a different way than the way that they report." (CSO KI)

Another key challenge identified by the majority of KIs was the lack of accountability by GHIs towards government and citizenships. Recipient countries are often not involved and are crowded out of decision-making and policy formulation conversations.

"Donors and funders are not currently accountable to anyone." (Academic KI)

3.3. Context: predicted challenges for the next 20 years

When asked about the major challenges that the global health system will likely face over the next 20 years, the KIs expressed numerous concerns. The most commonly mentioned challenges included:

1. **Shifts in the global burden of disease:** KIs acknowledged the rise in non-communicable diseases (NCDs), the presence of a double burden in some countries (with both infectious and chronic diseases), and the potential for new outbreaks and epidemics to emerge. These shifts require ongoing adaptation and response from the global health system.
2. **Shrinking fiscal space for global health:** KIs expressed concerns about the limited financial resources available for global health efforts. As economies face various pressures and competing priorities, many worried that funding for GHIs may become scarcer.
3. **Political turmoil and geopolitics:** KIs identified political instability, conflicts, and geopolitical tensions as major challenges to the global health system. These factors can disrupt health systems, hinder collaboration, and impede the delivery of healthcare services, particularly in fragile and conflict-affected regions.
4. **Inequities between and within countries:** KIs highlighted the persistent inequities between and within countries that remain unaddressed. These inequities, including disparities in access to healthcare and resources, pose significant challenges to achieving UHC and the wider SDGs.
5. **Health effects of climate change:** many KIs recognized that climate change poses significant health challenges, including the spread of infectious diseases, increased vulnerability to

extreme weather events, and the impact on food and water security. Addressing these health effects will require concerted efforts and adaptation strategies.

Additionally, some KIs acknowledged that future challenges may be unpredictable, emphasizing the need for the global health system to be prepared to react and adapt swiftly to emerging threats and changing circumstances. The KIs also raised concerns about achieving UHC and the SDGs by 2030, noting that many countries are not on track to meet these targets. Capitalist and neocolonial agendas of some donors were criticised, as they believed they can hinder sustainable progress, particularly in reducing out-of-pocket spending on healthcare. Overall, the KIs emphasized the complex and interconnected nature of the challenges facing the global health system and the need for comprehensive and coordinated efforts to address them.

3.4. Proposals for change

The KIs unanimously recognized the need for some degree of change within GHIs and the wider global health system to ensure their continued relevance and effectiveness in addressing evolving health priorities over the next 20 years. While specific proposals varied as detailed further below, there were several common suggestions for change.

Strengthen existing GHIs

The most frequent proposal among KIs was to strengthen the existing GHIs, recognizing their achievements and potential for impact. This involved enhancing their capacities, improving coordination, and ensuring alignment with country priorities. KIs also suggested cautiously defunding GHIs as priorities shift, allowing for a reallocation of resources.

Creation of new GHIs or merging existing GHIs

It is important to note that the desire for change did not necessarily mean creating more GHIs or establishing a single "super" GHI to oversee others. However, a few KIs highlighted the creation of new GHIs as a possibility, with the newly established Pandemic Fund being cited as an example of an opportunity for better coordination and response. However, this view was not widely shared, and there was more consensus around exploring options for merging existing GHIs with similar mandates, such as Gavi and CEPI. Among the minority of KIs that did suggest possible mergers, they lacked detailed rationale and evidence for the possible impact of such mergers, and did acknowledge that merging GHIs could potentially create more harm than good.

Future mandates

Regarding the future mandates of GHIs, there was no consensus among stakeholders. The contributions of GHIs in areas such as global public goods (GPGs) and market shaping were generally recognized and not seen as requiring fundamental shifts. Some advocated for retaining the original mandates, while others proposed expanding or changing them to address emerging health priorities. The opinions varied depending on the stakeholder group, with GHIs, multilaterals, and CSOs expressing more support for expanding mandates, while others focused on improving the existing system without major changes. Overall, KIs emphasized the importance of considering GHIs as interdependent actors within the wider global health system. They highlighted the role of the WHO and multilateral development banks in providing technical assistance (TA) and fostering

coordination at both the global and country levels. Proposals on mandates are further explored below.

3.4.1. Narratives for change: attitudes to change

The KIs overwhelmingly agreed on the need for change in the current global health system, recognizing its inadequacy in achieving UHC and strengthening health systems in the coming 15-20 years. However, opinions on the nature and extent of change varied among different types of respondents. Bilateral donors and GHIs expressed caution and a preference for avoiding major disruptions to the status quo, particularly at the global level, such as changes to secretariats or boards. They were concerned about the potential risks and trade-offs associated with significant changes. On the other hand, CSO, academics, and multilateral KIs were more open to substantial changes in the global health system, including adjustments to GHI structures and ways of working. CSO representatives and academics more readily questioned the very existence of GHIs:

“Rather than simply looking at the initiatives one by one, there is a need to interrogate the underlying principles and ideologies that were used to create this emergence of GHIs. The ideas, beliefs, and assumptions that led to the creation of the GHIs. Questioning this idea is fundamental: not looking at how they can be improved, but questioning their very existence. [...] As long as you’re failing to address the root causes of the problems, you’re continuing to operate in a neocolonial system.” (Academic KI)

The timeline for implementing these changes was seen as context-specific and dependent on the specific circumstances of each situation. There was no consensus on an ideal timeline, and KIs acknowledged that recommendations would need to be tailored to individual contexts rather than a one-size-fits-all approach. Overall, while there was agreement on the need for change, the attitudes towards it varied among different stakeholders, with bilateral donors and GHIs being more cautious and other groups being more open to transformative changes in the global health system.

3.4.2. Programmatic and health system priorities

Contribution to Universal Health Coverage and Primary Healthcare

The study revealed a lack of unanimous consensus on the programmatic and health system priorities of GHIs for the next 20 years. UHC, with PHC as a foundation, commonly arose as the key priority area. The vast majority of participants argued that GHIs should focus on sustainably strengthening health systems and contributing to the achievement of UHC; however, there was no agreement over the best way to do this, with contrasting views about the effectiveness of HSS-specific funding. Different stakeholder groups held diverse views, with some GHI representatives defending the vertical nature of their programs. However, the majority of KIs emphasized the need for GHIs to shift away from vertical disease programs and focus on more horizontal programming that can sustainably strengthen health systems and effectively address the current and future burden of diseases and emerging global challenges. Stakeholders from various backgrounds recognized the significant value that GHIs provide in terms of market shaping for GPGs and they expressed support for this role to continue. There was an appreciation for the African Union's vision to enhance vaccine manufacturing on the continent, and stakeholders welcomed this initiative.

Some KIs raised concerns about the sustainability and horizontal nature of the HSS interventions implemented by GHIs. They suggested that GHIs should reconsider their involvement in HSS and instead adhere to their original mandates. One informant even described disease-specific HSS as "oxymoronic," highlighting the perceived contradiction in combining disease-specific approaches with efforts to strengthen overall health systems. Overall, while there were differing views on the programmatic priorities of GHIs, there was a prevailing sentiment among KIs that a shift towards more holistic and horizontally-oriented approaches to HSS is needed to address the evolving health challenges of the future.

"There must be a realisation that GFATM can't carry on like it does forevermore. When it was set up it was revolutionary because HIV/AIDS back then was a relatively new disease and no one had a way of funding antiretroviral therapy so when it was set up, it was set up as an emergency mechanism for ARVs and it was incredibly effective. [...] 20 years later, I think it's the inability to evolve and make these services more institutionalized and sustained and part of the UHC agenda[...]. There should be a plan to institutionalise all the HRH responses and that countries fund all their own response mechanisms. And that means you have to strengthen the system. You don't just provide the service to just fund the services, you actually strengthen the system so they can procure their own drugs, they can set up their own services, for people living with HIV, TB, and malaria and have that institutionalized across the country." (Academic KI)

Nearly all KIs acknowledged the importance of tailoring programmatic and health system investments to each country's specific needs, taking into account factors such as epidemiology, economic situation, and political economy. They recognized that these priorities would evolve and change over time. Several suggestions were made regarding GHIs' priorities to support UHC. These included placing greater emphasis on strengthening universal digital health information systems in countries, as well as investing in health workforces to address the loss of skilled professionals. The establishment and enhancement of government laboratories, horizontal procurement, and supply chain systems were also highlighted as important areas of focus. It was proposed that GHIs should collaborate with country governments to strengthen laboratory systems rather than focusing solely on developing disease-specific diagnostics without adequate infrastructure and locally trained laboratory personnel. The importance of nationally owned and managed laboratory systems was emphasized, and stakeholders encouraged GHIs to work alongside governments to achieve this goal. KIs emphasized the importance of strengthening health systems and surveillance capacities to better respond to future pandemics and emergencies. The development and deployment of point-of-care diagnostics were also highlighted as an area where GHIs can play a significant role. Furthermore, community-based surveillance was mentioned as an important approach to enhance early detection and response to health threats. KIs also stressed the significance of prioritizing maternal, child, and adolescent health, and there was a general recognition of the need for more attention to NCDs. However, some KIs, including other GHIs, recommended that the rising burden of NCDs should be addressed primarily through government policies such as taxation and national screening programs, rather than relying solely on short-term funding from GHIs. The use of the WHO's Health System Building Blocks was suggested as a foundation for GHI investments in HSS. These building blocks encompass key areas such as governance, health workforce, service delivery, health information systems, and financing.

Research

The need for increased investment in global health research by GHIs was emphasized by several KIs, particularly those from academia, CSOs, and the private sector. These suggestions encompassed a wide range of research areas: implementation research; participatory research; capacity building to expand local research and development (R&D) capabilities; and clinical trials for new products such as vaccines and diagnostics. A common underlying theme was the need for GHIs to collaborate with local and regional research institutions as well as the private sector to carry out such research activities and ensure the funding goes to and stays in the Global South.

Technical assistance

There was a consensus among KIs regarding the important role of TA provided by GHIs. This role was recognized as an added value that should be continued and strengthened. However, there were different perspectives on how this role should evolve over the next 20 years. The majority of KIs highlighted the need to move away from reliance on international consultants or GHI secretariats for TA. Instead, they recommended the establishment of a more permanent and long-term in-country capacity that is integrated within the Ministry of Health (MoH). This in-country capacity would work alongside WHO and other relevant actors to provide technical support and expertise. The aim is to build sustainable and locally owned capacity that can effectively address the health needs and priorities of each country. By housing TA within Ministries of Health, there is an opportunity to strengthen collaboration and coordination among different stakeholders, ensuring a more coherent and harmonized approach to technical support. This approach also aligns with the principle of country ownership, where countries have greater control over their health agendas and decision-making processes.

Changes in mandate

In addition to the desired contributions of GHIs to PHC and UHC agendas, a range of other priorities for GHIs in addressing public health challenges were suggested. KIs emphasized the need to tackle underlying social, economic, and environmental factors that influence health outcomes. Another priority mentioned was the urgent need to address antimicrobial resistance (AMR), as well as the health impacts of climate change. KIs stressed the importance of adopting One Health approaches that consider the interconnectedness of human, animal, and environmental health. Pandemic preparedness and response were also highlighted by some as critical areas of focus for GHIs. Regarding social determinants of health, KIs emphasized that addressing these factors requires a broader approach that goes beyond the scope of GHIs alone. It was recognized that governments play a central role in addressing social determinants through policies such as taxation and investments in essential infrastructure, including water, sanitation, and hygiene. Overall, KIs, particularly CSOs, emphasized the need for a comprehensive approach to health that encompasses not only the absence of illness but also the broader social, economic, and environmental determinants of health. This approach aligns with the principles outlined in the Alma Ata Declaration, which calls for healthcare to be viewed holistically and address the underlying determinants of health.

“GHIs are largely defining health in terms of absence of illness. So it's the kind of very biomedical definition of health. So it's not about optimal wellbeing, total wellbeing, it's absence of illness. yes, we

need those technical solutions, but we're not really seeing those organisations engaging in conversations about the structural factors that make it difficult for states to run their own procurement programmes for childhood vaccinations or to produce for example vaccines that are needed locally [...] What needs to happen is that we need to think much more in terms of the Alma Ata declaration. And it's a reference to building a new international economic order that's conducive to health promotion and reducing material inequalities and health inequalities globally.” (CSO KI)

3.4.3. Financing

KIs proposed various changes to the financing models of GHIs. There was general agreement that there is no one-size-fits-all and countries should not necessarily be grouped or labelled by GHIs. However, some respondents thought that it would be important to classify to ensure transition and prioritise investments.

On-budget

The most common recommendation was to ensure that all funds are included in the national budget. This would involve declaring these funds to the Ministry of Finance and MoH, ensuring greater transparency and accountability in the use of resources, and allowing countries to have greater predictability and flexibility in allocating resources across different aspects of the health system.

Pooled financing

The concept of pooled financing was suggested to achieve a common budget with MoH ownership and stewardship, leading to better alignment with country needs and improved coordination. Pooled funding can provide countries with a more agile and manageable budget, reducing transaction costs and allowing for greater flexibility in programming. However, transitioning to this approach would require significant changes in governance and coordination structures. Joint accountability structures were also proposed to ensure effective oversight and management of pooled funds. Such structures would involve multiple stakeholders, including GHIs, governments, and other relevant actors, working together to monitor the use of funds, track progress, and ensure accountability for results. These proposed changes aim to enhance the alignment of resources with country priorities, improve coordination among different actors, reduce administrative burden, and increase resource management's overall efficiency and effectiveness in global health financing.

Longer-term funding

Another recurring suggestion from KIs was the need to transition to a longer-term funding horizon. This could be achieved through either grant or concessional financing mechanisms that provide a longer-term commitment of financial resources. There were many suggestions to increase grant timelines to at least five years, to allow for more sustainable and secure funding.

Concessional finance

Some participants proposed the utilization of concessional finance from regional development banks, in combination with grants. This would provide additional financial resources and extend the length of financial cycles, enabling countries to undertake sustained investments in HSS and UHC.

“Whatever is available today in grants should be working hand in hand with what is available in terms

of access to long term financing. We should better use the available financing that exists in public development banks.” (Bilateral KI)

Harmonising replenishment cycles

A wide range of KIs warned that replenishment models were not sustainable for the future of GHIs, amidst a shrinking fiscal space and competing priorities. Therefore, it was suggested to harmonise the replenishment cycles.

Private sector considerations

In terms of PPPs, strengthening financial regulation for blended finance was deemed important, to minimise risk. Another suggestion, which came from multiple academics and CSO informant, was for GHIs to put conditionalities on private sector investments to guarantee equitable access to GPGs.

Increasing domestic financing for health

There was consensus among all actors that domestic funding of basic health services needs to increase, with an important role for multilateral development banks and GHIs to play. However, proposals on how this should best be done were limited. One academic alluded to the challenging political economy which has been limiting domestic funding for health:

“We want more domestic financing. But that would require bigger wider changes with the way for example the global economy works, in particular the way in which resources are extracted out of poor countries, the way tax avoidance is allowed to continue... so I think it's right to focus more attention on how we fix these bigger problems that are harming countries. Many of the countries are continuing to have resources extracted that are really unfair. In a way, yes, we need to increase domestic financing for health, but we need to first make it easier for them to do this.” (Academic KI)

Finally, in terms of reporting expenditure, many KIs advocated for GHIs to be more rigorous and transparent about tracking and reporting where their funding ends up, as highlighted here by an academic:

“I'd like to see where the money is being spent and how much of it ends up in the countries or back in the Global North. So there's a lot of work ongoing to track expenditure, but I'd like to see these initiatives to be tracking the way in which that expenditure produces income. That will determine who is benefiting from these GHIs. It's not enough to say, 'this is what we've spent money on.' We need to know, well, who's benefited from all this expenditure? The large amount of this expenditure ends up in places that shouldn't be benefiting from these initiatives. [...] how did each dollar they spend shift income patterns? What did their dollars of expenditure contribute to this wider pattern of inequality?” (Academic KI)

3.4.4. Governance, coordination and alignment

There is wide recognition that it is very challenging to govern, coordinate and align GHIs. These separate entities were not originally intended to work together and work within a global health system that continues to expand and fragment. Nonetheless, there were several suggestions

for improving governance, coordination and alignment - mostly directed at GHIs themselves. According to the views shared by the majority of KIs, there is a strong consensus (with some KIs acknowledging risks), that decision-making power should be shifted and placed in the hands of governments in LMICs, particularly within the MoH. There is a clear desire for more meaningful engagement of in-country government and CSO stakeholders at all levels. The role of the WHO and the World Bank was noted to be important, especially given their country presence, but with conflicting views on to what extent and in which area(s).

Country ownership at the heart of GHI governance

One of the strongest themes emerging from all stakeholder groups and across all regions and countries was the need for country ownership and improved country involvement in developing priorities, in part through enhancing GHI relationships with MoH and ministries of finance. Several specific examples of how to improve country ownership were provided. One concrete suggestion was to embed GHI representatives into each MoH to reduce the dependence upon international consultants and GHI secretariats:

“Having that day-to-day interaction with the Ministry and then being able to use that local intelligence to build your programme or strategy or policy would be a better way to do it. In each MoH I would like to see a representative from Gavi, a representative from Global Fund, a representative from CEPI... because then you’re actually working alongside them, in partnership with them. [...] I think you would get a lot more out of the Ministry by working hand-in-hand with them to co-develop solutions, rather than Geneva saying, ‘this is what you’re going to do...” (CSO KI)

Frequent suggestions around strengthening in-country ownership in direct response to the challenges with global health governance being centred in Geneva and Washington DC were made, including building regional capacity and diversifying board membership. Multiple KIs reiterated the need to evolve away from being ‘Geneva-centric’ and move decision-making to country or regional level. Some people suggested that the GHI secretariats be moved out of high-income countries, or at least be made leaner and less costly.

The role of WHO as a global governance body was also valued by some, with suggestions for the future evolution of WHO including fewer programmatic silos and more governance and technical support at regional and country levels. There was no consensus around the potential use of WHO as a governing body for GHIs, but GHI and private sector KIs did generally express a desire to have more collaboration with WHO, particularly surrounding norm-setting, TA, and product development. The World Bank and regional development banks were noted by many to be an area for improvement of global and country governance, coordination and alignment of GHIs. One GHI informant said regional development banks are “pretty new to this whole thing,” while another GHI informant mentioned the need for the global health sector to become more multidisciplinary and work with development banks:

“...[there is a] need of Global Health [sector] working more with others.. because in a sense, more than health, it’s about development. So it’s also leaning on the organizations that have a broader network.” (GHI KI)

In terms of CSOs, many KIs recommended that they are more widely in decision-making processes and within governance bodies, particularly to ensure marginalised populations are reached and to amplify their important added value around advocacy.

Some actors were sceptical of private sector involvement in GHIs (particularly some of the CSO and academic KIs), while others were keen that their resources are used more. Private sector KIs recommended that GHIs and multilateral organisations involve the private sector in discussions regarding new innovations at an earlier stage and more systematically, to align and negotiate equitable access. The need for GHIs to strengthen their anti-corruption mechanisms was suggested by some.

Regional bodies

The increasing role of regional bodies in governance, coordination and alignment as well as the need to build regional capacity was highlighted by KIs throughout the data collection. Many KIs stressed that GHIs should make more effort to acknowledge and support regional initiatives and agendas, such as the New Public Health Order for Africa (10), the PAHO revolving Fund for Access to Vaccines (11), and the African Leadership Forum (12).

Coordination

There were strong opinions that no new coordination mechanisms should be established for GHIs, unless they are funded and binding, amidst recent lessons learned from previous coordination efforts. There were differing views about the coordination between GHIs. There was a general sense that countries need to be in the driving seat of any coordination efforts.

Re-shaping GHI boards

The Boards of GHIs were widely perceived as key levers for change, and in line with the challenges presented above, there was overall recognition that they needed to continue to diversify (including monitoring of this diversification and representation) and ensure meaningful representation of recipient countries. A bilateral donor suggested that having a forum for board chairs and vice chairs to come together and discuss would be beneficial. Meaningful CSO engagement on GHI boards was also emphasised:

“A Global Framework could be the first step in really mandating organizations to report on this, as they would on other indicators. I think that would be a really good step towards decolonizing global health. [...] So... on your Board, what's the representation on your Board? Where are they based? Is everyone on your board white and based in the US and UK or do you have people on your board that are actually in some of the countries that the organization is implementing projects? [...] Who's at the decision-making table, representing? When you're developing your strategy.. who's feeding into that? Who makes decisions about funding? I think we really want to see more representation, because right now it isn't representative of populations that are being targeted. More representation across the board. Racial representation, gender representation, representation from LICs as supposed to HICs.”
(CSO KI)

One suggestion was that regional representative seats on board, such as for the African Union or Africa CDC, be funded. Other suggestions included having a WHO observer role on each GHI board and to create KPIs to evaluate board compositions and encourage GHIs to ensure diversity. Some KIs

stressed the need for GHI boards to discuss among themselves in an effort to align and avoid duplication and competition. One key informant suggested that GHI boards should call for and fund the development of longer-term strategic visions (10 to 15 years) with clear milestones and metrics, and look to make significant (but evidence-based and well-considered) shifts within individual strategic periods.

Structural changes

Of all the GHI models, the GFF was most frequently identified as a good model to strengthen and expand. KIs appreciated its lean governance structure, in-country Liaison Officers, and its focus on children, adolescents and mothers. In terms of merging GHIs, the most common suggestions were to merge GFATM and Gavi, or Gavi and CEPI. One GHI representative suggested that good models should be adapted, rather than starting from a blank slate:

“I’m always a fan of not completely reinventing the wheel. I think you can modify the wheel. We shouldn’t be starting off with a blank sheet. If we all believe that there is a certain model or capability that we want to expand, then transplant that. Don’t say, well, that’s a really great model, I’m gonna make a copy-and-paste version because it’s never quite the same.” (GHI KI)

3.4.5. Performance indicators and accountability mechanisms

Performance indicators

Overall, the study found that there is strong appetite among many actors, aside from GHIs, to use performance indicators that go beyond singular disease targets and that GHIs should move from attribution to contribution of their impact at country-level. The power that donors have surrounding GHI performance indicators was recognised as an important lever for change. Better criteria for classifying countries was suggested. For example, some KIs noted that as using gross domestic product or Gini coefficients mask income disparity and inequalities, especially in MICs; different approaches to define beneficiaries might be required, such as using equity indicators.

Another suggestion raised by multiple CSOs and academics was to have overarching frameworks of indicators at a global level that could be used across all GHIs to compare their performance. KIs noted that there is a need for consensus around what indicators GHIs should use to measure their contribution to both UHC and HSS.

Some KIs suggested that GHIs develop country or regional-specific indicators in consultation with recipient countries. One CSO representative suggested that GHIs develop local indicators in consultation with the affected communities that they are targeting:

“I think every initiative should really engage every population that they are working on behalf of, for them to include some indicators. Because success can look very different for them [...] I just think it’s a big gap and [GHIs are] assuming that they know what success would look like. Whereas for them, success could look very different – it could be a very different type of indicator. So I think the indicators are there, they appease the GHIs, but I think it’s missing that local-led understanding of what success looks like, in addition to the other indicators.” (CSO KI)

Having more frequent and in-depth independent evaluations of GHIs was suggested by many KIs as a potential mechanism for improving the accountability of GHIs and their donors. Some suggested having joint evaluations.

Indicators to measure collaboration between the GHIs were also suggested as an avenue to incentivise collaboration. In terms of measuring the success of the global health system as a whole, few concrete ideas were identified. One informant was sceptical that this would be possible without first agreeing on the mandates and objectives of GHIs:

“Unless donors and governing boards agree to amend the mandates of GHIs to act as an ecosystem, with collective objectives, we cannot suggest how success as an ecosystem would be measured. It is unlikely there will be such consolidation in views in the near future.” (Academic KI)

Some KIs stressed that the ultimate success of the system should be based on the reduced dependence on (and ultimately no need for) GHIs. Breaking away from a siloed approach for measuring success to encourage collective action toward common goals was suggested by a private sector key informant.

Accountability mechanisms

Accountability mechanisms for GHIs, as well as donors and country governments, were noted to be important for coordination mechanisms, and for funding flows. There have been calls for increased transparency among the GHIs on what gets funded and where. Many actors acknowledged the importance of CSOs in holding GHIs and governments accountable. Many study were unaware of the activities and budgets of FIND and CEPI, which have little publicly available information in comparison to the larger GHIs. Some KIs were outraged that donors, particularly philanthropists, are given decision-making power without accountability mechanisms. There were suggestions to have stronger accountability mechanisms at country-level too, against corruption, and to ensure funding ends up where it is destined.

“We need mechanisms in place to hold people’s feet to the fire. [...] Having people’s feet to the fire at local level. For implementation. And that’s where I think the political will, the associated budgets behind it, and financing instruments are important.” (Private Sector KI)

Issues of accountability were also linked to wider debates around decolonisation in the health sector. One CSO informant proposed the creation of a global level ‘decolonisation framework’ to hold GHIs accountable for decolonising their current ways of working and board composition but was unsure which governing body (if any) should be responsible for monitoring such progress. Some KIs suggested the need for a diversification of the range of actors that GHIs are accountable to.

Amidst changing burdens of diseases and new arising global health challenges, there was consensus that GHIs should become more agile, responsive, and adaptive to emerging challenges in order to remain fit for purpose over the next 20 years. Finally, it was recommended by some KIs that GHIs should collect and report data on their impact on the environment in an effort to improve accountability.

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