

Appendix 11

Multi-stakeholder Consultation Summaries

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Acronyms and abbreviations

AU	African Union
CCM	Country Coordinating Mechanism
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 Mobilization
ECOWAS	Economic Community of West African States
EHSP	Essential Health Service Packages
EMRO	WHO Eastern Mediterranean Region
FGHI	Future of Global Health Initiatives
FIND	Foundation for Innovative New Diagnostics
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
KI	Key Informant
LMIC	Low and middle-income countries
NCD	Non-communicable disease
PDP	Product Development Partnership
PHC	Primary healthcare
R&D	Research and Development
SDG3 GAP	Sustainable Development Goal 3 Global Action Plan
SEARO	WHO South-East Asia Region
SG	Steering Group
TA	Technical Assistance
UHC	Universal Health Coverage
UN	United Nations
WAHO	West African Health Organization
WPRO	Western Pacific Region

1. Introduction

This document summarises each multi-stakeholder consultation held throughout the Reimagining the Future of Global Health study. The consultations were held with each WHO region (n=7¹) and an additional consultation with the Product Development Partnership Coalition. Two consultative meetings were also organised to share and deliberate the findings of the study: a hybrid consultation in Addis Ababa, co-hosted by the Africa Centre for Disease Control and Prevention, and a virtual consultation with the Reimagining the Future of Global Health Initiatives (FGHI) Steering Group.

2. Methodology

Multi-stakeholder consultations were held to complement the study findings and gain diverse perspectives on challenges and opportunities for change regarding GHIs and the broader global health system.

Data Collection

Each consultation followed a slightly different approach, based on participant availability and type of expertise. Participants were recruited through multiple avenues: suggestions from the FGHI Secretariat and members, The Wellcome Trust, key informants (KIs) that had been interviewed to inform the global or country-level studies, and through purposeful searches of websites and literature. Unique semi-structured topic guides were developed for each consultation, adapted from the global-level topic guide, with some additional questions based on findings from the literature and the global and country-level key informant interviews. Informed consent was taken from participants in order to audio-record and transcribe the data. Ethics approval was granted by the four universities involved in the consultations: University of Geneva (CUREG-2023-02-19), Stellenbosch University (South Africa) (N23/03/014), Aga Khan University (057-ERC-SSHA-2023), and Cheikh Anta Diop University (CNERS: n°00000179 MSAS/CNERS/SP). In total 76 participants were involved in the consultations (Table 1).

¹ There are six WHO regions, however for the purpose of this study, the AFRO region was divided into two subregions: Southern/Eastern Africa, and West Africa, so that the consultations could inform the South Africa and Senegal case studies, respectively.

Table 1. Overview of the regional consultation participants

WHO Regions	Number of participants (n=)	Type of participant	Countries represented	Type of consultation	Research consortium team responsible
AFRO (West)	17	Multilateral and regional technical and financial partners (n=10); Implementation partners (n=3) CSO (n=3) Academics (n=1)	Benin, Burkina Faso, Ivory Coast, Mali, Niger, Senegal	Individual key informant interviews via Zoom (between 1 and 1.5 hours each)	Université Cheikh Anta Diop de Dakar
AFRO (Southern and Eastern)	16	Recipient governments (n=7) Academics (n=4) Multilateral (n=3) NGO (n=2)	Egypt, Eswatini, Ethiopia, Kenya, Malawi, Uganda, Zambia	1.5 hour virtual multi-stakeholder consultation via Zoom and nine individual key informant interviews	Stellenbosch University, South Africa
EMRO	10	WHO EMRO/multilateral (n=5) WHO country office (n=1) Recipient governments (n= 3) NGO/CSO (n=1)	Afghanistan, Somalia, Sudan, Syria	1.5 hour virtual multi-stakeholder consultation via Zoom and individual key informant interviews	Aga Khan University, Pakistan
SEARO	11	Multilateral (n=1) Recipient governments (n= 1) Academics (n=3) NGO/CSO (n=6)	Bangladesh, India, Nepal, Sri Lanka, Indonesia, Bhutan	1.5 hour virtual multi-stakeholder consultation via Zoom and individual key informant interviews	Aga Khan University, Pakistan
EURO	2	WHO country office (n=2)	Azerbaijan, Tajikistan	Individual 1 hour key informant interviews	University of Geneva, Switzerland
WPRO	2	CSO (n=1) Government (n=1)	Philippines, Papua New Guinea,	Individual key informant interviews	University of Geneva, Switzerland
PAHO	19	Recipient governments (n=5) CSOs (n=10) Academics (n=3) Multilateral (n=1)	Colombia, Costa Rica, Haiti, Mexico, Peru	1.5 hour virtual multi-stakeholder consultation via Zoom	University of Geneva, Switzerland
Total number of regional participants	77				
Additional Consultation					

PDP Coalition	6	Product development partnership members	N/A	1.5 hour virtual consultation via Zoom	UNICE
Consultative Meetings					
Hybrid Deliberative Discussion co-hosted by the Africa CDC	29 in-person 16 online (via Zoom)	<p>In-person: Recipient governments (n=9), FGHI secretariat (n=2), FGHI co-chairs* (n=2), Wellcome Trust (n=2), CSOs (n=5), Multilaterals, (n=3), Regional organizations (n=3), Africa CDC (n=3), bilateral donor (n=2)</p> <p>Online: CSOs (n=2), Product development partnership (n=1), Recipient governments (n=2), Foundation (n=3), Wellcome secretariat (n=2), Bilateral (n=2), Independent global health consultant from the African continent (n=1), Multilateral (n=1), Academic (n=1), African Union (n=1)</p> <p>*co-chairs were counted in both their roles</p>	Central African Republic, Ethiopia, Ghana, Guinea-Bissau, Malawi, Somalia, Tanzania, Uganda	Full day in-person (African Union Commission) and online via Zoom	All
FGHI Steering Group	22 (excluding research team members/ FGHI Secretariat)	<p>Multilateral (n=2), Recipient governments (n=3), CSOs (n=2), Bilateral donors (n=8), Foundation (n=2), Wellcome Trust (n=3), FGHI co-chairs (n=1), FGHI secretariat (n=1)</p> <p>Of these, 12 were FGHI steering group members/assigned members</p>	Ghana, Indonesia	2-hour virtual multi-stakeholder consultation via Zoom	All
FGHI RLTT	43 (excluding research team members/ FGHI Secretariat)	Academic (n=6), Bilateral (n=8), Multilateral (n=9), CSO (n=4), GHI (n=4), Wellcome Trust (n=3), Foundation (n=1), Recipient Government (n=1)	Democratic Republic of the Congo	1 hour via MS Teams	All

Limitations

These consultations have certain limitations that need to be acknowledged. Firstly, the limited time available for discussions may have prevented a thorough exploration of issues and ideas. Secondly, there is a possibility of informant bias or information withholding due to the presence of multiple stakeholders in some of the consultations, potentially impacting the openness of discussions. Moreover, some participants may not have had sufficient time to adequately prepare meaningful responses due to the short timeframe of the study. Additionally, the consultations may not be fully representative of entire regions or groups, as recruiting a diverse range of well-informed participants within the study's limited timeframe posed challenges. Despite multiple attempts from the research consortium, including high-level participants such as ministers and multilateral stakeholders proved to be particularly difficult.

3. Findings

A summary of each consultation is provided below. Each summary includes a short description of the context, opportunities and challenges and suggestions for change.

3.1. Regional Consultations

3.1.1. West Africa Region

As per Table 1, 17 in-depth key informant interviews were conducted, a majority of which were with technical and financial partners. Most of them had experience with GFTAM, GFF, Gavi and Unitaïd. Only one person had experience with CEPI and none of the key informants had experience with FIND.

3.1.1.1 Context

In a region marked by political instability, a reduction in already low domestic funding (despite international commitments made by governments in favour of health), and the withdrawal of certain technical and financial partners, the GHIs appear to offer an opportunity to meet essential health needs. According to the stakeholders that were interviewed, some GHIs, especially GFATM and Gavi were perceived as indispensable for meeting the healthcare needs of certain vulnerable groups, particularly given the reduction in domestic expenditure for health, which is around 2 to 3%. The GHIs were also acknowledged as playing a crucial role in countries with ongoing security issues, such as Burkina Faso, Mali and Niger, where certain technical and financial partners have withdrawn due to the geopolitical context. A key informant noted that in 2020, French funding for health systems fell from two billion euros to 600 million euros for all French-speaking African countries except Mali.

3.1.1.2 Opportunities & Challenges

Challenges across the region are numerous and broadly similar to those identified in the Senegal case study. Identified challenges include the over-bureaucratization of GHI processes, confusion over the status and mandate of regional bodies, and the links between the various organizations, their respective fields of action and their operational procedures. Two challenges

particular to the countries of French-speaking West Africa were highlighted: safety issues and the almost exclusive use of English in a primarily French-speaking region. Some initiatives, such as GFATM, were said to be ‘running out of steam’. According to participants in the consultation, this initiative should begin a period of transition and should come to an end in 2030. Consultation participants argued that the GHIs have not made it possible to achieve the Millenium Development Goals, nor Universal health Coverage (UHC), because health aid, at 16 billion euros a year, is low in relation to an estimated need at a minimum of 300 billion euros (AFD Social Protection Director). According to some KIs, initiatives such as the *Fonds Commun au Niger* (Niger's Common Health Fund) (1) are not well known and would benefit from being capitalized on and sharing of lessons learned. This Health Fund is an extra-budgetary support fund coordinated by the Ministry of Health and financed by technical and financial partners and certain initiatives, including Gavi - although it has withdrawn. It provides funding for all 72 health districts and eight regions in the country, without any conditioning, on the basis of an annual action plan. Activities are financed and implemented according to their relevance to the health development plan and the priorities of the Ministry of Health. This financial instrument is backed by the national health strategy, and involves ongoing dialogue between the Ministry and technical and financial, enabling greater negotiation on the programs to be financed.

3.1.1.3. Suggestions for change.

Looking to the future, informants suggested several ways forward for GHIs, including investing more in health systems strengthening (HSS) and research and development (R&D) and clarifying their status and mandates. Other suggestions focussed on setting up regional funds hosted by the African Union (AU), for example, or relying on sub-regional economic bodies such as Economic Community of West African States (ECOWAS) or the West African Health Organisation (WAHO). Participants also suggested including population well-being as an indicator of GHI success; meaningfully involving CSOs and communities in regional coordination; ensuring the accountability of GHI to countries and populations; decentralising GHIs (e.g. from Geneva to funded countries); examining the challenges of equitable contribution to GHI funding (e.g., reviewing the fairness of contributions from the GFATM and examining the fairness of Global Fund contributions. Other suggestions included helping countries to move away from dependence on GHIs.

Table 2

Area	Suggestions from West Africa Regional Consultation participants
Programmatic / health systems	<ul style="list-style-type: none"> • Identify new health needs • Correct inequalities by directing actions towards countries where results are weak. • Create synergies between actions or programs to be decided at national level in the countries concerned. • Simplify procedures and make them more flexible, adapting to realities on the ground. • Begin a transition to withdrawal in 2030 (Gavi and FM): supply products to the poorest countries and stop financing emerging countries. • Merge GFATM with Unitaaid, GAVI and CEPI • Promote and strengthen South-South cooperation, innovation and technology, and human resources development.
Financing	<ul style="list-style-type: none"> • Initiate a transition to replace Gavi or the GFATM with funds such as pandemic funds or green funds. • Make GHIs complementary financing funds

	<ul style="list-style-type: none"> • Create a coordination system housed either at the World Bank or the FICS that would network all development banks (2.7 trillion USD per year available for global health). • Encourage domestic financing by getting governments to increase their financial contribution. • Capitalize on and share the experience of national financial instruments such as the Common Fund in Niger. • Set up a health fund for WAHO or West African Economic and Monetary Union (UEMOA).
Accountability Mechanisms and Performance Indicators	<ul style="list-style-type: none"> • Set up a high council at the United Nations, or a global oversight council. • Include affected communities and CSOs in decision-making bodies • Establish dialogue between technical and financial partners and country government • Integrate the well-being of populations as a criterion for evaluating investments (e.g. the significant change model based on qualitative data used within the GFF framework). • Establish accountability indicators for institutions and technical and financial partners
Governance, Alignment, Coordination	<ul style="list-style-type: none"> • Use existing community mechanisms such as the AU, ECOWAS, WAHO for management and coordination. • Set up a single initiative, pooling funds under WHO. • Be flexible and extend program implementation times. • Strengthen community lead monitoring: monitoring is carried out by the community on a regular basis, to collect data for advocacy on health systems and access to health care. • Set up harmonization bodies at country-level, with a single general report and a single request for funding

3.1.2. Southern and Eastern Africa Region

3.1.2.1 Context

Reductions in HIV and AIDS, TB and malaria incidence and improved maternal, neonatal and child health outcomes were cited as specific examples of gains made in the Southern and Eastern African region. A specific example of GHI support to governments for strengthening health care delivery activities was the GFATM which was described as having been ‘agile and responsive’ to funding requests for additional posts in one African country. Despite the aforementioned gains however, the overall sentiment in the consultation was that current GHI funding priorities are no longer adequately aligned with regional and country needs, and that investments no longer match disease burdens across the continent, compared to 20 years ago.

Participants highlighted that Africa’s epidemiological transition from a predominantly communicable disease profile to include Noncommunicable Diseases (NCDs), violence and unintended injuries as drivers of disease burden has changed country priorities and focus. NCDs, including mental health, were identified as a major emerging and future threat to health systems in the region, and was seen as one of the most neglected areas in terms of investments in domestic resources, external funding or research support. Those who have worked within the NCD arena for

many years felt that minimal - or even no - attention had been paid to these conditions or the risk factors that drive them. *"I am more a communicable [disease] researcher. I'd have to tell you that this [NCDs] is one of the most neglected areas when it comes to investments, whether it's from external sources, with this, from domestic sources where they stand in terms of investment, in research and understanding."*

The impact of climate change on the health of the African population, and how this relates to One Health was also raised as a concern for the future and was highlighted as an area that GHIs should focus their future efforts on.

According to the participants, most of the issues and concerns pertaining to current and future GHI support in the region and within countries related to strengthening health systems and Primary Health Care (PHC) towards UHC attainment. Dominant discourses by the participants on these subjects related to GHIs' lack of investment in health systems strengthening and the fragmentation caused by GHIs given the disease-specific nature of their mandates. Suggestions were made that GHIs should not only be focused on health care, but should also consider the broader health system. This would mean that investments should extend beyond the current focus. In terms of the verticalised nature of GHI support, it was felt that curative and therapeutic interventions, as opposed to promotive and preventive ones, were more costly and did not address underlying problems African countries face.

As indicated above, an important potential area for GHI investment is in PHC- both in terms of capacity development and in promoting general systems thinking, which was said to intersect with health systems strengthening. *"Countries may need investments in building capacities to be able to 'connect the dots' between sectors, rather than investments in hospital beds or cancer treatment centres, for example."*

An important perspective relating to the changing geopolitical situation globally was that aid is often tied up with geopolitics, and this should be considered when contemplating the future of health on the African continent. The increasing prominence of China and India compared to the US economy, and the shrinkage of Japan, the UK and France's economies will impact trade and health financing. For example, China and India are contributing on the global health stage through funding medicines. Many participants questioned how this would impact the future of funding on the African continent. This bigger picture should be considered when thinking about the future of GHIs and what this means for funding in Africa.

3.1.2.2. Opportunities & Challenges

Numerous challenges were cited with regard to the presence and work of GHIs in the region and in-country. As a result, fragmentation of and inefficiencies in health systems, caused by duplication of activities, lack of coordination, inequitable distribution of resources and verticalization of health care services were commonly reported as challenges.

→ Programmatic & Health System

In certain instances, it was felt that investments did not always translate into improved health outcomes or equity. An example was provided on Zambia, where maternal health coverage has improved but health outcomes have not. Yet, some GHIs continue to fund interventions that increase coverage and do not invest in determining the root causes, and consequently fail to address

underlying reasons for poor health outcome achievement. Vaccination was suggested as a potential area of collaboration, with one country's COVID-19 vaccination programme for children seen as a missed opportunity to vaccinate their parents. Another example was provided regarding GFATM - where a country was provided TA for developing concept notes on integrating HSS. This TA was from outside the country. However, at the time that the guidance was developed, the external experts were not able to travel to the country. This was perceived as frustrating, as there were numerous experts within the country, on the continent and the African diaspora who could have been involved, rather than relying on external TA.

→ Funding priorities

Overall, the sentiment in the consultation was that most donors only fund health conditions that pose a threat to their own countries. Furthermore, there was a sense that GHIs were not fully committed to addressing African country disease burdens, priorities and health system needs. GHIs were reported to dismiss country plans in favour of their own priorities, which, in turn, undermined country efforts and long term plans.

Despite positive reports, some GHIs were described as being less flexible in responding to country requests, focussing only on their specific areas of interest. These actions have created fragmentation and inefficiencies in the health system, as well as missed opportunities.

The tension between GHI and DAH actors and countries was another dominant theme in the consultation. With regards to DAH and domestic resource mobilisation trends in Africa, African-made policies, strategies and frameworks were often not adhered to by countries, nor reviewed when considering the continental and regional policy landscape. The African Union's 2021 Abuja Declaration (2) and the African Scorecard for Domestic Financing (3) were given as examples where greater accountability was required. It was noted that in 2021, only two countries had reached the 15% allocation based on the African Scorecard for domestic financing for health. Other concerns were that there is no clear guidance on how the 15% should be allocated, nor were there guiding criteria (e.g. based on need or context). It was felt that these and other African accountability frameworks are not respected by governments, nor adhered to, nor monitored, nor sufficiently reported on, and that there were no serious sanctions for non-adherence. Questions were raised as to "*who will hold who accountable?*" A call was made for the region to review these policies, strategies and frameworks and determine whether they are still applicable as most of them were developed many years ago.

Economic classifications of countries, and what this means for countries such as Ethiopia which is on track to move from a lower- to a middle-income country was raised, as this reclassification will mean that by default engagements with World Bank and the International Monetary Fund will change. Instead of being eligible for concessional loans, it will be eligible for commercial loans. There are thus concerns that once the country passes the threshold, it may be subject to a new range of requirements or commitments.

With regards to domestic resource mobilisation (DRM) for health, strong views were expressed that DRM should not be used to fill gaps or shortfalls of external funding but should be based on the health demands and fund health activities. Countries should also be more intentional about increasing their tax base in terms of tax-to-GDP (gross domestic funding) ratio.

Some participants suggested that GHIs can assist with identifying good practice examples for country investment from other countries, and can provide opportunities for funded countries to learn from and apply these lessons learned with the help of the GHIs: health security plans, NCDs and disease and mortality surveillance systems. An example of a future model for financing reforms which links to attainment of UHC and PHC draws on Malawi's move towards developing a more integrated package of care, for example HIV/NCD integration (4,5). A scenario was proposed whereby GHIs deliver integrated financing towards delivery of integrated care, which will mean a shift from funding vertical programmes.

When speaking from a GHI funders' perspective, country inefficiency was raised as a concern as available funding is not always used appropriately, with a suggestion that GHIs also focus on supporting countries to improve their technical and allocative efficiencies. However, at the same time, they should ensure that they implement processes and procedures that promote the attainment of these efficiencies.

→ Governance, coordination and alignment

Several concerns arose around the governance structure of GHIs, which was not considered adequate or appropriate. As a collective, GHIs across the region and within countries, are not aligned.

High-level officials reiterated the call for African Ministries of Health to be stronger about their needs and wants, through strengthening country leadership and negotiating and leading engagement with GHIs. It was suggested that countries should have a clear theory of change, move beyond being output-focused and adopt a people-centered approach to care. The differing needs, interests and power of actors including pharmaceutical companies, governments, communities, CSOs were highlighted, with each set of interests affecting how resources are allocated and managed, and how countries interact with each other.

The role of the Africa CDC was frequently mentioned. It was viewed as a body that can coordinate donors within the African context, with suggestions that it should play a greater role on the continent, focussing on local issues and using its position to leverage and coordinate institutions at regional and sub-regional levels.

Another challenge related to Africa's presence and capability when interacting with global actors, including GHIs and DAH, given the design of the global architecture. African Ministers of Health were said by some participants to often have very little influence over decisions made at high-level meetings in comparison to Heads of State. The consultation highlighted that Africa requires capacity enhancement and should be better prepared and able to present a united front or common agenda when engaging with GHIs and other global actors such as UN entities. Some suggestions were made as to how this could be attained and these are presented in the section below.

Furthermore, countries should ensure that they are able to negotiate with GHIs. An example of Rwanda's success at aligning funders' priorities with their own was cited, with requests for lessons learned to be distilled and disseminated in ways that would make them transferable to other systems.

These issues also speak to what was referred to as weak in-country capacities to negotiate with funders to better align their priorities with that of the country. Insufficient human resource capacity, inexperience with negotiating with GHIs and other global actors and heavy reliance of external funding creates an environment where funders have more power to push their agenda and over-burden staff and cause fragmentation.

The inclusion of both African and female representatives on GHI boards was a frequently stated concern, as was the inclusion of CSO representatives with narrow interests who did not lobby or represent wider societal issues.

3.1.2.3 Suggestions for change

Based on the aforementioned challenges, regional informants suggested the following in regard to the future of GHIs and the wider global health system in Southern/Eastern Africa:

Area	Suggestions from Southern and East Africa regional consultation participants
Programmatic/ health systems	<ul style="list-style-type: none"> • GHIs should be orientated towards Africa and streamlined where possible • Focus on UHC, HSS, PHC, integrated care, and build in-country capacities accordingly • Build on good practices towards health systems efficiencies • Capacity building is also required at the lower levels amongst HRH who work within primary health care. Efforts should be directed at investing in, motivating and retaining these frontline workers and managers, including community health workers (especially in rural areas) through training and mentoring programmes. • Patient-centered care was reported as central to all efforts. • Building the technical capacity of in-country officials and staff was also frequently mentioned. Funding in-country experts and organisations, higher education institutions, experts who form part of the African diaspora and actors who deeply understand the African context was urged. Where expertise does not exist, external experts should prioritise building in-country capacity.
Financing	<ul style="list-style-type: none"> • Better align funding priorities to country needs • GHIs to fund integrated care • For GHIs to continue to use innovative financing mechanisms • Couple technical assistance (TA) with GHI funding (to improve efficiencies for busy governments) • Regional collaboration and partnerships should be the foundation for building and pooling regional resources. • Continental frameworks for financing are required and should enforce, and state how, SDGs be captured in national responses to health. • 'Catalytic investments' for HSS
Accountability Mechanisms and Performance Indicators	<ul style="list-style-type: none"> • Country ownership of GHI activities and their national plans should be prioritised and strengthened. • Accountability mechanism(s) for the Abuja declaration

Governance, Alignment, Coordination	<ul style="list-style-type: none"> • Strengthen regional actors and African governments' ability to lead, engage with GHIs, DAH and other global actors towards a unified voice for Africa • Review and revise (outdated) regional agendas and frameworks • Leverage recent successes of the African Union, Africa CDC, New Public Health Order • Heads of States should take the lead in terms of setting the health agenda within their countries • Board members and those working within GHIs should spend time in-country to better understand the contexts; those who sit on Boards should be 'in touch' with what is happening on the ground in regions and within countries. • GHI Boards should have good gender and geographical representation • Regions should make strong 'business cases' and put issues regarding human security at the forefront of the agenda and then strongly advocate for change using 'numbers' (data) as evidence. Upcoming meetings such as the UN General Assembly in September, the Climate Summit (Nairobi in July) and the BRICS Summit were mentioned as opportunities to capitalise on. • Regional bodies should come together and discuss what is required to attain health goals, and identify which partnerships are required. Some examples are that a Health Security Plan for Public Health Events of Concern or a unified All Hazards Response Plan for Africa be developed for the region or continent. • Use of upcoming policy windows e.g. UN GA to consolidate regional priorities • Some proposed that some GHIs be merged, or aligned or that they collaborate with each other (e.g. for strengthened pandemic control; streamlined activities, processes (funding application processes) and technologies; capacity building activities). They could have joint country missions. • Numerous calls for more regional leadership programmes to be implemented. • For governments and CSOs to work in a complementary (and not conflicting) manner • Sharing of lessons learned
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Some examples of good practices, but also opportunities for GHI-specific improvements, were given, concerning GFF and GFATM (Box 1 and Box 2).

Box 1 The Global Financing Facility (GFF)

The value of GFF is that it comes with TA (e.g. training of country leaders to promote innovation). This was seen as a favourable and promising practice for how GHIs should be interacting with countries. One example was the use of TA (using GFF funds) for costing newborn ICUs. Another example from Zambia was that in-country experts were used (e.g. academics at higher education institutions) to assist with national health accounts and resource mapping. To avoid debt, it was suggested that the GFF should reconsider making their funding conditional on a loan.

Box 2 The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

Two requests were made by the regional informants. First, that GFATM expand their procurement platforms and systems, and that this can be done through partnerships with other GHIs. The GFATM is also said to have a mechanism for risk management relevant to its grants. It was felt that this was applicable to all parts of the health system as a tool to promote efficiency. The reason for this was based on the burdens placed on countries by the various GHIs and DAH funders whose systems are not aligned. For example, an accountant will have numerous mechanisms to work with, which translates into increased efforts and duplication. It was therefore recommended that the systems and processes offered by GFATM be mainstreamed and standardised for use across countries (i.e. if it is regarded as the gold standard by all).

A contrasting view however was that GHIs, such as GFATM consider adopting the processes of the country. Their focus should be on building in-country capabilities within national health systems. There were strong opinions that energy cannot continue to be expended on activities that are only focused on three diseases.

3.1.3. Eastern Mediterranean Region

3.1.3.1. Context

The burden of disease (BoD) trend in low-income fragile states is changing, with an ageing population in EMRO and SEARO and a higher burden of NCDs is being seen. GHIs are recognized for building country priorities towards disease control targets, data systems for decision-making, information systems and cost-efficient quality assured commodities and vaccines. Support from GHIs led to progress in disease indicators between 2000 and 2015, however since then, indicators have plateaued and are behind SDG targets, suggesting the need to rethink the current strategy. There remain large gaps in GHI-supported disease coverage including an expected surge in HIV cases, climate-related malarial episodes, TB control has plateaued, and Hepatitis B and C prevalence is high but underfunded. Co-infections also require an integrated response. In addition, domestic funding remains challenging in EMRO with domestic financing trends in low-income and fragile countries (Afghanistan, Djibouti, Somalia, Sudan, Syria, Yemen) looking concerning, and insufficient incentives for country governments to increase domestic funding on disease control. One respondent from a multilateral organization in the EMRO region noted, *“The domestic financing trends in the region do not look very promising.”*

3.1.3.2 Opportunities & Challenges

Programmatic and health systems

GFATM and Gavi were viewed as having built effective systems for disease quality-assured vaccines, medicines, diagnostic kits and bed nets at optimized prices. They were also credited for effective disease-specific data systems, which have helped with decision-making for

immunizations, TB, malaria and HIV. Disease advocacy provided by GHIs was also seen as necessary to counter country government traction and diversion of domestic funding towards curative care. At the same time, country governments have to a certain extent abjugated responsibility for resourcing disease control because of the availability of GHI support. Low-income and fragile countries are aid dependent for primary health care delivery: they do not want to lose foreign aid support and are thus disadvantageously placed to articulate and negotiate aid modalities with GHIs. Disease stewardship challenges are common to all low-income-fragile countries but vary across countries. There are promising beginnings in EMRO low-income fragile states for integrated working on essential health services package (EHSP) development under UHC commitments, with modalities being worked out with individual countries. A respondent from Somalia noted, *“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...but at least there is an attempt.”*

Weaknesses in planning and coordination were noted across disease programs, resulting in cross-programmatic inefficiencies. Convergence is required in deploying more comprehensively skilled human resources, multi-purpose screening and robust supply chains across priority communicable diseases. Consultation participants questioned the value of country-level vertical programs, which were often perceived as detrimental to integrated and impactful service delivery. GHIs do not need to rely on a vertical program as a channel for aid disbursement, and although this is to some extent realized at the global level, the perception at the country level remains tightly vertical. There is little attention to institutionalizing disease control efforts - the COVID-19 pandemic exposed the weakness of minimal investment in disease control systems, preparedness planning and lack of serious attention to IHR indicators.

Low-income-fragile countries in EMRO being aid-dependent are disempowered to articulate country priorities on aid modalities and aid priorities to GHIs. Country government and recipient organizations acquiesce to GHI set preferences and follow GHI guidelines as best as possible to continue receiving foreign aid. This creates an imbalance of power with those having contextualized country experience (local NGOs, government etc) unable to feed into the priorities and programming of GHI country support. Country commitments must match country disease burdens more closely. For example, the burden of malaria is decreasing but with climate change, there are likely to be more episodic cases. Tuberculosis levels are stagnant. HIV cases will increase hence planning should be to circumvent expected increase rather than guide on existing cases. A shift to contextualized HSS responses is required with greater articulation with country stakeholders.

Financing

Investments are largely led by individual GHIs rather than country stakeholders, reflecting what consultation participants described as a power imbalance where verticalized initiatives are donor-driven rather than institutionalized within a country-led PHC response. The efficiency of GHI funding with BoD in EMRO is compromised by duplicative vertical programs, with each GHI having its own very specific strategy, leading to less investment in health systems strengthening and the absence of a strategy to involve the private health sector.

In terms of funding disease control, to ensure meaningful progress in meeting disease targets resourcing will be required from GHIs in low-income-fragile countries. The issue within low-income and fragile countries is firstly of aid dependency for primary health care delivery as domestic funding is traditionally diverted to curative care, and secondly of complacency that GHIs will fund disease control efforts – countries have not been challenged or incentivized to fund disease control. GHIs have pushed countries to contribute more, as for example to move program management staff from GHI fund to domestic support but GHIs also find it difficult to stop funding to a country if it does not contribute its share. For example, in Somalia there is a perception that certain diseases are the responsibility of GHIs hence there is little incentive to resource these with country funds. A PHC fund is being created by the World Bank with contributions from GHIs to cover specific diseases as well as other PHC services (6) (7). Afghanistan is completely donor-funded with the health system funded on ad hoc basis, however the EHSP has been a point of integrated efforts by GHIs and other donors, with the GHIs completing the existing system and also benefiting from it. In Sudan, with an ongoing war, it was noted that the increase in domestic health resourcing goes towards conflicts and casualties, making long-term planning difficult. In this setting, the approach of co-financing taken by Gavi is very important, pushing even low-income states to some level of co-financing (8).

Greater financing flexibility is required because strict budget lines of the GFATM makes compliance difficult in fragile and conflict-affected settings. A country government representative noted, *“there is a common understanding that specific disease areas are supported by Global Health Initiatives; if there are additional domestic funds available, they will be plugged in areas where no donor support is present.”*

Performance indicators and accountability mechanisms

Historically, there has been insufficient alignment between GHIs, with umbrella country planning efforts, and little investment in transitioning from accountability of specific outputs to accountability of aid effectiveness. Several weaknesses were noted as linked to the weak capacities of country governments, and health systems and insufficient institutionalization of capacities. There is a positive perception that data analytics provided by GHIs help focus decision makers and higher leadership on disease control priorities that would otherwise be neglected due to other areas. Power-imbalance between GHIs and the government results in donor-driven output-based targets rather than a focus on health systems process of moving towards the targets.

As one respondent stated, the best target to move towards in the future would be a system where little GHI support is required: *“the best way to measure the success of GHIs is when they make themselves redundant in a country and support the country in moving towards self-support and sustainability”* However, the principles of aid effectiveness such as harmonization and accountability have not been well practised. Harmonization between GHIs and of GHIs with overall national health planning important, rather than GHI-specific country objectives and its outputs. Countries have weak capacity for performance accountability of aid which can be helpful to negotiate aid towards more contextualized, integrated and sustainable responses.

Governance, coordination and alignment

In terms of national health plans, stakeholders perceive that GHIs have not attempted to integrate disease control priorities within PHC systems. More coherence is expected with the recent development of essential health service packages and the commitment of states towards UHC. For example, GHIs are interested to support the EHSP in Somalia, modalities are being worked out. Afghanistan also has a EHSP and the GHIs are leveraging on the EHSP to deliver common targets, however there is reportedly a funding gap of \$200 million to meet country targets and more resourcing required particularly in HSS to achieve the targets. Country plans are necessary for GHIs as a focal point to integrate efforts, but several states do not have country plans in place. Data analytics provided by GHIs, such as immunization-deprived areas, can be used as a proxy indicator of underserved communities to be reached with integrated packages under a national plan. Digital disease information systems, introduced by GHIs, can be expanded to other diseases. GHIs have participated marginally in national health planning for PHC, mostly they work separately on target diseases. One respondent noted, *“each GHI has its own very specific objective and strategy, sometimes the investments are not in line with country priorities.”* Another representative of a country government noted, *“none of the countries in the EMRO have the power to dictate their own terms to the GHIs. The final words come from the GHIs and the countries follow their guidelines religiously.”* An informant from a multilateral organization said, *“One area that is missing in the GHI investments is the principle of aid effectiveness, that would increase harmonization between individual GHIs.”*

3.1.3.2 Suggestions for change

Area	Suggestions from EMRO regional consultation participants
Programmatic/ health systems	<ul style="list-style-type: none">• GHI supported stewardship of disease targets in EHSP packages as part of PHC for UHC plans• Build cross-programmatic efficiencies• More contextualized country responses, process focused rather than only output focused• Institutionalize disease preparedness and IHR compliance as part of disease response• Private sector integration
Financing	<ul style="list-style-type: none">• Catalytic funding to increase country commitments towards disease control• Funding to HSS within country PHC for UHC plans• Pivoting disease specific innovations (digital systems, supply chains etc) to larger PHC areas
Accountability Mechanisms and Performance Indicators	<ul style="list-style-type: none">• Re-focus on aid effectiveness and harmonization• Country resourcing for aid coordination

Governance, Alignment, Coordination	<ul style="list-style-type: none"> • GHIs move to integrated planning under umbrella national plan • Use of GHI data analytics to identify disadvantaged areas for converged PHC-HSS efforts
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3.1.4. South East Asia Region

3.1.4.1. Context

The burden of disease (BoD) trend in SEARO has already transitioned to a double burden of disease involving competing demands of unfinished communicable disease targets as well as rampant NCDs. Years of GHI investment in communicable diseases has also helped develop clearly defined evidence-based disease interventions, whereas for NCDs, clarity on their role still needs to be developed. Increasingly communicable diseases and NCDs are seen to co-exist in patients but there are disconnects within the system for an integrated response, thereby creating inefficiencies and missed opportunities for more comprehensive care. PHC platforms should be the basis for provision of GHI support in the future. A prolific private commercial sector exists in SEARO countries providing PHC, these are yet to be sufficiently integrated. Historically attention has been on a supply chain-led system and more needs to be done for community communication and demand.

Country investments are perceived largely led by the specific GHIs and international consultants/ academia rather than country stakeholders, hence are less grounded in local systems responses. SEARO countries have a considerable presence of local experts who are not leveraged for country planning by GHIs. Within countries, vested political interests, traction towards curative care and slow-moving bureaucracies hamper effective design and institutionalization of GHI support. GHI influence is required to have more multi-stakeholder and inclusive planning process. Domestic funding remains challenging even for middle income SEARO countries due to the fiscal stress from the double disease burden. Instances are seen in more economically developed states such as in India where government has over the years shifted to resourcing and institutionalization of TB DOTs with pooled support, but these need to be further transitioned towards PHC efforts rather separate funds for different diseases.

The private healthcare sector provides the majority of healthcare to people in the SEARO region. External aid is low compared to government spending but GHIs yield considerable importance in setting disease priorities within the countries. GHI-funded diseases are highly visible in policy and programming, although other diseases also exist with potentially a larger burden. A benefit of GHI involvement has been in building clear investment cases and interventions for aid disbursement to countries, whereas for NCDs the evidence is not always clear. Another benefit is CSO inclusion in aid disbursement and an attempt at making country decision-making more inclusive, although that has at times created parallel lines of funding. However, the power to make decisions lies mostly with GHIs as they control the funds, much less with governments and CSOs who follow the prioritized diseases and interventions.

3.1.4.2. Opportunities & Challenges

Programmatic and health systems

Most SEARO countries are focusing on improving the PHC provision and presently do not have enough facilities, human resources, drugs, or vaccines to self-sustain. Countries are willing to reform the platform to the health system delivery mechanism but are hampered by verticalized siloed disease programs whose tenure has been prolonged with GHI support. Coordination weaknesses between vertical programs were exposed during COVID-19 and health systems were not resilient. More synergies across diseases are required in GHI funding even in non-emergency settings – for example in Indonesia TB and HIV often co-exist but TB testing is done at some centres and patients must be sent to other centres for HIV screening, which results in missed cases. The main missing factor is that none of the global health initiatives are funding PHC delivery. The SEARO countries generally do not have a primary health care benefits package around which donors and GHI support can be mobilized. The foundation of the system for communicable disease prevention, screening and treatment must be PHC whether in the context of UHC or pandemic preparedness. India has more recently managed to exert stewardship by committing domestic financing for TB and institutionalizing GHI-funded parallel TB initiatives.

An NGO representative from Indonesia noted, *“A main challenge is the lack of integration across service areas for example a person diagnosed with both TB and HIV will need to go to two different clinics located far from each other, this is likely to result in loss to follow up for at least one condition.”*

A KI from India mentioned, *“[GHIs are] funding elements of the primary health care, but there is no primary health care benefits package that everybody supports. The big question for GHIs is, are they even able to come together? And what will make them come together to pool their resources to provide a robust primary health care system?”*

In terms of country priorities, GHIs often drive country priorities and these priorities are not grounded in the local context. The GHIs give high credence to international academia and experts, even if these have merely superficial exposure to LMICs, but disregard local experts. Hence the level of knowledge to make the right programmatic decision is not present. More horizontal integration and flexibility in terms of service delivery are required, rather than a tight focus on a particular disease control. Another disconnect with country realities is the lack of funding of private sector services by the GHIs, although the private sector in South Asia is the primary source of service delivery (9). One informant said, *“even though the private sector is the main source of service delivery in South East Asia, the GHIs have largely ignored the private sector.”* Country priorities for GHIs should re-focus to supporting countries to build institutional mechanisms and infrastructure that will sustain beyond the scope of a project, however, government leadership was noted to be crucial for this to happen. Thailand was seen by many KIs as a “leader in the region,” both in terms of its success in achieving UHC, and also the meaningful inclusion of CSOs in policymaking.

Financing

There was a realization that international funding for the national health system is shrinking, and this is a concern as there remain considerable unmet needs for communicable disease control

for which the role of GHIs will still be relevant. South Asian countries are facing a double BoD and although government funding is increasing, the funds largely go towards curative and emergency care. Even in Sri Lanka, where the state has traditionally funded disease prevention, there is an inability to sustain the funding given the rise in NCDs, road traffic accidents. and increasing out-of-pocket expenditure. The SEARO countries will not be able to successfully deliver without GHI support, however, the consultation participants from countries agree that the modalities of GHI support must be improved.

There are three sets of issues that need to be tackled for impactful and sustainable funding. Government health funding is inefficiently allocated, without proper planning and prioritization of communicable diseases due to vested interests of some sort of bureaucratic and political elites on what to prioritize. Second, existing GHI funding is inefficiently utilized. Third, there are several middlemen involved in the routing and management of GHI funding and hence the amount that trickles down to beneficiaries is little. Funding from GHIs must tackle all three issues of incentivizing government towards proper planning for communicable diseases, efficient utilization, and greater flow to recipients. Public sector capacity building is required for planning, efficient program management and utilization. An informant from Indonesia explained that *“there is a push from Global Fund to country government to provide funding for programme management example for human resources.”* The person noted that *“GFATM wants to be then able to utilize its funding for testing and treating more patients,”* which was thought to be a good strategy to improve funding commitments from country governments.

One successful example of greater domestic financing and aid coordination happened in India for TB control. A successful BMGF-funded TB pilot closely designed with the government was successfully adapted and upscaled with government funding with budgetary support by GFATM and other donors. Future efforts are required around PHC coordination and financing, rather than just disease-specific financing. The absence of EHSPs also impedes coordination efforts.

Continued GHI support is required in SEARO but with a shift in modalities for greater horizontal integration with other PHC services, more flexible decision-making space for fund utilization and leveraging on existing PHC or systems reforms. Insurance initiatives, social contracting and pooled funds have been initiated in SEARO countries which can benefit from GHI support. Catalytic measures are required from GHIs to incentivize governments towards more domestic funding and effective capacity building. Number of middlemen needs to be minimized for more direct benefit to recipients and accountability required of spending on administrative costs versus what actual service.

Performance indicators and accountability mechanisms

There is a strong perception that aid priorities are set by GHIs or the donor agencies providing funding to the GHIs and dominated by international consultants and experts. Country stakeholders should be in the driving seat in terms of modalities of funding and setting country priorities. A greater role of local experts, including PHC experts, is required in setting priorities. Countries with top-down government control should be pushed to involve multiple stakeholders in the planning and accountability process.

Accountability needs to be re-imagined and set up across different levels. One area for accountability is how much of the funding is supporting the government’s national plan – this is tricky because the

government often does not develop or update national plans being used to function on project mode. Another area for accountability is how much of the aid is being spent on administration and how much on reaching the beneficiaries. Taxpayers in the Global North too should question how much of the aid by GHIs reached the beneficiaries. Country governments being dependent on the aid provided by GHIs are disempowered to put sufficient pressure on the accountability of aid.

Governance, coordination, and alignment

The governance of GHI-provided aid must shift towards increased coordination, use of local PHC comprehensive platforms and inclusive participatory measures. There has traditionally been less focus on strengthening the system machinery that ensconces the GHI-supported disease programmes, leading to fragmented, disconnected delivery and inefficiency. Business as usual will not work and convergence is required on common PHC platforms. In some SEARO countries, domestic financing has been used to initiate insurance schemes but these are de-linked with the PHC services. Political priorities of country governments will change but disease priorities must be advocated and converged into domestic systems and reform initiatives. A fundamental shift is also required to shift the focus from supply-side logistics to demand-side perspectives. This resonates with GHI emphasis on civil society but a more deliberative focus on the people-centric ecosystem is required through GHI activities.

3.1.4.3. Suggestions for change

Area	Suggestions from SEARO regional consultation participants
Programmatic/ health systems	<ul style="list-style-type: none"> • Horizontal integration of GHI support into PHC and HSS initiatives, with GHIs providing investment case to country governments • Catalytic measures by GHIs for greater exercise of disease stewardship by country stakeholders - not limited to government but inclusive also of local experts and CSOs • Build cross-programmatic efficiencies across disease programs, more flexible spending & decision space • Private sector integration for disease control
Financing	<ul style="list-style-type: none"> • GHI role required to counter shrinking international funding to middle-income SEARO countries facing double burden of disease • Catalytic funding by GHIs to increase country commitments towards disease control, budgetary support • Building public sector finance management capacity for efficient utilization and planning • Reducing administrative middlemen involved in aid planning

Accountability Mechanisms and Performance Indicators	<ul style="list-style-type: none"> • Target setting and aid modalities to be led by country stakeholders and local disease-HSS experts • GHIs to push countries to included civil society in target setting and accountability • Re-focus on aid contribution to country PHC planning • Accountability of the proportion of funds spent on administrative costs versus actual services to community
Governance, Alignment, Coordination	<ul style="list-style-type: none"> • GHIs to leverage on local platforms for PHC/ relevant domestic financing initiatives • GHIs to widen emphasis from supplies systems to demand side measures • Leverage on GHI civil society emphasis to shift towards people centric governance and planning inclusive of community voices

3.1.5. European Region

3.1.5.1 Context

Countries in the WHO/EURO region that were identified as having (at least one) GHI presence included: Azerbaijan, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Moldova, Montenegro, North Macedonia, Romania, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan. Recruiting KIs from these priority countries was challenging due to the ongoing conflict in Ukraine and bureaucratic processes in the Ministries of Health, limiting the accessibility of informants. For these reasons, individual virtual interviews were conducted with informants identified through the SDG3 GAP secretariat. Individual interviews are ongoing thus findings will be further developed.

3.1.5.2. Opportunities & Challenges

Current challenges with GHIs included neighbouring conflicts in Ukraine and Afghanistan which have diverted funding and attention, competing or even clashing mandates of organizations and priorities for individual organizations, bureaucratic centralized government processes limiting the speed of activities and funding, language barriers, rural-urban disparities, and out-migration of health workers. Additional challenges will be identified from ongoing individual interviews once the data collection process is complete at the end of July 2023.

3.1.5.3. Suggestions for change

In Tajikistan, key priority areas suggested for investment are PHC (especially recruitment and retention of rural health workers), health information systems, and the integration of vertical disease programmes into PHC. The establishment of a Development Coordination Council on Health was highlighted as a success factor (10). It was established by the UN, and is hosted by the World Bank, and chaired by the EU and WHO. Its purpose is to coordinate and align health-related activities

in the country to collectively support the government in attaining the National Health Strategy. As outlined by this KI, the Council has been of added value for coordination and strategic discussions:

“It was quite beneficial because I mean we always say everybody loves coordination but nobody loves to be coordinated, right? So having everybody together and listening to each other and agreeing together on what we need to do - we need to be talking more, we need to be exchanging more [...] So now we have 5 different subgroups which facilitate more technical and in-depth discussions.”
(Multilateral KI)

3.1.6. Western Pacific Region

3.1.6.1 Context

Countries in the WHO/WPRO region that were identified as having (at least one) GHI presence include Cambodia, Lao, Mongolia, Papua New Guinea, Tonga, Fiji, the Solomon Islands, and Vietnam. It proved challenging to recruit a wide range of consultation participants in the WPRO region thus individual interviews were conducted with experts who were identified with assistance from the FGHI and Wellcome secretariats.

3.1.6.2. Opportunities & Challenges

One CSO informant noted that the GHIs will not be able to fully meet future health needs of the region. The WPRO region is predicted to have stagnating mortality attributable to NCDs up to 2040 (11). A key challenge in the region is high inequities between populations, with massive economic gaps. As one KI noted, “the poorest of the poor in the region are also the ones that are most vulnerable and marginalised to diseases and climate change and pandemics.”

Another challenge noted by a CSO informant was that, *“it's so easy and probably it's faster to see [GHI investment results] that are related to infrastructure or are related access to medicines etcetera. It's harder to see structural changes.”* She also noted that GHI support seems to be shrinking (and less in comparison to other regions), raising the question of the future global health financing situation, especially among marginalised communities (eg. People living with HIV) that some governments continue to neglect.

Opportunities for the future of GHIs that were mentioned by the informants included strong political will of the countries, and matching policies with funding - to “put the money where [countries say] it's important.” Another informant noted that government capacities and capabilities are a determining factor of GHI success:

“GHIs tend to mirror the capacity and capabilities of the ministries that they work with. So the weaker the ministry and the government are in being clear on their own policy objectives, the weaker the support is going to be or the process through which they provide long-lasting institutional change [...] as these government institutions become weaker, they're being almost overridden by some of these entities, who pretty much have caught large to go ahead and do what they want, for better or worse, and we're losing sight of the do no harm principles.”

3.1.6.3. Suggestions for change

It was suggested that the SDG indicators and other “global commitments that have already been given” are used to monitor and measure the success of GHIs.

3.1.7. Pan American Region

On May 4th 2023, a one-and-a-half-hour virtual consultation was held with a variety of regional actors in the Pan American Health Organization (PAHO) region. There were a total of 19 participants, including from five ministries of health (Table 1). They were identified through online searches and the FGHI Secretariat. Focus was placed on recruiting governments and implementing organizations that have experience working with GHIs, particularly in the South America subregion.

3.1.7.1 Context

In terms of political, financial, and governance arrangements, the participants noted a number of contextual challenges. Firstly, major health inequities between and within countries and certain marginalised communities i.e. informal workers. One participant explained that, *“there are pockets of poverty in these countries that are as equal in poverty as some low-income countries.”* Black communities and indigenous communities were also noted to have significant health disparities. Corruption was also noted to be an issue in many governments in Latin America. Another participant noted that, *“financing and the fiscal space is very restricted.”*

3.1.7.2. Opportunities & Challenges

Many challenges were described by participants regarding GHIs in their region. Firstly, they felt that the PAHO region received less GHI investments and visibility than other regions, notably WHO/AFRO, despite having some of the largest health inequities globally.

“I think manym many countries in our region do not have an idea what [GHIs] are and what they [do]...I think that's related to this part that in the region, we are mostly beneficiaries, but we are not as other regions, such as the African region, and we are also not funders, therefore our participation in this it's very limited.” (Country government representative)

“Countries of the Americas are seen as middle-income, upper middle-income countries so there is a tendency not to look at these countries or to graduate them quite quickly from these processes.”
(CSO participant)

Frustration was expressed about the Geneva-based GHIs:

“The solutions are in Geneva but it's very expensive to keep all these offices there. I think it's very costly. You know when a government gives money, Norway let's say, how much of that money goes to administration and never leaves Europe, never leaves the Swiss banks? And then how much money really reaches the countries? It's a terrible situation because when you have the opportunity to

look at the budgets of these organizations, it's amazing how expensive maintaining all this stuff in Geneva is [...] Surely it's not the most cost-effective.” (CSO participant)

Secondly, a competition between GHIs and between GHIs and CSOs, for funding and for disease priorities was observed. A *“lack of involvement or real connection with citizen organizations”* was noted by one participant. Fragmentation and overlap were also noted, with *“no coordination”* or *“common ground”* between actors.

3.1.7.3. Suggestions for change

In terms of opportunities for change, consultation participants suggested there should be more country ownership of GHI investments, stronger coordination between GHIs, and that GHIs to go beyond communicable-disease focus to improve the health of marginalised groups, acknowledging social determinants of health and the effects of climate change on health.

“We really need to better understand individual country contexts but also within countries the inequalities that exist at a more granular level.” (CSO participant)

To avoid duplication of efforts was also suggested. Further, it was urged (especially by the CSO and government participants) that GHIs invest more in the PAHO region, as they felt Africa continues to get disproportionately more attention.

Area	Suggestions from PAHO regional consultation participants
Programmatic/ health systems	<ul style="list-style-type: none"> • Stronger focus on PHC and community health • For GHIs to go beyond communicable disease focus • For GHIs to acknowledge and help to address social determinants of health • Help address shortage of rural health workers • Improve the health of marginalised groups including informal workers • Provision of technical expertise to countries
Financing	<ul style="list-style-type: none"> • Stronger country ownership of GHI investments • Generation of financial resources from tax revenues • Training actors on innovative payment systems to reduce waste and inefficiency • Focus on UHC, but also pandemic preparedness • Country-specific studies for UHC financing
Accountability Mechanisms and Performance Indicators	<ul style="list-style-type: none"> • Better tracking of GHI impacts at country-level
Governance, Alignment, Coordination	<ul style="list-style-type: none"> • Better coordination between GHIs and between GHIs and other actors

3.1.8 Product Development Partnership consultation

On May 5th 2023, a one-and-a-half-hour virtual consultation was held with the product development partnership (PDP) coalition. It is an informal group of 15 PDPs, chaired by FIND and the TBAlliance, that meet regularly to coordinate. All members were invited. Six participants attended the consultation, representing four PDPs. A list of open-ended questions were shared with the invitees in advance of the call and through slides shown during the consultation. The questions involved the current state, their desired vision for the future, and levers for change.

The added value of GHIs that they described in relation to product development can be summarised as: the provision of catalytic funding, the scale-up of innovations, and market shaping. In particular, Unitaid, CEPI and Gavi were noted to be vital actors for the PDPs in terms of implementing their innovations that are brought to market.

The major challenges with the GHIs that were noted included: 1) replenishment models of Gavi and GFATM “*sucking the oxygen out of the room*” and “*leaving behind a very poor set of funding*” for smaller institutions such as PDPs, 2) gaps between R&D for vaccines by PDPs and CEPI and the handover to Gavi, 3) heavy and slow administrative grant processes, and 4) the perpetuation of private sector interests.

Issues with GHIs and the private sector that were mentioned surrounded public investments that are made without conditions for access, the unequal flow of funds into the pharmaceutical sector (unlike for PDPs), and that during the COVID-19 pandemic, the large majority of financing for research and innovation went to institutions in the Global North. The ACT-Accelerator was not considered to have been very successful, as they believed it was governed by the Global North, subject to greed from HICs, and provided little guarantee to LMIC governments. An anecdote was provided of a Minister of Health from a middle-income country deciding to finance COVID-19 vaccine procurement and deployment independent of COVAX, as he correctly assumed that COVAX would have been unable to guarantee timely access to COVID-19 vaccines for his citizens through the global mechanism.

In terms of suggested areas of change, the consultation participants presented a number of ideas. One idea was to ‘*institutionalise*’ the dialogue between GHIs and PDPs to ensure more frequent and strategic discussions, including the content of their respective strategies. Another was to encourage GHIs to continue to use innovative financing mechanisms for market shaping, and for GHIs to support R&D and manufacturing capacity building in LMICs. There was consensus that priorities for disease investments should be determined by country governments and that decision-making and priority-setting should be happening outside of Geneva. Strengthening regional institutions was also noted to be a priority moving forward, to pool resources and expertise. The wider global health system was not discussed in detail, however, one participant suggested that WHO moves away from a siloed disease-programme approach to more cross-cutting issues such as climate change, which was noted to be an important contributing factor in the coming years toward a rise in communicable diseases. One concrete example of an attempt to improve coordination among the PDPs is the suggestion of the establishment of a Global Alliance for Diagnostics, which was recommended by the *Lancet* Commission on Diagnostics in 2021 (12) as a potential way to encourage advocacy for the inclusion of diagnostics in UHC programmes. This suggestion is currently being considered by FIND.

The PDP Coalition members thought that this Alliance would be of added value, particularly to allow LMIC actors to lead the R&D agenda for diagnostics.

3.2. Consultative Meetings

3.2.1. Hybrid Deliberative Discussion

On June 14th 2023, a full-day hybrid deliberative discussion was held at the African Union (AU) Commission, co-hosted by the Africa Centres for Disease Control and Prevention (CDC). Participants were purposefully invited based on the following criteria: whether they had already been involved in the research study, whether they represent country or regional views, and whether they have experience working with or for any of the GHIs that were within the study scope. In total, there were 29 in-person participants and a further 16 online (excluding FGHI secretariat and research consortium members) that were able to attend (Table 1). There were nine ministries of health, representing eight countries in Africa (Central African Republic, Ghana, Guinea-Bissau, Ethiopia, Malawi, Somalia, Tanzania, and Uganda). Only one bilateral donor was present (UK FCDO).

The deliberative discussion consisted of presentations from the research consortium, followed by opportunities to provide constructive feedback, and a group breakout session. There were five presentations given, concerning: the study methods, the global-level interview findings, the three-country case study findings, and a final presentation where draft vision scenarios and recommendations were presented. The participants were encouraged to provide feedback on all of the presentations. Following this, there was an hour allocated to a group breakout session to discuss and prioritise the final presentation (vision scenarios).

Feedback from the participants about the study methods mainly concerned the need to acknowledge the study limitations, such as the small sample size of the country case study and regional consultation informants.

Feedback about the country case studies was then collected. The findings were largely validated by the participants in the room. One participant saw “*cross-cutting relevance with a lot of commonalities*” between the three case studies. She noted that this could indicate that solutions to their challenges could be common- to help “*manage resources better*”. Another participant agreed that there were similar challenges across all three case studies: “*fragmentation, silos, verticalization, lack of coherence, lack of coordination...*” He said that, “*in 2023 we are still there, we have to acknowledge there is a problem [with GHIs].*” Another issue that he raised was that GHIs tend to provide TA by temporarily flying in consultants. He suggested that the research dives deeper into the issues surrounding the transition away from GHIs. A representative from an African Ministry of Health noted that GHIs have caused countries to think only in the “*short-term*”, largely due to their disease eradication targets, causing a lack of investments in HSS. He agreed with the proposed country case study recommendations- saying “*Everything is there.*” An additional suggestion was to emphasise the importance of country responsibility and the restructuring of governments - noting that some recommendations would need to be adapted to each country context. A comment from the Zoom chat from a CSO representative was that “the financial powers go as far as influencing programming at country level, in other words, they fund what they want to fund, even GFATM, although they say they do not do that, they do it.” An additional issue raised by a Ministry of Health representative was that some financing mechanisms of the GHIs are “*too focused on accountability*” rather than results.

The participants proposed additional recommendations, in addition to those presented. The issue of sustainability was very important. It was proposed that the GHIs and countries ensure efficiency and optimisation of available resources, capacity building, and spending on-budget, so that Ministries of Finance are well aware of what is available and who is involved. Ministries of Health should be the owners of national plans, with many participants urging that there is “*one plan, one budget*.” Several participants underlined the importance of increasing domestic financing for health. Harmonizing grant proposals to reduce the administrative burden on countries, and using co-financing were noted to be important enablers of this concept. A multilateral suggested earmarking HSS for some of the GHIs, while others thought that pooled financing for HSS would be the best way forward. One Ministry of Health representative stressed the need for local investments for the manufacturing of goods such as mosquito nets , questioning, “*where are the human capital investments and African innovations, being driven by African member states?*” The same participant also noted the need for more accessible, agile, and flexible funds during outbreaks. He explained that in his experience, rigid funding with “*objections*” and “*micromanaging*” from Geneva limits rapid and effective response on the ground. Another MoH representative urged that initiatives are demand-led by countries, with effective monitoring and evaluation and accountability mechanisms. He also proposed that GHIs contribute to the creation of local public health institutions in each local government to build sustainable capacity. Finally, a product development partnership representative on the Zoom chat noted that it is important to find ways to ensure that there are not duplications of efforts between actors.

In terms of measuring the success of GHIs, less dependency on GHIs was suggested as the goal. Multiple suggestions were proposed. Someone suggested the creation of key performance indicators for HSS to monitor input, output and impact of the GHIs. A suggestion from the Zoom chat was for GHIs to use UHC benchmarks or indicators that consider the percentage of coverage of services and interventions as well as measuring their contributions to access, equity, affordability and quality of services which could then be contextualised into each country's UHC roadmap. Another suggested the need for timeframes and targets to measure and eventually dissolve GHIs. “GHIs should work themselves out of the job.” However, participants were unsure which governing body or bodies should be responsible for the oversight of this goal. A question was raised about the future role that the Africa CDC and the AU should play in the governance of GHIs, and in a similar regard, a participant raised the question of how GHIs should and could best contribute to the New Public Health Order for Africa (13).

Finally, participants were asked to provide feedback on the draft vision and recommendations that were presented. Although a helpful exercise, there were suggestions to move away from the four vision scenarios that were presented, as they were too rigid and each had substantial risks and trade-offs that made it difficult for the participants to prioritise one over the other. One participant suggested the need for a *spectrum* of ambitious changes that is in everyone's interests, while another suggested that incremental changes are outlined, with a timeline. Participants agreed that placing a timeline on the potential phase-out of some GHIs would need to be context specific, and therefore not useful for this study. It was unclear how a ‘sunset clause’ should be defined. In any case, participants were keen that risks were clearly outlined and quantified for each recommendation, and that the actors that should be responsible for implementing each recommendation are suggested.

3.2.2. FGHI Steering Group Virtual Consultation

On June 22nd, 2023, a two-hour virtual consultation was held via Zoom with the FGHI Steering Group (SG) members. A total of fifty-six people were on the call in total (including research consortium and Secretariat members), 12 of whom were SG members (or appointed representatives of the SG members unable to attend), and many of whom were already familiar with the research process. Two presentations were given: the key study findings (Dr Natasha Palmer, Queen Margaret University), followed by a revised draft vision and recommendations (Professor Karl Blanchet, Geneva Centre of Humanitarian Studies). The SG members were then given 45 minutes to provide their feedback and suggestions on the presentations and final stages of the research during the virtual consultation and could send further comments on the draft vision and recommendations afterwards via an online form.

Key themes from the feedback that was provided emerged: the need to maintain the independence of the research (separate from the SG) for future implementation, understanding country perspectives, identifying changes that would lead to the biggest returns, and analysis of GHI models including risks and opportunities for change.

Several queries were asked during the consultation, including whether or not the country-level case study research would be expanded to other countries in the Asia Pacific region. The importance of ensuring the feasibility of recommendations was also discussed, as was the role of the SG in taking the findings of the research forward. A final point was made about the importance of translating the different outputs so that they could be shared with a wider audience. The Wellcome Trust assured the group that they are already planning to translate outputs to French and Spanish.

4. References

1. Fonds commun santé (FSC) [Internet]. [cited 2023 Jul 11]. Available from: <https://www.afd.fr/fr/carte-des-projets/fonds-commun-sante-fsc>
2. Hiv A. ... INFECTIOUS DISEASES. AFRICAN SUMMIT ON HIV/AIDS, TB AND OTHER RELATED INFECTIOUS DISEASES. ABUJA, NIGERIA. APRIL 2001 HTTP. UN ORG/ GA/ AIDS/ PDF/ ABUJA _DECLARATION
3. African heads of state adopt scorecard on domestic financing for health [Internet]. [cited 2023 Jul 11]. Available from: <https://www.bsg.ox.ac.uk/blog/african-heads-state-adopt-scorecard-domestic-financing-health>
4. Moucheraud C, Hing M, Seleman J, Phiri K, Chibwana F, Kahn D, et al. Integrated care experiences and out-of-pocket expenditures: a cross-sectional survey of adults receiving treatment for HIV and hypertension in Malawi. *BMJ Open* [Internet]. 2020 Feb 12;10(2):e032652. Available from: <http://dx.doi.org/10.1136/bmjopen-2019-032652>
5. Matanje Mwagomba BL, Ameh S, Bongomin P, Juma PA, MacKenzie RK, Kyobutungi C, et al. Opportunities and challenges for evidence-informed HIV-noncommunicable disease integrated care policies and programs: lessons from Malawi, South Africa, Swaziland and Kenya. *AIDS* [Internet]. 2018 Jul 1 [cited 2023 Jul 12];32 Suppl 1:S21–32. Available from: https://journals.lww.com/aidsonline/fulltext/2018/07011/opportunities_and_challenges_for_evidence_informed.3.aspx
6. World Bank Group. World bank supports primary healthcare and universal coverage to strengthen human capital in Pakistan [Internet]. World Bank Group. 2022 [cited 2023 Jul 12]. Available from: <https://www.worldbank.org/en/news/press-release/2022/06/06/-world-bank-supports-primary-healthcare-and-universal-coverage-to-strengthen-human-capital-in-pakistan>
7. Amin T. World Bank approves \$258m for National Health Support programme [Internet]. Breccorder. 2022 [cited 2023 Jul 12]. Available from: <https://www.breccorder.com/news/40178899>
8. Gavi. Proposal for HSS Support 2020: Sudan [2021-2025] [Internet]. Gavi; Date of Gavi approval: 29 April 2021. Available from: <https://www.gavi.org/country-documents/sudan>
9. Health Organization W. Primary health care systems (PRIMASYS): comprehensive case study from Pakistan [Internet]. [cited 2023 Jul 12]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/341143/WHO-HIS-HSR-17.37-eng.pdf>
10. 5: Health working group [Internet]. [cited 2023 Jun 25]. Available from: <https://untj.org/dcc/category/human-development-new/health-working-group-new/>
11. GBD Foresight Visualization [Internet]. Institute for Health Metrics and Evaluation. [cited 2023 Jun 25]. Available from: <https://vizhub.healthdata.org/gbd-foresight/>
12. Fleming KA, Horton S, Wilson ML, Atun R, DeStigter K, Flanigan J, et al. The Lancet Commission

on diagnostics: transforming access to diagnostics. *Lancet* [Internet]. 2021 Nov 27;398(10315):1997–2050. Available from: [http://dx.doi.org/10.1016/S0140-6736\(21\)00673-5](http://dx.doi.org/10.1016/S0140-6736(21)00673-5)

13. Moser F, Habtemariam MK, Forland F, Djoudalbaye B. A new precedent in international health cooperation from African public health leaders. *Lancet Glob Health* [Internet]. 2023 Jun;11(6):e828–9. Available from: [http://dx.doi.org/10.1016/S2214-109X\(23\)00171-7](http://dx.doi.org/10.1016/S2214-109X(23)00171-7)