Appendix 12

Lessons Learned from Previous Alignment and Coordination Efforts

Acronyms and Abbreviations

AAA	Accra Agenda for Action
ACT-A	Access to COVID-19 Tools Accelerator
CEPI	The Coalition for Epidemic Preparedness Innovations
CSO	Civil Society Organization
FGHI	Future of Global Health Initiatives
SDG3 GAP	Sustainable Development Goal 3 Global Action Plan
Gavi	Gavi, the Global Vaccine Alliance
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
GFF	Global Financing Facility
HSFP	Health Systems Funding Platform
HSS	Health System Strengthening
IHP+	The International Health Partnership and Related Initiatives
JANS	Joint Assessment of National Strategies and Plans
KI	Key informant
R&D	Research and Development
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
SWAp	Sector-Wide Approach
TB	Tuberculosis
TA	Technical Assistance
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

Previous Reforms

The global health system has experienced multiple reforms. It is important to take stock of the past reforms and understand their purpose and their outcomes (or lack of).

Donor alignment

In the Reimaging the Future of the Global Health Initiatives (FGHI) study, a few findings refer to donors, Global Health Initiatives (GHIs), and alignment with countries. One needs to go back to 2005 and the **Paris Declaration on Aid Effectiveness** to understand the origin of this principle. In Paris, five principles were endorsed by more than 100 governments and international organisations: Ownership, Alignment, Harmonisation, Managing for Results and Mutual Accountability. The Paris Declaration was followed in 2008 by the **Accra Agenda for Action** (AAA) endorsed by more than 80 low-income countries and 3000 civil society organisations (CSOs) from around the world, United Nations (UN) and multilateral institutions and global funds. The AAA highlighted four areas for improvement: Ownership, Inclusive partnerships, Delivering results and Capacity development (1).

Many of these principles and areas for improvement are mentioned several times in the research report. Several reforms were initiated during the last thirty years (Table 1). Many deserve to be mentioned as they could serve as a basis to rethink the future of global health and GHIs. Common lessons learned largely relate to the need for better donor coordination, alignment, accountability, and priority setting with country needs as the basis.

Relevant reforms

The **Sector-Wide Approach (SWAp)** was introduced in the mid-1990s and was applied to health as well as other sectors, informed by a similar logic at sector level to budget support (2). The SWAp values the ownership of the government in the various investments made in the country. It aims to limit the lack of coordination between donors and duplicative efforts in the health sector by offering a single platform for investments relying on a single national programme under the leadership of the government and disbursed through national procedures. SWAPs took various forms in different countries and sectors (3). Although SWAPs were successful in some cases, they were critically evaluated and progressively disappeared as donors withdrew as they prioritised projects where they could control risks and demonstrate outcomes. Some donors continued to favour investments in non-priority health areas such as hospitals instead of primary health care and tended to neglect population-based interventions (public health) (4).

The **International Health Partnership (IHP+)** was established in 2007 to improve effective development cooperation in health to meet the Millennium Development Goals and had a total of 66 partners by 2016. IHP+ aimed to provide technical support to countries and donors to improve coordination and alignment (5). In 2016, the IHP+ was transformed into Universal Health Coverage 2030 (UHC2030) to align with the SDGs and with an expanded mandate: to improve health system capacities in order to achieve UHC (6). As a working group of IHP+, the **Joint Assessment of**

National Strategies and Plans (JANS) approach was formulated (7). The Joint Assessment promoted a collective assessment of national health strategies or strategic plans – with an intent to ensure they were realistic, outcome-oriented – and could be used for shared planning. The assessment involved multiple stakeholders (including government, CSOs and development partners/donors), is country-led, and aligned with existing in-country processes.

An **H4+** partnership was established in 2008 by six UN agencies and the World Bank, and later expanded to include other agencies such as the GFATM and Gavi (8). It was initially established to accelerate progress in the top ten high-burden countries in maternal and child health through better global coordination of the major multilateral health agencies. The partnership was re-negotiated with the emergence of the Sustainable Development Goals (SDGs) - and became the H6 partnership- and resulted in a largely expanded agenda and a larger membership (12 agencies) (9).

The **Health Systems Funding Platform (HSFP)** was an early attempt to establish a platform to coordinate and mobilize pooling funding for Health System Strengthening (HSS) through national health strategies. The platform was established in 2009 following a request from Gavi and the GFATM to the World Bank's Taskforce on Innovative International Financing for Health Systems to help mobilize funds for HSS. It included WHO, World Bank, GFATM and Gavi (10–12). According to the interview data, the main reason the platform did not materialise is due to a lack of available funding and leadership change in the agencies.

The **SDG3 GAP** (13) was set up in 2019 following a request from a small number of member states to the World Health Organisation (WHO) to improve collaboration among actors at country level to help attain the SDGs. It is formed of 13 agencies including UN agencies, the World Bank, Gavi, GFF, and GFATM, and has been implemented in 67 countries as per the 2023 progress report (14). A lack of accountability mechanisms and incentives for change were the main reasons identified in the FGHI study that the Global Action Plan (GAP) has not yet been able to make substantial changes to the global health system.

The **Access to COVID-19 Tools Accelerator** (ACT-A) is aimed at speeding up the development, production, and equitable distribution of tools to combat COVID-19 (15). Launched in April 2020, it is a partnership between various organizations, including WHO, CEPI, Gavi, and GFATM. The ACT-A promotes international cooperation, funding, and coordination to accelerate the Research and Development (R&D) and delivery of these essential tools. It has been criticised for creating unequal power balances - having the International Federation of Pharmaceutical Manufacturers & Associations on its Coordinating Meeting, while government representatives, CSOs and scientists seem to be side-lined (16), and for not being able to prevent high-income governments from ordering a surplus of COVID-19 vaccines (17).

Consultation findings

The findings of this study highlight the need for transitioning the roles of GHIs as a group or as individual organisations. However, this is not the first time there has been a call for changes. Amongst study participants, there was a general consensus that these earlier initiatives were

conceptualised with good intentions, particularly regarding aid effectiveness and the need for organisations to work together towards common goals in a fragmented global health landscape. However, the key informants (KIs) and literature noted that the implementation of these initiatives has yielded only minor and/or short-term gains without significant sustainable impact. 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 explained that coordinating actors with different structures and mandates proved to be a difficult task, contributing to the limited effectiveness of these initiatives.

While there may be differing opinions regarding the need for additional initiatives, there was a consensus among informants on certain recommendations. The KIs suggested that these initiatives should consider structural changes to address the underlying issues within the global health system.

A key message that came out of the interview data, particularly at the global level, was the importance of involving both donors and recipient countries in decision-making on alignment processes. The need for a more collaborative approach where all stakeholders have an active role in shaping and driving the initiatives was made clear. Furthermore, KIs stressed the significance of initiatives having meaningful enforcement mechanisms, or "teeth," to ensure compliance and results. This could involve introducing incentives, accountability frameworks, and clear consequences for non-compliance.

Table 1 Lessons from previous alignment and coordination efforts

Initiative	Active	Main Aim	Advantages	Weaknesses	Lessons learned
SWAps	1990s -	In-country coordination and alignment	In some countries - improved coordination, better alignment with national priorities, increased efficiency, and strengthened health systems	Other countries - major challenges in implementation, governance, coordination, and financing. Cumbersome processes - failing at delivering tangible results.	➔ Difficult to measure results/impact (diffuse goals – poor data). ➔ Require negotiations between all parties with high transaction costs. ➔ Priority investments not always clearly defined and agreed upon ➔ Potential problems with lack of efficiency, transparency, and corruption via government systems.
IHP+	2007-2016	In-country coordination and alignment	Promoted principles of good health aid donorship – and produced standards of good investor behaviour.	Following development of principles – it was not evident how powerful the partnership was in altering investment behaviour – there were no specific financing modalities.	➔ Principles are useful and can establish a central ground for negotiations, operationalised e.g. through the GFF. ➔ Fundamentally they do not alter investor behaviour.
H4+	2008-2016	Coordination between global health agencies on selected countries	Focus on mother and child health services considering all functions of the health system. Focus on innovative service delivery approaches. Division of tasks and responsibilities between agencies.	Hard to evaluate the attribution of H4+ to outcomes above and beyond those of individual agencies. Coordination between agencies not always ensured all the way to the service chain. Little investment on the demand side of RMNCH services. TA commissioning creating competition between agencies.	➔ Can enhance inter-agency technical coordination. ➔ Minimal visible impact on operational performance or coordination. ➔ Heavy transaction costs ➔ Created in-house competition for resources – shared according to internal logic, not merit.

HSFP	2009-2011	Coordinated effort to invest in HSS	Harmonization to tools and processes through a set of joint mechanisms (M&E, finance and planning).	Differences between agencies (especially World Bank and GFATM) in funding mechanisms with duplication of funding schemes. Reluctance from some donors to give up control over how their funding was allocated and implemented. Not enough funding was available. Turnover in leadership.	➔ Rational alignment procedures are in part dependent on institutional due process – must align procedures and cycles. ➔ Difficult to define an overarching HSS plan. ➔ Difficult to measure value for money. ➔ No major incentive for donors to invest.
SDG3 GAP	2019-	Coordination between multilateral agencies	Focus on coordination and harmonization; aligning resources and increasing efficiency; improving measurement, monitoring, and accountability; enhancing country capacities and preparedness; and accelerating research and innovation. Country surveys	Apparent different levels of interest/commitment form agencies No formal management or leadership (as with H4+ etc) and clear accountability mechanism. Global technical working groups reasonably successful. Limited incentive for change of agencies. Limited funding for WHO country offices No mechanism for the agencies to systematically respond to country feedback and make sustainable changes	➔ Similar lessons to H4+ ➔ No requirement for compromises from agencies to enhance collective results.

ACT-A	2020-2023	International cooperation, funding, and coordination to accelerate the R&D	Provided a cross-agency analysis. Provided a costed work plan. Time-bound.	Was not immune to high-income country greed Could not equitably allocate funds. Difficult to intervene in the governance processes of individual agencies. Difficulties with determining membership and process to be inclusive and legitimate. Private sector influence.	➔ Extraordinary functions need to be time-bound. ➔ Think about process, inclusion and distribution of power sharing in advance. ➔ Manage transaction costs. ➔ Need to diversify management and coordination to reduce power imbalances

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