Written Responses to Reimagining the Future of Global Health Initiatives Study

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Written Response from Gavi

Introduction

The Gavi Secretariat thanks the FGHI report authors and the Wellcome Trust for leading this important initiative and appreciates the consortium for developing the final report. We have appreciated the opportunity to engage in the FGHI review process and the platform for deliberations and reflections among global health stakeholders. Going forward, Gavi will continue its engagement with FGHI as key stakeholders deliberate and reflect upon actions needed to deliver global public health effectively and efficiently. Gavi has been contributing to the Extended Commitment Task Team launched by FGHI.

After years of progress across many health indicators related to the core work of GHIs, the unprecedented disruption from the COVID-19 pandemic has put many of the countries we serve further away from meeting the 2030 Sustainable Development Goals, including Universal Health Coverage (UHC). FGHI's work complements Gavi's own independent evaluation to inform our next strategic period which will also conclude in 2030.

Summary of Gavi's high-level comments on the final FGHI report

The FGHI study and final report are a valuable exercise which required the utmost rigour. Gavi has communicated its concerns with the scope and methodology of the report and, while it is welcomed that the report has a statement included upfront that acknowledges some of the methodological constraints of the study, its limitations underline the needs for the report to be seen as one of many inputs into what must be a more comprehensive assessment of the global health architecture.

Despite our concerns with the report's methodology, Gavi agrees with the central theme of the report – which is that GHIs, including Gavi, should continue to adapt to better serve country needs and work together to improve the coherence of global health. As an Alliance of key global health partners, Gavi is already persuaded by the need for alignment across a wide range of public and private players to deliver health and the Gavi model has been putting this philosophy into practice since its inception, with a constant focus on impact, ensuring that "the whole is bigger than the sum of its parts". It is in Gavi's DNA to consistently adapt and innovate our approach to delivering immunisation outcomes across each of our 5 year-strategies. As we prepare to discuss our 2026-2030 '6.0' strategy with our Board, countries, and Alliance partners, we are already putting considerable effort into evolving the Gavi Alliance. We are working across countries, partners and organisations and updating our approach to Health Systems Strengthening (HSS) with the goal of helping countries deliver stronger primary health care (PHC) and immunisation outcomes in their pursuit of UHC. This includes work with the Global Fund and the other GHIs, as called for in the report, and importantly also increasingly with local partners who are well-suited to meet the evolving needs of countries and target the most marginalised. The FGHI work will be an important input into that process.

Across many of the areas where the paper makes recommendations for GHIs to change approaches – Gavi is either already implementing the suggested approach or is developing strategies to do so. Of the 41 recommendations in the final report, 29 of the recommendations are already being implemented or we agree with wholly or in part. 10 of the recommendations require further thought and deliberation. There are 2 recommendations which are specific to other agencies such as the Global Fund. Of the 19 recommendations already being implemented, examples include that Gavi has merged Project Management Units with the Global Fund across 11 countries; uses national pay scales for health staff and community health workers and has a well-defined transition and co-financing model which drives increased domestic resource mobilisation for immunisation. For example, in 2023 countries will provide 24% of the financing for the Gavi-supported vaccines, up from 10% a decade ago. During the period 2021 to 2025 countries will contribute $1.1 billion to the cost of vaccines. We are very interested in taking forward some of the other recommendations around streamlining operations and in some cases already have work underway – such as agreeing on common sets of metrics for HSS across GHIs.

While the final report includes a more detailed methods section, with more information on the type of participants interviewed, sampling techniques and analytical approaches, we are still concerned that some of the conclusions are based on either limited, inconclusive or weak evidence. This appears to be the case in regard to a criticism on graduation without rigour over the different graduation models and levels of success. As noted above, Gavi's co-financing model supports increased country ownership of their immunisation programmes and 19 countries have now transitioned and become fully self-financing and 10 more countries are expected to transition by 2030. Many weaknesses identified by the report seem to be driven by "perceptions" of interviewees rather than evidence and facts or are generalised from one GHI to others. Regarding governance and contributions during meetings, Gavi's Board makes decisions by consensus or by two-thirds majority of Board members (or their Alternate Board Members) present and voting when no consensus can be reached. It can be noted that it is rare that consensus can't be reached in the Gavi Board and a key value of the Gavi Alliance is the ability to reach consensus across the immunisation community, including on time sensitive issues. Gavi has established an Implementing Country Constituency caucus, the primary objective of which is to further strengthen engagement of implementing countries at Board level through routine consultations between Board meetings. Gavi has also assigned Special Advisors to Implementing Country Board representatives, to routinely gather feedback from the constituency on their priorities.

We also note that the number of countries used for case studies is small, and not always representative of the countries where GHIs work. The voices/concerns of beneficiaries do not seem to be considered. In terms of best practices, authors should provide a matrix/documentation on the data sources linked to each finding, an analysis of the strength of evidence for each conclusion (as recommended in the UNEG Norms and Standards for Evaluation guidance), and a sense of how generally they could be applied across the different GHIs.

Gavi believes the longevity of the report would be strengthened by presenting a more evenly balanced and evidence-based assessment of the relative strengths and weaknesses of the GHIs. In the next phase of the FGHI review it will be important to differentiate by GHI and be clear on which GHIs specific findings refer to, given the final report does not do this to the full extent and as such this undermines its utility.

For example, as had been explained in the case of graduation. Critically, a more balanced and evidence-based assessment would include evidence on the situation before GHIs were established, and more detail on the impressive results they have achieved, which have been underscored by numerous independent evaluations. For example, Gavi has now supported lower-income countries in delivering vaccines to over 1 billion unique children, saving over 17 million lives. Immunisation rates have risen by 20 percentage points in Gavi countries, there has been a 70% reduction in vaccine-preventable child deaths, and under 5 mortality has been halved. Indeed, the SDG indicator on immunisation is now one of the only global health indicators which remains on track, and which looks achievable by 2030. Gavi's market shaping strategy helps to build healthy global vaccine markets critical to the success of Gavi's mission. Price reductions have contributed more than US$ 300 million in cost savings across Gavi's core portfolio of vaccines in 2021-2022. A lot of these impressive results were driven by the innovative partnership approaches modelled by Gavi and other GHIs which helped to focus attention on key outcomes and sectors. It's important that this context, together with more individual examples of positive changes drawn from a broader and balanced selection of the six GHIs, including Gavi – and not just the recognition provided for increased resource mobilisation – is taken into account.

In the next phase of the FGHI process, Gavi would like to see greater reflection on why the GHIs were set up 20 years ago and a comparison or 'mapping' of what the architecture looks like now. We also note our concern that no comprehensive assessment of the global health system can be complete without including UN bodies and Multilateral Development Banks. When we consider the state of immunisation over time in the countries Gavi supports, immunisation rates had stagnated in the years prior to our creation. Existing organisations had difficulties in aligning sufficient support in countries behind the sector - which was characterised by fragmentation across many bilateral donor agencies and multilateral organisations. Gavi, the Vaccine Alliance was explicitly established to reduce fragmentation across immunisation and bring partners together under an integrated approach in support of countries and has been successful in doing so. As we consider potential changes going forward, it will also be important to map out the roles of other organisations in the present day – and not just limit the scope to the six GHIs considered under this process. That should include the increased role of regional organisations as well as other actors within the UN system, like WHO, and MDBs including the World Bank, in terms of how they contribute to supporting country needs. We are pleased to see increasing recognition of the role of other actors like the World Bank in the draft Commitments Framework.

Importantly, Gavi believes that in the next phase of the FGHI process, there needs to be consideration in more depth of the potential operational implications and the trade-offs involved for countries and GHIs themselves on the recommendations proposed, particularly those which are not yet being implemented by the GHIs. We note that some of the recommendations will benefit from greater consultation within and across GHIs and countries. When it comes to the report's recommendations on joint GHI investments in shared core functions, we do see benefit in exploring 'pooled' funding approaches to align around country strategies and leadership. This could also have the advantage of bringing the World Bank, MDBs and other parts of the UN system more closely into scope – which would bring greater value to the FGHI work overall. However, in order to facilitate improved coherence in the delivery of health programmes, it is critical to support implementing countries investing further in their cross-government coordinative systems to improve alignment internally, and provide a solid foundation for

coordination with the international ecosystem. We encourage the FGHI to include this perspective to ensure country ownership. We furthermore think the report could have better emphasised the need to diversify and innovate in the ways we finance global health, with domestic resources at the centre, to not only maximise resources but unlock potential new ones via innovative finance instruments.

We note that the report seems to conclude in most cases that a single, unified approach to delivery in health systems works in all areas. From our experience, having different organisations or partners focused on delivering outcomes can sometimes introduce a healthy amount of innovation, competition, and efficiency. At the same time, it can be noted that **there was an initiative** to develop an integrated health system strengthening platform between Global Fund, Gavi and the World Bank in 2012 and that this failed due to the different missions, Board priorities and operating model of each agency. Therefore, taking onboard lessons learned previously will be important, while also fully aligning in what we are seeking to achieve. Further consideration on the trade-offs that certain recommendations require needs to be built into the next phase of this work.

Gavi looks forward to engaging with FGHI stakeholders on options for change highlighted in this work, and to continue to grow our collaboration with other GHIs, driven as always by countries. There are opportunities for improvements that could be implemented in the short term or integrated into the design of our Gavi 6.0 strategy for 2026-2030.

Written Response from The Global Fund

The Global Fund Secretariat thanks the authors and the consortium for leading the research effort, feeding into an important initiative.

We believe that the FGHI Initiative is a timely opportunity to identify ways to make the global health architecture more streamlined and more effective in GHIs' collective support to countries, including ways for the Global Fund to continue evolving and adapting to meet changing country needs and priorities, and strengthen our coordination with other GHIs and other key players in global health to increase efficiencies and avoid further fragmentation of the global health landscape. The Global Fund is committed to working with the FGHI process to ensure a constructive and impactful outcome of this initiative.

We have recently completed a lengthy, rigorous and inclusive process with our Board and Committees to agree the Global Fund's 2023-2028 Strategy and key performance indicators to accelerate impact towards the SDG's 2030 horizon, which includes some significant strategic shifts which in many cases reflect the direction and objectives of the FGHI process. The highly consultative process, inclusive of civil society and affected communities, involved countries and relevant stakeholders across all regions where we operate in numerous discussions in the past few years around the future focus of the Strategy. The Global Fund Secretariat is pleased to be participating in the expanded Commitments Task Team and making inputs into the FGHI's Commitment Framework, highlighting longer term global strategic considerations and the shifts in our strategy which are relevant to the FGHI near-term action framework.

We note that the report contains some useful observations, including some recommendations that are already being implemented by the Global Fund, and others which are helpful and can be built upon to make improvements and accompany the desired changes. However, the Global Fund Secretariat is disappointed that the recommendations of the report are based on inadequate research and analysis.

In particular we have concerns about the research report's scope and methodology. Rigorous, evidence-based analysis is lacking. Limiting the recommendations to the six GHIs, will not bring the desired change or improvements at country level. The report does not take into consideration the wider global health ecosystem. Nor does it consider the drivers behind the creation of the GHIs as well as the reasons why these organizations operate differently from other modalities. There is very little acknowledgement of the impact achieved by the GHIs despite robust documentation on results, and a solid body of literature that could have been used to conduct more rigorous fact-based analysis. For example, assessing the connection between each GHI's current operating modalities and the impact delivered, would enable better understanding of the potential benefits and risks of proposed changes. Drawing largely on selective quotation from key informant interviews, the report appears to weight opinions over analysis of facts, evidence-based, peer-reviewed papers, and published evaluations and independent assessments.

The report contains a number of factual inaccuracies. For example, using Global Fund's public databases[1] shows that the share of disbursement amounts for governmental Principal Recipients (PR) was 59% in 2022, not 40% as claimed in the report. In some instances, the report misrepresents sources. For example,

[1] At 29 August 2023

a table describing the findings of a World Bank study[2] mentions verticalization and increased fragmentation in health, neither of which are found in the referenced study. The report largely ignores the context which led to the creation of the GHIs and their contribution to helping reduce fragmentation of aid flows, and in enhancing the responsiveness to country priorities.

In this context, we note important gaps in the report, including:

- An assessment of to what degree the impact that has been achieved by GHIs over the last 20 years has resulted from their distinct partnership and financing models.
- A rigorous analysis of the tradeoffs involved in making changes to the way the GHIs work, with robust consideration of the benefits and risks involved in implementing the report's recommendations to health outcomes, and specifically, to the GHIs' ability to save lives.
- Given that the majority of the recommendations are not new, a considered assessment of the reasons why they have not been implemented before or have led to inconclusive results.
- Any systematic assessment of how changes in the broader global landscape, including climate change, conflict, macroeconomic and financial prospects, demographics, scientific advances, etc., will likely change global health needs and priorities, and consequently, the role of GHIs.

We believe that several questions would deserve more careful consideration, for example:

- What is the appropriate balance between delivering on existing commitments under the SDGs (e.g. SDG 3.3) and the new commitments envisaged by the report?
- What investments and delivery modalities will most effectively drive health equity?
- What impact will the report's recommendations have on the overall effectiveness of the global health architecture given that they are limited to a subset of GHIs?
- What will be the role of civil society and communities in the future landscape envisaged by the report?
- Are this report's recommendations sufficiently responsive to the scale and pace of external challenges, including climate change, geopolitics, scientific advances, etc.?
- What is the most appropriate role of external grant funding compared to other external sources of funding, including concessional funding or blended finance, and versus domestic resources.
- What would be the impact of the recommendations on incentives for increased domestic financing and sustainability?

More detailed comments focusing on selected recommendations are available in the Annex.

[2] On page 26 Box 1 on Official Financial Flows Proliferation, fragmentation and verticalization.

Annex: Detailed comments on selected recommendations

Making a stronger contribution to UHC, including emerging disease burdens

The Global Fund's 2023-2028 Strategy puts an emphasis on funding programs through approaches that deliver integrated, people-centered quality services to meet individuals' holistic health needs and support UHC goals. This includes, as relevant, support for coinfections and comorbidities of HIV, TB and malaria and adjacent health areas, with the specific package of support requested by countries dependent on their priority needs and the total available resources. In particular, the Global Fund supports integrated care for many diseases. For example, the new guidance note - Supporting Health and Longevity for people living with HIV - outlines how investments can be used to support integrated services including for viral hepatitis and STIs. The RSSH information note outlines how funding can be used to support diagnosis and treatment for acute febrile illnesses, notably pneumonia and diarrhea. TB care pathways and diagnostics can also be used to support chronic lung conditions. Regarding NCDs, we do not have a broader mandate for NCDs in general, but can gladly contribute expertise in relation to multisectoral action in addressing the three diseases.

Although Global Fund funding is not unlimited, it is the country's decision to propose how to best use their resources to maximize impact. We note that resource constraints are one of the practical considerations leading countries to consider tradeoffs (e.g. expanding HIV programs into Hepatitis vs covering gaps in ART provision). In addition to the resource constraints, government run integrated programs too often fail to reach the most vulnerable populations, leaving out key and vulnerable populations to HIV, urban and rural poor at risk of TB, and the hardest to reach populations vulnerable to malaria. Where the Global Fund's investments are more focused and less integrated with government systems, they are specifically focused on remedying these significant health equity challenges.

Regarding the Global Fund's allocation methodology, it is a needs-based model that is designed to focus funds on countries with highest disease burden and lowest financial capacity. Within the HIV, TB and malaria resource envelopes, a formula distributes the available funding across countries primarily according to their disease burden, adjusted for their economic capacity. Allocations are then tailored as needed, based on country context, through a transparent and accountable process. The final allocations are therefore very much aligned with epidemiological and financial needs. In the latest allocations, the 15 highest burden countries for HIV, TB and malaria received over 60% of the total funding. The split of funds to HIV, TB and malaria is not based on disease burden alone. Other factors are also taken into account, such as the financing landscape, the effectiveness of investments, and the continuity of life-saving interventions currently financed by the Global Fund. In the last cycle, this split was revised to provide a greater share of funding to TB based on the total amount of funding, to respond to TB's increased share of mortality (as one measure of disease burden) while also protecting the progress made against HIV and malaria. Every three years, the methodology is reviewed over a 1.5 year period and updated to reflect the current context and incorporate lessons learned from the previous cycle. It will be reviewed again next year, building on the findings of an external and independent evaluation that is currently underway.

Strengthening health systems and integrated planning at country level

The Global Fund actively supports integrated planning at country level, with funding aligned with country priorities. However quality implementation which delivers results also often requires disease specific

plans that go into detail as disease challenges require complex, tailored responses to achieve their aims, for example, stratification of malaria interventions which deliver more health for less money. To this end, the important point is that national disease plans should be embedded within and aligned with national health sector strategies, and not replacing them. The Global Fund continues to support health sector and disease strategy planning, tailored to the context.

Role of CCMs to support UHC

All of the Global Fund's work comes in under a sub-set of UHC criteria and attempts are made to create wider and sustainable systems impact through grants as well as tackling specific diseases. At the moment CCM's scope and membership is not as wide as all 'UHC planning' and broadening it would present numerous challenges. For instance, many Health SWAPs have a multi-layered committee approach to ensure detailed discussions on different topics can take place at different levels within a broader hierarchy. In some countries the CCM is one of these sub-committees (as is Gavi's IPC), therefore nested in the wider sector-wide approach. This is not a bad model and maintains detailed discussion on specific issues within a broader approach and governance system. But there are many other variants. Many CCMs are connected to wider health governance mechanisms and wider discussions where these exist, including on national disease plans or health sector wide approaches, but these are not uniformly present and UHC planning as an actual joined up exercise across the whole health sector is not necessarily something that exists. 'Health sector wide' interventions are not really expanded upon in the report which is generally uncritical and under-nuanced about the strengths and challenges of HSS efforts to date. CCM's connections to the wider health governance landscape is already an explicit priority of the Global Fund– for example extensive work is being done on this under the CCM Evolution – and we recognize there is room for improvement.

Regarding transferring CCM roles to more routine governance structures, we note that CCM's connections to and optimal positioning within the wider health governance landscape is an explicit priority of the Global Fund. This includes support to CCMs to map and plan and practically to shift CCM functions into other bodies over time as appropriate, the challenge being to maintain adherence to Global Fund's principles such as community engagement and inclusion in new integrated bodies. We already have a number of countries where this is in progress. It is heavily dependent on local governance conditions and what is available to integrate with. CCM's are genuinely country-owned so the pace and direction of these shifts is also determined in-country by stakeholders not by the Global Fund.

One issue to highlight is coordination with non-GHIs, for example the Pandemic Fund, the World Bank and bilateral partners. Continued inclusion of a broad spectrum of actors is an important point since no other GHIs/non-GHIs are as inclusive as Global Fund's CCMs. More integration can have valuable impact, however it may also come at the expense of engagement of key and vulnerable populations and communities in health programs and so it should not be viewed as a panacea.

Longer grant periods

The Global Fund has implemented grant cycle lengths of 3- years and 5-years over its history. An important lesson from our past is that it is challenging for the Global Fund to commit funding for longer time horizons than donors are willing to commit to the Global Fund (3-years). Additionally, even if we were to fund in 5-

year cycles, it would not mean that these would align with countries' 5-year NSPs as there are many contexts in which NSPs do not line up back-to-back. However, this does not prevent the Global Fund from being more intentional in its support for investments that show impact over longer time horizons (e.g., RSSH, structural interventions). Our Strategy highlights the importance of the Global Fund creating better enabling environments in supporting such investments and this is an area we are continuing to work on. For example, the Secretariat is working with partners to develop maturity models for various RSSH areas that use a 10-year timeframe, facilitating longer-term conceptualization of how the funding should be targeted over time to build up the system.

Investments in procurement systems and supply chains

The area of procurement and supply chain is a renewed focus of Global Fund's investments, as outlined in the RSSH Information note. New 'critical approaches' have been developed to ensure that a more system building approach is taken, and these are being monitored. The Global Fund and Gavi work closely together to support countries to strengthen their supply chains and logistics for public health commodities, whether it is contributing in a complementary way to the construction of an ultramodern warehouse for health products (e.g. in Uganda) or working together to coordinate investments in digital logistics management information system (now happening in 11 countries) or investing jointly in training health supply chain leaders and managers. In addition, the Global Fund Secretariat is advancing the work underway with Regional Economic Communities (RECs) to build more resilient and sustainable regional procurement platforms as set out in the NextGen framework, along with the regional manufacturing capacity building. For example, we provide technical assistance to (sub-) regional pooled procurement platforms in particular in Africa. More matured and well-functioning in-country supply chains and infrastructures are key for regional manufacturing.

Investments in PFM

The Global Fund has had longstanding funding that supports and builds effective financial management systems. We strengthen national public financial management capacities in a wide range of countries to drive performance, efficiency and sustainability.

Common metrics for HSS and UHC

The Global Fund generally tracks programmatic progress based on globally agreed metrics/indicators, and is working with WHO on using common metrics for HSS, for example through the targeted Health Facility Assessments. Most of the RSSH indicators are commonly agreed upon indicators used by governments and partners.

Reducing costs for countries and increasing efficiency and effectiveness of GHI investments. In particular referring to the recommendation on "merging Project Implementation Units, and where possible site them in the MoH".

In the majority of cases where the Global Fund Principal Recipient of funds is a government entity, the associated Project Management Unit (PMU) are hosted by and in the MoH. There are ongoing efforts to

merge the Global Fund PMU with those of other GHIs, such as GAVI. Currently there are 13 countries where we have a joint PMU with Gavi (all in Africa), and 9 countries where we collaborate with other global health partners.

Together, Gavi and the Global Fund continue to align operational and financial strategies and policies in support of countries to increase efficiency and the impact we achieve.

As stated in the Global Fund auditing guidelines, for Global Fund grants managed by a governmental Principal Recipient (e.g. state-owned entity or statutory authority), the government supreme audit institutions are the preferred auditors, in line with the Global Fund principle of ensuring country ownership and aim to leverage national systems where possible. The Global Fund and Gavi have joined forces to strengthen the Supreme Audit Institutions of 7 countries in Africa to improve accountability of health donor funds. The Global Fund has also, with a certain frequency undertaken joint missions with other GHIs including GAVI to reinforce in-country coordination and is keen to collaborate with the GHIs to expand on this. Regarding joint reports, the Global Fund, as a partnership organization, encourages and leverages joint reporting to monitor progress, such as Malaria Indicator Surveys, Integrated Biological and Behavioral Surveillance (IBBS) Surveys etc.

Supporting Country ownership, capacity-building and charting a clear path to ending dependencies on GHIs: ***In particular referring to the report recommending "increasing funding through governments".***

As mentioned above, the share of disbursement amounts for governmental Principal Recipients (PR) was 59% in 2022. Moreover, the government PRs share based on disbursement amounts has been relatively stable in the past three Replenishment cycles.

On progressive increases in the portion going through governments there are two considerations, and on both of them the criteria are clear:

- Government capacity, which means that where capacity is an issue the Global Fund works through multilaterals or NGOs, which mainly happens in Challenging Operating Environments (COE) or countries with Additional Safeguard Policies.
- Community-based provision of services to key populations and other marginalized groups – where governments are willing and have the ability to do such social contracting, the Global Fund will work through them, and otherwise will fund civil society organizations directly. For the Global Fund to commit to "progressively increasing the proportion of contributions from GHIs to government-funded programs" would be contrary to the 2023-2028 Strategy.

Supporting Country ownership, capacity-building and charting a clear path to ending dependencies on GHIs: In particular referring to the following recommendation: "The Global Fund should provide clearer rules on co-financing and transition providing clear incentives for countries to prepare".

The Global Fund's Sustainability, Transition, and Co-Financing (STC) Policy was approved in April 2016 and implemented during the 2017-2019 and 2020-2022 funding cycles. The STC Policy formalizes the Global Fund's approach to strengthening sustainability, enhancing domestic financing and co-financing, and supporting countries to better prepare for transition away from Global Fund financing. The Global Fund's STC policy is published on our website and requirements are negotiated and differentiated in all countries where we work at least every 3 years. Since 2016, the Global Fund has also published transition

projections for countries alongside our eligibility list to ensure predictable and informed discussions about transition.

A Guidance Note on sustainability and transition for the 2023-2025 funding cycle is also available and aim to guide countries in better investing external financing and in catalyzing domestic resources in order to strengthen health systems and address critical sustainability and transition challenges.

We recognize that there is room to improve communication and implementation, in particular on co-financing, which we are actively working on for the 2023-2025 grant cycle. However, we should clarify thinking on incentives, since the more that donor funding is on-budget and controlled by donor governments, the less incentive countries will have to transition and replace it with domestic funding.

Governance: Strengthen working of GHI Boards to ensure effective participation and representation.

The Global Fund Board is already very inclusive, both in terms of implementer governments and non-state actors – more so than any other GHI (or non-GHI). The Governance Assessment process will review what further improvements can be made.

The Global Fund Board, supported by its Ethics and Governance Committee (EGC) and Coordinating Group (group of Chairs), may leverage ongoing initiatives and efforts relating to governance effectiveness and strengthening, including with respect to representation, effective transitions, and access to information, which are among a range of governance strengthening themes under ongoing discussion at the EGC. This attention to governance ways of working is necessarily complemented by efforts within Board constituencies themselves to ensure that internal constituency functioning, coordination and consultation, including selection of representatives, are best supporting engagement and constituency voice. In addition, the EGC-led work on governance culture picks up many of these themes, while future governance performance assessments present opportunities to further explore both barriers and potential adjustments.

Enforcing more effective alignment between GHIs and with wider health actors. In particular referring to the recommendation to enhance regular dialogue across Boards.

Dialogue between leaders provides space for such exchange and strategic reflection, which can then inform relevant discussions at Board level. The Global Fund Board Leadership's existing engagement with Board leaders from partner GHIs could be leveraged to advance relevant conversations, in close collaboration with the EDs/CEOs of the respective GHIs. Leveraging leadership roles and engagement between leaders would provide an appropriate and pragmatic approach to enabling dialogue across GHIs and their Boards.

To be noted that the Global Fund invites and includes representatives from other global health agencies to Board and Committee meetings (GHI/non-GHI) but is only included on the Boards of limited partner agencies and invited as an observer to the Board of the Pandemic Fund, and is rarely invited to participate in others.

Regarding the idea of a Joint Facilitation Council across the governing bodies of the GHIs to facilitate dialogue, our view is that it would be preferable to leverage existing leadership roles to enable dialogue

and coordination, rather than creating a new additional structure which may not support governance effectiveness or efficiency for either organization.

Enforcing more effective alignment between GHIs and with wider health actors: In particular referring to the recommendation to develop a single integrated governance structure across all GHIs at country level.

Such recommendation can be read as recommending setting up a Health SWAP where it does not exist. This is not particularly innovative, and it should not be looked from an overly ideal perspective. There are usually factors preventing these from being set up or run properly. The reality is probably that there are major capacity and political or other risks preventing governments from leading such an effort effectively and that in the absence of such structure other governance mechanisms are the only way of making progress.

Written Response from Global Fund Access Network (GFAN)

GFAN appreciates the significant efforts invested in producing the FGHI report and the importance of ongoing reflections on how to structure global health institutions to fill the gaps revealed by the COVID-19 pandemic. We would like to offer preliminary feedback and insights on various aspects of the report.

First and foremost, the report's extensive consultations with experts from diverse backgrounds, including government, academia, civil society, technical agencies, and funders, are commendable, and make the report into a valuable snapshot of the way GHIs are perceived after 20 years of operation. We would however like to share some constructive feedback regarding the content and structure of the report:

1. **Structure of the Findings:** The report's approach of merging all discussions into a continuous narrative, without distinguishing between consensus and divergent opinions, inadvertently diminishes the significance of areas of consensus while highlighting criticisms. The lack of clarity regarding which issues enjoy broad support and which represent minority viewpoints affects the report's overall balance. Furthermore, the report's structure does not effectively categorize or prioritize the issues raised during consultations. This results in a fragmented presentation of concerns without providing guidance on their relative importance or urgency. To enhance the report's utility moving forward, we recommend a clearer differentiation between consensus and dissenting views, as well as a prioritization of key issues.
2. **Coherence:** The report's Finding section juxtaposes conflicting viewpoints without adequate context or analysis. For example, the report contrasts perspectives on whether GHIs are too narrowly focused or have illegitimately expanded beyond their mandates. While both views have merit, subsequent steps in the FGHI process should offer an analysis that helps stakeholders understand the underlying reasons for these differing opinions and potential avenues for resolution.
3. **Factual Accuracy and Sourcing:** The inclusion of quotes from interviews without thorough fact-checking raises concerns about the report's accuracy and credibility. For instance, discrepancies in the figures related to HIV spending in Mozambique have been noted. These inaccuracies cast further doubt of the relevance of some of the criticism levied against GHIs, suggesting that they could be based on out-of-date inaccurate data.

We strongly recommend implementing a rigorous fact-checking process for all information included in the report to ensure its accuracy and reliability. Properly cited sources for statistics and claims should be provided to enhance credibility, and quotes containing

Further reading on the GFAN blog: [Future of Global Health Initiatives – Thoughts and Reflections from GFAN – Global Fund Advocates Network]

Written Response from Make Way Partnership

On behalf of the Make Way partnership, working on intersectionality for health equity and justice, we would like to share with you some feedback, with regards to the FGHI research report, particularly about the recommendations for strengthening the GHI ecosystem (chapter 7).

We welcome the recommendations of the report, given that they will be translated into concrete political commitments for global health initiatives, donor governments and implementing governments.
As a general observation, we noticed the lack of **rights-based language** in the recommendations, and we believe that strengthening the rights-based language will strengthen the political commitments that will follow. Additionally, we noticed the lack of recognition of community led health systems and their role in strengthening health systems and achieving UHC. The role of communities is critical to the do no harm approach and the lack of recognition in this document will be a setback for citizen engagement in the support of strong country ownership.

Our suggestions, per theme of recommendations:
Theme 1: Making a stronger contribution to UHC, including emerging disease burdens

- The political commitment could be more explicit on ensuring provision of services to vulnerable groups. Now, it says *"[…] ensuring that services are routinely available for all"*. you could add *"[…] available to all, taking into account different populations' specific needs and structural barriers to access care".*

Theme 2: Strengthening or at least doing no harm to health systems

- You could add "*national, sub-national and **community** health systems*", in the opening.
- There is recommendations that *"in contexts where government/DP health sector governance mechanisms are functional, the CCM functions could be transferred to the routine governance structures".* We would suggest that in the political commitments national governance mechanisms are intentionally strengthened, to take over.
- It is important for GHIs to not distort the health workforce labour market – this is already expressed in the recommendations.

Theme 3: Reducing costs for countries and increasing efficiency and effectiveness of GHI investments

- Here is where it can be highlighted that investments should be informed by human rights and gender equity lens/assessment. And the financing should be catalytic to support domestic resource mobilization and allocation of resources. And the need to strengthen the roles of communities in particular vulnerable communities in the development of applications.

In addition, under the **"change management" section (7.2),** there is a point that we consider very important, which should be reflected in the political commitments:
*This will require funders to focus more on overall system performance metrics as their outcome measure (and managing performance risks), and **give up some of their controls over fiduciary risks** (unless there are specific circumstances which highlight the need for particular measures). One aspect that will be important to the reforms is **accepting new ways of assessing contribution, rather than attempting to control inputs and processes so as to achieve attribution of results.***

And we fully agree that all parties need to commit to changes, as per your report's conclusions (and I quote) – *"not just the senior management of the GHIs, though these are critical; but also the funders and foundations whose internal fragmentation of programming has contributed to the problem; and other*

partners, such as within the UN system, which have also reinforced a siloed, disease-programme-based approach; NGOs, which have benefited from expensive, parallel delivery systems; and national country leadership, parts of which have benefited from the fragmented and untransparent funding flows. They are all part of a complex system with inter-dependencies, which have not been the focus here but have become an important part of the landscape."

Written Response from Policy Cures Research

Overall:

This report provides a thorough, timely and insightful set of recommendations for transforming Global Health Initiatives (GHIs). We are particularly encouraged by the inclusion of FIND, CEPI, and UNITAID, as their roles are integral to the global health R&D landscape.

Traditionally, global health R&D has functioned in isolated silos. Their inclusion in this process opens doors for a more nuanced discussion on R&D's future role and on re-envisioning how GHIs can operate in a landscape that offers strong connections and bridges for integration of R&D into national health agendas.

The comments that follow aim to highlight the need for better integrating R&D considerations into the broader vision for GHIs, particularly in how R&D can contribute to strengthening national healthcare systems. Doing so can contribute to building a global health ecosystem that is not only more resilient but also universally accessible and sustainable for all.

Rec. 1: Making a stronger contribution to UHC, including emerging disease burdens

Comment: In the spirit of making a stronger contribution to UHC, we suggest that the recommendation also calls out the need to support countries and GHIs to integrate R&D activities into UHC priorities. UHC serves as a primary channel for vulnerable populations to access cutting-edge health products and technologies. Therefore, it's crucial that countries and Global Health Initiatives (GHIs) incorporate R&D as a key component of their UHC plans. There are multiple ways in which national policy makers can make provisions to enable access to innovative global health products to those that need them the most. Ensuring they have a seat (and voice) at the agenda-setting table for R&D priorities (especially as they pertain to new products and innovations) will also help improve the prospects that the next generation of tools to fight global health issues will be acceptable and fit-for-purpose in the countries that need them the most. By calling out R&D in this recommendation, it also raises the need to create a holistic and effective healthcare system that not only treats but also innovates.

Rec. 2: Strengthening or at least doing no harm to health systems

Comment: We support the use of common metrics for HSS and UHC and would add that these should include indicators across the continuum from R&D to access and ultimately health impact at the population level. PCR, with the engagement and support of a multitude of stakeholders, developed a framework to assess the health and economic impact of investment in global health R&D which could serve as a useful tool for this process.

Recommendation 3: Reducing costs for countries and increasing efficiency and effectiveness of GHI investments

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

Comment: The recommendation rightly calls for making GHI investments more efficient and effective. It is important not to overlook the role that GHIs play in funding R&D, especially CEPI, UNITAID and FIND. By calling out the need to transparently share information on R&D funding and investments at the global,

regional and country level, GHIs will be better positioned to make investment and funding decisions going forward, thereby contributing to sustainability even in resource-constrained settings. We also believe that while reporting on the level of investment is an essential piece of data for advocacy and accountability, funders need to ensure that GHIs have the resources and capabilities to go further and demonstrate the impact and return on their programs and investments. Helping to set and standardize approaches to impact assessment will also help to tell a more unified impact story in the future.

Recommendation 5: Enforcing more effective alignment between GHIs and with wider actors

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

Comment: This recommendation can be strengthened by being explicit about the need to include representatives of patients and affected populations in the governance structures.

Written Response from Unitaid

General remarks:

1. On behalf of Unitaid, we would like to thank the research consortium for their work to prepare the 'Reimagining the Future of Global Health Initiatives' final report, and for including Unitaid as one of the six Global Health Initiatives considered in more detail.

2. The headline recommendations of the study are well noted, and we feel are well aligned to Unitaid's mandate and 2023-2027 Strategy. These recommendations should be considered carefully by all global health initiatives going forward.

Specific reflections on the report:

3. Unitaid's work is focused on making new medical products and approaches available and affordable in low- and middle-income countries. This is achieved by identifying innovative treatments and tools, tackling the equitable access barriers that are holding them back, and working in partnership to get them to the people who need them most – fast. With reference to Table 2 (page 22), we feel that the objective of Unitaid described here is complemented by our Mission statement to 'expand the reach of the best health products for those who need them most'.

4. We note the importance of market shaping (section 4.2) as a process to improve equitable access to health products. Market shaping interventions are a key element of a wider collaboration between countries, civil society, communities, technical & normative agencies, donors, and industry. At the same time market shaping is only one part of what needs to take place to enable increased access to affordable healthcare products. Research and development, product introduction, quality assurance and demand creation are also essential components of securing equitable access.

5. Hence, securing equitable access goes beyond some examples cited in the report, e.g., the pooled procurement of GeneXpert machines, which is less recent, and may include examples such as the important role played by community and civil society organizations to support the rapid scale-up of optimal HIV regimens, or using country-level operational research to demonstrate the feasibility and cost-effectiveness of community-based delivery models for the prevention of malaria in pregnant women and children.

6. Related to this, Unitaid would also like to highlight the key role, and collaboration of, WHO to shape priorities, e.g., with reference to the Strengths and Challenges for market shaping, page 39, and the role of WHO in partner coordination efforts.

7. The partnership between Unitaid and WHO has sped access to vital interventions that include best-in-class HIV and TB medicines, cutting-edge malaria-fighting tools, and major advances in prevention and care of cervical cancer and hepatitis C for people in resource-limited settings. Since 2017, WHO has facilitated the design and delivery of more than 160 Unitaid-funded studies. This critical research has underpinned more than 60 updates to health guidelines and implementation tools. National health programs and global scale-up partners then implement vital interventions that are critical in

advancing the care for people affected by or at risk of HIV, TB, malaria, cervical cancer, hepatitis C and COVID-19.

8. Effective collaboration delivers impact. Over the last few years, Unitaid has contributed to saving more than 750,000 additional lives across HIV, tuberculosis, and malaria. More than 100 countries are procuring and providing access to Unitaid-supported products, which reach around 170 million people each year, including more than 45 million children per year. By 2030, we estimate that more than US$ 7 billion will be saved by the global health community from equitable access to better health products such as optimal HIV treatment.

Way forward:

9. Through our 2023-2027 Strategy, Unitaid seeks to support the introduction and adoption of 30 key health products by 2030 (30 x 30), to advance disease-specific global health goals, and to support the delivery of Universal Health Coverage.

10. Furthermore, Unitaid will increase emphasis on creating systemic conditions for equitable and sustainable access, including regional manufacturing. This is in line with your observations (page 35) about the lack of product development and production at the local-level, and aligned with the objectives of US Government agencies, such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) five-year strategy, launched in 2022.

11. Here, Unitaid has already initiated work with key partners. Unitaid, The Global Fund and PEPFAR are partnering to accelerate the manufacturing of health products in Africa, with HIV rapid diagnostic tests (RDTs) as the initial product category[3] in focus.

12. We also recognize that diversity, equity, and inclusion are central to the delivery of our Mission and that integrating those values in every intervention will always yield better outcomes. Acting on this recognition means increasing engagement with everyone, from implementing partners to communities and country stakeholders (governments, civil society, for example), to invest and build better, more sustainable country- and community-driven programmes and products. Such an approach will help to facilitate a transition away from financial support from global health initiatives for many countries. Under our current strategy, Unitaid is working to maximize engagement with affected communities and responsiveness to their needs; increase alignment and synergies with governments in-country stakeholders, affected communities and civil society organizations; and further develop global alliances for product scale-up.

[3] https://www.theglobalfund.org/en/news/2023/2023-08-08-global-fund-pepfar-unitaid-collaboration-accelerate-approval-african-manufactured-hiv-rapid-tests/

Written Response from Unitaid NGO and Communities Delegation

The NGO and Communities Delegation to the Unitaid Board would like to provide the following feedback on the FGHI Report, with a particular focus on Unitaid, hoping that these reflections will help improve the analysis and recommendations. We welcome the effort of the research to improve alignment and efficiency across the global health architecture and generally agree with the recommendation to limit the proliferation of GHIs but rather strengthen the existing architecture. Nonetheless, we feel it is important to address some corrections with regard to Unitaid for this process moving forward.

- Firstly, the process took place over just six months, which may have led to the lack of a more in-depth and nuanced analysis of the GHIs' specific nature and their respective roles within the global health architecture.
- The report fails to point out specific overlaps in mandate between the five examined agencies, whether on market shaping, work on reproductive health, etc., and the value-added of each organisation in each area. The usefulness of the report is minimised because of this oversight.
- Lumping together GHIs in this analysis fails to recognise the distinct way they were created and how they each operate, making them incomparable in some regards and difficult to have a sweeping recommendation relevant to all.
- Secondly, the report fails to analyse the systemic challenges and weaknesses of the governments (North and South), as well as the elements of the interventions of the capitals. For example, it doesn't mention the huge influence of mega private foundations especially, the Gates Foundation, Wellcome Trust, and Open Society Foundations. The report therefore fails to situate the GHIs in the context of how global health is run and does not analyse the role of these non state donors in the creation, maintenance and policies of GHIs.
- Thirdly, civil society seems to be blamed for being a "lobby group for vertical approach", ignoring the fact that CSOs have been advocating for PHC and UHC for decades. CSOs have been advocating for public investment in health services and in training and retaining the health workforce at all levels, including CHWs. We also advocate for access to medicines, health infrastructures, and health information systems. Moreover, for decades, we have been campaigning for public services free at the point of use. All these elements are the real fundamental pillars of health systems and are essential to achieving UHC.
- Fourthly, UNITAID is scarcely mentioned, and therefore, so is its specific role in making medical products available, affordable, and ensuring quality and delivery. It is mostly lumped with the other GHIs as if it has the same function as, for example, the Global Fund, or the GFF.
- The report lists the GHI functions on page 28, however, this listing is incomplete, at least with respect to Unitaid. The report uses a very limited definition of market shaping, focusing on just pooled procurement as the main mechanism. Lumping all GHIs together in functions like market shaping and approaches like how they do such functions, leads to incorrect conclusions.
- Unitaid market shaping activities stretch far beyond pool procurement activities, focusing on (1) stimulating the development and production of medical products well adapted for use in resource-poor settings and at the community level. For example, UNITAID incentivised the production of products that have small markets, such as paediatric HIV and TB medicines; (2) overcoming regulatory barriers through support to the WHO Prequalification scheme; (3) supporting clinical trials, particularly in populations excluded from initial studies and support for implementation studies to support guideline development; and (4) supporting the market introduction and catalytic scale-up, through including- but not limited to- advance market commitment, enabling low prices via, for example, generic competition and price

supports/subsidies. Unitaid (and the Global Fund) also support demand creation, including community engagement, health literacy, and CS advocacy for and monitoring of the quality and equity of service delivery.

- Moreover, UNITAID works to overcome intellectual property barriers through voluntary measures, e.g., Medicines Patent Pool, and other means, including support for TRIPS-compliant law reform, awareness raising and capacity development to oppose granting frivolous patents, and awareness of governments' legal rights to use compulsory licence, as well as training patent examiners.
- The Chart description of Unitaid's function on page 29 is incomplete. Even a short version should include a reference to overcoming market barriers, creating demand, price reduction, and scaling up equitable access to needed diagnostics and therapies.
- In the discussion of market shaping and catalytic funding on page 32, Unitaid is probably the premiere example, and its exclusion is misleading. In fact, Unitaid pioneered work on market shaping since it was created before the concept became familiar. Likewise, the section discussing vulnerable groups and working with CSOs should also be amended to include Unitaid, with examples. Unitaid has had a focus on civil society engagement, and a formal policy, through and since its creation, and it has standardised CS engagement activities in its grants. It also grades project proposals on their equity focus in terms of meeting the needs of vulnerable and underserved populations.
- The bullet point on page 28 on advocacy "for" marginalised and disadvantaged groups is patronising. The commitment of Unitaid, the Global Fund, and other GHI to involve and support the voice and advocacy of marginalised populations is crucial to their mission.
- The siloing critique on page 49 is old and under-informed. Any time there is programming designed to focus on a previously neglected area, like access to therapeutic oxygen, this is somehow characterised as siloing and ignoring health system strengthening and integrated service delivery. The problem is that amorphous health system strengthening had not sufficiently addressed the availability and affordability of oxygen, thus causing thousands of preventable deaths. The market for medical oxygen was highly concentrated and had artificial distinctions between "medical" oxygen and "industrial" oxygen, with the former being much more expensive. Almost all meaningful health system strengthening requires fixing discrete weaknesses/problems and capacitating health systems to meet unmet needs. However, we recognise that there is room for increased integration of such programmes in the overall public health system. Condemning disease-specific programmes ignores their actual impacts, for example, AIDS programming, , in preparing countries to respond to Covid. The idea that health system strengthening occurs by thinking about everything at once is lazy thinking.
- More community ownership is central but lacking in the report. Greater emphasis on putting community voices and lived experience at the front and centre is crucial for improved health outcomes and to prevent perpetuating power imbalances across the GHIs. Meaningful involvement of communities across global health governance should be non-negotiable and donor responsibility should also be better emphasised throughout the recommendations.
- Lastly, the proposal for a Joint facilitation council is also creating yet another "initiative" where countries will have to devote their scarce resources. Creating another body would mean reporting to another committee, with more work. It is important to recognise that the study and report can be useful for countries to look at the future of health architecture, but decisions on which recommendation to take forward and how, must be made through a democratic process where all countries decide and commit themselves to whatever they decide. It will be essential if the report asks the countries to implement the recommendations,

based on a process they were not engaged with. In this case, however, civil society inclusion in existing and any future initiatives must be protected. Decision-makers should learn the lessons of ACT-A.

Written Response from University of Oslo's Centre for Development and the Environment

Thank you for this opportunity to comment on the report "Reimagining the Future of Global Health Initiatives." It concerns a longstanding problem of great importance, which has been further exacerbated in recent years byCovid-19. We have undertaken several research studies on this theme, adding to a now considerable body of literature (though we were not interviewed for the report). Rather than making detailed comments, however, we find it most appropriate to focus on one single limitation of the report: the inadequate attention paid to earlier initiatives which have sought – unsuccessfully – to address the problem.

The report repeats many of the lessons and recommendations that have already been made in previous assessments about the challenges of creating synergies between GHIs' disease-specific and technology- focused approach and broader strengthening of country health systems, not least in the Venice declaration thatcame out of the "maximizing positive synergies" process led by the WHO in 2009. In a process concerned with"re-imagining" the future of GHIs, it is important to not "re-forget" this past.

Any real assessment of past efforts to address the way GHIs fragment global health governance is, however, reserved for Appendix 12 of the report, where it is stated, correctly, that "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)." Seven such initiatives over the last 30 years are briefly described, and it is concluded that "Common lessons learned largely relate to the need for better donor coordination, alignment, accountability, and priority setting with country needs as the basis." Further: "The KIs suggested that these initiatives should consider structural changes to address the underlying issues within the global health system."

But the importance of this point on structural changes is not reflected in the main body of the report. Apart from a brief reference on p.3, concerning ACT-A, the only mention is on page 50 where it is, rightly, noted that "GHIs create powerful yet fragmented interest groups both internally and at country level".

Moreover, the report only superficially engages in how GHIs already work together, which would have been a critical first step to map out and build on to suggest "incremental change." Crucially, the report overlooked important findings from the GHIs themselves on how they might better cooperate. For instance, Gavi and theGlobal Fund presented a joint report in 2018 highlighting key areas where cooperation could be strengthened.It also discussed which areas of work would be more difficult to find synergies (and why).

One may ask: what is the point of making new recommendations for action until a proper study is made of thefailure of previous attempts? We suggest that this would involve a more in-depth political economy analysis than is contained in the report, including the role of private philanthropy in perpetuating fragmentation.