

The Future of Global Health Initiatives Research and Learning Task Team

Summary Note of Contributions

August 2023

Acknowledgements

We would like to sincerely thank the FGHI Research and Learning Task Team for their contributions and engagement since it was established in November 2022. We are particularly grateful to those who have shared analysis and presentations to the Task Team and contributed to the development of this document.

This document was prepared by Tom Harrison of the Wellcome Trust.

Further information

Contact details have been made available for each piece of work. Any queries about the work or analysis presented should be directed to the contributors in the first instance.

Further information about the Future of Global Health Initiative process can be found here: www.futureofghis.org

For general enquires about the FGHI process, please contact: secretariat@fghi.org

For enquiries related to the Task Team, please contact Clare Battle at: c.battle@wellcome.org

Table of contents

Section	Page
1. About the Future of Global Health Initiatives process and purpose of this document	3
2. Key themes from Task Team discussions	4
3. Research & analysis presented to the Task Team	
3.1. Norwegian Agency for Development Cooperation (Norad) <i>'Internal analysis undertaken to assess how Norwegian Official Development Assistance for health contributes to health system strengthening through global health partners'</i>	5-6
3.2. Ministry of Health, Malawi <i>'Addressing health sector fragmentation in Malawi through the Health Sector Strategic Plan III (2023-2030): Reforming for Universal Health Coverage'</i>	7-8
3.3. UK Foreign, Commonwealth and Development Office <i>'Transitions in Global Health and Implications for the Global Health Institutions'</i>	9-10
3.4. World Health Organization and Alliance for Health Policy and Systems Research <i>'Managing transitions from external assistance: Learning from a multi-country research programme'</i>	11-12
3.5. South African Development Community (SADC) and East Africa Community (EAC) <i>'Institutionalisation of Africa Leadership Meeting objectives in SADC & EAC Regions'</i>	13-14
3.6. Professor Irene Agyepong <i>'Lancet Commission on synergies between universal health coverage, health security, and health promotion'</i>	15-16
3.7. UK Foreign, Commonwealth and Development Office <i>'Progressive Partnerships between GHIs and Country Governments: An overview of upcoming FCDO-commissioned research'</i>	17-18
4. Task Team membership	19-20

1. About the Future of Global Health Initiatives Research and Learning Task Team

The Future of Global Health Initiatives (FGHI) process brings together a group of global, regional and national health stakeholders – from governments and international- and domestic-financing partners to civil society, health organisations, and academics – in a time-bound process of consultation and research throughout 2023, to reflect on how global health initiatives (GHIs), can be optimised to best support national health priorities and countries' progress towards universal health coverage (UHC).

The organisations at the core of this process are: The Global Fund to Fight AIDS, TB, and Malaria (Global Fund); Gavi, the Vaccine Alliance; the Foundation for Innovative New Diagnostics (FIND); Unitaid; the Global Financing Facility (GFF); and the Coalition for Epidemic Preparedness Innovations (CEPI). More information about GHIs and the wider process can be found here: <https://futureofghis.org/about>

In November 2022, a Research and Learning Task Team was established by the FGHI Co-Chairs¹, Mercy Mwangangi, former Chief Administrative Secretary, Kenyan Ministry of Health and John-Arne Røttingen, Global Health Ambassador, Norwegian Ministry of Foreign Affairs, to ensure the process was supported by a robust, action- and policy-orientated base of research and learning.

Convened by Wellcome, the Task Team brought together stakeholders with deep technical and research expertise on the key issues related to the Future of Global Health Initiatives process, from across government, civil society, academia and global health organisations². The group expanded in membership over time and its meetings were a collaborative and inclusive space to share and discuss analysis and internal research that were relevant, though not always central, to the wider Future of Global Health Initiatives process.

Since it was set up, the Task Team has advised on the delivery of a new study, commissioned by Wellcome, and carried out by an independent research consortium of five universities³. In addition, the Task Team has provided a space for partners to share updates on pieces of thinking, research or analysis that are relevant to the broader FGHI dialogue and represent additional valuable inputs to deliberations as the FGHI Steering Group seeks to move towards a set of 'commitments for collective action' by the end of 2023.

Purpose of this document

This document provides a summary of some of the analysis, commissioned research and other thinking that was shared with Task Team. This document aims to capture key themes that emerged from the discussions and ensure these can be considered by the FGHI Steering Group and other stakeholders as they seek to identify and enact commitments that will ensure global health initiatives are more efficient, effective and equitable in supporting country progress towards UHC.

¹ Steering group membership available here: <https://futureofghis.org/about/steering-group/>

² Full task team membership can be found in Section 5 (page 18)

³ Witter S., Palmer N., James R., Zaidi S., Carillon S., English R., Loffreda G., Venables E., Habib S., Tan J., Hane F., Bertone M.P., Hosseinalipour S-M., Ridde V., Faye A., Blanchet K., (forthcoming), *Reimagining the Future of Global Health Initiatives*, Queen Margaret University, Geneva Centre of Humanitarian Studies, Aga Khan University, Cheikh Anta Diop University, Institut de Recherche pour le Développement, Stellenbosch University

2. Key themes from Task Team discussions

This section outlines some of the recurring themes that emerged from presentations and from Task Team discussions. Further detail summarising the presentations and analysis can be found in Section 3.

Despite the significant health gains achieved through programmes delivered by global health initiatives, the GHI ecosystem as a whole suffers from fragmentation and a lack of effective coordination, which causes serious challenges in key areas including finance, governance and health care delivery.

Throughout the discussions, Task Team members heard and shared multiple case studies and anecdotal evidence which described how fragmentation in the GHI system can lead to duplication in planning, implementation, monitoring and reporting within health service delivery at the country-level. Members also heard testimonies about how fragmentation can disempower country governments, with programmes supported by key Global Health Initiatives at times failing to contextualise and implement health service delivery in line with country priorities. This can result in inefficiencies and poor care delivery on the ground.

The timing is right for an assessment of how global health initiatives are functioning.

Task Team members agreed that the current moment offers a unique opportunity to assess how GHIs operate alongside and within the wider global health architecture. Many stressed the importance of understanding the FGHI process in the context of broader political debates around the effectiveness of global health architecture writ large (e.g., the establishment of the Pandemic Fund; ongoing negotiations related to the Pandemic Accord; the High-Level Meeting on Universal Health Coverage at the United Nations General Assembly).

There is a significant amount of work ongoing to understand and identify possible solutions, at country, regional and global-level, and these are at various levels of maturity.

The Task Team heard presentations and testimonies about work underway to address challenges in the current ecosystem, including:

- case studies pointing to areas of improved alignment between GHIs and in-country health system processes, such as efforts to reduce the number of national strategic plans for health at country-level;
- examples of improved collaboration on health financing (such as pooled funding and greater coordination between GHIs);
- ideas for innovative approaches to the way the global health ecosystem measures and accounts for health systems strengthening.

Any structural, governance or financial changes that will affect the GHI ecosystem must advance equity, along with effectiveness and efficiency, in order to sustain and increase legitimacy.

Task Team members acknowledged and recognised that alongside efforts to improve effectiveness, the future of GHIs depends to a large extent on their ability to advance and embed equity in their approach, both in terms of the outcomes GHIs are held accountable for, as well as how GHIs themselves operate.

3. Research & analysis presented to the Task Team

This section provides an overview and summary of presentations that were shared with Task Team or FGHI Steering Group members. Each contributes valuable and complementary insights into issues related to the future of global health initiatives, alongside broader analysis.

3.1. Norwegian Agency for Development Cooperation (Norad)

‘Internal analysis undertaken to assess how Norwegian Official Development Assistance for health contributes to health system strengthening through global health partners’

Presented at Task Team meeting, 2 March 2023

About the presenters

Ingvar Olsen is Policy Director for Global Health and Austen Davis, Senior Adviser, both at Norad. Norad is the Norwegian agency for development cooperation.

About the analysis

At the request of the Norwegian Ministry of Foreign Affairs, Norad has undertaken analysis to assess how Norwegian Official Development Assistance (ODA) for health contributes to health system strengthening (HSS). As the major share of this support is channelled through Global Health Initiatives (GHIs) and multilateral agencies, colleagues at Norad have attempted to unpack and categorise their approaches to HSS and initiate a discussion on what added value GHIs have in strengthening capacity and sustainable health care systems in countries. Norad’s analysis pointed towards some indicative ‘key health system ingredients’ that donor governments could use to better understand how the programmes they support contribute to HSS. This was not a research exercise but rather a piece of internal analysis and was presented to the task team as a work in progress.

Overview

Currently, there are multiple definitions of what constitutes a health system. WHO’s ‘6 *Building Blocks*’, describe health systems in terms of six core components: leadership and governance; service delivery; health system financing; health workforce; medical products, vaccines, and technologies; and health information systems. It is a foundational framework, but places a heavy emphasis on health service *delivery*, and not on wider aspects of health systems such as public health and health security.

Similarly, health system strengthening investments have no standard inclusion criteria: each global health initiative defines this differently without an internationally accepted benchmark for HSS against which GHIs can measure themselves. Nor is there any distinction between financing of recurrent costs such as salaries as opposed to capital costs such as infrastructure, training, or digital infrastructure. Donor understanding of how much their support contributes to HSS is therefore challenging. To help provide a framework for this, Norad have identified some ‘key ingredients’ that should be included in donors’ analysis of health system

strengthening. These can be separated into: (i) disease specific system interventions (ii) essential health services (UHC) (iii) public health and health promotion (iv) health security, pandemic prevention, and response.

Using this framework, some broad calculations can be made about how Norwegian development assistance impacts HSS. Indicative analysis based on partial data suggest that somewhere between 13% and 31% of allocated spending from Norwegian ODA has contributed to health system strengthening. *However*, this is difficult to assess with rigour and also varies across programmes. The indicative breakdown for spend on HSS per GHI / multilateral organisations was as follows:

- Global Financing Facility for Women, Children and Adolescents (GFF): 100%
- Global Fund to Fight Malaria, HIV and Tuberculosis (Global Fund): approximately 33%
- Gavi, the Vaccine Alliance: between approximately 19-32%
- WHO (*excluding norm-setting functions*): 65%
- World Bank International Development Association (IDA): 100%
- Alliance for Health Policy and Systems Research: 100%

Looking beyond these categories, Norad also suggested a discounting approach to valuing HSS investments, by which different weights are used to differentiate investment types with varying levels of focus on strengthening locally owned, governed, and financed health systems. This approach proposes discounting investment in recurrent costs that encourage fungibility – and emphasise joint investment in prioritised system expansion/consolidation, pre-service training and institution building.

Implications for GHIs

To deliver increased institutional capacity in countries and ensure universal and sustainable access to essential health services, improved public health and health security, Norad pointed to a need for a collective effort from the global health system as a whole. Ideally, multilateral and GHI support should be focused on areas of agency value added, and be held to account both for the direct impact it aims for (e.g., the number of children vaccinated) and for the degree to which it contributes to enhanced and sustainable national institutionalized capabilities (such as procurement capacity, supply systems, cold chain management, data analysis and use). In addition, analysis point to the need to for greater effort to be paid towards country level transition plans that deal with capacity as well as financing – and engender better in-country coordination and partnership with public health authorities.

Related reading

Marchal, B., Cavalli, A. and Kegels, G. (2009). Global Health Actors Claim to Support Health System Strengthening—Is This Reality or Rhetoric? *PLoS Medicine*, 6(4), p.e1000059
Available at: <https://doi.org/10.1371/journal.pmed.1000059>

World Health Organization (1978). Declaration of Alma-Ata. [online] www.who.int. Available at: <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata>

World Health Organization. (2007). Everybody's business -- strengthening health systems to improve health outcomes: WHO's framework for action. World Health Organization. <https://apps.who.int/iris/handle/10665/43918>

For further information, please contact Ingvar Olsen, Policy Director for Global Health, Norad at Ingvar.Theodor.Evien.Olsen@norad.no

3.2. Ministry of Health, Malawi

‘Addressing health sector fragmentation in Malawi through the Health Sector Strategic Plan III (2023-2030): Reforming for Universal Health Coverage’

Presented at Task Team meeting, 20 April 2023

About the presenter

Dr Gerald Manthalu is Deputy Director of Planning and Policy Development in the Ministry of Health, Malawi.

About the analysis

Dr Manthalu shared insights on the current funding and governance landscape of healthcare delivery in Malawi and presented the current Ministry of Health-led ‘*Health Sector Strategic Plan III 2023-2030*’ (HSSP III). The HSSP III was envisioned and developed in response to long-standing fragmentation in funding, planning and service delivery in Malawi as is the case in many other low and middle-income countries. In his presentation, Dr Manthalu highlighted the need for fundamental reforms to the health care system, mostly tackling inefficiencies and fragmentation, if Malawi were to make further progress towards universal health coverage. That why the HSSP III seeks to reduce the number of national level strategic plans, which have proliferated in recent years from 19 to as many as 56, largely due to GHI requirements. Dr Manthalu presented the current health financing situation in Malawi and outlined how Ministry of Health-led action has changed how it works with GHIs.

Overview

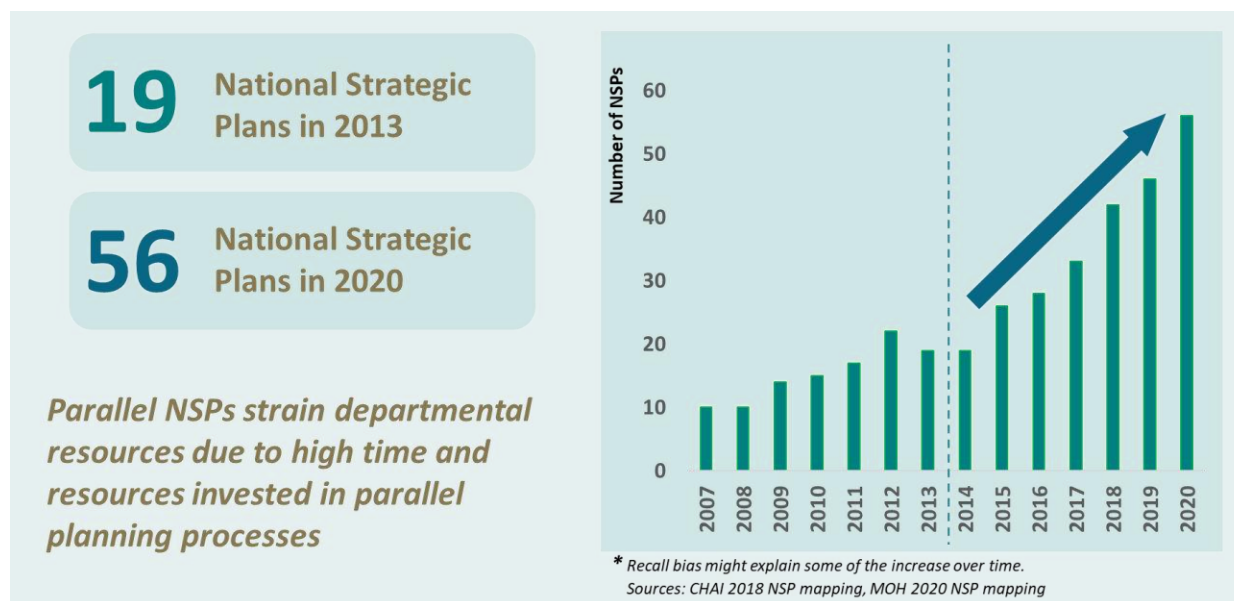


Source: Dr Gerald Manthalu, presentation to Research and Learning Task Team, 20 April 2023

In 2019, only 10 organisations funded 97% of the health sector in Malawi. However, this funding was implemented through approximately 166 health financing sources with over 260 implementing partners. Financing for health service delivery is dominated by donors (54.5%), with the rest coming from the public sector via general taxation (24%), and then the private sector/ households (21%). Despite stagnated real total health expenditure per capita and limited economic growth, Malawi had made positive progress towards increasing universal health coverage (UHC).

The Health Sector Strategic Plan III 2023-2030 (HSSP III) has been developed to help to address fragmentation and strengthen care delivery for Malawi. It seeks to significantly reduce the number of fragmented processes planning for, budgeting for, and implementing health care delivery through a *One Plan, One Budget, One Report* initiative. This is based on some longstanding examples of health service fragmentation in Malawi, such as training for health

care professionals, which comes from multiple financing sources via large number of organisations, which is often uncoordinated/



Source: Dr Gerald Manthalu, presentation to Research and Learning Task Team, 20 April 2023

Implications of implementing HSSP III for GHIs

As referenced, GHIs have contributed to fragmentation in Malawi through parallel financing mechanisms, financial management systems, governance mechanisms, resource allocation systems and implementation of service delivery. In particular, vertical funding has contributed to a fragmented Ministry of Health structure which implements vertical disease programmes instead of coherent health sector-wide priorities. However, the HSSP III has started to change the way GHIs work with the government.

- **Working with Global Fund:** Early in 2023, Malawi engaged the Global Fund to shift away from programmatic strategic plans in line with the HSSP III. This was initially “uncomfortable” for the Global Fund, but an agreement has been reached to explore an incremental approach. This is being preceded by an assessment of the ‘Health Services Joint Fund’ which pools resources from the UK, Norway and Germany. Currently, there is an agreement that in the next funding cycle, Malawi will focus on securing external investment for an integrated health services strategy, rather than programmatic strategic plans specifically for HIV, TB and Malaria.
- **Working with the Global Financing Facility (GFF):** The GFF have participated in and supported the development of HSSP III particularly the vision of a One Plan, One Budget, One Report agenda with all-inclusive decision-making platforms. It has also acknowledged that HSSP III could constitute a singular investment case for Malawi.

Related reading:

Ministry of Health, Malawi (2023) *Malawi Health Sector Strategic Plan III (HSSP III) - Document Management System*. [online] Available at: <https://dms.hiv.health.gov.mw/dataset/malawi-health-sector-strategic-plan-iii-hssp->

For further information, please contact Dr Gerald Manthalu, Deputy Director of Planning and Policy Development, Ministry of Health, Malawi at: gerald.manthalu@health.gov.mw

3.3. UK Foreign, Commonwealth and Development Office (FCDO)

'Progressive Partnerships between GHIs and Country Governments: An overview of FCDO-commissioned research'

Presented at Task Team meeting, 20 April 2023

About the research

UK FCDO Global Health Directorate has commissioned 5 in-country analyses (Zimbabwe, Tanzania, Ghana, Indonesia, Ethiopia) to assess what the GHIs collectively deliver, and how. Drawing insights from these examples, the analysis will identify learning that might be relevant to other contexts. This work was presented to the Task Team as an upcoming study; the analysis will be carried out in 2023 in consultation with the Global Fund to Fight AIDS, TB and Malaria (GFATM), Gavi the Vaccine Alliance (Gavi), the World Bank's Global Financing Facility (GFF) and Global Polio Eradication Initiative (GPEI). It will complement the work of the *'Reimagining Global Health Initiatives'* independent research study, as well as feeding into FCDO's internal thinking to define the UK's future vision for the GHIs.

Overview

The country case studies will examine progressive models that demonstrate ways that GHIs have attempted to and / or succeeded in harmonising and aligning support behind country health systems plans. Such models may look at:

- *what* the GHIs deliver beyond vertical disease outcomes – including a greater combined focus across agencies on primary health care, integrated services, essential public health functions; or
- *how* they deliver it, for example through progressive financing models including the pooling of funds, or at least reflecting funds on a single budget spreadsheet; governance models including the use of in-country structures, coordinated missions and dialogue; shared HSS monitoring framework and core indicators; streamlined procurement processes; and through coordinated transition planning across agencies.

The case studies will explore how countries have optimised flexibilities within institutional policies or arrangements, planning and budgeting mechanisms, and coordination and collaboration mechanisms. As well as in-country stakeholders, country teams/grant management teams based in Geneva/centrally will be key to understanding internal drivers and organisational structures around change. In relation to the progressive model being examined, the case-studies will include a historical perspective of how the model evolved; a present focus on its challenges, opportunities and impact; and a future perspective on what more is possible and desirable, and further bottlenecks to change.

The research will include a cross-cutting analysis: drawing together lessons from across the case studies to identify any commonalities or key differences. It will highlight the most significant factors that led to change and the steps required to get there, considering action from across multiple partners, at both country and global level. Based on this evidence, it will explore whether any systematic changes at the centre could enable change to be scaled-up

or replicated in other contexts. It will also consider the incentives of different partners and what shifts are needed to facilitate change. It may touch on lessons learned from other countries or contexts. It will include some recommendations that could be explored further during FGHI consultations or within GHI strategy/board discussions.

For further information, please contact Anna Seymour and Jo Scott-Nicholls, Senior Advisers (job-share), Global Health Directorate, UK Foreign, Commonwealth and Development Office at: seymour-scottnicholls@fcdo.gov.uk

3.4. World Health Organization, Alliance for Health Policy and Systems Research Health Financing Team

‘Managing transitions from external assistance: Learning from a multi-country research programme’

Presented at Task Team meeting, 2 June 2023

(Publication forthcoming)

About the lead authors

Susan Sparkes is a health financing technical officer in the Health Financing Team, WHO. Zubin Shroff is a technical officer at the Alliance for Health Policy and Systems Research, WHO.

About the research

WHO’s Health Financing Team and colleagues from the Alliance for Health Policy and Systems Research (AHPSR) presented research that sought to understand the key factors in achieving ‘sustained coverage’ when countries transition away from donor funding for health programmes. This was conducted in collaboration with four in-country academic partners in China, Georgia, Sri Lanka, and Uganda. The research was presented to the task team as a work in progress, with findings due to be published early 2024.

The research focused on the below programmes.

Country	Programme	Years	Donor	Coverage/ sustainability outcome
China	Basic Health Services Programme	1998 - 2007	World Bank/DFID	Partially achieved
	Hep B Vaccination	2002 - 2010	Gavi	Fully achieved
	HIV/AIDS RCC	2010 - 2013	Global Fund	Partially achieved
Georgia	Opioid Substitution Therapy	2003 - 2017	Global Fund	Fully achieved
	National Immunization Programme	2002 – 2018	Gavi	Partially achieved
Sri Lanka	Antimalaria Campaign	2003 - 2018	Global Fund	Partially achieved
	Expanded Programme on Immunisation	2003 - 2015	Gavi	Fully achieved
Uganda	Saving Mothers Giving Life	2012 - 2016	USAID	Fully achieved
	PEPFAR	2004 - 2017	PEPFAR/US Government	Challenges achieving desired outcomes

Summary of findings

The research team identified several key enablers that were associated with sustained coverage in a range of scenarios where countries have transitioned away from multiple sources of external assistance (including GHI assistance). They found that there was no single deterministic factor in either case, but the more factors that were present, the more likely positive outcomes were identified.

Key enablers to sustained coverage in the context of donor transition:

1. There needs to be a clear distinction between who is funding what and how
2. Budget cycles and governance mechanisms should be incorporated within domestic governance and financing
3. Align to government domestic salary scales and governance processes
4. Strategically integrate specific functions into domestic systems
5. Invest more broadly into system foundations, rather than only programmatically
6. Clear and transparent donor processes led by country teams
7. Favourable political/economic context
8. Avoidance of parallel mechanisms e.g., for information systems or service delivery
9. Purposeful actions to strengthen health system capacities, e.g., for procurement or public financial management

Recommendations and implications for GHIs

The research pointed towards a number of ways in which GHIs could support more sustainable coverage objectives regardless of the source of funding. These are not only related to transition, but are principles that be more broadly applied.

1. Identify opportunities to align and integrate with domestic health systems (e.g., input functions- information systems, procurement, health worker salaries, using public financial management systems, governance structures).
2. Differentiate and provide clarity on what and how funding is channelled for recurrent and capital costs
3. Build political alignment and commitment through active civil society and community-level engagement
4. Establish clear, transparent and realistic timelines and processes (including for co-financing) that are continuously and collaboratively assessed.
5. Create a non-competitive and efficient approach by coordinating donor policies and priorities with domestic systems and priorities (e.g., pooled funding, strategic engagement for long-term system strengthening and technical assistance).

For further information, please contact Zubin Shroff, Technical Officer, Alliance for Health Policy and Systems Research at shroffz@who.int or Susan Sparkes, Health Economics, Health Financing Team, World Health Organization at: sparkess@who.int

3.5. East Africa Community (EAC) and Southern African Development Community (SADC)

‘Institutionalisation of the African Leadership Meeting objectives in EAC and SADC regions’

Presented at Task Team meeting, 2 June 2023

About the presenters

Dr Regina Ombam is a Health Financing Dialogue Facilitator, East African Community & Dr Lamboly Kumboneki is a Senior Program Officer, Southern Africa Development Community.

About the work

Dr Ombam and Dr Kumboneki presented an overview of the Africa Leadership Meeting: Investing in Health⁴ objectives and the current state of play for ‘National Health Financing Dialogues’ in a range of countries in southern and east Africa. These dialogues are coordinated and delivered by East African Community and Southern African Development Community respectively and aim to provide dedicated coordination and technical support to countries to achieve universal health coverage and implement sustainable financing mechanism of their respective health system.

Overview

In 2019, the Heads of State of African Union members endorsed a pan-African plan to meet 4 headline goals related to health financing.

1. More Money for Health: increase health spending, via domestic resource mobilization
2. More Health for the Money’: improve outcomes, by investing in driving greater effectiveness and efficacy in the delivery of health care
3. Equity or Improved Financial Protection in Health
4. Strengthened country leadership and governance over health financing.

To help achieve this, African Union Member States agreed to institute Regional Financing Hubs alongside facilitating National Health Financing Dialogues. The key objectives of the dialogues are to:

- Mobilise and support national stakeholders to accelerate implementation of Health Financing Strategies and identify priorities and assess progress.
- Identify any health financing reforms required to build consensus on actions that are nationally supported and politically feasible, including any external health financing stabilisation needs.
- Develop work and technical support plans that can be funded and supported both domestically and by international partners to accelerate sustainable and effective domestic financing of health care.

⁴ African Union (2019) *Africa Leadership Meeting: Investing in Health | African Union*. [online] Available at: <https://au.int/en/newsevents/20190209/africa-leadership-meeting-investing-health>

Progress on National Health Financing Dialogues and implications for GHIs

The 36th Session of the African Union in February 2023 noted the progress to date on operationalising of Regional Financing Hubs (RFH) as well as National Health Financing Dialogue, both of which were described as key enablers for increasing the allocation of domestic resources for health. The African Union also reaffirmed its commitment to the implementation of the Abuja Declaration 15% target for domestic financing for health while transitioning away from dependence on partners' funding (a considerable amount of which is provided by GHIs).

Current status of health dialogues in the Southern Africa Development Community and East Africa Community regions:

Country	Region	Timeline
Burundi	EAC	Dialogue scheduled for September 2023
Kenya	SAC	Completed in June 2023
Malawi	SAC	Completed in 2022
Mauritius	SAC	Dialogue scheduled for September 2023
Mozambique	SAC	Completed in July 2023
Rwanda	EAC	Dialogue scheduled for September 2023
Zambia	SAC	Completed in 2023

Related reading

African Union (2019) *Africa Leadership Meeting: Investing in Health | African Union*. [online] Available at: <https://au.int/en/newsevents/20190209/africa-leadership-meeting-investing-health>

For further information, please contact Dr Ombam, Health Financing Dialogue Facilitator, East African Community at aruthi1968@gmail.com or Dr Kumboneki, Senior Program Officer, Southern Africa Development Community at: klamboly@yahoo.fr

3.6 Professor Irene Agyepong

‘Lancet Commission on synergies between universal health coverage, health security and health promotion’

Presented at Task Team meeting, 17 July 2023

(Published May 21, 2023)

About the presenter

Professor Irene Agyepong is a lead author of the *Lancet Commission on synergies between universal health coverage, health security and health promotion*. She is a Public Health Physician and member of the Public Health Faculty of the Ghana College of Physicians and Surgeons.

About the research

Published in May 2023, this study aimed to understand the intersections between the three leading agendas in global health of universal health coverage, health security, and health promotion and to identify key policies, institutional capacities, decision-support systems, and interventions that contribute across the three agendas and can make strength in one area amplify strength in the others. The Commissioners aimed to help stakeholders better align the efforts, cooperate more effectively and ultimately, save more lives.

Overview

Prior to the substantive research phase, the Commission has formulated a theoretical and conceptual framework which guided the research process. This shows that when interventions occur within intersections of the 3 global health agendas, they have the potential to influence activity which can cause both synergies and dis-synergies. It also identified the health system has the commonly pooled resources in which all of all these programmes interact and rely on for implementation.

Key findings

Fragmentation and dis-synergies between agendas are near universal and undesirable

Despite initial assumptions that dis-synergies would occur most prominently in low- and middle-income countries, the study found that these were prevalent in countries at **all** income levels. Counterproductive competition and fragmented investment are common when implementing these agendas which can act to undermine the ability of health systems to achieve any of them.

Covid 19 provided a warning about the impact of dis-synergies

The dis-synergies between health promotion, health security and universal health coverage witnessed and documented during the pandemic weakened health systems, made them less able to cope with day-to-day and emergency demands, and rendered people more vulnerable to serious disease. Conversely, universal health coverage and healthier populations have helped some countries withstand the pandemic.

Where synergies occurred, health systems could better accommodate the surge of patients from COVID-19 and minimise the burden of serious COVID-19 disease on health systems because of fewer comorbidities present in the population.

There is a mixed picture when analysing global case studies

Case studies across 11 countries identified, often simultaneously, both synergies and dis-synergies. For example, activities of the Global Fund were highlighted as both promoting synergies between health promotion, health security and universal health coverage as well as undermining these by having a focus of specific diseases.

Key drivers of dis-synergies are diverse and multi-dimensional

- Ill-considered national self-interest: i.e., vaccine nationalism and tied aid
- Coloniality: frameworks of thinking and doing that lead to misuse of power over others in decision making and implementation, with an assumption of inherent superiority without critical questioning of validity.

Recommendations that have implications for GHIs and other actors

The global health architecture and systems as whole should be oriented to maximise positive synergies between health promotion, health security and universal health coverage. To achieve this, the Commissioners outlined changes that are required in 3 areas.

1. Mindset shifts
 - Recognise that synergies are necessary to meet goals
 - Reframe individual country health goals towards positive synergies
 - Develop shared values internationally to support this
2. Changes to decision making
 - Demand and facilitate more nationally owned priorities
 - Adopt decolonised approaches
 - Global health agencies (and donors) should offer more flexibility
3. Changes to accountability
 - Understand that donors and organisations like GHIs hold substantial power
 - Ensure monitoring and accountability encompasses both national and global actors, with independent scrutiny and tracking of progress.
 - Recognise that national governments are ultimately those who should be held to account and hold GHIs accountable

Related reading

Agyepong, I., Spicer, N., Ooms, G., Jahn, A., Bärnighausen, T., Beiersmann, C., Brown Amoakoh, H., Fink, G., Guo, Y., Hennig, L., Kifle Habtemariam, M., Kouyaté, B.A., Loewenson, R., Micah, A., Moon, S., Moshabela, M., Myhre, S.L., Ottersen, T., Patcharanarumol, W., Sarker, M. Sen. G., Shitzaki, Y., Songane, F., Sridhar, D., Ssengooba, F., Vega, J., Ventura, D., Voss, M., Heymann, D. (2023). Lancet Commission on synergies between universal health coverage, health security, and health promotion. *Lancet (London, England)*, [online] 401(10392), pp.1964–2012. Available at: [https://doi.org/10.1016/S0140-6736\(22\)01930-4](https://doi.org/10.1016/S0140-6736(22)01930-4)

For further information, please contact Professor Irene Agyepong Public Health Faculty, Ghana College of Physicians and Surgeons at: iagyepong@gcps.edu.gh

3.7 UK Foreign, Commonwealth and Development Office

‘Transitions in global health and implications for the global health institutions’

Presented to Future of Global Health Initiatives Steering Group

About the analysis

In 2022, the Global Health Directorate at the UK Foreign, Commonwealth and Development Office (FCDO) convened a lively and thought-provoking two-hour discussion among health thought-leaders from across the world on the future of the global health architecture, with a specific focus on the Global Health Initiatives (GHIs). Chatham House rules brought candid talk. A summary of this discussion was shared with the FGHI Steering Group in December 2022. The discussions and opinions presented do not represent UK FCDO policy.

Overview

The discussion was based around 3 questions:

1. Should Global Health Initiatives (GHIs) remain focused on the current set of diseases or address the emerging health needs of the future? If so, what capabilities need to evolve or be redeployed?
2. Development assistance should strengthen health systems over the long-term and support the transition to sustainable domestic financing. What is the role of the GHIs in this and how best can they achieve it?
3. What would a radical rehaul of the global health ecosystem look like? What would the comparative advantage/value add of the GHIs be within this system?

It touched on key lessons learned from the last 20-year evolution of the GHIs and considered the future landscape in terms of changing burden of disease and health needs, opportunities in research and technology, and key shifts in geopolitics and economics. There was unanimous agreement that despite the GHI's huge impact on disease, there was need for fundamental changes from the current business model to address the multiple health challenges facing communities today: "*The system works well, but not for people*". The debate centred on what those changes should be, pivoting from 'tweaks' to a 'radical overhaul' of the existing system.

A thread of guiding principles emerged across the conversation to support the design of a future vision: take a long-term perspective (at least 10 years); maintain a focus on the collective goals of *self-financed* Universal Health Coverage (UHC), global health security and resilient health systems; strengthen our focus on prevention of illness and resilient communities; build greater agility and flexibility in how resources can be used to meet local need; shift towards a 'partnership' approach and greater agency and accountability to the Global South.

In practice this means exploring progressive new models in governance and oversight structures, health financing (including cost-sharing and pooling), and in *what* GHIs finance (towards global and regional public goods, system strengthening technical support, integrated delivery). It will require “*stomach, brains and hearts*” on the parts of all parties to interrogate the incentives and interests behind the current system and a willingness and humility to cede some long-held principles to move things forward.

Conclusions and implications for GHIs

The themes of the discussion were pulled together under 5 “P’s” and each hold significant implications for how GHIs could function in the future.

- **Politics & power:** The conversation highlighted the importance of shifting systems of accountability between Global North to Global South actors.
- **Participation:** Greater engagement of communities and providers is needed to ensure access to all basic services.
- **Price:** Crucial commodities must be priced so that low- and middle-income countries (LMICs) can access, buy and where feasible produce them. The market shaping role of some GHIs is likely to remain of critical importance.
- **Prevention and Primary Health Care:** GHIs should have primary health care and prevention as a core focus and concept.
- **Pragmatism:** Pragmatism is required in order to find a way forward that can deliver transformational change without undermining critical, life-saving functions currently performed by GHIs.

For further information, please contact Anna Seymour and Jo Scott-Nicholls, Senior Advisers (job-share), Global Health Directorate, UK Foreign, Commonwealth and Development Office at: seymour-scottnicholls@fcdo.gov.uk

4. Task Team membership

Below is a list of Research and Learning Task Team members. This does not include some of those who were invited to present at meetings and others who made valuable contributions as attendees for specific sessions.

Prof. Irene Agyepong, Public Health Faculty, Ghana College of Physicians & Surgeons
Clare Battle, Policy Lead, Wellcome Trust [Task Team lead, ex officio]
Prof. Christian Bope, Associate Professor, University of Kinshasa
Jens Busma, Deputy Head of Division, Global Health Policy and Financing, German Federal Ministry for Economic Cooperation and Development
Hannah Cameron, Senior Program Officer, Global Policy and Advocacy Team, Bill & Melinda Gates Foundation
Dr Kalipso Chalkidou, Head, Health Finance, Global Fund to Fight AIDS, Tuberculosis and Malaria
Kristine Chenier, Director, Global Affairs Canada
Dr Emilia Connolly, Chief Health Systems Policy Advisor, Partners in Health
Dr Mandeep Dhaliwal, Director of the Health Group, UNDP Bureau for Policy and Programme Support, United Nations Development Programme
Kate Dodson, Vice President, Global Health, United Nations Foundation
Alexandra Fullem, PDP Funders Group
Amanda Glassman, Former Executive Vice President, Centre for Global Development
Dr Nabeel Goheer, Chief of Asia, Middle East, Europe (AMEE) Region, PATH
Sue Graves, Deputy Director, Health Funds and Architecture, Bill & Melinda Gates Foundation
Hampus Holmer, Special Advisor, Swedish Ministry for Foreign Affairs
Dr Hajime Inoue, Advisor, Health, Nutrition and Population, Global Engagement, World Bank
Dr Zina Jarrah, Global Technical Lead, Health Financing, Management Sciences for Health
Joshua Kaufman, Acting Deputy Assistant Administrator, USAID's Bureau for Policy, Planning and Learning (PPL)
Ryuichi Komatsu, Visiting Professor, Institute of Tropical Medicine, Nagasaki University
Dr Daniel Kress, Lead Economic Advisor, Center for Healthy Development (CHD)
Dr Meghan Kumar, Assistant Professor of Health Economics, London School of Hygiene and Tropical Medicine
Dr Catherine Kyobutungi, Executive Director, African Population and Health Research Center
Rosana Lescrauwaet Noboa, Advocacy Officer, Global Health Global Access, Cordaid
Dr Benjamin Loevinsohn, Director of Immunization Financing and Sustainability, Gavi
Roman Macaya, Former Costa Rican Ambassador to the US, Costa Rica
Dr Gerald Manthalu, Deputy Director of Planning & Policy Development, Ministry of Health, Malawi
Shayon Mukherjee, Policy Manager, UK Foreign, Commonwealth & Development Office
Ayah Nayfeh, Senior Analyst, Global Health, Global Affairs Canada
Anders Norström, Ambassador for Global Health, Swedish Ministry for Foreign Affairs
Dr Marion Okoh-Owusu, Western North Regional Director, Ghana Health Service
Kristine Husøy Onarheim, Senior Advisor, Norwegian Ministry of Foreign Affairs
Toomas Palu, Adviser on Global Health Coordination, World Bank
Walaiporn Patcharanarumol, Director of Global Health Division, Ministry of Public Health, Thailand
Tara Prasad, Markets & Supply Manager, Centre for Health Emergency Strategy & Partnerships, UNICEF
Isadora Quick, Secretariat, Global Action Plan for Healthy Lives & Well-being for All

Dr Kumanan Rasanathan, Executive Director, Alliance for Health Policy and Systems Research

Jo Scott-Nicholls and Anna Seymour (Job-share), Senior Health Adviser, Global Health Directorate, UK Foreign, Commonwealth & Development Office

Joyce Seto, Specialist, Global Affairs Canada

Susan Sparkes, Health Economist, World Health Organization

Dr Douglas Webb, Manager, Health and Innovative Financing, HIV, Health and Development Group, United Nations Development Programme

Co-chairs and Secretariat

John-Arne Røttingen, FGHI co-chair, Global Health Ambassador, Norwegian Ministry of Foreign Affairs

Mercy Mwangangi, FGHI co-chair, former Chief Administrative Secretary, Ministry of Health, Kenya

Linda Muller, Head of Secretariat, Future of Global Health Initiatives