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Stewardship of the post-Lusaka Agenda global process: Issues and options

Final report

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About this report:

This report collates the views of health stakeholders engaged in the Lusaka Agenda and its aftermath across the global health eco-system, so beyond the GHIs. The report crystallises the various global functions needed to take forward meaningful action around the five shifts agreed in the Lusaka Agenda (December 2023) at the global level. In doing so, the report nuances these perspectives, identifying where consensus exists among stakeholders and where there is currently a range of opinion that would benefit from more dialogue ahead of decision-making. The report pulls out major risks, many identified by stakeholders themselves. Sample options are presented to illustrate how coherence and function in support of the five shifts could be achieved but as these examples are based on a 'mix and match' approach they could be shaped in a number of directions depending on appetite and depth of commitment to tackling the fundamental issues driving the whole process.

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1 INTRODUCTION: CONTEXT

The Lusaka Agenda[1] launched on UHC Day in December 2023 captures consensus and provides a foundation for coordinated action among global health stakeholders around five key shifts for the long-term evolution of Global Health Initiatives (GHIs) and the wider global health ecosystem (Box A). Together, these actions are intended to advance the overarching objective of improving the efficiency, effectiveness and equity of health financing, service delivery and inclusivity in order to strengthen health system capacities and accelerate progress towards universal health coverage.

Box A: The Lusaka Agenda Five Key Shifts

- Make a stronger contribution to primary health care (PHC) by effectively strengthening systems for health
- Play a catalytic role towards sustainable, domestically financed health services and public health functions
- Strengthen joint approaches for achieving equity in health outcomes
- Achieve strategic and operational coherence

The realisation of the shifts will require united and collective effort across stakeholder groups including all global health partners and concerned countries. Partner coordination and alignment is fundamental to promoting country leadership, priorities and systems, and to ensure active mutual accountability. But other aid effectiveness and country ownership behaviours and reforms are also essential. While the global health initiatives[2] (GHIs) are one entry point to this wider process, all partners have a role to play in taking the shifts forward in contextually appropriate ways.

In support of this effort, global partners aim to improve coordination, maintain and expand advocacy around achieving the five shifts and strengthening accountability. For most, the result of these efforts will be the advancement of the wider processes anticipated in the Lusaka Agenda, not only through the operationalization of the five shifts within the GHIs themselves, but also including the on-going evolution and reform of health financing and development assistance for health, expanding the application of the five shifts to all key health actors beyond the global health initiatives (GHIs), the adoption of a common vision of the role of development assistance for health, and sustaining commitment around increasing domestic resource mobilization.

While the objectives are generally clear, the best approach to stewardship and associated organisational arrangements around maintaining momentum around the five shifts are not. This report explores available options, identifies opportunities and risks, and provides guidance to stakeholders in making key decisions around moving this complex process forward. The report was commissioned by Norad as a contribution to discussions around next steps. It aims to serve as input for the broader Lusaka Agenda debates and processes and thus it is intended to capture and reflect a range of views, make suggestions for discussion and occasionally suggest concrete options which could be refined and evolved or – where appropriate - rejected.

[1] The launch of the Lusaka Agenda marked the conclusion of the first phase of what began as the Future of Global Health Initiatives (FGHI) process. The FGHI process was initiated by a range of stakeholders to build consensus on the evolution of the global health system: https://futureofghis.org

[2] The six GHIs that the Future of GHIs process focused on in the first instance included the Global Fund to fight AIDS, TB and Malaria, Gavi, the Vaccine Alliance, the Global Financing Facility for Women, Children and Adolescents, Unitaid, the Foundation for Innovative New Diagnostics (FIND), and the Coalition for Epidemic Preparedness Innovations (CEPI). This rapid mapping will use the same definition as the Future of Global Health Initiatives (F-GHI) process has throughout its work. GHI refers to organisations that integrate the efforts of stakeholders around the world to mobilise and disburse funds to address health challenges and do so by supporting the implementation of health programmes in low-and middle-income countries (https://wellcome.org/what-we-do/policy-and-advocacy/future-global-health-initiatives-process).

2 METHODS

Purpose, objectives, and scope

The **purpose** of this study is to develop a rapid mapping of potential platforms to support global health coordination, advocacy and accountability in the next stages of the post Lusaka Agenda process ensuring connection with on-going actions at regional and country level. The mapping is rooted in shared global health goals especially linked to health system strengthening and the advancement of universal health coverage including through primary health care (PHC). As part of the analysis, the findings assess learning from relevant past experiences and efforts to reform global health and development processes.

The **objectives** of the study are thus to: (i) explore options for partnership platforms able and willing to take forward the global coordination process, including advocacy and accountability of the Lusaka agenda; (ii) ensure these options are tethered to a sound understanding of previous experience working on global health goals and are clearly linked to advancing agreed health systems strengthening, UHC and PHC related goals; and (iii) consider strengths and opportunities as well as risks and limitations of different partnership options.

Scope and approach

The study is based on material collected through (i) interviews conducted with 20 key informants drawn in a roughly balanced way from different stakeholder groups (Annex B) and (ii) a review of documents including the results of previous surveys, interviews and reports linked to the post-Lusaka Agenda discussions. Annex B summarizes the methodology and includes a list of key informants and documents.

Limitations

The timing of the research during the July-August 2024 holiday period combined with the limited study duration means this is a rapid review that lays out options aimed at supporting further discussion rather than being an exhaustive or even a comprehensive study. It is also important to note that the GHIs were not interviewed for this rapid mapping; the focus was on global dialogue and related processes that could compliment the GHIs' on-going work through their internal structures governance processes. As a rapid exercise, the study does not fold in balanced views from across all global regions and focuses primarily on those of African countries and partners.

3 FINDINGS

This section presents the data collected in three intersecting analyses. The first part summarises past experience and lessons learned reflecting on implications for global action on the five shifts. The second part explores the main critical themes that have emerged through the research, and the third part analyses a handful of potential partnership platforms as options to support organisational arrangements for the global process going forward.

3.1 LESSONS LEARNED AND OPTIONS APPRAISAL

There was a strong consensus across the key informants that the intense global dialogue leading up to the launch of the Lusaka Agenda has been a positive experience for global health so far. The process around implementing or taking forward the five shifts with both short and longer term reforms in view (referred to as 'the process' in this study) marks what is in many ways more complex or challenging. Views about the level of traction the process was gaining varied considerably. For some key informants, the fact of the Joint Committee Working Group (JCWG) with its focus on improving GHI coherence and behaviours

is already an important step forward; they were optimistic that the results of the JCWG will be constructive, meaningful and – critically – will lead to material reforms in the global health system. For others, some of whom were not convinced that the self-generated and managed reforms would be significant, the JCWG was unlikely to deliver much concrete change. However, all agreed the JCWG needed time to deliver and that the process should respect this, remain optimistic and supportive. Whatever their level of optimism/ expectation, several key informants pointed out that there was no workstream on GHI co-financing policies and approaches or on domestic resource mobilization which, in their view, was at the very least a missed opportunity and at the outside, an indication of the limited tinkering anticipated by GHIs through this process.

Every key informant saw value in the process especially in relation to bringing change to global health and development modalities. At the global level, there was consensus around the value of the process to date, in particular, the benefit of building consensus around the five shifts, the network that has developed across the global health architecture and the potential change that could yet come. One informant pointed out that this was the first time a global process "explicitly connected modalities or ways of working with what we want to achieve". Other informants referenced the importance of ensuring the result was worth the (expected) level of effort with one suggesting in positive terms, "the juice is worth the squeeze".

Consensus began to fray a little in relation to what that change should or could look like, how achievable it might be and the methods best designed to move forward. Some informants remained ambitious for the process suggesting that success would mean the development of a shared vision for a "simplified aid system with a shared results framework that adds value". Several key informants, reflecting on progress overall, thought the process might be nearing the end of its "usable life" as a coherent movement that could drive change. Going forward, they suggested there was still scope to safeguard and continue to develop and use the global network to ensure continued dialogue. However, key informants from across all constituencies suggested it would be constructive to focus intensively on working differently in a limited group of engaged countries (pathfinders) and presumably documenting this experience, to support coherence and drive outcomes at country level.

Some suggested the process was not inclusive enough but was becoming more so over time. Interestingly, the name and references to the "Future of GHIs" and "the Lusaka Agenda" attracted comments from a number of key informants (especially donors) who felt the process needed re-branding and that there were some aspects of the process to date (insufficient inclusion was suggested by two key informants) that limited the appeal of the process to a wider group. Overall, based on comments from our interviews, this was not widely seen as a limitation. In fact, the key informants we talked to generally felt the process was becoming increasingly inclusive. This reflects also the ways in which the process is evolving from its original germination as a tightly focused discussion about long term reform of global health initiatives to a wider process of reform in health and development assistance. The process currently continues to evolve, and this is a reflection that it continues to be 'live'.

Specifically, looking at where momentum was currently coming from, Africa countries and African intergovernmental bodies and regional organisations are leading and energising the process. This momentum potentially creates an engine of change that marks this as a fully new departure from other aid effectiveness reform processes in the past which have tended to be donor country-led. For many, this momentum creates the best opportunity for all global and country stakeholders to effect meaningful reforms in the development assistance for health eco-system. However, it is worth noting that among key informants from donor partners and global health agencies, there were some signs of – at worst – fatigue and at best what could be characterised as caution that this so-far constructive and fairly organic process could lead to the establishment of another major global process especially without a clear sense of purpose,

explicit consensus among all stakeholders, or a concrete idea of what results could be achievable beyond those delivered by the JCWG. So far, there is no proposal for major global architecture and the process continues to evolve with care and through consensus. It is a major challenge widely recognised among key informants that maintaining forward momentum requires a fine balance between structure and process without 'over-baking' or over formalising either.

Despite this range of views around the "what next and what is possible" questions, all key informants understood and shared the view that this process needed to have impact in countries. This impact ultimately needed to be expressed in terms of stronger health systems, better primary care arrangements and concrete progress towards increasing access to basic services by all people while reducing financial hardship (UHC/ PHC). As well, key informants agreed that the process would need to avoid the pitfalls of previous reform processes and somehow continue to create something new, a real departure from, at least, the recent past.

Although impact in countries is its main objective, the potential value of the process is high level, global health reforms that are not immediately themselves country-focused. The range of incentives and motivations in the global health architecture means that the current system cannot work differently in any individual country without a number of root and branch reforms taking place at headquarter level and in the way that global stakeholders organise themselves and deliver their development assistance. One key informant observed that "a lack of finance may drive the change" process if stakeholders don't reform themselves implying that a reduction in funding could also have a marked effect on how health priorities are identified, addressed and funded. According to many key informants it would be a missed opportunity to narrow the focus back to something like "better partnerships among global stakeholders in specific countries as proof of concept" as this would probably not include that deeper and more difficult reform at the organisational level. The SDG GAP (and others) already tried – and many suggested failed – to create this kind of change.

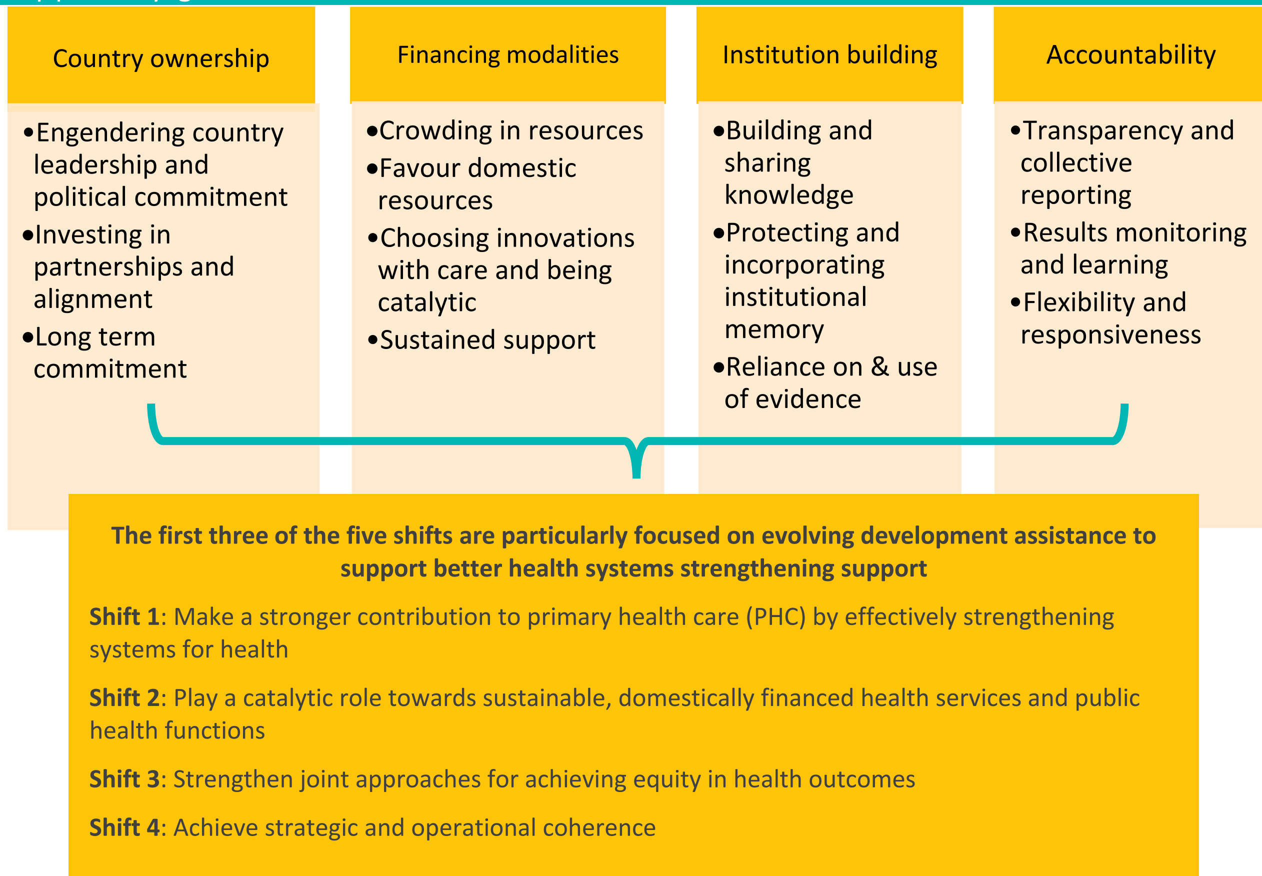
In order to shape thinking around the nature of reform in the global architecture, we have collated **two further analyses** here to help guide further discussion about options for taking forward and sponsoring. The first draws on research and evidence that summarises key success factors and barriers in the practice of HSS[3]. These success factors summarise an analysis of a wide range of published audits, evaluations and reviews of global HSS practitioners in order to distil learning. Figure 1 summarises results into four categories.

The review of the practice of system strengthening highlighted that better HSS was associated with strong and sustained country leadership at the institutional level, the role of specific individuals or groups of individuals, positive global partner behaviours, astute political processes involving parliament, civil society, and wider government engagement (inclusivity), and financing practices that reinforced all of these features. These findings are unlikely to be considered novel to most stakeholders and are consistent

[3] In the context of this study, the health system strengthening definition used is based on the work of the HSS Evaluation Collaborative prepared in the context of the Future of GHIs process: "HSS interventions are defined to include (a) **consideration of scope** (with effects cutting across building blocks in practice, even if not in intervention design, and also tackling more than one disease), (b) **scale** (having national reach and cutting across more than one level of the system), (c) **sustainability** (effects being sustained over time and addressing systemic blockages), and (d) **effects** (impacting on outcomes, equity [including gender equity], financial risk protection, and responsiveness, even though these impacts may occur after a time lag). Maria Paola Bertone, Natasha Palmer, Krista Kruja, Sophie Witter, How to design and evaluate health systems strengthening? Collaborative development of a set of health systems process goals. On behalf of HSSEC Working Group 1. *The International Journal of Health Planning and Management*, Volume 38, Issue 2. p 279-288. First published: 28 December 2022. https://doi.org/10.1002/hpm.3607. The analysis also draws on recent additional qualitative research undertaken for Norad: Allison Beattie, Giorgia Lattanzi, Marta Medina and Samantha Page. 2024. A rapid assessment of current approaches to supporting health system strengthening and health financing. Final report, hera, January 2024.

with the commonly expressed aim to ensure development assistance is "owned" by governments and is "on (one) plan, on (one) budget, on (one) account". The first four of the five shifts will require focused and sustained improvements in the practice of health systems strengthening making the success factors directly relevant to the post - Lusaka Agenda process. The health system strengthening analysis process identified that no individual approach or partner was 'best' at HSS. Rather, there is a 'mixed economy' of health actors who pay different roles in the HSS ecosystem. These findings around HSS together with the summary of HSS success factors document in summary form what has emerged from the literature and from the FGHI process to date. They touch on best practice and experience around HSS in recent years and have been well captured in the FGHI discussions and processes so far.

Figure 1. Success factors for better performing health systems strengthening support by global health actors



3.1.1 LESSONS FROM PAST GLOBAL HEALTH REFORM PROCESSES

To support prioritisation in where to go next with the post Lusaka process, the second analysis (below) is new and has been undertaken for this study to summarise the behaviours and features associated with large scale global health reform processes in the past. The analysis draws on the reflections of key informants collected in this and in previous rounds of consultations, supplemented by a rapid documentary review. Key informants were asked to reflect on previous attempts to leverage significant reform in the global health and development system. Where and why did these initiatives succeed best? What are the key lessons to learn as the Post-Lusaka Agenda seeks to build lasting impact and sustainable change? Key informants referenced initiatives of various types, duration and intensity including the Independent Accountability Panel for Women's Children's and Adolescent Health, the Global Preparedness Monitoring Board, the IHP+ and associated Joint Assessment of National Strategies (JANS) process, the Muskoka Initiative, reflections on the work and impact of the Commission on Life-Saving Commodities, the Global

Action Plan for Healthy Lives and Well-Being, the RMNCAH High Level Financing Process (a precursor to the Global Financing Facility), UHC/ PHC related learning and delivery processes and other processes including the MDGs/ SDGs, the brief flowering of global commitment to SWAPs and short lived processes like the Utstein Group.

The behaviours and features of previous processes are relevant for all the five shifts and some elements, such as trust or political commitment, are relevant across them all. Although not a systematic review, reflections on aspects of these processes from the perspective of engendering sustained focus and a sustainable outcome for health identify both positive and limiting features. These are summarised in Table 1.

Table 1. Reflections on previous globally-driven health and development processes

Most often referenced positive behaviours	Most often referenced negative behaviours
○ **Legitimacy and governance** as key drivers of change ○ **Focus:** Shared purpose, goals and targets ○ **Sustained commitment** through global level goals that cross political lines ○ **Broad inclusivity** with modest enabling resources ○ **Momentum**: Country governments committed and providing a strong push; governments in charge ○ **Political economy:** Reinforces country capacity, tackles fundamental barriers, supports systemic change ○ **Dialogue** based on accurate data and analysis and tracking that builds national capacity ○ **Accountability:** Resources, time, and leadership to support meaningful accountability cycle that includes remedy and action	○ **Sudden suspended political commitment** for example, through a change of government and/or shift in development priorities ○ **Lack of sustained commitment** and leadership ○ **Unwillingness to adopt a systemic focus** (addresses vertical health issues or works in limited range of countries) ○ **Health delinked from politics** and governance issues; identification of what meaningful change is achievable not sufficiently nuanced ○ **A degree of 'projectisation':** Process is development partner centred/ delivered; lacks genuine partnership or country driven approach ○ **Finance focused**: Overly centred on dispersing funds and associated transient inputs; insufficiently attentive to building domestic resource commitment and capacity ○ **Accountability** processes are superficial and do not engender meaningful change (remedy and action)
Features of more successful processes	**Features of less successful processes**
➢ Trust among all partners ➢ Relationships and the role of specific individuals (and groups of individuals) although this is a risk for failure too when individuals move away. ➢ Commitment over a prolonged period ➢ A defined end point ➢ The right degree and level of formality/ institutionalisation ➢ Genuine and widespread country leadership and a recognition the process is inherently political ➢ Allows time to socialise the process and ensure all stakeholders can participate and have room/ opportunity to shape the process. ➢ Inclusion of a wide range of stakeholders from the start including civil society organisations ➢ Resources are available both to support the process (through a secretariat or accountability mechanism) and its implementation in countries but are not the driver of programming (and do not have to be spent as a matter of priority or as a primary reflection of the value of the process).	x Opacity about the scope and purpose and/or design complexity x Financing uncertainty or financing at the centre especially pressure to disburse x Lack of inclusion/ lack of country centredness x Insufficient grip on politics and the political economy of health x Fails to address deep rooted fundamental conditions and barriers x Lack of knowledge among key partners about how governance and budgeting processes work (how funds flow, how decisions are taken) x The initiative "breaks health systems" apart rather than strengthening them (by creating a need for complex country-based processes or visibility of compliance; external partners draw skills from the public sector by hiring competent country based staff) x Limited meaningful or sustained impact on health outcomes of people. x Lack of transparency and inability to withstand/ learn from failure

Although the Lusaka Agenda in its widest sense has achieved a level of consensus around how the global health architecture should evolve (mainly by identifying the behaviours and posture of a strengthened global health system), it has not yet achieved sustainable outcomes. Several key informants identified that there are stakeholders who resist the idea of the Lusaka Agenda and FGHI becoming a 'brand'. On the other hand, most were appreciative of the potential for the process to create the space for the development of a common vision for global health in the future and therefore to anticipate and shape major reforms that look beyond the SDGs, rather than just short-term, superficial improvements.

These observations raise critical points for the post-Lusaka Agenda process and its future evolution beyond the work of the JCWG, suggesting key areas of learning and focus to drive real progress around the five shifts. Principal amongst these are a focus on institutional reform, a purposeful and acknowledged mandate, clear goals and results, and sustained high level commitment from all stakeholders. And, although getting to this point has taken significant effort and is a necessary condition for meaningful future collective action, **there is a clear fork in the road at this juncture; one road leads to some helpful tinkering and better alignment while the other leads to fundamental reform albeit over a longer timeframe.**

Summary of Findings Part 1: The process has reached a natural fork, and stakeholders are looking at whether and how to build consensus around the next phase at the global level. While there is broad consensus around the value of the process to date, the primacy of PHC for strengthening health outcomes, and the importance of country ownership and focus, views about the specifics moving forward are currently somewhat peppered across a range of ideas and levels of commitment with the strongest momentum emerging from countries themselves. Drawing on the success factors for health system strengthening and considering the features of the more successful institutional reform processes in the MDG/ SDG eras, whatever global stakeholders choose to do should (i) be clearly articulated with shared goals, trackable results and measurable outcomes; (ii) balance meaningful institutional and behavioural change with inclusivity at global, regional and country levels (bearing in mind the risks to institutional reform of having to find full consensus on all aspects), and (iii) ensure direct line of sight with impact on external health and development assistance behaviours and practices at country level.

3.2 THEMATIC ANALYSIS

This section lays out the key thematic issues arising from the data exploring the diversity of views and concerns at this point of the process. The thematic analysis aims to pick out elements of consensus/ near consensus as well as to isolate the specific points of contention that might need more discussion. Although the focus of this analysis is the global process, on some points, key informants were keen to ensure that the regional or country momentum would be strong factor in orienting, structuring and ultimately measuring the success of global level processes.

Dialogue and Engagement:

a. **Dialogue** lies at the centre of sustaining the process; the five shifts and making progress on these underpins dialogue across stakeholders. Dialogue is a political process; it takes time and needs shaping, convening, negotiation. The value of the working group as an informal space was appreciated and there is caution around creating too much structure too quickly. However, as one key informant so clearly identified, to maintain momentum and purpose, there is a need to "*focus extensively on cooperation and information exchange* [to address the] *large gap in the amount of information possessed by different stakeholders, and…to continue sharing information appropriately and sufficiently...*" particularly in relation to dialogue related to GHIs.

b. **Among African countries, a common observation was that there has been a notable step change in engagement, leadership and sense of purpose among African governments and political leaders during this process.** For example, key informants identified that:

- Ministers of Health are "fully aware and on board, fully briefed and ready to take action" as the process develops.
- Ministers have defined key "asks" from the post-Lusaka Agenda process which include to reduce reporting requirements, eliminate duplication, streamline applications to global funds, and support them to strengthen health systems in line with their own strategies.
- A roadmap calls for sustained high level political commitment, regional engagement, and for ministries of health to strengthen and update their public financial management (PFM) systems, laws and relevant policies to improve financial management and facilitate alignment of external resources with national systems.

This focus and set of defined expectations have led to Africa Union engagement with specific discussions and milestones planned for building institutional capacity at the regional level. For example, Ministers of Health are expected to discuss the proposed Roadmap for Africa at the end of August in the margins of the WHO-AFRO Regional Committee meeting in Brazzaville with a possible outcome the establishment of a dedicated workstream and secretariat in the Africa CDC.

c. **Indeed, explicit demand from countries is essential to maintaining momentum and keeping the whole process meaningful and responsive**. One thought emerging from recent discussions relates to the value of regions connecting to each other through a peer-to-peer network to support lesson learning, shape direction, articulate agreed priorities and maintain demand for difficult reforms in the global health architecture linked to the five shifts. Many stakeholders agreed that the idea of pathfinder countries generally and getting to work in concrete ways in the most engaged countries specifically was a useful next step in order, among other things, to document what works and demonstrate value and impact.

d. **Many stakeholders considered that it would be appropriate and timely to expand the political dialogue to G7, G20, UNGA and other groupings.** While there are specific accountability-related proposals below, key informants also referenced the value and importance of linking to a higher level political dialogue early and often in order to raise awareness, expand participation and increase the political importance of the process.

Advocacy and inclusion:

e. **The role of global coordination and advocacy is a necessary compliment to regional and country momentum**. Although Africa is currently an energetic driver of the process, most key informants from across all stakeholder groups recognised that the global level needs nurturing and support. Global coordination includes maintaining momentum among all stakeholders on the five shifts but also maintaining and deepening the engagement of all partners in support of progress through the GHI boards and as partners to country and regional processes. The five shifts imply multiple actions across different groups over protracted timeframes and it is clear that this increasingly an articulated process (with multiple parts and offshoots) does not need to be (and probably should not) fully orchestrated from a global level; regional/ country momentum should move alongside and go faster and deeper where there is opportunity and political will. But global coordination and global advocacy will help ensure common purpose and broad demand among all stakeholders including donors.

f. **There are multiple dimensions of inclusivity and all of them need more attention, nurturing and investment.** Key informants across all stakeholder groups raised issues related to inclusion and participation.

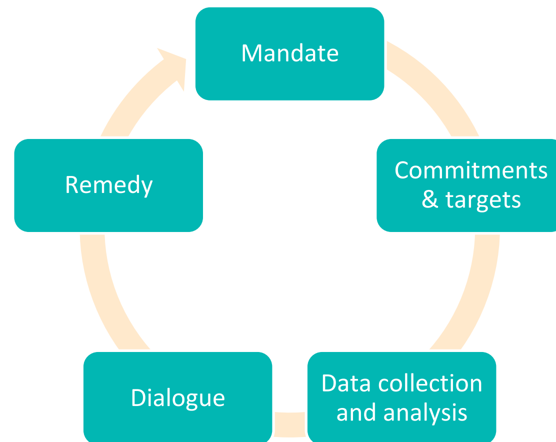
- **Transparency around prioritisation and processes**: a clearly defined and adequately resourced **global process** will better ensure that communication, coordination and information are available to all stakeholders. This is a strong motivation to invest in global arrangements. For those who feel excluded or unable to contribute and participate meaningfully or for those who simply feel under-informed at regional or country level, this will be especially valuable.
- **Reaching and engaging all countries**: Peer to peer learning and interaction "works best". More than this though, several key informants identified that the only practical way to hold global health stakeholders fully accountable would be through partner country engagement. Whether there are pathfinder countries or not, somehow the process needs 'socialising' across all countries. **Regional bodies** can help with this.
- **Within countries**: Engaging and broadening engagement across **civil society** within countries is a fundamental driver of the primary health care approach and one pillar of universal health coverage. Inclusion also means enabling all parts of society to participate in health and development processes, to hold governments accountable (more below on this) and play their full part as citizens. Civil society organisation (CSO) stakeholders were vocal around the need to include them in all levels of dialogue (country, regional and global) to ensure they are best able to fulfil their mandate to expand the inclusion of civil society in the process.

g. **The practicalities of meaningful coordination and advocacy requires a secretariat that is appropriately tasked, adequately resourced and suitably accountable for its results.** All stakeholders agreed that this was necessary. At the same time, there was also clear consensus that such a secretariat should be hosted within an existing body rather than created from new. Options for hosting are assessed in the next section. The functions of such a body might include:

- **Inclusion**: Ensure meaningful engagement and inclusion of all stakeholders. Liaise and interact with relevant bodies and organisations including representatives from CSO partnership platforms to promote inclusion and engagement especially at the points where critical aspects of the process are discussed and key decisions are made.
- **Coordination**: practical assistance and activities to promote participation, maintain coherence and drive momentum including sharing tools, language/ text for speeches, position paper summaries and other material to shape stakeholder alignment and facilitate opportunities to increase impact.
- **Advocacy**: deliver material, participate where needed/ possible in promoting the aims, objectives, progress and activities linked to the process to encourage stakeholders to continue moving forward and to bring new stakeholders into the process.
- **Communication**: support interaction among stakeholders, create a one-stop shop for information about the process, progress, up-coming events, past events, speaking opportunities and side events at larger global or regional meetings linked to concrete results-driven plans. Provide public communications as well as supporting better communication with and between stakeholders.

Accountability

h. **Accountability is a distinct function from coordination and advocacy and requires completely different arrangements**. Accountability was seen by all key informants as a critical area that so far was under-discussed or planned. There was a distinction made between monitoring and tracking progress towards the five shifts on the one hand and genuine accountability for achieving meaningful results on the other. This is supported by the experience of previous global processes as well. As one key informant aptly pinpointed, accountability includes a clear mandate, explicit commitments and targets, data collection and analysis to monitor progress, and then the most critical steps, dialogue around the data and what they reveal, together with course correction or other remedy.



Speed and informality have kept the whole process fairly light and "authentic" or organic until this point. This has been valued by all stakeholders and there is a legitimate concern that institutionalising the process will kill the energy and momentum. On the other hand, key informants, especially from countries, pointed out that legitimacy and long term accountability can only be achieved through a structured and formal architecture that draws in member states. UN formality would complement AU commitment. Partner countries and other stakeholders (including some donors) identified how potentially disappointing it would be if donors were not willing to get behind African country-led initiatives.

i. **Identifying more succinctly who should be accountable for what across the global health architecture remains a live discussion.** While it was clear that the GHIs themselves have work to do in relation to evolving their institutional arrangements, processes and cultures, the responsibilities and commitments of the wider global health eco-system as well as regional and country partners remains less crystalised. Accountability is seen as a critical engine to drive action but identifying its direction, scope and results is a necessary first step.

Options for accountability: The first choice to be made relates to the 'fork in the road' referenced in part 1 above. If the process is to be more than helpful tinkering and actually bear down on meaningful and sustained (but difficult) reforms across the whole of the global health eco-system, accountability for progress requires an explicit mandate and concrete process. Accountability seems also to be progressing among the GHI focused work (through the JCWG) at regional and country levels. The Africa region through WHO Afro and in partnership with CDC, is putting a roadmap in front of African Ministers of Health for discussion and validation. If endorsed, the next step may be to develop an accountability process linked to the roadmap although at the time of writing, this is not clear. All of these accountability systems should – in due course – be linked to one another at least in loose terms if not formally. Table 2 summarises the three main options for global level accountability.

Table 2. Options for taking forward accountability

Options	Degree of traction among key informants	Experience in other reform processes
WHA route Mandate defined and conferred through the World Health Assembly	This seemed a relatively straightforward option to many stakeholders. However, there were concerns about (i) whether ministers of health were the right political leaders (as opposed to heads of government and/ or ministers of cooperation, planning, finance, foreign affairs or others); and (ii) the ability of WHO to take on the accountability coordinator role given widely held views about the need to reform WHO and ensure it is resourced appropriately for its role in all settings.	WHA resolutions confer roles and responsibilities on the WHO to take action and report regularly to member states. UHC2030 is currently working with others to prepare a WHA resolution on out-of-pocket (OOP) expenditure as a means to commit WHO resources to this aspect of UHC and refresh the importance of addressing OOP spending for equity. WHA resolutions will be largely health sector focused – and limited. It is difficult for a WHA resolution to capture sustained wider government commitment.
UNGA route Mandate defined and conferred through an UNGA process introduced by the G20 for example	Although seen as more difficult in some respects, this option was considered by many to be the most secure, highest impact accountability related option. The potential role of the G20 was attractive to many across all stakeholder groups especially given the current Brazilian and upcoming South African presidencies.	UNGA resolutions need to include periodic reporting to create sustained impact. They can raise awareness, galvanise donor action, support dialogue and create a pathway to global health organisation reforms (e.g. UHC and NCD resolutions). While WHO and other organizations can be given responsibility to take aspects of the resolution forward, they can also be required to make reforms to be able to undertake the assigned mandate.
Voluntary route Self-administered process or an informal M&E framework for global level processes administered by a recognised global health partner based on a scorecard or other mechanism	Almost all key informants agreed that meaningful accountability could not be informal or voluntary. Organisations 'could not mark their own homework'.	Experience from reform processes in the global health space suggest that a lack of objectively verifiable criteria and measures, regularly and transparently measured would make it very difficult to tackle difficult processes. Voluntary reforms often require significant peer pressure and/ or financing conditionalities to be successful.

Irrespective of what route is selected, the full cycle of accountability needs to be established. Crucially, this includes a forum for dialogue around the periodic results as well as the opportunity to promote remedies and to assess progress on previous remedies agreed and disseminated to stakeholders for implementation.

j. **At a global level, the most appropriate mechanism to define and confer a mandate is through a resolution negotiated and passed by member states at an intergovernmental body** such as the UN General Assembly (UNGA) or – as a second but distinctly less high level option – the World Health Assembly (WHA). Considering possible entry points, many stakeholders were attracted to the potential role of the G20, particularly for an UNGA resolution. The current and near future presidencies of the G20 might be open to discussing/ introducing such a resolution. Some also suggested that the AU/CDC or a group of African countries (potentially working in cooperation with

other regions) might raise a resolution at the WHA if that route is chosen. Connecting reforms (and associated accountability mechanisms) to the future evolution of the global architecture, one key informant observed that stakeholders should “Either use the multilateral system or cut funding to GHIs…”.

A considerable advantage of the multilateral/resolution option is that it would require broad engagement of member states (of either UNGA or WHA) and therefore would strengthen inclusion and increase transparency. It would also ensure the political engagement of countries and put countries into the driver’s seat. Limitations on both options relate to the level of effort required. However, the multilateral route also has the advantage of including the necessary crystallisation of ‘direction, scope and results’ identified in paragraph i above. And this kind of clarification and shared understanding, as noted in the review of previous global health reform experiences, is a feature in more successful efforts.

Where WHO is expected to take a defined role in the process (if that is agreed), either route would require WHO reforms linked to its structure, capacity, and organisational arrangements (with accountability for these reforms). For example, one key informant identified that the WHO was “still structured into vertical departments” despite broad agreement that integrated PHC and integrated HSS is the basis for UHC and the five shifts. Others highlighted that the challenge created by WHO’s institutional structure (separately constituted global and regional entities). Others suggested that at country level, WHO held a dual role that was difficult (potentially impossible) to reconcile. On the one hand, they were at the service of ministries of health (member states) with technical, political economy and policy guidance. On the other hand, external stakeholders looked to WHO to take on a convening role, to represent their views to government and to support alignment among external partners. It’s worth noting that WHO has incorporated the Lusaka Agenda into its next Global Program of Work and has indicated its willingness to take on a defined role going forward. However, for WHO to house or host global arrangements to support on-going dialogue, advocacy, communication and potentially at least some element of accountability measures, most suggested that there are complexities to address including potential conflict of interest.

k. **What results would accountability processes track?** Some key informants offered clear ideas regarding the criteria and indicators for tracking in a global accountability process. Examples are highlighted in Table 3.

Table 3. Sample indicators to monitor change/ impact in countries

Bearing in mind that there are various groups working on accountability indicators, indicators to measure commitment to UHC and indicators to monitor HSS*, the scant list gathered here below are simply to illustrate examples from a range of key informants. This is by no means a concrete or coherent suggestion; any accountability process will require a full and inclusive discussion both in terms of its orientation and structure as well as its focus and criteria. However, these examples highlight what is at the front of key informants’ thinking in relation to trackable outcomes to measure impact for countries and people.

- Measures that track “one plan, one budget, one M&E process” including what funding organisations are in or out.
- Proportion of external financing (by organisation/ donor) that moves through commercial bank accounts vs government accounts [can reveal both snapshot and trend]
- Proportion of funding on-budget
- Funds placed into pooled funding mechanisms with associated planning and tracking

- The proportion of Principal Recipients that are government entities
- Proportion of co-financing, source of co-financing funds, periodicity of disbursement
- Service delivery coverage (SDC) vs OOP and/ or catastrophic expenditure measured together as both a snapshot and trend. [they are symbiotic in that SDC has to increase while OOP/ catastrophic expenditure decreases to make UHC gains]
- Human resources for health: the number in pre-service training by cadre, absorption rates, retention rates, migration rates.
- Funding (by amount and source) for essential commodities.

** The most recent of these is the paper published by the Centre for Global Development the same week as this report was tabled: Sophie Witter and Pete Baker. 2024. "Tracking Delivery on the Lusaka Agenda." CGD Policy Paper 336. Washington, DC: Center for Global Development.* [*https://www.cgdev.org/publication/tracking-delivery-lusaka-agenda*](https://www.cgdev.org/publication/tracking-delivery-lusaka-agenda)

Health financing as a prevalent theme:

l. **Health financing issues** bump at the edges of all aspects of the wider global health and development reform process although not all stakeholders think they should. For most, health financing (both from external partners and by governments) and associated funding modalities lie at the heart of the issues and reforms under discussion.
   - **Country's own health budgeting and financing**: The heart of health financing is in public budgets; external financing affects the natural accountability lines from government to citizens. These lines should include parliamentary oversight and scrutiny especially in relation to debating and approving the public budgets.
   - **Source and amount of funding**: All the well understood challenges of external funding were referenced in key informant interviews as well as those in previous months. In both absolute and relative terms, external financing can dwarf national resources, change incentives, weaken systems and skew national prioritisation processes.
   - **De-fund and diversify**: Although the GHIs are working through the agreed JCWG workstreams and are expected to pursue reforms through that platform, some key informants suggested that the core of the problem is not being addressed since it was about the quantum of external financing, its tied uses, the lack of sufficient domestic resource contributions and the range and number of livelihoods that now rely on maintaining the current system. Some informants highlighted as an example, that the JCWG did not even include a focus on co-financing or any aspect of financing. A few (more than three) key informants identified that a reduction in external funding was an alternative strategy to reforming global health organisations.
   - **Domestic health financing as a 'distraction' from alignment and harmonisation in countries**: For a minority of key informants, the whole country-centred process should be focused not on domestic health financing but rather on partner alignment and coordination in countries, improving country-based processes and supporting harmonisation among external partners with government systems to the extent possible. These are in fact interlinked for most stakeholders but there is a concern that emphasising one over the other enables different stakeholders to deflect reforms at different stages.

Other recurring themes:

m. **Equity and inclusion**: Yet, while external financing is at the heart of many health and development challenges, it is also an important driver of equity, protecting access to basic services by minority or criminalised groups for example, and acting at least in some contexts, some of the time to ensure inclusion.

n. **Speed and informality keep the process light,** and "authentic" but legitimacy and long-term accountability can only be achieved through a structured and formal architecture that draws in member states. UN formality would complement AU commitment.

Summary of Findings Part 2: The key thematic issues arising in the key informant consultations and documentary evidence are not particularly new, although the momentum and leadership emerging from African countries is. Matching this leadership with political and financial resources and commitment from all stakeholder groups is vital to maintaining the process. The range of issues raised in this analysis do remain "live" and pose an ever present set of challenges to a process that could simply coast to a stop. The issues themselves are not the core problem; the importance of alignment, country leadership, and better health financing modalities, for example, have been well understood for a long time and would have been "solved" by now if the solving were easy. The main points emerging from this analysis are (i) the strong consensus around the value of and need for dedicated coordination and communication arrangements including for advocacy, (ii) the need for more consensus around whether and how to address accountability, and (iii) the central role of inclusion and equity across all the geographies, processes and stakeholders.

3.3 PARTNERSHIP ANALYSIS

For some aspects of the global process, especially around coordination, dialogue and communication, accountability and inclusion, a defined institutional home or some level of formality will be a necessary condition for future progress. While there is significant consensus around the need for a secretariat of some kind and an institutional home for at least some global level processes, the candidate options, mandate and scope of work are less clear.

3.3.1 THE QUALITATIVE FRAMEWORK TO GUIDE PARTNERSHIP ASSESSMENTS

To support thinking, three partnership options (UHC2030, UHC-P, and SDG3 GAP) were specifically analysed from a range of perspectives including their capability, suitability to take on various roles and alignment with the five shifts. A framework for the analysis supported a qualitative assessment, and the identification of advantages and limitations as well as opportunities. The framework and the full analysis of each of the three partnerships scrutinised is in Annex A. Candidate partnerships to review were selected based on three criteria: they needed to be global in scope not regional; they needed to concerned with results either aligned with or adjacent to the five shifts (UHC, health systems strengthening, PHC) and not disease specific or vertical in focus; and they needed to be open partnerships that already incorporated at least some of the main actors in global health with scope to include more. The three partnerships analysed were selected as potential options to support the post-LA global process because they met these criteria. No others were identified. And, although the analysis found that all three partnership institutions could play a role in promoting the advancement of the global process and contribute to the achievement of the five shifts, none of them alone would be in a strong position to lead all aspects of this process.

3.3.2 UHC2030

The platform most likely to fulfil some of the main requirements to support global convening processes appears to be UHC2030, a partnership organisation that has constituency-based governance in place, a wide (and growing) network of CSOs/ NGOs engaged at all levels, and a structure that supports dialogue, lesson learning and reflection. UHC2030 has an established constituency structure with broad representation in the Steering Committee and structured opportunities for stakeholders to exchange and promote best practices around achieving UHC, including through a focus on strengthening health services.

This structure creates strong potential with minimal adjustments for UHC2030 to be systematic in its engagement of different stakeholder groups around the five shifts. It is also in a reasonably good position – at least at global level – to contribute to advocacy around and improving alignment with the GHIs and other global health partners as a group. A further advantage of UHC2030 is the recent establishment of its new strategic framework which places emphasis on strengthening the accountability of the platform and its constituencies for the work that it does as a partnership, encouraging accountability by its members at least in relation to their UHC oriented work. In its current structure, mandate and capacity, however, UHC2030 is not a platform that could fully convene and steer the overarching global process to accomplish the results expected by global partners and as a partnership hosted by WHO, the UHC2030 platform has limited convening power.

UHC2030 does not have (and does not aim to have) a direct influence/impact at country level but rather it relies on its "low and middle income country" constituency which appears to be engaged more than in the past. Key informants (and our independent analysis) point to the gap between supportive dialogue and advocacy in a peer-to-peer context and a more formal, structured accountability process, the latter being something currently well beyond the partnership's scope, capacity and resourcing. There is, too, a question about suitable or appropriate lines of accountability within the global health system (discussed above in section 3.2). Would a voluntary partnership platform be an appropriate body to hold government partners and multilateral organisations accountable? One could easily see how a diverse, valued platform would have an important role to play and should be included. To lead such a process may be a different question.

In summary, UHC2030 is strong on advocacy, communication, engagement and inclusion along with technical resources, experience, capacity and skills related to institution building (and reform). It is less clearly a political level convenor and has limited or no mandate for independent accountability of stakeholders for the behavioural, programmatic and other elements implied in the five shifts.

3.3.3 UHC PARTNERSHIP (UHC-P)

WHO's Universal Health Coverage Partnership (UHC-P), active at country, regional and global levels, could play a helpful role in reinforcing the core objectives of the Lusaka Agenda in countries. UHC-P was established to promote policy dialogue and supporting countries in strengthening the respective health systems building blocks. To be more clearly oriented around the five shifts, UHC-P objectives related to strengthening policy dialogue with partner countries (including advocacy for strengthening health systems in the dialogue with partner countries, and at regional and global levels) would need to be specified in such a way as to focus on supporting governments in proactively aligning the GHIs and other partners around country policy, programming and funding modalities for UHC. The start of UHC – P Phase V as of 2025 would be an opportunity to do this. However, key informants were ambivalent as to whether WHO in its current structure and the UHC-P with its current scope of work or even with a revised scope of work would be the key organization to drive the Lusaka Agenda forward effectively. Furthermore, UHC-P is focused on providing evidence based advice and guidance as well as practical support to countries and has no mandate around accountability. One further challenge is the significant variability of the UHC-P presence among countries in terms of its influence, perceived expertise and profile. The extent to which UHC-P has been able to gain traction in the most complex environments is highly dependent on the role and performance of individuals (in UHC-P itself, in government, and among other global health partners in country and on demand and engagement from countries). The UHC-P as a platform will be well positioned to help 'socialise' the five shifts in the many countries where it has a presence, supporting governments and providing clear and helpful information to stakeholders across various groupings. As a global convenor or in relation to providing secretariat services, supporting global dialogue or in other respects anticipated in this study, the UHC-P was assessed as unlikely to be the strongest choice.

3.3.4 SDG3 GLOBAL ACTION PLAN (SDG3 GAP)

The SDG3 GAP, also hosted by WHO, was initiated to increase structured coordination and alignment of its signatories in each of the partner countries where they all worked together. Its reports should provide an opportunity for accountability against this commitment. Indeed, the 2023 progress report provides evidence of some successful steps among health organisations of various kinds in coordinating better among themselves in some countries. For example, in some countries working groups have been established to facilitate alignment with national policies and strategies. However, given the limited resources of the SDG3 GAP, the country-specific level of operations, and its voluntary nature, it is not clear whether and how these activities could be maintained or expanded to more countries. Or, in fact, how meaningful they are in relation to the wider aid effectiveness issues that the Lusaka Agenda references and aims to address. There is limited scope to discuss the SDG GAP reports in any significant meeting with wider stakeholders and little commitment to remedy. The SDG GAP track record on accountability is assessed as weak. Evidence also suggests that the SDG3 GAP has declined over the last five years in terms of level of engagement among its own signatories. The independent evaluation of the SDG3 GAP, expected to be published later in 2024, is expected to lay out options for WHO and signatories reshape the SDG3 GAP and better fulfil its mandate. At this stage – with limited results achieved – options are to continue (struggle on), to significantly restructure, or to sunset the initiative. The SDG3 GAP signatories could promote their own secretariat to promote, coordinate, and – possibly - steer the complex process to achieve the objectives defined by the five shifts of the Lusaka Agenda. However, this may lead to increased confusion with the JCWG and would create a potentially discordant note in relation to fulfilling the role of convening sovereign governments to discuss relevant reforms among the signatories and themselves. In addition, the low level of resource assigned to the process, the limited secretariat capacity, the very country specific and voluntary nature of much of the SDG3 GAP process (a couple of global working groups are an exception) makes the GAP an unlikely option to convene a wide range of global partners for a multifaceted process that includes dialogue, coordination, communication, advocacy and meaningful accountability.

3.3.5 SUMMARY AND DISCUSSION OF PARTNERSHIP ANALYSIS

Based on this analysis, Table 4 provides a summary of how each platform was assessed against the four framework categories. The table highlights where individual platforms are most likely to be in a reasonably strong position. An important caveat regarding this analysis (in addition to others already mentioned) is that it concerns the platform itself as an organ not as the sum of its various members. So, the SDG3 GAP, for example, includes members that individually or even collectively have maximum experience, skills, capacity and reach. But the SDG3 GAP as an *instrument* to harness this capacity has been assessed as overall fairly weak.

The table highlights that no platform excels across all framework criteria or even in three out of the four quadrants of assessment. In particular, none of the platforms is assessed as strong in relation to accountability when this is defined in its **full cycle of mandate, commitments data collection, dialogue and remedy**. It is evident that despite important attributes and some strong/ promising performance in some areas, none of the three platforms provides the full range of competencies, experience, reach, mandate and credibility to step up as an 'all in one' convenor to meet all global process needs. And, although other partnership options were identified, for a range of different reasons none of these was considered in and of itself to be a possibility to convene the global process either. Specifically, some were insufficiently global, others were not considered thematically suitable, politically well-oriented or sufficiently capacitated to take on a secretariat process in a meaningful or credible way. In addition, some options provided excellent opportunities and were considered capacitated but inappropriate choices to take on the role of a global

secretariat given the dynamics of the process. These include regionally-based organisations particularly WHO - Afro, Africa CDC/ AUC, and other global bodies such as the UN Foundation which is currently maintaining communications around global engagement as a stand-in for longer term arrangements. As identified in the thematic analysis, the role of WHO was considered by most to be critical and a natural option but not without some drawbacks. These drawbacks included concerns about WHO's capacity, the role it plays at country level (can it ever be a neutral convenor of a complex process where it has a mandate and strong institutional orientation around supporting the host country?), and the clear blue water between its current performance and the mandate, skills, and resources it would need to take on the role in ways that would keep the political and institutional elements of the process alive and at the forefront across the global architecture. Nonetheless, even with noted limitations, there was a strong, practically universal desire among stakeholders to see WHO succeed. For many, WHO has the legitimacy, the convening power, the history and the global responsibility to lead and it is not an option to assign this role elsewhere.

Table 4. Summary of partnership platforms against the four framework categories of qualitative assessment

Platform	Quadrant 1: Past & future potential	Quadrant 2: Coordination & Advocacy	Quadrant 3: Accountability	Quadrant 4: Experience & knowledge
UHC 2030	+++	++++	+	+++
	Constituency arrangements already in place; Strong on advocacy, engagement, inclusion; potential to support coordination & dialogue if stakeholders agree to be convened by UHC2030.			
UHC Partnership	++	++	+	++++
	Strong expertise and knowledge combined with a wide reach to countries; limited experience or mandate around global convening and dialogue. Primarily aimed at promoting and responding to country demand			
SDG3 GAP	++	+	+	++
	Limited global footprint/ experience and focused on voluntary participation of 13 organisations rather than a full range of stakeholders. Evaluation suggests it's a platform that has gained limited traction. Unlikely to evolve sufficiently to meet post LA needs.			

There is also a tendency to 'technical-ize' health systems interventions (reinforced by some global health partners) downplaying political economy factors, wider cross government or political reforms and the related dimensions of health systems. This tendency to focus on technical and programmatic elements of – for example – UHC leads to continual side-stepping of what is a deeply political process which, although it may have technical aspects to it, cannot be significantly advanced without sustained political commitment, and, as the Lusaka Agenda fully encapsulates, without a recalibration of external assistance in ways that make that political process the driver of country action. While this challenge may be generally supported (and many of the key informants and published health policy analysis affirms), it is also the case as referenced in the thematic analysis, that most country partners saw the WHO as the natural choice for a global (or country) convening role and the option they were most comfortable with. Others became more stuck at this point; they raised concerns around WHO along the lines expressed above but also pointed out that there was no other natural partner. The solution for many lay partially in wrapping up WHO reforms

into accountability processes. Another solution lies in moving aways from a single 'one-stop-shop' for the global process. These options are tackled in Section 5 below.

Summary of Findings Part 3: There is no single partnership currently working at global level that is fully competent, capacitated, mandated and resourced to take on a comprehensive stewardship of the global process. Partnership candidates are each individually limited in specific ways. In addition, regional bodies, while holding a number of strengths especially linked to legitimacy, and governance and convening power, are by their nature, unable to take on global stewardship roles. There was a strong sense, though, across the range of key informants and generally emerging from the literature, that the WHO was the most appropriate and clearly mandated partner to take on the stewardship of global coordination and advocacy. This sense was especially strong among partner governments who are of course member states of WHO and see coordination and advocacy as part of WHO's core mandate. They also feel comfortable with WHO operating in their countries in a coordination role as, generally speaking, there was a sense that WHO was attuned diplomatically and would not overstep in this function. Of course, for other partners, including donor countries working in partner country contexts, this is one of the critical complexities of WHO. Both the host country and the donor country group supporting the host country are member states of WHO; they all have certain expectations of WHO's role and capacity and in many (most) contexts, it appears these can be difficult to explicitly articulate and fully reconcile. Among the partnership platforms, all has potential to make a contribution. UHC2030 offers the greatest potential to take on some specific roles especially related to advocacy, inclusion, and secretariate functions.

4 RISKS

In addition to the clear risk that the process may fizzle out before it delivers much impact for people, or indeed that it simply achieves some satisfying consensus building on what should be done to improve the performance and delivery of global health partners, four key risks emerge from the findings. These are summarised in Table 5.

Table 5. Risks

Risk	Description	Mitigation
Meaningful long term commitment gives way to internalisation	Reform becomes the day to day job of specific individuals not urgent, whole of organisation work.	Although the process needs individuals to engage on behalf of their organisations, principals should be expected and encouraged to participate and lead, taking responsibility for their policies, actions, and decisions in the presence of their peers during periodic fora. This will help maintain political commitment and individuals and organisations are held accountable for on-going evolution of the process. This risk was raised in relation to the GHIs but also to the potential for WHO to take on a leadership role in the global dialogue and accountability process without, itself, undertaking meaningful reforms to enable it to deliver progress on the five shifts.
Bureaucratization (The tail wags the dog…)	The process becomes over structured/ over institutionalised too quickly and people disengage	The process has carefully resisted this risk so far using a phased approach with defined end dates. Going forward, although there is clearly a need to build some level of institutionalisation, it should be the minimum required, allowing structures to evolve organically and as a result of demand.

Risk	Description	Mitigation
Lack of Consensus	The need to find the common denominator renders the process little more than tinkering	The consensus needed to deliver the Lusaka Agenda was a heavy policy and diplomacy lift. Going forward, it would be sensible to couch actions within one or more of the five shifts. However, points requiring consensus include adopting an approach to accountability, considering whether and how to define concrete targets (and associated policies, processes and measures) for any or all of the five shifts and if so, for which stakeholders? Our research suggests that stakeholders are prepared for "majority decision/ action" over full consensus in relation to next steps. While positive overall, there is then a risk of fragmentation where stakeholder groups start sending out conflicting messages.
Over-ambition (Everything everywhere all at once)	Process tries to do too much, too quickly and ultimately fails to focus.	Much of the reform proposed by the five shifts will occur (if it does occur) in lumps and surges rather than as a steady stream of change. It can be more worthwhile to focus on delivering one meaningful, sustained reform than working across multiple channels simultaneously. For this process to grow and flourish (avoiding the previous three risks), it needs to achieve results and build on success.

5 OPTIONS AND RECOMMENDATIONS

A question for reflection that key informants were asked to consider was firstly, was it "worth it" to tackle substantive reforms in spite of risks? The majority thought that absolutely yes, it was and, as one key informant framed it, "the juice is worth the squeeze". However, it was also clear to many that a stewardship platform at global level should not try to deliver all necessary global process functions. And it should possibly consider working opportunistically on shifts 1-4 but not necessarily, systematically, on shift 5.

In light of this, and given the complexity of choices around next steps, this final section suggests options for the way forward and provides some recommendations where these seem sensible and overall supportive to moving the process forward. For the most part, however, recommendations give way to options for stakeholders to discuss and decide upon, taking something of a 'mix and match' approach. The risks of over planning and over bureaucratizing (Table 5) are kept firmly in view. Processes need to be demand driven, meaningful, and respond proportionately to articulated needs.

The options laid out here are not mutually exclusive and in fact should be seen as complimentary to one another and are laid out as something akin to a menu. A proposed vision of how the global structures could work is presented.

5.1 OPTIONS

This section summarises suggested options for the way forward in relation to three distinct global functions under discussion: (i) Coordination and dialogue (with secretariate services); (ii) Engagement, inclusion and advocacy; and (iii) Accountability

5.1.1 TO SUPPORT GLOBAL COORDINATION AND DIALOGUE

Coordination is aimed at maintaining momentum, supporting communications within and across stakeholder groups, regions and countries, identifying next steps and fostering a sense of direction and purpose. The secretariat or 'home' of coordination (whether it takes on other functions or not) is the main driver or steward of dialogue, coordination and communication across all stakeholder groups linked to the post-Lusaka process.

The key features of dialogue, coordination and communication functions include:

- Dialogue requires sustained commitment at the right level (probably higher than sector level)
- An established organisation as host is preferred as a host as no new architecture will be supported
- Yet on-going country government (member state) engagement is vital to maintaining currency
- For coordination, must be seen by all or most countries and stakeholders as a legitimate steward in the global health system
- Able to take on a global convening role in terms of capacity, resources, gravitas (credibility) and experience
- Structured to include resourced and competent secretariat functions (which may be delivered by another body)
- Structured to leverage and support a wider on-going political dialogue and process.

Troika based at WHO	WHO HQ working with regional level	Establish a Board or Panel
•Establish and fund a secretariat in WHO •Arrange governance as a troika with one donor government and one partner government on rotation	•Establish and resource panel including regional representatives •Focus on engagement and inclusion •Identify strategic direction	•Resource regional CSO bodies to host engagement platforms •Panel mamebers could be drawn from constituencies •And regional representatives

5.1.2 TO SUPPORT ADVOCACY ENGAGEMENT AND INCLUSION

Engagement and advocacy are functions that can be widely taken on approaches emerge as possible options to support inclusion through engagement and advocacy…

The **key features** of engagement and advocacy functions include:

- A broad network of partners including CSOs and NGOs at global, regional and country levels
- A strong emphasis on equity and inclusion
- Connecting and demonstrating impact of global dialogue at country level
- Investment in inclusion to provide maximum opportunities to understand and shape policy and action, to advocate for specific actions at different levels, and to link to accountability processes

WHO	UHC2030	Decentralise to regions
• Establish and fund a secretariat in WHO that is geared to advocacy as well as coordination • A multi purpose secretariat that can support a dialogue process and advocacy/ inclusion	• Establish and resource a communication and advocacy platform • Focus on engagement and inclusion ensuring partners are informed and can contribute meaningfully to both dialogue and accouuntability	• Resource regional CSO bodies to host engagement platforms • And to undertake peer-to-peer interaction

5.1.3 ACCOUNTABILITY

Accountability is the most complex dimension of the global functions. Howsoever agreed, the global approach to accountability will compliment regional and national accountability and wider actions already in progress especially in Africa. Both are needed and ideally they will work together.

The **key features** of global accountability functions emerging from the rapid mapping include:

- The demand for accountability is broad and comes from across all stakeholder groups but especially from countries.
- A requirement that accountability for the reform of global health organisations should be underpinned by a clear and unequivocal mandate from countries.
- For most, the multilateral system is the most appropriate and strongest option to define and confer that mandate.
- Requires clear targets, criteria and results to be tracked in order to monitor meaningful progress or change (no "bamboozling" indicators) and identify who is accountable to whom and for what.
- Accountability processes need to cover the fully set of functions including a forum to discuss data, develop remedies and review progress made in relation to remedies
- A forum for dialogue around accountability results should have a clear mandate and a wider remit than just accountability.
- Accountability processes should be conducted by an independent body or panel.
- Such an independent panel would most likely be best hosted by WHO whether it was UNGA or WHA that conferred the mandate; however, reform and restructuring (with suitable resources) would be needed within the WHO to take on this role.
- Scorecards have shown mixed results in the past and rarely seem to drive challenging and difficult institutional change.

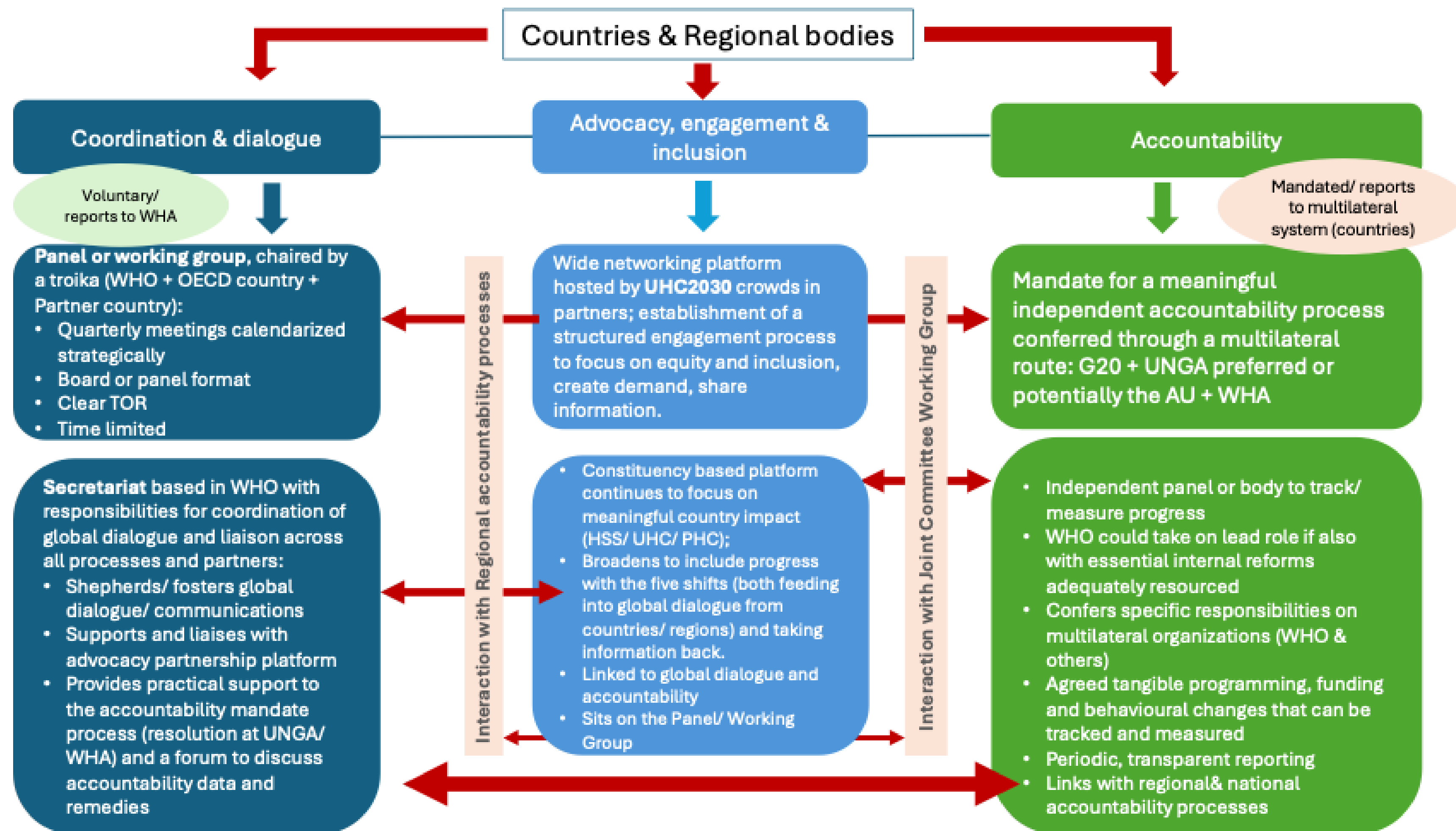
World Health Assembly resolution	UNGA Resolution	Scorecard
• Introduced by the AU or a group of countries • Pathway to providing a mandate to WHO to lead accountability • Less likely to tackle essential WHO reforms • Probably easier/ less of a heavy lift to achieve	• Introduced by the G20 or other group of like-minded countries • Could include explicit criteria to track progress and lay out a prolonged engagement period with UNGA reports on three yearly cycles • Would be best placed to require WHO reforms aimed at strengthening convening, intra-organisational communication, and tecnhnical/ normative guidance roles in relation to health systems strengthening and financing	• Informal and voluntary • Relies on peer pressure and organisational motivation • Would likely need an agreed process to measure the results and publish them. • The experience of scorecards to hold global organisations to account is mixed.

5.2 SUMMARY OF OPTIONS

The various options outlined above are potentially mutually complimentary and should be selected and paired depending on opportunity, a willingness to engage, commitment, resources and timeframe. Options are thus not mutually exclusive. Indeed, there are strong arguments to distribute responsibilities to some extent in order to ensure that functions do not 'bleed into' one another or become tangled in ways that obscure purpose or progress. Figure 5 shows two options for the arrangement of global processes based on carving out new remits/ forums/ processes within existing organisations and – where sensible – refurbishing existing mandates to meet evolving needs linked to the achievement of the five shifts.

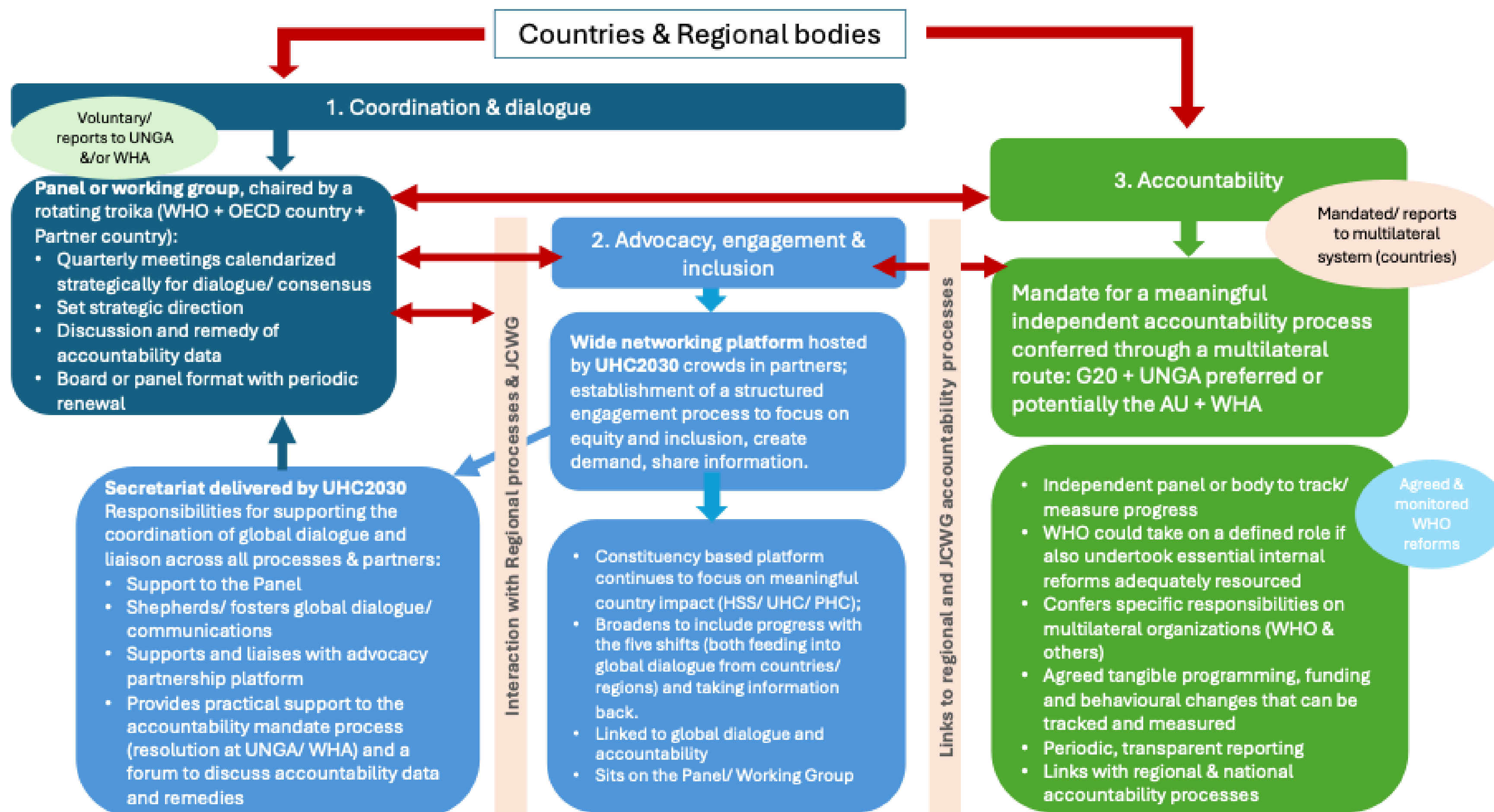
Region to region interaction: Africa region partners working on African country-centred issues interacting with similar LAC and Asia regional groups for dialogue, mutual support, peer to peer learning and building common approaches and demands. Potentially, there may be scope for the UHC2030 partnership platform to support interaction among regional partnership bodies and facilitate country to country/ peer-to-peer learning if adequately resourced to do so

Figure 2. Two proposed options for post-Lusaka Agenda continuity



In this second option, there are still three processes that work together but there is more coherence. The troika headed panel still convenes major political stakeholders including regional bodies, CSO representatives, and others. As a political process, this panel takes responsibility for setting strategic direction, responding to accountability data, identifying and reviewing progress on remedy and other key elements. The secretariat for this panel could be delivered by UHC2030 which could continue also to convene the global engagement, inclusion and advocacy process. Accountability remains an independent process to be developed through a global mandate

A second option for continuing the post-Lusaka Agenda global dialogue, coordination, advocacy and accountability processes

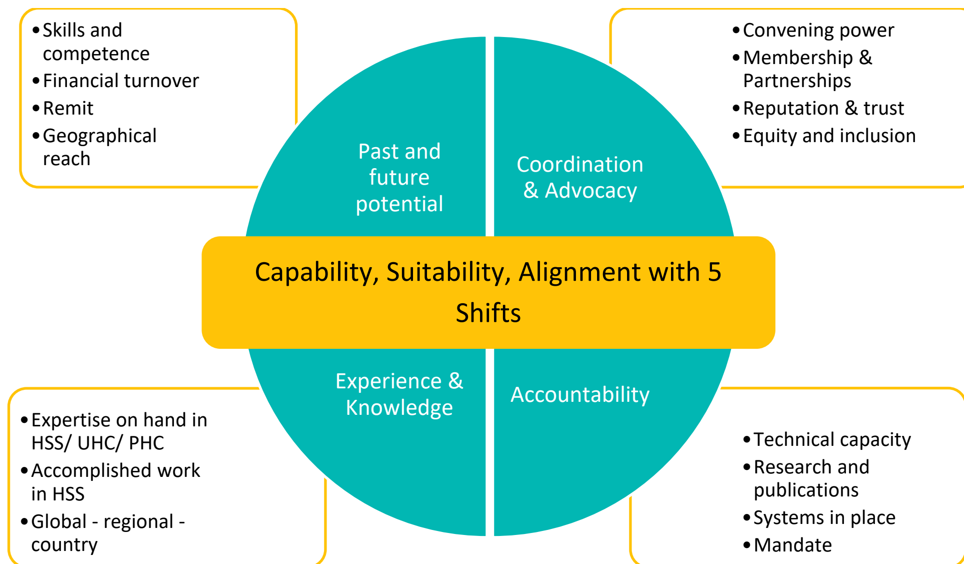


ANNEXES

ANNEX A: PARTNERSHIP ANALYSIS

Description of the partnership analysis process

Figure 3. Tentative framework to guide analysis of partnership platforms



Platforms assessed

Three partnership platforms (the UHC 2030, UHC Partnership, the SDG3 GAP) were assessed against the framework above using qualitative analysis of data available through reports, audits and published reviews combined with statements and comments from key informants. The resulting rapid analysis is laid out in the table below and summarised in section 3.3 of the main report. It is important to recognise the limitations of the analysis (rapid, qualitative, includes subjective views) but also its strengths (factual evidence where available, geared to analysing credibility and potential, not reliant on material published by the platform itself). The analysis thus reflects a composite of each platform's mandate, intentions, perceived performance, attitude to their future role and the views of others bearing in mind that as a rapid review exercise, these views have not been canvassed systematically.

Table 6. Analysis table summarising the profiles, track records and suitability of three partnership platforms

	UHC2030	UHC Partnership	SDG3 GAP
Basic information			
Current purpose of the partnership	UHC2030 is a global multi-stakeholder platform to accelerate sustainable progress towards UHC. Its membership includes countries, civil society, the private sector, foundations, UN agencies, and other international organizations that work collectively to achieve UHC2030's mission to build equitable and resilient health systems that leave no one behind and that provide the foundation to achieve health security.	The purpose of the UHC-Partnership (UHC-P) is to strengthen Ministries' of Health commitment and capacity to build health systems and advance UHC. Specific objectives are to strengthen national and regional capacities to address key health systems components with a focus on NCDs and health security and, since 2022, Covid19. The UHC-P produces guidance and policy notes to support country decision-making. The UHC-P is seen by WHO as the operationalization of the UHC2030 platform, funded by some donors (e.g. the EU) as part of their contribution to the UHC-P.	The Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), established in 2019, is based on the commitments made by 13 multilateral health, development and humanitarian agencies to strengthen their collaboration with each other in partner countries where they all operate and to take joint action to provide more coordinated and aligned support to country-owned and led national plans and strategies. https://www.who.int/initiatives/sdg3-global-action-plan
Where is the partnership housed	WHO HQ in Geneva, Switzerland	WHO HQ in Geneva, and six WHO Regional Offices.	WHO HQ in Geneva
Brief history (year launched, provenance, starting point, evolution)	Emerged out of the IHP+ which was expanded in early 2016 to focus on HSS for UHC with a broad scope to increase domestic spending in countries. UHC2030 members commit to working together with "renewed urgency" to accelerate progress toward UHC through building equitable and resilient health systems in line with UHC2030's Global Compact for progress towards UHC/PHC. The new Strategic Framework 2024-2027 includes three "pathways": **advocacy** (influencing decisions by political, economic and social institutions to advance UHC), **accountability** (tracking the	The UHC Partnership (UHC-P), formally called "Health Systems Strengthening for Universal Health Coverage" Partnership is a thematic fund managed by the World Health Organization (WHO), established in 2011 by an agreement between the European Commission (DG DEVCO) and the WHO Geneva, following the 2010 European Council Conclusions on the "EU's role in Global Health". In the following years, Belgium, Canada, France, Germany, Japan, Luxembourg, Ireland, and the United Kingdom joined the UHC-P with contributions. The UHC-P has been implemented in phases with the Phase IV currently expanded until June 2025, after	The SDG3 GAP was launched at the 2019 UNGA after a bilateral initiative (Germany, Norway, UK and others) to focus attention on how agencies collaborate (or not) in countries. WHO stepped in to lead the process, formalised it with the current name and focused it around seven "accelerator" thematic groups, two of which (health financing and PHC) have gained some traction.

	UHC2030	UHC Partnership	SDG3 GAP
	implementation of commitments), and **alignment** (convening stakeholders).	which the EU has committed further funding until the end of 2028.	
Financing trends/ sources	Total funding for the UHC2030 Secretariat (carried forward and new funding) ranged from $5.31 m in 2021 to $4.53 m in 2023 to $3.66 m in 2024. No 2025 budget yet.	The total funding by donors to the UHC-P increased since 2012 and amounts to an average contribution between 2018 and 2024 of $60 million per year. Donors can fund country placements directly.	Roughly US$11 million since 2019 mainly from Germany and Norway, some from WHO catalytic funding. According to the current programme director funding is declining.
Size in # of countries reached	Historically, 66 countries joined the IHP+ and with the transformation to UHC2030, there are now 81 countries, engaged in UHC2030	Currently 125 countries are participating[1] in the UHC-P	As per the annual report 2024, the SDG3 GAP approach has been used in 69 countries[4]
Number and type of members	UHC2030 membership is drawn from four constituencies: countries and territories, multilateral organizations and global health initiatives, civil society organizations, the private sector and philanthropic foundations.	Not a membership organisation but a programme delivered by WHO; 150 health policy advisors, located in WHO country offices and some at the WHO Regional Offices and Head Quarters in Geneva.	The thirteen multilateral organisations committed to the SDG3 GAP: Gavi, GFF, the Global Fund, ILO, UNAIDS, UNDP, UNFPA, UNICEF, Unitaid, UN Women, World Bank Group, WFP, WHO.
Staffing size	The UHC2030 Secretariat consists of eight staff members	A total of 150 health policy advisors with a small programme management team.	At WHO HQ, there is a small SDG3 GAP Secretariat (fewer than five people).
Governance arrangements	The UHC2030 platform is co-hosted by the WHO and the World Bank and the OECD. The governance structure consists of: A constituency based UHC2030 Steering Committee, meeting twice a year as a hybrid/in person meeting in Geneva; the UHC Movement Political Advisory Panel, providing guidance to the UHC2030 Steering Committee to strengthen political support for UHC; and the UHC2030 Secretariat which follows up on	The UHC-P is governed by the Joint Working Team (JWT) at WHO HQ, comprising of representatives of all divisions and departments. Annually a high level steering committee within WHO reviews implementation and EU and WHO senior officials meet to review progress. Twice a year the Multi-Donor-Coordination Committee (MDCC) including WHO HQ and Regional Offices and all donors meet. Three times a year, “live monitoring” sessions are held, rotating among six WHO	The SDG3 GAP Secretariat is in WHO HQ. The 13 signatories met initially twice a year until the Covid19 pandemic. Since then, partner agencies meet infrequently and at technical not higher level.

[4] https://iris.who.int/bitstream/handle/10665/376857/9789240094949-eng.pdf?sequence=1

	UHC2030	UHC Partnership	SDG3 GAP
	the conclusions and recommendations of the SC, through its annual workplan.	regional offices, presenting country based examples of the implementation of the programme.	
Past and future potential			
Forward look	In 2016, the 5th and last IHP+ Performance Report was published, tracking progress on the implementation of effective development cooperation (EDC). The transition from IHP+ to UHC2030 had the consequence that no new monitoring report was published. After the UNGA 2019 High Level Meeting (HLM) and the follow up HLM in 2023, a UHC2030 Task Force developed a new strategic framework, aiming at defining clear results and indicators for the future work of UHC2030. Country representatives committed to the three pathways (advocacy, accountability and alignment) identified in the 2024 Strategic Framework with Secretariat monitoring.	The continued presence of the UHC-P in 125 countries has the potential to support a future coordination body for the LA in terms of strengthening its policy dialogue capacity. WHO through the UHC-P could support any global, regional or country based structure in its effort to encourage the GHIs and countries to improve their coordination, alignment and cooperation. The UHC-P would be well positioned to support through its health policy advisors at country level the process of achieving the five key shifts for the long-term evolution of the GHI ecosystem.	The analysis of SDG progress and impact is mixed. The 2024 progress report states: "…While the SDG3 GAP seems to be adding value in certain areas, contexts and countries, incentives and funding for stronger collaboration among agencies remain weak. In some contexts, there may be other platforms that are better positioned to facilitate better collaboration in specific fields, especially in the context of Emergencies…". An evaluation has been done to be published in September 2024 with reform to the initiative anticipated.
Skills and Competence:	UHC2030 is a global platform to promote UHC with expertise from all constituencies, including co-hosting organizations, the WHO, World Band and the OECD.	Expertise deployed to countries through the WHO Country Offices.	Theoretically, the 13 signatories present a combination of all the skills and competence needed to strengthen PHC/ UHC.
Geographical reach	Through its constituencies and as part of the WHO, UHC2030 is a global platform.	125 countries in all WHO regions, with an emphasis on low and middle income countries. Almost half of all partner countries are in Africa.	The approach has been introduced in 69 countries but intensity of cooperation among the 13 co-signatories is unknown.
Summary	Part of the 2024-2027 Strategic Framework is the strengthening of advocacy for UHC, which the UHC2030	Unpredictable, variable and country specific progress that relies on the individuals deployed. Looking at the	Very modest gains noted. Advocacy plays a minor role in the SDG3 GAP where accelerators sometimes gain

	UHC2030	UHC Partnership	SDG3 GAP
	Secretariat will facilitate and promote in all relevant regional and global events and also facilitate the exchange between the UHC2030 constituencies. However, in terms of executive power, UHC2030 has no mandate.	experience during the past 12 years, coordination and advocacy has not always worked out effectively as it depends on the wider staff and leadership in respective WHO Country offices, government engagement, and context in addition to the skills of the individual expert in place.	some momentum (PHC-A, Sustainable Funding for Health-A, and the gender equality working group). Although some coordination was apparently achieved in some countries, generally an unsuccessful partnership.
Coordination and advocacy			
Convening power	Convenes its members. Focused on groups that have specifically become members of UHC2030.	None specifically.	None beyond convening its own 13 signatories and even here, it has diminished in recent years.
Membership/ Partnerships	UHC2030 has a wide range of members and partners as indicated above and in this link	Nominally, 125 potential partner countries which are those where WHO has an office and has deployed a UHC-P expert. Donors: Belgium, Canada, France, Germany, Ireland, Japan, Luxembourg, UK	13 signatories working in up to 69 countries as presented in the 2024 progress report. It is evident that 69 country governments are not necessarily fully engaged.
Reputation and trust	Global reputation and sphere of operations. UHC2030 has the reputation to facilitate the promotion of UHC at a global level rather than in countries.	The UHC-P reputation and trust depends strongly on individuals and varies country by country. It is a demand driven programme to some extent. Reliable guidance can be accessed through the website.	The added value of the SDG3 GAP has become less clear to the extent that its signatories no longer meet regularly. Not widely known.
Track record on equity and inclusion	Beyond language around this, no objectively verifiable tracking material on equity and inclusion at impact level. However, the platform is inclusive in itself (most organisations can join).	Beyond language around equity and links to the WHO GPW which references equity and inclusion, no objectively verifiable tracking material on specific engagement in or impact on equity and inclusion.	Beyond language around this, no objectively verifiable tracking material on equity and inclusion.
Summary	UHC2030 is well placed to convene a wide range of partners for the discussion of complex topics. It is assessed that it could convene partners for aid effectiveness dialogue and reform but would need to be supported to do so with additional resources.	The UHC-P advocates through its programme staff and through publishing quality guidance on its platform website. It is not equipped or oriented around coordinating a range of partners for a difficult purpose. It could not easily expand	The role of the SDG3 GAP is to foster better cooperation among signatories expressed through better, more efficient delivery in individual countries harmonised around one plan, one budget and one M&E plan. The SDG3

	UHC2030	UHC Partnership	SDG3 GAP
		its current programme systems to start coordinating a disparate group.	GAP does not measure this in objectively verifiable terms.
Accountability			
Technical capability	The technical capability of the Secretariat itself is limited in terms of financial and human resources and UHC2030's added value is to provide common, evidence-based tools by tracking and regularly communicating on implementation of UHC commitments.	Within its agreed remit, the UHC-P has technical capability through its network of health policy advisors. At an institutional level, the UHC-P collates knowledge from across its donor organisations and provides guidance to countries.	Potentially significant technical capability but a limited secretariat and country specific focus means this capability is not systematically harnessed or institutionalised.
Research and publications	None although individuals and member organisations conduct/ publish research.	Extensive. The Partnership produces regular publications, which can be found here and includes tools/ guidance to countries.	Reports have been published but no research.
Systems in place	UHC2030's tracking tools (and publications) include the State of UHC commitment review, The Data Portal, Country Profile Dashboards, as well as a range of technical, evidence-based products, such as the UHC Global Monitoring Report.	Manages a technical hub on its website where knowledge and guidance and technical tools for wider use are collated.	There are few or no discernible systems in place beyond the seven accelerator processes.
Mandate	Mandate conferred by funding partners and member organisations who have agreed to advance the UHC2030 programme.	Mandate from funders and host organisations; mandate implied by countries that host a UHC-P technical expert.	Mandate 'self-conferred' by 13 organisations who have voluntarily agreed to cooperate in specific countries.
Summary	As a platform, the UHC2030 is not in a position to hold members to account for their behaviour. It has no mandate and no capacity. Its members have joined the UHC2030 to work on UHC not to be held to account for their own behaviour and actions. UHC2030 would require a mandate, resources and additional capacity and it would likely have spin-off	Through the UHC-P, the three host partners deliver their mandate to strengthen health systems in support of UHC with a specific focus on PHC. UHC-P is rich in knowledge and acts as a resource for countries. UHC-P's actual contribution to country systems is highly dependent on the individual in post and the context in country.	The capability of the SDG3 GAP to strengthen accountability of its signatories and partner countries is weak and delivered mainly through voluntary commitment. Most actions rely on individual behaviour at country level rather than high level institutional reforms. Limited results have been achieved (inevitably therefore) and

	UHC2030	UHC Partnership	SDG3 GAP
	implications for their current work and objectives.		where there has been progress, this is process focused and local in nature.
Experience and knowledge			
Expertise on HSS/ UHC/ integrated PHC	Through its constituencies and as part of WHO HQ has access to a high level of expertise in HSS for UHC through an integrated PHC approach. Knowledge is dissipated across organisations and occasionally compiled in supportive guidance notes.	Strengthening HSS to achieve UHC with an integrated approach to PHC is the main objective of the UHC-P. Expertise is held by individuals deployed to countries. https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_16-en.pdf	The SDG3 GAP accelerators focus on different components of health systems, above all primary health care, and health financing. Knowledge of issues is potentially significant but organisational capacity to apply knowledge is evidently limited.
Accomplishments in HSS	The main accomplishments by UHC2030 are the increased use of stakeholders of the platform as a promotional exchange and update of global initiatives for HSS for UHC. Many members and a wide network. Lack of objective criteria to measure impact.	The Programme has contributed documenting knowledge and supporting the development of technical tools for HSS and for the advancement of UHC/ PHC. Lack of objective criteria to measure impact.	It is difficult to assess what the platform itself has accomplished as achievements are not systematised or necessarily a result of cooperation and alignment by the signatories. Lack of objective criteria to measure impact.
Global presence	UHC2030 is a global level partnership.	The UHC-P is a global partnership with a presence at regional and country levels.	As SDG3 GAP is global and has been introduced in 69 countries.
Regional links	UHC2030 occasionally provides support to WHO regional offices, e.g. EMRO in 2022 facilitating the respective country compacts	Regional links are provided by the WHO Regional offices and funded positions in six regional offices	No specific regional presence.
Country engagement	UHC2030 indirectly links to countries but only through constituency activities	Strong country presence through 150 individuals deployed to 125 countries.	Intended to operate at country level.
Summary overall assessment			
Assessment 1 **Alignment with LA**	UHC2030 is aligned with the LA as shown in its new Strategic Framework 2024-2027.	UHC-P is mentioned in the GPW14 in turn aligned with the LA	The SDG3 GAP is aligned with the five expected shifts of the Lusaka Agenda.
Assessment 2 **Strengths and opportunities**	The strength of UHC2030 is its extensive platform and links through constituencies to a wide network of countries and	Through the UHC-P, there is potential to provide technical guidance around the five shifts, promote knowledge building,	The initial purpose of the SDG3 GAP provided an opportunity for stronger coherence, coordination, and alignment

	UHC2030	UHC Partnership	SDG3 GAP
	regions and partners. The opportunity is to reach the network with information, engagement and motivation to pursue the five shifts.	increase monitoring and collate achievements or progress in 125 countries.	among signatories. In the context of the LA, it is unclear whether and how the SDG GAP should pivot.
Assessment 3 **Weaknesses and limitations**	Limited human and financial resources. Not a weakness but the UHC2030 is a partnership platform so is focused on creating a forum for its partners. Its mandate and capacity are thus limited.	The decisive weakness of the UHC-P is also its strength: the distribution of technical knowledge to countries with resultant variability, limited structure and lack of systematised knowledge.	The main weakness is the voluntary and country focused nature of the initiative which means it depends on individuals and is largely about tinkering in countries rather than root and branch reform.
Assessment 4 **Overall judgement**	UHC2030 is a valuable platform for countries and partners to access through their constituency groups to exchange best practices and promote HSS to achieve UHC/ PHS. In its current structure, with its current mandate and capacity, it is not a platform that could steer the process of achieving the five shifts. But it is in a good position to support and reinforce - at global level - advocacy and alignment of its members to the five shifts. It does not have a direct influence/impact at country level nor a mandate from countries but does have a LMIC constituency which appears to be engaged more than in the past.	The UHC-P could play a useful role in supporting the five shifts at country, regional and global level as it is active at country, regional and global levels perhaps supporting the socialisation of the five shifts. However, the UHC-P within its current scope of work, i.e., promoting policy dialogue and supporting countries with technical backstopping and guidance, would not necessarily be well oriented around supporting the political economy of institutional change among partners.	The SDG3 GAP should theoretically be a strong candidate to support the global coordination around the advancement of the five shifts given its purpose. It is possible that in its reformulated structure (potentially sometime in the future) it might play a constructive role. However, the SDG3 GAP has gained little traction with its signatories, has over-'technicalised' its mission and under-invested in political economy analysis. It has achieved few concrete results at global or institutional level (by its own admission). With its current resource structure, its track record and its orientation, the SDG3 Gap is unlikely to have the credibility to tackle global aid effectiveness.

ANNEX B: KEY INFORMANTS AND METHODS

Table 7. Key informants

Constituency	Number/ proportion of key informants
Global health organizations and multilateral partners	5
Donors and funders	4
Governments of low and middle income countries & regional intergovernmental partners	4
Civil society and communities partners	4
Research and learning community partners	1

B3: Methods

An informal 'Future Arrangements' sub-group has continued to work informally beyond the sunsetting of the Lusaka Agenda Working Group and Secretariat at the end of June 2024 to develop initial thinking about the way forward. It is expected that proposals emerging from this work may be further discussed further at upcoming meetings in September and October. This rapid mapping (commissioned by Norad) is intended to contribute to this process.

Figure 4. Summary of methods to be used

Where possible, data, evidence and analysis were recycled. This aimed to ensure a wider set of voices were included.

Primary data

Primary data was collected through **key informant discussions** were conducted. Key informants were categorised by constituency: global health agencies and partners, intergovernmental organisations, governments (recipients and donors), civil society groups. A draft set of questions to guide the interviews was developed and included in the inception report.

Secondary data

The mapping will rely on a range of secondary data including the following types of material:

- **Recent consultations and survey data** from the last 18 months specifically the most recent data that includes responses relevant to the next phase of the post-Lusaka Agenda process
- **Published material** related to the Future of GHIs process specifically the post-Lusaka Agenda period as well as material that relates to issues and concerns adjacent to the post Lusaka Agenda process but not necessarily speaking directly to it.

- **Meeting reports, summaries and minutes** reflecting discussion points and decisions and documents linked to specific organisations and partnerships scrutinised in this study
- **Recently completed health systems strengthening analysis** commissioned by Norad

Data analysis

Data was triangulated where possible and relevant to identify key thematic areas emerging in relation to the main objectives and questions. The findings were structured to develop observations and draw conclusions. Specifically, the analysis and conclusions were structured to address the objectives, identify pros and cons of different partnership platforms, and then sift out alternative options in relation to addressing accountability. Data analysis led to the identification of conclusions, facilitating the formulation of practical, options and where possible, applicable recommendations.

Phases of the study

The review was conducted in four distinct phases including inception, data collection and analysis, report writing with conclusions and recommendations, and validation and finalisation. Mapping work was discussed at the pre-final draft stage by the informal post-Lusaka Agenda working group. The consultants planned to present the draft report with an accompanying slide deck.

Figure 5. Phases of the assignment delivery

Assumptions and risks

The main assumptions and risks in terms of undertaking the study relate to reaching enough of the right people (those who are connected, engaged, interested, relevant) in the timeframe available (especially given that the work is undertaken during the northern hemisphere summer holiday period) and accessing the most pertinent documents. Our assumptions include that we will collect sufficient data to make the exercise worthwhile, that partners will respond to interview requests and that we will cover the most critical of the options. Key informants will be assured of confidentiality.

ANNEX C: TERMS OF REFERENCE

RAPID MAPPING OF EXISTING MECHANISMS AND INITIATIVES THAT COULD PLAY AN ACTIVE ROLE IN SUPPORT OF LUSAKA AGENDA FOLLOW-UP

5.2.1 BACKGROUND

The Lusaka Agenda launched on UHC Day in December 2024 captures consensus and provides a foundation for coordinated action around five key shifts for the long-term evolution of Global Health Initiatives (GHIs) and the wider global health ecosystem:

1. Make a stronger contribution to primary health care (PHC) by effectively strengthening systems for health
2. Play a catalytic role towards sustainable, domestically financed health services and public health functions
3. Strengthen joint approaches for achieving equity in health outcomes
4. Achieve strategic and operational coherence
5. Coordinate approaches to products, research and development, and regional manufacturing to address market and policy failures in global health.

The realisation of the shifts requires united and collective effort across stakeholder groups. Partner coordination and alignment is key to support country leadership, priorities and systems, underpinned by mutual accountability.

As the Lusaka Agenda Working Group (LAWG) and its Secretariat sunsets at the end of June 2024, many strands of work related to the implementation of the Lusaka Agenda are already being taken forward by specific partners or groups, and in Africa there are ongoing efforts to identify the regional arrangements needed to take this work forward at the continental level.

To complement these efforts, the LAWG has welcomed a set of preliminary objectives identified by a sub-group looking into possible future arrangements as a useful foundation for ongoing collaboration at a **global** level:

- Ensure umbrella coordination of partner-led streams of activity related to Lusaka Agenda implementation.
- Coordinate global advocacy and accountability activities around the implementation of the Lusaka Agenda
- Facilitate strategic dialogue and collaboration to explore wider implications of the Lusaka Agenda conclusions for health financing and development assistance
- for health.

An informal 'Future Arrangements Sub-Group" will continue to work informally beyond the sunsetting of the LAWG and Secretariat at the end of June, to develop initial thinking and a refined proposal to be discussed further at upcoming meetings in September and October.

As a contribution to this process, Norway (Ministry of Foreign Affairs and Norad) has volunteered to undertake a rapid mapping of existing partnership platforms that could play an active role in support of some aspects of the Lusaka Agenda follow-up. The mapping will also be used by Norad for internal purposes related to the further development of its Health Systems Strengthening (HSS) portfolio.

5.2.2 SCOPE

Large parts of the Lusaka Agenda link to existing work in different organizations and collaborative arrangements. These may have different strengths and weaknesses, including around technical capacity, political aspects and accountability. In taking this forward, it makes sense to use and strengthen some of the existing mechanisms/initiatives wherever possible, rather than creating new arrangements. Any additional innovation should be focused on added-value actions at a global level for improved alignment and better coordinated partner support at country-level for key areas of the Lusaka Agenda.

While focusing on objective 1 of "ensuring umbrella coordination of partner-led streams of activity related to Lusaka Agenda implementation", the mapping will also include existing accountability and advocacy efforts in these mechanisms/initiatives related to the Lusaka Agenda. Throughout the FGHI and the Lusaka Agenda processes, these have been highlighted as key for the Lusaka Agenda to deliver on. Earlier initiatives on aid and development effectiveness have not always been taken forward into practice, and lessons learned from these efforts should also inform the mapping exercise's analysis of these opportunities to promote accountability.

The rapid mapping will take a light-touch/focused approach and include the following existing partner collaboration platforms:

- The SDG3 GAP perhaps focusing on its most relevant "accelerators" (e.g. the Sustainable Health Financing Accelerator (SFHA) and the PHC Accelerator)
- UHC 2030
- The Universal Health Coverage (UHC) Partnership at WHO
- Other initiatives (tbd)

Although the focus is on the global level, the mapping should be cognisant of existing/emerging arrangements to support the Lusaka Agenda at regional level, primarily in the African region, to understand complementarity and potential synergies.

5.2.3 APPROACH AND METHODS

In view of the limited time frame and scope, data will be collected through desk review complemented with a limited number of key informant interviews. The level of detail will necessarily need to be commensurate with the level of effort but will aim at background information and findings being accurate and reliable, and backed by data sources and proper analysis. Due attention to political economy dimensions should be included when relevant.

Annex 1 provides an overview of key questions that will guide the mapping assignment.

5.2.4 DELIVERABLES

- A report not exceeding 10 pages, with annexes, up to max 20 pages in total. Reader-friendly language, visuals and an executive summary are important. The report will provide a set of recommendations – based on different perspectives – for the sub-group to further discuss.
- Powerpoint presentations (via Microsoft Teams/Zoom) to the "Future arrangements sub-group" of the Lusaka Agenda reference group will occur in late August/early September 2024 (date TBC)

The mapping is not likely to gain "one answer" but should help inform future arrangements for Lusaka Agenda follow-up and move forward in a meaningful way.

5.2.5 MANAGEMENT AND OVERSIGHT

Norad has commissioned this assignment from hera, an independent cooperative company of health and social development sector experts committed to evidence-based support for the right to health and development. Norad will oversee all administrative and liaison aspects related to the review.

The “Future arrangements sub-group” of the Lusaka agenda WG, led by Wellcome Trust and comprising of representatives from donor and implementing governments, global health organizations, civil society and other partners, (with others welcome to join the sub-group) will serve as a reference group for the rapid analysis. This will involve providing input into the TORs and to discuss and provide comments to the first draft of the report in late August/early September (Date TBC), in advance of the proposed Lusaka Agenda side meeting on the margins of UNGA in September 2024.

This will be an independent piece of work intended to provide a useful input to discussion among supporters of the Lusaka Agenda. Sub-group members will be invited to act as an informal reference group for the work, but outputs will represent the views of the authors only and will not be expected to be endorsed by sub-group members.

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